Integrating community care: build on the AARS platform?

Building on PCN footprints is the NHS strategy for delivering community care

The NHS Long Term Plan initially set out a requirement for community services to be configured around PCN footprints, with expanded community multi-disciplinary teams providing proactive and anticipatory care to people with more complex needs.

This was further developed in the Fuller report, which set out a vision for integrated multi-professional neighbourhood teams to support people who need proactive care in the community.

The teams bring together staff from across PCN areas, including general practice teams, physical and mental health community teams, secondary care teams, social care teams and care staff. **King's Fund, July 2024.**

AARS was introduced as a novel way of expanding primary care access.

The Additional Roles Reimbursement Scheme (ARRS) was introduced in response to government manifesto commitments to improve access and workforce pressures in primary care. The benefits of the ARRS are evidence that the new roles have a place in the future of primary care.

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.

ARRS staff have, enabled the development of new ways of working, such as multidisciplinary working and integrated neighbourhood teams in primary care. 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.

NHS Confederation, Assessing the impact and success of the Additional Roles Reimbursement Scheme, Feb 2024.

The existing ARRS workforce has been assured as part of the PCN Direct Enhanced Service which has been renewed indefinitely from 2025.

To compensate for falling GP numbers, the NHS has been adding headcount for specific primary care roles

'The Goals of ARRS

The primary goal of the ARRS is to alleviate the increasing pressures on general practices and improve access to healthcare services for patients. By expanding the clinical and non clinical teams through the reimbursement of additional roles, the scheme seeks to:

Enhance the capacity of primary care services to meet the growing demand for healthcare.

Deliver a broader range of services to patients, thereby improving patient outcomes and satisfaction.

Support the integration of services within PCNs, facilitating a more collaborative and efficient approach to patient care.

Drive forward the shift towards a more preventative approach to healthcare, reducing the reliance on hospital services and promoting community-based care.

The Roles Covered by ARRS

The ARRS roles in primary care are diverse, each contributing uniquely to patient care and the broadening of services offered by PCNs. From clinical pharmacists to first-contact practitioners, these roles are reimbursed through ARRS funding, enabling PCNs to more effectively meet the complex health needs of their communities.

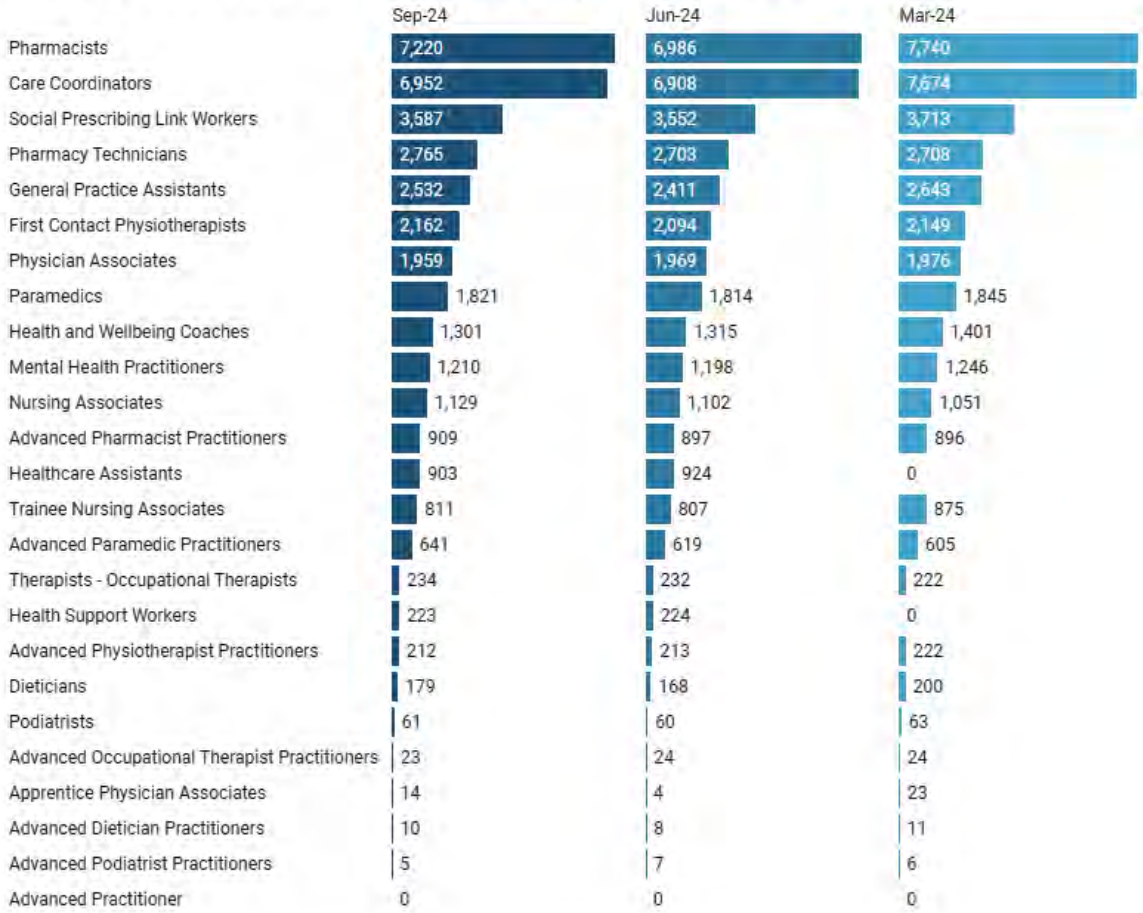
The ARRS roles list is regularly updated, with ARRS roles 2024 introducing new opportunities for PCN ARRS expansion'.

