Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

Manchester Local Care Organisation
Leading local care, improving lives in Manchester, with you

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

Additional Roles Reimbursement Scheme (ARRS) Toolkit

Manchester ARRS Oversight Group

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Contents

The ARRS Group

Background

The ARRS Citywide Group was convened in April 2021 between Manchester Health and Care Commissioning (MHCC), Manchester Local Care Organisation (MLCO), the GP Federations and the Primary Care Networks (PCN's) in order to consolidate the available information for practices and PCNs and support them to make best use of the funding available to them.

In the 2019 GP contract, it was announced that additional funding was available for the newly created PCNs to access to reimburse them for appointing non-medical roles, recognising that "by far the biggest challenge facing general practice is that it doesn't have enough people to do the work required".

However, as the complexity of the PCN service specifications has increased, it has become apparent that General Practice will require the help of this expanded workforce to deliver against them as a wider Primary Care Team and access the associated funding streams.

We also know from the document Integrating Care Next Steps that the direction of travel will be to deliver place-based care specific to local populations. In Manchester we already have established Integrated Neighbourhood Teams who are ideally placed to help us to align services to local need.

So far, PCNs and General Practice have been focused on the immediate necessities: the establishment of the Networks and their developing infrastructure, understanding the ARRS recruitment, plus the additional and ongoing work associated with Covid Vaccination Programme.

However, there are a multitude of forthcoming requirements against which PCNs will soon be measured. Nationally, we have the reinstatement of four of the PCN DES service specifications: the enhanced requirements of the 21/22 Investment and

Impact Fund, the full restart of QOF with no payment protection, and locally the requirements of the Manchester Primary Care Quality, Resilience and Recovery Scheme (PQRRS).

These are in addition to the strategic aims of the NHS Long Term Plan that are further expanded upon in the 21/22 Operational Planning Guidance.

Therefore, full utilisation of the ARRS funding will be essential to implement the requisite workforce to support General Practice with its current pressures and improve local health outcomes and address health inequalities in line with these aims.

ARRS in Manchester

In 2020/21, Manchester did not access £4m of unclaimed ARRS funding. In 2021/22, we want to ensure that PCNs and practices make the best use of this funding to support their core work, the recovery from COVID-19, and make headway against the plethora of local and national targets.

To embed the new workforce, we will need to focus on induction, supervision and a model that provides continued professional development, peer support and career progression that runs in parallel to local and national outcome-based objectives.
We may also need to draw on the organisational support of Manchester Health and Care Commissioning (MHCC) and Manchester Local Care Organisation (MLCO), who are perhaps more suited to provide the employment infrastructure than the still-developing PCNs.

We need to ensure that training hubs are coordinating the required clinical placements and developing the clinical supervisors to support staff working in Primary Care Manchester and ensure that the offer is robust and consistent
We need to be mindful of the burden on resource both in terms of personnel - who will train them? And estate - where will they be trained? When planning the simultaneous placement of new roles, and both undergraduate and post graduate placements.

This toolkit aims to outline the ARRS programme and describe the current situation, delineate the outcomes required from local and national guidance, identify the barriers and set out possible solutions to enable PCNs to successfully anticipate and deliver against these by utilising the full potential of the ARRS roles and funding available.

What ARRS roles are available?

The roles available under the ARRS programme are:

- Advanced Clinical Practitioner (Physio, Paramedic, Podiatrist, Pharmacist)
- Care Coordinator
- Dietician
- First contact physiotherapists
- Health & Wellbeing Coaches
- Mental health worker
- Nursing Associate/Training Nursing Associate
- Occupational Therapist
- Paramedic
- Pharmacist
- Pharmacy technician
- Physician's Associate
- Podiatrist
- Social prescriber

How can they help?

Whilst some of the ARRS roles are familiar to and already embedded within General Practice, such as pharmacists and pharmacy technicians; others, such as dieticians and podiatrists are less well established.

Maximising the full usage of ARRS funding will necessitate drawing on the widest possible pool of staff and thinking strategically about how they might function in a primary care setting to support against not only practice-level demands but the breadth of wider Network functions and requirements.

Therefore, following discussion at the ARRS Citywide Group, we wonder whether it might be useful to consider the roles as performing Core or Supportive functions.

Core functions and Supportive functions

It is reasonable to think of the ARRS Roles in two ways, either that they perform core functions to the network or supportive functions.

Core functions are those that will be able to contribute significantly to practice sustainability and patient experience but are also crucial to the delivery of the PCN DES as their skills are inextricably linked to the required deliverables; this will include all clinical and AHP roles.

Supportive functions will enable us to add local depth and quality to the services offered and look to improve against the less tangible measures and wider determinants of health.

This may not be an immediately apparent priority but the clear direction of travel for national and local strategy will be using the data-driven Population Health Management methodology. To this end, it is important that PCNs are enabled to keep one eye on the future as they look to address immediate and longer-term priorities; this will include all the personalised care roles.

Example of how we might delineate core and supportive roles:

Role	Core	Supportive
Clinical Pharmacist	✓	
Pharmacy Technician	✓	
Paramedics	✓	
Physician Associates	✓	
First Contact Physiotherapists	✓	
NA/ TN	✓	
Mental Health Practitioners (1/ network)		✓

Podiatrist		✓
Occupational Therapist		✓
Dietician		✓
Advanced Practitioner (1/Network)		✓
Advanced Practitioner		✓
Health and Wellbeing Coach		✓
Social Prescribing Link Worker		✓
Care Co-Ordinator		✓

Clinical Pharmacists

Clinical pharmacists work in primary care as part of a multidisciplinary team in a patient facing role to clinically assess and treat patients using expert knowledge of medicines for specific disease areas.

They will be prescribers or if not, should be working to complete an independent prescribing qualification following completion of the 18-month CPPE pathway. They work with and alongside the general practice team, taking responsibility for patients with chronic diseases and undertaking clinical medication reviews to proactively manage people with complex polypharmacy; especially for the elderly, people in care homes and those with multiple comorbidities.

GM Training Hub Webinar on Pharmacists and MH Practitioners: [YouTube]

Pharmacists role in general practice: [Presentation]
This presentation covers some general information on the role of pharmacists in General Practice and what they can bring.

Signposting to your Pharmacist: [Presentation]
This presentation is written for General Practice Reception Staff, introduces their role, how they can support the Practice clinical team and how they can help with different types of queries.

Additional Resources can be found here on TeamNet.

Pharmacy Technicians

Pharmacy technicians play an important role within general practice and complement the clinical work of clinical pharmacists in General Practice. Their deployment within primary care settings allows the application of their acquired pharmaceutical knowledge in tasks such as audit, discharge management, prescription issuing. Work is often under the direction of clinical pharmacists as part of the PCN pharmacy team.

The discipline can operate either at practice level or across a wider footprint and as their employment can sit at practice level, PCN or as part of a larger organisation.

