Strengthening and mobilising ARRS roles to unlock capability and potential

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"Every day, more than a million people benefit from the advice and support of primary care professionals – acting as the first point of contact for most people accessing the NHS and providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves".

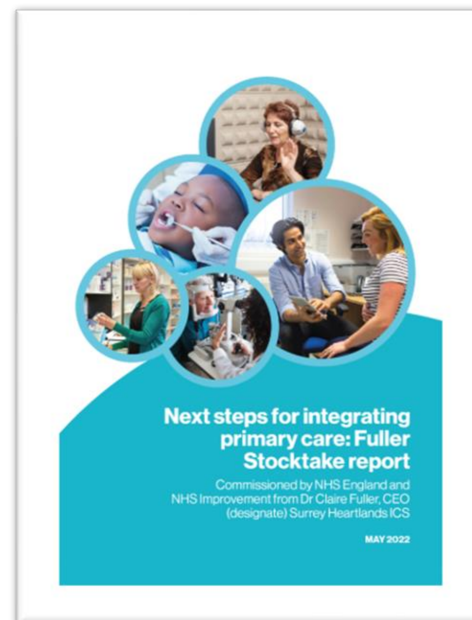
(NHS England and NHS Improvement, 2022)

THANK YOU!

INTRODUCTION

The Fuller report (NHS England and NHS Improvement, 2022)suggests two cultural shifts are required to meet increasing challenges in primary care.

- Move towards a psychosocial model of care
- Realignment of the health and care system to a population-based approach.

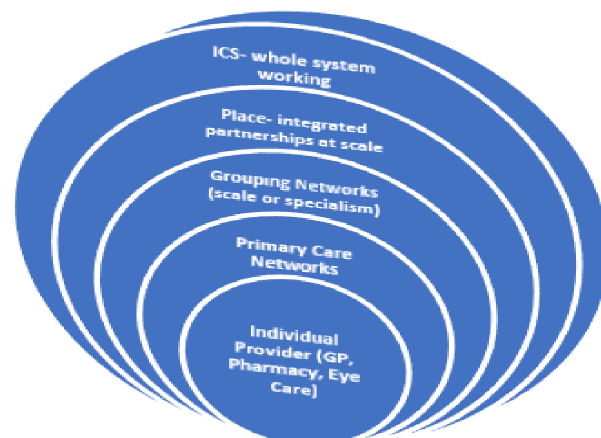


Research also suggests that new clinical delivery models are needed to reduce the burden on general practice and alter how care is delivered (Baird et al., 2018). Evidence suggests additional roles could undertake some of the GP's work (Wanles 2002).

The NHS long-term plan articulates a commitment to transforming the primary care workforce into multidisciplinary teams of professionals from different disciplines working together to provide joined-up care (NHS England, 2022a).

As part of the long-term plan, GPs are encouraged to change from traditional service models to team-based models, develop non-medical roles, extending the skill mix within the GP team. Introducing new roles to enhance the scope of practice offers a real opportunity to manage the significant challenges described below(Baird et al., 2018).

The South Yorkshire and Bassetlaw Primary Care Strategic plan 2020-2024 sets out a commitment for transformation, introducing new services, improving coordination between those services that exist and supporting the adaptation of the workforce to meet population health needs and address health inequalities. The principle of 'layers of scale' describes the focus of delivery at each level. Workforce is the thread binding each layer together. The movement toward multi-disciplinary team working is the common denominator.



Significant Challenges

- Rising demand for GP services and people's unmet appetite for more influence over their lives (NHS England and NHS Improvement, 2021).
- Increasing complexity and disease burden with multi-morbidities (Baird et al., 2018).
- People are living longer with long-term conditions (Baird et al., 2018).
- Shortage of GPs (Health Education England, 2006).
- Low staff morale (Nuffield Trust, 2022)
- Patient satisfaction with general practice is at an all-time low (NHS England and NHS Improvement, 2022).
- Additional demands of treating COVID.

Additional Role Reimbursement Scheme (ARRS)
The Network Contact DES supports the recruitment of new additional staff to deliver health services (NHS England, 2021). Bringing an additional 26,000 staff into general practice by 2024. Through ARRS funding PCNs can cover the salary and on-costs of recruiting and managing additional roles. PCNs can choose from 13 roles. Five of these roles are practitioners known as allied health professionals (AHPs).

Care Co-ordinator
Dietitians
Health and Well-being Coach
Mental Health Practitioner
Nursing Associate
Occupational Therapists
Paramedics
Pharmacists (Clinical)
Pharmacy technicians
Physician associates
Physiotherapists (First Contact)
Podiatrists
Social prescribing link workers

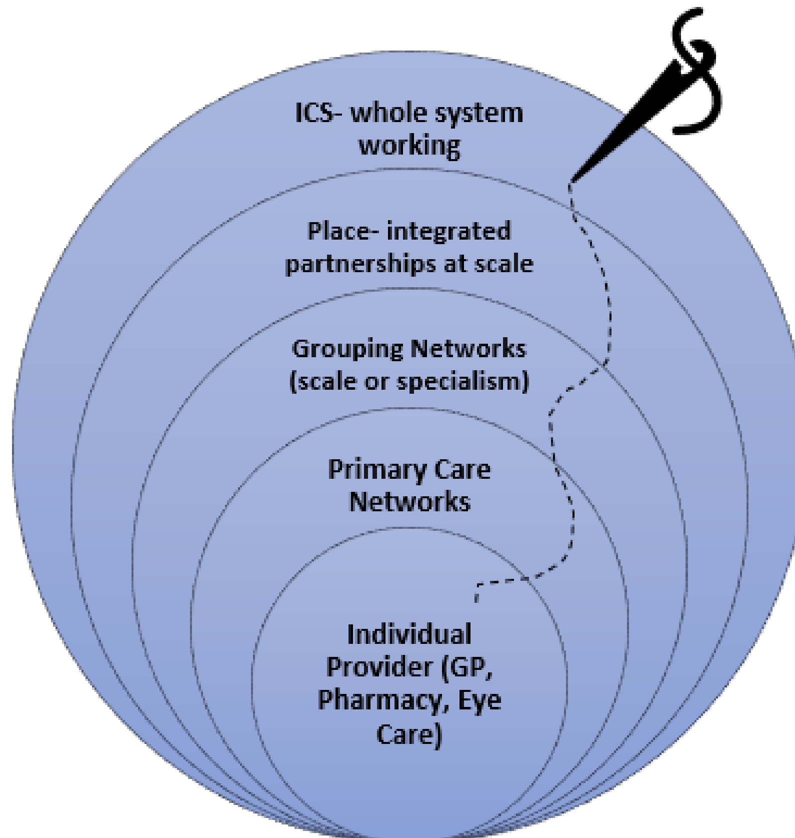
Allied Health Professionals (AHPs) are the third largest clinical workforce in the NHS, with 185,000 AHPs caring for people, families, and communities in the UK (NHS England, 2022b). AHPs can play a vital role in the transformation of primary care. They can also contribute to the integrated care system mission to improve population health, tackle inequalities, and enhance productivity and effectiveness (NHS England, 2022).

