Annex B - Additional Roles Reimbursement Scheme - Minimum Role Requirements

B.1. Clinical Pharmacist

B1.1. Where a PCN employs or engages a Clinical Pharmacist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Clinical Pharmacist is enrolled in, or has qualified from, an approved 18-month training pathway or equivalent that equips the Clinical Pharmacist to:

a. be able to practice and prescribe safely and effectively in a primary care setting (for example, the CPPE Clinical Pharmacist training pathways[82,83]); and

b. deliver the key responsibilities outlined in section B1.2.

B1.2. Where a PCN employs or engages one or more Clinical Pharmacists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Clinical Pharmacist has the following key responsibilities in relation to delivering health services:

a. work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas;

b. be a prescriber, or completing training to become prescribers, and work with and alongside the general practice team;

c. be responsible for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple co-morbidities (in particular frailty, COPD and asthma) and people with learning disabilities or autism (through STOMP – Stop Over Medication Programme);

d. provide specialist expertise in the use of medicines whilst helping to address both the public health and social care needs of patients at the PCN's practice(s) and to help in tackling inequalities;

e. provide leadership on person-centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, whilst

[82] https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop
[83] https://www.cppe.ac.uk/wizard/files/general-practice/clinical-pharmacists-in-general-practice-education-brochure.pdf

contributing to the quality and outcomes framework and enhanced services;

f. through structured medication reviews, support patients to take their medications to get the best from them, reduce waste and promote self-care;

g. have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload;

h. develop relationships and work closely with other pharmacy professionals across PCNs and the wider health and social care system;

i. take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties), liaison with community pharmacists and anticoagulation; and

j. be part of a professional clinical network and have access to appropriate clinical supervision. Appropriate clinical supervision means:

   i. each clinical pharmacist must receive a minimum of one supervision session per month by a senior clinical pharmacist[84];

   ii. the senior clinical pharmacist must receive a minimum of one supervision session every three months by a GP clinical supervisor;

   iii. each clinical pharmacist will have access to an assigned GP clinical supervisor for support and development; and

   iv. a ratio of one senior clinical pharmacist to no more than five junior clinical pharmacists, with appropriate peer support and supervision in place.

B.2. Pharmacy Technicians

B2.1. Where a PCN employs or engages a Pharmacy Technician under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Pharmacy Technician:

a. is registered with the General Pharmaceutical Council (GPhC);

[84] This does not need to be a senior clinical pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

b. meets the specific qualification and training requirements as specified by the GPhC criteria[85] to register as a Pharmacy Technician;

c. enrolled in, undertaking or qualified from, an approved training pathway. For example, the Primary Care Pharmacy Educational Pathway (PCPEP) or Medicines Optimisation in Care Homes (MOCH); and

d. is working under appropriate clinical supervision to ensure safe, effective and efficient use of medicines

in order to deliver the key responsibilities outlined in section B2.2.

B2.2. Where a PCN employs or engages one or more Pharmacy Technicians under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Pharmacy Technician has the following key clinical, and technical and administrative responsibilities, in delivering health services:

B2.2.1. Clinical responsibilities of the Pharmacy Technician:

a. undertake patient facing and patient supporting roles to ensure effective medicines use, through shared decision-making conversations with patients;

b. carry out medicines optimisation tasks including effective medicine administration (e.g. checking inhaler technique), supporting medication reviews, and medicines reconciliation. Where required, utilise consultation skills to work in partnership with patients to ensure they use their medicines effectively;

c. support, as determined by the PCN, medication reviews and medicines reconciliation for new care home patients and synchronising medicines for patient transfers between care settings and linking with local community pharmacists.

d. provide specialist expertise, where competent, to address both the public health and social care needs of patients, including lifestyle advice, service information, and help in tackling local health inequalities;

e. take a central role in the clinical aspects of shared care protocols and liaising with specialist pharmacists for more complex patients;

f. support initiatives for antimicrobial stewardship to reduce inappropriate antibiotic prescribing;

g. assist in the delivery of medicines optimisation and management incentive schemes and patient safety audits;

