Surrey Training Hub

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

# Additional Roles Reimbursement Scheme (ARRS)

## Resource Booklet 1


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# Contents

# Introduction

**Surrey Training Hub hopes this resource booklet helps to support general practices and PCNs across Surrey Heartlands in their workforce planning.**

**The information covers all current 15 roles within the Additional Roles Reimbursement Scheme (ARRS).**

**The booklet offers information, tools and links to help with the understanding of the various roles and how they support primary care.**

The Additional Roles Reimbursement Scheme (ARRS) is the most significant financial investment element within the Network Contract DES and is designed to provide financial reimbursement for Primary Care Networks (PCNs) to build workforce capacity.

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 (LMC, 2019).

## Directed Enhanced Service Specification (DES)

Following the introduction of the primary care networks (PCNs) in 2019 as part of the NHS Long Term Plan significant additional funds have been invested into PCNs. The Network Contract Direct Enhanced Service (DES) underpins the role of PCNs in empowering general practice and improving the range and effectiveness of primary care services, enabling wider partnership working across the health and care system and greater innovation to address local health needs. The need to invest in a wider primary care workforce has led to the introduction of the Additional Roles Reimbursement Scheme. This scheme offers general practice a more diverse workforce and more resilient to support the delivery of the services that the Surrey population needs. For further information:

https://www.england.nhs.uk/publication/des-guidance-2020-21

A complementary resource to support the information set out in DES around the AHP workforce entitled Allied Health Professionals (AHPs) in Primary Care can be accessed using the link below:- AHP Implementation Guidance.pdf

**Table 2: Maximum reimbursement amounts per role for 2021/22**

| Role | AfC band | Annual maximum reimbursable amount per role [69] | Page |
|---|---|---|---|
| Advanced Practitioner | 8a | £55,670 | 18 |
| Clinical Pharmacist | 7-8a | £55,670 | 6 |
| Physiotherapist | 7-8a | £55,670 | 21 |
| Paramedic | 7 | £53,724 | 26 |
| Physician associate | 7 | £53,724 | 45 |
| Podiatrist | 7 | £53,724 | 31 |
| Occupational therapist | 7 | £53,724 | 36 |
| Dietitian | 7 | £53,724 | 41 |
| Pharmacy Technician | 5 | £35,389 | 8 |
| Mental Health Practitioner | 5-8a | 50% *(employed and provided by the PCN's local provider of community mental health services)* | 10 |
| Social prescribing link worker | Up to 5 | £35,389 | 49 |
| Health and wellbeing coach | Up to 5 | £35,389 | 55 |
| Nursing associate | 4 | £29,135 | 12 |
| Care coordinator | 4 | £29,135 | 51 |
| Trainee nursing associate | 3 | £25,671 | 12 |

[69]The maximum reimbursable amount is the sum of (a) the weighted average salary for the specified AfC band plus (b) associated employer on-costs. These amounts do not include any recruitment and reimbursement premiums that PCNs may choose to offer. If applicable, the on-costs will be revised to take account of any pending change in employer pension contributions. The maximum reimbursement amount in subsequent years will be confirmed in line with applicable AfC rates.

## Workforce Planning

Effective workforce planning can help with strengthening your organisation's understanding of current and future demand for services and how new and enhanced roles can support with meeting this demand and delivering services.

There are a number of tools and guidance available to support employers with workforce planning and the implementation of these new roles within primary care:

NHS Employers has a web section on workforce planning

Health Education England (HEE) has issued guidance for the planning process

Skills for Health has produced a six step workforce planning methodology tool

NHS Improvement offers a self-assessment tool that enables employers to carry out an organisational diagnosis and identify areas of improvement

The Workforce Repository and Planning Tool (WRaPT) is a web based strategic planning tool for health and social care that enables the collection, analysis and modelling of workforce information to establish the relationship between capacity and service activity

### Six Steps Approach to Workforce Planning

This e-learning programme can be used as a tool to support health and social care organisations with workforce planning. The programme is made up of six steps which will guide the health and social care professional through the principles and activities of planning.

Please select the link to access this tool:

https://www.e-lfh.org.uk/programmes/six-steps-approach-to-workforce-planning/

HEE Star is a tool developed to bring structure and coherence to conversations about workforce challenges and to support workforce transformation. The primary function of the STAR is as an Organisational Development Tool, enabling a comprehensive diagnostic of workforce requirements and better definition and prioritisation of solutions. This interactive resource, showcases offers and products from HEE in order to fulfil a chosen solution. https://www.hee.nhs.uk/our-work/hee-star

Further information can be found in Resource Booklet 2 when available.

# Clinical Pharmacist

**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, can complete an independent prescribing qualification following completion of the 18- month Centre for Pharmacy Postgraduate Education (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.

## Training/Development

- Clinical Pharmacists employed through the Network Contract DES will need adequate training and experience. This can be gained by the 18-month Primary Care Pharmacy Education Pathway (PCPEP). This pathway equips the pharmacist to be able to practice and prescribe safely and effectively in a primary care setting.
- All Clinical Pharmacists will be part of a professional clinical network and will always be clinically supervised by a senior Clinical Pharmacist and GP clinical supervisor.
- Independent prescribing is in addition to the training pathway and will be completed following completion of the PCPEP.

## Pre-requisites

- Pharmacy degree and registration as a pharmacist with the General Pharmaceutical Council or the equivalent regulatory authority in your home country.

## Length of course

- 18-month pathway, including 28 days dedicated study days.
- Learner receives a statement of assessment & progression on completion of the pathway.
- No placement is required as the Clinical Pharmacist will be employed within primary care whilst completing the PCPEP.

## Benefits to patients

- ✓ Patients often get to consult with pharmacists for two or three times longer than a doctor due to current GP workload intensity, eg 20–30 minutes, which they appreciate.
- ✓ Medications are checked regularly and are appropriate for patients' conditions, and this improves wellbeing and quality of life if reviews have previously been too infrequent due to unmanageable GP and nurse workload. This reduces the likelihood of conditions worsening or leading to other complications and side effects that result in a future need for acute care.
- ✓ All prescribers in the practice can learn from the clinical pharmacist and therefore use increasing medicines knowledge and expertise to improve patient treatment.

## Benefits to PCN's

- ✓ GPs no longer carry out the activities that clinical pharmacists can carry out instead.
- ✓ Clinical pharmacists support the achievement of QOF indicators and quality improvement projects.
- ✓ Improvements in patient's safety. Changes in prescribing practice that can be implemented across the PCN e.g. MHRA alerts where a drug is withdrawn or indications change.
- ✓ Considerable savings can be made by improving prescribing processes across all prescribing staff.
- ✓ Clinical pharmacists forge closer links with community pharmacy and improve patient advice/signposting – All prescribers in the practice learn from the clinical pharmacist and therefore increase their own knowledge when consulting with and treating patients.
- ✓ Patient access increases as patients consult with the clinical pharmacist rather than GP for medication needs and advice.

## Benefits to the wider NHS

- ✓ Closer monitoring and management of patient medicines improves their care, wellbeing, and their ability to self-care and manage their own conditions. This reduces avoidable urgent or emergency hospital attendances and the risks of medicine-related side effects.

# Pharmacy Technician

**Pharmacy Technicians** play an important role within General Practice and complement the work of Clinical Pharmacists through utilisation of their technical skillset. Their deployment within primary care settings allows the application of their acquired pharmaceutical knowledge in tasks such as audits, discharge management, prescription issuing, and where appropriate, informing patients and other members of the PCN workforce. Work is often under the direction of Clinical Pharmacists, and this benefit is realised through the creation of a PCN pharmacy team.

## Training/Development

- Pharmacy technicians undertake a level 3 course which can be through a fully funded apprenticeship programme before they can register with the General Pharmaceutical Council (GPhC)
- The new initial education and training standards for pre-registration trainee pharmacy technicians is being tested with placements in General Practice, through the Pharmacy Integration Fund (PhIF).

## Pre-requisites

- Registered with the GPhC.

## Benefits to patients

- ✓ Help to increase patient action to support and advise on taking medicines and medicines optimisation.
- ✓ Work in partnership with patients to ensure they use their medicines effectively.
- ✓ Provide specialist expertise, where able to demonstrate competence, to address both the public health and social care needs of patients, including lifestyle advice and service information.

## Benefits to PCN's

- ✓ Supervise practice reception teams in sorting and streaming general prescription requests, so as to allow GPs and clinical pharmacists to review the more clinically complex requests.
- ✓ Work with the PCN multi-disciplinary team to ensure efficient medicines optimisation, including implementing efficient ordering and return processes and reducing wastage.
- ✓ Provide training and support on the legal, safe and secure handling of medicines, including the implementation of the Electronic Prescription Service (EPS).

