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# EVALUATION OF THE IMPACT OF THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

## ROTHERHAM & DONCASTER

SARAH WITHERS

AUGUST 2023

South Yorkshire

PRIMARY CARE

WORKFORCE & TRAINING HUB

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I am particularly grateful for the assistance of Andrew Carrick in literature searching and discussion, without whose help this project could not have been completed in the timescale required and for the valuable input of Louise Berwick and Dr Alan Shirley.

Strategic Lead Additional Roles Programme
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# Executive Summary

**Background**

The Additional Roles Reimbursement scheme (ARRS) was initially introduced in January 2019[41] as the new contract framework for GPs was agreed, supporting the recruitment of additional staff. Four years since the launch of the scheme,understanding the Place experience in Doncaster and Rotherham of ARRS implementation and impact is important to the subsequent plans needed to enhance the potential benefits of the scheme. Sharing the learning gathered through this project can build on local knowledge to further strengthen ARRS roles across South Yorkshire with effective implementation, recruitment, retention,and multidisciplinary working.

There is diversity of Places, PCNs and roles in the ARRS in Doncaster and Rotherham which is also representative of the diversity seen across England. This determined the approach of the project. This diversity is also apparent in the employment models and approaches to implementation.

**Objectives**

• To understand the national expectations of role implementationfrom the literature

• To describe Place experience in Doncaster and Rotherham of role implementation and impact from the perspective of PCNs, Service Providers and individuals working in ARRS roles.

• To assess ARRS role employment and delivery scope in relation to Annex B of the Network Contract Directed Enhanced Service (DES) requirements.

• To identify areas of consensus, difference and to share learning across South Yorkshire proposing recommendations.

**Approach**

➢ A background literature review was undertaken reviewing description of benefits and challenges of ARRS implementation.

➢ An online survey was distributed to PCNs and other employers of ARRS staff, focussed on the implementation of Annex B of the DES requirements.

➢ A range of online meetings and interviews took place to gather information on the experience of implementing and delivering ARRS roles.

The short time frame of this project limited the range of stakeholders engaged and the number of roles explored. Specifically, this constraint meant that local patient and public views were not sought.

**Key findings**

Benefits described in the literature include improvements in patient access, GP capacity and patient outcomes alongside a positive impact on the health care economy. These findings, with different levels of impact and confidence are seen across many of the roles.Some roles are yet to have an evidence base. Patient and public awareness remains an area with variation dependent on the role and work to do. Similar challenges are consistently experienced in ARRS implementation and service delivery. Access to appropriate training and supervision, difficulties with role clarity and challenges in belonging and identity are described frequently.Constraints such as estates capacity and IT infrastructure appear to be system wide.

**Doncaster and Rotherham**
There were 41 responses to the online survey representing approximately 200 ARRS staff. The findings demonstrated that across Places providing clinical supervision at the appropriate frequency with the appropriate supervisor, in some roles, remains the largest challenge, with a secondary challenge of assuring that all roles are undertaking roles duties as described in the DES. There is some variation between Doncaster and Rotherham in the extent of each of these challenges. 26 online interviews were completed describing the experience of working in PCNs/ providing services / or using skills and services of ARRS staff. The areas covered included: Identifying constraints and challenges, successes and enablers and reflecting on the learning of the interviewees.

**Benefits of implementation**
The benefits described in the wider literature have also been described in the interview data across Places. Roles consistently associated with positive impact on GP capacity and quality are identified below:

| Place | MSK FCP | Pharmacists | Paramedic Home Visit | Physician Associates | Mental Health Workers | Social Prescribing Link Workers | Care Coordinators |
|---|---|---|---|---|---|---|---|
| Doncaster | X | X | | X | | X | X |
| Rotherham | X | X | X | | X | X | X |

Successes have been seen across many roles and services as improved systems and processes have been established with increased PCN management capacity alongside regular and effective communication strategies that have built relationships and underpinned governance.

**Challenges to implementation**
In relation to the rapid expansion of Primary Care teams to include different professions and new roles, consistent themes emerge such as the importance of role clarity, training and supervision capacity and the importance of belonging and identity for ARRS staff. Lack of estates and IT infrastructure are both identified as constraints.

**Conclusion**
This report outlines some of the expectations of implementation of the ARRS and some of the benefits and challenges experienced in a national and local context. The complex environment of Primary Care and ongoing existing workforce pressures have undoubtedly contributed to challenges in implementation.In addition, the variety of employment models can materially affect the experience and impact of those employed through the Additional Roles Reimbursement Scheme and the experience and resource required in PCNs to support the ARRS. However, there are common experiences and learning across Doncaster and Rotherham which are consistent with national experience and will be relevant across South Yorkshire. Whilst significant progress to ARRS implementation has been made, improving patient access and Primary Care capacity, there are further opportunities to extend again the impact of a wider multidisciplinary team to embed effective recruitment, retention, and sustainability.

## Recommendations/Areas for future work

| **Ensure ARRS funding is used optimally for DES requirements.** | Understand the variance of ARRS funded roles with DES requirements where roles not consistently aligned |
|---|---|
| **Supporting effective recruitment** | Adopt new ways of working to implement consistent job descriptions, terms and conditions and salaries. |
| **Supporting training and development** | Review opportunities to support GP supervision capacity to enable the adoption of roles to improve access and GP capacity.<br>Develop multi professional supervision capacity |
| **Support effective implementation** | Review models of employment in place in South Yorkshire<br>Identifying enablers and barriers to effective implementation & impact |
| **Support effective retention – belonging and identity** | Consider sustainable working patterns and practices to create a wider team with the effective use of estates capacity |
| **Identify opportunities to expand roles effectively.** | For example: Physician Associates, Mental Health Workers, Health, and Well Being Coaches |

**Evaluation of the Impact of the Additional Roles Reimbursement Scheme in Doncaster and Rotherham May-August 2023**

## Introduction

The Additional Roles Reimbursement scheme (ARRS) was initially introduced in January 2019[41] as the new contract framework for GPs was agreed, supporting the recruitment of additional staff working in General Practice. This was part of the commitment to increase capacity in Primary Care and an important aspect of delivering an enhanced range of services that were part of the expectation of Primary Care Networks (PCNs), also being newly implemented[4] . In addition, this scheme introduced a mechanism for funding the development of wider multiprofessional teams within Primary Care which could provide a basis for improving services[3] .

