The King's Fund>

Integrating additional roles into primary care networks

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About this report

This independent report was commissioned by the Department of Health and Social Care. The views in the report are those of the authors and all conclusions are the authors' own.

The King's Fund is an independent charity working to improve health and care in England. Our vision is that the best possible health and care is available to all.

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Key messages

- In January 2019 the Additional Roles Reimbursement Scheme (ARRS) was introduced in England, which would eventually support the recruitment of 26,000 additional staff working in general practice by 2023/24. This scheme formed a critical plank of the government's manifesto commitment to increase the number of annual appointments in general practice by 50 million.

- The ARRS represents a huge scale of ambition and requires the implementation of significant and complex change across general practice. While primary care networks (PCNs) have swiftly recruited to these roles, they are not being implemented and integrated into primary care teams effectively.

- We found that PCNs are in their early stages of development and in many cases lack a clear, shared overall purpose and strategy or a clear, shared vision and buy-in for the ARRS roles. Many PCNs do not share a team identity, and this makes deploying network-wide staff in a supported way very complex when there are different strategies, different cultures and different identities to be managed.

- The confusion around strategy is also linked to a lack of agreement about whether the roles are primarily intended to deliver the requirements of the PCN contract or to undertake what might be considered the 'core' work of general practice.

- The potential contribution of additional roles to general practice is not universally understood, despite large amounts of written guidance, job descriptions and roadmaps, all of which may even have added to the confusion.

- We found ambiguity among some GPs about what multidisciplinary working would mean for them and their working practices, both clinically and in the way in which their practices are run. While the national direction of travel appears to be that multidisciplinary working in general practice is a key part of the future vision, there has not been enough consideration about how GP roles, or the organisation of general practice itself, might need to change as a result.

- The cultural change required by the introduction of additional roles, and new approaches to teamworking, requires extensive organisational development, leadership and service redesign expertise and this has not been adequately available to PCNs, nor is it present in many individual practices. All of this has been compounded by the impact of the Covid-19 pandemic on general practice.

- This lack of effective and supported implementation means that the core needs of individuals working in ARRS roles – autonomy, belonging and contribution – are not being met in many cases.

- A variety of support – including clinical supervision and managerial, human resources (HR) and peer support – is critical to the effective integration of ARRS roles within general practice and yet there is inadequate additional funding to provide PCNs with the capacity to provide this support well.

- Centralised or subcontracted employment models have the potential to provide some of this support more easily but have the downside of ARRS staff feeling even more distanced from the teams they are working alongside.

- A lack of an adequate estate is fast becoming an issue in many areas. The solutions will require expertise in the design and use of space to support multidisciplinary teamworking, and it is not clear how PCNs will access such expertise.

- The uncertainty around the future of funding for the ARRS roles after 2023/24 has started to generate concern. Expectations of the impact that these roles will have are high, but like all new roles, it will take time before they are fully understood. Creating stability and certainty will play an important role in this.

- We found examples of good practice and positive stories of implementation, but to ensure successful implementation of the roles we make recommendations including:

  - a clearer, shared vision for a multidisciplinary model of care
  - a comprehensive package of support for implementation of the scheme
  - a focus on future sustainability, including funding, estates strategy and career progression
  - leadership and management skills development embedded in GP specialist training.

① Introduction

Multidisciplinary teams are fundamental to the future of general practice. Evidence from the United Kingdom (UK) and internationally suggests that team-based care offers advantages in delivering the core attributes of general practice that we have identified previously (**Baird *et al* 2018**), including improved access, more efficient co-ordination and improved continuity (**Wagner 2000**). Fundamental to this approach is the belief that when practices draw on the expertise of a variety of team members, patients are more likely to get the care they need (**Schottenfeld *et al* 2016**).

In January 2019, a new five-year contract framework for general practitioners (GPs) was agreed, a central feature of which was the Additional Roles Reimbursement Scheme (ARRS), which would support the recruitment of, initially, 20,000 additional staff working in general practice by 2023/24. These additional roles form a critical plank of the government's manifesto commitment to increase the number of annual appointments in general practice by 50 million (**Conservative Party 2019**). The roles are also key to delivering the enhanced range of services expected of primary care networks (PCNs), also introduced in 2019 to bring GP practices and others together to work at scale.

Under the initial 2019 contract agreement, NHS England and NHS Improvement would contribute to the cost of the specific new clinical roles within PCNs, with the different roles coming in over the period of the contract. Initially the funding covered 70 per cent of the ongoing salary costs plus on-costs for three roles – clinical pharmacists, physician associates and first-contact physiotherapists (with community paramedics able to be recruited from 2021/22) – along with full funding for social prescribing link worker roles during the contract period.

Updated contracts for 2020/21 and 2021/22 set out increases in the scale and ambition of the new roles. NHS England and NHS Improvement now reimburse 100 per cent of the salary costs and on-costs for the range of additional roles and the number of staff funded under the scheme will increase to 26,000 by 2023/24. This means that, on average, each PCN will have approximately 20 full-time equivalent staff funded through the ARRS by 2023/24. Eligibility for reimbursement extends to a wide range of roles:

- care co-ordinators

- clinical pharmacists

- social prescribing link workers

- pharmacy technicians

- dieticians

- first-contact physiotherapists

- health and wellbeing coaches

- mental health practitioners

- nursing associates and trainee nursing associates

- occupational therapists

- paramedics

- physician associates

- podiatrists.

PCNs have swiftly recruited to these roles and the ARRS has undoubtedly accelerated the development of multidisciplinary teams within and across general practices. However, anecdotal data suggests that the roles are not being implemented and integrated into primary care teams effectively and there is a risk that the scheme will fail to have the intended impact. Given the importance of these roles in helping to tackle the increasing pressures in general practice and the long-term sustainability of services, successful implementation of the roles is crucial.

Integrating the ARRS roles and making multidisciplinary teams function effectively is a complex task. The King's Fund has a long history of supporting and developing teams working in and across health and care systems, and more recently we have been working with general practices and PCNs as they develop team-based models of care. Drawing on this experience and expertise, we developed this project to explore the factors affecting the successful implementation and integration of the ARRS roles within general practice.

2 Methodology

For this study we focused on four ARRS-funded roles: pharmacists, physiotherapists, link workers and paramedics. We selected these roles for several reasons: they have been covered under the ARRS for the longest period; they represent a mix of both clinical and non-clinical roles; and they represent a mix of employment models. We focused on those employed under the ARRS and therefore have a PCN role, rather than those who may have been previously recruited and funded directly by practices.

We reviewed the available literature that provided guidance on implementing the ARRS roles, including from national bodies and professional organisations. We also searched workforce data to explore what data sources are currently available to measure and assess the effective implementation of these roles.

We carried out focus groups and semi-structured interviews with professionals from each of the four ARRS staff groups. We also interviewed stakeholders from relevant national bodies and PCN clinical directors and managers.

In total we recruited 48 participants from across England for the study, including 15 pharmacists, 10 physiotherapists, five link workers and three paramedics. Participants also included eight stakeholders from national bodies (the Chartered Society of Physiotherapy, the College of Paramedics, Health Education England, the National Association of Link Workers, the NHS Confederation, NHS England and NHS Improvement, the Royal College of General Practitioners and the Royal Pharmaceutical Society) and seven PCN clinical directors and managers.

A full methodology can be found in the Appendix.

3 Findings

Literature

As the ARRS is new, there is limited evaluative literature to examine. There are evaluations of pilot schemes implementing pharmacists and first-contact physiotherapists within general practice (eg, **NHS South, Central and West Commissioning Support Unit 2020**; **Mann *et al* 2018**) but these pre-date the ARRS.

Extensive guidance on the implementation of ARRS roles is available from NHS England, Health Education England and the various professional bodies. Examples include:

• models of recruitment and employment (**NHS Confederation 2021b**; **NHS England and NHS Improvement 2021**)

• detailed roadmaps for training (**Health Education England 2021a**, **2021b**)

• guidance for implementing roles (**NHS England 2021**; **NHS England and NHS Improvement 2020b**).

We also found multiple case studies outlining best practice in implementing the roles (eg, **NHS England and Portsdown Group Practice 2021**; **NHS England and NHS Improvement 2020a**; **Chartered Society of Physiotherapy undated**). In addition to guidance on the websites of professional and national bodies, the FutureNHS collaboration platform contains a wide range of guidance, sample job descriptions and other forums.