Responsibilities can include:

- Review and provide enhanced support to patients who are on a high number of medications and /or on high-risk medications.
- Support medication reviews under the direction of the lead clinical pharmacist.
- Writing and reviewing procedures relating to medication.
- Writing training materials.
- Responding to medication queries by acting as first contact for any initial queries from patients.
- Liaising with pharmacies that supply medicines.
- Completing medicines audits and supporting patients to manage their medication correctly.
- Producing reports to check that the medication prescribed is cost effective.
- Forging relationships with external agencies within the health and care system.

GMTH webinar on Pharmacy Technicians and Physician Associates available here

Additional Resources can be found here on TeamNet.

Paramedics

Paramedics in Primary Care have the skills and expertise to undertake complex decision making and risk management. They can assess, examine and manage patients of all age ranges with a variety of acute undifferentiated and chronic conditions.

Paramedics can also support PCNs with the delivery of Enhanced Health in Care Homes and overall their intervention should reduce the need for admission to hospital.

To practice as a Paramedic, you must be registered with the Health and Care Professions Council (HCPC).

To support the progression and retention of Paramedics within the Primary Care Workforce the Manchester ARRS Group has developed a Paramedic Career Pathway, which you can find here.

First Contact Practitioner Courses available locally:

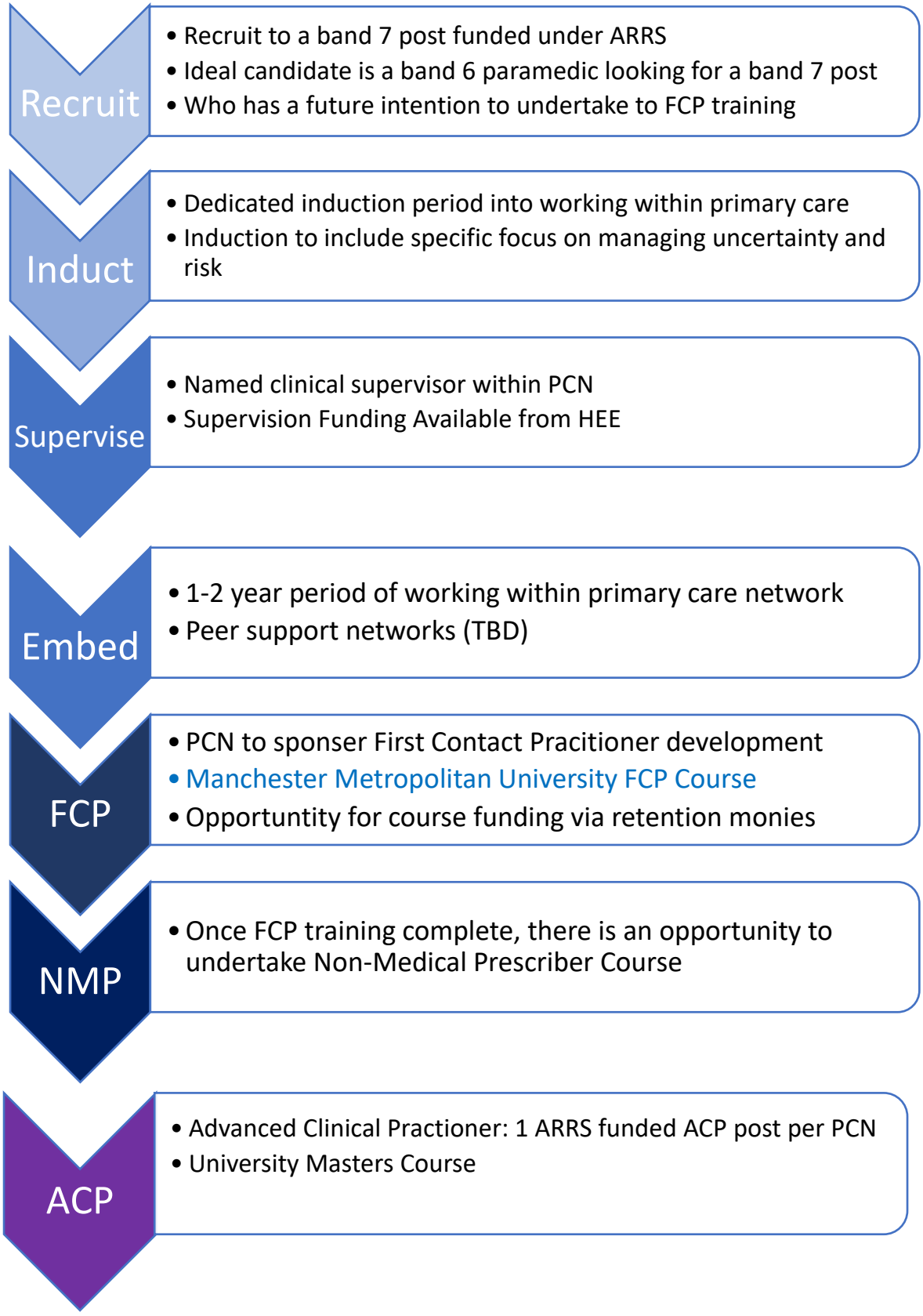
- https://www.mmu.ac.uk/hpsc/cpd/course/first-contact-practitioner-in-primary-care/
- https://www.salford.ac.uk/courses/single-module/first-contact-practice-primary-care-level-7-30-credits

GP Ready Programme for all FCPs joining the Primary Care Workforce – this is run by GM Training Hub

GM TH webinar on Paramedics and Physiotherapists: [YouTube]

Additional Resources can be found here on TeamNet.

Manchester ARRS Group: Paramedics Career Pathway



Physicians Associates

Physician associates are healthcare professionals with a generalist medical education who work alongside doctors providing medical care as part of the multidisciplinary team. They are dependent practitioners who work under the supervision of a fully trained and experienced doctor.

A PA's role is most suited to employment by PCN or individual practice. If the PA is in their preceptorship year, they will need a single practice as a training lead. Roles will vary dependent on need, for example, areas that struggle to recruit GPs may wish to utilise them as member of the generalist medical team. Whereas those areas fortunate enough to have less acute recruitment requirements may benefit from developing PA's into a more focused, specialised role performing a particular function for the PCN, ideally against a uniform process that all practices can benefit from.

These roles would require engagement in training and support from other services. Examples of this might include:

- Specialising in baby checks, post-natal health and infant feeding problems.
- Specialising in MH with view to providing continuity of care and engagement of these diagnosed with an SMI and continued promotion and undertaking of health checks.
- Specialising in LD with view to providing continuity of care and engagement of these diagnosed with a LD and continued promotion and undertaking of health checks.
- Specialising in frailty and provide clinical support to the MDT approach of the Care Home DES.

