



Primary Care  
Network  
NHS Confederation

# Assessing the impact and success of the Additional Roles Reimbursement Scheme

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# About us

## The NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. For more information visit [www.nhsconfed.org](http://www.nhsconfed.org)

## Primary Care Network

The Primary Care Network is part of the NHS Confederation. It supports, connects and empowers primary care members to maximise the impact they have on patient care and drive change. For more information visit [www.nhsconfed.org/primary-care](http://www.nhsconfed.org/primary-care)

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# Foreword



**Professor Aruna Garcea**  
**GP and Chair**  
**Primary Care Network**

The NHS has been through a lot since 2019, when primary care networks (PCNs) and the Additional Roles Reimbursement Scheme (ARRS) were introduced. The achievement of exceeding 50 million appointments and beating the 26,000 new staff recruitment goal cannot be overstated. In spite of the challenges, primary care has recruited over 34,000 new patient-facing staff and met the target to provide an additional 50 million appointments four months ahead of schedule. The success of the scheme is more than simply delivering on the ambitions, but primary care consistently going above and beyond to deliver for patients.

However, to build sustainable general practice and deliver on the new ambitions of the NHS Long Term Workforce Plan, progress cannot stop now. Primary care still faces challenges from high levels of demand, unfit estates and the race to get the right digital infrastructure in place.

As a network, we are committed to supporting primary care to maximise its impact on patients and drive change. As part of that work, we have considered the broader future of the additional staff in primary care and their potential to support the delivery of integrated care.

# Key points

- The Additional Roles Reimbursement Scheme (ARRS) was introduced in response to government manifesto commitments to improve access and workforce pressures in primary care. The scheme has begun to address many of the long-term challenges facing primary care and has successfully met every target set in 2019.
- The benefits of the ARRS are evidence that the new roles have a place in the future of primary care. But continued success will require more than simply renewing the scheme. This report explores the views of Primary Care Network members on the ARRS so far and the challenges and opportunities it presents. It also considers priority actions for the future to ensure the scheme continues to make a positive impact on patient care, access pressures and integration.
- ARRS staff can, and have, supported and enabled the development of new ways of working, such as multidisciplinary working and integrated neighbourhood teams in primary care and should be supported to continue this role. Flexibility for local leaders to select the roles they need will be key to the future of the ARRS and the continued development of new services which are tailored to local needs.
- The existing ARRS workforce has been assured as part of the PCN Direct Enhanced Service for 2024/25, but to provide stability, primary care leaders are looking for commitment beyond 2025.

- The scheme currently provides insufficient funding for supervision or training. These must be addressed in any future iteration of the scheme to ensure it remains financially sustainable for PCNs.
- By tackling workforce recruitment challenges in isolation (without structural enablers such as estates and digital or retention/professional development) an opportunity for a more thorough intervention was missed.
- ARRS staff are a new pool of staff to primary care, but they are often working elsewhere in the system and as such recruiting into primary care risks increasing competition or exacerbating workforce challenges in other sectors. A long-term approach to workforce improvement requires greater cross system integration.

# Background

The Additional Roles Reimbursement Scheme (ARRS) was launched in 2019 as part of the government’s manifesto promise to improve access to general practice. The government committed to funding an extra 50 million general practice appointments by 2024 and to increase the staff available across primary care to increase capacity to deliver the additional appointments.

In addition to clinical staff, the manifesto included aims to extend social prescribing, which would support patients struggling with the wider determinants of health, such as housing, poverty and isolation. The ARRS addressed this promise by including social prescribing link workers as one of the first roles available as part of the scheme. These additional staff would be able to connect primary care to other local organisations and bridge the gap between community, charity and local authority services, bringing together health and wellbeing within a general practice setting.

As primary care prepares for the 2024/25 GP contract, this report reflects on the success of the ARRS against the original aims and its progress towards overcoming existing challenges in primary care. It provides a set of recommendations for how the scheme can develop beyond 2025.