The extent and reach of this scheme was extended in 2020/2021. Initially, roles included Physician Associates, Pharmacists, Physiotherapists, Paramedics and Social Prescribing Link Workers with less than 100% reimbursement[41] in most cases. However, from 20/21 the scheme included a wider range of Allied Health Professional Staff and clinical support staff, a wider range of staff supporting Personalised care and population health approaches and some Nursing roles were included.

## Project Background

In April 2023 Doncaster and Rotherham Place sought to undertake an evaluation of the Additional Roles scheme to gain an understanding of aspects of impact in these areas. The South Yorkshire Primary Care Workforce Training Hub agreed to undertake a high-level review to be completed in August 2023.

The diversity of roles, responsibilities and approaches that ARRS staff undertake in providing clinical care and seeking to improve population health and impact is complex and not amenable to a single approach of evaluation or a small number of easily collected metrics to measure the impact of this scheme. An added complexity in evaluation is the extent to which the variation in implementation approach and context is being assessed rather than the potential impact of the role if implemented consistently. More well-established roles have been implemented in some areas in Primary Care for many years and are more well understood with a broader range of published evidence than others, which are new and developing within their own local and network frame of reference.

The objectives of this project were:

- To understand the national expectations of role implementation from the literature
- To describe Place experience in Doncaster and Rotherham of role implementation and impact from the perspective of PCNs, Service Providers and individuals working in ARRS roles.
- To assess ARRS role employment and delivery scope as reported by PCNs in relation to Annex B of the Network Contract Directed Enhanced Service (DES) requirements.
- To identify areas of consensus, difference and to share learning across South Yorkshire
- To propose areas for further work and consideration

The range and scope of the project was planned with reference to the short timescale of this evaluation project (May- August 2023), it was agreed that data would be reviewed from other sources to assess the ‘additionality’ requirement.

**Approach**

In the light of this context, these objectives have been addressed through gaining an understanding of grey and published literature, with consideration of information relating to impact on the health system, the impact in the Primary Care team, the outcome and experience of patients and the public to gain a wider understanding of the impact and experience of role implementation.

An online survey was distributed to PCNs and other employers of ARRS staff, focussed on the implementation of the DES requirements, specifically seeking information on registration, training & development, supervision availability and roles and responsibilities of these staff.

A range of online meetings and interviews took place to gather information on the experience of ARRS roles through implementation, delivery, and impact. These meetings also provided local examples of service arrangement and delivery.

There are limitations with the project and approach, the short time frame for completion has limited the number and breadth of roles and stakeholders that could be included. It also shortened the period available to collect survey information and to schedule interviews.

Advanced Clinical Practitioner, Podiatry, Mental Health worker models and Nursing associate (training or qualified) roles have not been identified in this evidence review. Podiatry and Mental Health Workers have been included in stakeholder engagement however these roles have not been widely explored.

## Findings

### Literature Background

A review of the literature was undertaken across databases and including grey literature for the different ARRS roles in place to review identified benefits and outstanding challenges of role delivery, implementation, and impact in relation to ARRS Clinical care roles in place in Doncaster and Rotherham.

### Benefits

#### Improvement in patient access and GP capacity

There are several roles associated with underpinning evidence demonstrating an improvement in patient access, and improved patient capacity for the GP workforce namely Paramedics, Pharmacists, Physician Associates First Contact Physiotherapists (FCPs), Social Prescribing Link Workers (SPLWs) and Dietitians [2,7,9,10,21,23, 33,35,36,37].

The need for more robust evidence on the effectiveness of social prescribing in reducing GP workload is widely identified [18,38,43,44].
Pharmacy and FCP roles can impact up to 20-30% of the traditional GP caseload [5,35] highlighting the opportunities for impact.

#### Improvement in outcomes

In addition to improving Primary Care access and capacity some of these roles have brought specific expertise into Primary Care which have been shown to improve patient safety and patient reported outcomes [14,17,19,34,47,50].
Improved outcomes by optimising treatment have been evidenced in clinical pathways involving Paramedics, Pharmacists, Dietitians and FCPs [2,6,9,11,19,22,33,35,46,51].
Most SPLW services also describe improvements in measures of wellbeing, mental health, and social connection for many of those engaging with SPLWs [18,38,43,44].

#### Stakeholder acceptability and satisfaction

Where roles and services provided are clear to patients these patients report high levels of satisfaction with services, e.g., FCP and Physician Associates. Some professions bring opportunities for more diverse or hidden roles to the public and patients and in these cases, roles may not be used optimally due to a lack of patient and Primary Care team awareness. [1,15,33,35]

#### Impact on the wider healthcare economy

Staff in Additional Roles contribute to the wider health care economy by reducing costs due to more effective resource utilisation [6,9,14,33,35,36,47,45].
Specifically reducing locum costs, [11,27] reducing A&E attendances and admissions [2,8,32] and reducing secondary care referrals and investigations [6,9,14,35,36,45].
Studies also suggest a reduction on health service use and costs for SPLW and HWB services [13,20,22,24,25,29,30,43].
HWB coaches have an impact in prevention and early intervention [28,41] and support behaviour change and improve health outcomes for those with long standing conditions which can reduce health care utilisation including A&E visits [22,25,30,47].
The wide scale implementation of Care coordinator roles is relatively new and diverse in terms of national implementation, the published evidence base for the impact of this role is limited.