[85] The training requirements for Pharmacy Technicians are currently in transition and further information is available on the General Pharmaceutical Council (GPhC) website. This information will provide the specific criteria to register as a pharmacy technician – see https://www.pharmacyregulation.org/i-am-pharmacy-technician

h. support the implementation of national prescribing policies and guidance within GP practices, care homes and other primary care settings. This will be achieved through undertaking clinical audits (e.g. use of antibiotics), supporting quality improvement measures and contributing to the Quality and Outcomes Framework and enhanced services;

B2.2.2. Technical and Administrative responsibilities of the Pharmacy Technician:

a. work with the PCN multi-disciplinary team to ensure efficient medicines optimisation, including implementing efficient ordering and return processes, and reducing wastage;

b. 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;

c. provide leadership for medicines optimisation systems across PCNs, supporting practices with a range of services to get the best value from medicines by encouraging and implementing Electronic Prescriptions, safe repeat prescribing systems, and timely monitoring and management of high-risk medicines;

d. provide training and support on the legal, safe and secure handling of medicines, including the implementation of the Electronic Prescription Service (EPS); and

e. 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.

B.3. Social Prescribing Link Workers

B3.1. A PCN must provide to the PCN's patients access to a social prescribing service. To comply with this, a PCN may:

a. directly employ Social Prescribing Link Worker(s); or

b. sub-contract provision of the service to another provider

in accordance with this Network Contract DES Specification.

B3.2. Where a PCN employs or engages a Social Prescribing Link Worker under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Social Prescribing Link Worker:

a. has completed the NHS England and NHS Improvement online learning programme[86]

b. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute[87]; and

c. attends the peer support networks run by NHS England and NHS Improvement at ICS and/or STP level;

in order to deliver the key responsibilities outlined in section B3.3.

B3.3. Where a PCN employs or engages one or more Social Prescribing Link Workers under the Additional Roles Reimbursement Scheme or sub-contracts provision of the social prescribing service to another provider, the PCN must ensure that each Social Prescribing Link Worker providing the service has the following key responsibilities in delivering the service to patients:

a. as members of the PCN's team of health professionals, take referrals from the PCN's Core Network Practices and from a wide range of agencies[88] to support the health and wellbeing of patients;

b. assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community;

c. co-produce a simple personalised care and support plan to address the patient's health and wellbeing needs by introducing or reconnecting people to community groups and statutory services, including weight management support and signposting where appropriate and it matters to the person;

d. evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs[89];

e. provide personalised support to patients, their families and carers to take control of their health and wellbeing, live independently, improve their health outcomes and maintain a healthy lifestyle;

f. develop trusting relationships by giving people time and focus on 'what matters to them';

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[86] https://www.e-lfh.org.uk/programmes/social-prescribing/

[87] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

[88] These agencies include but are not limited to: the PCN's members, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

[89] Including considering if the persons needs are met (for example, reasonable adjustments, interpreter etc).

g. take a holistic approach, based on the patient's priorities and the wider determinants of health, including supporting people to take up employment, training and welfare support;

h. explore and support access to a personal health budget where appropriate;

i. manage and prioritise their own caseload, in accordance with the health and wellbeing needs of their population; and

j. where required and as appropriate, refer patients back to other health professionals within the PCN.

B3.4. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the Social Prescribing Link Worker(s). This could be provided by one or more named individuals within the PCN. A PCN's Core Network Practices must provide monthly access to clinical supervision with a relevant health professional.

B3.5. A PCN will ensure the Social Prescribing Link Worker(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

B3.6. A PCN must ensure referrals to the Social Prescribing Link Worker(s) are recorded within GP clinical systems using the new national SNOMED codes (see section 7.4.1 and 5.4.7).