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This report reflects on the success of the ARRS against its original aims

## **At a glance: The Additional Roles Reimbursement Scheme**

In 2019 the scheme was launched with the commitment to introduce 26,000 extra staff into primary care practice by 2023/24. Initially, primary care networks (PCNs) could choose from five roles. Over time the list has grown to 17, many of which had not previously been available within primary care. PCNs can

recoup the employment costs of these roles from the scheme up to their allocated funding allowance, based on the size of the patient population. The additional staff were intended to see patients who would otherwise have seen a GP but did not require a GP intervention. As a result, GPs would have increased capacity to provide appointments to those patients who required a GP or would benefit from greater continuity of care.

To make use of the scheme, each PCN determines a baseline staff number, agreed with the commissioner. Only recruitment into additional roles above this baseline can be claimed through the ARRS. Each PCN is then assigned a 'single combined maximum sum' which is the full monetary value they can claim through the scheme. This funding covers the employment costs – including wage, pension and national insurance – of the new member of staff, in theory enabling them to be employed by the PCN without incurring additional costs to practices. PCN leaders can then determine the skill mix they need and recruit into the available roles at the most appropriate pay banding covered by the scheme.



# Setting the right goals

As stated in our vision for at-scale general practice, the success of any plan for the future of primary care depends on its ability to positively impact workload, to diversify and retain the workforce while also tackling physical and digital infrastructure challenges. To achieve this, any scheme should target these areas and their enablers.

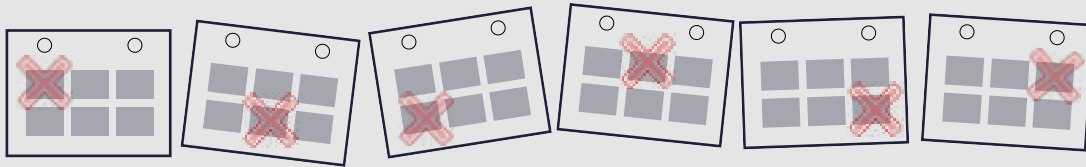
The infographic on page 10 highlights progress to date against key targets.’

# Progress against key targets



## Deliver 50 million more appointments\*

– met by 30 November 2023



The target will be further surpassed by the end of March 2024, demonstrating even greater success than initially promised in the 2019 manifesto.



## Recruit 26,000 ARRS staff\*

– achieved in March 2023

**34,000** staff  
in place



Patients have **access to a range of practitioners** which **do not require a referral** from a GP.

**Workforce continues to grow**, providing **vital support to primary care** at a time **when GP workforce is shrinking**.\*

However, recruiting staff from other sectors in primary care has started to create competition and shortages in high-demand staff, including mental health practitioners, paramedics and clinical pharmacists.



## Expand social prescribing

– significant growth by September 2023

**3,001** FTE  
**0** social prescribing  
link workers (SPLW)



The SPLW role into primary care was welcomed by members, who were seeing a growing number of patients presenting with non-health issues.

However, recruitment has been hampered by lack of understanding of its function and benefits on patient health. Evidence for the health impact of social prescribing is growing,\* but further support for the role to flourish is required.

# Measuring success

## Access

In 2019, access was identified as a growing issue for patients and stretched staff within general practice. 308 million appointments had been delivered in 2018, rising to 312 million in 2019 when the manifesto and ARRS were announced. This large growth in appointments indicated a rise in demand, just as patient satisfaction was decreasing. Therefore, it was vital to target access to relieve the growing pressure on the workforce. Workforce is a key enabler of improving access, so the scheme was welcomed by primary care providers.

But tackling workforce issues in isolation meant an opportunity was missed to build a comprehensive plan. The Fuller stocktake has since emphasised the importance of estates and digital (in addition to workforce) as the enablers for creating the capacity for wider improvements led by local decision-making. Our work on designing the future of primary care through our Design Groups has recognised access as an outcome of enablers, including workforce. The ARRS was not a standalone solution to this problem.

Increasing the primary care workforce through the ARRS has improved access to general practice, providing over 50 million more appointments in 2023 than in 2019. While demand and pressure remain high, an additional 31,000 roles joining primary care has allowed providers to run additional appointments and extend existing services. The increase in skill mix within primary care teams has also allowed new services to be provided in primary care settings for the first time. Across the country, patients can now access services such as menopause, learning difficulties and

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The increase in skill mix has allowed new services to be provided in primary care settings

asthma clinics staffed and supported by ARRS practitioners. The number of additional clinics vary across the country and challenges such as estates and workforce shortages prevent some providers from expanding their offer.