Workforce data

There is limited quantitative data available on the roles employed under ARRS. In September 2021 the NHS Digital PCN workforce dataset had information reported from 78 per cent of PCNs, although there is significant geographical variation in the coverage of data, with only 59 per cent of PCNs reporting in one region compared to 90 per cent in another. To take account of this difference in coverage we estimated the number of full time equivalent (FTE) staff per 100,000 patients

using the number of patients registered with a GP in the PCNs returning data. We then applied these figures to the whole population to calculate estimates for each region, adjusting for the missing data.

Of the four ARRS roles examined with the PCN workforce data, pharmacists are the largest group followed by social prescribing link workers, physiotherapists and then paramedics. We found that between June and September 2021 the PCN workforce increased across all four roles under study in this report. Some of the increases were much larger than others. For example, there was a 52 per cent increase in the number of FTE paramedics. We could not find data on attrition, as this was masked by additional recruitment.

It is also important to note that this data only covers staff employed by PCNs under the ARRS scheme, not those working in the four roles employed by individual practices.

Figure 1 **Selected full-time equivalent ARRS roles per 100,000 population, June 2021**

(Source: NHS Digital 2021)
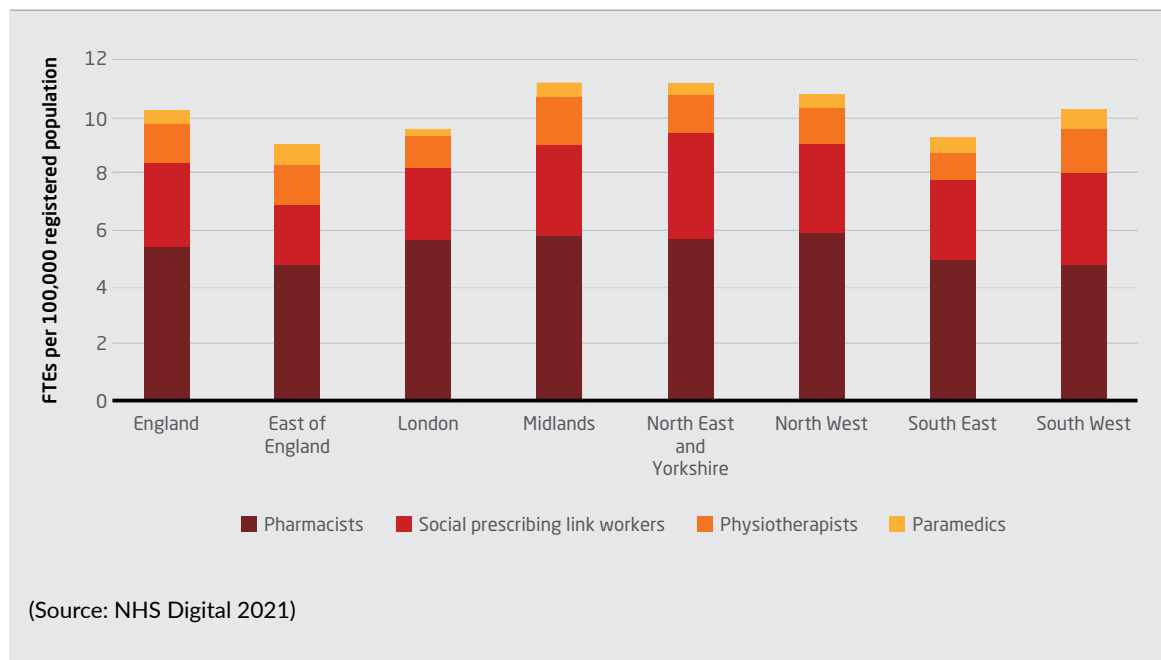
We could not find data on individual attrition, as this was masked by additional recruitment.

Findings from the interviews and focus groups

The scale of ambition that the ARRS represents is huge and requires the implementation of significant and complex change across general practice. While we heard positive experiences from PCN clinical directors and from ARRS professionals themselves, and found good-practice case studies in the literature, overall we found a less positive picture of the implementation of the ARRS roles and areas where improvement will be required. We have divided our findings from the interviews and focus groups into two main sections, the first looking at what PCNs need in order to successfully implement this significant change programme, and the second examining the extent to which the fundamental needs of staff working in ARRS roles are being met. We also look briefly at the impact of the Covid-19 pandemic. We close this section with a summary of profession-specific issues.

Primary care networks' ability to successfully integrate the additional roles

It was clear from our research that the fact that many PCNs are in their early stages of development affected their ability to fully embrace and integrate the additional roles. Added to this was limited leadership capacity within PCNs or access to a wider infrastructure to support cultural and organisational change within primary care. All of this has been compounded by the impact of the Covid-19 pandemic on general practice.

The need for a strategy and clarity of purpose

A lack of a clear, shared vision and buy-in for the ARRS roles across PCNs was evident in our research and was linked to the fact that PCNs in many cases lack a clear, shared overall purpose and strategy. Knowing which roles to recruit, and how to deploy them effectively, was not always clear. A PCN clinical director phrased it this way:

> *'Supermarket Sweep' with Dale Winton... was this gameshow where people have this trolley and you could run around this fake supermarket and just throw everything in, right. And I just use that analogy for the way we employed PCN staff, it's like being in a sweetshop... you're putting loads in because they're free.*

At the heart of this issue was a lack of agreement about the role and purpose of PCNs and the sovereignty of individual practices. Despite the significant ambitions

for PCNs (Baird and Kumpunen 2019), in reality they are often a vehicle for delivering the specific demands of the Directed Enhanced Service (DES) contract, with individual practices maintaining their own identity and strategy. There was clearly disagreement within PCNs and among the ARRS professionals themselves about whether the roles should be used only to deliver the PCN's specifications, or whether they were to provide extra capacity to 'core' general practice. This was further complicated when staff from the same profession had already been employed directly by practices, for example paramedics or pharmacists. For some, this manifested itself in differences within the PCN about how the roles should be used:

> *And I think one of the things that I'm really struggling with as the senior is... getting my pharmacists, who the practices believe are theirs, to deliver PCN work, when the practice kind of thinks: 'Well, hey, I've got this person and I want them to do x, y and z', which is not necessarily part of the DES.*
> (Pharmacist)

Participants reported a lack of understanding or agreement about what the individual roles could, or should, contribute and how they would best be deployed across the network in pursuit of that vision. Case studies from our literature scan recommended taking a system-wide approach, looking beyond practices and PCNs to the wider system so that clinicians could be deployed across different parts of the pathway and there would be a system-wide approach to the delivery of care:

> *So, there's a constant tension about what is the purpose... once we know the purpose, we'll know how to use the staff, either at a population level or at practices. But I think at the moment it's heading in the wrong direction to provide a stable layer of support or additional patient support.*
> (Stakeholder)

Conversely, where PCNs had been able to develop a clear and shared vision and strategy, this informed their plan for recruitment:

> *So, we started off thinking about [the] vision and purpose [of the PCN] for quite a long time actually, thinking about what we're really here to achieve and what value we want out of the PCN. And we used that to dictate which ARRS roles we would look at first.*
> (PCN clinical director)

One PCN clinical director had set up an audit in which every GP in the network was asked to complete a simple questionnaire each time they saved a patient record, asking them to record the skills that would have been needed to meet that patient's needs and replace the need for an appointment with a GP:

Now, I very deliberately didn't put the names of the roles. I didn't say physician associate or paramedic because I knew people wouldn't know what they do. I've broken it down into skills, because I don't think it's about the role, it's about the skill.
(PCN clinical director)

However, the same clinical director found that the preferences of individual practices were given precedence over the PCN's decision-making, potentially because the PCN strategy was not felt to take precedence over individual practice needs or wants. This tension between PCN and practice priority was a feature of our research and affected the way in which staff were deployed.