## Benefits to the wider NHS

- ✓ Develop relationships with other pharmacy technicians, pharmacists and members of the multi-disciplinary team to support integration of the pharmacy team across health and social care including primary care, community pharmacy, secondary care and mental health.
- ✓ Help in tackling local health inequalities.
- ✓ Support initiatives for antimicrobial stewardship to reduce inappropriate antibiotic prescribing.

## Sample appraisal

Multi-Professional Appraisal Toolkit KSS.PDF

## Sample Job Descriptions

Clinical-Pharmacist JD Example.pdf
Pharmacy-Technician JD Example.pdf

# Mental Health Practitioner

There are now a range of roles from bands 5-8a which could be recruited into, including Improving Access to Psychological Therapy (IAPT). From April 2021, every PCN will become entitled to a fully embedded full-time mental health practitioner, employed and provided by the PCN's local provider of community mental health services, as locally agreed. 50% of the funding will be provided from the mental health provider, and 50% by the PCN (reimbursable via the ARRS), with the practitioner wholly deployed to the PCN.

Mental Health Practitioners working in PCNs take on a 'first contact' role as this can reduce the workload of GPs in practices. The role will involve liaison with practice clinicians, as well as liaison with secondary care, social workers and voluntary sector staff, where appropriate, and making best use of third sector and other community opportunities for promotion of patient wellbeing and maintenance of mental health.

## Requirements

The mental health practitioner may be any registered clinical role operating at Agenda for Change Band 5 or above including, but not limited to, a Community Psychiatric Nurse, Clinical Psychologist, Mental Health Occupational Therapist or other clinical registered role, as agreed between the PCN and community mental health service provider.

As a guide, the Primary Care Mental Health Practitioner could be responsible for the assessment, structured intervention and signposting of a cohort of patients as follows:

- Those presenting with existing diagnosis of mental illness, who are currently not open to secondary care, inappropriate for other therapies such as Talking Space Plus (Oxon IAPT) and experiencing symptoms which would mean them accessing primary care in the short term or in particular as frequent attenders.
- Those without an established mental health diagnosis who require mental health support and/ or brief intervention and/ or signposting where that would otherwise be provided by a GP.
- Those with diagnosed personality disorders whom have been discharged from other services/ therapies or who are awaiting inclusion in, for example, the Complex Needs Service (and who therefore cannot access specific support such as Talking Space Plus) and who require holding support or signposting.
- Those presenting non-specific, as yet undefined, mental health needs/ distress to reception, for whom a telephone or face to face brief assessment can take the place of a GP triage or brief assessment.
- Individual practices may choose to include other patient cohorts, such as review of those diagnosed with anxiety or depression, who would otherwise require a review with a GP. They may also include annual mental health reviews of those on the practice 'severe and enduring mental illness' register (or similar) with conditions such as bipolar, schizophrenia, severe depression with psychosis.

## Benefits to patients

- ✓ Easier access to mental health services in a community setting, i.e. closer to home
- ✓ Improved mental health helps people to better manage their physical health
- ✓ Improved recovery – self-referrals tended to require fewer sessions, health outcomes and quality of life
- ✓ Improved equity of access for patients with both mental and physical health conditions.

## Benefits to PCN's

- ✓ Improved access – therapists can see patients, via self or GP referrals, that would otherwise access their GP, thus balancing workload better and allowing GPs to focus on physical health
- ✓ Reduction in prescribing for mental health conditions if patients can access psychological therapies sooner
- ✓ Improved clinical reach, eg for PTSD, social anxiety disorder, OCD etc.

Please see the Training Hub website for further details as more info is expected around this role.

## Sample appraisal

Multi-Professional Appraisal Toolkit KSS.PDF

# Nursing Associate & Trainee Nursing Associate

The **Nursing Associate** is a new support role in England 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 are members of the nursing team, who have gained a Nursing Associate Foundation Degree awarded by the Nursing and Midwifery Council (NMC).

The NMC has developed and published standards of proficiency for nursing associates. These standards set out the knowledge, competencies, professional values and behaviours expected of a nursing associate at the point of registration. They will help employers to understand what nursing associates can contribute to patient and service-user care.

**Standards of proficiency for nursing associates**
https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/nursing-associates-proficiency- standards.pdf

Nursing Associates work with people of all ages in a variety of settings in health and social care.

The role was introduced in response to the Shape of Caring Review (2015), to help build the capacity of the nursing workforce and the delivery of high-quality care.

The nursing associate role will be a vital part of the wider health and care team as:

- ✓ The role will build the capacity of the nursing workforce and support the delivery of high-quality care as they are trained to work with people of all ages in a variety of settings.
- ✓ The two year Foundation Degree programme will enable NA's to perform more complex and significant tasks than a healthcare assistant, but not the same scope as a graduate registered nurse.
- ✓ This in turn will enable nurses to focus on more complex clinical work
- ✓ The role will increase the supply of nurses by providing a progression route into graduate-level nursing.
- ✓ They can support the training and supervision of students and junior staff

## Regulation of nursing associates Comparison to nurse proficiencies

| **Nursing Associate**<br>6 platforms | **Registered Nurse**<br>7 platforms |
|---|---|
| Be an accountable professional | Be an accountable professional |
| Promoting health and preventing ill health | Promoting health and preventing ill health |
| Provide and **monitor** care | Provide and **evaluate** care |
| Working in teams | **Leading and managing nursing care** and working in teams |
| Improving safety and quality of care | Improving safety and quality of care |
| **Contributing to** integrated care | **Coordinating** care |
| | **Assessing needs and planning care** |

# Nursing Associate & Trainee Nursing Associate continued

## Training/Development

- Prior to commencement of the nursing associate 2 year programme, applicants are required to complete the Care certificate and have evidence of level 2 functional skills/ GCSE in maths and English.
- The two year Foundation Degree programme prepares trainee nursing associates to work with people of all ages and in a variety of settings in health and social care within the four fields of nursing - adult, paediatrics, mental health and learning disability.
- Often they will attend 1 day a week in university and will be required to successfully complete exams and assignments over the 2 years.
- Trainee nursing associates are required to undertake clinical placements in settings other than their primary place of employment.
- Trainees must complete at least 2,300 programme hours which are divided to achieve an equal balance of theory and practice learning and must be offered protected learning time in which they are supported to learn.
- Trainee nursing associates can be supervised by an NMC-registered nurse, midwife or nursing associate, or by any other registered health and social care professional. Supervisors will serve as role models for safe and effective practice and are expected to contribute to the record of achievement.
- Following the changes in the NMC educational standards (2018) students/learners are now assigned a practice supervisor, practice assessor and an academic assessor. See link below: https://www.nmc.org.uk/standards-for-education-and-training/standards-framework-for-nursing-and-midwifery-education/

## Difference between a nursing associate and an assistant practitioner

There are similarities, but while assistant practitioners are highly skilled in their specific area of practice, the nursing associate role has a wider remit. Nursing Associates have more transferable skills and competencies and are able to work across a range of settings and specialities.

Qualified Nursing associates are accountable practitioners who are registered with the NMC and require to revalidate every three years like a registered nurse. Assistant practitioners are not registered practitioners.

## Nursing workforce at a glance

| Task/ Skill | Health Care Assistant | Nurse Associate | Practice Nurse |
|---|---|---|---|
| **Differences in the roles, role includes:** | Undertakes tasks, records, reports, part of the team | Supports, delegates, administers, promotes, manages. Part of team. | Leads, manages, supports, works autonomously, decision maker, supervisor, reviews, delegates |
| **Cervical screening** | **No** | **Yes** | **Yes** |
| **Medication administration** includes: oral, sublingual, buccal, inhaled, nebuliser, SC, IM, IV, rectal, vaginal, ocular, intranasal, Dermal | **No** only IM working under PSD | **Yes** Excluding PGDs | **Yes** |
| **Immunisation** | **Yes** • some adult (x4) IMMS only • nasal spray flu for children | **Yes** • adult • nasal spray – flu for children only | **Yes** |
| **Long Term Condition reviews** (Asthma, COPD, Diabetes, Hypertension) | **No** | **Yes** | **Yes** |
| **Supervision** and support HCA's and Pre-Registration Student Nurses | **Yes** - HCAs **No** - student nurses | **Yes** | **Yes** |
| **Understand 'DNA,CPR' decisions** and verification of expected deaths | **No** | **Yes** | **Yes** |
| **Venepuncture** | **Yes** | **Yes** | **Yes** |
| **Dementia reviews** | **No** | **Yes** | **Yes** |
| **Catheter care** for both genders, suprapubic catheter care and bladder scanning | **No** | **Yes** | **Yes** |
| **Stoma care** | **No** | **Yes** | **Yes** |
| **Wound care** compression bandaging, prevent and manage skin breakdown effectively | **Yes** Basic wound care only, after the wound assessment of NA or RN | **Yes** | **Yes** |
| Decision to make specialist **Referrals** | **No** | **Yes** in consultation with RN | **Yes** |
| **Risk assessments** using tools such as MUST, MMSE, falls assessment, NEWS2 | Some recording and interpretation with reports and action to NA or RN | **Yes** | **Yes** |
| Basic **Mental health** and physical first aid advise | **No** | **Yes** | **Yes** advance |
| **Health promotion, smoking cessation** | **Yes** | **Yes** | **Yes** and referrals |
| **Spirometry** | **Yes** Measurements only | **Yes** Interpretation | **Yes** |