B3.7. Where a PCN employs or engages one or more Social Prescribing Link Workers under the Additional Roles Reimbursement Scheme or sub-contracts provision of the social prescribing service to another provider, the PCN must ensure that each Social Prescribing Link Worker has the following key wider responsibilities:

a. draw on and increase the strength and capacity of local communities, enabling local Voluntary, Community and Social Enterprise (VCSE) organisations and community groups to receive social prescribing referrals from the Social Prescribing Link Worker;

b. work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities;

c. have a role in educating non-clinical and clinical staff within the PCN through verbal or written advice or guidance on what other services are available within the community and how and when patients can access them;

B3.8. A PCN must be satisfied that organisations and groups to whom the Social Prescribing Link Workers(s) directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B3.9. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the Social Prescribing Link Worker(s) and the process for referrals.

B3.10. A PCN must work in partnership with commissioners, social prescribing schemes, Local Authorities and voluntary sector leaders to create a shared plan for social prescribing which must include how the organisations will build on existing schemes and work collaboratively to recruit additional social prescribing link workers to embed one in every PCN and direct referrals to the voluntary sector.

B.4. Health and Wellbeing Coach

B4.1. Where a PCN employs or engages a Health and Wellbeing Coach under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Health and Wellbeing Coach:

a. is enrolled in, undertaking or qualified from appropriate health coaching training covering topics outlined in the NHS England and NHS Improvement Implementation and Quality Summary Guide[90], with the training delivered by a training organisation listed by the Personalised Care Institute[91];

b. adheres to a code of ethics and conduct in line with the NHS England and NHS Improvement Health coaching Implementation and Quality Summary Guide;

c. has formal individual and group coaching supervision which must come from a suitably qualified or experienced individual; and

d. working closely in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider to identify and work alongside people who may need additional support, but are not yet ready to benefit fully from social prescribing

in order to deliver the key responsibilities outlined in section B4.2.

[90] https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/
[91] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

B4.2. Where a PCN employs or engages one or more Health and Wellbeing Coaches under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Health and Wellbeing Coach has the following key responsibilities, in delivering health services:

a. manage and prioritise a caseload, in accordance with the health and wellbeing needs of their population through taking an approach that is non-judgemental, based on strong communication and negotiation skills, while considering the whole person when addressing existing issues. Where required and as appropriate, the Health and Wellbeing Coach will refer people back to other health professionals within the PCN;

b. utilise existing IT and MDT channels to screen patients, with an aim to identify those that would benefit most from health coaching;

c. provide personalised support to individuals, their families, and carers to support them to be active participants in their own healthcare; empowering them to manage their own health and wellbeing and live independently through:

i. coaching and motivating patients through multiple sessions to identify their needs, set goals, and supporting patients to achieve their personalised health and care plan objectives;

ii. providing interventions such as self-management education and peer support;

iii. supporting patients to establish and attain goals that are important to the patient;

iv. supporting personal choice and positive risk taking while ensuring that patients understand the accountability of their own actions and decisions, thus encouraging the proactive prevention of further illnesses;

v. working in partnership with the social prescribing service to connect patients to community-based activities which support them to take increased control of their health and wellbeing; and

vi. increasing patient motivation to self-manage and adopt healthy behaviours;

d. work in partnership with patients to support them to develop their level of knowledge, skills and confidence enabling them to engage with their health and well-being and subsequently supporting them in shared decision-making conversations;

e. utilise health coaching skills to support to develop the knowledge, skills, and confidence to manage their health and wellbeing, whilst increasing their ability to access and utilise community support offers; and

f. explore and support patient access to a personal health budget, where appropriate, for their care and support.

B4.3. The following sets out the key wider responsibilities of Health and Wellbeing Coaches:

a. develop collaborative relationships and work in partnership with health, social care, and community and voluntary sector providers and multi-disciplinary teams to holistically support patients' wider health and well-being, public health, and contributing to the reduction of health inequalities;

b. provide education and specialist expertise to PCN staff, supporting them to improve their skills and understanding of personalised care, behavioural approaches and ensuring consistency in the follow up of people's goals with MDT input; and

c. raise awareness within the PCN of shared decision-making and decision support tools.