Even when there was a willingness to address the issues, there was felt to be limited time or capacity within PCNs to have the kinds of conversations that would be necessary to create an overall strategy:

There are some [GPs] that don't have the time to find out how this benefits the practice or how this benefits the patients, or don't even have the time to breathe because I mean I do sympathise [with] my clinical colleagues that are very much under pressure where they don't actually have time to think.
(Stakeholder)

The need for a shared understanding of the individual ARRS roles
A common theme that participants across the different ARRS roles raised was the fact that there was no clear understanding within general practice of what those professionals were able to offer. While some felt that was perhaps inevitable, as these were often new roles and would be worked out over time, it was a considerable cause of stress for both ARRS professionals and the wider team:

And there's an educational component for the GPs... What is the best way to utilise a social prescriber? What can a care co-ordinator really do for you? Because at the moment we've got a tool, and no one's shown us how to use it and we don't know

what we're trying to build with it. So, something around clarity and something about time and something around just recognising that this isn't going to be a quick fix.

(Stakeholder)

Misunderstanding about what the individual ARRS roles could offer was common across the different roles. It appeared that for first-contact physiotherapists and for link workers this was partly because of a problem in accessing services in other parts of the health and care system. For example, a lack of access to physiotherapy treatment in the community meant that first-contact physiotherapists employed under the ARRS scheme, whose role is assessment and referral but not treatment, found it hard to get traction for what they were there to do:

It was a struggle to start with, to get all the clinicians we work with [to realise] that we weren't a physiotherapy treatment service… So, we did an awful lot of meetings and talking and education and, as everybody said, really getting to grips with the admin staff. But our difficulty is there's such a constant change of staff… and admin changes all the time, and our GPs, unfortunately. So, when we have locums coming in, again you might pick up they've come in a couple of weeks later and they're already thinking you're a treatment service.

(First-contact physiotherapist)

Likewise, link workers reported receiving referrals that were not appropriate for their role but were being made because of a lack of alternative provision:

You become a last-chance saloon, because mental health services are so overrun that you, you know, we're supposed to be dealing with low to mid or working alongside, you know, primary mental health services to support them, but not being that main deliverer, and that's happened quite a lot, where you've got people who are on the edge and not appropriate for services.

(Link worker)

Several of the ARRS staff said that they wanted more guidance, for example, about how long a structured medication review would take or the potential role of a social prescriber. Given the extensive amount of guidance about ARRS roles that is available from national bodies such as NHS England, Health Education England and the various professional bodies, this was surprising. However, the breadth and

extent of this guidance may be at the heart of the issue, as it was clear that PCN leaders did not have the time or headspace to absorb that guidance, nor to socialise it with others in their PCN.

> *As an example, various bodies have created 'roadmaps' for different ARRS professionals, outlining the core competencies needed and the different stages of career progression* (Health Education England 2021a). *Some are more structured than others, but they were seen to be particularly complicated to interpret for PCNs and practices: The NHS, essentially, produced hundreds and something pages of a roadmap, which specified various restrictions you can and cannot employ and it was quite vague at the time.*
> (PCN clinical director)

The need for increased internal and external capacity to support organisational and cultural change
It was clear that written guidance on its own did not mitigate the need for work to understand and embed the ARRS roles. Participants in our research suggested that access to support for the organisational and team development that would be needed to embed the roles was lacking. In some areas, training hubs, clinical commissioning groups (CCGs), local medical committees or GP federations offered support and training but there was distinct variation in the ability to access such support. PCN development money could be used to buy in support, but often PCN leaders or practices did not know what was available or what support might be the most helpful to them. One interviewee contrasted this with the support available within NHS provider trusts when they were introducing new roles:

> *Our CCG has played a role in trying to facilitate it, but actually these are provider jobs in provider organisations and again it depends on the maturity of the PCN, but a lot of them are still running on a wing and a prayer. And many practices' HR [human resources] department is their practice manager who is already also their finance department and their training department and their complaints department, and you're right, when you're trying to bring in a new workforce you wouldn't dream of opening a new department in a hospital and just employing 15 of said people and locking them in a space and saying get on with it.*
> (Stakeholder)

Models of employment and recruitment support
We heard about a range of employment models, including direct employment by the PCN, subcontracting from a local voluntary sector organisation or NHS trust and rotational posts (see 'Profession-specific issues', p32). Often the models used were pragmatic, according to local circumstances, even within one profession:

> *We have a really mixed pattern across the whole of the county so we've got multiple PCNs. Some of them work very similarly, we're embedded into the practice for our care; and others are a hub model where we provide the care from our centres. Some of that is determined by their facilities and how much space they have, which is becoming more and more precious.*
> (Physiotherapist)

One of the issues of subcontracted models was related to variation in terms and conditions, particularly when roles were subcontracted from NHS organisations, because general practice is not subject to Agenda for Change. This caused tensions within individual professional groups who were employed under different models:

> *One of the issues that we had with our paramedics in my previous PCN was that they were practice-employed rather than under [the rotational model]. And each of them had different terms and conditions. So, their holidays were different, their pay rates were different, and when they started speaking to each other, that caused all sorts of problems.*
> (Paramedic)

It could also create tensions between different roles in practices as, for example, practice nurses are not subject to Agenda for Change and so do not benefit from the associated pay rises and benefits.

Centralised models of employment, where additional roles are employed by GP federations or NHS trusts, did seem to mitigate issues of pay competition between practices, particularly when the local job market was small or constrained, and helped to allay the concerns of employers in other parts of the NHS (NHS Confederation 2020) that they would lose staff to PCNs if they were paid at a higher rate. Again, the issue of practices as individual businesses with the ability to determine their own recruitment, terms and conditions, and indeed to compete within a marketplace for staff, was raised.

Subcontracting entire services, such as link workers or mental health practitioners, from a third-party provider in particular affected integration with practices and the PCN, as the individuals were not seen as an integral part of the primary care team but as a bolt-on additional service.

External support for recruitment was, in the main, seen as a positive:

> *You're, usually, working alongside organisations who are well used to hosting these roles and they have got job descriptions. They know exactly how to support them from a professional perspective. They can help you with advertising, going through the CVs, making sure that we're selecting the right person.*
> (PCN clinical director)

> *Now, I am a GP, I don't understand what level seven capability means in terms of paramedic competencies. They were then quite vague around, well, how many years of experience you need to have before you can work in primary care… we, actually, ended up having to employ an independent consultant… without that support I don't think I would have got where we were because even the CCG could not tell us about the recruitment criteria.*
> (PCN clinical director)

However, expert external recruitment could also create tensions between those who wanted to ensure the right professionals were recruited and PCNs and practices that wanted to maximise the number of roles. Senior pharmacy and physiotherapy staff reported PCNs wanting to end their use of expert recruitment input because they felt it was impeding their supply of staff by discounting too many candidates, whereas the professional support was keen to ensure that staff met appropriate competencies.

Clarity and certainty of funding
Although the ARRS lasts for a number of years, the end of the funding period is coming closer, which meant some practices were becoming concerned about what would happen after that period:

> *I think the other barrier that's starting to filter through a little bit now is that obviously the contract is getting shorter and shorter. So when we recruited at the beginning, five years. Brilliant, yes, no problem. Now it's like: 'Oh, well, we're going*

to offer you a, you know, two-year contract and then we don't really know what's happening.' You know, why would you want to leave your job for something that you don't know you're going to be in for the long term?
(PCN clinical director)

This was particularly the case for employing practices, who held liabilities and risks for the ARRS roles and did not always trust that these liabilities would be shared between them and the PCN. There was likewise uncertainty about employing roles that may not be fully funded under the ARRS:

The apprenticeship route for [physician associate] is not currently included in the ARRS. The apprenticeship levy only covers the education element of it. So, PCNs now will be in the situation of: 'I don't want to employ a trainee physician associate, even though that might attach them to the practice because I'll have to find the 80 per cent of their salary, rather than charge it [to] the ARRS.'
(Stakeholder)

The rigidity of the rules around the roadmap and reimbursement meant PCN clinical directors did not always feel able to take risks:

They couldn't tell me whether I could employ a paramedic who had less than five years of primary care experience, and I ended up having to escalate it to regional NHS level and eventually the answer was: 'Well, we can't really confirm, but if you want to employ at risk, the chances are you might not be able to put that through additional roles reimbursement, so the practice would have to pay for the paramedic', and so we had to play it safe and had to turn down six very good applicants because they didn't have five years in primary care.
(PCN clinical director)

The need for estates advice and redesign
Many participants raised a lack of space in practices as an issue – not only for accommodating the ARRS staff but also for an increasing number of GP registrars:

It's much harder for either a clinical role like [a first-contact physiotherapist (FCP)] where you're spread across all six practices and we have an extra complication because unlike... well, like many other practices, we are very short of physical space,

clinical space, to the extent that we couldn't actually host [an] FCP within any of the six practices.
(PCN clinical director)

For some, availability of physical space dictated how the roles were deployed and on what days:

We're trying to think creatively by having appointments at different times of the day, by rotating staff around different practices, by putting some of the ARRS roles into extended access hubs so that they work evenings and weekends... particularly the physios.
(PCN clinical director)

A survey of PCN clinical directors by NHS Confederation found that more than 90 per cent of respondents felt that a lack of estates infrastructure was hindering their progress and more than 98 per cent that more funding for primary care estates was needed (NHS Confederation 2021a).