**Challenges**
Commonly occurring challenges in the adoption and implementation of Additional Roles in Primary Care include:

**Access to appropriate training, supervision, and support**
The importance of access to appropriate training, supervision and support is identified as a challenge[41] particularly where GPs are required to be supervisors, this is reported predominantly for Physician Associates, Pharmacists and Paramedics[1,23,39]. This has been described as an 'expectation- preparedness' gap by Cottrell et al 2021[12] which was identified with implementation of Physician Associate roles in Primary Care. To bridge this gap requires support with high levels of supervision during the preceptorship period, which can cause pressure for GPs[15,16,49].

**Role Clarity and Patient and Public awareness**
Confusion about the clarity of some of the roles has been reported in individual role literature and wider reviews[31,41]. Diversity of skills and roles can lead to confusion within the Primary care team and with patients about the roles of some clinicians[15,49,33,47].
Raising awareness can improve utilisation and acceptance and improve effective integration and collaboration within the team[47]. This challenge of patient and public awareness has been demonstrated by a recent debate in the UK Parliament about the use Physician Associates in the NHS[51] where the lack of patient and public knowledge of the role and the understanding of the extent of the implementation of this role were highlighted.

**Belonging and identity**
If a lack of shared understanding about the purpose or potential contribution of these roles is predominant in undermining these characteristics, the lack of a stable 'home team also contributes to the difficulty of key needs of autonomy, belonging and contribution of staff being fulfilled. There are also specific challenges related to individual roles and approaches.
There are challenges about 'belonging' in the present context of Primary Care. It has been widely recognised that PCNs have been in early stages of development with varying levels[31] of cohesion, shared identity, and priorities as the ARRS was introduced and implemented. PCN 'teams' were not in existence before the implementation of ARRS and the teams that existed were largely strong and practice based adding further to the challenges of 'belonging' to a team that had not yet fully formed in a network-based role where other much stronger team identities exist.
Some employment models have enabled staff to remain within a home team, often sub-contracted, where these elements are less predominant. In these instances, attention must be paid to helping staff to become embedded within PCNs to enable practices to use services effectively. However, there are local examples where this challenge has been overcome.
The additional challenges of lack of estates, IT infrastructure and significant remote working can also contribute to feelings of isolation.

## Place specific Feedback Doncaster

**Annex B DES Requirements- ARRS Staff training, supervision, and role responsibilities- survey feedback**

**Survey**

This survey assessed the fulfilment of specific contract specifications as described in in Annex B of the Directory of Enhanced Services (DES). It was distributed amongst a group of stakeholders with a bias to those operationally responsible for employing ARRS staff.

It included questions regarding appropriate registration, appropriate and available training, and supervision and an assessment of delivery of the responsibilities as outlined. The survey responses represented working status of approximately 103 ARRS staff from 25 responses providing care in Doncaster. These were submitted over a 3-week period in June 2023. Due to the anonymity in the survey, there may be a small number of staff who have been represented by 2 respondents. All PCNs were represented however not across all roles.

| Responses received | Roles |
|---|---|
| Multiple or all PCNs that receive services | Health & Wellbeing Coaches |
| | Care Coordinators |
| | Mental Health Workers |
| | Dietician |
| | Social Prescribing |
| | MSK FCP |
| Two PCNs | Physician Associates |
| | Pharmacists |
| | Pharmacy Technician |
| One PCN only | Counsellor |
| | Podiatrist |
| Roles outstanding | Paramedic |

In 4 PCNs appropriate registration of these staff in these roles is reported, there is some uncertainty reported in the remaining PCN. All staff are on track to complete all the training required for the role by the DES. Care coordinators in some areas are still in process of completing training as are Pharmacists in 1 PCN.

Supervision, which in this context is regular support from a named senior or experienced clinician/ practitioner to promote high clinical standards and develop professional expertise, is being accessed at the appropriate frequency with an appropriate supervisor by many respondents. Some PCN's do experience difficulties in providing supervision to some roles both in frequency and in providing an appropriate supervisor.

In Doncaster this is commonly reported, across a range of roles including Pharmacists, pharmacy technicians, Mental Health Workers, Dieticians, Care Coordinators and Social Prescribing Link Workers. In 2 of these roles, Mental Health Workers, and Social Prescribing Link workers the difficulty was reported across all PCNs by respondents.

All roles are taking on all the responsibilities outlined in the DES and Investment and Impact Fund (IIF)in some PCNs, with some reporting work outside these expectations.

In some PCNs Pharmacist and Pharmacy Technician roles are taking 75% of the DES responsibilities whereas in other PCNs staff in the same role are delivering 25% of the responsibilities. . The reason for this is not clear, for example whether staff are new in post and in the process of taking on responsibilities or whether this is an intentional approach to job planning.

The most commonly occurring additional work being done outside of DES and IIF responsibilities is cited as work done in response to practice or business needs for both clinical and administrative tasks.

**Table 1: Summary of Findings**

| | Number of PCNs responding | Staff Numbers | Appropriate Registration<br><br>Yes/No/ Uncertain | Training & Development<br><br>Completed or on track for completion | Access to Supervision<br><br>Frequency and appropriate supervisor | Proportion of Roles & Responsibilities undertaken. Associated with DES /IIF |
|---|---|---|---|---|---|---|
| | | | | | | |
| Care Coordinators | 3 | 21 | Yes | Yes | 1 PCN reports frequency & supervisor difficulties. | 75-100% |
| Social Prescribing Link Workers | 5 | 16 | Yes | Yes | All Doncaster Difficulty with frequency & supervisor | 100% |
| Health & Wellbeing Coaches | 3 | 9 | Yes | Yes | No difficulties | 100% |
| Pharmacists | 2 | 18 | Uncertainty in 1 PCN | Yes | 1 PCN reports frequency & supervisor difficulties. | 25-75% |
| Pharmacy Technicians | 2 | 5 | Uncertainty in 1 PCN | Yes | 1 PCN reports frequency & supervisor difficulties. | 25-75% |
| Physician Associates | All | 8 | Yes | Yes | No difficulties | 100% |
| First Contact Physiotherapists | 5 | 18 | Yes | Yes | No difficulties | 100% |
| Dietitians | 2 | 3 | Yes | Yes | 1 PCN reports frequency & supervisor difficulties. | 100% |
| Podiatrist | 1 | 1 | Yes | Yes | No difficulties | 100% |
| Mental Health Workers | 3 | 5 | Yes | Yes | All PCNs report frequency & supervisor difficulties | 100% |
| Paramedics | 0 | | | | | |