The National AHP strategy is a framework demonstrating the transformative potential of this workforce in supporting the NHS(NHS England, 2022b). AHPs can focus on the prevention of ill health alongside improving health and wellbeing. Thus, ARRS roles can offer solutions to many of the challenges faced by primary care networks; however, the shift of culture and practice to team-based approaches require a significant shift in culture and investment in organisational development.

Primary care organisations are starting to respond to challenges by embracing the opportunities that team-based work can bring. All PCNs in Sheffield have employed additional roles and are starting to think about the culture shift required to develop primary care multidisciplinary teams.

“Primary care is working collectively within the primary care setting and across wider provider partnerships taking advantage of economies of scale and supporting the development of integrated and seamless models of care”.

SYB Primary Care Strategy 2020-2024



ARRS Project aims:

1. Understand the impact of the ARRS roles in Sheffield.
2. Identify and share good practices.
3. Gain assurance that we are meeting the ARRS role requirements.
4. Identify gaps, unmet needs, or ways these roles can be optimised.

By working on these aims, we expect to:

- ✓ To better understand how PCNs are utilising ARSS roles in optimising general practice addressing health inequalities, and improving the quality of care.
- ✓ To showcase examples of good practice and how these roles can add value to general practice.
- ✓ To identify any gaps and areas for improvement.
- ✓ To share learning.
- ✓ Make recommendations for improvements.

It is important to work on this now because:

The ARSS roles have been in place since 2019, and funding beyond 2024 is uncertain.

ARRS provide PCNs with the opportunity to:

- ✓ Try out new allied health professional roles
- ✓ Test and evaluate proof of concept
- ✓ Diversify and develop the primary care workforce
- ✓ Understand the role that AHPs can play in tackling health inequalities in primary care.
- ✓ Understand how AHPs can support general practice and relieve the workload burden on GPs.

FINDINGS

This report summarises findings from a narrative review of ARRS roles in Sheffield. PCNs were invited to participate in a 30-minute guided conversation to determine their perspectives on i) the challenges of employing and managing ARRS roles, ii) the benefits of diversifying the primary care workforce, and iii) the potential for developing a multidisciplinary team approach.

Interviews were conducted online. Stakeholders included practice and locality managers. ARRS roles included the following professions: Occupational Therapists, Physiotherapists, Paramedics, Pharmacists, Mental Health Practitioners, and Physicians Associate. Three of these had left their post within the first year.

Aim 1: Understand the impact of the ARRS roles in Sheffield

Each Network has a different complement of ARRS roles determined by historical arrangements, population health needs and local partnership working with voluntary sector organisations. Case examples defined the impact of roles. Most networks didn't collect any data or outcome measures for ARRS. Anecdotal examples of impact were evident. Reasons for not having any impact data thus far were time, infrastructure support and complexity.

People employed through ARRS could give impact examples from personal experiences. Some of these have been kindly provided (see Aim 2). ARRS employees had multiple motives for coming to work in primary care.

- ❖ The opportunity to manage complex caseloads
- ❖ The opportunity to work in a primary care team
- ❖ The opportunity to have First Contact Practitioner training
- ❖ The opportunity to train to become an Advanced Clinical Practitioner

- The opportunity to work in assets-based approaches
- The opportunity for a better work-life balance (hours and shift patterns)
- The joy of having more autonomy and the ability to genuinely influence and develop services

ARRS participants were able to articulate the culture and working conditions which retained them in the post:

What matters to me? The ARRS role experience.

- I feel listened to
- I can influence and contribute to 'making a difference.'
- I can develop networks and contacts across PCNs
- I feel like I belong to a team
- I am noticed for my work and my contribution
- I feel welcome
- I have a sense of purpose
- My work is varied
- I have an office space I can access where I see other team members
- I have access to relevant IT systems
- I have a nominated clinical supervisor
- I have opportunities for peer support
- I understand what's expected of me and have a clearly defined role and job plan
- I have dedicated time for improvement and development work

"Just meeting for a quick coffee or having lunch together makes the difference to my week and whether I feel part of the team"

"I felt invisible, nobody acknowledged I was there, came to say hello, I might as well not be there"

Hold a team huddle and fuddle. Providing an opportunity for people to come together creates a sense of belonging and facilitates growth in social relationships and fosters team identity.

What matters to primary care networks

Networks recognise they are in varying degrees of maturity and feel more development work would be beneficial to maximise the potential of ARRS and mature network collaboration. Networks would like help to develop team-based working, organisational support to facilitate transformational change and 'time-out' to think more statically about workforce planning.

Networks had concerns about recruiting to ARRS roles. Specifically, pharmacy and care coordinators. They were also concerned about 'how to attract new people into primary care'. There was a general concern about the lack of knowledge of newer ARRS roles such as Occupational Therapy, Paramedics and Dietetics. Particularly around providing professional supervision and career development for professions, they have little experience in employment.

Most networks discussed the need for clear and simple 'light touch' referral pathways to ARRS roles- an investment of time to get this right and a 'no door is closed policy' was thought to be the best approach. "*Avoids wasted time and gives patients a better experience*".

Clinical Directors expressed an appetite for workforce development and innovation. There was a pioneering spirit and a willingness to try new ways of working. However, PCNs voiced concerns such as "*we only know what we know*" and "*we employ what we know*". The limited understanding of how an ARRS role can contribute and add value to general practice was seen as a barrier to networks diversifying their workforce.

GP

“Traditional roles are familiar and easy to recruit to, whereas new roles to primary care such as Occupational Therapy or Dietetics are harder for networks to conceptualise”.

Having a clear vision, defined purpose, and a job plan was high on the list of desirable attributes for ARRS job satisfaction. Where networks had recruited to roles without underpinning development, retention in the roles was a problem.

In summary, although there was a generally positive response to ARRS roles and their impact beyond anecdotal examples, it was difficult to determine the specific impacts.

Aim 2: Identify and share good practices.

There were multiple examples of good practices and developments worthy of sharing across networks. A snapshot of these has been provided below; these are by no means exhaustive.

Occupational Therapy

"I have taken on a care home leadership role. This involves leading the delivery of enhanced health in care homes and meeting the Network Contract for DES. Designing robust systems to ensure every new resident has a personalised care plan in place, which is reviewed annually. I am supporting personalised care approaches by providing training and multidisciplinary support for care coordinators".