Not only is the amount of space an issue, but also the type of space available is problematic. Multidisciplinary teamworking requires different physical spaces than traditional consulting rooms, particularly shared office and meeting spaces, and most PCNs did not usually have access to support to help them redesign and make the best use of available space:

There's micro teams collaborating together, you need physical spaces that are not just one-to-one consulting rooms, you also need those group spaces and quite a versatile estate, which we really don't have.
(Stakeholder)

One PCN did have support from their CCG to employ an external consultant specifically to advise them on estates but many of our respondents raised a lack of appropriate space as an issue, with little confidence that there were plans to address this:

But it's always going to be seen as secondary to, first of all, day-to-day service delivery, and then to workforce; in the hierarchy it's always going to be at the bottom, which is a real problem I think and is one that's only going to get worse.
(Stakeholder)

While increased remote and flexible working may offer some solution to estate pressures, previous research by The King's Fund on staff experiences of remote working in general practice during the Covid-19 pandemic found associated challenges. Remote working increased flexibility and the ability to participate in off-site meetings, but staff reported feeling isolated from peers and found it even more challenging to access appropriate professional support (**Baird *et al* 2021**).

Are GPs ready for a move to multidisciplinary teamworking?
A theme across our interviews and focus groups was that there is a lack of clarity about what multidisciplinary working might mean for the way in which GPs and practices themselves operate, and an ambiguity from some GPs about the roles. One PCN clinical director summed it up as follows:

> *This has implications which fundamentally alter the nature of UK general practice. One consequence (intended or otherwise) of creating a multi-professional workforce is that the role of the GP is changing from personal practitioner responsible for a caseload, to consultant/supervisor at the head of a 'junior' team. How we feel about that as a profession might in turn determine how medical graduates would view a career in general practice I guess.*

The anxiety about multidisciplinary working manifested itself in a variety of ways. First, there was a feeling that the ARRS roles take the 'easy' work, leaving GPs feeling overwhelmed by complex cases with no respite:

> *Every time somebody takes an aspect of my work, they often take the work that is either simplest or fun and that leaves me with ever-more complex and exhausting things, and we've got to look at the model of GP as well.*
> (Stakeholder)

Second, there was a feeling that, overall, the roles are a burden rather than a help because of the need to supervise them:

> *They may do additional workload, but they're not necessarily carrying any additional clinical risk, which is going back on to the GP.*
> (Stakeholder)

And finally, it was thought that the ARRS roles are second best and only being funded as it is not possible to recruit more GPs.

The fundamental needs of staff in ARRS roles: the ABC Framework

Given our findings on the ability of PCNs to successfully implement and integrate the additional roles, it was unsurprising that the staff we spoke to expressed frustration about their role and indeed that some had resigned from ARRS roles. To better understand what the ARRS staff would need to thrive, we have drawn on previous work from The King's Fund (**West *et al* 2020**; **West and Coia 2019**), which identified three core needs that must be met to ensure staff wellbeing and motivation at work, and to minimise workplace stress (*see* Figure 2).

Figure 2 The ABC framework of health care staff core needs K

Autonomy
The need to have control over one's work life, and to be able to act consistently with one's values

- **Authority, empowerment and influence**
  Influence over decisions about how care is structured and delivered, ways of working and organisational culture
- **Justice and fairness**
  Equity, psychological safety, positive diversity and universal inclusion
- **Work conditions and working schedules**
  Resources, time and a sense of the right and necessity to properly rest, and to work safely, flexibly and effectively

Belonging
The need to be connected to, cared for by, and caring of colleagues, and to feel valued, respected and supported

- **Teamworking**
  Effectively functioning teams with role clarity and shared objectives, one of which is team member wellbeing
- **Culture and leadership**
  Nurturing cultures and compassionate leadership enabling high-quality, continually improving and compassionate care and staff support

Contribution
The need to experience effectiveness in work and deliver valued outcomes

- **Workload**
  Work demand levels that enable the sustainable leadership and delivery of safe, compassionate care
- **Management and supervision**
  The support, professional reflection, mentorship and supervision to enable staff to thrive in their work
- **Education, learning and development**
  Flexible, high-quality development opportunities that promote continuing growth and development for all

(West *et al* 2020, p 28)

We now examine each of these areas in turn, identifying key themes across the different groups.

Autonomy

Autonomy refers to the need for volition, choice and freedom to organise our experiences for ourselves, and for self-integrity – being able to integrate our behaviour and experiences with our sense of self – for example, as a provider of high-quality and compassionate care.
(**West *et al*, 2020**)

Staff working in ARRS roles need to have influence and voice within their organisations. They also need to have the right work conditions, including the resources and facilities they need to do their job. ARRS staff we interviewed often reported feeling marginalised from decision-making and a lack of ability to influence how their roles should develop:

Because I'm spread so thinly, I can't do big pieces of work. I want to. I want to run audits, I want to work on opioids... I haven't got the capacity to do that. The expectation from my PCN was to do [structured medication reviews (SMRs)] and SMRs only. I basically wasn't given any control of my ledgers; they have just booked me in SMRs. They've not listened to me.
(Pharmacist)

One PCN clinical director suggested that GPs had become used to an unhealthy way of working and this may have been a reason for ARRS staff being asked to work in the same way:

Working in primary care is isolating, involves managing a great deal of risk and coupled with unreasonable workload and no protected CPD [continuing professional development], most health care professionals would struggle. We, GPs, have been working under these conditions because we do not have a choice and over the years it has become the norm, but this is not what ARRS staff would (quite rightly) put up with.

A number of participants gave examples of the benefits of having a 'critical mass' of staff, partly so they felt less isolated, but also because it gave them a more

significant voice and drive within the PCN as they could develop and agree a common work plan across the PCN (or in some instances multiple PCNs):

> *I think you need to get enough people into role so that there's a critical mass of people to start to do that teambuilding structure and for them to feel that they are making a difference.*
> (PCN clinical director)

> *We've formed sort of a mini PCN team, if you like... a GP who we've acquired through some local funding, a physician associate, two community matrons through the community trust and two care co-ordinators who work with them to do a lot of the administrative stuff. The team is known as the anticipatory care team.*
> (PCN clinical director)

Access to information for care and triage was critical for a feeling of autonomy. Some ARRS staff were able to proactively drive their own workload; for example, some paramedics or first-contact practitioners spoke of being able to take cases directly from duty lists. For others, though, restrictions on how they were able to access information hampered their ability to practise. Having permissions to both read and write into patient records was a particular issue for link workers and their ability to practise safely:

> *How can you employ somebody and not allow them... you know, how can you employ a social prescriber link worker and not allow them to have access to patient records? And the complexity... and they need access to those records because they need to actually input into those records, so we know what's happening.*
> (PCN clinical director)

Professional and managerial leadership and advocacy were also key, with leaders acting as a link between ARRS staff and other practices, their PCN or professional networks. This allowed ARRS staff to have a voice in settings or meetings where they were not necessarily present.