B4.4. A PCN must be satisfied that organisations and groups to whom its Health and Wellbeing Coach(es) directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B4.5. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the PCN's Health and Wellbeing Coach(es). This could be provided by one or more named individuals within the PCN. The Health and Wellbeing Coach must have access to regular supervision from a health coaching mentor. In addition to this, formal and individual group coaching supervision must come from a suitably qualified or experienced health coaching supervisor.

B4.6. A PCN will ensure the PCN's Health and Wellbeing Coach(es) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

B4.7. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Health and Wellbeing Coach(es).

B.5. Care Coordinator

B5.1. Where a PCN employs or engages a Care Coordinator under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Care Coordinator:

a. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute[92]; and

b. works closely and in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider and Health and Wellbeing Coach(es),

in order to deliver the key responsibilities outlined in section B5.2.

B5.2. Where a PCN employs or engages one or more Care Coordinators under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Care Coordinator has the following key responsibilities, in delivering health services:

a. utilise population health intelligence to proactively identify and work with a cohort of patients to deliver personalised care;

b. support patients to utilise decision aids in preparation for a shared decision-making conversation;

c. holistically bring together all of a person's identified care and support needs, and explore options to meet these within a single personalised care and support plan (PCSP), in line with PCSP best practice, based on what matters to the person;

d. help people to manage their needs through answering queries, making and managing appointments, and ensuring that people have good quality written or verbal information to help them make choices about their care, using tools to understand peoples level of knowledge, confidence in skills in managing their own health;

e. support people to take up training and employment, and to access appropriate benefits where eligible for example, through referral to social prescribing link workers;

f. assist people to access self-management education courses, peer support or interventions that support them to take more control of their health and wellbeing;

g. explore and assist people to access personal health budgets where appropriate;

h. provide coordination and navigation for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals; and

[92] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

i. support the coordination and delivery of MDTs within the PCN.

B5.3. The following sets out the key wider responsibilities of Care Coordinators:

a. work with the GPs and other primary care professionals within the PCN to identify and manage a caseload of patients, and where required and as appropriate, refer people back to other health professionals within the PCN;

b. raise awareness within the PCN of shared decision-making and decision support tools; and

c. raise awareness of how to identify patients who may benefit from shared decision making and support PCN staff and patients to be more prepared to have shared decision-making conversations.

B5.4. A PCN must be satisfied that organisations and groups to whom its Care Coordinator directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B5.5. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the PCN's Care Coordinator(s). This could be provided by one or more named individuals within the PCN.

B5.6. A PCN will ensure the PCN's Care Coordinator(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

B5.7. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Care Coordinator(s).

B.6. Physician Associates

B6.1. Where a PCN employs or engages a Physician Associate under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Physician Associate:

a. has completed a post-graduate physician associate course (either PG Diploma or MSc);

b. has maintained professional registration with the Faculty of Physician Associates and/or the General Medical council following implementation of statutory regulation, working within the latest code of professional conduct (CIPD);

c. has passed the UK Physician Associate (PA) National Re-Certification Exam, which needs to be retaken every six years;

d. participates in continuing professional development opportunities by keeping up to date with evidence-based knowledge and competence in all aspects of their role, meeting clinical governance guidelines for continuing professional development (CPD), and

e. is working under supervision of a doctor as part of the medical team,

in order to deliver the key responsibilities outlined in section B6.2.

B6.2. Where a PCN employs or engages one or more Physician Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Physician Associate has the following key responsibilities, in delivering health services:

a. provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable);

b. support the management of patient's conditions through offering specialised clinics following appropriate training including (but not limited to) family planning, baby checks, COPD, asthma, diabetes, and anticoagulation;

c. provide health/disease promotion and prevention advice, alongside analysing and actioning diagnostic test results;

d. develop integrated patient-centred care through appropriate wording with the wider primary care multi-disciplinary team and social care networks;

e. utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks;

f. participate in duty rotas; undertaking face-to-face, telephone, and online consultations for emergency or routine problems as determined by the PCN, including management of patients with long-term conditions;

g. undertake home visits when required; and

h. develop and agree a personal development plan (PDP) utilising a reflective approach to practice, operating under appropriate clinical supervision.