# Nursing Associate & Trainee Nursing Associate continued

## Benefits to patients

Nursing Associates are making a great contribution to patient care and service delivery by:

- ✓ Improved patient communication.
- ✓ Assisting registered nurses with a greater range of care- giving responsibilities.
- ✓ They are able to be more patient- centred and act as a patient advocate.
- ✓ They are able to identify and escalate concerns with patients deteriorating health,
- ✓ Display leadership qualities and support other trainees' development and exchange skills, knowledge and good practice enhancing the quality of services.

## Benefits to PCN's

Employers have the opportunity to invest in the nursing associate role as part of wider workforce planning and skills mix transformation. An independent evaluation of the first two waves of the nursing associates programme revealed a number of benefits arising from the introduction of the role, including:

- ✓ Improved service delivery and increased patient access as nursing associate develops new skills and competencies.
- ✓ Nursing associates can take on additional skills (within their scope of practice) allowing practice nurses to spend time with more complex patients eg: cervical screening.
- ✓ Nursing associates can support with the achievement of QOF indicators.
- ✓ Improved staff retention through career progression.
- ✓ Introducing the Nursing Associate role provides a recognised career pathway for bands 1-4 staff
- ✓ Funding available via ARRS/apprenticeship route
- ✓ The ability to 'grow your own' and develop your own nursing workforce

## Sample appraisal

Practice Nurse-Nurse Associate Appraisal Example.pdf

## Sample Job Description

Nursing Associate JD Example.pdf

# First Contact Practitioners (FCP)

**First Contact Practitioners (FCP)** are a diagnostic clinician working in Primary Care at the top of their clinical scope of practice at Agenda for Change Band 7 or equivalent and above. This allows the FCP to be able to assess and manage undifferentiated and undiagnosed presentations. **A First Contact Practitioner service is provided by a registered health professional.**

It is the minimum threshold for working as a first point of contact with undifferentiated undiagnosed conditions in Primary Care. With additional training, FCPs can build towards advanced practice.

To become an FCP, recognition is required through Health Education England, whereby a clinician must have completed a taught or portfolio route.

FCPs refer patients to GPs for the medical management of patient presentations and pharmacology outside their agreed scope of practice.

FCPs work at a master's level (level 7) in their clinical pillar of practice but have not yet reached an advanced level in all four pillars of practice to be verified at AP level.

The clinician must typically have 3-5 years post preceptorship experience before starting Primary Care training to become an FCP.

The following professions have either been mapped or are being mapped against the FCP title:-

| Profession | FCP – A Roadmap to Practice published |
|---|---|
| Physiotherapist | October 2020 |
| Paramedics | January 2021 |
| Podiatrists | March 2021 |
| Occupational Therapists | TBC |
| Dieticians | TBC |

## Road Maps

A Roadmap to Practice Paramedics.pdf

A Roadmap to Practice Physio.pdf

## Supervision of FCP's

Appropriate supervision will be required for all FCP's working in Primary Care.

GPs / APs who have completed the 'first contact' course can provide clinical supervision to FCPs. **Details on this course will be available via the Surrey Training Hub website as they become available.**

For further details on supervision for these roles please contact Surrey Training Hub direct

# Advanced Practitioners (AP)

Advanced practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes.

Health Education England (2017) defines Advanced Clinical Practice as:

*"Advanced practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence."*

An AP works at Agenda for Change band 8a or above

## Training/Development

**Description of Role**

An advanced practitioner reimbursement tier may apply to the following PCN roles: Nurses, Clinical Pharmacist; Physiotherapist; Occupational Therapist; Dietician; Podiatrist and Paramedic. To be reimbursable at band 8a, this role needs to have the following additional minimum requirements, plus these extra responsibilities.

**Training Requirements**

The PCN must ensure that the practitioner both:

- Is educated to master's degree level in relevant area of expertise; and
- Has the capabilities of advanced clinical practice set out in section one of the Multi-professional Framework for Advanced Clinical Practice in England. https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

## Clinical Responsibilities

The PCN must ensure that each band 8a advanced practitioner has the following additional responsibilities:

- 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
- They will be able to manage undifferentiated undiagnosed conditions and identify red flags and underlying serious pathology and take appropriate action
- They will use complex decision making to inform the diagnosis, investigation, and complete management of episodes of care within a broad scope of practice
- They will actively take a personalised care approach and population centred care approach to enable shared decision making with the presenting person
- They will have completed the relevant training in order to provide multi-professional clinical practice and CPD supervision to other roles within primary care, for example first contact practitioners and the personalised care roles.

## Table to show capabilities across Band 7 and Band 8a (AfC) in Primary Care.

| First Contact Practitioner Band 7 | Advanced Practitioner Band 8a |
|---|---|
| • Manages undifferentiated undiagnosed conditions.<br>• Able to identify red flags and underlying serious pathology and take appropriate action.<br>• Works within practice, across PCN, multi-organisational, cross professions and across care pathways and systems including health, social care, and the the voluntary sectors.<br>• High level complex decision making to inform the diagnosis, investigation, management, and on referral within scope of practice.<br>• Actively takes a personalised care approach to enable shared decision making with the presenting person.<br>• Contributes to audit and research projects.<br>• Contributes to education and supervision within their scope of practice for the multi-professional team.<br>• Facilitates interprofessional learning in area of expertise.<br>• Promotes and develops area of expertise across care pathways.<br>• Working toward Advanced Clinical Practice (level 7 across all 4 pillars). | • Manages undifferentiated undiagnosed conditions.<br>• Able to identify red flags and underlying serious pathology and take appropriate action.<br>• Works within practice, across PCN, CCG and ICS, multi organisational, cross professionals and across care pathways and systems including health, social care, and the voluntary sectors.<br>• High-level of complex decision making to inform diagnosis, investigation complete management of episodes of care within a broad scope of practice.<br>• Flexible skill set to adapt to and meet needs of the PCN Population and support public health<br>• Manages medical complexity.<br>• Actively takes a personalised care and population centred care approach to enable shared decision making with the presenting person.<br>• Actively engages in care from a Population care viewpoint.<br>• Leads audit and research projects.<br>• Leading audit within areas of capability.<br>• Provides multi-professional AP clinical and CPD supervision across all four pillars with relevant training.<br>• Leads education in their area of expertise.<br>• Enables, facilitates, and supports change across care pathways and traditional boundaries<br>• Working toward level 8. |

# Physiotherapist

**Physiotherapists** 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. Physiotherapists working in this role can be accessed directly by self-referral or by staff in GP practices who can direct patients to them to establish a rapid and accurate diagnosis and management plan to streamline pathways of care.

## Training/Development

- A physiotherapy degree (BSc) is required to work as a physiotherapist in any setting.
- For band 7 roles Health Education England Primary care First Contact Practitioner (FCP) capability training must be completed as the minimum threshold for entry to primary care and be supported by appropriate governance and indemnity.
- Health Education England primary care FCP training can begin 3-5 years postgraduate
- For band 8a roles the Health Education England FCP primary care training must be completed, and they must be working at an advanced level of practice i.e. at master's level (level 7) across all four pillars of advanced practice.

Physiotherapists  providing a first point of contact service means that patients presenting with a musculoskeletal problem for a GP appointment are offered an appointment with a physiotherapist instead. Physiotherapists working in general practice are able to address the needs of a large proportion of the patient population. They have the clinical expertise and autonomy to assess, diagnose and treat patients with a range of conditions, including MSK, neurological and respiratory conditions.

Physiotherapists can help patients with musculoskeletal issues such as back, neck and joint pain; assessing and diagnosing issues, giving expert advice on how best to manage their conditions, and referring them onto specialist services as and when necessary. It has been estimated that MSK conditions alone account for around one in five GP appointments.