"I am working closely with the GP to improve the quality of care in care homes. I have contributed to raising awareness and understanding of mental capacity assessments, assessing for supportive seating, providing equipment, and supporting activities of daily living. I have assessed eating and drinking difficulties and cognitive deficits as well introduced new systems for multidisciplinary communications".

"Patient A was suffering from long-term chronic pain. She was referred for low mood and problems with low motivation; she was struggling to get the help she needed and not attending important appointments. I introduced some interventions focusing on wellbeing, such as relaxation and mindfulness. I supported her in modifying and pacing her daily life activities and forward plan for appointments. Patient A gained increased awareness of the need to rest before attending appointments, and she gained some strategies which helped her attend her appointments. She felt more informed and empowered with new techniques to manage her chronic pain, which, in turn, helped to improve her mood".

"I looked a who was regularly attending and what their needs were. I worked with individuals to develop a personalised care plan to manage help-seeking behaviours. Collaborating with the multidisciplinary team in an assets-based approach to meet people's needs. I provided a point of contact for continuity of care and completed a comprehensive occupation-focused mental and physical health assessment, including lifestyle and social factors. Working with the patient, we co-produced a personalised plan based on their assets, contexts, resources and support networks. The ultimate goal was self-management and coping skills, reducing calls to 999 or attendances at the GP practice".

Dietetics

"I have been working with GP surgeries to perform clinical searches and actively invite patients with Type 2 Diabetes in for a discussion regarding the NHS low-calorie diet pilot. This supports the loss of weight and achieving diabetes remission. GPs and practice nurses have indicated that they see this as added value as it frees their time in terms of having the conversation with patients, and it can lead to positive change in terms of lifestyle as it opens the door for patients to consider other options even if this particular pilot is not for them".

"I have been doing Orlistat initiation and reviews as part of dietetic consultations. This involves checking that patients are taking the medication and appropriately and routinely, reiterating the need to follow a suitable diet alongside taking it to minimise side effects and achieve weight loss and being clearer about the need to achieve the 5% weight loss over 12 weeks for a continued prescription beyond this. I had a patient who was not taking it routinely and gaining weight before dietetic intervention. Following the dietetic intervention, he lost 9.3kg (7% body weight) over ten weeks despite extremely limited mobility levels".

"I had a patient with Type 2 Diabetes on 1000mg Yaltormin BD, HbA1c static at 61 mmol/mol for eight months and weighing 112.7kg before dietetic intervention. She had a poor dietary intake, missing 1-2 meals during the day, then grazing at night due to hunger and boredom, and limited physical activity outside her occupation due to needing a knee replacement. I provided diabetes dietary education, and following the request by the patient, I liaised with the GP regarding her prescription and Orlistat was initiated. She lost 16.3kg (14.6% body weight) over four months. HbA1c reduced to 51 mmol/mol. She had requested a change to a weekly GLP-1 during the course of dietetic input; however, with the reduction in HbA1c, there was no longer a clinical need to consider it at the current time, thus providing a cost saving to the GP's budget".

> *"It was the little things I needed guidance on, new ideas, ways of doing things. My dietician understood I worked all different hours and the challenges I faced, she gave me real suggestions, doable answers and understood the cultural implications of my families type of food. Having the support to be able to talk through alternatives, ideas, and suggestions, is more important than any book you could give a patient. Face to face, one to one, is invaluable.".*
>
> *Patient Story*

Physiotherapy

"I had a patient who had been to A&E and was diagnosed with a frozen shoulder. The referral from the GP was confirmed as a frozen shoulder. Following my assessment, I referred the patient for an urgent as I suspected brachial neuritis. The MRI and neurology outpatient appointments confirmed this diagnosis. This highlighted a training need for the practice on brachial neuritis".

"A patient was referred with lower back pain. On assessment, I noticed reduced definition over suprasternal notch, which the patient has been aware of over the last couple of days. I queried a goitre and liaised with GP to organise the relevant tests. This reduced the need for a 2nd appointment".

"Discussing clinical cases with GP led to a patient with unusual shoulder pain, being referred for further investigations which picked up a previously undiagnosed fracture".

Paramedics

"My role involves seeing acutely unwell patients in their own homes and running clinics in the surgery. I also help with taking blood in and out of surgery and vaccines, and I have trained all staff in the Network on how to perform Basic Life Support. Doing these extra tasks when I have free time takes the pressure off the GPs and other staff members too".

"I dealt with severely unwell patients routinely working as a Paramedic in the Ambulance Service, so I can use this experience and knowledge to quickly and safely assess patients to determine their medical needs. One such case was when I was asked to visit an elderly patient to assess his new mobility problems - within minutes of arriving, and I discovered that the patient was very unwell and that he, without prompt emergency treatment, would go into cardiac arrest. Unfortunately, as I had predicted, the patient went into cardiac arrest, and we were unable to revive him".

"I was asked to see a lady whose family had, late in the day, requested a review of skin tear and missed medications. I was able to attend the same afternoon, assess her wound, identify, and prescribe for an acute infection, suggest a plan for her medication review and refer her to district nursing services and Active Recovery for monitoring and support. This would likely not be able to be provided by her GP due to time constraints."

"I visited a gentleman who was feeling intermittently dizzy. I undertook a detailed assessment and noted he had a slow heart rate, which had not been documented before. I was able to review his medication and undertake a basic ECG, revealing a suspected 3° heart block. I arranged for him to attend ED via a 999 ambulance."

"I visited a lady whose family were concerned that she was increasingly tired, with a suggestion made by her GP that an admission may be required. I was able to undertake a holistic consultation which identified that the lady was likely entering the final stages of her life. We were able to extend the visit, to allow us to discuss all her and her family's thoughts, hopes and worries and to instigate the implementation of an EOL care plan. The rapport I created with her, and her family allowed them to feel they were involved and central to the care-planning, resulting in them asking I attend to verify her death a couple of weeks later."

Care Coordinator

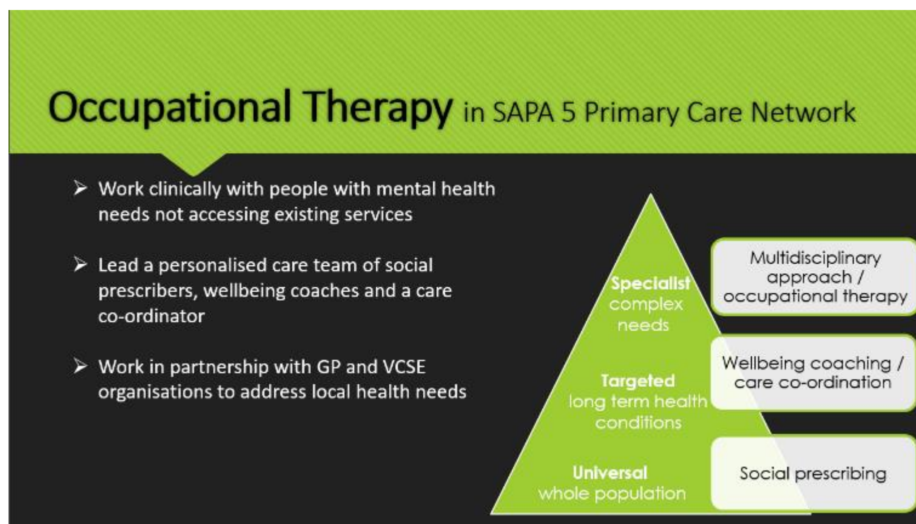
"As Care Coordinator and Communications Manager, I feel that I have benefited our PCN - increasing awareness of additional roles by creating new communication platforms, sending regular updates to our practice teams and being on hand to answer any questions or queries. Becoming a Single Point of Access has meant that our practice teams have one point of contact for all network service enquiries and allows easier access to signposting and referrals, saving our GP's time."