B6.3. A PCN's Core Network practices must identify a suitable named GP supervisor for each physician associate, to enable them to work under appropriate clinical supervision.

B.7. First Contact Physiotherapists

B7.1. Where a PCN employs or engages a First Contact Physiotherapist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the First Contact Physiotherapist:

a. has completed an undergraduate degree in physiotherapy;

b. is registered with the Health and Care Professional Council;

c. holds the relevant public liability insurance;

d. has a Masters Level qualification or the equivalent specialist knowledge, skills and experience;

e. can demonstrate working at Level 7 capability in MSK related areas of practice or equivalent (such as advanced assessment diagnosis and treatment);

f. can demonstrate ability to operate at an advanced level of practice,

in order to deliver the key responsibilities outlined in section B7.2.

B7.2. Where a PCN employs or engages one or more First Contact Physiotherapists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each First Contact Physiotherapist has the following key responsibilities, in delivering health services:

a. work independently, without day to day supervision, to assess, diagnose, triage, and manage patients, taking responsibility for prioritising and managing a caseload of the PCN's Registered Patients;

b. receive patients who self-refer (where systems permit) or from a clinical professional within the PCN, and where required refer to other health professionals within the PCN;

c. work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of movement and function issues, to create stronger links for wider services through clinical leadership, teaching and evaluation;

d. develop integrated and tailored care programmes in partnership with patients, providing a range of first line treatment options including self-management, referral to rehabilitation focussed services and social prescribing;

e. make use of their full scope of practice, developing skills relating to independent prescribing, injection therapy and investigation to make professional judgements and decisions in unpredictable situations, including when provided with incomplete or contradictory information. They will take responsibility for making and justifying these decisions;

f. manage complex interactions, including working with patients with psychosocial and mental health needs, referring onwards as required and including social prescribing when appropriate;

g. communicate effectively with patients, and their carers where applicable, complex and sensitive information regarding diagnoses, pathology, prognosis and treatment choices supporting personalised care;

h. implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training;

i. develop integrated and tailored care programmes in partnership with patients through:

    i. effective shared decision-making with a range of first line management options (appropriate for a patient's level of activation);

    ii. assessing levels of patient activation to support a patient's own level of knowledge, skills and confidence to self-manage their conditions, ensuring they are able to evaluate and improve the effectiveness of self-management interventions, particularly for those at low levels of activation;

    iii. agreeing with patient's appropriate support for self-management through referral to rehabilitation focussed services and wider social prescribing as appropriate; and

    iv. designing and implementing plans that facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence, and reduce the need for pharmacological interventions;

j. request and progress investigations (such as x-rays and blood tests) and referrals to facilitate the diagnosis and choice of treatment regime including, considering the limitations of these investigations, interpret and act on results and feedback to aid patients' diagnoses and management plans; and

k. be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice.

B7.3. The following sets out the key wider responsibilities of First Contact Physiotherapists:

a. work across the multi-disciplinary team to create and evaluate effective and streamlined clinical pathways and services;

b. provide leadership and support on MSK clinical and service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care;

c. develop relationships and a collaborative working approach across the PCN, supporting the integration of pathways in primary care;

d. encourage collaborative working across the wider health economy and be a key contributor to supporting the development of physiotherapy clinical services across the PCN;

e. liaising with secondary and community care services, and secondary and community MSK services where required, using local social and community interventions as required to support the management of patients within the PCN; and

f. support regional and national research and audit programmes to evaluate and improve the effectiveness of the First Contact Practitioner (FCP) programme. This will include communicating outcomes and integrating findings into own and wider service practice and pathway development.

B.8. Dietitians

B8.1. Where a PCN employs or engages a Dietitian under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Dietitian:

a. has a BSc or pre-reg MSc in Dietetics under a training programme approved by the British Dietetic Association (BDA);

b. is a registered member of the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B8.2.