The new roles have also supported access improvements by simplifying pathways for patients. The increase in first-contact staff, who can see patients without a GP referral, alongside improved triage through the introduction of care coordinators and digital services in general practice, allows patients to book directly into appointments with the right practitioner for their needs. Where this is done well, and supported by effective triage and staff training, patients can see the right practitioner at the right time without needing to be referred by a GP. However, first-contact practitioners and care coordinators alone cannot create improved pathways. For providers without effective triage procedures and tools, this process can lead to inappropriate bookings and waste more time.

## Case study: Well Up North PCN, Northumberland

Well Up North PCN employs five first contact MSK practitioners who work across ten practices and provide appointments which patients can book into directly by ringing their practice or using the e-consult service. Prior to the establishment of the service, only one practice had MSK provision and patients would require a referral to other services.

This service streamlines patient experience without compromising patient safety because of the robust supervision, note-taking and communication protocols in place that ensure any patients who do need to see a GP are referred as soon as possible. Patient and staff feedback is positive and the service delivers over 1,000 appointments a month which would otherwise need to go through a GP for referral.

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At a time when access pressures are extremely high, additional direct-to-patient services provided by ARRS roles are reducing unnecessary GP appointments and making it simple for patients to see the right practitioner as soon as possible.

## Multidisciplinary approach to patient care

In 2015, general practice was facing a GP shortage and the government pledged an additional 5,000 GPs to bolster the workforce. However, GP numbers continued to decline and the 2019 commitment to supporting general practice with non-GP staff was an innovative approach to increasing appointments and addressing the pressures on the GP workforce. Moreover, the design of the scheme to allow primary care leaders to select which of the available roles to recruit was a positive step towards letting local leaders lead and tailoring services to local demand. It is through local knowledge of the population and service design that innovation and population-focused care can thrive. The ARRS is a key example of setting policy which empowers local leaders to build teams and services which meet local need.

ARRS staff bring a new range of skills and expertise to primary care which can be used to support patients with a diversity of care needs. For example, they have contributed to the expansion of bespoke multidisciplinary teams (MDTs), including frailty teams, mental health and wellbeing, and long-term conditions. These MDTs improve patient care and support peer learning by bringing practitioners together to share knowledge, expertise and design person-centred care plans. This can also reduce GP workload as GPs are able to act as an expert generalist providing oversight for any care plans created as part of MDTs. When supported by strong lines of communication back to the GP, this can enable effective management of a patient's health without additional GP interventions.

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The design of the scheme was a positive step towards letting local leaders lead

Our members are also exploring how they can learn from MDT models in countries like [Brazil and the Netherlands](#) to build on the range of skills provided by the ARRS staff. By taking inspiration from global models, our members are broadening the horizons of holistic, patient-centred care and redefining the relationship between clinical and non-clinical care.

To maximise the diversity of skills and learning potential of MDT working, the importance of building a cohesive team [cannot be overstated](#). Without a genuine team culture and cohesion between those involved, the team will experience significant strain and have limited positive impact on staff and patients.

## Case study: Leyton Collaborative PCN, London

Leyton Collaborative PCN uses its ARRS staff to support frailty-focused MDTs which aim to proactively manage the PCN's Ageing Well cohort who experience mid to mild frailty. Once the cohort has been identified, the MDT delivers interventions by reaching out by telephone to potentially frail patients and following up at one, three, six and nine weeks after the initial contact. An additional call is made at 12 months to ensure that a patient's long-term health is also supported.

They have established a multi-agency and multidisciplinary team including care coordinators, social prescribing link workers and health and wellbeing coaches employed as part of the ARRS. The MDT reviews patient needs and helps them to access services and manage their own health and wellbeing. Each role in the MDT supports a different area of the patient's health, wellbeing and experience of the health and care system, ensuring that they receive effective and holistic care which takes into account the full context of the patient.