# **Physiotherapist** continued

The role of the Physiotherapist may include some of the following activities:

- To work as part of a multi-disciplinary team in a patient-facing role
- Provide clinical expertise, acting as first-contact physiotherapist and making decisions about the best course of action for patients' care (including in relation to undifferentiated conditions). This will involve seeing patients, without prior contact with their GP, in order to establish a rapid and accurate diagnosis and management plan
- Progress and request investigations to facilitate diagnosis and choice of treatment regime, understanding the information limitations derived from these and the relative sensitivity and specificity of particular tests, request diagnostic services such as x-rays and blood test, and interpret and act on results to aid diagnosis and the management plans of patients
- Deliver programmes of supported patient self-management, in ways that facilitate behavioural change, optimise individuals' physical activity, mobility, fulfilment of personal goals and independence, and that minimise the need for pharmacological interventions
- To help improve the quality of care and operational efficiencies to deliver an excellent and effective service within general practice

See https://www.england.nhs.uk/gp/expanding-our-workforce/first-contact-physiotherapists/ and https://www.primarycarephysio.co.uk/ for more information and as reference to the above information.

## Benefits to patients

- ✓ Quick access to expert physiotherapy assessment, diagnosis, treatment and advice
- ✓ Prevention of short-term problems becoming long-term conditions
- ✓ Improved patient experience
- ✓ A shorter pathway, so patients have fewer appointments to attend
- ✓ Simple logistics, so patients are less likely to miss appointments or to suffer administrative errors
- ✓ Opportunities to gain lifestyle/physical activity advice
- ✓ Longer appointment times, meaning patients feel listened to, cared for and reassured
- ✓ By 2024, all adults in England will to be able to see a musculoskeletal first contact physiotherapist at their local GP practice without being referred by a GP.

## Benefits to PCN's

- ✓ Release of GP time through reallocating appointments for patients with MSK problems (30% of all GP appointments)
- ✓ Reduced prescription costs
- ✓ In-house physiotherapy expertise gained
- ✓ Increased clinical leadership and service development capacity
- ✓ Support in meeting practice targets
- ✓ Reduced pressure on GPs and other practice staff
- ✓ Making this part of the GP business model can optimise resources and reduce costs
- ✓ Services that generate additional income, eg the provision of steroid injections by FCPs can often be funded by local CCGs whereby GP practices are paid per injection.

# Physiotherapist continued

## Benefits to wider NHS

- ✓ Reduced number of physiotherapy referrals into secondary care
- ✓ Reduced demand and waiting times for orthopaedics, pain services, rheumatology and community physiotherapy and CMATS (Clinical Musculoskeletal Assessment and Treatment Services)
- ✓ Improved use of imaging
- ✓ Continued support of individuals with conditions requiring physiotherapy is assured.

## Supervision for Physiotherapists in Primary Care

Appropriate supervision will be required for all physiotherapists working in Primary Care.

Existing GP Educational supervisors are able to supervise physiotherapists undertaking FCP and AP roles and ***do not*** need to attend additional training.

GPs who have completed the First Contact Practitioner Supervisor Development course **can** provide clinical supervision to physiotherapists undertaking FCP and AP roles. **Details on this course will be available via the Surrey Training Hub website as they become available.**

For further details on supervision for these roles please contact Surrey Training Hub direct

Guidance on supervision can also be found in the First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal) - A Roadmap to Practice.

## First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal) - A Roadmap to Practice

A Roadmap to Practice Physio.pdf

AHP Appraisal form.pdf

## Sample Job Description

Physiotherapy JD Example.pdf

# Paramedic

**Paramedics** are autonomous health care providers who are regulated by the Health and Care Professions Council (HCPC) and the College of Paramedics (CoP) is their professional body. Specialist/FCP/community (Band 7) Paramedics are trained to independently provide care that does not require the intervention of a doctor. They can assess, investigate, diagnose, plan and implement care for patients presenting with diagnosed and undiagnosed conditions and address continuing medical needs, and work collaboratively with the general practice team to meet patient needs. They will need to prioritise and triage the needs of patients accordingly making any necessary referrals for investigations in the appropriate manner. Part of their responsibilities may include visiting patients in their home to assess their medical condition at the request of the lead clinician, whilst working as part of a clinical team within a number of practices and across a PCN.

**NB:** To ensure a sustainable workforce model to support both PCN's and core service delivery work is continuing with local providers.

## Training/Development

- A BSc in a training programme approved by the College of Paramedics
- For Band 7 roles, Health Education England Primary Care FCP capability training must be completed as the minimum threshold for entry to primary care and be supported by appropriate governance and indemnity
- Health Education England primary care FCP training can begin 3-5 years postgraduate
- For Band 8a roles, the Health Education England FCP training must be completed, and they must be working at an advanced level of practice i.e. at master's level (level 7) across all four pillars of advanced practice

Paramedics providing a first point of contact service means working with patients presenting with undifferentiated, undiagnosed problems relating to minor illness or injury, abdominal pains, chest pains and headaches.

Paramedics work at various levels of clinical practice (from newly qualified to consultant level), so when employing a paramedic in primary care, employers need to be clear about the scope of practice the paramedic will be expected to work within to ensure applicants possess the correct skills and knowledge to undertake the role.

**NB:** A first contact practitioner (paramedic) is equivalent to a specialist/community paramedic.

## Benefits to patients

- ✓ Patients can currently spend two to three times longer consulting with Paramedics compared to GPs, e.g 20-30minute meaning patients feel listened to, cared for and reassured
- ✓ Quick access to diagnosis, treatment and advice in regards to minor ailments and injuries
- ✓ Receive the right care, first time – safely managed in their own homes or in the community
- ✓ Improved patient experience.

## Benefits to PCN's

- ✓ Frees up GP time, reduces GP stress by taking on home visits
- ✓ Supports delivery of Enhanced Health in Care Homes
- ✓ Practice workload is supported by an extra generalist resource increasing capacity to provide the most appropriate response first time to 999 calls and providing proactive care within the community
- ✓ Patient care improves due to the increase in access and timely interventions by skilled paramedics
- ✓ Undertake acute home visits on behalf of GPs, especially for local elderly or immobile population
- ✓ Increased clinical leadership and service development capacity

## Benefits to wider NHS

- ✓ Reduction in waiting times for patients accessing urgent care
- ✓ Reduction in avoidable trips to A&E attendances and associated admissions
- ✓ Relieve workload pressure and reduce impact on ambulance and secondary care.

# **Paramedic** continued

| | **Paramedic** | **Specialist Paramedic/ First Contact Practitioner/ Community paramedic** | **Advanced Paramedic Practitioner** |
|---|---|---|---|
| **Job description** | | | |
| **Recommended salary equivalent to** | NHS Agenda for change band 6 | NHS Agenda for change band 7 | NHS Agenda for change band 8 |
| **Reports to** | At discretion of practice. Examples could include:<br>• Advanced Paramedic Practitioner (if in post),<br>• The Partners (Clinical), and The Practice Manager (Administrative)<br>• Senior Nurse | At discretion of practice. Examples could include:<br>• Advanced Paramedic Practitioner (if in post),<br>• The Partners (Clinically), and The Practice Manager (Administrative)<br>• Senior Nurse | At discretion of practice. Examples could include:<br>• The Partners (Clinical), The Practice Manager (Administrative) |
| **Core clinical duties** | • Diagnose and treat patients presenting with minor illness. (If further training has been completed, which would require investment from the Practice)<br>• Issue medications as appropriate following policy, patient group directives and local pathways.<br>• Undertake the collection of pathological specimens including intravenous blood samples, swabs etc.<br>• Conduct home visits to patients who are unable to attend the surgery. | • As for paramedic, and<br>• Triage patients wishing to see a health care professional, making any necessary referrals to other members of the health care team.<br>• Support the delivery of 'anticipatory care plans' and lead certain community services as agreed (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing). | • As for Specialist Paramedic, and<br>• To prescribe medications as appropriate following policy and local pathways. |
| **Prescribing status** | • Cannot prescribe. | • Cannot prescribe. | • Can enrol on a course to become an independent prescriber; if practitioner has evidence of successful completion of other study at Masters Level. |
| **Line management / mentoring responsibilities** | • To mentor pre-registration paramedics on placement at the practice. | • As for paramedic, and<br>• To line manage practice paramedic(s) if required.<br>• To mentor junior members of staff including paramedics employed by the practice, and pre-registration paramedics on placement at the practice. | • As for Specialist Paramedic, and<br>• To have some management responsibility (either to line manage specialist and practice paramedic(s) if required, or to have some management responsibility for a work stream)<br>• To mentor junior members of staff including paramedics and specialist paramedics employed by the practice, and pre-registration paramedics on placement at the practice.<br>• Mentor as a clinical supervisor for specialist and advanced Paramedics. |