B8.2. Where a PCN employs or engages one or more Dietitians under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Dietitian has the following key responsibilities, in delivering health services:

a. provide specialist nutrition and diet advice to patients, their carers, and healthcare professionals through treatment, education plans, and prescriptions;

b. educate patients with diet-related disorders on how they can improve their health and prevent disease by adopting healthier eating and drinking habits;

c. provide dietary support to patients of all ages (from early-life to end-of-life care) in a variety of settings including nurseries, patient homes and care homes;

d. work as part of a multi-disciplinary team to gain patient's cooperation and understanding in following recommended dietary treatments;

e. develop, implement and evaluate a seamless nutrition 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;

f. work with clinicians, multi-disciplinary team colleagues and external agencies to ensure the smooth transition of patients discharged from hospital back into primary care, so that they can continue their diet plan;

g. make recommendations to PCN staff regarding changes to medications for the nutritional management of patients, based on interpretation of biochemical, physiological, and dietary requirements; and

h. implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training.

B8.3. The following sets out the key wider responsibilities of Dietitians:

a. undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order; and

b. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives.

B.9. Podiatrists

B9.1. Where a PCN employs or engages a Podiatrist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Podiatrist:

a. has a BSc or pre-reg MSc in Podiatry under a training programme approved by the College of Podiatry;

b. is a registered member of the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B9.2.

B9.2. Where a PCN employs or engages one or more Podiatrists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Podiatrist has the following key responsibilities, in delivering health services:

a. work as part of a PCN's multi-disciplinary team to clinically assess, treat, and manage a caseload of patients of all ages with lower limb conditions and foot pathologies, using their expert knowledge of podiatry for specific conditions and topics;

b. utilise and provide guidance to patients on equipment such as surgical instruments, dressings, treatment tables and orthotics;

c. prescribe, produce, and fit orthotics and other aids and appliances;

d. provide specialist treatment and support for high-risk patient groups such as the elderly and those with increased risk of amputation;

e. support patients through the use of therapeutic and surgical techniques to treat foot and lower leg issues (e.g. carrying out nail and soft tissue surgery using local anaesthetic);

f. deliver foot health education to patients;

g. implement all aspects of effective clinical governance for their own practice, including undertaking regular audit and evaluation, supervision, and training;

h. liaise with PCN multi-disciplinary team, community and secondary care staff, and named clinicians to arrange further investigations and onward referrals;

i. communicate outcomes and integrate findings into their own and wider service practice and pathway development; and

j. 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.

B9.3. The following sets out the key wider responsibilities of Podiatrists:

a. undertake continued professional development to understand the mechanics of the body in order to preserve, restore, and develop movement for patients;

b. provide leadership and support on podiatry clinical service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care;

c. provide education and specialist expertise to PCN staff, raising awareness of good practice in good foot health;

d. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives; and

e. undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order.

B.10. Occupational Therapists

B10.1. Where a PCN employs or engages an Occupational Therapist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Occupational Therapist:

a. has a BSc in or pre-reg MSc in Occupational Therapy under a training programme approved by the Royal College of Occupational Therapists;

b. is a registered member of the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B10.2.

B10.2. Where a PCN employs or engages one or more Occupational Therapists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Occupational Therapist has the following key responsibilities, in delivering health services:

a. assess, plan, implement, and evaluate treatment plans, with an aim to increase patients' productivity and self-care;

b. work with patients through a shared-decision making approach to plan realistic, outcomes-focused goals;

c. undertake both verbal and non-verbal communication methods to address the needs of patients that have communication difficulties;

d. work in partnership with multi-disciplinary team colleagues, physiotherapists and social workers, alongside the patients' families, teachers, carers, and employers in treatment planning to aid rehabilitation;

e. where appropriate, support the development of discharge and contingency plans with relevant professionals to arrange on-going care in residential, care home, hospital, and community settings;

f. periodically review, evaluate and change rehabilitation programmes to rebuild lost skills and restore confidence;

g. as required, advise on home, school, and workplace environmental alterations, such as adjustments for wheelchair access, technological needs, and ergonomic support;

h. advise patients, and their families or carers, on specialist equipment and organisations that can help with daily activities;

i. help patients to adapt to and manage their physical and mental health long-term conditions, through the teaching of coping strategies; and

j. develop, implement and evaluate a seamless occupational therapy 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.