From the findings of this survey, providing appropriate supervision at the appropriate frequency with the appropriate supervisor remains the largest challenge reported. There is a secondary challenge of assuring all roles are undertaking role duties as described in the DES

**Experiences of the Additional Roles Reimbursement Scheme (ARRS) Interview feedback**

During May and June 2023, 14 interviews were completed as 1:1 meetings or group discussions, transcribed and analysed for themes.
The conversations followed a flexible topic guide which included:

- Describing the experience of working in PCNs/ providing services / or using skills and services of ARRS staff
- Identifying challenges and constraints
- Identifying successes and enablers
- Reflecting on learning through the period of employment or service delivery

The roles of participants are summarised below:

| Individuals in Roles | Subcontracted Providers | Digital & Transformation Leads | Groups |
|---|---|---|---|
| Dietitians | Be Well Health Coaches | North | CDS &D&T Leads |
| Pharmacists | SYHA- SPLW | Central | cancelled |
| Mental Health Workers | Pure Physio | South | |
| Physician Associates | | East | |
| Paramedics | | 4Ds | |

A wide group of participants were approached, and it was possible to have role, service and PCN leadership representation in interviews. Unfortunately, due to unforeseen circumstances it was not possible to hold a group discussion with the Clinical Directors.

The information and discussions recorded as part of this impact evaluation has demonstrated common areas of challenge, constraints, enablers, and solutions about ARRS particularly from the perspective of those working in 'Additional Roles', leading services and staff providing and organising these services and Digital & Transformation Leads. There are reflections from long standing service providers and those in the early stages of implementation. PCN Digital & Transformation leads have contributed a range of information particularly with reference to the development of the Care Coordinator role in Doncaster.

The lack of opportunity to interview the Clinical Directors as a group mean that there are limited reflections from the GP perspective in Doncaster on the way different roles contribute differently to GP capacity, patient outcomes, and experience and the scope for roles to continue to develop within Primary Care.

**Challenges and constraints**

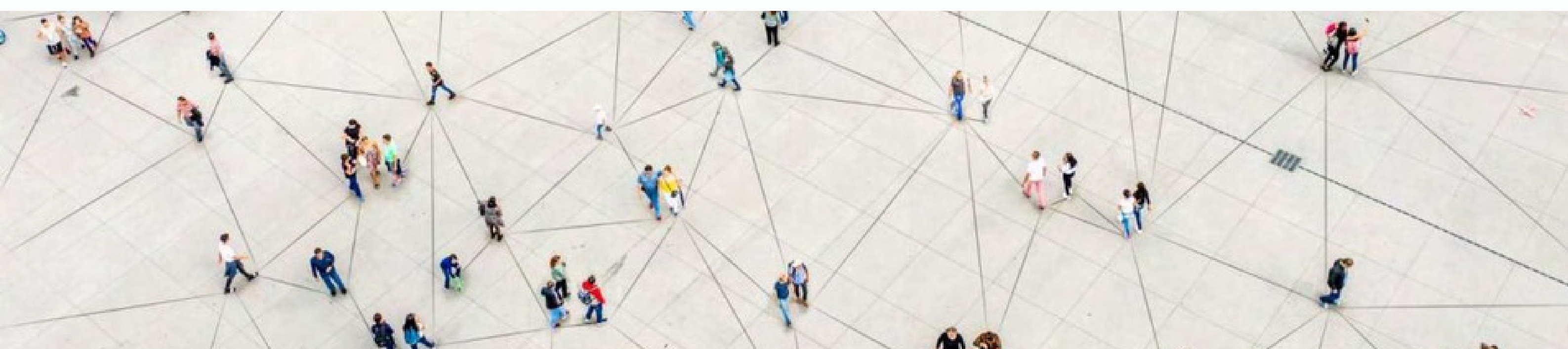
Role and Service respondents in addition to Digital & Transformation leads have identified similar cross cutting challenges as well as specific ones relevant to individual roles and contexts.

**Role Clarity**

Confusion and uncertainty over the role boundaries and purpose is a common obstacle to effective implementation in roles as varied as Mental Health Workers, Care Coordinators and Health and Wellbeing coaches. It was also a difficulty described by pharmacists early in the implementation of Primary care roles. It has been particularly true for the health coaching service: Initially, health and wellbeing coaches faced challenges in integrating with primary care networks, as the concept of health coaching was new to many. However, over time, they have established partnerships and gained access to the networks' systems for appointments and record updates. The investment of time and effort has also been characteristic of the work associated with the development and implementation of Mental Health Workers in Primary Care. The establishment of the Care Coordinator role has also experienced difficulties in gaining agreement on the roles and responsibilities. Areas where the caseload or remit is clear, such as Physiotherapists in FCP roles or Primary care-based Pharmacy roles, have not experienced these challenges to the same degree.

**Network Diversity**

Each network has its own preferences, and this diversity is noted by many respondents as a challenge in providing services as it requires significant investment in time and attention to manage these differences. There was frustration when investment and commitment by services of time in joint work and collaboration did not result in implementation of agreed new developments or improvements. The difference in requirements by PCNs and the difference in demand for services is a challenge for services in providing accessible and equitable services. Role respondents also reflected that different models of delivery, roles, and responsibilities of those in the same profession in different or the same PCNs did cause tension particularly if the standards of service provided did not appear to be equitable. This challenge was found in clinical and non- clinical roles. Managers reported that varying degrees of communication and collaboration between practices added complexity to managing care coordinator roles across a PCN. Varying approaches and interpretation of the national framework was unhelpful to managers and those in role alike.