Belonging
> *The need for belonging reflects our desire to feel and be connected to others – to feel included, valued, respected and supported in teams and organisations and to care and be cared for in those contexts. There is abundant evidence to show that*

support from colleagues enables people to thrive in their work, helps them to cope with difficult work experiences, and buffers them from the wider organisational factors that cause irritation and stress.
(**West** *et al* **2020**, p 68)

I've found myself to be incredibly lonely. It's been really hard to feel like part of the team but not feel like part of the team. You always feel like the outsider coming in. You always feel like, I always feel like I'm re-introducing myself… I always feel I'm spread so thinly that nobody really, really knows me all that well.
(Pharmacist)

One of the strongest themes that emerged from our work was one of isolation and loneliness, which came from being spread across multiple teams. ARRS roles are very often deployed across practices that have different cultures, systems and processes, and this lay at the heart of many of the issues we identified in our review. Most PCNs are made up of multiple practices, and even those that comprise just one practice usually cover multiple sites. While individual practices and sites may have had good teamworking models in place, very often PCNs did not have a sense of team or identity beyond the individual practices, which meant PCN roles did not 'belong' to a single team. PCN clinical directors had attempted to create a PCN identity, through lanyards or badges, or joint events, but it was clear that individual practice cultures and processes were dominant.

We have previously identified the fundamentals of effective teams within primary care, based on the work of Professor Michael West (**Baird** *et al* **2020**; West 2012):

- a small number of meaningful objectives

- clear roles and responsibilities among team members

- time to reflect on how the team is working together.

It was clear from our conversations that because of a lack of cohesion and strategy across PCNs, these fundamentals were not present and so having an effective team approach across the whole PCN was rare. It is common for those working in ARRS roles to have their hours split pro rata according to the number of patients within each practice of the PCN, rather than in response to a shared strategy and objectives across the PCN. As a result, those staff needed to become part of

multiple practice teams in the absence of a single PCN team. Those who worked at smaller PCNs or at fewer practices often had a better experience:

> [S]ome of those smaller PCNs I talked about at the beginning, they are the ones that have managed to create... that team with that common purpose, the sharing of support and everything else.
> (Stakeholder)

It was clear from our conversations that this sense of being in a team was often lacking for ARRS staff and played a significant role in staff retention and wellbeing.

Induction

A good induction was felt to be key to help staff feel less isolated, but was often lacking, particularly when there had not been a predecessor. We heard examples of good practice, including written induction plans, comprehensive information technology (IT) induction and lots of time for shadowing clinical and administrative staff. We also heard of poor practice:

> One practice's induction, it was literally like there's the fire exit, we have a cup of tea at half past 10, and that was my induction from them.
> (Pharmacist)

Working across multiple practices that did not share systems and processes meant that ARRS staff often had to undertake separate inductions in all the different practices but without a single overview or approach. Within practices, practice managers, reception staff and administrative staff were key to helping roles to embed quickly. If they understood the roles and the referral pathways, they were able to support patients to access new services and help the staff feel part of the team.

> With my first practice they were really, really keen, they had quite a few GPs who were very sort of up for social prescribing, so I didn't have to convince anyone, which was really, really good, and they've got a really good team ethos, and I was put in the medical secretary room, so I managed to establish those relationships with admin and reception, all those people, so it was so good, it became so embedded so quickly there.
> (Link worker)

Many staff in ARRS roles may not have worked in general practice before, and found that particularly isolating:

> *I found it quite hard to start with because coming from a community background, I used to manage a pharmacy and I had 14 members of staff that worked for me, including pharmacists and pre-registrars. So, for me, sort of being told to go in a room on your own and just get on with it, I did struggle with that a little bit because I'm used to being part of a really big team.*
> (Pharmacist)

We heard that a lack of network management or HR processes within PCNs was problematic. Those employed by external bodies, for example, GP federations, reported good initial induction and HR processes, but still lacked induction within the PCN and individual practices. At its poorest, a poor induction could leave staff feeling disconnected:

> *I thought I was a resilient person because of my professional past. And it has been extremely hard. Emotionally it's been extremely hard. And with anyone starting a new role, you need to find your place, to find your feet, to find the dynamics of the team. You do feel alone.*
> (Link worker)

Contribution
> *The need for contribution reflects a need to make a positive difference through our work as well as to achieve valued outcomes, such as to deliver high-quality care that improves patients' lives. This reflects a deep human motivation to be able to influence our environments for the better. The need for contribution is met, first and foremost, when workloads do not exceed the capacity of staff to deliver valued outcomes. It is also met by ensuring that staff have enabling supervisory support, focused on removing obstacles in the workplace, which creates cultures of learning and accountability rather than directive, controlling cultures focused on blame. And it requires ensuring that staff are continuously learning, developing their skills and growing their professional knowledge.*
> (West *et al* 2020, p 29)

The ability to feel and demonstrate value was clearly affected by the way in which the ARRS roles were deployed and how many practices they covered. Those

in ARRS roles reported being able to get more feedback and interaction with colleagues when they were on fewer sites:

> *Because the impact for individual practice is watered down [even though] there is definitely a demand, [in] terms of individual practices I don't think the staff really feel their impact, and, therefore, I suspect the FCP [first-contact practitioner], the additional roles staff themselves, therefore, don't get that feedback.*
>
> (PCN clinical director)

The lack of shared understanding or agreement about the purpose or function of the ARRS roles within the practices of the PCN affected the ARRS staff's sense of being valued and appreciated:

> *I have practices where they would not give a clinical room for a social prescriber link worker. They don't invite them to their clinical meetings. Staff don't know who they are, and for them I think it feels… I think they probably feel… it's difficult for them to feel that they're appreciated.*
>
> (PCN clinical director)

It was important that practices understood whether or not individuals would be able to 'hit the ground running', which was often not the case when staff were working within general practice for the first time. Managing expectations about what staff working in the ARRS roles would be able to do immediately, as opposed to in the longer term, was often critical:

> *I think you need at least 18 months, really, before you start really seeing these people settle in and start doing what you need them to do. I think that's the reality, and I think if you try and expect any more than that sooner…, these guys need time to adapt, understand how general practice works, understand their capabilities and build their confidence up and know what they're doing and for us to kind of work out what they're good at and what we can get them doing before you start to really reap the benefits.*
>
> (PCN clinical director)

High expectations of the roles, sometimes based on the results of pilot schemes and best-practice case studies, were not always met in reality:

The pilot schemes have had really good outcomes in terms of reduced follow-ups, reduced referrals on to orthopaedics, reduced need for painkillers, early starting of exercises, all the rest of it. So, I think when they can start prescribing... when they can start doing those things and be proper autonomous practitioners as well, brilliant sailing.
(PCN clinical director)

Those professionals who were demonstrably able to take workload away from GPs felt better appreciated than those who were providing new services, or less visible input:

With physio it's been very different. The physios go in, they do the first-point-of-contact appointments. I think GPs really value it because it takes work directly off them, and they can see it, it's tangible. Whereas with the pharmacist it's less tangible because there's a lot of work that goes on in the background that they don't see, it's just... that they're doing it.
(PCN clinical director)

Participants highlighted the need for a variety of support, including professional leadership, HR and practice manager leadership, clinical and peer support and managerial support.

The amount of support available to ARRS staff was variable, with link workers in particular feeling they lacked access to the support they needed. Where support was not available, workers were left feeling isolated.

Clinical supervision
Clinical supervision was identified as increasing safer clinical behaviour and therefore patient safety; however, access to supervision was often constrained by a lack of capacity, incentives, funding or recognition of the work involved. There is no specific funding to cover the supervisor role, which impacted on the ability to find supervisors:

I've got a GP who's interested to be their supervisor, but then they have to take two full days out of their working week for free to be their supervisor. There's no gain in it for them.
(Physiotherapist)

Various ARRS staff reported feeling that clinical supervisors were 'too busy', unavailable or inaccessible. Where clinical supervision happened at all, many spoke of it being infrequent, brief and/or group based. Similarly, clinical directors emphasised that clinicians did not have the 'headroom' to invest in developing and supervising ARRS staff to a point where they could reap the benefits, because they were overwhelmed by their day-to-day work. Clinical directors spoke of clinicians not having the time to complete mandated training to allow them to supervise ARRS staff. Similar issues about a lack of GP time available for supervision had also been found in the evaluations of pilot programmes (**Mann *et al* 2018**).

