NIHR | Applied Research Collaboration West

Health Innovation West of England

Service delivery | Workforce

Evaluating the effectiveness of the Additional Roles Reimbursement Scheme

The Additional Roles Reimbursement Scheme (ARRS) introduces non-GPs into primary care to expand and enhance the workforce. ARRS aims to reduce pressure on GPs, while increasing access to primary care appointments and specialist expertise. This project evaluated implementation of the ARRS including anticipated and unintended consequences, to inform decision-making.

Project summary

General practitioners (GPs) have seen an unprecedented rise in workload pressure in recent years. General practice is facing a workforce retention crisis, not enough GPs are being recruited and retained to meet service needs.

At the same time, a more multidisciplinary approach to patient care is needed. This would improve patient outcomes and offer more holistic care, ensuring they see the most appropriate professional for their needs.

The ARRS scheme introduces non-GPs into primary care to expand and enhance the workforce. We gathered evidence through both data analysis and interviews, about how it is being implemented. This includes barriers and facilitators to implementation, and the system's impact on patient outcomes and staff roles.

We used NHS Primary Care Network (PCN) and GP workforce data, combined with data from the GP Patient Survey, to look at the uptake in ARRS roles across England between 2020 and 2022. We also used patient-level data from the Clinical Practice Research Datalink (CPRD) to describe the patients seen by staff in ARRS-eligible roles. We compared the outcomes of their consultations with GP and practice nurse consultations.

We recruited participants from three different Integrated Care Systems (ICSs). Challenges included identifying key stakeholders and equivalent roles from different ICSs, given the different structures of these systems.

Addressing health inequalities

Our analysis of the primary care workforce covered almost all general practices and PCNs in England. We linked the workforce and patient survey data to the area-level Indices of Multiple Deprivation. This allowed us to describe variation in commissioning of ARRS roles by deprivation, and to account for deprivation when analysing patients' experiences of services.

Our ongoing patient-level analysis using CPRD data also linked with Indices of Multiple Deprivation. This allowed us to include deprivation in our description of consultations with ARRS roles and to account for deprivation in our analysis of the outcomes of consultations.

Interviews covered a broad geographical area, including areas of higher deprivation that contribute to health inequalities. In the interviews we were interested in the challenges of implementing ARRS in a range of contexts and the impact of inequalities on its implementation.

We identified early on in data collection that inflexibility in ARRS had the risk of exacerbating health inequalities. PCNs were sometimes unable to make full use of the funding because of challenges recruiting to areas of high deprivation. We specifically asked all subsequent participants about this issue and have incorporated this into our final analysis.

> "I think our GPs are still massively overworked; the workload is still huge. Post-pandemic, the workload has just gone through the roof. So, I think they're grateful that without these roles they'd just be collapsing."

Outcomes

Our key findings were:

1. Uptake of the scheme was rapid, increasing from 280 full-time equivalent (FTE) staff in direct patient care roles to 12,335 FTE from March 2020 to September 2022. The median PCN-level FTE was 10 (Sept 2022), with a wide range from 7-14 FTE for the 25th and 75th percentiles.

2. ARRS inflexibility reportedly prevented some PCNs from using funding because of challenges recruiting to deprived areas. This increases the risk of the scheme exacerbating health inequalities. However, this wasn't reflected in the workforce data, which found no commissioning variation by Indices of Multiple Deprivation. IMD may capture different aspects of deprivation from those affecting commissioning.

3. ARRS staff were valued. Success was gauged by broadening the expertise in primary care rather than reducing GP burden. Effectiveness was maximised by placing multiple roles within one PCN or practice. Administrative roles were particularly desirable, to address high workloads.

4. We identified several challenges:

- Scheme inflexibility
- Creating a sustainable workforce with career progression
- Managing scope and expectations
- Navigating supervision and roadmap progression
- Infrastructure and integration issues
- Unintended consequences included impacts on secondary care and existing primary care staff

Implications for service improvement

ARRS roles have been commissioned rapidly since the scheme started. Our ongoing patient-level analysis of consultations with staff in ARRS roles will provide comparisons of the outcomes of these consultations (re-consultations, referrals, tests and prescriptions) compared with consultations with GPs and nurses, supported by comparisons of clinical resource use and cost.

Reimbursement needs to be more flexible. Increased incentives may be necessary to ensure areas of high deprivation can recruit and retain staff. Identification of these areas may involve additional measures beyond those captured by the area-level Indices of Multiple Deprivation.

There are still challenges with career progression, role scope, supervision, infrastructure and integration and these need to be addressed. The system's impact of staff moving from other roles into primary care needs to be considered, to prevent staff shortages and deficiencies in services in other parts of the pathway.

Next steps

Our recommendations are:

- Engagement with the policymakers who introduced the scheme is needed
- Recommendations should be developed and disseminated, particularly with local ARRS staff, decision-makers, training hubs, GP federations and third party employers
- Increased support (clinical and emotional) for personalised care workers
- Ongoing analysis of patient-level data. This will provide insight into the patients who consult with staff in ARRS roles, and the consultation outcomes compared with consultations with GPs and nurses. However, we don't know how PCNs are deploying staff in ARRS roles across their constituent practices. This limits our understanding of how PCN-level decisions affect patients.

This project was undertaken by Health Innovation West of England (the new name for West of England Academic Health Science Network) and National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) West with funding from the Accelerated Access Collaborative at NHS England, and support from the NIHR.

Key partners

The project was sponsored by the three local Integrated Care Systems, who identified primary care workforce as a shared priority for innovation and improvement:

- Bristol, North Somerset and South Gloucestershire
- Bath and North East Somerset, Swindon and Wiltshire
- Gloucestershire

More information

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Care settings

- ✓ Primary care

Cross-cutting themes

- ✓ Quality improvement and culture
- ✓ Workforce

Solution themes

- ✓ Operations or logistics

Innovation types

- ✓ Service

Innovation status

- ✓ Research