| | Paramedic | Specialist Paramedic/ First Contact Practitioner/ Community paramedic | Advanced Paramedic Practitioner |
|---|---|---|---|
| **Person Specification** | | | |
| **Knowledge** | • Current clinical knowledge<br>• Commitment to sharing knowledge and skills | • As for Paramedic, and<br>• High levels of current clinical knowledge.<br>• Ability to mentor/train junior staff. | • As for Specialist Paramedic, and<br>• Possess a critical awareness / knowledge of issues in primary care, and the interface between different fields of practice. |
| **Skills, Behaviours and Attributes** | • Confident to work independently and make own judgements. | • As for Paramedic, and<br>• Enhanced knowledge base, complex decision making skills, competence and judgement in primary care. | • As for Specialist Paramedic, and<br>• Is innovative, and has the ability to develop / change practice and or services in a complex and unpredictable environment, achieved through an appropriate period of expertise, portfolios of evidence, and a Master's degree.<br>• Be able to provide evidence of meeting all the capabilities for the four pillars of advanced clinical practice. (Clinical Practice, Leadership and Management, Education and Research)<br>• Be able to support audit/ research within the practice and deliver patient or service improvements following this.<br>• Have experience of educating others. |

Further Information about the various levels of paramedic can be found in the Guide for General Practice Employing a Paramedic produced by Fareham and Gosport and South Eastern Hampshire CCGs. The College of Paramedics have also produced an Employers Guide for Paramedics in Primary and Urgent Care and developed an interactive Digital Career Framework which provides some very useful information to demonstrate the range of roles within the paramedic profession.

# **Paramedic** continued

## Supervision for Paramedics in Primary Care

Appropriate supervision will be required for all paramedics working in Primary Care.

Existing GP Educational supervisors are able to supervise paramedics undertaking FCP and AP roles and ***do not*** need to attend additional training.

GPs who have completed the First Contact Practitioner Supervisor Development course **can** provide clinical supervision to paramedics undertaking FCP and AP roles. Details on this course will be available via the Surrey Training Hub website as they become available.

For further details on supervision for these roles please contact Surrey Training Hub direct.

Further guidance on supervision can be found in the **First Contact Practitioners and Advanced Practitioners in Primary Care: (Paramedicl) - A Roadmap to Practice** (please see below for a link).

### First Contact Practitioners and Advanced Practitioners in Primary Care: (Paramedic) - A Roadmap to Practice

A Roadmap to Practice Paramedics.pdf

### Sample Job Description

Paramedic JD Example.pdf

### Sample appraisal

AHP Appraisal form.pdf

# Podiatrist

**Podiatrists** are healthcare professionals who have been trained to diagnose and treat foot and lower limb conditions. Podiatrists provide assessment, evaluation and foot care for a wide range of patients, which range from low risk to long-term acute conditions. Many patients fall into high risk categories such as those with diabetes, rheumatism, cerebral palsy, peripheral arterial disease and peripheral nerve damage.

## Training/Development

- Must have a BSc to work as a podiatrist in all settings.
- Health Education England Primary care FCP training must be completed as the minimum threshold for entry to primary care and be supported by appropriate governance and indemnity.
- Health Education England primary care FCP training can begin 3-5 years after the completion of a postgraduate degree

As the experts in lower limb health and disease, Podiatrists have the requisite knowledge, skills and training to work as first point of contact practitioners in primary care. The College of Podiatry believes that assigning more podiatrists into primary care settings will increase the capacity of both primary and secondary care, improve health outcomes for the population, enhance patient experience and save money. See https://cop.org.uk/ and https://primarycareone.nhs.wales/careers/primary-care-roles-in-wales/podiatrists/

Working within general practices and across PCNs, Podiatrists are competent to prescribe medicines in two ways, supplementary, using a written clinical management plan (CMP) in partnership with a doctor, or independently, following additional training. This enables the Podiatrist to provide patients with direct access to the interventions they need. This is not only valuable to patients but increases capacity within primary care settings by relieving pressure on GPs and the primary care teams.

# **Podiatrist** continued

As highly skilled healthcare professionals, podiatrists within primary care reduce pressure on GPs through their ability to prescribe independently. This significantly reduces demand for GP appointments and home visits and provides patients with direct access to the medicines they need, when they need them.

A fully integrated primary care podiatry service can safely diagnose, manage, rehabilitate and prevent disease related complications of the feet, ankles and lower limbs, particularly around MSK, diabetes, rheumatoid conditions and peripheral arterial disease. They also have a significant role in the public health and prevention agenda specifically around falls prevention, cardio-vascular risk reduction, medicines management and reconciliation, antibiotic stewardship and keeping people mobile and active. Podiatrists have the ability to utilise advanced diagnostic techniques including imaging and can prescribe independently for a range of lower limb conditions saving GP time and resource.

The role of the Podiatrist may include some of the following activities:

- Work as part of a PCNs multi-disciplinary team to clinically assess, treat and manage a caseload of patients of all ages with lower limb conditions and foot pathologies using expert knowledge of podiatry for specific conditions and topics
- Utilise and provide guidance to patients on equipment such as surgical instruments, dressings, treatment tables and orthotics
- Prescribe, produce and fit orthotics and other aids and appliances
- Provide specialist treatment and support for high-risk patient groups such as the elderly and those with increased risk of amputation
- Support patients using therapeutic and surgical techniques to treat foot and lower leg issues
- Deliver foot health education to patients
- Liaise with PCN multi-disciplinary team, community, and secondary care staff and named clinicians to arrange further investigations and onward referrals as necessary
- Communicate outcomes and integrate findings into their own and wider service practice and pathway development
- Develop, implement and evaluate a seamless podiatry support service across the PCN, working with community and secondary care where appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working
- Provide leadership and support on podiatry clinical service development across the PCN
- Provide education and specialist expertise to PCN staff as needed
- Ensure delivery of best practice in clinical practice, caseload management, education, research, and audit to achieve corporate PCN and local population objectives

# **Podiatrist** continued

## Benefits to patients

- ✓ Access to screening, diagnostics and tailored care plans
- ✓ Increased access to the right care, closer to home
- ✓ Patients are kept active and mobile
- ✓ Support people to manage their condition so that they can recover faster and stay in work and/or return to work earlier
- ✓ Receive education and advice on inappropriate footwear, which can contribute to poor balance and an increased risk of certain conditions or risk of falling
- ✓ Prevent and correct deformity, relieve pain and treat infections.

## Benefits to PCN's

- ✓ Work with other healthcare professionals such as dieticians, GPs, nurses and physiotherapists
- ✓ Relieve pressure on other primary care colleagues
- ✓ Help reduce patient attendance at the practice by intervening early and helping them stay well
- ✓ As highly skilled healthcare professionals, podiatrists within primary care reduce pressure on GPs through their ability to prescribe independently. This significantly reduces demand for GP appointments and home visits and provides patients with direct access to the medicines they need, when they need them.

## Benefits to wider NHS

- ✓ Prevention of complications from long-term conditions and reduction in the number of unnecessary referrals made to secondary care
- ✓ Early interventions within the community to reduce A&E attendances and unnecessary hospital admissions by facilitating early detection and intervention of potentially life-threatening conditions.

## Supervision for Podiatrists in Primary Care

Appropriate supervision will be required for all podiatrists working in Primary Care.

Existing GP Educational supervisors are able to supervise podiatrists undertaking FCP and AP roles and ***do not*** need to attend additional training.

GPs who have completed the First Contact Practitioner Supervisor Development course **can** provide clinical supervision to podiatrists undertaking FCP and AP roles. Details on this course will be available via the Surrey Training Hub website as they become available.

For further details on supervision for these roles please contact Surrey Training Hub direct

### Sample appraisal

AHP Appraisal form.pdf

### Sample Job Description

Podiatrist in PCN JD Example.pdf

# Occupational Therapist

**Occupational therapists** (OTs) support people of all ages with problems resulting from physical, mental, social, or development difficulties. 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).