Practices considering employing a PA in their preceptorship role, please see the below as this is a very comprehensive offer from GM Training Hub and fulfils the eligibility criteria for the HEE funded £5k funding for practices:
https://www.gmthub.co.uk/gp-ready-programme/physician-associate

There is also a HEE funded alternative PATH that offers remote supervision and support for employers of Physician Associates (PAs) in General Practice and Primary Care.

GM Training Hub Webinar on PA's: [YouTube]

Additional Resources can be found here on TeamNet.

Useful Links:

- https://www.fparcp.co.uk/employers/pas-in-general-practice/
- https://www.hee.nhs.uk/our-work/primary-care/physician-associates-primary-care
- https://gmprimarycarecareers.org.uk/generalpractice/careers/physician-associate/peer-support/

First contact Physiotherapists

First Contact Practitioners (FCP) are qualified autonomous clinical practitioners who can assess, diagnose, treat, and manage musculoskeletal (MSK) problems and undifferentiated conditions and, where appropriate, discharge a person without a medical referral.

FCPs working in this role can be accessed directly by patients, or staff in GP practices can refer patients to them to establish a rapid and accurate diagnosis and management plan to streamline pathways of care.

To practice as a Physiotherapist, you must be registered with the Health and Care Professions Council (HCPC).

All Physiotherapists entering the Primary Care Workforce will need to have completed or enrol on a First Contact Practitioner University Course.

First Contact Practitioner Courses available locally are detailed below:

- https://www.mmu.ac.uk/hpsc/cpd/course/first-contact-practitioner-in-primary-care/
- https://www.salford.ac.uk/courses/single-module/first-contact-practice-primary-care-level-7-30-credits

GP Ready Programme for all FCPs joining the Primary Care Workforce – run by GM Training Hub.

GM TH webinar on Physiotherapists here.

Additional Resources can be found here on TeamNet.

Mental Health Practitioners

Mental Health Practitioners have been added to the ARRS scheme from April 2021. These roles are designed to support adults and older people. The practitioner will be fully embedded in primary care working as part of the PCN MDT.

These roles are part of a 3-year programme of recruitment of mental health staff to PCN's to enable delivery of the NHS Long Term Plan's commitment to redesign community mental health services with the aim to move towards a new place based, multi-disciplinary service across health and social care.

In line with the wider community mental health transformation programme the focus of these posts will be to support people whose needs cannot be met by IAPT services but who may not meet the current threshold of secondary mental health services. The role can be reimbursed at Band 5 – 8a and the level of reimbursement will depend on the practitioner the PCN chooses to recruit. The practitioner can be any clinical registered role such as a community psychiatric nurse, clinical psychologist or mental health OT.

As this is part of the wider transformation and expansion of community mental health services, the practitioner will be employed by the secondary mental health provider. The PCN will only need to fund 50% of this role with the mental health provider funding the other 50%.

The practitioners will

- Carry a small caseload across all GP Practices
- Be part of the Living Well MDT that can identify lead practitioners and help provide enhanced support for patients with more complex needs
- Be aware of and utilise appropriately the range of services available locally including Voluntary Sector and Community Groups

Where feasible and with the agreement of the mental health provider, PCNs can also recruit a practitioner for Children and Young People under the same employment model.

Additional Resources can be found here on TeamNet.

Nursing Associates/ Trainee Nursing Associates

Nursing Associates are a new supporting role that bridges the gap between Healthcare Support Workers and Registered Nurses to deliver hands-on, person-centred care as part of the Nursing Team. Nursing Associates work across all 4 fields of Nursing: adult, children's, mental health and learning disability.

Due to the scarcity of trainees NA's practices or PCNs may look to initially "grow their own" from existing workforce. This represents an exciting development opportunity for our Healthcare Support Worker workforce to build on and develop their skills and knowledge through the Trainee Nursing Associate (TNA) apprenticeship.

Once trained their role can include:

- Phlebotomy
- Immunisations
- Cervical screening
- Management of long-term conditions

All of which can supplement existing nursing skills, free up nursing time for more complex patients and broaden the clinical capacity of the practice/PCN team.

GM Webinar on NA's and TNA's available here.

Additional Resources can be found here on TeamNet.

Podiatrist

Podiatrists provide assessment, evaluation and foot care for a wide range of patients which range from low risk to long-term acute conditions. They can minimise the impact and consequence of long-term conditions such as:

- Prevent and delay onset of deterioration of chronic conditions.
- Maintain and maximise mobility.
- Help to reduce the number of falls.
- Enable independence leading to improved quality of life and reduced social exclusion.
- Reduce the need for secondary, surgical or pharmacological intervention.
- Reduce hospital admissions and unnecessary hospital referrals.
- Support patients living with long term conditions.
- Keep people mobile and in work.

Many patients who are in high risk categories include those with diabetes, rheumatism, cerebral palsy, peripheral arterial disease and peripheral nerve damage.

All Podiatrists coming into the Primary Care Workforce will need to have completed or enrol on a First Contact Practitioner University Course.

Training:

- First Contact Practitioner Courses available locally:
    - Manchester Metropolitan University – First contact practitioner in primary care
    - Salford University – First contact practice in primary care: Level 7
- GP Ready Programme - for all FCPs joining the Primary Care Workforce run by GM Training Hub.
- GM Training Hub webinar on Podiatrists and OTs and Dieticians

Additional Resources can be found here on TeamNet.

Occupational Therapist

OTs provide interventions that help people find ways to continue with everyday activities that are important to them. This could involve learning new ways to do things or making changes to their environment to make things easier.

As patients' needs are so varied, OTs help GPs to support patients who are frail with complex needs, live with chronic physical or mental health conditions, manage anxiety or depression, require advice to return or remain in work and need rehabilitation so they can continue with previous occupations (activities of daily living).

OT's dual physical and mental health training means they can comprehensively assess and start interventions with patients straight away. As OTs can offer dual services to patients, they can spend time with patients to address both their physical and mental health needs.

Example of tasks that the role is trained to deliver:

- Specialise in complex needs and identifying social support.
- Diet and lifestyle advice.
- Health promotion.
- Assisting patients suffering with mental health and musculoskeletal problems to return and remain in work.

For more practical ideas see the Royal College of Occupational Therapists guide.

There are also significant elements of the Care Home ES which would be well supported by OTs, making them versatile members of the PCN workforce.

All Occupational Therapists joining the Primary Care Workforce will need to have completed or enrolled on a First Contact Practitioner University Course.

Training:

- First Contact Practitioner Courses available locally:
    - Manchester Metropolitan University – First contact practitioner in primary care
    - Salford University – First contact practice in primary care: Level 7
- GP Ready Programme - for all FCPs joining the Primary Care Workforce run by GM Training Hub.
- GM Training Hub Webinar on Occupational Therapists and Dieticians

Resources:

- Health Education England - Resource page on OTs in primary care.

Additional Resources can be found here on TeamNet.