B10.3. The following sets out the key wider responsibilities of Occupational Therapists:

a. provide education and specialist expertise to PCN staff, raising awareness of good practice occupational therapy techniques; and

b. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives.

B.11. Nursing Associate

B11.1. Where a PCN employs or engages a Nursing Associate under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Nursing Associate:

a. meets the specific qualification and training requirements as specified in the Nursing Midwifery Standards of proficiency by having undertaken and completed the two-year Foundation Degree delivered by a Nursing and Midwifery Council (NMC) - approved provider; and

b. is registered with the NMC and revalidation is undertaken in line with NMC requirements.

B11.2. Where a PCN employs or engages one or more Nursing Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each nursing associate has the following key responsibilities in relation to delivering health services:

a. work as part of the PCN's MDT to provide and monitor care, under direct or indirect supervision[93];

b. improve safety and quality of care at every opportunity;

c. contribute to the delivery of integrated care;

d. work with the PCN MDT to ensure delivery of nursing associate duties complement existing workforce;

e. provide support and supervision to training nursing associates, healthcare assistants, apprentices, and those on learning assignments/placements as required;

f. support registered nurses to enable them to be able to focus on the more complex clinical care;

g. develop relationships across the MDT to support integration of the role across health and social care including primary care, secondary care, and mental health;

h. perform and record clinical observations such as blood pressure, temperature, respirations, and pulse;

i. after undertaking additional training, provide flu vaccinations, ECGs, and venepuncture, and other relevant clinical tasks as required by the PCN, in line with the competencies of the role;

j. promote health and well-being to all patients, for example undertaking the NHS health check;

k. care for individuals with dementia, mental health conditions, and learning disabilities;

l. advise patients on general healthcare and promote self-management where appropriate, including signposting patients to personalised care colleagues and local community and voluntary sector services;

m. communicate proactively and effectively with all MDT colleagues across the PCN, attending and contributing to meetings as required;

n. maintain accurate and contemporaneous patient health records; and

o. enhance own performance through continuous professional development, imparting own knowledge and behaviours to meet the needs of the service.

B11.3. A PCN must ensure that the postholder has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.

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[93] For example, as set out in the NMC Standards for Nursing Associates

B.12. Trainee Nursing Associate (TNA)

B12.1. Where a PCN employs or engages a training nursing associate (TNA) under the Additional Roles Reimbursement Scheme, the PCN must ensure that the TNA:

a. has a minimum of GCSE Maths and English at grade 9 to 4 (A to C) or Functional Skills Level 2 in Maths and English;

b. is working towards completion of the Nursing Associate Apprenticeship programme; and

c. is enrolled on a foundation degree awarded by a Nursing and Midwifery Council (NMC) - approved provider over a 2-year period.

B12.2. Where a PCN employs or engages one or more TNAs under the Additional Roles Reimbursement Scheme, the PCN must ensure that each TNA has the following key responsibilities in relation to delivering health services:

a. delivery of high quality, compassionate care whilst undertaking specific clinical and care tasks under the direction of a registered nurse (or other registered care professional dependent on PCN), with a focus on promoting good health and independence;

b. work as part of a PCN's multidisciplinary team (MDT), delivering a high standard of care that focuses on the direct needs of the patient;

c. work with a supervisor to take responsibility for developing own clinical competence, leadership, and reflective practice skills within the workplace, while on placements and through attending the Nursing Associate Training Programme; and

d. develop by the end of the Nursing Associate Training Programme the ability to work without direct supervision, at times delivering care independently in line with the individual's defined plan of care, within the parameters of the nursing associate role, accessing clinical and care advice when needed.