## Strengthening collaboration across sectors

While the ARRS has increased competition and concerns about the availability of practitioners including paramedics, pharmacists and mental health practitioners, it has also provided opportunities for greater collaboration. Rather than viewing other providers as competitors for a small and in-demand workforce, some of our members have shared their success in creating shared workforce arrangements and developing relationships with system partners. These relationships support the sustainability of employing additional roles in primary care and lay the foundations for further integration.

Some of the most successful agreements see staff rotate through primary and secondary care at agreed intervals to prevent the workforce being depleted. These agreements work best at scale where the interface between primary and secondary care can be simplified, with at-scale primary care providers providing a single point of contact, and a smaller workforce can be deployed across a larger area, reducing duplication. However, these arrangements are still rare and can be challenging to establish.

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The ARRS has provided opportunities for greater collaboration

### Case study: Valens PCN, Northumberland

Workforce has always been a priority in primary care and Valens PCN saw the potential in extending multidisciplinary working to include system partners. The PCN had recruited heavily into ARRS roles and dedicated time to developing MDTs and partnerships with local organisations that could support their ARRS staff to support patients.

Working with key partners in adult social care, mental health and in the community has enabled Valens PCN to collaborate on the delivery of new multidisciplinary models of care. For example, a daily frailty MDT has been in operation since late 2020 to provide a proactive approach to managing the care

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of elderly patients and reducing hospital readmission. In this model, care is retained in the community or transferred from secondary to community-based care within a structured framework and supported by robust pathways. This structure allows the team to feel connected and supported to flourish, leading to true integrated, collaborative working as well as supporting future workforce development by using PCN additional roles such as social prescribing for maximum benefit.

## Case study: Merton Health Limited and London Ambulance Service, London

Having identified the need to recruit paramedics to deploy within their PCNs, in 2020 Merton Health Limited (MHL) reached out to London Ambulance Service (LAS) with a proposal to recruit and subcontract paramedics to the federation. As a result of discussions with LAS they agreed to recruit 12 0.5 WTE band 6 paramedics (six WTE) across six PCNs as part of a six-month pilot during which the paramedics would work 50 per cent of their time for the PCN and 50 per cent with LAS on two-week rotations.

With 12 paramedics, there was always one paramedic available to the PCN as part of this rotational model. Once the paramedics were recruited, LAS provided monthly peer support and supervision, as required by the ARRS reimbursement specifications, as well as maintaining responsibility for annual leave and rota management.

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The pilot saw a 50 per cent reduction in rapid response visits and a 50 per cent reduction in referrals to the CLCH rapid response service during the same period.

The pilot was a success. MHL and LAS have continued to develop the rotational paramedic model and expand into new services.

## Integration and progress towards integrated neighbourhood teams

In our [vision for primary care](#), we stated that: “Integrated neighbourhood working requires partners across a community to come together – with local citizens at the centre – to find solutions to local health and care needs, looking beyond the medical model of care to wider determinates of health”. One of the key steps in bringing partners together is building a shared workforce. This collaboration can then develop into successful integration as staff are no longer siloed, but part of a larger, cross-sector team to provide wraparound care across a geographical area.

Staff such as clinical pharmacists, mental health practitioners and paramedics present opportunities for building integrated teams with system partners, while non-clinical roles like social prescribing link workers are already forging relationships beyond the health service and with citizens to bring new expertise and valuable community level insight into the design and delivery of better care. These connections represent a vital step towards integrated teams at different scales by building the relationships necessary to forge new ways of working.

## Case study: Alliance for Better Care – social prescribers supporting communities

In Surrey and Sussex, the Alliance for Better Care, a GP federation, has recruited 20 social prescribers to work across all their PCNs to liaise with patients to understand their needs and deliver personalised care. They explore the wider determinants of health alongside their patients to help make improvements and offer support where it is needed. This includes:

- A bereaved men's group in response to social isolation and bereavement from the pandemic. This is a peer support group that meets once a month.
- An initiative aimed at tackling neighbourhood health inequalities, by focusing on young families. The aim is to ensure families are aware, and make best use, of all the health and support services that are accessible to them.
- Offering wider wellbeing support offer to refugees and asylum seekers in hotels around the area. This has included personal training in hotels as well as planned trips to Crawley Football Club.