Dieticians

Dietitians are healthcare professionals that diagnose and treat diet and nutritional problems at an individual patient and wider public health level. They work in a variety of settings with patients of all ages. Dietitians support changes to food intake to address diabetes, food allergies, coeliac disease and metabolic diseases.

Dietitians also translate public health and scientific research on food, health, and disease into practical guidance to enable people to make appropriate lifestyle and food choices. In this way, they are likely to provide more of a supportive role against aspirational Population Health Management aims, such as weight management and reducing the risk of diabetes.

To practice as a Dietician, you must be registered with the Health and Care Professions Council (HCPC).

All Dieticians joining the Primary Care Workforce will need to have completed or enrolled on a First Contact Practitioner university course.

First Contact Practitioner Courses available locally:

- https://www.mmu.ac.uk/hpsc/cpd/course/first-contact-practitioner-in-primary-care/
- https://www.salford.ac.uk/courses/single-module/first-contact-practice-primary-care-level-7-30-credits

GP Ready Programme for all FCPs joining the Primary Care Workforce run by GM Training Hub

GM TH webinar on Dieticians and OTs and Podiatrists: [YouTube]

HEE Case Studies on Dieticians in Primary Care here.

Additional Resources can be found here on TeamNet.

Advanced Practitioner

An Advanced Practitioner is a clinician with a verified portfolio of evidence at a Masters level of practice across all four pillars of practice: leadership, clinical, education and research, who has a minimum of 5 years post graduate experience working across all the whole scope of advanced practice.

It must be noted that this role is NOT open to nurses with an Advanced Clinical Practice qualification under current ARRS funding.

This role is limited to 1 per PCN under 99,999 registered population, so PCNs would need to think creatively about how to get the best out of them. One option might be to embed them within existing services to support reactive community care or delivery of the EHCH specification.

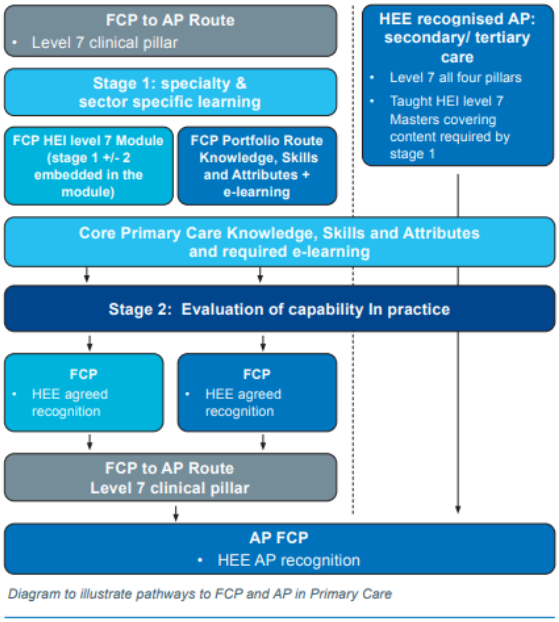
Advanced Practitioners requirements:

- Hold a full masters ACP or credential matched through HEE
- Advanced practitioners will be held on a directory at the HEE Centre for Advancing Practice

The role is banded at 8a and under ARRS funding is currently open to:

- Dieticians
- Occupational Therapists
- Paramedics
- Pharmacists
- Physiotherapists
- Podiatrists

FCP to AP Route in Primary Care:



Additional Resources can be found here on TeamNet.

Useful Links:

https://www.hee.nhs.uk/our-work/advanced-clinical-practice/what-advanced-clinical-practice

Health and Wellbeing Coach

They will predominately use health coaching skills to support people with lower levels of patient activation to develop the knowledge, skills, and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals. They may also provide access to self-management education, peer support and social prescribing.

They can also play a crucial role in helping the wider PCN to understand the barriers for individuals and groups in accessing support in the community and use this insight in developing community-based support, working as part of the wider social prescribing model.

Example tasks that role is trained to deliver:

- Offers 1:1 or group sessions with patient's health and wellbeing support needs
- Diet and lifestyle advice
- Health promotion

Ongoing regular supervision from a health coaching mentor is required. Any health coaching provider will have to be accredited by the Personalised Care Institute (PCI).

GM Training Hub Webinar on all 3 Personalised Care Roles: [YouTube]

Additional Resources can be found here on TeamNet.

Social Prescribing Link Worker

There are many different models for social prescribing, but most involve a link worker or navigator who works with people to access local sources of support.
Link workers give people time and focus on what matters to the person as identified in their care and support plan. They connect people to community groups and agencies for practical and emotional support.
Link workers typically work with people over 6-12 contacts, including phone calls and meetings, over a three-month period. They have a typical caseload of up to 250 depending on the complexity of people's needs.
Social prescribing works for a wide range of people, including people:

- With one or more long-term conditions
- Who need support with their mental health
- Who are lonely or isolated
- Who have complex social needs which affect their well-being

From a GP perspective, practice teams should consider those patients that are frequent attenders with often unexplained physical symptoms, social isolation, mental health difficulties, and poorly controlled long-term conditions. In this way, SPs can help to increase uptake against health check and vaccination programmes and support delivery of both core GP and PCN DES requirements.
If employment for social prescriber workers is via SLA with the third sector, PCNs can claim an additional £2,400 per year as contribution towards additional costs, within the maximum reimbursable rate for the role.

GM Training Hub Webinar on all 3 Personalised Care Roles: **[YouTube]**

Additional Resources can be found here on TeamNet.

Useful Links:
https://www.england.nhs.uk/personalisedcare/social-prescribing/
https://gmprimarycarecareers.org.uk/generalpractice/careers/social-prescriber/peer-support/

Care Co-ordinator

Care Coordinators provide extra time, capacity and expertise to support patients in preparing for or following up clinical conversations they have with primary care professionals.

They work closely with GPs and other primary care professionals within the PCN to identify and manage a caseload of identified patients; making sure that appropriate support is made available to them and their carers and ensuring that their changing needs are addressed.

They focus on delivery of personalised care to reflect local PCN priorities, health inequalities or groups of patients identified through risk stratification. They can also support PCNs in the delivery of Enhanced Health in Care Homes.

Example tasks that role is trained to deliver:

- Can take on the administrative support of caseloads of patients working with the wider team to identify patients that require additional support.
- Can offer support with personalised care requirements and work with social prescribing link workers and/or health and wellbeing coach.

GM Training Hub Webinar on all 3 Personalised Care Roles: [YouTube]

Additional Resources can be found here on TeamNet.

Useful Links:

- https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/
- https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/

What are the national and local outcome measurements for General Practice in 21/22?

Overall, there are more than a dozen national, local and practice level outcome measurements for General Practice in 21/22. Below is a summary of the outcomes against which we believe the ARRS roles can support.

