HEALTH
INTEGRATION
PARTNERS

Additional Roles Reimbursement Scheme – making it work

Exploring uncharted territory

January 2021

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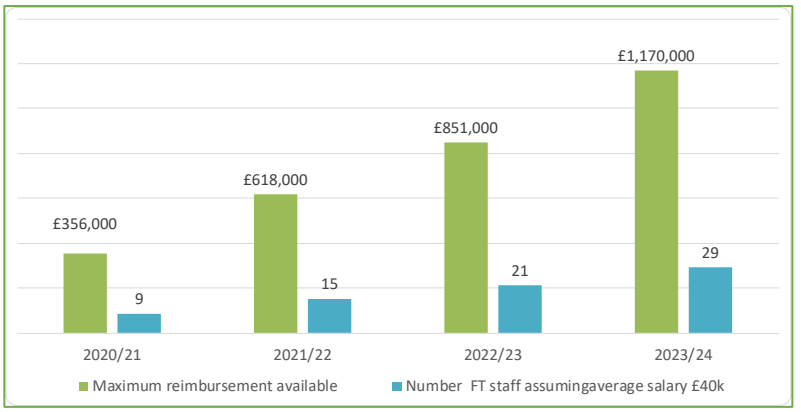
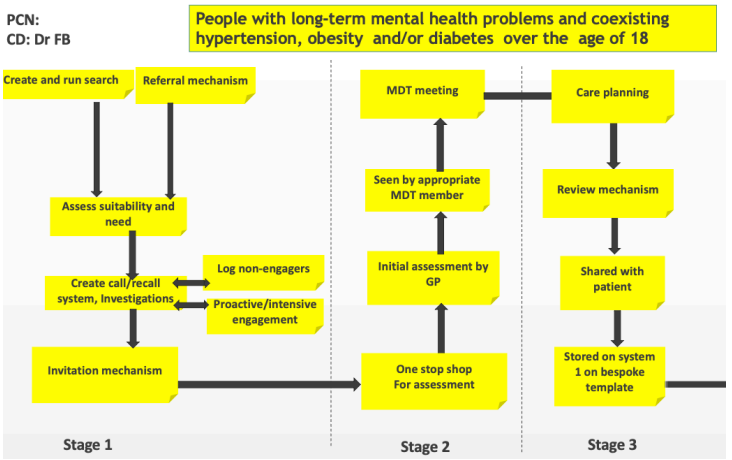
ARRS is the payment mechanism, not the workforce

By 2024 a PCN with a population of 50,000 people will be able to access £1.17m funding for additional roles through the ARRS amounting to around 30 FTE additional staff.



Despite the ARRS presenting a huge opportunity for General Practice to boost its workforce and change the way it delivers care for its local population, for many groups the potential change in workforce structure and ways of working are uncharted territory with associated risks.

To understand the opportunities and potential downsides, we asked PCNs to decide on an initiative they would like to deliver using their ARRS team members and then plotted a process map of the practice/PCN and patient journey. This was informed by sample job descriptions and salary scales for each of the ARRS roles and the PCN budget, the PCNs priorities, budget and population health data.



We then analysed the steps with the group through four lenses to understand what factors would contribute to a safe, effective service:

Lens	Workforce	Operations	Organisational	Demographic
Examples	Recruitment and onboarding	Case finding and care pathways	Leadership and engagement	Local needs such as isolation, language
	Training and Supervision	Equipment and workspace	Unaccounted costs of change	Engaging patients and patient groups
	Rostering and managing performance	Quality assurance and clinical governance	Collaboration within PCN and existing services	Obtaining and using population health data

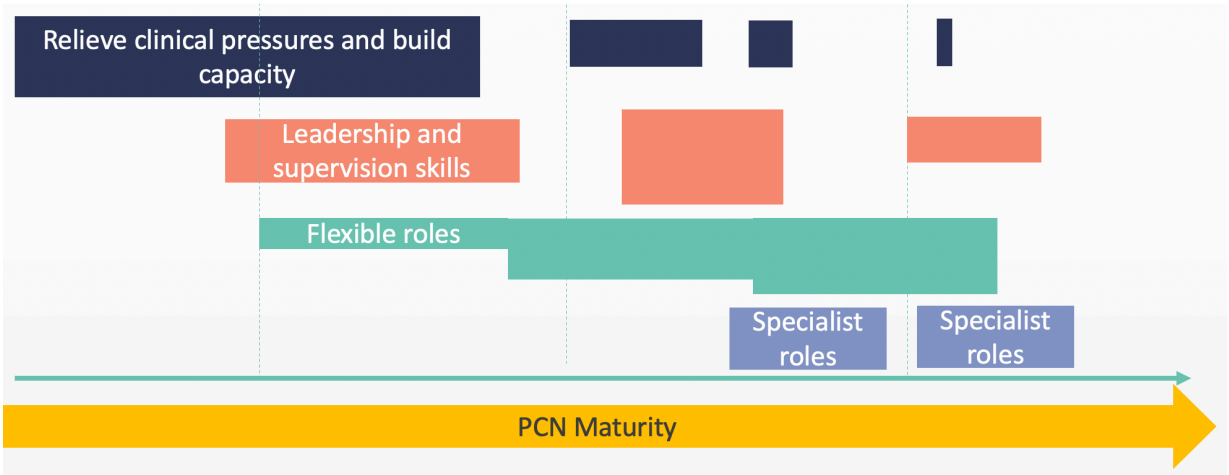
Optimising the benefits of the ARRS requires careful planning and implementation.