## Optimising economies of scale

The ARRS was established to provide staff to work at PCN level as the at-scale benefits to resource sharing were already recognised. Moreover, growing the primary care workforce at neighbourhood and place is key to improving the resilience of primary care. Initially ARRS staff were expected to operate at the 30,000–50,000 population level. However, in response to local need, to improve equity of access, and strengthen career opportunities, many areas have been able to optimise ARRS by deploying them into services

at a bigger scale across a place level. This increase in scale improves equity of access to ARRS appointments by providing the same service to a larger area and reducing the impact of a shortage of specific roles in some PCNs. Where some PCNs have found it difficult to recruit into certain roles, sharing staff at place level improves access to the full skill mix available in the scheme.

One of the shortfalls of the scheme is the lack of built-in career progression for additional staff. The ARRS itself does not support upskilling staff and/or career development and it is most likely that staff will move to new roles with other providers. At-scale providers like GP federations and larger PCNs can draw on the strength of a larger team with more opportunities for learning and develop in-house career pathways. Some members have even benefited from upskilling existing ARRS and moving them into higher bands where they could provide supervision support to new staff members.

An at-scale approach to employment also reduces the overall administrative burden of recruitment, HR and management by having a single employer which manages the needs of all staff within that patch. Many GP federations have been providing this service for a number of years thereby freeing up PCN resources.

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An at-scale approach to employment reduces the administrative burden of recruitment, HR and management

## Case study: Bolton GP Federation

While the ARRS is structured in such a way that all staff recruited as part of the scheme must be employed by a PCN, many PCNs have partnered with their GP federation to employ ARRS staff on their behalf and deploy them at a greater scale. Bolton GP Federation supports seven PCNs in Bolton and has demonstrated several innovative methods of supporting their PCNs through subcontracting and managing their ARRS staff.

The federation coordinates the enhanced access provision for their partner PCNs and is able to coordinate the workforce required by drawing from the full range of ARRS employed

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across those PCNs. Each PCN determines the skill mix they require for their portion of the enhanced access offer, and the staff are managed and deployed into the service by the federation. This frees up PCN time and reduces duplication of effort, in addition to reducing variation in service for patients.

Moreover, in 2022, following a successful bid for some ARRS underspend in the system, the federation was able to employ physician associates (PA) to deliver a cardiovascular disease quality improvement project. Each PA conducted their project at PCN level so that each PCN would have results tailored to their population and needs, but the overarching programme was coordinated by the federation.

## Easing pressure in secondary care

The increased capacity and skill mix that the ARRS has brought to primary care has supported patients to receive care close to home when they may otherwise have had to be referred into secondary care. Moreover, many of our members have demonstrated that this has reduced the pressure on secondary care and freed up capacity for patients who require those services. The additional appointments provided by the ARRS staff also provides patients with more opportunities to access primary care, which can reduce the number who present at emergency departments.

### Case study: Central Thistlemoor PCN, Peterborough

Central Thistlemoor PCN engaged in a population health management project to identify high frequency primary and emergency care users and to identify potential interventions to reduce A&E attendance. The PCN identified 400 patients who accessed emergency departments (EDs) more than twice a

year and general practice ten times or more but had no long-term conditions.

On review this cohort on average contacted the practice 20 times a year and attended ED five times a year. The team reached out through text messages and phone calls to help engage the cohort and provide support. A team of staff who were trained on motivational interviewing spent around an hour with each patient finding out what mattered most to them. Patients who engaged are now supported by a variety of practitioners, including their GP, health and wellbeing coaches and social prescribers who are supporting them with their health and wellbeing.

Forty-five per cent of patients who engaged with the PCN were referred to social prescribers, who signposted them to services which offer non-medical support. Presentations at ED by this cohort dropped by around 30 per cent and general practice attendance by 75 per cent.

## Ongoing challenges

While the ARRS has successfully met its targets, providers have experienced challenges and limitations in engaging with the scheme. To build on the success of the first five years, future policymakers should learn from the experiences of primary care leaders and address the wider determinants of successful workforce expansion and the challenges of introducing new roles into a traditionally independent sector.