National priorities and measurements

1. **NHS Operational Planning**
    - Support health and wellbeing of staff.
    - Deliver COVID-19 Vaccination programme and meet needs of those with Covid-19.
    - Transforming delivery of services.
    - Restoration of elective and cancer services and managing increasing demand on mental health services.
    - Expanding priority care capacity to improve access, local health outcomes and address health inequalities.
    - Transforming community and urgent and emergency care.
    - Working collaboratively across systems to deliver on these priorities.

2. **QOF**
    - QOF QI - LD and Cancer Projects

3. **COVID Vaccination ES**

4. **Weight Management ES**

5. **Long COVID ES**

6. **PCN DES**
    - Enhanced Health in Care Homes.
    - Structure Medication Reviews.
    - Early Cancer Diagnosis.

- Extended Hours Access.

7. **Investment and Impact Fund**
    - Flu vaccination uptake.
    - Learning Disability annual health checks.
    - Social Prescribing referrals (Proactive Primary Care).
    - Standardised GP Appointment Categories.
    - Cardiovascular Health.
    - Improving Access.
    - Sustainable NHS.

Local priorities and measurements

- Primary Care Quality, Recovery and Resilience Scheme
    - Improving demographics.
    - LD and SMI Health Checks.
    - COVID Vaccination programme.
    - COVID follow-up.
    - Practice QI.

General Practice Contracts 21/22 National, Local and PCN DES

I have reviewed the following documents and highlighted the relevant areas with regards to General Practice and required outcomes expected for the expanded (ARRS funded) Primary Care Workforce.

There are some clear overarching aims and outcomes which I think we can use to help plan and utilise our primary care ARRS funded workforce – see table

- NHS England – 2021/22 Priorities and Operational Planning guidance
- NHS England – Update on Quality Outcomes Framework Changes for 2021/22
- NHS England – QOF QI Support People with Learning Disabilities
- NHS England – QOF QI Cancer
- NHS England – Covid-19 Enhanced Service Specification
- NHS England – Enhanced Service Specification Weight Management
- NHS England – Enhanced Service Specification Long Covid
- NHS England – GP Contact
- NHS England – Network Contract DES Early Cancer Diagnosis Guidance
- NHS England – The Framework for Enhanced Health in Care Homes
- NHS England – Structed Medication Reviews and Medicines Optimisation
- NHS England – Investment and Impact Fund 2020/21
- NHS England – Primary Care Networks Plans for 2021/22 and 2022/23

	Pharmacist	Pharm Tech	Physio	Paramedic	Phys Assistant	NA/TNA	Personalised Care Roles	OTs	Dieticians	Podiatrist
NATIONAL PROGRAMMES										
QOF	Meds reviews	Meds reviews		HVs for bloods, CD reviews	CD reviews when trained	Bloods, foot checks, smears				
Increased uptake of routine imms and vaccinations					Yes under PSD ? consider defined role to inc baby check /imms/ infant feeding	LT goal increase capacity and flexibility across PCN to provide services in both routine and ext hours	Supportive role for non-responders			
QOF QI							Uptake of health checks, screening			
COVID Booster Vac programme	Vaccinators if agreed by PCN	Vaccinators if agreed by PCN	Vaccinators if agreed by PCN	Vaccinators if agreed by PCN	Vaccinators if agreed by PCN	Vaccinators if agreed by PCN	Increasing uptake	Vaccinators if agreed by PCN	Vaccinators if agreed by PCN	Vaccinators if agreed by PCN
	Pharmacist	**Pharm Tech**	**Physio**	**Paramedic**	**Phys Assistant**	**NA/TNA**	**Personalised Care Roles**	**OTs**	**Dieticians**	**Podiatrist**
Seasonal Flu ES	Vaccinators			Vaccinators	Vaccinators	Vaccinators	Increasing uptake			
Weight Management ES						Increasing uptake	Increasing uptake	WM advice	Increasing uptake, work with local teams	
Long Covid ES			MDT approach to management /support				MDT approach to management /support	MDT approach to management /support/facilitate return to work		
PCN DES										
Enhanced Health in Care Homes	SMRs	SMRs	Rehabilitation functions	Acute visiting	Regular rounds	Nursing input		*Advanced Falls support- see next table	*Feeding support- see next table	*Advanced input – see next table
SMRs	Meds reviews	Meds support								

Early Cancer Diagnosis						LT goal increase capacity and flexibility across PCN to provide services in both routine and ext hours	Non-responders to screening and cancer care reviews			
	Pharmacist	**Pharm Tech**	**Physio**	**Paramedic**	**Phys Assistant**	**NA/TNA**	**Personalised Care Roles**	**OTs**	**Dieticians**	**Podiatrist**
Extended Hours Access (consolidated April 22)	Appointments		Appointments		Appointments					
Anticipatory Care (From Apr 22)				Involve in planning and application	Involve in planning and application		Involve in planning and application			
Personalised Care (From Apr 22)				Involve in planning and application	Involve in planning and application		Involve in planning and application			
Investment & Impact Fund 21-23										
Standardised GP Appointment Categories										
Improving prevention/LD health checks/demographics/flu/HTN/	Audit and case finding of HTNs/Fam hyperchol	Audit and case finding of HTNs/Fam hyperchol		Audit and case finding of HTNs, LD HCs, flu uptake	Audit and case finding of HTNs, LD HCs, flu uptake	Flu uptake, LD HCs	Flu uptake, LD HCs			
	Pharmacist	**Pharm Tech**	**Physio**	**Paramedic**	**Phys Assistant**	**NA/TNA**	**Personalised Care Roles**	**OTs**	**Dieticians**	**Podiatrist**
Proactive Primary Care/SP referrals/Care Home planning	SMRs			Care home support planning admission reduction, reviews	Care home support planning admission reduction, reviews		Increase SP referrals			
Support improved access to Primary Care	Audit and contact patients to reduce MDIs	Audit and contact patients to reduce MDIs								

Deliver better outcomes for pts on medication	Audit and meds review, SMRs									
Sustainable NHS	Audit and contact patients to reduce MDIs	Audit and contact patients to reduce MDIs								
	Pharmacist	**Pharm Tech**	**Physio**	**Paramedic**	**Phys Assistant**	**NA/TNA**	**Personalised Care Roles**	**OTs**	**Dieticians**	**Podiatrist**
Increase uptake of health checks for LD and SMI	Medication review – STOMP		MDT approach for LD checks if required		Could consider defined role within practice/ PCN for leading on SMI + LD checks	LT goal increase capacity and flexibility across PCN to provide services in both routine and ext hours	Promote attendance and aim to engage with none responders Provide support and guidance as required – MDT approach	Support MDT approa h for LD checks if required	Support MDT approach for LD checks if required	Support MDT approach for LD checks if required
SMRs, Medicines Optimisation and Prescribing Safety	Yes	Yes					Promote attendance or routine checks and aim to engage with non-responders			
	Pharmacist	**Pharm Tech**	**Physio**	**Paramedic**	**Phys Assistant**	**NA/TNA**	**Personalised Care Roles**	**OTs**	**Dieticians**	**Podiatrist**
LTC management	Yes MR/meds op	Yes SMR/medsop	Yes First contact for relevant MSK issues	Yes Could review or manage acute on chronic presentations	Yes ? as generalist or specialist area	Yes support PN workload	Promote attendance or routine checks and aim to engage with non responders Help to relevant community support groups if appropriate	Yes if not provided by another service- MDT approach	Yes if not provided by another service- MDT approach	Yes if not provided by another service- MDT approach
111 CCAS/Urgent Care	Yes – help to deflect OTC queries	Yes – help to deflect OTC queries	First contact for MSK issues	Yes help deal with acute demand/concernsinc visits	Yes either as generalist or specialtist area		Help provide support for frequent attenders/ those struggling with physical/financial circumstances			
PQRRS										
	Pharmacist	**Pharm Tech**	**Physio**	**Paramedic**	**Phys Assistant**	**NA/TNA**	**Personalised Care Roles**	**OTs**	**Dieticians**	**Podiatrist**

