surrey and sussex lmcs

**To: All Practices in Surrey and Sussex LMCs**

22 February 2019

Dear Colleagues

## GP Contract Agreement 2019: Update – Additional Roles Reimbursement Scheme (ARRS) and other Workforce support

The Additional Roles Reimbursement Scheme is the most significant financial investment element within the Network Contract DES; it is designed to provide financial reimbursement for Primary Care Networks to build workforce capacity, via an investment mechanism first used as part of the General Practice Charter in 1966, when 70% staff reimbursement of nursing and reception staff was introduced, and is now widely recognised as having been a pivotal part of the revitalisation of UK General Practice at that time.

The ARRS investment sum will rise from £110 million in 2019/20 to £891 million in 2023/24, which for an average 50k sized network equates to £92k in 2019/20 rising to £726k by 2023/24, with an estimated 20000+ reimbursable additional posts providing workforce capacity to support General Practices.

The five reimbursable roles are:

- Clinical Pharmacists from 2019
- Social prescribing link workers from 2019
- Physician associates from 2020
- First contact physiotherapists from 2020
- First contact community paramedics from 2021

These posts have been identified as ones for which personnel will be available, which already provide proven benefit within some practices, and their role links to delivering relevant elements of the NHS Long Term Plan, via the National Service Specifications.

A description of the intended role/core responsibilities for these posts is available at Annex A, although it will be for PCNs to decide the job description of their own staff.

The ARRS will increase incrementally over five years; 70% of the on-going salary costs of these posts, except for social prescribing link-workers 100%, will be met by the scheme.

The eligible maximum reimbursable pay that can be claimed by a PCN will be (section 1.26):

- Weighted average salary on the Agenda for Change band
- associated employer on-costs.

Local Medical Committees for
Croydon, Kingston & Richmond, Surrey,
East Sussex and West Sussex

The White House
18 Church Road
Leatherhead
Surrey KT22 8BB

T: 01372 389270
F: 01372 389271

www.sslmcs.co.uk

PCNs will have flexibility to choose to recruit across their roles, noting that NHS England intends every GP practice should have access to a pharmacist. To support this the existing Clinical pharmacists in the General Practice Scheme, will be subsumed into the ARRS. Otherwise the aim is to support an additional workforce. PCNs will decide who will be the actual employer; this may be a lead practice, GP Federation, NHS provider or social enterprise partner.

In 2019/20 introductory arrangements will apply, in that every network >30,000 population will be able to claim 70% funding for one WTE Clinical Pharmacist and 100% funding for a WTE social prescribing link-worker unless the CCG agrees to a different request i.e. two Clinical pharmacists or two social prescribing link-workers. For 2020/21, each PCN will be allocated a single combined maximum reimbursement sum covering all five roles. This will be based on weighted capitation, with the exact weighting mechanism confirmed during this year. Detailed guidance on payments, data monitoring and assurance will be published during 2019. This expenditure will only occur if PCNs recruit to these posts.

Other workforce support agreed within the Contract Agreement includes continuing the following programmes:

- GP retained and retention schemes
- Practitioner Health Programme across England
- GP Forward View Practice Resilience Scheme

In addition, NHS England is introducing, during 2019, a two-year Primary Care Fellowship Programme available to newly qualified GPs and nurses entering General Practice; further details of this programme are awaited.

This update should be read in conjunction with LMC updates on:

- PCNs and the Network Contract DES
- Integrating Urgent Care Services
- National Service Specifications and the NHS Long Term Plan.

With best wishes

**Dr Julius Parker**
Chief Executive

1.2. Clinical pharmacists

Description of role/core responsibilities

• Indicative Agenda for Change Band 7-8a

Clinical pharmacists will have a key role in supporting delivery of the new Network Contract DES Service specifications. For the new Structured Medications Review and Optimisation requirements this will include tackling over-medication of patients, including inappropriate use of antibiotics, withdrawing medicines no longer needed through NHS-led programmes such as low priority prescribing and medicines optimisation more widely. For Enhanced Health in Care Homes residents will benefit from regular clinical-pharmacy led medicines reviews.

The following sets out the key role responsibilities for clinical pharmacists:

a. Clinical pharmacists will work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas.
b. They will be prescribers, or training to become prescribers, and will work with and alongside the multi-disciplinary team across a Primary Care Network. They will take responsibility for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple long term conditions (in particular COPD and asthma) and people with learning disabilities or autism (through STOMP - Stop Over Medication Programme).
c. They will provide specialist expertise in the use of medicines while helping to address both the public health and social care needs of patients in the network and help in tackling inequalities.
d. Clinical pharmacists will provide leadership on person centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, while contributing to the quality and outcomes framework and enhanced services. Through structured medication reviews, clinical pharmacists will support patients to take their medications to get the best from them, reduce waste and promote self-care.
e. Clinical pharmacists will have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload. The role has the potential to significantly improve quality of care and safety for patients.
f. They will develop relationships and work closely with other pharmacists across networks and the wider health system.
g. Clinical pharmacists will take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties) and anticoagulation.

1.3. Social Prescribing Link Workers

Description of role/core responsibilities

• Up to indicative Agenda for Change Band 5

Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'link workers' who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners.