B12.3. Over the course of the 2-year TNA programme, develop the skills and knowledge to provide direct care to patients and families which may include:

a. after undertaking additional training, provide flu vaccinations, ECGs, venepuncture, and other relevant clinical tasks as required by the PCN, in line with the competencies of the role;

b. supporting individuals and their families and carers when faced with unwelcome news and life-changing diagnoses, for example by providing relevant information on the diagnosis, signposting patients to further information, or referral to social prescribing link workers etc.;

c. performing and recording clinical observations such as blood pressure, temperature, respirations, and pulse;

d. discussing and sharing information with registered nurses on patients' health conditions, activities, and responses; and

e. developing an understanding of caring and supporting people with dementia, mental health conditions, and learning disabilities.

B12.4. A PCN must ensure that the postholder has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.

B.13. Paramedics

B13.1. Where a PCN employs or engages a Paramedic under the Additional Roles Reimbursement Scheme, the PCN must ensure that the paramedic:

a. is educated to degree/diploma level in Paramedicine or equivalent experience;

b. is registered with the Health and Care Professions Council (HCPC);

c. has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic";

d. has a further three years' experience as a band 6 (or equivalent) paramedic; and

e. is working towards developing Level 7 capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the Advanced Clinical Practice Framework.

B13.2. Where a PCN employs or engages a Paramedic to work in primary care under the Additional Roles Reimbursement Scheme, if the Paramedic cannot demonstrate working at Level 7 capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each Paramedic is working as part of a rotational model, in which they have access to regular supervision and support from clinicians signed off at clinical practice level 7.

B13.3. Where a PCN employs or engages one or more Paramedics under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Paramedic has the following key responsibilities, in delivering health services:

a. work as part of a MDT within the PCN;

b. 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;

c. advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services;

d. be able to:

   i. perform specialist health checks and reviews within their scope of practice and in line with local and national guidance;

   ii. perform and interpret ECGs;

   iii. perform investigatory procedures as required; and

   iv. undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance;

e. support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing);

f. provide an alternative model to urgent and same day GP home visit for the network and clinical audits;

g. communicate at all levels across organisations ensuring that an effective, person-centred service is delivered;

h. communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required;

i. maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice; and

j. communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices.

B.14. Mental Health Practitioners

B14.1. The mental health practitioner role may be undertaken by 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.

B14.2. Where a PCN engages one or more Mental Health Practitioners under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Mental Health Practitioner has the following key responsibilities, in delivering health services:

a. provide a combined consultation, advice, triage and liaison function, supported by the local community mental health provider;

b. work with patients to:

i. support shared decision-making about self-management;

ii. facilitate onward access to treatment services; and

iii. provide brief psychological interventions, where qualified to do so and where appropriate;

c. work closely with other PCN-based roles to help address the potential range of biopsychosocial needs of patients with mental health problems. This will include the PCN's MDT, including, for example, PCN clinical pharmacists for medication reviews, and social prescribing link workers for access to community-based support; and

d. may operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and the mechanism of booking between the PCN and the provider.

B14.3. A PCN must ensure that the postholder is supported through the local community mental health services provider by robust clinical governance structures to maintain quality and safety, including supervision where appropriate.

B.15. Advanced Practitioners

B15.1 Advanced Practitioners are designated to the Network Contract DES roles for Clinical Pharmacists, First Contact Physiotherapists, Dietitians, Podiatrists, Occupational Therapists and Paramedics.

B15.2 Where a PCN employs or engages an Advanced Practitioner as outlined in B15.1 under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Advanced Practitioner:

a. has a master's degree level in the relevant area of expertise;

b. is working at a master's level aware 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 competencies[94],

in order to deliver the key responsibilities outlined in section B15.

B15.3 Where a PCN employs or engages an Advanced Practitioner under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Advanced Practitioner has the following additional key responsibilities to those outlined in the relevant section of this Annex B, in delivering health services:

a. assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team;

b. manage undifferentiated undiagnosed condition and identify red flags and underlying serious pathology and take appropriate action;

c. use complex decision making to inform the diagnosis, investigation, complete management of episodes of care within a broad scope of practice;

d. actively take a personalised care approach and population centred care approach to enable shared decision making with the presenting person; and

e. complete 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.

[94] Multi-professional framework for advanced clinical practice in England