Improving demographics							Increase uptake			
LD and SMI health checks							Increase uptake			
COVID Followup							Increase uptake			
Practice QI	Run audit/QI process	Run audit/QI process								
Digital workflow and inclusion							Increase uptake			
Education and practice development										

* Please see Framework for Enhanced Health in Care Homes, courtesy of Nicky Boag, Head of Allied Health Professionals for the MLCO.

The Framework for Enhanced Health in Care Homes Enhanced Health in Care Homes, courtesy of Nicky Boag, Head of Allied Health Professionals for the MLCO.

Care Element One: Enhanced primary and community care support	
4.5 Hydration and nutrition support	**Dietitian ARRS role support**
4.5.1 Poor hydration and poor nutrition can often lead to confusion, falls, and poor health; therefore, good practice in primary care support to a care home is to enable effective management of each resident's hydration and nutrition. **4.5.2** Best practice includes: a. Every person's hydration and nutrition should be reviewed regularly and included in their care plan. Where clinically appropriate, they should have access to specialist dietetic and speech and language professionals, who should form part of the extended MDT in line with best practice for hydration and nutrition. b. The care home should have a nutritional screening policy in place with one staff member taking responsibility for this policy within the home. c. Staff employed by social care providers should undertake clinical training and professional development, which is critical in promoting good nutrition for older people. Technology can also provide innovative solutions. Several areas have connected clinicians with care homes using high-definition cameras. The system enables clinicians to observe an individual's ability to feed themselves unaided, without requiring a call-out. They can then work with the home and person involved to ensure they are supported to eat and drink well. d. When appropriate, and in line with local policy, community nursing teams should provide supporting services for staff employed by social care providers. This could include, for example, administering subcutaneous and intravenous fluids to maintain optimum hydration status.	A Dietitian ARRS role could offer: • Education in the impact or poor hydration and poor nutrition to residents and strategies to promote good oral intake that would benefit all residents. • Education for homes to ensure that regular nutritional screening is completed accurately and is in place for all residents to ensure that signs of malnutrition are identified in a timely manner and referrals are made for specialist assessment to the appropriate service. • Education to ensure all homes are aware of referral pathways to ensure all residents access appropriate specialist intervention. This will include pathways to both dietetic and Speech and Language services. • Completion of specialist dietetic assessment for patients identified as malnourished to identify cause, individualised care plans put in place and on-going review of outcomes. • Dietitians will have access to secure software that will enable them to complete remote assessments with residents at times when it is not appropriate to enter the care setting e.g. at times of Covid-19 outbreak where care homes are isolating residents. Advice on menu planning to ensure a balanced diet and optimum nutrition is provided to care home residents.
Care Element Two: MDT support including coordinated health and social care	
5.6. Leg and foot ulcers	**Podiatry ARRS roles support**
5.6.1. Effective wound care can support people to live in good health for longer. Leg and foot ulcers are wounds that fail to heal within a few weeks and are common in older, less mobile people. They can have a profound negative impact on quality of life in terms of pain, malodour and leakage, impaired mobility, anxiety, sleep disturbance, and social isolation.	A Podiatry ARRS role could offer: • Training programmes for all staff on basic foot care, footwear and when to escalate for specialist podiatry assessment. • To be a point of contact for staff to provide advice and guidance.

5.6.2. Most leg ulcers are due to poor venous return and can be healed if people receive an accurate diagnosis and appropriate treatment. Therefore, it is important that anyone who has a wound on their leg or foot that is not healing or not likely to heal should receive an assessment from a clinician with expertise in leg and foot ulcer management. **5.6.3.** Best practice includes: a. The care home should have an up to date leg and foot ulcer policy, either as a stand-alone document or as part of another policy such as wound care. Such policies should reflect national guidance where it exists. b. Care home staff should be offered training and support to ensure the appropriate care of a resident with a leg or foot ulcer by undertaking initial wound care and referring to the local service that undertakes leg and foot ulcer assessment and care planning. c. Care home staff should be supported to continue to ensure that the resident receives appropriate individualised care while awaiting the outcome of the leg and foot ulcer service recommendations. d. Care home staff should be supported to implement the recommended care plan of the leg and foot ulcer service in partnership with local NHS services. e. The care plan should focus on enabling and empowering the resident to keep active and undertake activities and interventions that promote wound healing.	• Footcare where high clinical risk comorbidities exist and/or there is risk of skin breakdown and ulceration. • Comprehensive assessment, intervention and provision of bespoke orthotics as appropriate for complex foot conditions. • Wound care for feet in the presence of vascular disease, excluding venous ulceration. • Pressure assessment and management advice.

Care Element Three: Falls prevention, reablement and rehabilitation including strength and balance	
6.2. Reablement and rehabilitation services	**OT ARRS role support**
6.2.1. Reablement and rehabilitation provide specialist assessment and treatment. Their purpose is to restore independent functioning, thereby improving health and wellbeing. These services should be available to people living in care homes in the same way as they could expect within their own home. Access to these services will be available as part of the Ageing Well model and delivered under the remit of Urgent Community Response (UCR) 2-day response as clinically appropriate. It is best practice for activity coordinators to form an important part of a reablement team. They help facilitate and support exercise and other activities for the individual.	An OT role could provide advice and support to reablement staff in the delivery of activities and exercises aimed at improving mobility and maintaining independence. For residents who are mainly confined to bed they can offer specialist assessment and provision of advice to care staff regarding management to prevent pressure areas and development of contractures e.g. advice regarding positioning; sitting out of bed (see “posture and seating” below).
6.3. Falls, strength and balance	**OT ARRS role support**