Personalised Care Teams

SAPA 5 PCN started to build an ARRS team in April 2021 with an occupational therapist, social prescriber and care coordinator; by May 2022, the team had grown in size. It has two occupational therapists, a dietitian, three social prescribers, a care coordinator and three health and wellbeing coaches. The Personalised care Team uses a holistic, person-centred approach to:

- *Enable people to improve their participation and to function in everyday life and activities*
- *Support people to access Statutory, Voluntary, Community or Social Enterprise services or groups*
- *Support and empower people with complex needs in coordinating their care and managing their health*

A weekly multidisciplinary meeting led by the Occupational Therapist is utilised to triage referrals, discuss complex cases, share learning, and seek peer support.



*South Lincolnshire primary care has developed a **Living Well Team,** which enables people living with a range of health problems and chronic conditions to overcome the barriers so they can participate in everyday life. The team includes **Occupational Therapists**, a **Health and Wellbeing coach**, **social prescribing link-workers**, a Care Co-ordinator, and a **Mental Health Practitioner**. **The Living Well Team** provides prevention and early intervention solutions in primary care. They focus on enabling people to successfully self-manage their conditions and build resilience. This can minimise crises, prevent further deterioration and promote independence and social inclusion.*

Aim 3: Gain assurance we are meeting the ARRS role requirements.

Employers need to ensure ARRS staff are operating within their capability limits and provided with appropriate supervision. PCNs are responsible for ensuring that all staff meet the education and training requirements set out and operate within the scope of their practice or capability for their discipline. Advanced practitioners must be operating at academic level 7 in each of the four pillars of practice: clinical practice, leadership, education and research. The HEE multi-professional Advanced Clinical Practice (ACP) framework sets a vision for consistently developing this critical workforce role to ensure safety, quality, and effectiveness.

Induction

- ARRS role had varying experiences of induction. When there was a robust planned induction, people felt part of the team quicker, setting the tone for a good working relationship.
- PCNs acknowledged that the current workforce pipeline for these roles is secondary care. The cultures, structures and organisations are very different in secondary care. Most people felt they needed extra time to adjust to working in primary care settings and needed more support in the first few weeks.

Organisational Development

- There was a consistent concern from PCNs about the lack of infrastructure, resources and support for these new roles. Some networks had started to re-organise and design team-based working approaches (SAPA 5 personalised care team example). Others admitted that ARRS roles were working in relative isolation and had not yet moved to a team approach.
- The lack of capacity and capability for organisational change work was cited as a barrier to transformation.
- CDs recognised the need for development work but expressed a need to access a person with improvement skills or organisational change expertise.
- ARRS roles described one of the biggest challenges was learning to cope with working across a network and meet competing demands from each practice. There were multiple practices with multiple systems and ways of working.

Estates

- One of the biggest challenges was a lack of space, e.g., for team meetings and shared integrated working spaces. Some PCNs said they had limited their ARRS roles due to lacking clinic rooms and workspaces. Although most roles were agile and flexible many staff had to work at home. Co-location of ARRS and regular communication between roles can potentially prevent duplication of effort.

Supervision and support

- ❖ The impact of remote working and COVID-19 on ARRS roles has created a greater sense of isolation.
- ❖ Where ARRS works well, there is a good supervision and support structure. A matrix of support and supervision provided by line managers, professional experts and peers, was most valued.
- ❖ Some ARRS roles felt professionally isolated, especially those from secondary care that was used to working in larger interdisciplinary teams. ARRS roles were reaching out to each other and building new networks across PCNs.
- ❖ ARRS roles value peer support meetings for advice with complex cases.

Employment models

There are a variety of employment models:

- ❖ Directly employed in a practice
- ❖ Employed by a network
- ❖ Secondments from a provider organisation
- ❖ Sub-contracted from a provider organisation
- ❖ Rotational (Yorkshire Ambulance Service)

Participants described the unique advantages and disadvantages of each model. There are mixed views on the benefits of centralising services, e.g., such as the PCS physiotherapy model. Most PCNs wanted to employ their own staff; however, they also described the advantages of managing a professional group of staff together.

Pharmacy employment modes have recently changed to a devolved model of employment into networks. Clinical Directors expressed concerns about retaining and recruiting pharmacists, and some networks are struggling to attract staff. Since the change in model pharmacists reported a sense of disconnection from each other as a community of practice. There was also a concern about whether networks in isolation could support the involved career development and supervision of growing pharmacy teams.

Where a centralised employment model doesn't exist, the ARRS roles have benefited from regular peer support and developing networks where they can meet to learn and share ideas. Peer support networks are currently patchy and would benefit from a strategic approach to coordination.

Aim 4: Identify any gaps, unmet needs, or ways in which these roles can be optimised.

Gaps in knowledge

- ❖ There was a tendency to employ familiar roles. Some of the newer roles were not very well understood, and gaps in knowledge on what potential they could offer.

Infrastructure support

- CDs and practice managers described concerns about providing clinical supervision and competency assessment due to a lack of knowledge of the roles and what they can offer. In addition, there were concerns about covering all the on-costs, such as buying in AHP professional supervision.
- PCNs described a lack of expertise in role redesign and development.

Team Based-approaches

- Most ARRS roles didn't identify themselves as in a multidisciplinary team or functioning collaboratively with other ARRS roles in a team-based approach.
- ARRS roles generally work across networks and engage daily with multiple practices. The transient nature of this role presents a challenge for truly integrating into practice and feeling 'part of the team'. Feeling part of a team and having a sense of belonging was high on the list of things that create job satisfaction and a key element of why people stay in a role. Good communication mechanisms were highly prized.

