Medical Assistant in General Practice: An Evaluation

Commissioned by

Health Education England (North-West)

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Executive Summary

- This report presents the findings of a small-scale qualitative evaluation produced by Health and Social Care Evaluations (HASCE) at the University of Cumbria, and commissioned by Health Education England (North-West). The evaluation assessed the introduction of the role of Medical Assistant (MA) in a single General Practice, in order to identify the areas of success, areas of challenge, and areas for improvement and future opportunity (particularly in terms of wider delivery of the role).

- This evaluation is of an existing Medical Assistant role in a single Practice. The Practice, situated in the North West, has independently developed a Medical Assistant role, training an existing receptionist to deliver a range of tasks in support of the General Practitioner (GP). Based on a role initially developed in the United States, the MA role has been proposed as one potential way of alleviating workload stress on GPs and improving the delivery of patient care in General Practice.

- The evaluation conducted seven semi-structured interviews with key stakeholders in the implementation of the Medical Assistant role at the General Practice, using an interview schedule informed by Role Theory. This explored the formation of the MA's 'identity', the successes of the role, the conflicts the role had encountered, how expectations of the role had been managed, how it had affected the use of resources, and the significant contexts underlying its implementation.

- In terms of the Quadruple Aims, the evaluation found that the MA role had delivered a number of reported improvements: improving patient flow within surgery hours, increasing the time efficiency of appointments, and reduction of waiting times; supporting patient experience by 'translating' or reiterating information from the GP which may be hard to understand; and, due to a well-prepared and mentored implementation of the role, an improvement in staff experience of care.

- One of the most important factors in the success of the MA role was the clarity with which it was articulated to staff and patients (both verbally and in the MA's practice), as supporting a specific set of needs within the Practice. The report recommends that other

Practices seeking to implement an MA similarly articulate the purpose of, and need for, the role in terms of the specific relationships it would be supporting.

- The context of the Practice – the small size of the practice, the visible need for the role, and the embeddedness of the MA herself – alongside mechanisms such as strong verbal communication and visual signifiers (i.e. distinct uniform) were all key to preventing confusion over potentially overlapping roles occurring.

- Because the role encompasses clinical and social aspects of patient care including health promotion and prevention advice, any wider delivery of the role will require considerable flexibility in order for prospective MAs to fit the varied contexts they will be working in. This includes developing skills specific to patient demographics, as well as attending to the variation in the needs of GPs being supported by the role, and the physical spaces available for the MA to work alongside GPs.

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1 Introduction

1.1 Evaluation Context

This report presents the findings of a small-scale qualitative evaluation of the introduction of the role of Medical Assistant (MA) in a single General Practice, in order to identify the areas of success, areas of challenge, and areas for improvement and future opportunity (particularly in terms of wider delivery of the role). The evaluation was produced by Health and Social Care Evaluations (HASCE) at the University of Cumbria, and commissioned by Health Education England (North-West).

The Future of Primary Care report[1] identifies that, currently, General Practitioners (GPs) spend on average 11% of their time on administration, emails and tasks which do not necessarily require a doctor or nurse to complete. The report argues that:

> This is a major cause of workload stress and a significant issue cited by GPs leaving the profession early. […] If administrative staff (such as medical assistants) took on half of this work, this would be equivalent to 1,400 more full-time GPs in England.[2]

As such:

> There is […] a case for training support staff, including healthcare assistants and existing administrative staff, to assist healthcare professionals in the administrative aspects of their work.[3]

Based on a role initially developed in the United States, the MA role has been proposed as one potential way of alleviating workload stress on GPs and improving the delivery of patient care in General Practice. In examples from the United States, the Medical Assistant performed a 'hybrid' role between clinical and non-clinical duties, supporting GPs in their day-to-day management of patients, including responding to emails, reviewing test results, arranging follow-up

[1] *The Future of Primary Care.* Primary Care Commission, 2015. Available at: https://www.hee.nhs.uk/sites/default/files/documents/WES_The-future-of-primary-care.pdf
[2] *The Future of Primary Care*, p.47
[3] *The Future of Primary Care*, p.22

appointments and effectively filtering the administrative burden for GPs, passing on only those things that required 'direct attention'.[4]

In the North West of England, GP surgeries report a higher percentage than the national average of Admin and Clerical staff.[5] As a result, there is considerable potential for the implementation of Medical Assistant roles in the region; supporting both the recommendation of the *General Practice Forward View* report that:

> The success of general practice in the future will also rely on the expansion of the wider non-medical workforce – including investment in nurses, pharmacists, practice managers, administrative staff and the introduction of new roles such as physician associates and medical assistants.[6]

As well as the Primary Care Commission's recommendation that 'New approaches to the best use of administrative support roles need active piloting and evaluation.'[7]

1.2 Evaluation Methodology

This evaluation is of an existing Medical Assistant role in a single Practice. The Practice, situated in the North West, has independently developed a Medical Assistant role, training an existing receptionist to deliver a range of tasks in support of the GP. The implementation of new roles requires careful analysis of contextual factors and adjustments in role perception. As such, the evaluation is based on qualitative data collected from semi-structured interviews.