6.3.1. Each year around one third of people aged over 65 experiences one or more falls, this figure rises to 50 per cent for those over 80 years old. Falls rates among care home residents are much higher than among older people living in their own homes. A fall can result in suffering, disability, loss of independence, and decline in quality of life. **6.3.2.** Falls and fracture prevention and management are not the preserve of one profession, service or organisation, and everyone can help with falls prevention. The consequences of a fall or fracture cuts across all agencies working with older people, and with support to understand their contribution all agencies can be part of the solution. **6.3.3.** Physical activity is a primary determinant of bone, muscle and joint strength, as well as functionality. NICE guidance identifies low muscle strength and poor balance in later life as the most common preventable risk factors for falls. Regular physical activity is associated with up to 40 per cent risk reduction of fall-related injuries and up to 66 per cent risk reduction of bone fractures. However less than 1 in 3 of men (31 per cent) and 1 in 4 (24 per cent) of women meet the guidelines for muscle-strengthening exercises; with even lower proportions in those aged over 65 years. **6.3.4.** Many falls and fractures can be prevented and managed by well organised services and organisations working in partnership with the individual residents and their carers. Effective falls prevention and management can make a significant contribution to improving quality and outcomes and supporting people to live in good health for longer. **6.3.5.** Best practice includes: **a.** Falls risk assessments should, where relevant, form part of the CGA-based holistic assessment process which is included in the nationally commissioned EHCH model. **b.** Care homes should have a policy in place to determine how falls risks will be assessed and managed. This should include how to get the resident from the floor when they have fallen, and when to call for additional support/advice e.g. via 111/999. **c.** Care home staff should be offered training and support on how to undertake a physical activity assessment with an individual and develop a personalised physical activity plan on admission to the home. **d.** Care home staff should be offered training on falls prevention and management and physical activities (including advice on muscle strengthening and balance activities) and be supported to use this knowledge by the MDT. **e.** Care home staff should be supported to ensure the safety of the individual by providing an appropriate individualised falls prevention plan which is linked to their personalised care and support plan. **f.** People living in a care home should have access to local falls specialist services as clinically necessary.	**An OT could offer:** • Falls prevention advice. • Training to care home staff regarding falls prevention and management. • Advice on identifying people at high risk of falls, complete falls risk assessment and action plans. • Advice on how to complete moving and handling plans for patients at risk of falls. • Review of mobility equipment being used to ensure they are in good working order, recommend/arrange replacements as appropriate. • Ensure patients who are able to mobilise have an appropriate waling aid. • Ensure all new residents they have a mobility plan in place. • Work with the care homes to encourage a proactive review of falls incidents and lessons learnt. • Training to care homes staff to have the skills to support residents to be involved in daily routines and maintain independence. • Advise on transfers and equipment options where indicated. **Posture and seating** • Advising homes on suitable seating provision, both specialist and standard lounge chairs. • Identify and assess patients who require specialist seating. • Training around posture management, risk of contractures, detrimental effects of being confined to bed for long periods. • Identify and assess patients who may require sleep systems to maintain postural alignment. **Behavioural and Psychological** • Many residents will have a dementia or cognitive impairment so educating care home staff to have a better understanding of behaviour and management of behaviours. • Advice and education regarding reality orientation. • Advice and education regarding sleep hygiene.

	Occupation • Educating care home staff to have a better understanding of meaningful occupation. • Education of care home staff to work with people who have reduced motivation and decreased ability to participate in meaningful activity.

How does the financial model work?

The live financial dashboard is available here

Below we have detailed a reference to aid interpretation of the ARRS financial spreadsheet. This is a 'live' spreadsheet detailing both citywide and PCN-specific positions, which will be supplied on a monthly basis to PCNs for discussion at their Network meetings, with the citywide position highlighted at Locality Subgroup. There are three important points to be aware of:

1. The total budget for the ARRS roles in Manchester is £8.99m, but MHCC, like all CCGs, have only been supplied with an initial allocation of £5m. This £5m must be allocated in-year by PCNs in order for MHCC to initiate the process by which to access the rest.

2. For this reason, it is essential that PCNs regularly and accurately, report their recruitment positions as without the assurances that the money has been allocated, the city will not be able to access the second drawdown.

3. Because the £5m represents the total balance currently in receipt at MHCC, all of the forecasts have been calculated based on this rather than the full £8.99m

Please find an explanation of each column below:

Annual Budget 100% (B)

This is the total envelope assigned by PCN population and Manchester in total, available for ARRS funding from NHSE. 55.6% (£5m) of this is immediately available to MHCC and 44.4% (£3.99m) needs to be drawn down from the national pot.

In order to access this £3.99m, the city as a whole must breach the £5m total initially allocated to MHCC.

It is assumed that the full £8.99m will be available, however, as national budgets are currently being set on a 6-monthly basis, this is pending confirmation by NHSE.

Annual Budget 55.6% (C)

This is the total amount of funding currently in receipt by MHCC available for use against the ARRS roles. Once the £5m allocation is breached by all Manchester PCNs, MHCC will be able to access the extra £3.99m in order to support the scheme.

Forecast underspend/overspend based on 55.6% (A)

This details the forecasted spend based on the 55.6% (£5m) of ARRS funding currently in receipt by MHCC, not against the full total available to the PCN including national drawdown. We have chosen to represent the forecast based on the initial allocation because national budgets are only being set 6 months in advance, although we anticipate that the full value will be available once the £5m ceiling is breached.

YTD Budget 55.6% (D)

This is the year to date proportion of the 55.6% initial allocation calculated to the last month.

YTD Expenditure 55.6% (E)

This is the PCN's actual expenditure incurred in the year to date based on the information supplied by the PCN.

YTD Variance (F)

This is the PCN's year to date budget minus expenditure.

Forecast expenditure (G)

This is the forecast total expenditure for the PCN for the whole year. The variance (column L) of this is against the 55.6% allocation in column B, NOT the total potential budget in column A.

Forecast variance (H)

As above.

% overspend/underspend based on 55.6% (I)

This is the percentage of column H (Forecast variance) against column C (Annual budget 55.6%).

WTE (J)

Your total WTE of staff currently employed in PCN.

What are the different models of employment?

There are a number of models through which PCNs can employ their ARRS staff each with their own considerations with regards to suitability for post, training and development and sustainability:

1. Service agreement with another provider (including rotational models).
2. Service agreement or subcontract with another organisation e.g. GP Federation.
3. Direct employment by host practice or PCN, where if possible.

There are clear benefits for options 1 with regards to recruitment, HR, training and ongoing CPD requirements and can give the flexibility of a large employer to respond to changes in demand. However, rotational models may create increased work for primary care given the requirement to re-induct on a regular basis so careful consideration needed to ensure that any agreement is workable for both parties.

Employment by primary care providers does mean that supervision, training and governance becomes our responsibility, but it does give us the opportunity to embed these roles within the primary care setting and perhaps allow more nuance to align with local health needs

For more information on the employment considerations when recruiting to ARRS roles including some role specific examples please **click here.**

Supervision

The Network Contract DES outlines a number of requirements that every PCN must comply with in relation to roles recruited through the ARRS scheme. This list of requirements includes a specific request for all additional roles to have “access to appropriate clinical supervision and administrative support”.