> *"I feel I belong when I can join the practice staff for lunch and socialise with them".*
> *"I feel I belong when people know my name, I am invited to attend and contribute to practice meetings".*
> *"I was able to meet with the reception team and talk to them personally about my role and the types of referrals I can take, this improved the type of referrals I was receiving and also built trust"*

Recruitment and induction

- Some PCNs are experiencing difficulties recruiting new roles, such as care coordinators, or longer-standing roles, such as pharmacy. Recruitment to pharmacy roles had been a particular struggle. The variation in terms and conditions across networks was cited as a common cause.
- The quality of inductions to the new roles was varied, ranging from "*superb*" to "*not-so-good*". This was also impacted by the COVID restrictions 2020-21.
- People in ARRS roles expressed discomfort with negotiating contacts and terms and conditions, and most want to keep as close to the Agenda for Change terms and conditions as possible.
- The commitment to training and development in primary care was seen as an advantage and a potential draw from other sectors. "*The opportunity to train as an FCP was a massive draw for me, and there are very few clinical Band 7 roles in secondary care.*" In a competitive market where allied health professionals will be in shorter supply, this offer was seen as a significant advantage for primary care.

What does a good induction look like?

"Starting a new job is always unnerving, and the delivery of a sound, robust induction can help enormously dispel concerns, concrete a sense of belonging and manage expectations for both parties. Joining a PCN was far removed from the acute setting I had been working in for over two decades. Everything was alien and yet on arrival I was greeted warmly, had time to meet new colleagues and learn where I should be during the week. I was provided with a laptop, parking advice shared, where the best cafes were and provided me with a clear sense of expectation for my first few weeks of employment. I had access to team members and I went home eager for the following day as I felt instantly apart of a well-established team. I could ask anything at anytime. Unlike more traditional roles where you are likely to be alongside peers, autonomous working didn't concern me. Initially as I was unsure how an induction could take place given the location and geographical challenges. In truth, my concerns were dispelled on the first day. Everyone knew who I was, I was expected, and plans had already been made to provide me with a working station for each day. I felt welcomed and valued which maximised my sense of belonging".

Workforce development

- It was recognised that very little attention was paid to developing career pathways for the new roles.
- No strategies for future workforce development were evident beyond recruitment to the full ARRS funding. No ideas or thoughts about how primary care can 'grow its future workforce.
- There is value in bringing ARRS roles together for learning and sharing good practices. Some networks reported the ARRS roles were perceived as practice assets rather than network assets which could be a barrier to future development work.
- People in ARRS roles talked about wanting the opportunity to design clinical pathways and services so that referrals are directed to the relevant point, their skills are used to maximum capacity and waste is eliminated.
- Networks tend to meet the training needs rather than collaborate with other networks to pool training resources.
- Sheffield doesn't employ any Podiatrists in PCNs. GPs felt this role should sit with secondary care and were worried about duplication of already available services. HEE has provided information for PCNs on the role that podiatrists can play in public health, prevention and keeping people active (see appendix).

"8% of GP consultations for MSK are for foot and ankle pain. Enabling people who have foot pain to self-refer to a podiatrist working as a FCP … has the potential to significantly reduce the burden of foot and/or ankle pain on GPs, improve patient's quality of life and prevent work-related absence." https://www.hee.nhs.uk/our-work/allied-health-professions/podiatrist

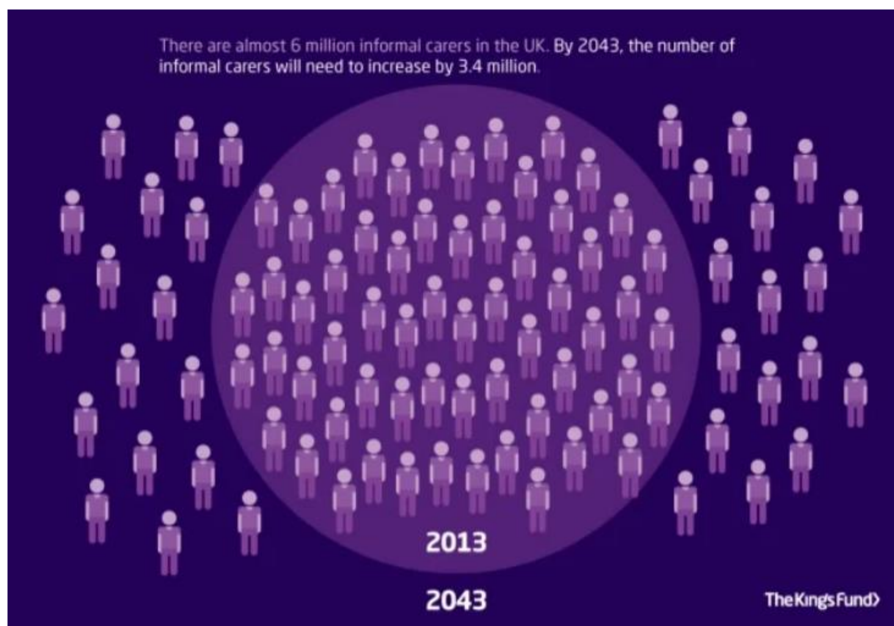
- The networks discussed tensions arising between meeting contractual obligations and wider population health and prevention work. There was recognition that ARRS roles could play a key role in local communities with preventative interventions. However, this development work requires additional capacity to design, develop and deliver.

Access to population health data to inform workforce planning

- All networks expressed a desire to have better population health data. They recognised that this could inform workforce planning. Some PCNs had limited data sets, and others sighted a lack of time as a barrier to using population health data in this way. Others cited a lack of skills, e.g., knowing how to interpret the data available and relate this to workforce planning.

Involvement of the unpaid carer

- The needs of patients were front and centre of discussions; however, the needs of informal carers were not part of this discussion. This could be because of the content of the guided conversations or potentially highlights a gap in thinking about how ARRS roles could support communities and informal carers as part of a wider prevention strategy.



DISCUSSION

TACKLING HEALTH INEQUALITIES

Allied health professionals uniquely contribute to tackling health inequalities (Dougall & Buck, 2021). AHPs often work across several organisational boundaries, are well placed to see cross-system pathways and flows, and work on seamless integration.

There is a perception that tackling health inequalities is for people working at scale; however, there is an important role that allied health professionals can play in individual consultations. Such as i) influencing locally on the design and delivery of services within networks ii) connecting a patient to services to meet their needs iii) advocating for their needs with another professional.

The Kings Fund (Dougall & Buck, 2021) has produced guidance on how AHPs can be more aware of health inequalities, take action and advocate for others. One example in Blackpool primary care was when paramedics created a 'high-intensity user programme' that recognised the need to provide tailored one-to-one support to address mental health and social issues affecting 'frequent' service users. Scaling up this project to over 36 teams generated savings in the region of 2 million (300 patient cases over three years).

Making every contact count approach (Royal Society for Public Health, 2015) recognises the opportunity to have everyday conversations about health and wellbeing. To ensure patients are cared for equally, focus on prevention and early detection, be person-centred and ensure people are not disadvantaged by barriers to accessing support.