The evaluation conducted seven semi-structured interviews with key stakeholders in the implementation of the Medical Assistant role at the General Practice. Interviews were conducted either via telephone or in person, depending on availability. The participants were sampled purposively in order to gather a cross-section of staff across the practice, all of whom had experience of the new role in practice. The participants involved were:

- The Medical Assistant

[4] *The Future of Primary Care*, p.22

[5] General Practice Workforce Survey 2016 North West England Overview summary report. Available at: https://hee.nhs.uk/sites/default/files/documents/North%20West%20General%20Practice%20Workforce%202016.pdf

[6] *General Practice Forward View*. NHS England, 2016. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf, p.22

[7] *The Future of Primary Care*, p.47

- General Practitioner supported by the MA
- General Practitioner
- Practice Pharmacist
- Practice Nurse
- Administrative Staff
- Practice Manager

In order to ensure this work is grounded in a strong theory-base, the structure of the interviews was informed by Role Theory. This enabled the evaluation to build on the work of previous evaluations, which have demonstrated success using this theory to analyse new roles in healthcare; in particular those which challenge conventional boundaries and identities between clinician and non-clinician, and the public perception of the 'point of delivery' at which healthcare begins.[8]

Beginning from the idea that role behaviours are associated with social positions, are contextually bound, and have specific expectations within an organisation, Role Theory allows an evaluation to focus on how people adapt to new positions – both their own and others around them – in terms of organisational status, interpersonal relations and social expectations.

For Role Theory, certain positions within an organisation dictate specific roles to be performed or require certain patterns of behaviour.[9] Roles are associated with sets of people who share a common identity (for example, nurses, administrative and clerical staff, doctors and so on). Such roles persist, in part, because of their functions within larger social systems. As such, understanding how these roles can be successfully adjusted or changed – such as introducing the concept of a Medical Assistant into the flow of General Practice – requires in the first instance a

[8] See, for example, Desborough, Jane; Forrest, Laura; Parker, Rhian. "Nurse satisfaction with working in a nurse led primary care walk-in centre: an Australian experience." *Australian Journal of Advanced Nursing*; 31.1 (Sep-Nov 2013): 11-19; Brookes, Kim; Davidson, Patricia M.; Daly, John; Halcomb, Elizabeth J. "Role theory: A framework to investigate the community nurse role in contemporary health care systems." *Contemporary Nurse: a Journal for the Australian Nursing Profession*; 25.1/2 (May/Jun 2007): 146-55; Murray, Teri A. "Using role theory concepts to understand transitions from hospital-based nursing practice to home care nursing." *The Journal of Continuing Education in Nursing*. 29.3 (May/Jun 1998): 105-111. Blakely, Thomas J.; Dziadosz, Gregory M. "Social Role Theory and Social Role Valorization for Care Management Practice." *Care Management Journals*; 16.4 (2015): 184-187.

[9] See Biddle, B.J. (1979). *Role theory: Expectations, identities, and behaviours*. New York: Academic Press.

highly contextualised account of how the new role affects the interpersonal relations in a given workplace.

Based on this theoretical perspective, the interviews covered the following areas:[10]

- Individual's perception of the successes, obstacles and areas for improvement;
- Perception of patient responses to the new role;[11]
- The key value (economic, social and cultural) that the new role has brought;
- How the new role has affected what Role Theory terms the 'normative expectations' from both patients and staff on the Medical Assistant; in other words, how the relationships between the Medical Assistant role and existing roles within the General Practice affect the understanding of, and delivery by, the new role.

The interview data was then analysed in order to provide an account of the key 'ingredients' for the role's success. The analysis was then organised in order to identify the contextual factors, organisational and behavioural factors affecting expectations around and successes of the role.

[10] See Appendix 1 for the interview schedule.

[11] No quantitative data was available at this stage to document patient feedback specifically on the role itself, and the scale of the evaluation project prevented a larger survey of patient views being conducted.