Ongoing requirements for supervision, CPD, peer support and career progression should be major consideration in choice of employment model for each role.

Having the right level of supervision in place is key for both staff and patient safety and will also be essential for staff retention. We need to be mindful however, of the burden in General Practice particularly if the role requiring supervision does not directly positively impact on GP workload.

Supervision for clinical roles should be considered in two ways: direct clinical supervision and CPD supervision; this approach reflects latest HEE guidance.

Clinical Supervision
This is provided in the clinical setting, usually by GP or by a verified and recognised Advanced Practitioner. The frequency and structure of delivery should be flexible to individual requirements and complexity of the role.
Clinical supervision includes:

- Debrief and discussion of individual cases
- WPBA
- Reflecting and reviewing practice

CPD Supervision
This is provided by the employer or line manager but could also be offered by a senior professional from across the MDT. There is a requirement to evidence-maintained capabilities against an agreed framework on a regular basis.
CPD supervision includes:

- Developing professional relationships
- Discussing way of working

- Developing teams
- Identifying learning needs, opportunities and support
- Reflection on incidents/learning events
- Peer review

Role Specific Supervision

The table below outlines the required forms of supervision for each of the clinical ARRS roles.

It is our recommendation that in order to support both patient and practitioner safety, each clinical role recruited through the ARRS has access to the following types of supervision:

Clinical roles	Clinical supervision	CPD supervision	An appropriate named individual in the PCN to provide general advice and support on a day to day basis
Pharmacy Technician	☑	☑	
Physician Associate	☑	☑	
First Contact Physiotherapist	☑	☑	
Dieticians	☑	☑	
Podiatrist	☑	☑	
Occupational Therapists	☑	☑	
Nursing Associate and	☑	☑	☑
Trainee Nursing Associate	☑	☑	☑

Please note that all First Contact Practitioners and Advanced Practitioners will require a Roadmap trained supervisor.

In the case of Clinical Pharmacists, the PCN DES specifically requires the following levels of supervision. Each clinical pharmacist must receive a minimum of one supervision session per month by a senior clinical pharmacist and the senior clinical pharmacist must receive a minimum of one supervision session every 3 months by a GP clinical supervisor.

Must have access to an assigned GP clinical supervisor for support and development.

There will be a ratio of one senior clinical pharmacist to no more than 5 junior clinical pharmacists with appropriate peer support and supervision in place.

The training and supervision of pharmacists is relatively complex and if a practice was looking to employ a pharmacist directly they would be advised to read the following NHS Futures page for more resources.

Supervision is also required for the non-clinical personalised care roles: Social Prescriber, Health Coach and Care coordinator, whilst ideally a member of the hosting clinical team should be available to provide day-to-day support, if third-sector contracts are utilised rather than direct employment the assumption is most of this will be devolved to lead employer. However, recommended supervision requirements vary between the three roles so need to be closely delineated.

It is our recommendation that in order to support both patient and practitioner safety, each personalised care role recruited through the ARRS has access to the following types of supervision:

	Social Prescribing Link Worker	Health and Wellbeing Coach	Care Co-ordinator
A first point of contact for general advice and support and (if different) a GP to provide supervision. This could be provided by one or more named individuals within the PCN.	☑	☑	☑
It is recommended that link workers are also able to access clinical supervision as described in the Social prescribing link workers: Reference guide for primary care networks - Technical Annex (Annex F), which can be from their GP supervisor or another relevant health professional in the PCN.	☑		
Access to a GP (either their named supervisor or another appropriate GP) to provide advice on patient related concerns and to support with appropriate safeguarding procedures.	☑	☑	☑
Attendance at the peer support networks run by NHS England and NHS Improvement at ICS/STP level.	☑		
Access to regular supervision from a health coaching mentor, and individual and group coaching supervision from a suitably qualified or experienced health coaching supervisor.		☑	

Additional Resources can be found here on TeamNet.

Useful Links:

https://www.hee.nhs.uk/our-work/allied-health-professions/enable-workforce/roadmap-faqs

What is the Role of the Training Hubs?

- Link with HEIs to ensure future workforce supply is aligned to PCN workforce plans.
- Support PCNs to become approved learning environments.
- Help embed the new roles in primary care by ensuring an adequate number of trained clinical supervisors to support the expanded workforce.
- Provide career support and promote staff retention through coaching and mentoring schemes.
- Provide education programmes to support CPD of staff.

Greater Manchester Training Hub Offers to Support ARRS roles:

GP Ready Programmes

These will be led and facilitated by Greater Manchester Training Hub with some detail still to be finalised. The programmes offer tailored training for Physician's Assistants, First Contact Practitioners and Pharmacy Technicians to support their integration into General Practice.

Physician Associates

https://www.gmthub.co.uk/gp-ready-programme/physician-associate

First Contact Practitioners

https://www.gmthub.co.uk/gp-ready-programme/first-contact-practitioner

Pharmacy Technicians

https://www.gmthub.co.uk/gp-ready-programme/pharmacy-technicians

First Contact Practitioner Roadmap Supervisor Course

GMTH will deliver the HEE accredited course.

Who can do the 2-day courses to become a roadmap supervisor?

Because the Roadmap supervisor is accountable for verifying a portfolio of evidence and signing a clinician off to be working at a masters level of practice academically

and in practice, for quality assurance and governance, we need to outline and maintain strict criteria:

- GPs (GP Trainer Educational Supervisors do not need to do the 2-day course but have an optional Multi-professional top up half day that is optional that they can do on their update training- see FCP verification below).
- A clinician who has a postgraduate masters degree.
- A First contact Practitioner who is on the First Contact directory.
- An Advanced practitioner who is on the Advanced practice directory.

Expressions of interest in the course can be submitted through this Microsoft Form.

Non-Medical Prescribing – click here.

Support to become an undergraduate learning environment - click here.

Estates

We know that General Practice estate in Manchester is of variable quality and specification and limited capacity, a problem exacerbated by the physical distancing and infection control measures currently applied to healthcare settings. It is therefore difficult to see how, realistically, we can grow the ARRS workforce without a matching Estates strategy, as despite some increased flexibility through remote working, this only offers a partial solution.

In an ideal world we should be able to rely on a comprehensive Primary Care Estate plan to support the development of the new model, in line with planning for the ICS, the likely ‘left shift’ of activity born of outpatient transformation, and move toward the ultimate goal of a multidisciplinary, co-located primary care team.

Unfortunately, due to limited capital funding for estates and suitable real estate opportunities there are no easy answers, and as such practices and PCNs will need to continue to be as clever as possible within the confines of their existing provision. Community services are due to undertake a mapping exercise to see where space might become available, but, as services restart, it seems unlikely that there will be much potential for primary care to stake a claim.

Additional Resources can be found here on TeamNet.