**Belonging and Identity**
The difficulty for those employed in ARRS staff roles to work from multiple locations is also recognised as a challenge in maintaining staff in post. Creating a 'home- from -home' with a sense of being embedded and part of the team is an important factor in retaining ARRS. Isolation was a common theme. This has been managed and mitigated by regular meetings and opportunities to be brought into the team but is hampered by the pressure on estates. The pressures on workforce such as Pharmacy and the difficulties of recruiting in wider services was also highlighted. Physician Associates also reported the difficulty of working to different expectations in different practices, where their remit is different. This can be experienced as not feeling trusted, feeling frustrated and resulting in clear preferences of where to work. Frustration can be heightened when GP colleagues take different approaches to each other in their clinical advice and guidance.

**Multiagency collaboration and communication**
For some services the requirement for multi-agency collaboration and communication is particularly important in contributing to the effective running of services, this was recognised as an ongoing challenge. Care coordinators have enabled this challenge to be effectively addressed in some PCNs managing patient flow and ensuring 'no-one falls through the cracks.'

**Speed of Implementation**
It has been recognised by Digital &Transformation leads that implementing several new services or approaches in a short time caused confusion and difficulty, and subsequently they have implemented new services in a phased manner. The speed of change also highlighted the cultural differences between organisations, the impact of which had not been fully considered by many PCNs when approaching additional roles in Primary Care.

**GP capacity to provide training and supervision.**
This challenge was highlighted by supervisors and Digital & Transformation leads in terms of loss of GP capacity and from individual GP feedback. However, this was not common area of discussion during role respondent interviews.

**Constraints**

- Estates and pressure on facilities was identified by most as an ongoing challenge when considering new staff working within the Primary Care Network (PCN). When implementing new and less well understood roles this adds difficulty. In addition, in early phases of implementation services being less visible meant that is took longer before new referral habits became embedded which the potential of a loss of capacity due to the lack of visibility as a reminder to support behavioural change.
- Role and service respondents noted lack of IT integration as a constraint; absorbing additional time and effort, this is particularly demanding for those working across practices and PCNs.
- Improving patient acceptance of differing service location has been seen. It was noted that patients can be reluctant to accept services that are not provided at the GP practice, change in location was highlighted more than concerns about patients accessing members of the wider multi-disciplinary team. In this case the location not traditionally associated with health care provision.

- The difficulty of providing data that is meaningful to Primary Care that demonstrates outcome and impact that immediately relates to GP capacity is a challenge for some services. This is particularly true of some of the Personalised care roles such as Health and Wellbeing Coaches or Social Prescribing Link Worker services.

**Successes and Enablers**
Important successes were reported during the interviews.

**Impact on GP Capacity**
From the stakeholders interviewed there was agreement about where positive impact can be seen for GPs and patients in terms of quality of primary care services and GP capacity although it was recognised that this was hard to quantify in some areas.

| Role | Capacity | Improved outcome |
|---|---|---|
| The MSK FCP service | X | X |
| Pharmacists | X | X |
| Physician Associates | X | |
| Mental Health Practitioners | X | X |
| Social Prescribing Link workers | X | X |
| Care coordinators | X | X |

**Quality of Care**
There is evidence of the development and implementation of multi -disciplinary models and pathways of care which shorten pathways and improve services for patients, these new models often require persistence and resilience from staff to succeed due to the constraints of estates and IT systems in addition to the challenges noted.

**Patient Satisfaction**
There were many examples of services demonstrating that patient experience was positive, and that staff experience was also motivated by the value that they were able to deliver to patients.
'the (patient) feedback was overwhelmingly positive…. The overall theme was that they felt listened to and that they felt respected, they were given the time to talk.' (Social Prescribing Link Worker Service)

‘it's just the patient stories. It's just unbelievable and staff, they love it. They feel like they are making difference. They are giving people the tools and skills right at the beginning and they love it, they are, and I wasn’t sure they would do ‘cause it's been hard for them because the culture is completely different…in each GP surgery in the same PCN is completely different.’ (Mental Health Service Manager)

This feedback continues not show the commitment of services in engaging with PCNs despite some of the challenges described. ‘we’ve got to hang on to the quality because it'll just become another service that that under delivers if we're not careful.’

**Enablers**

- The Digital & Transformation leads can illustrate systematic approaches to the development of PCN roles, attention to team dynamics, identity and belonging within some ARRS roles.

- There are established relationships across Doncaster with a wide range of service providers reaching across providers of health and social care interventions. Implementing mechanisms for good communication between services and PCN employed teams that allowed development, feedback and updating to maximise effective service delivery. These approaches have built relationships and trust and have provided opportunities for conversations and difficulties to be discussed and resolved. This is seen through the models of engagement across organisations such as South Yorkshire Housing Organisation (Social Prescribing Link Worker Provision), Be Well (Health & Wellbeing Coach service provider, RDaSH (Rotherham, Doncaster, and South Humber NHS Foundation Trust Mental Health Team Provider) or PURE Physiotherapy (MSK FCP service provider). This has been particularly noted in resolving role boundaries and purpose, in the implementation of new services or ongoing reporting and update maintaining multi- agency communication.

- There are examples of GP practices where staff clearly express their appreciation of the support, development, and training that they receive and where they are considered a core part of the team. All expressing this view also express their subsequent desire to remain embedded in these working environments.

Other challenges such as the diversity of Practice or PCN needs or desires often appear to have been managed by ‘work arounds’ rather than resolution with service providers adapting to the present requirements. Individuals in roles do manage ongoing tensions in difference in role description, standards for delivery and varying degrees of discomfort with their role expectations.

PCN leadership teams, individuals and services report challenges in implementation however have demonstrated learning and a creative approach to managing difference, developing relationships, and implementing change. The PCN management capacity appears to have been important in developing the care coordinator roles and multi-disciplinary models of care.