## Training/Development

- A BSc degree in occupational therapy is required to work as an occupational therapist in any setting.
- Health Education England Primary care FCP training must be completed as the minimum threshold for entry to primary care and be supported by appropriate governance and indemnity.
- Health Education England primary care FCP training can begin 3-5 years after the completion of the postgraduate degree

Occupational Therapists (OTs) in primary care can assess, plan, implement and evaluate treatment plans with an aim to increase patients' productivity and self-care. They work with patients through a shared-decision making approach to plan realistic outcomes-focused goals. OTs undertake both verbal and non-verbal communication methods to address the needs of patients that have communication difficulties, whilst involving MDT colleagues, physiotherapists, social workers, alongside patients' families, teachers, carers and employers in treatment planning to aid rehabilitation. Where appropriate, they support the development of discharge and contingency plans with relevant professionals to arrange on-going care in residential, care home, hospital, and community settings.

OTs periodically review, evaluate and change rehabilitation programmes to rebuild lost skills and restore confidence, and may provide advice on homes, at school, and workplace for environmental alterations. They can teach coping strategies and support adaptation to manage long-term conditions for physical and mental health, and also advise on specialist equipment and organisations to help with daily activities. OTs can help to upskill other primary health care professionals and work as part of a multidisciplinary general practice team to help deliver more collaborative and coordinated self-care approach to further benefit patient care.

## Benefits to the patients

- ✓ Improves the individual patient's independence
- ✓ Improves specific self-care skills
- ✓ Therapists provide compensatory techniques to improve an individual's ability to complete self-care tasks following a change in functional abilities
- ✓ Improve strength and endurance for functional tasks
- ✓ Can work on functional cognition and visual deficits with the therapist
- ✓ Benefit from caregiver training from the therapists
- ✓ Patients receive expert advice in adaptive equipment and home modifications, such as, through home evaluations.

## Benefits to PCN's

- ✓ Can work as part of the multidisciplinary general practice team
- ✓ Deliver more collaborative and coordinated selfcare and environmental adjustments advice alongside their colleagues to benefit patient care
- ✓ Help to better manage the patient's own selfcare, keep them well and reduce visits to the practice the patient may have otherwise needed to make.

# Occupational Therapist continued

## Benefits to the wider NHS

- ✓ Deliver health promotion initiatives to their local community
- ✓ Can assist in reducing much more costly crisis interventions by helping patients maintain their health and wellbeing through better selfcare, patient independence and much needed environmental adjustments
- ✓ Teach and inform the public and health professionals about occupational therapies to improve their health outcomes and ensure they live well
- ✓ Work to ensure occupational therapy is included as a priority in on-going patient selfcare and condition management

Occupational Therapists can deliver health promotion initiatives to their local community and assist in reducing much more costly crisis interventions by helping patients maintain their health and wellbeing through better self-care, patient independence and much needed environmental adjustments. OTs teach and inform the public and health professionals about occupational therapies to improve their health outcomes; further benefiting PCNs and patient care.

See https://www.bma.org.uk/media/2144/bma-pcn-handbook-march-2020.pdf for more information and as reference to the above information.

## The role of the Occupational Therapist may include some of the following activities:

- Participate in rapid assessment for patients who present with a variety of acute and long term neurological, multifactorial and age related conditions
- Ensure effective communication where this may be impaired
- Ensure a high standard of clinical care for the patients under your management
- Interpret and analyse clinical and non-clinical facts to form an accurate diagnosis and prognosis in a wide range of conditions

- To undertake comprehensive assessment of patients, using investigative and analytical skills and to formulate individualised management and treatment plans
- Be responsible for a designated caseload of patients
- Use a range of standardised and non-standardised assessment tools and techniques to identify presenting strengths and difficulties
- Enhance and develop the skills and dexterity, co-ordination and palpatory senses for assessment and manual treatment of patients
- Refine treatment techniques in line with the most recent evidence of clinical effectiveness
- Devise individualised therapy management or treatment plans which may be implemented and supported by other members of the multidisciplinary team
- Provide proactive and reactive advice, teaching and instruction to relatives, carers and other professionals
- To have a working knowledge of equipment, minor adaptations and resources including ADL equipment, therapy and rehabilitation aids, moving and handling equipment
- Consider the needs of carers to ensure necessary support systems are in place and to involve them in the rehabilitation process

# Occupational Therapist continued

## Supervision for Occupational Therapists in Primary Care

Appropriate supervision will be required for all occupational therapists working in Primary Care.

Existing GP Educational supervisors are able to supervise occupational therapists undertaking FCP and AP roles and ***do not*** need to attend additional training.

GPs who have completed the First Contact Practitioner Supervisor Development course **can** provide clinical supervision to occupational therapist undertaking FCP and AP roles. Details on this course will be available via the Surrey Training Hub website as they become available.

For further details on supervision for these roles please contact Surrey Training Hub direct

### Sample appraisal

AHP Appraisal form.pdf

### Sample Job Description

Occupational Therapist JD Example.pdf

Surrey Training Hub

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

# Dietitian

**Dietitians** are healthcare professionals that diagnose and treat diet and nutritional problems, both at an individual patient and wider public health level. Working 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.

## Training/Development

Dietitians must be registered with the Health and Care Professions Council (HCPC). To register with the HCPC, completion of an approved degree in dietetics is required. This is usually a BSc (Hons) degree, although there are shortened postgraduate programmes available. A degree apprenticeship standard in dietetics has also been approved.

- Health Education England Primary care FCP training must be completed as the minimum threshold for entry to primary care and be supported by appropriate governance and indemnity.
- Health Education England primary care FCP training can begin 3-5 years postgraduate
- Advanced Dietitians can now train to become supplementary prescribers.

# **Dietician** continued

Dietitians working within primary care networks would be included as essential members of the general practice team, and would support and enable patients to self-manage their conditions. They are trained in behaviour modification methods and motivational interviewing. The role can also provide primary care diabetic services that include dietary, lifestyle and medication modification, and in some cases is that as a result patients do not need to see their GP for insulin and antidiabetic agent modification. The Dietitian would act as a first contact role to make initial assessments and refer on to the GP according to red flags symptoms.

## The role of the Dietitian could include the following activities:

- See patients with a wide range of different conditions via a range of different means e.g. one to one consultations, via email, telephone, virtual, domiciliary visits and visits to care homes
- See patients from primary care who self-refer with a predetermined and agreed range of symptoms and/ or conditions.
- Receive and respond to patient referrals from GPs, practice nurses, health visitors, district nurses, nursing home nurses, allied health professionals for example.
- Prescribe appropriately for management of long term conditions such as for diabetes, renal disease and pancreatic disease (if qualified to prescribe).
- Manage appropriate use of nutrition supplements and feeds, from commencement to review to discontinuation.
- Undertake health promotion activities such as/ and if appropriate, Health Checks.
- Utilising behaviour change skills and follow up patients when deemed necessary.
- May be involved in delivering patient education sessions (often jointly with other healthcare professionals) e.g. for diabetes, weight management.
- May be involved in delivering nutrition training for primary care and nursing home staff e.g. malnutrition screening, making an appropriate referral.

## Benefits to patients

- ✓ Receive advice on eating habits to help the patient improve their health and wellbeing
- ✓ Receive a tailored eating plan
- ✓ Receive support to manage conditions including diabetes, heart disease, being overweight and obesity, cancer, food allergies and intolerances
- ✓ Longer consultation times with dietitians leading to improved outcomes

## Benefits to PCN's

- ✓ Upskill other primary care professionals in nutrition
- ✓ Deliver more collaborative and coordinated nutrition care alongside their colleagues to benefit patient care
- ✓ Help to get patients better and keep them well
- ✓ Dietitians have the potential to reduce the demand on GP time by patients because their services are effective.

## Benefits to wider NHS

- ✓ Assist in reducing costly A&E attendances and avoidable hospital admissions by helping patients maintain their health and wellbeing through a healthy balanced diet
- ✓ Teach and inform the public and health professionals about diet and nutrition
- ✓ Work to ensure nutrition is included as a priority in patient care.

# **Dietician** continued

## Supervision for Dietitians in Primary Care

Appropriate supervision will be required for all dietitians working in Primary Care.

Existing GP Tutors are able to supervise dieticians undertaking FCP and AP roles and ***do not*** need to attend additional training.

GPs who have completed the First Contact Practitioner Supervisor Development two day course **can** provide clinical supervision to dieticians undertaking FCP and AP roles. Details on this course will be available via the Surrey Training Hub website as they become available.

For further details on supervision for these roles please contact Surrey Training Hub direct

The Association of UK Dietitians produced this paper to describe how Dieticians can be an essential member of the general practice and PCN workforce, and truly add value to patients and their outcomes:

### Sample appraisal

AHP Appraisal form.pdf

### Sample Job Description

Dietitian JD Example.pdf

### Other document

BDA Dieticians in Primary Care.pdf

# Physician Associate

**Physician Associates** (PAs) are healthcare professionals with a generalist medical education who work alongside doctors providing medical care as an integral part of the multidisciplinary team. Physician Associates are dependent practitioners who work under the supervision of a fully trained and experienced doctor. They bring new talent and add to the skill mix within teams, providing a stable, generalist section of the workforce which can help ease the workforce pressures that the NHS currently faces.