# A whole-system approach to workforce planning

Recruitment is a key challenge for many providers, with significant variation across the country. While key indicators like deprivation and rurality affect recruitment to GP roles, there is limited evidence for what impacts ARRS staff recruitment. This suggests that further research into what influences shortages of particular roles within a system would enable each system to identify, and potentially address the issue at scale rather than leaving each provider to tackle the problem in isolation. Furthermore, ongoing implementation of the recently published NHS Long Term Workforce Plan should actively consider the needs and capacity of the ARRS workforce.

ARRS has introduced new roles to primary care, but they do not exist in a vacuum. Rather, each member of staff comes from a pool of potential staff shared with other sectors, including community pharmacy and mental health. For each new staff member recruited to primary care, there is potentially one less available to other parts of the system. This has created local challenges and tensions in addition to widespread operational pressure in community pharmacy.

Workforce sharing and joint recruitment has its challenges. For example, the mental health practitioner (MHP) role has been beset by challenges including workforce shortages, difficulties navigating the requirement for 50 per cent of funding to come from a mental health trust and supporting a large patient population as the sole practitioner in many cases.

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ARRS has introduced new roles to primary care, but they do not exist in a vacuum

The funding requirement was introduced to deliver a more integrated approach to out-of-hospital mental health care. This was among the first measures to mandate this level of collaboration. While some areas have found the process challenging, others have reported the benefits of the time and effort to get the right arrangements in place. Setting up the support available for MHPs and ensuring the job requirements are correct is often a joint consideration and requires good working relationships between the trust and primary care.

As there is a shortage of MHPs available to trusts and primary care, and the funding requirement is not always feasible for one or both partners, tensions have arisen when funding or staff have not been available, and in those areas the relationship between primary care and the trust risks being eroded. In these scenarios, alternative solutions are required. Members have reported the success other roles have had, including health coaches, occupational therapists and social prescribers, in supporting a patient's mental health. Ultimately, however, they recognise that access to an MHP has the greatest impact. Exploring alternative methods of employment such as rotations, building integrated cross sector teams, and other solutions co-designed with the local context in mind would reduce pressure on staff to cover a large area alone, and reduce potential complications around funding and recruitment.

### **Recommendation**

Shared funding commitments for roles like mental health practitioners should be evaluated and, where necessary, enable alternative contracting and funding arrangements co-designed between primary care and mental health providers.

Now that there is a growing and diversified workforce pool in primary care, it is essential that this is better connected to other system partners. This would support the growth of multidisciplinary teams into teams of teams that provide wraparound care to the local community. PCNs and GP federations that already have ARRS staff working across a neighbourhood footprint have developed the blueprints for this kind of integration, but they need to be supported by the freedom to develop flexible contracts and design services that enable effective integration beyond the boundary of primary care.

### **Recommendation**

At-scale HR and employment support for ARRS staff has been a demonstrable success and providers should be encouraged to explore potential at-scale support in their area.

While the number of available roles has grown, caps on the number of certain practitioners which could be employed has felt arbitrarily restrictive as it does not account for local need, or availability of that workforce. Each year the increase in the number of advanced practitioners which could be employed has been welcomed, and the 2023 decision to remove the cap on the mental health practitioner role has allowed providers greater flexibility and autonomy to build MDTs around the available staff and the needs of patients. This trend towards increased flexibility and autonomy should continue to support wider MDT working.

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The trend towards increased flexibility and autonomy should continue



## Recommendation

Ensure increased ARRS flexibility to allow primary care to determine their workforce needs within the funding available, including the number of practitioners which are funded and the flexibility to contract and deploy where most appropriate.

## Finance

The ARRS has a fixed budget with indicative pay bands for each role. PCNs have pay flexibility within the band to balance skills and experience with cost to get the most out of their allocation of the fund. Providers that recruit at the top of the pay bands often do so to provide a financial incentive for roles in short supply in their local area. This often solves the immediate recruitment issue, but can increase competition between providers.

Moreover, in recent years, ARRS staff have been eligible for pay rises in line with the Agenda for Change pay uplift. Funding for these uplifts has not kept pace with inflation and has remained within the five-year contract uplift – as a result PCNs that have recruited at the top of pay bands, and those that have used their whole ARRS allocation struggle to meet the additional costs. Where an organisation has used their full allocation, employers have to find funds from elsewhere by cutting other services or reducing investment in improvements. Centrally funded increases to NHS salaries outside of primary care has led to recruitment challenges within the sector and could be addressed with the inclusion of pay uplift clauses in the PCN Direct Enhanced Service.