The conversations and insight gained through the conversations for Doncaster place have demonstrated a commitment across the system to implement new roles and models of care. It is still a work in progress and there have been significant challenges and obstacles to overcome. There is evidence that learning has occurred, and services are having an impact on patients and on Primary Care capacity.

**Place Specific Feedback Rotherham**

**Annex B DES Requirements ARRS Staff training, supervision, and role responsibilities- survey feedback**

**Survey**

This survey assessed the fulfilment of specific contract specifications as described in in Annex B of the Directory of Enhanced Services (DES). It was distributed amongst a group of stakeholders with a bias to those operationally responsible for employing ARRS staff. It included questions regarding appropriate registration, appropriate and available training, and supervision and an assessment of delivery of the responsibilities as outlined. The survey responses represented working status of approximately 110 ARRS staff from 16 responses providing care in Doncaster. These were submitted over a 3- week period in June 2023. Due to the anonymity in the survey, there may be a small number of staff who have been represented by 2 respondents. All PCNs were represented however not across all roles.

| Responses received | Roles |
| --- | --- |
| Multiple or All PCNs that receive services | Pharmacist |
| | Pharmacy Technicians |
| | Paramedics |
| | Social Prescribing Link Workers |
| | First Contact Physiotherapists |
| | Care Coordinators |
| One PCN only | Physician Associates |
| | Nurse Associates |
| Outstanding role | Mental Health Workers |

The survey responses represented working status of approximately 103 ARRS staff from 16 responses providing care in Rotherham. Due to the anonymity in the survey, there may be a small number of staff who have been represented by 2 respondents.

All staff are reported as registered should their role require it and the staff represented are all on track to complete all the training required for the role by the DES. Care coordinators in some areas are still in process of completing this as are the Paramedics working in one PCN as part of newly implemented rotational paramedic scheme with Yorkshire Ambulance Service.

Supervision, which in this context is regular support from a names senior or experienced clinician/practitioner to promote high clinical standards and develop professional expertise, is being reported as being accessed at the appropriate frequency with an appropriate frequency by most respondents. In one PCN there is difficulty accessing the appropriate supervisor at the appropriate frequency for care coordinators and in the paramedic provision there is some difficulty reported in accessing supervision with an appropriate supervisor.

There are several roles some reporting full alignment with the responsibilities outlined in the DES and IIF, with some reporting additional responsibilities. The most commonly occurring additional work is cited as being responsive to practice or business needs.

**Table 1: Summary of Findings Rotherham**

| | Number of PCNs responding | Staff Numbers represented | Appropriate Registration<br><br>Yes/No/ Uncertain | Training & Development<br><br>Completed or on track for completion | Access to Supervision<br><br>Frequency and appropriate supervisor | Proportion of Roles & Responsibilities undertaken. Associated with DES /IIF |
|---|---|---|---|---|---|---|
| | | | | | | |
| Care Coordinators | 3 | 21 | Yes | Yes | 1 PCN reports frequency & supervisor difficulties. | 50 -75% |
| Social Prescribing Link Workers | All | 15 | Yes | Yes | No difficulties | 75-100% |
| Pharmacists | 2 | 11 | Yes | Yes | No difficulties | >75% |
| Pharmacy Technicians | All | 19 | yes | Yes | No difficulties | 50-75% |
| Physician Associates | 2 | 2 | Yes | Yes | No difficulties | 75% |
| First Contact Physio | 5 | 10 | Yes | Yes | No difficulties | 100% |
| Paramedics | All | 21 | Yes | Yes | 1 PCN reports frequency & 1 PCN supervisor difficulties. | 75-100% |
| Nursing Associates | 1 | 1 | Yes | Yes | No difficulties | 75% |
| Dietitians | All | 3 | Yes | Yes | No difficulties | 100% |
| Mental Health Workers | 0 | | | | | |

From the findings of this survey 2 challenges remain. There is some divergence from the DES and Impact Investment Fund (IIF) in the responsibilities undertaken by the majority of roles and secondly in providing appropriate supervision at the appropriate frequency across some roles in some PCNs.

**Experiences of the Additional Roles Reimbursement Scheme (ARRS) Interview feedback**

During May and June 2023 12 interviews were completed as 1:1 meetings or group discussions, transcribed and analysed for themes. The conversations followed a flexible topic guide which included:

- Describing the experience of working in PCNs/ providing services / or using skills and services of ARRS staff
- Identifying constraints and challenges
- Identifying successes and enablers
- Reflecting on learning through the period of employment or service delivery

The roles of participants are summarised below:

| Individuals in Roles | Subcontracted Providers | PCN Managers | Groups |
| --- | --- | --- | --- |
| Pharmacy | Physio | Rother Valley South | PCN Managers |
| Pharmacy Tech | Paramedic | Wentworth | CDs meeting |
| Admiral Nurse | | Maltby and Wickersley | |
| Dietician | | | |
| Paramedic | | | |

**TOTAL 12 completed meetings**

A wider group of participants were approached; however, it was not possible to have discussions with some groups, services, or individuals. Amongst this group were Physician Associates, Voluntary Action Rotherham and some PCN managers.

Drawing together the information and discussions recorded as part of this impact evaluation has demonstrated common areas of challenge, constraints, enablers, and solutions in implementing ARRS.  Rotherham PCNs have learnt from early experiences to act on areas within their control, this has led to learning on models and factors which support effective implementation and delivery of the Additional Roles Reimbursement Scheme. From these conversations it has been clear that PCN leadership teams recognise that different roles contribute differently to GP capacity, patient outcomes, and experience and that there is scope for roles to continue to develop within Primary Care.