GP Tom Holdsworth and Occupational Therapist Julie Clifford discuss how additional roles can support house bound older people experiencing frailty. Julia shares her prevention model which is saving GP time and ensuring those unable to attend the practice have a holistic assessment.

podcast https://ockham.healthcare/podcast-tom-holdsworth-julia-clifford-sheffield-frailty-project/

Julia Clifford Occupational Therapist discussing prevention approaches.
https://youtu.be/XXtqmbfUI9g

AHPs are encouraged to speak up (Dougall & Buck, 2021) and find ways in which they can contribute to conversations about health inequalities.

ARRS roles are providing GPs with new insights into local issues and generating ideas on how to best use resources. The Kings Fund (2020) suggests involving ARRS roles in strategic planning could provide greater understanding of local landscapes and health inequalities. ARRS roles can inform decisions on which groups to give extra attention and how roles can work together to reach underserved populations. They have unique insights into local services, which can reduce unfair and avoidable differences in healthcare (The Kings Fund, 2020).

GPs articulate the impact of health inequalities that they see, including poverty, low health literacy, unemployment, lack of social support and other factors. They have limited access to local population health data to inform strategic workforce planning according to local needs. More support is also needed to inform the collection of meaningful outcome data and additional skills for analysing and interpreting data available for business planning.

AHPs want to make a greater contribution to strategic priorities and support GPs to manage the demands of the Network DES.

Involve your ARRRS roles in practice meetings, development projects, and strategic planning conversations. Invite them to highlight examples at team meetings and share learning from addressing health inequalities at an individual level. Create a collective vision, aim or values to make this work a visible priority.

PARTNERSHIP WORKING

Local places and neighbourhoods are where connection to the community is strongest (Buck D, Wenzel L, 2021). Primary care networks are working closely with communities at place and neighbourhood level, including the voluntary sector, to develop partnerships to address health inequalities and meet the Network DES.

Mobilising ARRS roles to work together in designing clinical pathways and developing new ways of working strengths primary cares agency. Multidisciplinary team collaboration fosters high-quality person-centred care (NHS England, 2022) and is at the heart of the new vision for primary care.

WORKFORCE PLANNING AND INNOVATION

All PCNs felt there was more work to do around effective workforce planning, using ARRS to improve community offers, serve local populations and keep care closer to home while improving the health and wellbeing of local populations. PCNs would like support with harder-to-fill vacancies such as pharmacy and coordinators. There is a national drive to hire from local communities for team members with similar cultural backgrounds or languages to the local population (Dalton et al., 2016). There are potential opportunities to explore bulk network recruitment, advertising in different ways, and attracting employees from out of the health sector. Some of the challenges

included providing attractive and competitive terms and conditions, how to develop future leaders and retention of current roles.

TEAM-BASED PRIMARY CARE

Team-based care is defined as:
…the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated, high-quality care (Dalton et al., 2016)

Team-based care is thought to offer several potential advances (Dalton et al., 2016)

- ✓ Expanding access
- ✓ Reducing waiting times
- ✓ Additional patient education
- ✓ Behavioural health and support
- ✓ Self-management support
- ✓ Care coordination
- ✓ Increased job satisfaction
- ✓ Matching patients to team members with the relevant training or skills to find the most relevant team member to address their needs.

A proposed benefit of this approach is that a larger, more diverse team are more likely to facilitate effective multidisciplinary communications, problem-solve and meet patients' needs in a collective approach.

Research suggests that the development of existing primary care models towards an integrated multidisciplinary team-based approach warrants close attention (Dalton et al., 2016) so that organisations are supported to grow and evolve new cultures and ways of working. Although new models of team-based care are thought to be the future of primary care, it's important to acknowledge that it's not a panacea, and considerable investment is required to develop, recruit, and sustain these new ways of working.

To achieve this transformation, primary care requires fundamental changes in culture, organisation of care, education, training and development, and changes to the interactions between roles and colleagues (Dalton et al., 2016).

This could be achieved by practical strategies to support delivery, such as developing a practice mission statement for a team-based approach. The Fuller Stocktake suggests creating the conditions for reform with a common shared purpose (NHS England and NHS Improvement, 2022). A mission statement can guide decision-making and inform the practice's structure, recruitment, processes, and language.

Co-produce a practice philosophy based on person-centred team-based care and introduce this to service users in as many ways as possible. Invite feedback and continue to describe how this model differs and what patients can expect in the future.

Regular team meetings that include the ARRS roles can promote a strong sense of unity and build effective collaborative team working. Developing structures that support team communication, sharing good practices, planning and organising services will be beneficial. Work needs to be undertaken to manage patients' expectations. Custom and practice suggest that patients are used to seeing a single practitioner over multiple episodes of care over many years and may find it disconcerting to shift to team-based care models in which they are expected to have relationships or involvement with several clinical and non-clinical team members (Dalton et al., 2016).

CLINICAL LEADERSHIP

The ICS implementation guide on effective clinical and care professional leadership (NHS England and NHS Improvement, 2021) supports and recognises the importance of leadership for safe and effective care. Evidence suggests that senior leadership roles for AHPs (May & Fillingham, 2018)have quantifiable benefits to provider organisations (NHS England and NHS Improvement, 2021).

Unleashing the leadership potential of AHPs in ARRS roles is important so that clinical leadership in primary care is diverse. Leadership roles give greater voice and visibility to the ARRS workforce and recognise their contribution to system-wide challenges and opportunities (NHS England, 2022).

Attention must be paid to career development and advanced practice to maximise ARRS roles and build capability and capacity for the future. Further work to explore how new technologies could enable access and greater reach. A critical mass of ARRS trained in prevention approaches to optimise impact.

RECOMMENDATIONS

Aim 1: Understanding the impact of the ARRS roles in Sheffield.

The ARRS roles have the potential to impact six key domains. 7.4b of the Network contact requires employers to undertake a review and appraisal of ARRS. The recommendation from this review is to a) ensure the minimum role requirements (Annex B) are being delivered and b) to use these six domains of impact as a discussion guide for exploring and realising the full potential of the ARRS roles.

Impact case studies are powerful narratives to demonstrate the value added. A greater focus on outcome measurement would also tell an impact story. "*We need to know that what we are doing adds value*".

i) Process measures such as data related to referrals, number of signposts, and number and type of interventions.

ii) Clinical outcome measures specific to the population.