2 Findings

2.1 Introduction

The following sections present a summary of the main themes collected from the interview data. In keeping with the evaluation approach, these are organised into six headings which, informed by Role Theory, help to delineate the key relationships at work in the implementation of a new role.

2.2 Identity

The General Practice where the MA role is situated has c. 3000 patients, mainly around or over retirement age. It is a small practice based in a house on a residential street. One GP – referred to here as 'Dr Robson'[12] – has a high proportion of patients, many of whom are elderly and have comorbidities. Due to patients valuing the long-term consistency of care, they may put off visiting the practice if Dr Robson is not available. This can result in a long list of patient consultations. Dr Robson proposed the MA role in order to address these issues, using existing models from the United States, and a similar pilot project in Sheffield, as the template. Following a 3-month trial, the role was continued.

In this sense, while the role draws upon existing models, participants generally described as very much shaped around the specific requirements, and relationships, of the particular GP.

> From my point of view, the role that has been developed [here] was very much enabling Dr Robson specifically to have more time seeing the patients, rather than being bogged down with the administrative processes, some note-taking and also basic examinations. Freeing him up by having the Medical Assistant do that role, that has meant that he can really concentrate on seeing the patients and dealing with the co-morbidities and the complex patients that he tends to get. (Participant 2)

> Basically it's assisting the Doctor before he sees the patient. The patient would come in, the Doctor would look at the reason for the appointment first of all, we always give a reason. Then if it's something that the Medical Assistant can help

[12] Participants have been given pseudonyms for the purposes of this research.

> him with before the patient goes in, such as taking blood pressure or any bloods that need taking, then they obviously do that, which saves the Doctor quite a bit of time really. Also, logging information and referral letters as well. (Participant 1)

The MA, 'Helen', has worked at the practice as a receptionist for some time, and her MA role has developed more recently. She is also trainee practice manager. The fact that the role has emerged out of a specific set of circumstances related to one GP means that Helen has benefitted from role-specific mentoring and coaching, which Dr Robson has provided on a patient-by-patient basis. This helps her comprehend why treatment decisions are made, gives her insight on the ongoing care of patients and provides a learning and development opportunity as she benefits from contextual information that adds to her clinical knowledge-base.

It is apparent that the gradual accrual of knowledge minimised anxiety or ambiguity as Helen took on the role[13] and she is keen to keep learning and taking on more responsibilities. Dr Robson argues that the role must, in this way, be develop from the particular needs of individual GPs, rather than being overly prescriptive. In this sense, the identity of the MA has been formed iteratively:

> I think it has become more clearly formed. I think the girls on reception now are used to things that they can go to Helen with, because they know she can deal with it […]. I think it probably has become clearer as we've gone along. I'm sure in the beginning even Dr Robson perhaps wasn't completely clear as to how it was going to work, so I definitely think it has evolved as we've gone along. (Participant 3)

While other staff noted an evolution of the role, in particular in comparison to other roles which potentially overlapped in purpose, Helen herself reported seeing the identity of the role as clear from the beginning:

> It was very clear as to what was going to happen and what it was going to involve, as well. Initially it started off as more of an admin role, but being in the consultation as well. As I became more confident in being with the patient on my own, I was then able to be left to get a background, and for Dr Robson to do the

[13] Rizzo, J., House, R. and Lirtzman, S. "Role Conflict and Ambiguity in Complex Organizations." *Administrative Science Quarterly*. Vol. 15, No. 2 (Jun., 1970): 150-163

> full consultation. Then where needed after my training, I was able to do the clinical bits as well. (Participant 5)

A shared understanding of the reasoning for the role thus developed confidence in her new identity and the role specific responsibilities Dr Robson has assigned to her. As with previous iterations of the MA model,[14] Helen helps with 'rooming' the patients: that is, settling them into a room, helping them take off coats and then conducting preliminary checks including taking blood pressure, updating their health records, weight and height. She also sits in on consultations and can action administration requests, update patient records and help with referrals. Helen runs her own bloods clinic and can administer flu jabs and this assists a fast turnaround of patient care, as they can often get bloods done during their visit.