## Challenges and Constraints

### Recruitment and Retention

Clinical Directors and PCN managers both identified a consistent primary theme of difficulty of recruiting and retaining staff.
Competition between practices, PCN and Place were noted meaning that some areas found it particularly hard to recruit and retain. A significant factor in this competition is diversity of pay, terms and conditions. There was a recognition of workforce stresses and strains in some professions and concern about availability of staff was particularly mentioned in Pharmacists due to workforce supply and Physician Associate roles due to competition. Tension was caused by diversity within a PCN, where people, employed in the same role and on the same job description, were employed on different terms and conditions.
Other working practices and difficulties had contributed to rapid ARRS staff turnover in some areas. Some reasons cited included: poor induction and poor operational processes, such as how to book annual leave or poor communication with staff. If the expectations of PCNs and new staff did not align or there was a lack of understanding about the individual's abilities in the Primary Care context the early period of employment was difficult. ARRS staff being 'spread too thinly' was repeatedly mentioned as a cause for unhappiness and turnover. This was also reported as a characteristic particularly of some of the early recruitment.

### Training and supervision

The extent of training and supervision required for some roles and new staff at the beginning of employment was also a 'surprise' that caused difficulty due to the lack of GP capacity. There was frustration that newly trained staff would move to alternative primary care employment despite the investment in training. Time pressure and lack of capacity has also been apparent in the time to manage HR and staff issues. Clinical Directors also identified that GPs may not have had the opportunity to access leadership training and thus not developed the specific leadership skills now required to operationally manage, lead, and develop diverse teams.

### Role Clarity

Some role respondents noted that there were challenges in clarifying their role and expectations of Primary Care practices and PCNs. This required a lot of investment in meeting time and individual conversations and could be difficult when practices had fixed views. Staff experience of the content of some roles remained different across the practices which meant that staff employed in the same role may have significantly different duties. Lack of attention to small operational issues had caused disproportionate difficulty to staff. In this area the staff in ARRS roles who were interviewed were also largely embedded in other teams and so were supported in the operational, professional and communication challenges that they reported. However, the PCN managers described high staff turnover in some areas where individuals were employed which could be related to a lack of organisational maturity within the PCN or difficulty in gaining cooperation between practices.

**Network Diversity and cultural differences**

The diversity in practices' approaches was considered manageable by some providers if expectations were appropriate. The challenge of providing bespoke services across a PCN however was reported as a strain on services.

The culture of Primary Care was reflected as being markedly different to other Health care organisations often resulting in culture difference for both staff coming into PCNs and for GPs and PCN Managers. One role respondent noted the tension between the business-driven perspective and the quality agenda they felt their service was pursuing. There were examples of competing demands and tensions between practice led priorities and PCN level requirements. PCN managers also reported that the flexibility in working patterns, hours and bases expected by staff who had previously been employed by other organisations was challenging. There was a need to gain new understanding of how different roles and professions organise their time to deliver safe services. This again had not been expected and had caused some tension.

**Constraints**

- Estates and pressure on facilities was identified by most as an ongoing challenge when considering new staff working within the Primary Care Network (PCN). In some PCNs the number of practices and branch surgeries has made employment, delivery and integrating of some ARRS staff more difficult.
- Role and service respondents noted lack of IT integration as a constraint; absorbing additional time and effort, this is particularly demanding for those working across practices and PCNs.
- Lack of flexibility in using the funding was identified by some as a constraint.
- Clinical Directors noted a lack of PCN Management support, particularly in the early period of implementation, and there remain concerns about resilience and the identification of this as a risk. In addition to the way that PCNs must function as entities, difficulties with VAT and the new demands of integrating and the operational management of staff led one respondent to comment that 'we are out of our depth in doing this'.

**Successes and Enablers**

There have been some important successes noted through the interviews.

**Impact on GP Capacity**

From the stakeholders interviewed there was about where positive impact can be seen for GPs and patients in terms of quality of primary care services and GP capacity although it was recognised that this was hard to quantify in some areas.

Some roles were commonly mentioned in interviews and meetings as ones which were delivering benefits in terms of GP capacity and quality of care. As expected, there was varying impact on GP capacity with different roles.

**Roles associated with positive impact on GP capacity and quality**

| Role | Capacity | Improved Outcome |
|---|---|---|
| The MSK FCP service | X | X |
| Pharmacists | X | X |
| Paramedic Home visiting | X | X |
| Social Prescribing Link workers | X | X |
| Care coordinators | X | X |

The Admiral Nurse service, which is a part ARRS funded service (supporting families in dementia care where there are complex needs), was reported as a valuable service with a positive impact on quality, although with a less clear link to GP capacity. The Mental Health workforce was also noted as having significant potential but had not yet been widely established.

**Quality of Care**

There is evidence of the development and implementation of multi -disciplinary models and pathways of care which are shorten pathways and improve services for patients, improve GP capacity and improve population health.

These new models often require persistence and resilience from staff to succeed due to the constraints of estates and IT systems in addition to the challenges noted to improve pathways and patient experience.

**Improving consistency in employment approaches**

Having recognised the diversity in employment approaches as one of the most significant challenges, the majority of PCN leadership teams are identifying methods to align pay, terms and conditions for ARRS staff. The approaches vary. PCN managers are instituting processes which support effective working and encourage belonging and identity including improving induction and bringing new staff into the team. These include, staff being in small teams with buddies and peer support, regular 1:1s, meetings and an inclusion in the wider team events. In many cases there has been a reduction in the number of practices ARRS staff are expected to work from and a reduction of rotational posts.

**Enablers**

- PCN managers being in post has allowed some of the identified challenges to be addressed.
- A developing culture which supports flexibility and adaptability with ARRS staff has generated a much more stable staff team in some areas and allowed more effective recruitment. This has often been alongside implementing intentional team approaches and paying attention to communication to improve the embedding of staff.
- Mechanisms for good communication between subcontracted services and PCN employed teams that allowed development, feedback and updating to maximise effective service delivery. When working with other services and organisations there is evidence of proactive approaches with regular review meetings to enable feedback and discussion and inclusion in events to support communication and team working
- Established, well -defined and delivered subcontracted services that manage the staff team, service delivery and operational issues were universally recognised as helpful and effective.

