Skill mix in clinical care

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Skill mix is a term given to a general process of reviewing and, if necessary, changing the traditional ways in which health care is delivered to patients. Health care should meet the needs of patients and enhance the quality of their care. This often involves changing the roles of individuals as well as the way in which health care teams work. The Royal College of Physicians of London considered this matter in 1996 and published a joint statement with the Royal College of Nursing in the *JRCPL*[1]. This was expected to encourage skill sharing amongst different health care professionals, but in practice progress has been patchy.

The Royal College of Physicians now presents a report to be published later this year seeking a radical review of the role undertaken by all health professionals. This is needed in order to implement a policy of skill mix and flexible working, designed to redistribute the ever-increasing workload and thus leaving doctors and nurses in a better position to apply their specific skills to management of patients. The expanded role of nurses across a range of clinical activities should be encouraged. A new post of health care practitioner is suggested, with a potential range of innovative roles which are discussed in the report. In addition, the role of medical secretaries should be re-evaluated and enhanced.

There is nothing revolutionary in these proposals – rather they aim to enhance existing practices. Thus, nurse practitioners have already made major contributions to the New Deal[2], particularly in allowing doctors to rest overnight. Nurse practitioners are trained (usually in a one year course following some experience as a staff nurse) to undertake many of the tasks traditionally carried out by junior doctors, such as venepuncture, administering intravenous antibiotics, performing electrocardiograms, bed management, and assessment and emergency treatment of patients according to agreed protocols. In hospitals where nurse practitioners hold the bleep at night, training grade doctors have at least managed to get some sleep. However, not everything has been straightforward: there remain issues surrounding responsibility and accountability, but it has been a step forward. One of the problems, of course, is that the country is short of nurses as well as doctors, and in some parts (such as London and the South East) this shortage is particularly marked. Thus, creating nurse practitioners is not the overall solution, as we have difficulty in filling the D and E grade nursing posts from which nurse practitioners are usually recruited. It makes sense, therefore, to examine the potential for a new type of post – namely the health care practitioner to take on some of the tasks at present undertaken by nurses, thus freeing nurses to develop their abilities and deliver the many nursing skills so badly needed in our wards.

It is in the area of delivery of care that tribalism among health care professionals is most evident. Care that has been traditionally delivered by one group of professionals is passed on to another group only with difficulty and with concern for loss of status. Nevertheless, examples of good practice are emerging all the time. In some areas, community pharmacists are being encouraged to extend their role to take over duties formerly carried out by general practitioners. Other examples include nurses trained to undertake endoscopy[3], nurse-led clinics in diabetes care, and the use of physiotherapists as first-line therapists for the management of patients with back pain.

Several groups have developed a different way of delivering health care, some of which have important messages for the NHS:

- The Royal Navy delivers care to its personnel on board warships via medical assistants, who are trained over a number of years to cope with a wide variety of health care problems in the absence of a medical officer. The medical assistant can consult a medical officer at any time and increasing use is made of telehealthcare to examine problems and give advice. A similar system is used in the British Army, particularly for immediate care on the battlefield.
- In the United States, physician's assistants now have an independent health care role. However, health care is organised rather differently in the USA and this model may not be appropriate to the UK at this time.
- A number of centres in the UK have developed new types of health care posts in response to a crisis situation. For example, in Southend Hospital medical emergency assistants have been trained to take over some tasks in the A&E department and thus help the doctors to deliver care more effectively.

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Clin Med JRCPL 2001;**1**:259–60

There are, however, a number of problems associated with the *ad hoc* development of new roles. Hence the idea of the health care practitioner for whom there would be a defined career pathway, and the development of a specific training curriculum. Issues relating to accountability would need to be addressed.

While much of the work of the health care practitioner is similar to that being envisaged for a nurse practitioner, the post carries a number of advantages. First, the training period is shorter, as it takes up to six years to train nurse practitioners assuming that they work as a staff nurse for about two years. Second, nursing does not recruit well from the male and ethnic minority sectors of the population. There is evidence from the education and training consortia in the NHS, who are working with training and enterprise councils, that such groups are attracted into health care work if the label of 'nurse' is dropped from some job titles.

It is also proposed that medical secretaries should at last be given recognition for their central role in the medical team. Their administrative and organisational skills should be recognised, developed and remunerated appropriately.

The Royal College of Physicians report also reinforces earlier recommendations, notably the need to increase the numbers of consultants and re-examine the evolution of their long-term career structures; to develop more intermediate care beds; and to improve hospital information systems in order to reduce the large clerical burden which weighs heavily on all NHS health professionals.

Conclusions

The Department of Health is currently looking for innovative ways to deliver health care to patients in order to cater for their increasing expectations. In April 2000, it published a consultative document on workforce planning entitled *A health service of all the talents*[4]. One of its aims is the creation of a more flexible workforce. It is clear from discussions about the modernisation of the NHS that the government is seeking to develop this theme and the NHS plan[5] published at the end of July 2000 confirms this aim of flexible working with the removal of traditional tribal barriers, but in a spirit of collaboration and co-operation rather than the 'blame culture' that has been all too prevalent in the past. The present Royal College of Physicians proposals, which recommend imaginative new roles for health care professionals, precisely address these issues and should be examined carefully. The opportunities are enormous, but can only be delivered by a flexible workforce, associated with the significant consultant expansion that allows them to develop their skills for better health care.

References

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