Furthermore, the current scheme does not provide provision for benefits such as maternity or sick pay, meaning many potential staff are discouraged from moving to primary care. Larger PCNs and federations are more likely to be able to optimise scale to

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ARRS staff have been eligible for pay rises in line with the AfC pay uplift

offer greater benefits, but the disparity between larger and smaller providers risks exacerbating a growing two-tier system for staff in primary care with different terms and conditions. For primary care to continue to attract new staff, there should be support to achieve financial and contractual parity with the rest of the NHS and address the challenge of financial resilience within current contracts.

While employment costs for the additional roles are covered, many employers have found that they face further costs such as IT provision (both kit and extending licenses), as well as ongoing training. This can pose a disproportionate financial challenge to smaller providers with a lower overall budget and fewer contracts for additional services. 2023 was the first year that training time for first-contact practitioners was included in the scheme and members received this support with enthusiasm as it took pressure off already stretched budgets.

### **Recommendation**

Further work is required to align primary care contracts and funding to the rest of the NHS to ensure that primary care remains equipped to support a greater shift to out of hospital care. This would also ensure that primary care is seen as an attractive employment prospect in line with the benefits and pay uplifts available in the wider system.

## Supervision

[NHS England guidance on ARRS](#) explains the GP supervision requirements for each role to ensure patient safety and provide support to ARRS staff. However, this support takes time to do well and is inadequately reflected in the funding allocation. In a small

organisation, it can be difficult to find additional funds or available staff for supervision, and practices in deprived areas experience disproportionate GP shortages which would compound the issue and leave them less likely to be able to meet the supervision levels required to take on new staff.

Including provision for supervision in future funding models would ensure that ARRS roles are embedded effectively, lead to improved patient care and provide job satisfaction for individuals. This provision also presents an opportunity to improve GP retention, as members have shared their success in retaining GPs in supervision roles as an alternative to retiring. This keeps them in the workforce and reduces the number of hours of GP clinical time that are lost to supervision.

Not only is clinical supervision by a GP a requirement, it also offers some development and learning opportunities. For all staff, working with mentors (whether this be GPs or other more senior practitioners) supports their development and illustrates potential career pathways. This is particularly the case for roles like paramedics and MHPs that often find themselves the sole practitioner in their PCN. Mentorship or supervision from a practitioner within their discipline would reduce professional isolation and provide peer support. Ensuring that all roles which provide mentorship and supervision are recognised in ARRS guidance will be key to increasing the provision of this offer across the country.

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Clinical supervision by a GP offers development and learning opportunities

### **Recommendation**

Future funding models should include provision for the supervision, training and ongoing personal development required to retain and improve the workforce.

## Estates

A key challenge of successfully implementing ARRS from the outset has been the lack of infrastructure to support the additional staff. The most significant infrastructure limitations have been estates and IT as many providers have struggled to house their new staff and ensure they have effective IT solutions to connect to the wider team.

In May 2023, the RCGP reported that nine in ten practices did not have enough consultation rooms and two in five staff who responded to the survey believed that their premises were not fit for purpose. Our members have also shared their own difficulties in providing sufficient consultation space, influencing our network's ongoing recommendations for prioritising primary care inclusion in any future national estates plan.\* To combat these limitations, employers are working creatively to introduce hot desking or hybrid working solutions which allow staff to rotate through available space or work remotely where appropriate to do so. While these solutions can improve the issue in the short term, some are unsustainable in the long term and the NHS Confederation has already called for improvements to capital funding and investment in urgent areas such as estates. Primary care estate investment has lagged behind other sectors in the last decade and was not addressed as part of the access recovery plan.

### Recommendation

Greater investment in primary care capital for estate and digital as part of the upcoming national estates plan and ongoing commitments to improved capital funding.