PCN leadership teams, individuals and services report challenges in implementation however have demonstrated learning and a creative approach to using funding and employing staff. The PCN management capacity appears to have been important in improving processes and embedding learning.
There is agreement about where positive impact can be seen for GPs and patients in terms of quality, capacity, and patient experience. It is important to recognise that the hope that 'I would have time to breathe in my working day' has not been experienced by the GPs contributing to this evaluation. There is a common thread that the growth in GP workforce remains a priority despite additional staff in the primary care team and that the extent of unmet need and demand continues to drive the feeling that 'we're still working as hard as ever'. However, the reflection that 'I would have probably snapped by now if we hadn't had the Home visiting service' provides a counterpoint to an anecdotal reflection that these roles aren't making a significant difference. There is also the reflection that this scheme has provided new and additional staff who have helped 'open eyes to act on a wider context' and this has helped move the Primary Care team to an MDT model which brings specific expertise embedded into Primary Care.

**Cross 'Place' Discussion**
**Common challenges to implementation of new roles**

In relation to the rapid expansion of Primary Care teams to include different professions and new roles, consistent themes emerge such as the importance of role clarity, training and supervision capacity and the importance of belonging and identity for ARRS staff.

The challenges of role clarity have been improved by respondents over time as knowledge of the role and individual has developed there remains a challenge, in some areas, in the staff fulfilling the roles and responsibilities outlined in the DES.
Survey and interview feedback consistently points to a lack of GP capacity for clinical supervision particularly in the early periods of implementation in particular roles. This was particularly noted in relation to the volume of clinical supervision required by Physician Associates however other roles requiring less supervision are also drawing on a limited resource. There was a suggestion that this also impacts on the decisions to recruit into roles. Other roles such as Social Prescribing Link Workers and Care Coordinators also report some deficit in supervision provision.

The need to have a 'home' and a 'home team' was spoken about by respondents whilst reflecting that it was challenging to find one and difficult to be asked to move on. Individuals and PCNs have found pragmatic ways to manage individuals however it remains a challenge for wider workforce transformation due both to the constraint of lack of estates capacity in addition to some feedback that ARRS staff aren't always considered part of the core team.

The importance of effective communication and governance structures, attention to recruitment and retention processes and a new approach to multiagency collaboration are recognised as factors which mitigate some of these risks to delivery. Network diversity, cultural and professional differences, and the speed of implementation of change with a lack of organisational resource have also been noted as additional complexities to implementing this scheme.

Similar strains across Places are the constraints on Estates and IT capacity and capability. Access to systems and accurate reporting data was also seen as a challenge by some services.

**Common benefits of implementation**
The benefits described in the wider literature have also been described in the interview data.
As described in Place based feedback some roles were commonly mentioned in interviews and meetings as ones which were delivering benefits in terms of GP capacity and quality of care with consistency across Rotherham and Doncaster.

**Roles associated with positive impact on GP capacity and quality**

However, there are roles and models which are in place and effective in one area and less so in the other.

PCNs have chosen which roles and services to prioritise and although have been constrained in implementation by a range of factors including workforce supply have expressed preferences and judgements about which services and roles are most supportive of their needs and those of their populations. Future work could look to develop roles which have already been particularly effective in supporting patient access and GP capacity.

In relation to patient outcomes and stakeholder acceptability there is data from individual services to demonstrate impact and the feedback that is received. There are also services who regularly analyse and develop action plans to address areas for improvement.

In both Doncaster and Rotherham subcontracted and PCN hosted models of delivery were reported as effective. However, to be successful hosted PCN models of delivery required significant investment in operational and team management.

During the interviews, PCN teams brought together these experiences of challenges and identified important learning which is helping effective implementation and delivery, and which is supporting some of the challenges maximising the potential of Additional Roles staff.

- A consistent approach to employment practice with reference to roles, including job descriptions, terms and conditions and salaries is key for a sustainable workforce in Primary Care
- The needs and requirements of the PCN needs to be established before recruitment.
- Preparation for role and job plan development with an understanding that it may take some time for the member of staff to work at full capacity and level of skill.
- Flexibility and adaptability to the individual and role in terms of development of role and operational delivery need to be managed i.e., caseload, base and working hours.
- Embedding the person and the role is crucial through normal good working practices.
- Effective communication and negotiation are key skills in PCN leadership.

**Conclusion**

This report outlines some of the expectations of implementation of the ARRS and some of the benefits and challenges experienced in a national and local context. The complex environment of Primary Care and ongoing workforce pressures have undoubtedly contributed to challenges in implementation. In addition, the variety of employment models can materially affect the experience and impact of those employed through the Additional Roles Reimbursement Scheme and the experience and resource required in PCNs to support the ARRS. However, there are common experiences and learning across Doncaster and Rotherham which are consistent with national experience and will be relevant across South Yorkshire. Whilst significant progress to ARRS implementation has been made, improving patient access and Primary Care capacity, there are further opportunities to extend again the impact of a wider multidisciplinary team to embed effective recruitment, retention and sustainability.

| **Recommendations – areas for future work** | |
|---|---|
| **Ensure ARRS funding is used optimally for DES requirements.** | Understand the variance in ARRS funded roles with DES requirements where roles not consistently aligned |
| **Supporting effective recruitment** | Adopt new ways of working to implement consistent job descriptions, terms and conditions and salaries. |
| **Supporting training and development** | Review opportunities to support GP supervision capacity to enable the adoption of roles to support access and GP capacity.<br>Develop multi professional supervision capacity to support a wide range of staff. |
| **Support effective implementation** | Review models of employment in place in South Yorkshire<br>Identifying enablers and barriers to effective implementation & impact |
| **Support effective retention – belonging and identity** | Consider sustainable working patterns and practices to create a wider team.<br>The effective use of estates capacity will need to be considered to support this. |
| **Identify opportunities to expand roles effectively which are presently employed in Rotherham or Doncaster but not both.** | For example: Physician Associates, Mental Health Workers, Health and Well Being Coaches |

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