## Training/Development

Physician Associate students already have an undergraduate degree in a life science and/or a significant background in healthcare. To become a Physician Associate, students take a 2-year, full-time, intensive postgraduate course at Diploma or Masters level in Physician Associate studies. A list of courses can be found here: https://www.fparcp.co.uk/becoming-a-pa.

It includes over 1,400 hours of clinical placement experience in both acute and community settings. A new route via a 4-year Undergraduate Masters programme will run subject to approval. Once qualified, physician associates must maintain 50 hours of CPD per year and sit a recertification examination every 6 years.

Physician Associates (PAs) provide care for presenting patients, from initial history taking and clinical assessment, through to the diagnosis, treatment and evaluation of care. The PA will demonstrate critical thinking in the clinical decision-making process, including assessment and diagnostic skills, leading to the delivery of safe care for all patients. They will work collaboratively with a practice team to meet the needs of the patients, supporting the delivery of policy and procedures. The role will provide a holistic, clinical service, with support from GPs as required, implementing agreed plans and following approved protocols, adding value to the PCN workforce.

PAs are a relatively new member of the clinical team, seen as complementary to GPs rather than a substitute. Following the announcement of the General Medical Council (GMC) to regulate PAs, the ministerial statement outlines the next part of the consultation process to regulate the role under statute. The UK and devolved governments are now working together alongside stakeholders to develop and then consult on draft legislation. It's anticipated that regulation could be completed by the end of 2021. Once this is in place, separate and additional legislation is required for PA prescribing rights. It may take several more years beyond regulation for PAs to be able to prescribe. The PA role work in conjunction with and are complementary to the existing team.

# Physician Associate continued

By employing a PA, it can help to broaden the capacity of the GP role and skill mix within the practice team to help address the needs of patients in response to the growing and ageing population. There is a lot of general information in the employers section including 'An employer's guide to Physician Associates': https://www.fparcp.co.uk/employers/guidance and it suggested that GP practices only consider recruiting PAs who are registered on the Physician Associate Managed Voluntary Register.

Physician associates are in patient-facing roles and in general practice they see patients in their own appointments. As physician associates are dependent practitioners, they are supervised by a GP, and they cannot currently prescribe. The scope of practice for any particular physician associate will therefore develop over time at the discretion of their named supervising GP, who has overall responsibility for the physician associate. As with other roles, the named supervising GP does not have to be present at all times that the physician associate is working; their day to day work can be overseen by any GP that is present at the time. This can be structured in different ways, but anecdotal examples include lunchtime meetings with a GP and sometimes the wider team, ad hoc advice where appropriate for urgent complex referrals, and meetings at structured points in the day for GPs to sign prescription requests. In a GP surgery, physician associates see patients of all ages for acute and chronic medical care. Physician associates can refer also patients to consultants, the Emergency Assessment Unit (EAU) or to A&E when clinically appropriate, attend home visits and review incoming post and laboratory results. Physician associates are an additional health care team member to help the practice reach Quality Outcome Framework targets.

## The role of the Physician Associate may include some of the following activities:

- Elicit a comprehensive history
- Produce a problem-oriented history
- Perform a complete and directed physical examination
- Formulate a differential diagnosis
- Communicate a patient-focused management plan of care
- Order appropriate tests and interpret test results
- Prepare prescriptions for signature
- Educate and counsel patients and families
- Arrange for follow-up care and/ or referrals to specialists
- Perform, for example; injections, aspirations, basic phlebotomy, dipstick urinalysis, collection and preparation of cultures, fluorescein exam, minor surgery, diagnostic tests, take vital signs
- Home visits/ calls for nursing and homebound patients

### Benefits to patients

- ✓ Patients can currently spend two to three times longer consulting with PAs compared to GPs, eg 20–30 minutes
- ✓ As an additional member of the workforce, PAs should decrease access to care
- ✓ Patients may be given a longer appointment with a PA to help address unmet medical needs.

# Physician Associate continued

## Benefits to PCN's

- ✓ Frees up GP time and reduces GP stress by consulting with patients with routine care needs
- ✓ Ensures a level of continuity and added value
- ✓ PAs can take part in audits and quality improvement
- ✓ Practice workload is supported by an extra generalist resource – Easier access often results in better patient satisfaction

See https://www.fparcp.co.uk/employers/pas-in-general-practice for more detailed information. The document also outlines the requirements of a range of assessments to be completed by physician associates working in primary care during their first year in order to support the evidence they need for their revalidation.

## Sample appraisal

Multi-Professional Appraisal Toolkit KSS.PDF

## Sample Job Description

Physician Associate in Primary Care.pdf

Physician Associate JD Example.pdf

# Social Prescriber Link Worker

**Social prescriber link workers (SPLW)** give people time and focus on what matters to the person as identified through shared decision making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support. They work within multidisciplinary teams and collaborate with local partners to support community groups to be accessible and sustainable and help people to start new groups. Social prescribing complements other approaches such as 'active signposting'.

SPLW typically support people on average over 6-12 contacts (including phone calls, meetings and home visits) with a typical caseload of 200- 250 people per year, depending on the complexity of people's needs and the maturity of the social prescribing scheme.

## Training/Development

PCNs are required to ensure that social prescribing link workers complete the following training:

- Completion of the NHSE/I online learning programme: https://www.e-lfh.org.uk/programmes/social- prescribing/
- Enrolled in or qualified in appropriate training as set out by the Personalised Care Institute

PCNs must provide social prescribing link workers with:

- Regular access to clinical supervision provided by a GP
- Access to GP IT systems to enable them to record referrals using SNOMED codes

# Social Prescriber continued

## Benefits to patients

✓ People with LTCs and their carers benefit from access to additional, non-clinical support options via primary care. Patients experience positive outcomes associated with their health and wellbeing; and can become less socially isolated and more independent.

## Benefits to PCNs:

✓ SPLW can significantly reduce GP consultations (59% of GPs think as much).One in five GPs regularly refer patients to social prescribing. 40% would refer if they had more information about available services. GPs and their existing staff recognise the importance of social support as an alternative to medication. Simple referral processes for GPs and other clinical staff are very helpful.

## Benefits to the wider NHS

✓ SPLW are already having a positive impact on GP consultation rates, A&E attendances, hospital stays, medication use and social care. The University of Westminster led an evidence review looking at the impact of social prescribing on demand for NHS healthcare. The review found: an average of 28% fewer GP consultations and 24% fewer A&E attendances where social prescribing 'connector' services are working well.As much as a 33% reduction in A&E attendances and 58% reduction in unscheduled hospital admissions. Social prescribing seen that generally people's health and wellbeing improves and contributes to building stronger communities. Social prescribing allows the provision of innovative community-based services that complement traditional medical interventions.

For more information and useful links:

- Home | The Social Prescribing Network
- Home | National Academy for Social Prescribing (socialprescribingacademy.org.uk)

More info on the Surrey Training Hub Website

## Sample appraisal

Social Prescriber JD Example.pdf

Social Prescriber appraisal form

# Care Coordinators

**Care Coordinators** play an important role within a PCN to proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services. Care Coordinators could potentially provide extra time, capacity, and expertise to support patients in preparing for or in following-up clinical conversations they have with primary care professionals. They will work closely with the 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 carer's and ensuring that their changing needs are addressed. This is achieved by bringing together all the information about a person's identified care and support needs and exploring options to meet these within a single personalised care and support plan, based on what matters to the person.

## Training/Development

Care Coordinators require a strong foundation in enabling and communication skills as set out in the core Curriculum for Personalised Care. These can be achieved via a two day health coaching skills course and additional training as guided by Health Education England. Care coordinators should also access statuary and mandatory training, including but not limited to:

- Principles of information governance, accountability and clinical governance
- Maintenance of accurate and relevant records of agreed care and support needs
- Identify when it is appropriate to share information with carers and do so
- The professional and legal aspects of consent, capacity, and safeguarding

Care Coordinators should be familiar with the six components of the universal model for personalised care with a specific focus on:

- Support for self-management
- Personalised care and support planning
- Shared decision making
- Social prescribing
- Personal Health Budgets

# Care Coordinators continued

## Benefits to patients:

- ✓ The patient's go-to person if their needs change or if something goes wrong with service delivery – The care coordinator ensures that there are no gaps in the patient's service provision – Many elderly and disabled people with highly complex needs struggle to coordinate with all the relevant services directly on their own – Improved patient education and understanding – Better health outcomes – Patients can eliminate unnecessary appointments, procedures and tests – Patients feel more empowered and actively engaged in their treatment

## Benefits to PCNs:

- ✓ Ensuring seamless service provision significantly decreases the risk of the patient deteriorating and thereby reduces the overall cost of care and the likelihood that additional interventions will be needed in future. By identifying high-risk patient populations before they incur costlier medical intervention, employers can begin to reduce both practice expenses and total NHS costs – Employers can gain access to additional data that can reveal practice population health levels and risks – Care coordinators glean information about patients' treatment histories, medication adherence, new symptoms and management of chronic conditions.