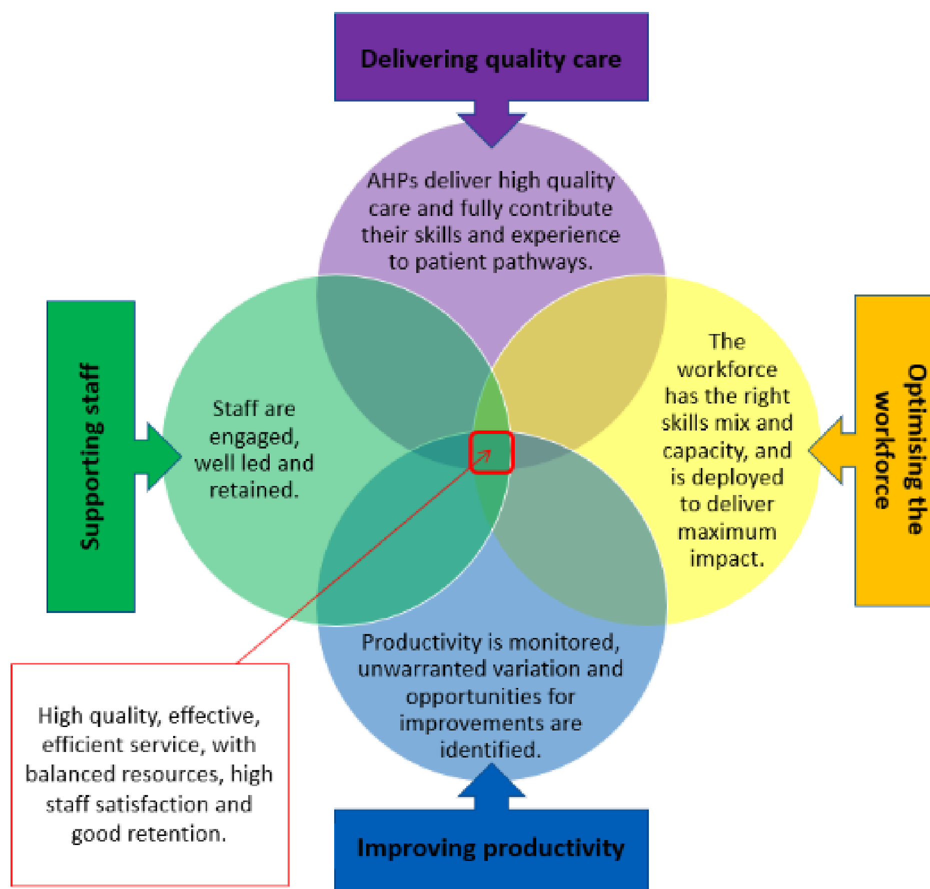
iii) Patient-reported measures. Goal attainment scales, self-efficacy measures, mood assessments, behaviour change measures or quality of life and wellbeing measures.

Aim 2: Gain assurance we are meeting the ARRS role requirements.

Annexe B of the Network DES sets out the minimum role requirements, including the educational and development specific to each ARRS role.

Recommendations from this review include:

- Clear governance and reporting processes are in place, including agreed performance indicators and outcome measurement. An annual appraisal will include wider community and population health objectives.
- The operating model is built around local population health priorities and includes a regular delivery review to improve practices and ensure you have the right staff in the right place.
- Coordination of ARRS roles into professional groups to foster sharing of good practice joined-up thinking and solutions to shared challenges, support and building local system networks. This potentially fosters faster growth and adoption of new ways of working.
- Creating generic induction guidance for ARRS roles based on the 'what matters to me' narratives, including suggestions for supervision models for AHPs.
- The AHP Quality dashboard- a framework for evidencing and improving the safe, effective and efficient use of AHP resources (NHS England, 2022a). Provides a helpful governance framework for services employing AHPs to monitor the consequences and impact of different workforce models on care delivery (see below).



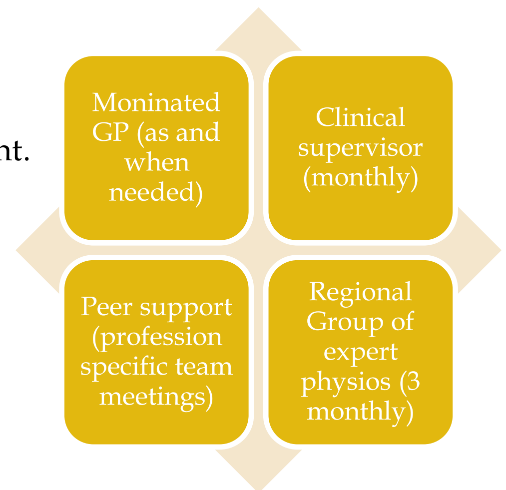
Skills development

- Equipping staff with motivational interviewing and active listening skills builds effective therapeutic relationships and enables ARRS roles to work in an asset-based approach.
- ARRS roles would benefit from training on self-management, shared decision making and personalised care to ensure patients are viewed as assets and are encouraged to play an active role in their care.
- Cross-training team members can ensure the practice is standard and address the interdependencies of roles so that teams can work cohesively together.
- Support the development of integrated and profession-specific learning networks or action learning sets.

Aim 3: identify and share good practices.

Supervision and support

- Getting the induction right is seen as hugely important. Allowing the ARRS roles to shadow meetings, providing opportunities for them to see the Network in action and meeting key people in the first few weeks is highly valued.
- Having a matrix of supervision and support is highly valued. There are some good examples of this in Physiotherapy (see matrix)



- Buddying systems with ARRS across networks have proven valuable, e.g., Paramedics in neighbouring networks have provided each other with informal peer support. An Occupational Therapy peer support network meets monthly, bringing together lone working OTs for support.
- A primary care preceptorship programme could be beneficial to support new roles, introduce them to ways of working in primary care, manage expectations and build networks between networks. West Yorkshire Primary Care Workforce Hub have developed a 12 -week Paramedic preceptorship programme for new paramedics to primary care. This supports a rotational model for paramedics from Yorkshire Ambulance Service to rotate into primary care.

Workforce planning and development
Most PCNs recognised the need for improvement work and organisational development to accompany growing the workforce. Lack of time, capacity and skills are the biggest barriers to making this happen. A centralised resource that could support organisational development work was a popular suggestion.

- Clarifying roles and standard work procedures and ensuring that issues arising around role blurring are discussed regularly.
- ARRS roles highly value being
  involved in developing referral pathways and shaping the service to maximise their impact.
- Explore different models to support recruitment, e.g., joint appointments, subcontracting and rotational models.
- Work with the ICS workforce hub to attract funding for workforce development and innovation funding.
- Visiting other primary care models in the UK generates new ideas and learns where it's working well elsewhere.
- Promotion events, seminars, website information for CDs and Practice managers to find out about the roles they are least familiar with and support them in choosing additional roles in the future.

Workforce modelling is based on population health needs and an agile workforce planning and deployment approach.

- Improved access to population health data.
- Utilise electronic rostering for transparency.
- Competency frameworks are in place to maximise opportunities to work at optimum skills.
- Job planning for AHPs.
- Exploring local authority and third sector community estates to support MDT meetings and provide community bases and spaces for team-based activities.