In contrast, one paramedic spoke of how two of their practices had assigned protected time for named GPs to provide supervision, increasing accessibility compared with GPs at one practice:

> *I have a named GP, who they have organised, a slightly lighter workload, so they have time to do supervision during the day... Whereas at the other practice, everything is just booked up and yes, all the GPs are there and they're willing to help you but you're trying to catch them in between a patient or you're sending a message and then just waiting to see who gets back to you.*
> (Paramedic)

External support models were often described favourably as they removed tasks and responsibility from overwhelmed practices and practice staff. Interviewees talked of HR support being covered by external employing organisations, and clinical and peer support being provided by voluntary, community and social enterprise organisations, hub models, PCNs and GP federations. For example, physiotherapists described using the hub model for supervision:

> *Actually, in terms of the formal supervision, we provide that to ourselves. We don't ask the GPs to do it because it was never factored in when the service was established, so we do it all.*
> (Physiotherapist)

Managerial support
Managerial support played a critical role in ensuring ARRS staff had a good understanding of their roles and responsibilities and what constituted appropriate tasks and volumes of workload. GPs and practice managers also advocated for

ARRS staff to ensure they received appropriate work. Managers were important allies for ARRS staff, given the new and evolving nature of the ARRS roles. One physiotherapist stated how they educated GPs about the ARRS physiotherapy roles and how they were supported by their practice manager to get appropriate work:

> [T]he other useful thing was actually having real good support from my practice manager and the partners that actually if the GPs are sending you rubbish, send it straight back.
> (Physiotherapist)

GP or managerial support was felt to be most effective where such individuals had a vision or strategy for the ARRS roles and would be better where individuals had a desire to lead and support, rather than perceiving that they had merely drawn the short straw. As one national stakeholder put it:

> I think they need a purpose, and they need the leadership to go with it. And what I think maybe hasn't happened with the leadership side is the PCN [clinical director] are often people that put up their hand at the wrong moment or didn't step back when everyone else did.
> (Stakeholder)

Managers struggled to find time to plan management activities and others cited a lack of clarity around what a supportive role entailed.

Previous research by The King's Fund on managing staff in different locations found that leaders needed to develop new skillsets, particularly around managing complexity and coping with the lack of immediate oversight and control (**Baird *et al* 2021**).

Peer support
Participants frequently highlighted peer support as being important, for several reasons including promoting teamworking and belonging and preventing isolation and attrition. It was also recognised as key for helping to navigate changes:

> When you're at the forefront of a practice change, peer support is really important. And peer support comes from both your own profession, but obviously peer support

from other professionals who are doing similar roles, so GPs, in this instance. And so, time with your peers is critical.
(Stakeholder)

Access to training and development
Interviewees frequently cited the idea that training and development should be an ongoing process for staff employed in the ARRS. Despite this and the fact that ARRS roles are described as training roles, interviewees cited numerous factors that inhibited access to training. They described how training was not necessarily seen as part of the ARRS role or adding value to the PCN – rather it was a luxury and the choice of the staff member:

> *I actually resigned. I was told that I had to make up all the [Centre for Pharmacy Postgraduate Education training] days that I'd done on my training as unpaid overtime, which I argued. I argued and said: 'You can't do that because I was contracted as having to do that as part of my role. It's a paid thing. You get the ARRS because I'm doing the course. This is my role.'*
> (Pharmacist)

In addition, ARRS staff employed by external organisations were not always seen as part of practice teams and were therefore excluded from practice training. For some roles, training requirements were better, and for some they were less well understood. Link workers frequently cited a lack of training due to a lack of understanding of their needs and roles. Many relied on self-learning and seeking free online courses and networks to join unless they were employed by a charity that provided more guidance. For ARRS staff themselves, one national stakeholder repeatedly heard that some suffered a lack of time to attend training, which was linked to burnout. The late arrival of some of the roadmaps, and resulting extra work needed to provide portfolio supervision, the uncertainty of the future of ARRS roles and the perception that training may enable staff to move on to new roles outside of the practice also meant training was inhibited.

> *These roles coming out prior to the roadmap... it's almost like we're back-pedalling. So, contracts were set up without this being factored in, and now we're doing the supervision and it is hard, it's really hard. I've got really established clinicians that are really busy, not helped by the pandemic at all, trying to produce roadmap*

documents that they've done so much work [on], they're really good at their role, and I sit in clinic with them and they're brilliant, but they've still got to go through this portfolio route. It is a challenge; I'm quite happy to say that.
(Physiotherapist)

A manageable workload
Evidence from previous research shows a strong link between workload and wellbeing for health and care staff (**West *et al* 2020**). Increasing workload was becoming problematic for some of those we interviewed, reflective of ongoing pressures in general practice:

The fact we were full time, with only 3.5 hours a week for admin, just meant we all felt pretty drained and the enjoyment wasn't always there as you were so tired.
(Physiotherapist)

And also, they've recently said to me: 'We want you to do all the care homes… if you take out an hour a day every day.' There are 27 care homes. I can't do 27 care homes in an hour a day every day and then do SMRs [structured medication reviews] for the rest of my time. It's far too much. And even though I've said this is an issue, nobody's listening.
(Pharmacist)

Workload issues and a lack of available staff also meant it could be difficult to change underlying practice:

Every Monday at the practice I look for an appointment with a first-contact physio so that, for somebody with a back pain or a problem that needs assessment but doesn't need a GP, and invariably I end up booking them with a GP because the next appointment for a physio is 10 days down the line because there's not enough of them. So, whenever these roles are few, it's not going to change the way we work.
(PCN clinical director)

Again, the pressures in general practice and a need to 'fire fight' rather than plan led to increasing workloads and/or tensions between practices trying to deliver core services and PCN staff trying to deliver the requirement of the DES contract.

Career progression

Participants in the interviews and focus groups frequently raised the opportunity for career progression within ARRS roles. ARRS staff, PCN clinical directors and national stakeholders recognised its importance for retaining interest in the role and therefore for staff retention.

However, the constraints of ARRS funding meant that pay progression was often not possible within ARRS roles, although many interviewees also reported other barriers to career progression. These included uncertainty about the future of the ARRS roles themselves or unclear routes for progression:

> *[Some are thinking] there is no career progression here for me, there is no future for me, it's just a testbed. What is sustainability, is this just for five years, what's going to happen? So, you have people already thinking about that.*
> (Stakeholder)

> *The problem with social prescribing is you do it and you're not rewarded for experience. There's nowhere to go with it unless you want to manage people.*
> (Link worker)

ARRS roles themselves potentially offered a greater level of professional autonomy than was possible in other settings. As an example, one national stakeholder suggested that development opportunities for paramedics via ambulance trusts were usually 'few and far between' and therefore the ARRS roles offered more opportunities in that respect, supporting progression.

The impact of the Covid-19 pandemic

It is important to note that the Covid-19 pandemic has had an impact on many of the staff we interviewed. Interviewees frequently mentioned the context of the pandemic as both a barrier and a facilitator to embedding ARRS staff into practices and PCNs. Many spoke of joining their PCN just at the point of the first national lockdown in the spring of 2020, resulting in a lack of, or poor, induction processes, being unable to meet teams in person and developing feelings of isolation. Others spoke of having non-role-specific tasks – such as checking in with care homes (link workers) and managing the vaccine rollout (pharmacists) – thrust upon them on arrival. This meant that while their work was valued, it was not the work that they

were hired to do, and they were subsequently unable to add value in the intended way. Some highlighted the need for better supervision models due to an increase in the complexity of cases during the pandemic (link workers), and others shared that they had struggled to socialise their roles with patients due to lockdown and not seeing people face to face. Recruitment was also affected as exams were delayed for some roles due to the pandemic.

Conversely, some staff mentioned that their roles allowed them to meet more people and work more closely within teams to achieve Covid-related tasks. The pandemic promoted belonging and teamworking for some. Others mentioned that practices were learning from how things had changed during the pandemic and were trying to retain and evolve more effective working and pathways such as upskilling ARRS staff to take on more tasks.

Profession-specific issues

Link workers

Our research found that there was an extremely poor understanding of the role of link workers within PCNs, linked to the fact that they were frequently introducing a new model of care within general practice that is not widely accepted or understood. This had a range of consequences.

- Staff were left to their own devices to design their own role and to identify free training and external support networks. They often felt very isolated within the practice.

- The fact that these roles are non-clinical meant that access to IT systems and patient records was frequently inhibited, with link workers having to design their own patient management records, with a resulting lack of integration with the rest of the practice.

- A lack of access to wider services, particularly mental health and housing services, meant that link workers were frequently being asked to work with patients who had significant and complex needs that they were not trained to deal with.