## Benefit to wider NHS

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# Differences between Care Coordinator and Social Prescriber roles

These are general guidelines regarding the roles and differences between them. There may be local variations developed due to service provision and local PCN needs.

**Care Coordinators**

Care Coordination is a long term, integrated, evidence based programme centred around supporting people with disabilities, mental health needs, older people and their families/carers, by working together with people to help them:

- build and pursue their personal vision for a good life,
- stay strong, safe and connected as contributing citizens,
- find practical, non-service solutions to problems wherever possible,
- build more welcoming, inclusive and supportive communities.

Where local area coordination already exists in an area, it can complement social prescribing by supporting particular cohorts of people for the longer term and building community capacity and connections.

**Social Prescriber Link Worker**

Social prescribing links patients with non-medical support to improve their physical and mental wellbeing. Link workers give people time and focus on what matters to the person as identified through shared decision- making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support.

Social prescribing works for a wide range of people, including those:

- 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 wellbeing.

SPLW have an important role to play in the community too. Working closely with local partners, they can identify and address gaps in voluntary and community sector as well as helping to make groups sustainable. The roles refer back to each other to improve patient resilience and build the wider team around the patient.

# Care Coordinators continued

| Care Coordinators | Social Prescriber Link Worker |
|---|---|
| • Responsive to individual needs, focusing on developing a personalised care plan (maintaining health and wellbeing)<br>• Identify and work with a cohort of people to support their personalised care requirements, using the available decision support aids<br>• Areas of support might include; mental health assessments, care plans (creating and reviewing), carers support, coordinating responsive services (PAC)<br>• Cohorts of patients might include; End of Life, Dementia/ Parkinson's, Mental Health, Social care<br>• Bring together all of a person's identified care and support needs, and explore their options to meet these into a single personalised care and support plan, in line with PCSP best practice<br>• Help people to manage their needs, answering their queries and supporting them to make appointments<br>• Ensure that people have good quality information to help them make choices about their care<br>• Areas of support might include; mental health assessments, care plans (creating and reviewing), carers support, coordinating responsive services<br>• Short-medium-long term support (review process included)<br>• Navigator/signposting role – help people to navigate to difference services (knowledge of referral routes required)<br>• Referring to Social Prescribers for help with signposting and supporting patients to access services<br>• Open caseloads. Patients able to make contact if ongoing concerns or queries | • Proactive service, targeting groups or individuals, focusing on prevention (improving health and wellbeing)<br>• Areas of support might include; Housing (ASB, Home move, repairs, neighbour disputes), Money, debt & benefits (benefit entitlements - employment and disability, applications and assessment support), Lifestyle (mental health and wellbeing), Education, employment & training and Digital inclusion<br>• Short-Medium term support (6 sessions).<br>• Holistic approach<br>• Often focusing on behaviour change to facilitate engagement<br>• Personalised goal focused (SMART goals) with 5-ways to wellbeing influence<br>• Signposting and support to engage with local services and groups<br>• Attending community visits with clients on initial appointments<br>• Introduction to voluntary sector support E.g. Age UK- information & advice (Attendance Allowance, Blue badge etc...), Pathfinder, Befriending, Wellbeing, Journey to work services, disability support services etc...<br>• Building strong local connections within the community - integral to role<br>• Identify and coordinate efforts to support gaps in services<br>• Potential involvement in local voluntary steering groups |

Surrey Training Hub

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

# Health and wellbeing Coach

**Health and Wellbeing Coaches** (HWBCs) 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.

HWBCs will use a non-judgemental approach that supports the person to self-identify existing issues and encourages proactive prevention of new and existing illnesses. This approach is based on using strong communication and negotiation skills, supports personal choice and positive risk-taking, addresses potential consequences, and ensures people understand the accountability of their own decisions based on what matters to the person.

They will work alongside people to coach and motivate them through multiple sessions, supporting them to self-identify their needs, set goals, and help them to implement their personalised health and care plan.

## Training/Development

- The Personalised Care Institute will set out what training is available and expected for HWBCs. Further information will be provided when published. HWBCs will be required to be trained in health coaching in line with the NHSE/I Implementation and quality summary guide
- Training will include understanding the basics of social prescribing, plus an accredited health coaching skills programme (minimum of 4 days) and documented practice hours, along with opportunities for reflection and follow up activities
- 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).

## Benefits to patients:

- ✓ Interventions that ‘coach’ or actively support people to self-care.
- ✓ It is person-centred and empowering and based around a person’s own aspirations and goals.
- ✓ There is an increased patient activation and increases in preventative behaviours and self-management.
- ✓ Shown to improve two-way communication and partnership working.
- ✓ Overall improved health outcomes

# Health and wellbeing Coach continued

## Benefits to PCNs:

- ✓ Patient activation is associated with fewer visits to general practice.
- ✓ Support for people to self-manage their own health is increased and reduced demand for care due to improved patient wellbeing.
- ✓ There is seen to be increased efficiency due to quicker discharge from caseload and potential to cut waiting times.
- ✓ Less waste identified from unnecessary tests and medication.
- ✓ Long term sustained benefits in terms of cost reductions and service development.
- ✓ There are reported increase in job satisfaction amongst health and care professionals actively using the approach.

## Benefits to wider NHS:

- ✓ An independent evaluation showed that, of over 5,000 referrals to Healthy Change (Nottingham Public Health team) in the first year: – The service successfully referred over 80% of clients to lifestyle change services. This enabled over 75% of members to achieve one or more additional goals at end of the coaching period. Service was rated as good or better by over 85% of members.
- ✓ There was a reduced “Did Not Attend” rates for specialist lifestyle services as well as supporting lifestyle change; and improved self-care.
- ✓ Coaching shown to address lifestyle factors that are key determinants of health inequalities.

NHS England and NHS improvement provided a webinar on Social Prescribers, Care Coordinators and Health and Wellbeing Coaches on 04-11-20, which includes a wealth of information and resources and can be found in the table below:

### Sample appraisal

Care Coordinator Appraisal Form Example.pdf

### Sample Job Description

Health Wellbeing Coach JD Example.pdf

Care Coordinator JD example.pdf

# Further Useful Links, Tools and Documents

- **Wessex tool** Project overview useful in workforce planning in using a task based approach in considering various roles, the differences, overlap, benefits.
- **ARRS roles in PC** New Roles in Primary Care Guidance This Health Education England Primary Care National Toolkit has been created to enable PCNs to develop their workforce. It refers not only to ARRS roles but to all new roles in Primary Care.
- **Health Education England Star** https://www.hee.nhs.uk/our-work/hee-star is an interactive tool which generates questions and discussions. It is an effective model to support workforce transformation, explores workforce challenges, and enables creation of bespoke
- **The primary care network handbook** https://www.bma.org.uk/media/2144/bma-pcn- handbook-march-2020.pdf pages 8-13 in particular.
- **Appraisal's:** Appraisal is an annual requirement for NHS staff. Below links offer some guidance and structure for the appraisal process which can be adapted by individuals and practices to meet their specific needs:

1. NHSE's document - AHPs working in Primary Care - a reference guide for PCNs https://www.england.nhs.uk/south-east/our-work/info-professionals/medical/south-east
2. KSS Multi-professional appraisal toolkit

**The Surrey Training Hub is here to help support the development of your workforce:**

- Training Hubs were introduced by Health Education England in 2015 with the aim of delivering key educational and workforce programmes to support Primary Care
- They had various local names; the local Health Education England opted for the name Community Education Provider Network (CEPN), and later renamed as Training Hubs
- The NHS Long Term Plan (Jan19) committed additional funds to Primary Care and for the development of PCN workforce and more recently in the NHS People Plan (2020/2021)
- Training Hubs exist to facilitate education and training for the current and future multi- disciplinary Primary Care teams

**Please visit the Surrey Training Hub website for all your training and education needs.**

**https://www.surreytraininghub.co.uk**

**The Surrey Training Hub would like to thank Sussex & Kent Training Hubs for their collaboration with this booklet**

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