Employment models

- A standardised approach to employment to vanquish variation and the internal market of staff moving across PCNs for more favourable terms and conditions. The Fuller Stocktake (2022) recommends the adoption of NHS contracts for Ts and C's, using established good practices (NHS England and NHS Improvement, 2022).
- The key to new roles is to ensure everyone in the team understands their place in the team.
- Changing skill mix usually requires a change in systems and processes (Baird et al., 2018)
- Models are focused on prevention, proactive interventions and upstream strategies (NHS England and NHS Improvement, 2022).
- AHPs are deployed centrally
  - ✓ allows flexibility in care delivery
  - ✓ allow re-deployment where necessary

Leadership

- Senior AHP leadership in primary care would strengthen strategic focus and provide professional leadership and expertise to enhance current arrangements.

- Unlocking the potential of ARRS would:
  - ✓ Support system redesign, shift to a culture of team-based working.
  - ✓ Support the implementation of new ways of working, focusing on quality and efficiency.
  - ✓ Build workforce capacity and capability and develop sustainable ways to retain the ARRS roles.
  - ✓ Promote and attract the future workforce by developing preceptorship and student opportunities.
  - ✓ Utilise evidence to enable AHPs to work at the top of their competencies and their unique skills.
  - ✓ Building leadership capacity in the non-medical workforce.
  - ✓ Developing aspiring leaders already within the system and increasing the diversity of professions in leadership roles.

Facilitating a cultural shift to prevention and MDT working.

- Reiterate "teamness" in conversation; language is key! Contestant language and terminology to promote the team-based approach.

> Hello I am ….. I am a member of your primary care team

- A change in the ethos of care involves contacting patients before appointments, shifting from reactive to proactive. Patients see other health professionals instead of the GP.
- ARRS staff can be trained to take basic physical observations, creating time efficiencies.
- Staff trained in health coaching and motivational interviewing.

Aim 4: Identify any gaps, unmet needs, or ways in which these roles can be optimised.

IT as an enabler.
This review recognised the potential of IT as an enabler. Further work needs to be undertaken to explore and understand how IT can enable collaboration, support workforce planning and be utilised in patient interventions. Suggestions include:

- Shared care records
- Population health data dashboards
- Digital technologies at scale
- Business intelligence tools

Ways in which technology can be used to enhance services:

- A short video on YouTube to introduce the additional roles team. Who am I, and what can I do for you?
- Explore convenient ways of using technology for consultations, advice sessions, group interventions or self-management programmes.

SUMMARY

It is hoped this report will stimulate further discussion of the ARRS roles. This new workforce has yet to reach its full potential, and further development work is required to support the transition into a new model of team-based working in primary care. The findings of the review echo those of the 2022 Kings Fund research (Baird & Beech, 2022). '*extensive cultural, organisational and leadership development skills are required.*'

In addition, it is hoped that this report has identified some helpful suggestions and recommendations which may serve useful for networks striving to implement ARRS roles. Networks must invest in transforming cultures, systems, and processes to foster strong multidisciplinary team relationships and promote effective communication.

Primary care aspires to be an attractive workplace, to recruit high-quality team members and retain those currently employed. ARRS roles can clearly articulate the benefits of working in primary care; however, further work is needed to develop a future workforce pipeline, maximise and optimise the current workforce, and evaluate the impact to date.

NB Pictures featured in the report are from Microsoft stock images or developed by the author.

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APPENDIX

Blogs

Understanding your demand
https://www.pcnacademy.org.uk/blogs/reducingdemand-step1
matching supply to demand
https://www.pcnacademy.org.uk/blogs/reducingdemand-step2
Proactively managing people to turn up frequently
https://www.pcnacademy.org.uk/blogs/proactive-on-fas
Leadership development in primary care
https://www.kingsfund.org.uk/blog/2022/06/how-can-we-develop-professionally-diverse-leadership-primary-care

Video

AHP superpowers Podiatrist https://youtu.be/s_vFlr1D69k

AHP superpowers Dietician https://youtu.be/BSeOyZaeFxQ
AHP superpowers Occupational Therapist https://youtu.be/hDNKwfSxXwI
AHP superpowers Paramedic https://youtu.be/Dx67lQprwRM
AHP superpowers Physiotherapy https://youtu.be/ymmu3gYylHA

Examples of Community Power

New Local Community Power
https://youtu.be/orw8gZ1Bwxg

Healthier Fleetwood
https://www.healthierlsc.co.uk/primarycare/primary-care-networks
https://www.healthierfleetwood.co.uk/
https://youtu.be/uV78dLa3G4U

The Community Paradigm: why public services need radical reform and how to achieve it

Community Power: The Evidence

AHP Job Planning
https://www.england.nhs.uk/ahp/allied-health-professionals-job-planning-a-best-practice-guide/
https://www.england.nhs.uk/wp-content/uploads/2021/05/aps-job-planning-best-practice-guide-2019.pdf

AHP skills can be further developed

- Multi-professional framework for advanced clinical practice in England
- Advanced and consultant level national network (advanced clinical practice and consultant roles)
- Musculoskeletal core capabilities framework
- Non-medical prescribing by allied health professionals
- Clinical academic careers
- Allied Health Professionals Careers Resource
- Allied health professionals job planning: a best practice guide
- Improving Rehabilitation Services
- Promoting-AHP-careers
- Teaching resources

Network Contract Direct Enhances Service 2022

7.4 Additional role requirements

7.4.1. To ensure the satisfactory provision of health services, a PCN must comply with the following requirements in relation to any Additional Roles:

a. Additional Roles must:

i) be embedded within the PCN's Core Network Practices and be fully integrated within the multidisciplinary team delivering healthcare services to patients; have

ii) have access to other healthcare professionals, electronic 'live' and paper-based record systems of the PCN's Core Network Practices, as well as access to admin/office support and training and development as appropriate; and

iii) have access to appropriate clinical supervision and administrative support,

iv) and whether the arrangements are through direct employment or engaged via a service contract from a third party, they must be intended for a minimum of six months, unless the purpose is to provide temporary cover (e.g., sickness or parental leave) for an individual employed through the Additional Roles Reimbursement Scheme.

b. The PCN must consider the appropriateness of, and if considered appropriate, the PCN must (whichever is relevant) either carry out or input to, a review and appraisal process for Additional Roles.

c. The PCN must ensure that any Additional Roles comply with the minimum role requirements in Annex B of this Network Contract DES Specification to be eligible for the Additional Roles Reimbursement Sum. A PCN may build upon the requirements set out in Annex B of this Network Contract DES Specification in relation to any Additional Role job/service description.

d. The PCN must ensure the PCN's approach to deploying the Additional Roles is set out in the Network Agreement.