The process helped PCNs to understand their blind spots and the complexities of employing and retaining additional roles. We were also able to understand the resource implications for delivering new services and risks to patient safety. Not every proposed change turned out to be a change for the better! Three headline findings the groups generated were:

1. Develop a phased, strategic workforce plan:

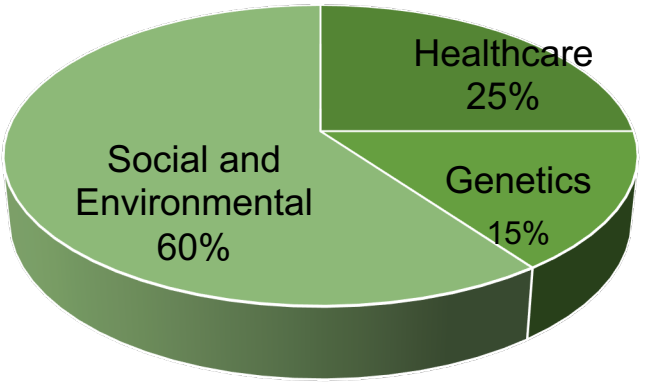
Phase	Challenge	Solution	Potential Roles
1	We don't have the bandwidth to deliver the DES , service changes or find new ways of working	Aim to relieve clinical pressure to release bandwidth and assist with PCN engagement	Clinical Pharmacists Physician Associates FCP Paramedics
2 -3	We need to have leadership to create change and provide supervision to ARRS develop and retain them	Recruit new roles who can offer capabilities such as leadership, supervision and specialist experience	Potentially all roles – focussing on the person and their experience rather than the qualification
2-4	We need roles that are flexible around delivering services and not just providing clinical services	The non-clinical roles offer flexibility around how they are deployed.	All non-clinical roles: SPLW Care-co-ordinators Health and wellbeing coaches
3-4	We are now established and collaborating with local partners. We need specialist roles for some areas.	Share relatively expensive specialist roles across PCNs or through secondment with existing providers	Dieticians Occupational Therapists Podiatrists

A phased. Strategic approach allows for a workforce to be built that aligns with the ambition of the PCN and population needs as the PCN matures in capability and access to higher levels of reimbursement.



2. The non-clinical roles included in the ARRS offer huge potential

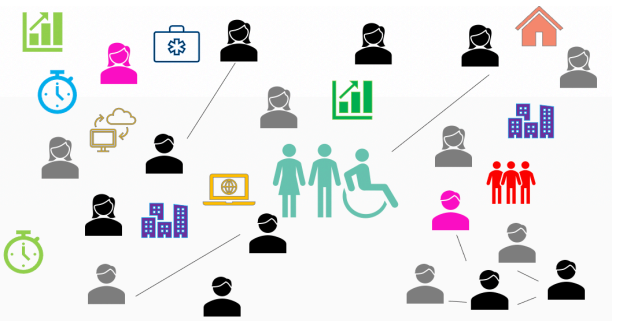
For our PCNs, process mapping showed that specialist clinical ARRS services (or socially prescribed alternatives) were already adequately provided when balanced against the cost of employing and retaining them at PCN level. Often the problem was co-ordinating access, case management and administration.



When we explored the patient segments who would benefit from new or re-organised PCN led services, we frequently overlooked the determinants of their health being driven by socioeconomic factors and focussed on managing the resultant clinical outcomes. Investing in non-clinical roles offered significant opportunities to re-model how care is personalised and provided downstream to avoid over medicalisation.

3. Developing an operating and development plan is essential

The ARRS is the payment mechanism, not the workforce. We found that to develop an effective workforce requires attention to a number of areas which were often in the PCNs blind spot and increased in scale and complexity as the PCN matured.



Some key areas in the plan included:

- Supervision and training
- Line management structures
- Estates, equipment and IMT
- Employment models
- HR Administration
- Rostering, MDT working
- Quality and governance
- Financial management

With a finite workforce, many of these areas could have as direct effect on retention.

Many of these areas would be important across all PCNs and some areas, such as estates, would need collaboration. The workload of developing the plans could be shared and some areas, such as HR administration centralised.

We would like to thank the PCNs who participated in the workshops.

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