> She does a lot of the admin support for the GP, but she can also do some of the clinical support as well, like taking blood pressure and taking any blood tests that need to be done. It's a bit of a unique role really, because the Healthcare Assistant is more supporting the Nursing team, whereas Helen is really supporting the GP. (Participant 4)

> It isn't just a case of somebody being there and just sort of taking notes for [Dr Robson] or doing his paperwork, you are actually involved in helping the patient and doing the medical side of things that you're trained to do. (Participant 1)

While the identity of the MA has developed in this way, some formal indicators are used to signify the distinctiveness of the role: for example, Helen wears a blue tunic when acting as MA to distinguish her from Administrators, Nurses or Healthcare Assistants.

2.3 Successes

Participants reported a number of successes for the new role. Improvements in patient care were linked to a reduction in clinical appointments:

> I think there have been improvements in patient care, because you're able to just do more than one thing. You're not taking up more clinical appointments. You're saving a flu appointment, you're saving a blood appointment, because you're able

[14] Sinsky, C., Willard-Grace, R., Schutzbank, A., Sinsky, T., Margolius, D. and Bodenheimer, T. "In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices." *Annals of Family Medicine*. Vol. 11, no. 3 (May/June 2013): 272-278

> to do them there and then. […] I can carry on an appointment by booking appointments and things like that, whilst he goes into his room and starts on his next appointment. (Participant 5)

There was a general sense that the MA supported the Practice to run smoothly, particularly if Dr Robson is running late, by being able to prepare patients and brief Dr Robson on the specifics of the patient's reasons for attending.

> [The main successes are] timely production of referral letters, filling out forms. The GP quite often doesn't have time to do it in the middle of surgery, so things can get delayed, so having Helen to fill out all the paperwork has streamlined that side of Practice. Also, I think it's actually speeded up the consultations themselves, because she can help the patients to come in and undress, get on the bed, which has helped a lot. (Participant 6)

Dr Robson suggested that the MA role helps reduce GP errors and omissions; generally, he does not overrun to the same extent with Helen assisting him and believes this adds 30% efficiency to his role (although it is not currently clear how this was quantified). There was a perception that the role drives efficiencies in patient care, reduces time-consuming and distracting tasks and as a consequence helps to avoid 'GP burnout' (Participant 8).

Another theme around success was how the MA role was perceived to help reduce patient anxiety, specifically by offering patients a 'friendly face' and decreasing extended periods of waiting. as Helen is present and keeping a flow of patient support and interaction.

> Patients often waited a while to see this particular doctor, for various reasons; because he is very, very thorough. Normally they might have been waiting say half an hour, to see him. Now, Helen brings them into another room and does all the preliminary things that the Doctor would normally do. (Participant 4)

Alongside this, positive effects on Dr Robson himself were noted as justifying the risks of implementing the role:

> [S]eeing how he was so much happier in his role, which means that he's going to be a better Doctor when he is at work, I think that's important and I think the surgery have got their heads around that now. (Participant 2)

It addresses patient care and engenders an effective way for the practice to operate. The staff interviewed have commented that patients are reporting satisfaction with the role, and staff and patients can see and understand the benefits her role brings to the practice.

> INTERVIEWER: Do you think there's been an improvement in patient care then? Has that been measured?
>
> INTERVIEWEE: I'm not sure how they're measuring that objectively, but definitely patient's feedback has been phenomenal. (Participant 4)

The role has valuable social aspect alongside its clinical support. Helen can break-down, translate and reiterate information the GP has shared with them and which may be hard to comprehend.

> She's learning things herself as well by sitting in with Doctor Robson, and just listening to how he is with the patients, and the medical terminology of things is obviously improving for her as well, so I think that's a good thing. (Participant 1)

This social aspect of the role was also present when participants attributed its success to Helen's pre-existing embeddedness within the Practice:

> We've found the patients are quite happy with it. They've got to know Helen, anyway. They're quite comfortable with her. They knew her beforehand anyway, which is quite helpful [...]. They see that they are getting that little bit of extra care in a way, because they're being seen by two people rather than one, so they do appreciate that they're actually getting quite good care. (Participant 1)

One of the emerging successes identified was the potential for the role was to create an alternative path for career development. This was provided as one reason administrative staff were enthused about the new role.