Social prescribing can help to strengthen community resilience and personal resilience and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people's active involvement with their local communities. It particularly works for people with long term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which impact on wellbeing.

Social prescribing link workers will have a key role in supporting delivery of the Comprehensive Model of Personalised Care.

The following sets out the key role responsibilities for social prescribing links workers:

a. They will in 2019/20 take referrals from the network's members, expanding from 2020/21 to take referrals from a wide range of agencies. Primary Care Networks that already have social prescribing link workers in place, or who have access to social prescribing services may take referrals from other agencies prior to 2020/21
b. They will:
• provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes;
• develop trusting relationships by giving people time and focus on 'what matters to them'; • take a holistic approach, based on the person's priorities, and the wider determinants of health;
• co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services; and
• evaluate the individual impact of a person's wellness progress.

c. The role will require social prescribing link workers to manage and prioritise their own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. Where required and as appropriate, the social prescribing link workers will refer people back to other health professionals within the network.
d. Social prescribing link workers will draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. They will ensure those organisations and groups are supported, have basic safeguarding processes for vulnerable individuals and can provide opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence.

e. Social prescribing link workers will work together with all local partners to collectively ensure that local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.
f. Social prescribing link workers will have a role in educating non-clinical and clinical staff within the network on what other services and support are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

2. Workforce roles beginning from 2020/21

2.1. Advanced Practice Physiotherapists

Description of role/core responsibilities

• Indicative Agenda for Change Band 7-8a

Advanced Practice Physiotherapist have advanced skills to assess, diagnose, treat and manage musculoskeletal (MSK) problems and undifferentiated conditions. This will involve seeing patients, without prior contact with their GP, to establish a rapid and accurate diagnosis and management plan, thus streamlining pathways of care. They can work independently and do not require supervision, thus helping to release workload currently undertaken by GPs. Patients can either self-refer or be referred by the network's members.

Advanced Practice Physiotherapists will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities for FCP physiotherapists9:

a. They will work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of Musculoskeletal (MSK) issues, to create stronger links for wider MSK services.
b. They will assess, diagnosis, triage and treat patients either via patient self referrals or referrals from a professional within network and take responsibility for managing a complex caseload (including patients with long term conditions, comorbidities and multi-factorial needs). Practice physiotherapists will progress and request investigations (such as x-rays and blood tests) to facilitate diagnosis and choice of treatment regime.
c. They will develop integrated and tailored care programmes in partnership with patients and provide a range of treatment options, including self-management, exercise groups or individual treatment sessions. These programmes will facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence and reduce the need for pharmacological interventions.
d. They will develop and make use of their scope of practice and clinical skills, including those relating to independent prescribing, injection therapy and imaging referral rights (where qualified/experienced).
e. They will provide learning opportunities for the whole multi-professional team within primary care. They will also work across the multi-disciplinary team to develop more effective and streamlined clinical pathways and services.

f. They will liaise with secondary care MSK services, as required, to support the management of patients in primary care.
g. Using their professional judgement, they will take responsibility for making and justifying decisions in unpredictable situations, including the in the context of incomplete/contradictory information.
h. They will manage complex interactions, including working with patients with particular psychosocial and mental health needs and with colleagues across primary care teams, sectors and setting.
i. They will be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice.

2.2. Physician Associates

Description of role/core responsibilities

• Indicative Agenda for Change Band 7

A physician associate is a trained healthcare professional who works directly under the supervision of a doctor as part of the medical team. They are usually generalists with broad medical knowledge but can develop expertise/specialisms in a particular field. The responsibilities of the role include direct patient contact through assessment, examination, investigation, diagnosis and treatment.

Physician Associates will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities for a physicians' associate:

a. They provide first point of contact for patients presenting with undifferentiated, undiagnosed problems
b. Taking comprehensive patient histories and providing physical examinations, they will establish a working diagnosis and management plan (in partnership with the patient).
c. They will deliver integrated patient centred-care through appropriate working with the wider primary care and social care networks.
d. They will undertake home visits and clinical audits.

3. Workforce roles beginning from 2021/22

3.1. Paramedics – Advanced Paramedic Practitioners

Description of role/core responsibilities

• Indicative Agenda for Change Band 6

Advanced paramedic practitioners work autonomously within the community, using their enhanced clinical assessment and treatment skills, to provide first point of contact for patients presenting with undifferentiated, undiagnosed problems relating to minor illness or injury, abdominal pains, chest pains and headaches.

Advanced Paramedic Practitioners will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities for advanced paramedic practitioners:

a. They will assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team.
b. They will advise patients on general healthcare and promote self-management where appropriate, including signposting patients to other community or voluntary services.
c. They will be able to:
• perform specialist health checks and reviews;
• perform and interpret ECGs;
• perform investigatory procedures as required, and
• undertake the collection of pathological specimens including intravenous blood samples, swabs etc.

d. They will support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing)
e. They will provide an alternative model to urgent and same day GP home visit for the network and undertake clinical audits.
f. They will communicate at all levels across organisations ensuring that an effective, patient-centered service is delivered.
g. They will communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required. They will maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice.