The Queen's Nursing Institute
International Community Nursing Observatory

ARRS Workforce Impact Survey

The impact of the introduction of the Additional Roles Reimbursement Scheme (ARRS) on the General Practice Nursing workforce in England

The Queen's Nursing Institute's International Community Nursing Observatory

The QNI launched the International Community Nursing Observatory (ICNO) in November 2019.

The ICNO analyses data and trends in the community nursing workforce data in greater depth, to aid understanding of the challenges faced by services. It will collate and analyse data about community and primary care nursing services at a regional, national and international level.

Professor Alison Leary MBE, Chair of Healthcare and Workforce Modelling at London South Bank University (LSBU) and a Fellow of the QNI is Director of the ICNO.

The idea behind the foundation of the ICNO originated from an independent strategic review conducted in 2018 by executives at Barclays Bank plc, through the 'Unlocking Insights' programme, led and managed by the charity Pilotlight. The 'Pilotlighters' at Barclays highlighted that data relating to the community nursing services workforce is often incomplete and this leads to barriers which prevent the progression of policy development, service enhancement and improvements to the care of individuals, families, carers and communities.

The ICNO seeks commissions designed to support data gathering and analysis that will provide evidence to enhance service planning and delivery in health and social care settings.

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Authors: Professor Alison Leary MBE and Dr Geoff Punshon.


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‘The attainment of national and global health goals can be achieved only with a health workforce that is adequate in number, distribution, skills, motivation, and performance.’

Summary of findings

- The introduction of ARRS roles was a major workforce change with little or no consultation with GPNs despite potentially impacting on their work.
- Inequitable pay and conditions were reported. ARRS colleagues were reported to be on higher Agenda for Change banded salaries and have more access to professional development.
- Work/care previously done by GPs/GPNs was shifted to ARRS colleagues that they could not complete due to lack of knowledge, skill, being out of scope, regulatory issues or unfamiliarity with context (primary care). This meant care was left incomplete with GPNs having to perform rescue work, complete the episode of care or teach colleagues. This was most commonly reported in the management of long-term conditions.
- ARRS roles contributed positively to distribution of work and clinical outcomes/quality of care when used in context of professional expertise, for example mental health nurses, pharmacists undertaking medicines reviews, dietitians offering an extra service previously not available. When roles were used out of normal context and jurisdiction, they impacted on workload of GPNs as ARRS professionals were seeking more advice, support and leaving work incomplete.
- The introduction of ARRS roles appears not be based on demand but rather availability/funding. The scope and design of roles appears to be largely unexamined. The roles appear to be implemented to fill a deficit in already established roles (GPs and GPNs) rather than as an additional value-added role arising from workforce/work redesign.
- Role creep and the burden of supervision, particularly for Trainee/Nursing Associates was a recurring theme.
- GPNs felt that more people delivering care who could not complete episodes of care led to more taskification, task orientated, disjointed care, repetition of work (for workforce and patients) and subsequent risk as care was fractured.
- Perception of disinvestment/devaluation of nursing was a recurring theme. Low morale was reported because of this.
- There were high expectations and assumptions from employers that GPNs would support, educate, and supervise roles but without consultation or the provision of extra resources.
- Resources and support are required to support even experienced professionals adapting to working in primary care.

Introduction

The attainment of national and global health goals can be achieved only with a health workforce that is adequate in number, distribution, skills, motivation, and performance. This has been formally recognised by the inclusion of a ‘health worker density and distribution’ indicator within the monitoring framework for the sustainable development goals by the United Nations (UN 2017).

Change in the workplace affects the workforce. Major changes should be assessed for potential impact on the workforce. Such changes should not disadvantage the workforce in terms of

investment, labour and equality (WHO 2016). Workforce impact assessments (WIA) can clarify the potential or actual impact of major changes on the workforce and act as a meaningful form of workforce engagement, however they are either rarely used in healthcare or used partially or inconsistently (Nove et al 2017).

A General Practice Nurse (GPN) is a registered nurse who works autonomously within a Multidisciplinary Team (MDT) within General Practice (GP) surgeries as part of a Primary Healthcare Team, they screen and treat people of all ages, including babies, children and adults in addition to providing traditional aspects of nursing care such as wound care, immunisations, vaccinations, Cervical cytology sampling, ECGs and hold clinics for patients with Long Term Conditions such as asthma, heart disease and diabetes and run vaccination programmes. A key role of the General Practice Nurse is to offer health promotion advice in areas such as contraception, weight loss and smoking cessation in addition to emphasis on promoting Women's and Men's health. A key focus of their role in health promotion is to work with and enable patients to manage their health care needs. According to NHS Digital there are over 16,000 registered nurses, who deliver more than 6 million patient appointments per month within general practice, on average 84 million per annum, excluding some vaccination programmes. (NHS Digital 2023).

In 2019 the Additional Roles and Reimbursement Scheme (ARRS) was introduced into general practice in the English NHS by Health Education England. The scheme funded the salaries and in some cases costs, of 17 types of workers to expand the primary care workforce which could be ' chosen to meet the needs of local populations'(HEE 2019). These roles included care co-ordinators, pharmacists, paramedics and associate professionals such as Nursing Associates, Physicians Associates and their trainees.

It is unclear if any demand modelling was done for these types of workers' labour, but a review of the literature and exploration of the grey literature did not yield a WIA or any modelling of labour demand for this initiative. The Queen's Nursing Institute (QNI) has received several anecdotal accounts of impact on the General Practice Nursing (GPN) workforce of the introduction of ARRS. This included issues such as pay inequity and increased workloads. The work is therefore a retrospective workforce impact assessment.

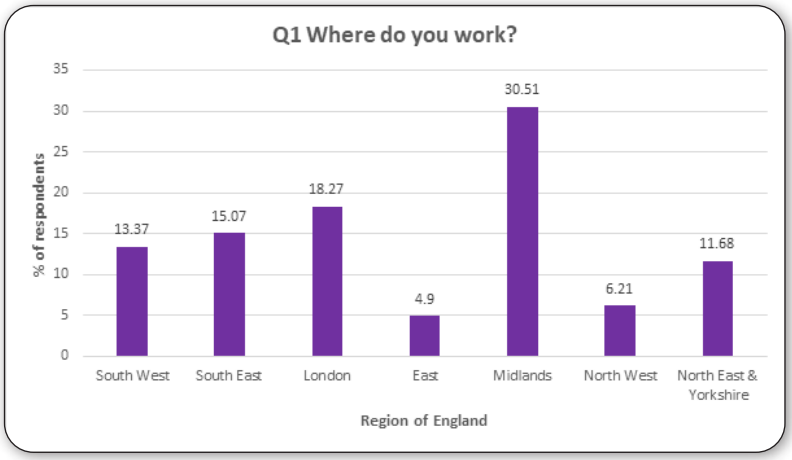
Method

A workforce impact assessment was designed and distributed as a cross sectional survey via a survey platform (SurveyMonkey). This survey was sent via the QNI to ~900 General Practice Nurses.

The survey consisted of 21 questions and resulted in 531 responses. This gives a response rate of 60%. The estimated completion rate was 76% to 100% but this included the final free text question. Data was analysed using descriptive statistics and content analysis of free text.

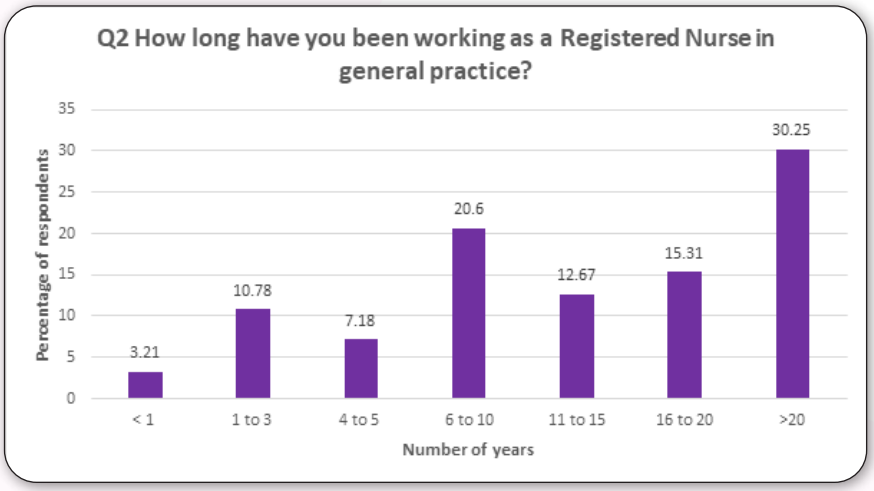
Results

Q1 Please tell us where you work? (Answered 531, skipped 0)



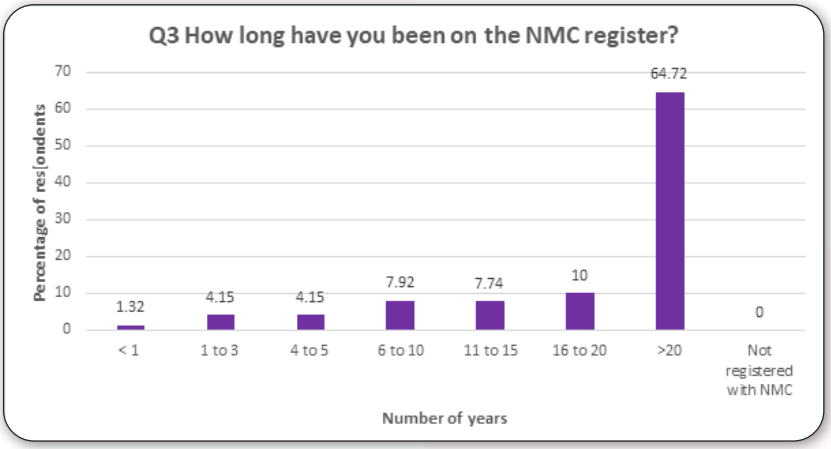
‘The scheme funded the salaries and in some cases costs, of 17 types of workers to expand the primary care workforce which could be ‘ chosen to meet the needs of local populations’ .’

Q2 How long have you been working as a Registered Nurse in general practice?
(Answered 529, skipped 2)



The most common length of time working as a Registered Nurse (RN) in general practice was over 20 years (30.25% of respondents) with a further 15.31% between 16 and 20 years. 21.17% in total of respondents had been working for 5 years or less.

Q3 How long have you been on the NMC Register?
(Answered 530, skipped 1)



64.72% of respondents had been on the NMC Register for over 20 years with a further 10% for 16 to 20 years.
In total 9.62% had been on the register for 5 years or less.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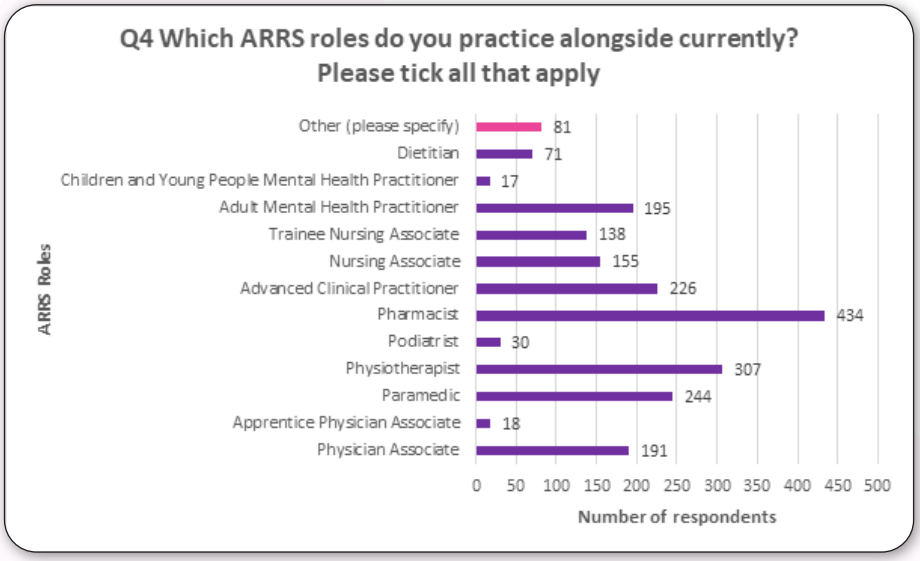
‘Work should be allocated with a focus on risk, unpredictability, complexity and acuity of the situation and not simply task competency. Situational awareness is crucial for safe care.’

Q4 Which ARRS roles do you practice alongside currently?
(Answered 525, skipped 6 (respondents could choose more than one answer)



Respondents most common ARRS role was pharmacist (434) followed by physiotherapist (307), paramedic (244), advanced clinical practitioner (226), adult mental health practitioner (195), physician associate (191), nursing associate (155) and trainee nursing associate (138).

None of the other roles had over 100 responses. The three most common ‘other’ responses were social prescribers (22), health and well-being coaches (18) and care co-ordinators (13).

The 81 ‘other’ responses were as follows:

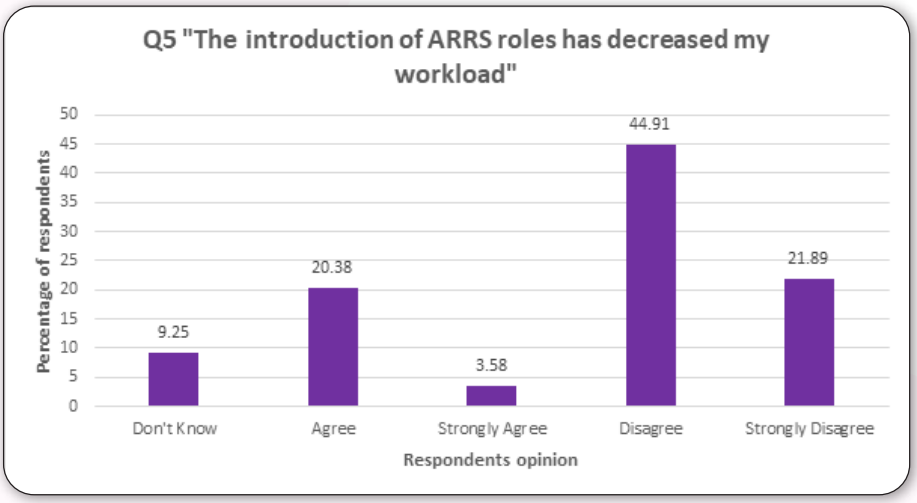
Role	Respondents
Social prescriber	22
Health and Well being coach/worker/trainer	18
Care coordinator	13
Practice nurse	7
HCA	5
Pharmacy Technician	5
Occupational Therapists	4

Advanced Nurse Practitioner	3
Diabetes Specialist Nurse	2
Enhanced Nurse practitioner/community	2
General practice	2
GP Assistant	2
MSK practitioner	2
Pharmacist assistant	2
Assistant Nurse Practitioner	1
Clinical GPA	1
Dental Hygienist	1
Diabetes champion	1
GP	1
Link worker	1
Living better nurses	1
Mental Health Coach	1
Mental health practitioner	1
Mental health support worker	1
Mental health worker	1
Neighbourhood practitioner	1
Non-medical prescriber	1
Paediatric Trainee Clinical Practitioner	1
Physio	1
Specialist Nurse Practitioner	1
Trainee Advanced clinical practice	1
Trainee GPs and FY1	1
Trainee nursing associate	1

‘Initially when the money was first released there was an explosion of new positions and roles, however many of these people had never worked in Primary Care, the support and training needed was provided retrospectively and, in my opinion, has been insufficient.’

We asked participants about perception of impact on workloads:

Q5 The introduction of ARRS roles has decreased my workload
(Answered 530, skipped 1)



In total 23.96% (3.58% strongly) of respondents agreed with the statement ‘The introduction of ARRS roles has decreased my workload’.
66.8% (21.89% strongly) disagreed with the statement.
9.25% of respondents elected for don’t know.

The free text was completed by 113 respondents.

Although ARRS colleagues can see some of the patients the GPN would have seen, colleagues needed support, particularly those new to General Practice.

In terms of workload, although this could be shared with ARRS colleagues such as long-term conditions, reviews were from the perspective of that professional group and so much of the holistic work was not done:

‘They will see long term conditions patients but leave complicated patients especially in diabetes to the GPN very often no follow up dates have been booked or even bloods.’

Referrals to areas outside expertise such as complex MSK or mental health were helpful in terms of a positive impact on GPN workloads and patient benefits:

‘I now have other colleagues I can refer patients to that are more knowledgeable and can enhance the care I am providing my patients.’

ARRS roles seeing patients but only completing part of the work, for example leaving follow up not done or not requesting bloods due to not being familiar with care was seen as generating more work and increased risk:

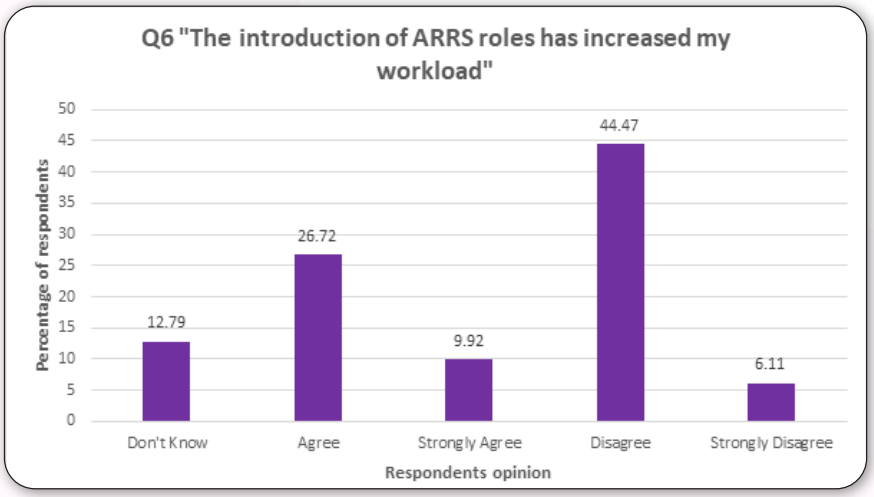
‘Initially when the money was first released there was an explosion of new positions and roles, however many of these people had never worked in Primary Care, the support and training needed was provided retrospectively and, in my opinion, has been insufficient. This has also

‘Some ARRS colleagues new to role were understandably risk averse and sought support from GPNs which was welcomed but increased workloads.’

added to GP workload as they are accepting responsibility for supporting more staff, these means increased debrief time.’

The overall impact was that the introduction of ARRS changed the work and workload rather than decreased it.

Q6 The introduction of ARRS roles has increased my workload
(Answered 524, skipped 7)



36.64% (9.92% strongly) of respondents agreed with the statement ‘ The introduction of ARRS roles has increased my workload’.
50.58% (6.11% strongly) disagreed with the statement.
12.79% of respondents elected for don’t know.

There were 166 free text comments.

There were four principal recurring topics in this response. They were: having to teach and supervise new colleagues, new to role or new to primary care without any additional time or resources, duplication of work due to inexperience in primary care or change of role, even if an experienced clinician, care left undone, and completing incomplete care provided by colleagues. Some ARRS colleagues new to role were understandably risk averse and sought support from GPNs which was welcomed but increased workloads.

Supervision and teaching/knowledge deficit:
‘More patients sent for tests that may not have been sent previously, constantly being asked advice/to review patients’.

‘Supervision and training of apprentices.’

‘Training time, doing the parts they are unable to do (not holistic care).’

‘The pharmacists and paramedics have limited ability to recognise LTCs [long term conditions], limited knowledge of LTCs and their treatments, inability to have a joined up approach to pts care, poor knowledge of wounds, vaccinations and basically what general practice nurses do.’

‘As a result of the ARRS roles, I now see much more complex patients, as they are more inclined to take the more straightforward cases.’

‘I am a nurse manager so have organised training for pharmacists to undertake respiratory reviews.

The paramedics are also undertaking simple asthma reviews. So my workload has increased. I am the only clinician able to undertake complex reviews. My concern is that some ARRS roles will not be able to do this. Their reviews are different and less robust. This is to do with time but also understanding. I am anticipating tasks asking me for advice which I'm happy about, but it makes me reflect on the role of ARRS.'

Duplication of work done by those not familiar with the work, the complexity of work, not within scope of work/practice and/or the work environment of primary care:

'Repetition of work, they do a review but not everything is covered so you are having to go over it again, sometimes having to contact pt again. Review dates not being added to consultation, so pts are being missed for recalls.'

'To an extent - these professionals review patients but don't always complete the QOF requirements for reviews and then they are sent to the nursing team to mop up/review properly. I would say on occasions asking the nursing staff what to do with a patient re asthma diagnosis for example would save appts however I have found they have been advised to book in with a nurse after they have had a consultation with an ARRS role for us to explain we cannot do what they have been told we can and we need to do some diagnostics first before we can treat.'

'As they can't prescribe they come to me to prescribe.'

'Care is disjointed and there is duplication of work , misunderstanding of recall systems and ways of working causing patients to be asked to come in when there is no clinical requirement but the book is passed to the nurse as the solver of all issues - despite poor compliance and recent reviews/repeated education only weeks earlier or the patient would have been due to receive a letter to TCi for multiple LTC and early invites for 1 condition block the nurse appointment and unable to complete the review as we don't have all the relevant information or not enough time has been booked as no info on f12 button ([place name] birthday recall).'

Incomplete care and care left undone was a common issue, often around ARRS staff working outside of traditional scope of practice.

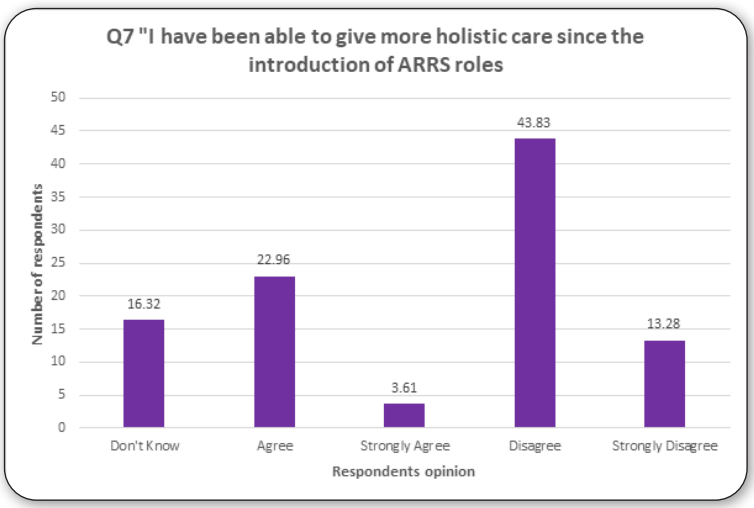
'As per above often not even referring the patients to specific care like structured education, district nurse bloods.'

'Have to double check pt notes / diaries are not being cleared and care plans not completed therefore additional work comes back to me.'

'Extra appointments made with Nurse after seeing.'

We asked if GPNs capacity to give more holistic care had changed.

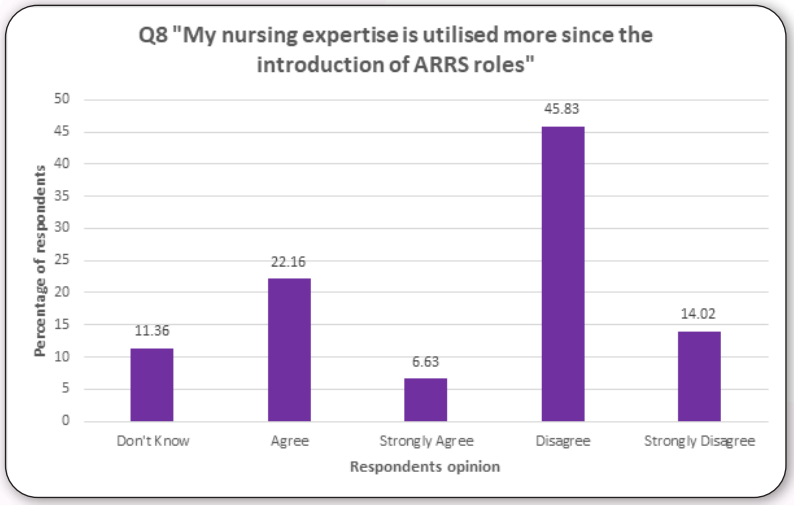
Q7 I have been able to give more holistic care since the introduction of ARRS roles
(Answered 527, skipped 4)



26.57% (3.61% strongly) agreed with the statement 'I have been able to give more holistic care since the introduction of ARRS roles'.
57.11% (13.28% strongly) disagreed with the statement.
16.32% of respondents opted for don't know.

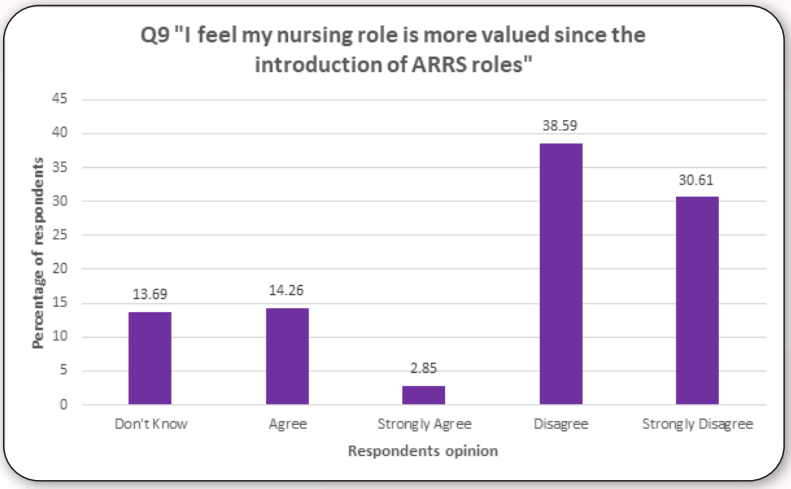
‘Incomplete care and care left undone was a common issue, often around ARRS staff working outside of traditional scope of practice.’

Q8 My nursing expertise is utilised more since the introduction of ARRS roles
(Answered 528, skipped 3)



28.79% (6.63% strongly) agreed with the statement ‘My nursing expertise is utilised more since the introduction of ARRS roles.’
59.85% (14.02% strongly) disagreed.
11.36% of respondents opted for don’t know.

Q9 I feel my nursing role is more valued since the introduction of ARRS roles
(Answered 526, skipped 5)



17.11% (2.85% strongly) agreed with the statement ‘I feel my nursing role is more valued since the introduction of ARRS roles’.
69.2% (30.61%) disagreed.
13.69% of respondents opted for don’t know.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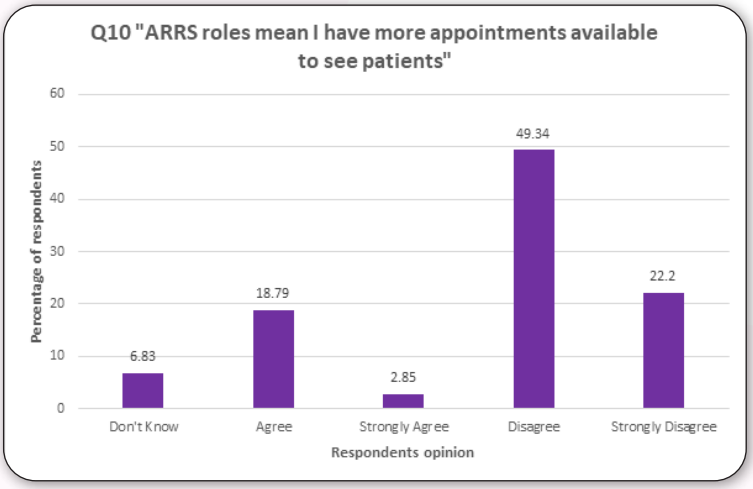
‘Care is disjointed and there is duplication of work , misunderstanding of recall systems and ways of working causing patients to be asked to come in when there is no clinical requirement but the book is passed to the nurse as the solver of all issues.’

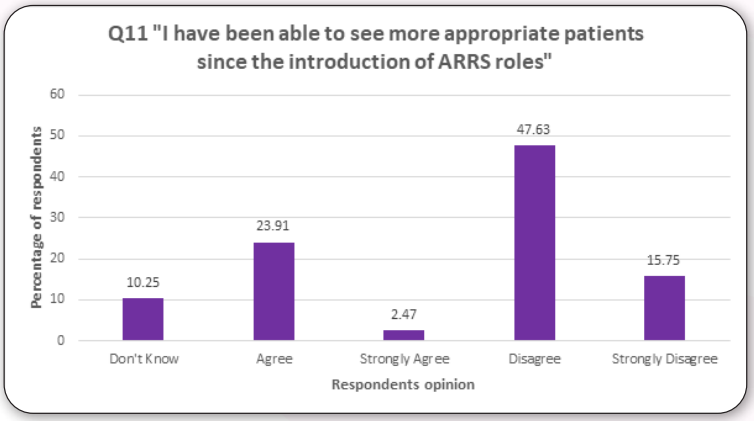
We asked if ARRS had increased nursing capacity in terms of available appointments:

Q10 ARRS roles mean I have more appointments available to see patients.
(Answered 527, skipped 4)



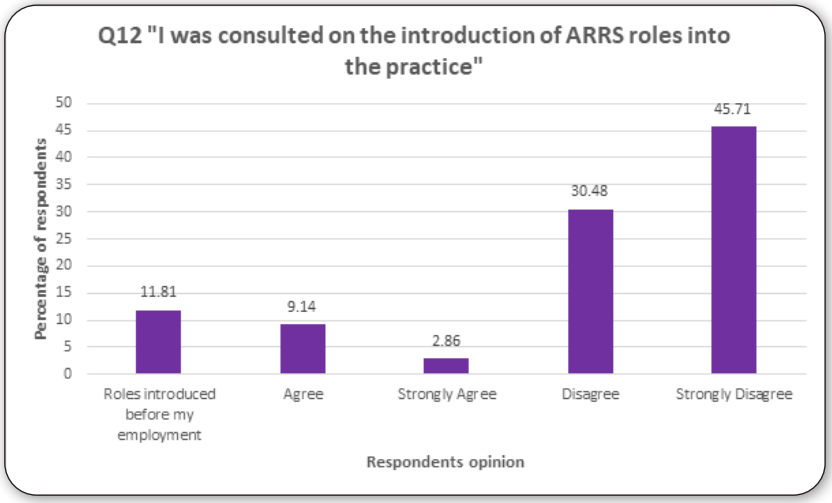
21.64% (2.85% strongly) of respondents agreed with the statement ‘ARRS roles mean I have more appointments available to see patients.’
71.54% (22.2% strongly) disagreed.
6.83% of respondents opted for don’t know.

Q11 I have been able to see more appropriate patients since the introduction of ARRS roles
(Answered 527, skipped 4)



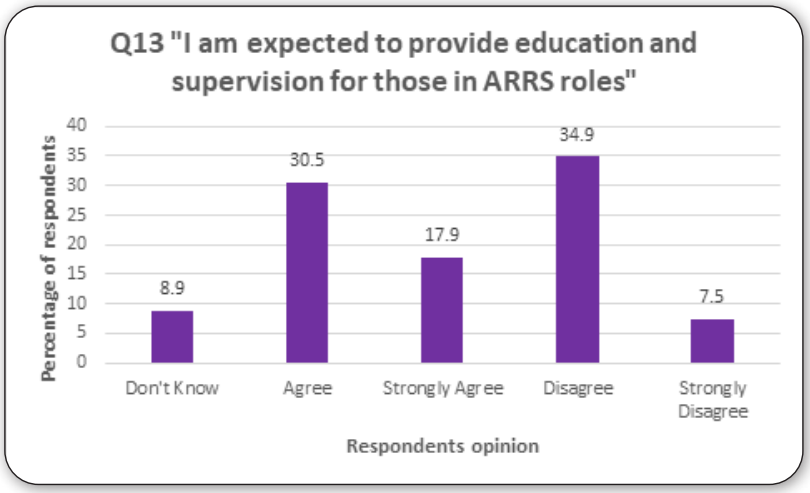
26.38% (2.47% strongly) of respondents agreed with the statement ‘I have been able to see more appropriate patients since the introduction of ARRS roles’.
63.38% (15.75%) disagreed.
10.25% of respondents opted for don’t know.

Q12 I was consulted on the introduction of ARRS roles into the practice
(Answered 525, skipped 6)



12% (2.86% strongly) of respondents agreed with the statement 'I was consulted on the introduction of ARRS roles into the practice'.
76.19% (45.71% strongly) disagreed.
11.81% of respondents had the ARRS roles introduced before they were employed.

Q13 I am expected to provide education and supervision for those in ARRS roles
(Answered 527, skipped 4)



48.4% (17.9% strongly) agreed with the statement 'I am expected to provide education and supervision for those in ARRS roles'.
42.4% (7.5% strongly) disagreed.
8.9% of respondents opted for don't know.

There were 412 opinions and 115 comments.

There were five main areas covered in the free text comments. These were as follows.

1. Provision of training and education:

'Part of my role and responsibilities as an RGN is to support learners and educate and teach students and TNAs'.

'They sit in my clinics and I train them. No extra time is given to do this, it's expected to do during patient consultations.'

'Training in Diabetes - Anticoag – Asthma'

2. Supervision:

'Clinical supervision and line manager.'

'Supervision and training of skills and asked to sign off, or having these roles constantly sit into observe my own clinics.'

‘They sit in my clinics and I train them. No extra time is given to do this, it’s expected to do during patient consultations.’

‘Trainee NA. Placed in practice despite it not being appropriate, Had to ‘find’ work for her to do which took time. Did not know her experience of qualifications, which made it difficult when trying to supervise her.’

3. Mentoring and shadowing:

‘Mentorship training of primary care skills.’

‘Trainee nursing associate shadowing and supervision for competencies.’

‘Shadowing, mentoring and debriefs.’

‘Shadowing but also introduction to nursing role and provision of insight - however this is sought by the nursing team rather than the PCN/practice to try and reduce any negative impact.’

4. Carrying out inductions and orientation:

‘One to one with the induction programme and observation of my clinic.’

‘None just orientation.’

‘This is everything from orientation, location, digital and systems access to advice on protocols and management - especially long-term conditions.’

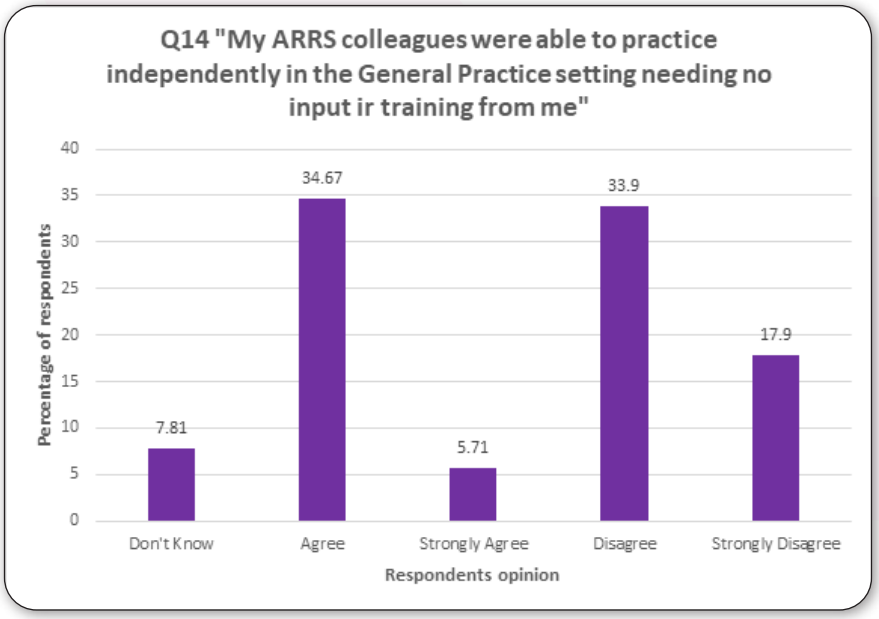
5. Issues regarding prescribing:

‘Discussion of patients; signing prescriptions; information’

‘Support to paramedic colleague doing prescribing’

‘Help with guidelines targets practice policy some clinical guidance re prescribing’

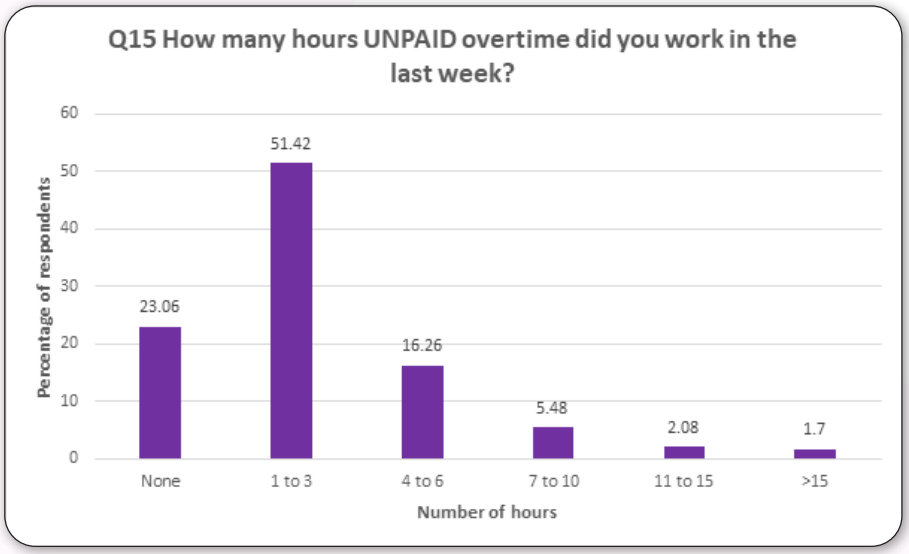
Q14 My ARRS colleagues were able to practice independently in the General Practice setting needing no input or training from me
(Answered 525, skipped 6)



40.38% (5.71% strongly) of respondents agreed with the statement ‘My ARRS colleagues were able to practice independently in the General Practice setting needing no input or training from me’.
51.8% (17.9% strongly) disagreed.
7.81% of respondents opted for don’t know.

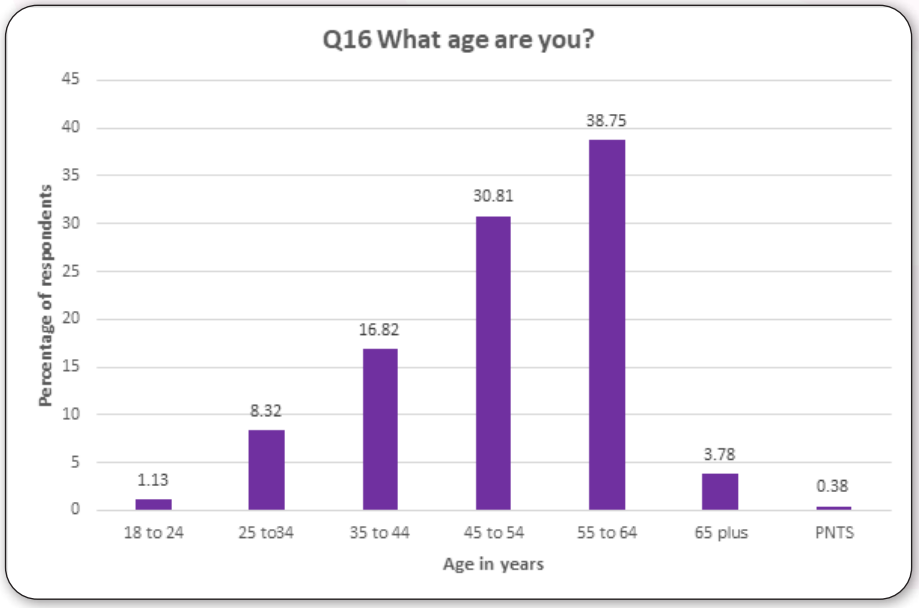
‘ARRS roles are paid more than GPNs and have less qualifications, little to no experience and require support from GPNss earning much less. It reinforces the message that nursing isn’t a valued profession.’

Q15 How many hours UNPAID overtime did you work in the last week? Please include unpaid breaks if you worked through them
(Answered 529, skipped 2)



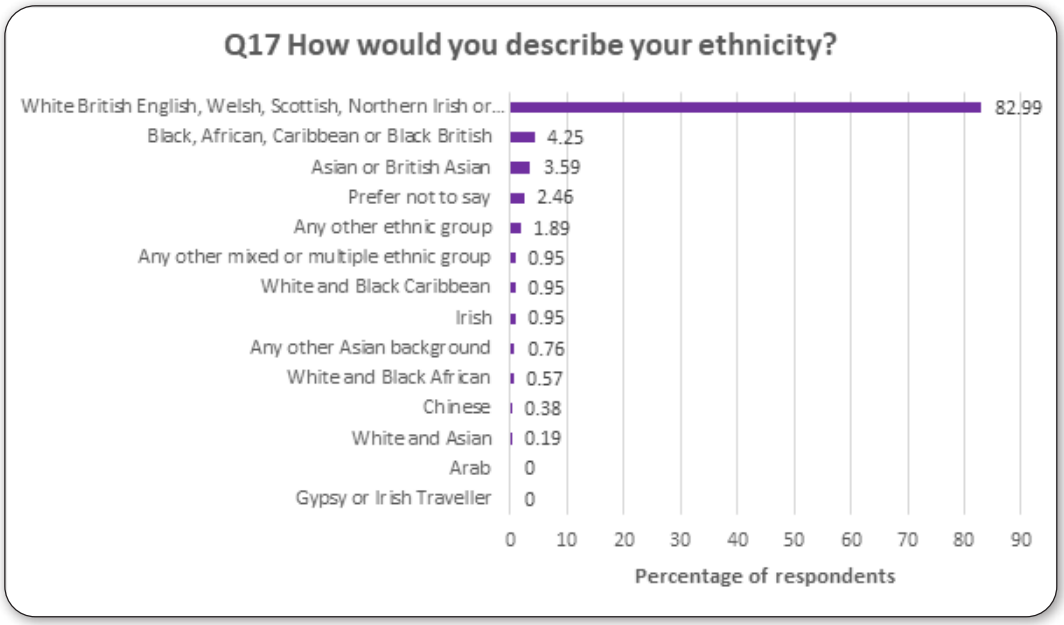
23.06% of respondents did no unpaid overtime over the last week
51.42% did between 1 and 3 hours
16.26% 4 to 6 hours
5.48% 7 to 10 hours
2.08% 11 to 15 hours and
1.7% more than 15 hours.

Q16 What age are you?
(Answered 529, skipped 2)

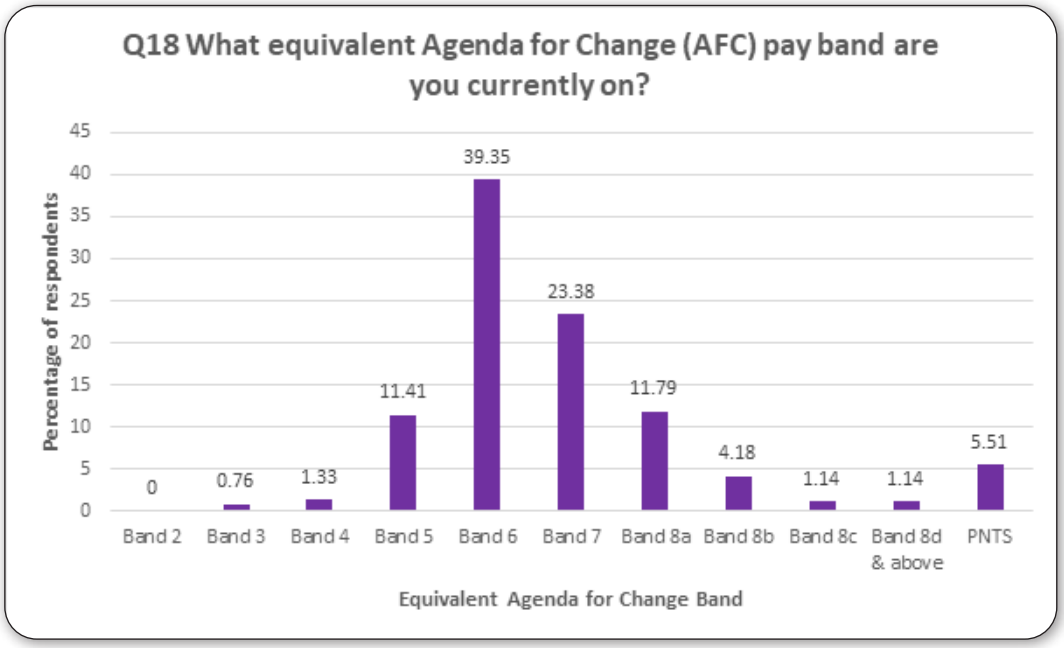


*PNTS prefer not to say

Q17 How would you describe your ethnicity?
(Answered 529, skipped 2)



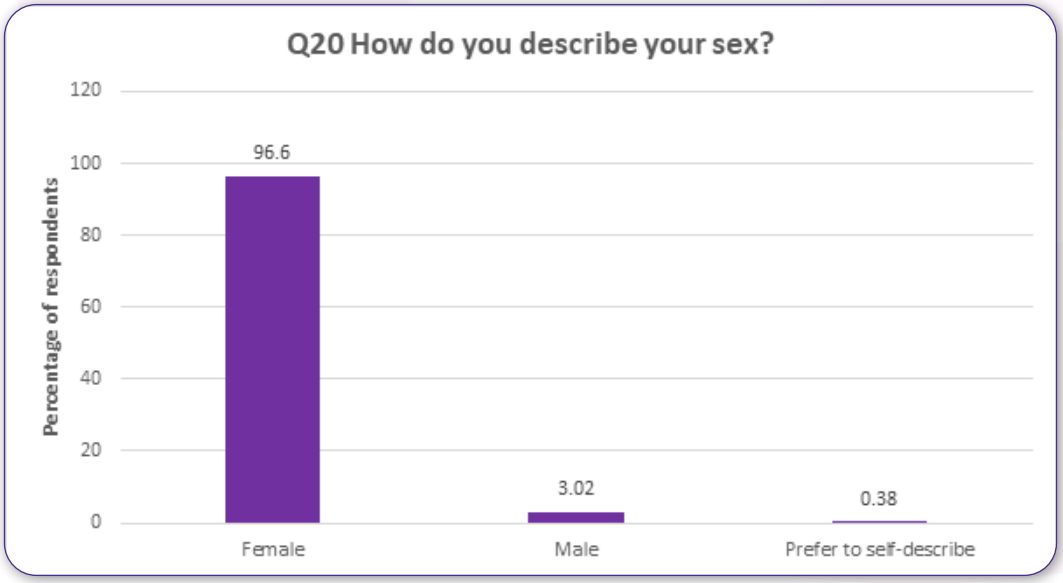
Q18 What equivalent Agenda for Change (AFC) pay band are you currently on?
(Answered 526, skipped 5)



‘ARRS roles are allowed unlimited training time and get better terms and conditions compared to practice employed staff. This causes disruptions in the team.’

Q19 Where did you work immediately before your current General Practice role?
(Answered 529, skipped 2)

Q20 How do you describe your sex?
(Answered 530, skipped 1)




DIABETES UK
What else?
Portion size

‘No consultation. No longer holistic care. Care now becoming a tick box exercise where patient doesn’t fit. Patients confused who they are and what they do. Care more fragmented. My job satisfaction has plummeted. Not sure I want to do it any more.’

Q21 Is there anything else you would like to tell us about the impact of ARRS roles on your work?

When asked if respondents wanted to make any other comments, 227 responded. Several issues emerged in addition to the ones already reported such as the expectation of providing supervision.

Pay, developmental opportunities and inequity

A recurring issue was inequitable pay and conditions. GPNs were expected to support and supervise ARRS colleagues, for lower pay. They also had less access to developmental opportunities and paid time for learning compared to ARRS colleagues.

‘ARRS roles are allowed unlimited training time and get better terms and conditions compared to practice employed staff. This causes disruptions in the team.’

‘ARRS roles are paid more than GPNs and have less qualifications, little to no experience and require support from GPNs earning much less. It reinforces the message that nursing isn’t a valued profession.’

‘It has created more work. We were never asked about our input. We get paid less then ARRS staff for doing more. They aren’t as highly experienced as we are. We have to supervise them, although they often are paid in excess of us. The GPN role is disappearing We are not valued like they are even though we do more of the work. The GPN role in a whole is undervalued, under paid and under appreciated.’

‘It has increased the need for us to provide supervision and training, when we are paid less than these colleagues it is very demoralising.’

‘I feel the impact of the ARRS role has been double fold nurses feel undervalued, with less recognition and the pay terms and conditions difference is apparent. Due to the lack of communication from the PCN and practices there is a lack of understanding and communication re the ARRS roles in the team. With no clear direct supervision and embedding of the roles I feel that the ARRS also feel unsupported, like they don’t belong or feel part of the wider team all of which reduce the wellbeing of all staff and positive culture. Some of these need to be addressed for recruitment and retention of all the roles.’

Changes in work, taskification, rescue and duplication/workload intensification/loss of continuity

The taskification of care was frustrating, in order to employ people with less experience in primary care including those with limited experience, GPNs reported an additional rise in care delivered as protocolised tasks which they found unfulfilling compared to person centred care they aspired to.

There was also a theme of devaluation of the GPN role that occurred frequently.

‘No consultation. No longer holistic care. Care now becoming a tick box exercise where patient doesn’t fit. Patients confused who they are and what they do. Care more fragmented. My job satisfaction has plummeted. Not sure I want to do it any more.’

'The main impact that saddens me is how we have devolved patient care into a series of tasks delivered by different people in the practice setting. Diabetes patients used to have one holistic appointment with a nurse once or twice a year dependent on their health status. Now they can have 4 or even 5 separate appointments. Patients hate it and I hate the lack of continuity, debasement of my skills and knowledge and the fact that patients are so inconvenienced. To be fair - the GP partners hate it too. They had no choice but to take on these roles and all I speak to say they would have preferred to spend more of the money on doctors and nurses.'

The GPNs felt they completed more rescue work due to fractured care/taskification

'I am seeing patients who have already been seen by an ARRS role because their needs were not managed properly leading them to come back. This leads to a lack of patient confidence and more appointment time taken up. This does not always occur of course but fairly often.'

'I think the idea of ARRS roles in General Practice is a good one sadly they aren't actually 'Additional'. They are usually a lesser skilled and cheaper replacement for an outgoing member of staff. This in turn just puts more pressure on the registered clinician to oversee their work.'

'Nursing staff are being pushed to focus more on treatment room work and more of the long-term condition work is being passed to ARRS roles (particularly pharmacists). However, these ARRS led reviews often focus heavily on medications and do not follow the holistic review that is usually delivered by the nursing team. We are finding that patients are coming to see us despite having already had a review because they have not been supported to self-manage only received a change in their meds. We are therefore doubling up on work and patient satisfaction is affected'

'Often make mistakes and refer patients inappropriately to other services. Notes not clear Feel patients get passed from pillar to post instead of being dealt with by 1 clinician & patients are often dissatisfied as dealt by many health care professionals and don't know where they are. Patients not followed up appropriately & get lost in the system. Patients have more complaints over their medications not being issued on time & some medications being issued with wrong dosages. Lack of communication Don't feel some of these additional roles in Primary care have benefitted patients, only there to reduce GP's workload - what's needed is more GPs'

'Some creating additional work by having patient re referred back. Additional questions and support needed for ARRS staff as no experience of working in primary care and the autonomy required. No allocated time for supervision, mentorship it is in addition to PN [GPN] role, no remuneration for teaching qualifications and skills, and not on Agenda for Change pay scales (question above needs amending) unlike ARRS staff'

'The patients are often assessed by these practitioners who are not able to prescribe, they are then referred to me and my workload has increased'

'It gives more stress and not helpful! Often counterproductive and adds to my workload. Have to mark them off with assessments! Have to argue guidelines as they tell patients what is not guideline, e.g. Asthma!'

'Too many too quickly. Patients seem to be increasingly frustrated by seeing so many different practitioners and I end up having to explain and sort things out for them, or they are sent back to see me for follow up anyway'

'Within general practice a GPN will know the patients well and have plans for care. These can be derailed by ARRS roles when they have input into patient care. GPNs already take responsibility for quality work with patients and generate their own workload. Add to that the GPs generate workload and now ARRS also generate workload without being aware of how the individual practice works and the level of skills and expertise already within the nurses in the practice. We have never been asked about suggested/planned ARRS roles within the PCN and it seems that these roles are currently to reduce GP workload. We are then asked to mentor/train/sign off new skills developed by ARRS roles. There is plenty of work within general practice for all but certainly more consultation within the general practice team not just with GPs. There appears to never be an assessment of the impact of these roles within the practices or how they are integrating within the practice'.

'I think the idea of ARRS roles in General Practice is a good one sadly they aren't actually 'Additional'. They are usually a lesser skilled and cheaper replacement for an outgoing member of staff. This in turn just puts more pressure on the registered clinician to oversee their work.'

An unplanned workforce

ARRS was seen as both an opportunity and an issue of being an unplanned workforce with a poorly defined purpose apart from being a ' free'resource to practices. Responses to question 12, indicated there was little engagement with GPNs prior to implementing the roles and this is reflected in the comments, particularly the Trainee/Nursing Associate for which GPNs as RNs, were responsible for supervising. There was a call for associate level professionals, particularly nursing associates, to have more regulated definition of scope of practice.

'ARRS roles mean that the PCN employs staff that we don't necessarily need. 'Spending the budget' don't want to employ practice nurses or GP's which are needed. So far my experience is that many in ARRS roles clinical skills do not match that was on CV / interview and therefore not meeting needs of the practice with additional training required.'

'ARRS seems to be a 'sticking plaster' over the issues that are currently being seen in general practice. Experienced GPNs are feeling pushed out and are underrepresented in implementation of these roles. The general GPN workforce feel undervalued. We do not know how long funding will be available for - what happens if/when it is withdrawn. Can the decimated GPN workforce pick up the pieces? There also seems to be no clear directive on the ARRS roles, especially that of NAs. Some seem to be encouraged to work outside their sphere of competence, undertaking LTC reviews and patient Management. Drivers seem to be reduced workforce cost for Management and lack of understanding of their own role. Black and white guidelines specific to General Practice for the NA role specifically need to be developed to assist with this and maintain best outcomes for patients. I have no doubt that some NAs are capable, but need to show this by completing appropriate training, i.e. top up to RN.'

'I work as a clinical director for a PCN and overall see a great improvement to the offer to our local population health. I see the addition of the ANP and TNA to the ARRS roles as game changers. Huge role for nurses as generalists and educators especially given the ageing of the current majority of GPNs. We have fresh well qualified new nurses who now have a career pathway. If PCNs can work effectively and the Fuller report is implemented then the role of the GPN will thrive & excel.'

'….No-one seems to know what exactly they are doing let alone achieving. I thought initially that they would be a good thing to take some pressure off, but they seem to create more and duplicate everything. Unimpressed by this initiative. Practice Management like them because they are funded by the PCN so 'free' to the practice'.

In Summary

ARRS appears to have impacted the workforce in several ways. This ranges from a lack of resources to support those new to primary care, expectations of others of GPNs filling a gap and lack of consultation regarding a major workforce change, leading to feelings of devaluation. There are some significant equity issues highlighted particularly around pay and opportunity. There appears to have been no substantial demand modelling for new roles, either nationally or locally.

Recommendations

1. There should be full and meaningful workforce engagement in any major change affecting the workforce.
2. Inequity of opportunity for example, development opportunities and pay inequity needs to be addressed.
3. The introduction of ARRS roles appears not be based on demand but rather availability, including the availability of funding. The scope and design of roles appears to be largely unexamined. The roles appear to be implemented to fill a deficit in already established workforces rather than as an additional value-added role arising from workforce redesign. Demand modelling should take place if implementing new roles.
4. The benefits of ARRS roles used to meet specific previously unmet demand were clear, but there needs to be clarity around all roles and scope of practice, particularly for those new to primary care.
5. There needs to be more resourcing of teaching, supervision, and support, not only for new roles but also those transitioning to a new area of practice.
6. There should be scrutiny at a regional and national level of how the ARRS impacts on the overall workforce strategy in primary care and the community healthcare workforce.

References

- Health Education England (2019) Expanding Our Workforce https://www.england.nhs.uk/gp/expanding-our-workforce/ (Accessed Dec 2023)
- NHS Digital (2023) Primary Care statistics https://app.powerbi.com/view?r=eyJrIjoiODg3N2Ji-iZGUtMDQxMC00ZDkyLThlYTEtNGZjZmU0YjAzMmFiIiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9 (accessed December 2023).
- Nove, A., Cometto, G. & Campbell, J. Assessing the health workforce implications of health policy and programming: how a review of grey literature informed the development of a new impact assessment tool. Hum Resour Health 15, 79 (2017). https://doi.org/10.1186/s12960-017-0252-x
- UN (2017) Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development United Nations https://unstats.un.org/sdgs/indicators/indicators-list/ (Accessed December 2023)
- WHO (2016) Global strategy on human resources for health: workforce 2030 (WHA69.19) World Health Organization

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