> It gives current staff an opportunity to progress as well, which I like, because reception, sometimes you're a bit stuck in General Practice as to where you would go next, from an admin role. [...] There might be slightly different roles that you can take on, but then after that it's management, and not everyone wants to be a Manager. (Participant 2)

2.4 Conflicts

Initially, there was some very minor issues when Helen took on the additional role, as some staff may have been unsure of her new status and the purpose of the role. For example, one participant noted how important it was to distinguish the role visually from both Nurses and Healthcare Assistants:

> It's like a pale blue top. It's different to our Nurses and it's also different to the Healthcare Assistants as well, because we don't want to portray her as a Healthcare Assistant when she isn't. The patients know visually that they're dealing with somebody who is slightly different. (Participant 1)

However, once the contextual boundaries of the role were embedded through clinical practices and visual cues, participants reported that public perception of the new role was clear:

> Patients know that she's not a receptionist, but she's not a qualified Nurse as such. The patients know visually that her role is slightly different. (Participant 1)

The wider investment in new roles across Primary Care may also be seen as a cause of some confusion as to what an MA was, or was supposed to be:

> We signed up to become a Physician's Associate Training Practice after we'd started training Helen, so there was a bit of confusion about which was which and who does what. There is still confusion there, but the edge that Helen has, is that whilst she might not have had as many clinical training skills as they have, because they're getting clinical examination skills and those kinds of things, and they'll have been running clinics themselves […] Helen's role is very much to assist the GP and make them more efficient and speed things up. (Participant 2)

Hence, the MA is not a 'generalised' role, but one borne out of very specific working relations both between staff, and between staff and patients. The 'assistive' role of the MA is very much defined by a combination of the working practices of the GP, and the administrative background of the MA:

> What I've seen from Physician's Assistants, is that whilst they are really good, they don't necessarily have those administrative skills behind them. I think that gives you a bit of an edge really, if you are becoming an Assistant to a GP. (Participant 2)

Situating the role in terms of clear relational needs in this way helped to alleviate any potential conflicts in the early stages of the role:

> Initially, before we had the meeting, some of the girls on the reception were wondering why it was happening. Once it was explained to them -- the other Doctors have maybe been a bit envious. (Participant 4)

As the end of this quote suggests, a further conflict in the role formation arose from the financial impact of its implementation (see below, 2.6), and how this affected the distribution of resources around the Practice.

> I'll be honest, I was very anti it when he told me about it, because I was just like, "We can't afford this." In fairness, we had some risks in the surgery about it, because he's got that role and other Doctors don't, but then other Doctors didn't want it, but then from a pure business point of view it's a partnership, so obviously, it's not just him paying for that. (Participant 2)

However, participants noted that to date the other GPs in the Practice had not been concerned about a lack of their own MA:

> Initially I think it was frowned upon because of the financial side of things. I thought that maybe because it was centred more around Dr Robson and his requirements - did the other GPs want somebody as well? At the moment, no, they're quite happy doing things how they do it. (Participant 5)

> I suppose from my perspective the only obstacle has been the funding, in that it's not equitable across the other GPs and there was a little bit of, "Is this really fair? We're paying as a Practice for this service, but [for] Dr Robson -- and we're not paying for it for the other two Doctors." But then when asked, they didn't really want that service, and they could all appreciate that it made Dr Robson's working day better, so they were happy to go along with it. (Participant 3)

The distance between the GPs not currently supported by the MA also suggests a potential conflict in role implementation, which may take a more prominent effect in different Practices. As one participant noted:

> I think some of the Doctors maybe felt a bit threatened by having somebody work alongside them. (Participant 3)

However, while this particular MA role has arisen from the specific context of Dr Robson's work, several participants suggested that most GPs would benefit from the role (even if they were initially wary).

> So maybe even though you feel you don't need that support, actually probably for the good of the Primary Care team, you do need that support, because, should you be doing all that paperwork at the end of your session, when somebody else who is getting paid less than you per hour could do that for you, and free up your time to do more useful roles? (Participant 3)

2.5 Expectations

New roles, and the expectations they carry with them, involve transitions which require individuals to negotiate and integrate these changes into their sense of identity.[15] When Helen took on the new role, expectations regarding role performance and purpose were addressed primarily through Practice meetings between staff, and verbal explanations to patients at the start of consultations so that they understand and accept her presence. This was assisted by an inclusive approach to filling the role, which participants felt helped to avoid both potential conflicts and unrealistic expectations:

> The job role was offered once Doctor Robson had come up with this, it was offered out to all of us and for one reason or another, various reasons, people were unable or didn't really fancy the idea of it, I suppose. Helen really liked the idea of it, she'd already been doing a lot of referral letters and things for Doctor Robson, so she quite liked the idea of that really. We all sort of knew what the role would basically be, so once Helen started the role it was discussed at a staff meeting as well, that Helen would be doing this. (Participant 1)

This has helped to ensure that expectations are managed via clear lines of communication around the scope and need for the role in the Practice itself. Staff at the practice subsequently report a high level of satisfaction with the new role:

[15] Murray, Teri A. "Using role theory concepts to understand transitions from hospital-based nursing practice to home care nursing."