- While models which see link workers subcontracted from voluntary sector organisations provided better access to profession-specific support, we found

they could fail to generate a sense of belonging and teamworking within practice teams.

First-contact physiotherapists
- The key issue for first-contact physiotherapists was that practices typically held an incorrect perception that the role was treatment based rather than purely diagnostic. This led to duplicate referrals and frustration for patients. A lack of access to community physiotherapy added additional pressure.

- Many first-contact physiotherapists had little desire to take on their role full time within PCNs and preferred to spend at least part of their time in other services.

- Staff reported value from working across different parts of the care pathway, which meant they could better support patients across their whole journey.

- First-contact physiotherapists tended to be at ease with more autonomy than some other roles and seemed less concerned with how they fitted into the primary care team. The fact they were often employed in dual roles meant they had better access to peer support.

- A hub model of delivery, with first-contact physiotherapists employed centrally, was highlighted as a good route to ensure support and supervision.

Paramedics
- Rotational models, where paramedics rotated between the ambulance trust and PCNs, seemed to work particularly well for this role, allowing paramedics to retain and build their skills, but also to retain benefits such as shift allowances and Agenda for Change progression.

- Again, staff in these roles tended to be at ease with more autonomy than some other roles, although they felt that autonomy was initially reduced in primary care compared with their ambulance trust roles.

- The ARRS was seen as a good opportunity for progression for paramedics beyond what is available in ambulance trusts – there were more opportunities for training and development and this allowed progression towards autonomous working.

- Many struggled to receive profession-specific supervision due to challenges around identifying and finding time to train suitable candidates.

Pharmacists

- Given clinical pharmacists have been employed in general practice for some years, we were surprised that they still had many of the same issues as those in newer roles.

- There was a strong sense that they were not being given tasks appropriate to their competencies. Many felt that GPs underappreciated their abilities or wanted them to focus on 'tick-box' tasks and medication reviews.

- Pharmacists often felt isolated, especially if they had moved from hospital settings where team structures were in place. There was a strong consensus that having a critical mass of pharmacists and technicians, with leadership support, was important.

4 Conclusions and recommendations

ARRS roles have the potential to make a significant contribution to the quality of patient care in general practice and represent a significant investment in the future sustainability of general practice. These roles need to be carefully embedded and integrated into teams if they are to reach that potential for patients and to meet the needs of staff working in the roles. Critically, this depends on successful multidisciplinary teamworking across general practice. At present, many PCNs do not have the necessary capacity or skills to do this.

PCNs are relatively new and many lack the shared strategy and clarity of purpose necessary if they are going to recruit and deploy the ARRS roles in the most effective way. The complexities of 'sovereignty' between practices and the PCN cause issues for those employed in ARRS roles. Many PCNs do not share a team identity, and this makes deploying network-wide staff in a supported way very complex when there are different strategies, different cultures and different identities to be managed.

While skills that enable people to work in multiple teams are important for ARRS roles, the evidence is clear that stable membership of a 'home' team is essential for wellbeing and effectiveness. Dropping in and out of teams can undermine connection, community and belonging, and we saw that clearly in our research. Building a critical mass of ARRS staff within PCNs or individual practices may help to increase peer support and establish a 'home' team, as will roles that rotate or split between secondary care and primary care. Nevertheless, this does not address the issues of how to integrate the ARRS roles into a wider multidisciplinary team at either practice or PCN level.

The confusion around strategy is also linked to a lack of agreement about whether the roles are primarily intended to deliver the PCN DES requirements or to undertake what might be considered the 'core' work of general practice.

There was a general ambiguity from some GPs about what multidisciplinary working would actually mean for them and their working practices, both clinically and in the way in which their practices are run. Some expressed a feeling that ARRS roles were taking the interesting or 'easy' work away from them, leaving them with too much complexity, or that ARRS roles were a second-best solution to a shortage of GPs or practice nurses. While the national direction of travel appears to be that multidisciplinary working in general practice is a key part of the future vision, there has not been enough consideration about how GP roles, or the organisation of general practice itself, might need to change as a result.

The potential contribution of additional roles is not universally understood, and this was the case across all of the roles we studied, even those such as pharmacists who have been a feature of general practice teams for the longest time. The large amounts of written guidance, job descriptions and roadmaps have not had the intended impact and may even have added to the confusion.

The cultural change required by the introduction of additional roles, and new approaches to teamworking, requires extensive organisational development, leadership and service redesign expertise and this has not been adequately available to PCNs, nor is it present in many individual practices. This is in contrast to the support that exists for change within NHS trusts. While PCNs have received some development funding, more active support is clearly needed to make the necessary changes in organisational culture and structure that are required to adequately integrate the ARRS roles, including the development of a shared strategy and purpose, an analysis of workflow and role redesign.

A variety of support – including clinical supervision and managerial, HR and peer support – is critical to the effective integration of ARRS roles within general practice and yet there is inadequate additional funding to provide PCNs with the capacity to provide this support well. Managing and supporting staff working across different locations requires leaders to have particular skills in managing complexity and coping with the lack of immediate oversight and control and yet there is limited access to this kind of leadership skills development in general practice. Centralised or subcontracted employment models have the potential to provide some of this support more easily but have the downside of ARRS staff feeling even more distanced from the teams they are working alongside.

In addition, a lack of an adequate estate is fast becoming an issue in many areas. The solutions will require expertise in the design and use of space to support multidisciplinary teamworking, and it is not clear how PCNs will access such expertise.

The uncertainty around the future of funding for the ARRS roles after 2023/24 has started to generate concern. Expectations of the impact that these roles will have are high, but like all new roles, it will take time before they are fully understood. Creating stability and certainty will play an important role in this. The Covid-19 pandemic has obviously had an impact on the deployment of ARRS roles, and indeed we heard both positive and negative impacts. Learning from that experience and taking proactive steps to address the issues identified need to be a clear part of recovery from the pandemic if the significant investment in ARRS roles is to have the intended impact.

Our recommendations as a result of our research are as follows.

A clearer, shared vision

- A clearly stated shared vision for a multidisciplinary model of care at both individual practice and PCN level is essential. National bodies, including the Department of Health and Social Care and NHS England, together with the professional bodies, need to develop and communicate a clear understanding of the multidisciplinary model of care and the potential implications for the way in which GPs will practise in future.

A comprehensive package of support

- Integrated care systems (ICSs) will need to ensure PCNs' greater access to local organisational development, leadership skills development and service redesign support if they are to develop shared strategies and competencies for ARRS roles.

- ICSs should consider how they will support practices in the necessary redesign of the primary care estate if multidisciplinary teamworking is to become a reality.

- Health Education England and the professional bodies representing the additional roles should consider how the current roadmaps and other guidance can be streamlined and communicated in different ways that make it more

accessible and practical for PCNs, practices and professionals to understand and implement.

- PCNs and individual practices should consider how they will plan to build the numbers of additional roles to improve peer support and increase the possibility of team leadership roles and opportunities for management supervision.

- PCNs must ensure ARRS roles have clear and easy access to a range of support, including clinical supervision and managerial, HR and peer support. Those providing support need access to, and the capacity to undertake, training and development in the necessary leadership skills.

- PCNs and practices need to carefully plan their strategy for embedding ARRS roles, considering the implications for staff who work in network-wide roles or across multiple practices that have individual systems, cultures and practices.

The future sustainability of the ARRS

- The Department of Health and Social Care and NHS England should provide as much clarity as possible on the plans for the long-term funding of the ARRS roles after 2023/24 in order to provide certainty and stability for both ARRS staff and PCNs.

- Future national contract negotiations should address the need to adequately fund the managerial, clinical supervision and training needs of the ARRS roles.

- NHS England should consider the development of a clear estates strategy for primary care, building on the 2019 *General practice premises policy review* (**NHS England 2019**) to include how to give backing to the redesign of premises to support multidisciplinary teamworking.

- NHS England, Health Education England and the professional bodies should consider how career progression for staff working in ARRS roles will be supported, which should include appropriate flexibility in funding so that staff can be employed at more senior levels.

- The Royal College of General Practitioners and deaneries should ensure that management and leadership skills training is fully embedded within GP specialist training.