\* See NHS Confederation (2021), Primary Care Networks: Two Years On. Rankine, R (2023), A Year On From the Fuller Stocktake, NHS Confederation. NHS Confederation (2023), Primary Care Recovery Plan: What Primary Care Leaders Need To See. NHS Confederation (2023), Empowered, Connected and Respected: a Vision for General Practice At Scale and Primary Care Networks.

## Data and digital innovation

To embrace innovation and deliver increased options for patients, our members have reported that digital innovation and IT improvements have proved vital to the implementation of the ARRS. Digital infrastructure for virtual appointments, working across practices, can optimise hybrid working, enable relevant practitioners to access patient records, and expands the access options available to patients. This must also be supported by improvements in triage which ensure patients get the right support first time and in a way that is simple for patients to understand and access.

Primary care data remains problematic with inconsistency of recording and under-reporting. National systems like the GP Appointments Data (GPAD) Dashboard do not track the full scale of activity in primary care. To accurately assess activity, demand and capacity, data collection needs to be improved with greater consistency in how activity is recorded in systems. Data improvements are also required to support continued workforce development and planning, for example, the ability to have data on attrition rates of ARRS staff. Developing the current primary care workforce dashboard to provide additional information, such as attrition rates, would enable issues to be addressed at a national level.

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Data collection needs to be improved to accurately assess activity, demand and capacity

### Recommendation

Expand support to commission digital solutions at scale to enable integrated working across the health service and reduce unwarranted variation.

Develop the primary care workforce dashboard to support tracking workforce development including staff turnover on a national scale.

## Patient education

The introduction of new roles into primary care has required a cultural shift not just for staff in primary care, but for patients. While there are many models for delivering primary care, they have all traditionally been GP led and patients often still expect to see a GP first. For patients and practices, the role of a GP remains vital to providing clinical leadership, supporting patients with complex symptoms, and providing continuity to those who need it.

However, with the development of MDT working and the growing skill mix in primary care, patients are often unaware that they can see a different practitioner more suited to their needs. Engaging patients in the development of new services, and ensuring they understand the pathways available will help patients make informed decision about their own health and care needs and strengthen the trust between professional and patients.

### **Recommendation**

Raising patient awareness of, and confidence in, multidisciplinary primary care is essential. The national education campaign on the roles available in primary care must be continued and integrated care systems supported to increase tailored campaigns at local level.

# Conclusion: the future of the ARRS

Ultimately, the ARRS scheme has met its key targets and delivered improvements to access, workforce pressures, and the range of services available direct to patients. The benefits of the scheme are evidence that the new roles have a place in the future of primary care, but continued success requires more than simply renewing the scheme.

Primary care and its partners have adapted to the new ways of working required to make a success of the new roles, but they are working against challenges that, if resolved, would enable further progress. The sustainable future of primary care, as envisioned by our network, will require further workforce development to be supported by policy which recognises its interconnected enablers and focuses on sustainability.

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The new roles have a place in the future of primary care

## Creating conditions for success: our recommendations

- Ensure increased ARRS flexibility to allow primary care to determine their workforce needs within the funding available, including the number of practitioners that are funded and the flexibility to contract and deploy where most appropriate.
- Future funding models should include provision for the supervision, training and ongoing personal development required to retain and improve the workforce.

- Greater investment in primary care capital for estate and digital as part of the upcoming national estates plan and ongoing commitments to improved capital funding.
- Further work is required to align primary care contracts and funding to the rest of the NHS to ensure that primary care remains equipped to support a greater shift to out-of-hospital care. This would also ensure that primary care is seen as an attractive employment prospect in line with the benefits and pay uplifts available in the wider system.
- At-scale HR and employment support for ARRS staff has been a demonstrable success and providers should be encouraged to explore potential at-scale support in their area.
- Expand support to commission digital solutions at scale to enable integrated working across the health service and reduce unwarranted variation.
- Raising patient awareness of, and confidence in, multidisciplinary primary care is essential. The national education campaign on the roles available in primary care should be continued and integrated care systems supported to increase tailored campaigns at local level.
- Develop the primary care workforce dashboard to support tracking workforce development including staff turnover on a national scale.
- Shared funding commitments for roles like mental health practitioners should be evaluated and, where necessary, enable alternative contracting and funding arrangements codesigned between primary care and mental health providers.



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