> I think it's probably gone over my expectations really, in a good way. Everything Helen does, and how she is assisting Doctor Robson. […] It's very good, it's been very good. (Participant 1)

Patient expectations have been favourably assisted as they have witnessed Dr Robson working with Helen (see below, 2.6) to facilitate her training during patient consultations. Dr Robson notes that patients are often more adaptable than may be presumed and his experience has been that they have readily accepted the MA role. Staff and patients at the practice generally understand that Helen's role is to support the GP, not replace him, and this manages patient expectations about role purpose and definition. However, whilst her role is to support the GP, her enhanced skill-set and insight on patient's needs adds to the Practice's capacity and flexibility.

In addition, the management of expectations around the role was perceived to have been supported by mentoring provided by Dr Robson. This appears to have minimised what Murray describes as 'role strain':[16] anxieties around role functions, and disruption to other staff.

> As long as there is somebody who is willing to take on the role, there's somebody who can mentor and train them and that they can be spared from their other roles in the practice. We were very lucky in that we had that capacity and not all surgeries will have. (Participant 6)

2.6 Resources

A new role will inevitably introduce a change in resource use for a Practice. In this case, there was a general theme in participants' responses that use of resources such as time, skills and finances have been improved: the MA role allows Dr Robson to focus on his skills as a clinician, rather than on routine procedures and administrative duties that are time-consuming.[17] The role enables improved patient management and gives the practice resilience due to Helen filling a significant gap in patient care and GP support needs.

> From what I've seen, she'll call one patient in and do the history, then that patient will either stay in that room, or they might move to his room whilst she calls in the

[16] Murray, Teri A. "Using role theory concepts to understand transitions from hospital-based nursing practice to home care nursing."

[17] Hutchinson, L., Marks, T. and Pittilo, M. "The physician assistant: would the US model meet the needs of the NHS?" BMJ Vol. 323 No. 24 (Nov 2001): 1244-1247

> next patient. They do it in a kind of concurrent way really. That speeds things up, but it also means that -- part of the issue with seeing the elderly is that it takes quite a while for them to even get into the room. If she's called them in and got all that bit done, if we need a blood pressure doing, they've got the coats and the jumpers and all of those layers off, which needs to happen. (Participant 2)

One of the key successes of the role, and its identification as a distinct role from both administrative and clinical roles, was the physical proximity of the MA activities to both the patients and GP.

> I think the main difference is that she's working alongside Dr Leonard, so they're holding the clinics together. It is one clinic. What happens is, she will bring the patient in, she'll record the history, take blood pressure and then she'll feed that back to Dr Leonard. […] They need two rooms to run this operation, generally. […] she'll call one patient in and do the history, then that patient will either stay in that room, or they might move to his room whilst she calls in the next patient. (Participant 2)

The use of space thus enables patients – particularly those who may take longer to move from room to room – to be seen more efficiently:

> That speeds things up, but it also means that -- part of the issue with seeing the elderly is that it takes quite a while for them to even get into the room. If she's called them in and got all that bit done, if we need a blood pressure doing, they've got the coats and the jumpers and all of those layers off, which needs to happen. (Participant 2)

As mentioned above (2.4), the investment in the MA was initially seen by some as a risk, given its financial implications; as well as raising questions over the distribution of resources (i.e. if one GP was supported by an MA, but others were not). With this in mind, it is worth noting how one participant articulated how the skills of the MA role were beginning to have a benefit to all GPs:

> As time has gone on the other GPs have seen the benefit, because they know now that they can ask, even though Helen's not sat in with them, they've got a referral that needs doing, they can ask her to do that […]. So although she might not have that role with them formally, they know that she's got those skills so they can play on them if they need to. (Participant 3)

2.7 Contexts

Several key contexts underlying the success of the role were identified during the course of the interviews. The role was initially discussed in Practice meetings, and participants all suggested that they had been aware of the ideas behind the role before the formal job role was produced. Thus, the role was implemented in a context that was well-prepared and informed of its purpose. The need for the role was also articulated in relation to a specific shortage of doctor hours due to the recent retirement of a senior partner:

> Obviously when you're down on doctor hours, they're stretched to capacity. Dr Robson had said he was doing a lot of the routine stuff, which he didn't necessarily have to do. Someone else could take that off him. (Participant 4)