Appendix: Methodology

Literature review

For this research we conducted a rapid review of available literature that provided information, guidance and recommendations on the implementation or retention of ARRS roles. We searched relevant national bodies for each of the target roles (the Chartered Society of Physiotherapy, the College of Paramedics, the National Association of Link Workers, the Royal College of General Practitioners and the Royal Pharmaceutical Society), education providers (FutureLearn and Health Education England), relevant NHS sites (the NHS Confederation and NHS England and NHS Improvement) and relevant general practice organisations (Ockham Healthcare and the Royal College of General Practitioners). We excluded anything linked to patient experience and wider considerations of multidisciplinary working in general practice.

The literature provided us with baseline information on current recommendations and guidance for implementation, and better equipped us to set out the background and context to the research. It also helped to inform our approach to the focus groups and interviews, identifying key areas to focus our questioning on: recruitment, induction, training and support, estates and technology, as well as more broadly, retention, attrition and practice.

Data searching

Initial examination of available data identified two useful sources of data: General Practice Workforce data and Primary Care Network Workforce data, both published by NHS Digital.

The General Practice Workforce data includes data on the roles employed in general practices from 2015. We used data from June 2021.

The Primary Care Network Workforce data includes data on the roles employed by PCNs. This data is available quarterly from March 2020. The coverage of the PCN data in March 2020 was low (15 per cent) although it had increased to 78 per cent

by September 2021. This limited the analyses we were able to carry out with the available data. However, the increasing level of coverage will make future time-series analyses possible.

We used the two most recent quarters of PCN data where coverage was more than 70 per cent (June and September 2021). We summarised the (full-time equivalent) number of pharmacists, physiotherapists, paramedics and link workers that PCNs employed, by region of England. Variability in the size of PCNs and in the availability of relevant data meant we were unable to adjust for the differing coverage by region (Morciano *et al* 2020).

Focus groups and interviews

Four focus groups – one with each subset of ARRS staff – and a series of interviews with key stakeholders and PCN clinical directors were originally proposed. Due to difficulties in recruiting, we adapted the methods to ensure adequate data capture.

We recruited participants by email using The King's Fund's existing networks and via the Chartered Society of Physiotherapy, the National Association of Link Workers, the NHS Confederation's PCN Network, the Pharmacists in General Practice Network and the Royal College of General Practitioners. We also used a social media platform (Twitter). We recruited a total of 48 participants.

We conducted four focus groups: two with pharmacists (n=11 across the two groups) and two with physiotherapists (n=9 across the two groups). We interviewed four additional pharmacists and one additional physiotherapist. We also interviewed five link workers and three paramedics.

We interviewed eight stakeholders from relevant national bodies (the Chartered Society of Physiotherapy, the College of Paramedics, Health Education England, the National Association of Link Workers, the NHS Confederation, NHS England and NHS Improvement, the Royal College of General Practitioners and the Royal Pharmaceutical Society) and seven PCN clinical directors or managers, as originally proposed.

We provided participants with information sheets, privacy statements and consent forms ahead of their focus group/interview. We obtained written consent from

focus group participants and verbal consent from interviewees. We created semi-structured focus group and interview schedules, tailored to the participant group. Content included questions on practice, support, recruitment, induction and career progression.

We conducted all of the focus groups and interviews using online web conferencing software (MS Teams) between 26 August and 11 November 2021. The focus groups lasted approximately 90 minutes. The interviews with ARRS staff lasted approximately 30–45 minutes while the interviews with national stakeholders and PCN clinical directors/managers lasted approximately 60 minutes. We digitally recorded all focus groups and interviews, except one interview, and took fieldnotes. Fieldnotes were taken for the one interview not recorded. Participants did not receive any remuneration for their involvement.

We sent recordings to a third party (1st Class Secretarial) for transcription and anonymised returned transcripts before we undertook our analysis.

Two researchers descriptively analysed the interviews and focus groups using MAXQDA 2020 Plus. Initial coding themes were devised based on findings from the literature. The two researchers coded a single transcript and discussed discrepancies, revised coding descriptions, added new codes and then coded a further subset of the transcripts. The subsequent review of the framework resulted in minimal revision of a small number of code definitions and the addition of one new code. Subsequently, the rest of the transcripts were coded without any further changes to the framework. Data under each code was then reviewed for cohesiveness and summarised to aid write-up. The codes were synthesised into an overarching framework, drawing parallels between the data and the ABC Framework developed by colleagues at The King's Fund (**West *et al* 2020**; **West and Coia 2019**). This suggests that a sense of autonomy, belonging and contribution is required for staff to maintain their wellbeing and motivation in the workplace. Subsequently, we created two overarching themes. The first was 'Primary care network's ability to successfully integrate additional roles', which consisted of subthemes encompassing the practicalities, understanding and resources required. The second was 'The fundamental needs of staff in ARRS roles', which consisted of subthemes containing data demonstrating the need for autonomy, belonging and contribution of staff in these roles.

Patient and public involvement and approvals

The Health Sciences Research Governance Committee at the Department of Health Sciences, University of York approved this research project after an ethics review process (HSRGC 2021/465/A: 'Challenges to the implementation and integration of the ARRS staff in PCNs'; approved 30 July 2021).

We sought patient and public involvement for the project using the University of York's Involvement@York programme. A panel of four programme volunteers provided comments and feedback on the research protocol and associated materials, which were incorporated into the delivery of the project. This included changes to the language used on the consent forms and information sheets to make them more accessible.

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About the authors

Beccy Baird works in the health policy team at The King's Fund, leading research and analysis across a range of health care issues with a focus on general practice. She has worked in the NHS and social care for more than 25 years, and before joining the Fund was associate director for service improvement in a cancer network. Beccy spent two years in San Mateo County, California, developing a model of integrated health and social care funding and delivery for older people. She began her career as a researcher in older people and mental health services.

Beccy has an MSc in health systems management from the London School of Hygiene and Tropical Medicine. She is a qualified coach practitioner, accredited with the European Mentoring and Coaching Council.

Laura Lamming works in the policy team at The King's Fund. Before joining the Fund in 2020, she worked in various academic health research departments, including the University of Bradford, the Bradford Institute for Health Research and the Cambridge Institute for Public Health.

During her career, Laura has worked on projects promoting physical activity, medication adherence and healthy eating in regional or primary care settings as well as quality improvement projects in hospital settings. Laura has an MPhil in Public Health from the University of Bradford, which looked at physical activity promotion apps that provided feedback on user affect.

Ree'Thee Bhatt is a GP trainee on a placement working with the policy team at The Kings Fund. She previously worked as a paediatric trainee for three years covering general paediatrics, newborn intensive care and paediatric neurology in the Thames Valley Deanery. Currently, she is a GPST1 trainee on the Imperial College and Imperial Healthcare NHS Trust scheme in north-west London.

Her previous research background includes presentations and publications presented nationally and internationally at conferences in subjects ranging from Covid-19 in neonates to breastfeeding patterns in communities in South Africa. As part of the Next Generation GP London cohort and an Imperial training

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Jake Beech left The King's Fund in October 2021. He was a researcher in the policy team, supporting the Fund with its responsive and monitoring work. He helped ensure the Fund had a good overview of key developments in health and social care, including scoping new and emerging issues.

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The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.

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The King's Fund > Ideas that change health and care

The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 with the aim of supporting the recruitment of 26,000 additional staff into general practice. While primary care networks (PCNs) have swiftly recruited to these roles, how well are they being implemented and integrated into primary care teams?

Integrating additional roles into primary care networks explores how ARRS roles are being embedded within general practice, focusing on the experience of staff working within these roles and the people managing them. The authors highlight a number of factors that are having an impact on how well the roles are being implemented and integrated, including a lack of shared understanding about the purpose or potential contribution of the roles, combined with an overall ambiguity about what multidisciplinary working would mean for GPs. In addition, there are practical considerations regarding adequate estate and questions over future funding for the roles.

The authors share examples of good practice and positive stories, but make a number of recommendations to ensure successful implementation, including:

- a clearer, shared vision for a multidisciplinary model of care

- a comprehensive package of support for implementation of the scheme including improved support for clinical and managerial supervision

- streamlining and communicating current guidance and roadmaps in different ways that make them more accessible and practical for PCNs, practices and professionals to understand and implement

- a focus on future sustainability, including funding, estates strategy and career progression

- leadership and management skills development embedded in GP specialist training.