The problem of capacity was also linked to the relative size of the practice. For example, one of the key successes of the role was reducing the number of appointments needed for individual patients. While this would be of benefit to Practices in general, the effects were particularly notable due to the strains on the appointment system in the MA's Practice:

> For such a small surgery, appointments are fairly limited anyway and with the increase in patients as well, it's handy to be able to do those different things in the one appointment. (Participant 5)

This also related to patient engagement with the role:

> Probably in the beginning there was an element of "What's this all about?", because we've got quite an elderly population and they are quite set in their ways. I think because we're a small surgery, they've adapted to it really well… (Participant 3)

Likewise, the size of the Practice was an enabling context for identifying suitable candidates for the MA role:

> I think it was easier for us because we already had a good idea of the skillset of the staff member who is doing it. In a bigger Practice, that might not be so apparent. There again, they'd have a bigger pool of staff to pull from. (Participant 6)

> It is a very unique surgery. It's a small surgery and it's a unique surgery in that lots of people are part-time. (Participant 2)

Thus, the size of the Practice appears as a crucial context affecting the success of the role thus far.

At the same time, Helen's current role as an MA involves factors that are likely to be transferable to a more generalised training programme, provided that sufficient support is given to trainees: including timely feedback, good links with mentors and supportive collegiate relationships. For Helen, having support and a positive working relationship with staff at the practice seems to have made role transition easier; resonating with Desborough et al.'s[18] observation that colleagues can be a good source of help and advice when staff are taking on new roles.

One participant noted that the specific skill-set required for the MA role was fairly distinct, and this would have an impact on how individuals were recruited to the role. In this case, the context of recruitment in General Practice (as opposed to other sectors) may become a significant aspect of whether a role in successful or not:

> It's making sure you pick the right person, which in General Practice, they're not quite used to recruiting in that way really, because they're all small businesses recruiting. It's important that you're thinking about what you're doing. [...] I used to work for the CCG and you think about recruitment in a different way there. You might do some sort of personality test, whereas in General Practice you wouldn't. [But] I think it is important for the role. (Participant 3)

Others suggested that the need for the role to be embedded within the working practices of the surgery meant that MAs would be better recruited internally, and there was support for the idea that, anecdotally at least, General Practices around the area had a similar range of untapped resources in their administrative staff.

> I personally think it's better to recruit from within the surgery, if possible. Someone that would upskill from a reception or admin role. It's not just about having those admin or reception skills, it's also about knowing the Practice. So, that would be key for me. (Participant 2)

[18] Desborough et al.. "Nurse satisfaction with working in a nurse led primary care walk-in centre."

In turn, the success of the role was linked to the extent to which staff shared the vision behind the role:

> Everyone's got to be on board. You've got to work as a team. It would certainly work in […] a similar sized Practice and [with] similarly forward-thinking GPs. It would definitely work there, I know for a fact. A larger surgery, again it depends on the team, doesn't it? It's all about awareness raising. (Participant 4)

3 Summary and Recommendations

3.1 Quadruple Aims Summary

In terms of the Quadruple Aims, the evaluation found that the MA role had delivered a number of reported improvements:

- Participants reported a strong sense that the MA role delivered value for money. The risk involved in the creation of a new role which bridged clinical and non-clinical skills was perceived to be well-justified by the benefits, which included improving patient flow within surgery hours, increasing the time efficiency of appointments, and reduction of waiting times.
- While there was no direct sampling of patient views, participants were all in agreement that there had been few adverse effects on patient experience; that patients had a clear understanding of the MA role and purpose; and that feedback had been very positive.
- The evaluation also found that the MA improved efficiencies around the reduction of appointments (for example, by being able to take blood tests immediately, rather than booking a further appointment), and increased capacity for GPs, which contributed to improving efforts on prevention.
- Despite some initial questions around potential overlap of roles, financial implications and distribution of resources, the MA role had, in a relatively short period of time, improved staff experience of care, with strongly positive feedback from all participants.

3.2 Recommendations for Wider Implementation

A number of key themes emerged from the evaluation data which can inform inform the future development of the role and its wider implementation.

- One of the key factors in the success of the MA role was the clarity with which it was articulated to staff and patients, as supporting a specific set of needs within the Practice. In this sense, the MA role is very much based on the requirements of the GP they are supporting. In this case, the MA addressed specific disruptions or slowness in the patient flow which had, in part, arisen from the GP doing tasks that did not require a doctor or nurse to do.

- One contextual aspect which enabled this clarity was that the MA emerged from a specific requirement for just such a role (see above, 2.7). This allowed a distinct space for growth and development of a contextually-sensitive set of working practices.
    - Therefore, it is strongly recommended that, where other Practices are seeking to implement an MA, the purpose of, and need for, the role is clearly articulated in terms of the specific relationships it would be supporting.
    - It should be acknowledged that this 'need' for the MA may not be apparent in other Practices (indeed, other GPs in the single Practice did not require the role for themselves); or is less immediately identifiable. In those cases, there is potential for more overlap of roles between MAs and existing staff.

- The single Practice in this evaluation had avoided the potential for overlap with other roles, and its potential to lead to confusion regarding where one role ends and another begins.[19]
    - The context of the Practice – the small size of the practice, the visible need for the role, and the embeddedness of the MA herself – alongside mechanisms such as strong verbal communication and visual signifiers (i.e. distinct uniform) were all key to preventing such confusion from occurring in this case.

- While the MA role involves a number of generalisable tasks and skills, the evaluation found that its success in this single Practice was very much based on good communication between staff, and strong and consistent mentoring by the GP. In Helen's case, the expert and targeted advice and support given by Dr Robson has been beneficial and has been a key element in the successful transition Helen has achieved. Wider research has also demonstrated how mentoring is significant in supporting role development and implementation;[20] whereas the absence of support can create role stress[21] as well as ambiguity about role definition and identity.
    - A robust mentoring system, embedded within the needs of the individual Practice, should be a formative part of the implementation of the MA role.

[19] Brookes, et al. "Role theory: A framework to investigate the community nurse role in contemporary health care systems."
[20] Desborough et al.. "Nurse satisfaction with working in a nurse led primary care walk-in centre."
[21] Desborough et al.. "Nurse satisfaction with working in a nurse led primary care walk-in centre."

- The size of the Practice was frequently found to be important to the success of this particular MA role. This meant that in some cases, the success of the MA role was due to a specific skill set which may not be present in every General Practice workforce. For example, one participant noted that having the 'whole experience' of what happens in General Practice was key to the MA's success, this was something more easily learned at smaller Practices.
    - The role depended on 'pulling together' administrative skills with clinical training (e.g. phlebotomy, infection control, understanding of sterile fields and so on). Alongside this, Helen's IT skills, her friendly and calm manner with patients and her willingness to learn new skills, such as performing ECGs, are significant factors in developing her role in a site specific way.
    - Because the role encompasses clinical and social aspects of patient care including health promotion and prevention advice, it will require considerable flexibility in order for prospective MAs to fit the varied contexts they will be working in: for example, the needs of an inner city practice that has a younger population will be different to the needs of the Practice observed.
    - In addition, successfully implementing the MA role into general practice may require practical factors such as having enough space for the MA to conduct a preliminary consultation with patients prior to them seeing the GP. The importance of physical proximity to the success of the MA was raised in several discussions.

- Finally, the fact that the success of this role was based on individual skills and relationships means that it is difficult, from this study alone, to suggest whether the MA role may be effective when supporting more than one GP in a Practice. Other GPs at the Practice were, however, seeing benefits to their work from having an MA on site.

Appendix 1

Medical Assistant in General Practice

Interview Schedule

1 Identity
What do you understand the role of the Medical Assistant to be? What does it do, and how does it differ from other roles within the practice? Prompts: How clearly do you think the role has been articulated? Was it always clear, or did it become clearer as the pilot went on? How is being articulated? E.g. formally in documentation; announced in staff meetings; by the activities of the MA as the role develops; etc.
2 Successes
What, in your view, have the main successes of the Medical Assistant pilot been? Prompts: Has there been an improvement in patient care? How might this be measured? Can you give examples of these? Where do you see the role developing from here?
3 Conflicts
What, in your view, have the main obstacles been around the pilot? Prompts: Is it always clear how the MA 'fits' with existing systems? Is there any unproductive overlap with other roles? If anther practice were to adopt the role, what would you advise them to do to avoid these?
4 Expectations
Has the role met your own expectations? Prompts: Where did you get your expectations from? How easy has it been to implement the new role in practice? Do patients understand the role, and how it is different to other roles in the practice? How?
5 Resources
Do you think that the Medical Assistant is an improved use of resources? Prompts: financial resource; time resource; making use of existing staff ability; etc.
6 Contexts
How easily do you think this role could be rolled out to other General Practices? Do you think there were any aspects to the success (or otherwise!) of this pilot that were specific to this Practice? Prompts: size of Practice; demographics of patients; history of new interventions in Practice, etc.