NHS England,2023.

The AARS workforce is diverse delivering a range of primary and community care services

There were 36,862 staff working through ARRS as of 30 September 2024, compared to 37,294 at the end of March.

Primary care workforce, ARRS roles September 2024



NHS England, September 2024.

What's missing from the local line-up? How would AARS services build?

'The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage in general practice. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a Clinical Commissioning Group (CCG) or a local NHS provider. Reimbursement through the new Additional Roles Reimbursement Scheme will only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule is also essential for demonstrating value for money'.

Network Contract Directed Enhanced Service Additional Roles Reimbursement Scheme Guidance, NHS England 2019

For 2025/6, there will be an 'Enhancement of ARRS, with GPs and practice nurses added in to the main scheme, minimum GP salary + on-cost reimbursement increased in line with the BMA salaried GP pay range and with no caps on numbers'. **BMA**

Does this mean that there literally is no restriction on the numbers of GPs who could be hired?

What could a 'fully loaded' PCN look like?

What would be the scope and capacity to deliver existing and new individual care services?

What services could then be transferred from hospitals?

How would these services be co-ordinated with traditional local community care services?

It would be interesting to do an inventory check on how many of these positions have been taken up locally, PCN by PCN

Role	PCN 1	PCN 2	PCN 3	PCN 4
social prescribing link worker				
clinical pharmacists				
physician associates				
first contact physiotherapists				
pharmacy technicians				
health and wellbeing coaches				
care co-ordinators				
occupational therapists/ dietitians/ podiatrists				
Paramedics				
nursing associate				
mental health practitioners				
GP assistants				
digital and transformation lead				
advanced practitioners				

If all G&W PCNs were polled, what would coverage look like by Place and PCN

It would be interesting to do an inventory check on how many of these positions have been taken up locally, PCN by PCN

What would be the benefit if all posts were maximised?

Role	PCN 1	PCN 2	PCN 3	PCN 4
social prescribing link worker	X	X		
clinical pharmacists		X	X	X
physician associates	X		X	
first contact physiotherapists		X		X
pharmacy technicians	X			X
health and wellbeing coaches		X	X	
care co-ordinators	X	X	X	
occupational therapists/ dietitians/ podiatrists		X	X	
Paramedics	X			X
nursing associate	X		X	
mental health practitioners		X		X
GP assistants	X	X	X	
digital and transformation lead	X			X
advanced practitioners		X	X	

Role	PCN 1	PCN 2	PCN 3	PCN 4
social prescribing link worker	X	X	X	X
clinical pharmacists	X	X	X	X
physician associates	X	X	X	X
first contact physiotherapists	X	X	X	X
pharmacy technicians	X	X	X	X
health and wellbeing coaches	X	X	X	X
care co-ordinators	X	X	X	X
occupational therapists/ dietitians/ podiatrists	X	X	X	X
Paramedics	X	X	X	X
nursing associate	X	X	X	X
mental health practitioners	X	X	X	X
GP assistants	X	X	X	X
digital and transformation lead	X	X	X	X
advanced practitioners	X	X	X	X

Also, they need not all be located to an individual PCN. What if certain roles were conflated, realising the benefit of scaling?

Co-locating many of these functions would help build multi-disciplinary teams.

MDTs would begin to develop as a unified capability with its own culture.

Should there be a lead PCN coordinator for each of these services across the G&W Place?

Premises then becomes a big issue. Where would they be housed?

Does AARS create complications or opportunities?

But are all the capabilities of these organisations co-ordinated? How are patients' health records shared, for example?

There are significant organisational crossovers between Guildford PCN, GP Federation and Procare.

Then, there is the Procare JV with the RSCH whose Community Hospitals all provide services to patients in their neighbourhoods. The RSCH also runs outpatient clinics.

Charities, voluntary organisations and specialist companies like CSH Surrey also operate in this field.

The object of AARS is to build multi-disciplinary teams, but in PCNs supporting GP practices.

AARS team members could easily have been recruited from local community care operations.

Many of these patients have co-morbidities and will depend on services from different care locations.

Just consider, for example, how many different care providers a diabetes sufferer might see.

How AARS services are co-ordinated with local community care

Most GP practices are not set up to take on a bigger role; taking full advantage of AARS would be a challenge for many

‘Despite PCNs now delivering new services their development has not been uniform, with success often being dependent on local factors. This means that systems have a role to play in promoting integration at place through primary care leadership, providing supporting infrastructure and committing to transformation both in empowering PCNs themselves and in recognising that PCNs – as the ‘building blocks’ of ICSs - are the transformation that underpins all others’.

This becomes a system-wide challenge.

Because the plan is to move patients into the community, hospitals will need to be involved.

Essentially, it would mean creating a new organisation and management structure.

Re-reading the Fuller Stocktake proposals is worth doing.

Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.'

Next steps for integrating primary care: Fuller stocktake report, May 2022.

The important question is how will they 'evolve'?

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. 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.

Delivering integrated care: it's local teams which will drive the future NHS

Darzi says that the NHS should 'simplify and innovate care delivery for a neighbourhood NHS'. 'The best way to work as a team is to work in a team: we need to embrace new multi-disciplinary models of care that bring together primary, community and mental health services'.

There is nothing much that is new about care workers operating in multi-disciplinary teams (MDTs). The problem has been unifying staff from different NHS entities and also working with social care organisations and charities.

The ICB is responsible for drawing up the strategy, allocating the funding and promoting delivery.

But none of the NHS provider organisations which would need to combine to deliver integrated care are under its control.

The extra funding for GP practices, properly harnessed, will radically strengthen the building of MDTs.

The ICB must ensure that it is properly financed.

Probably the best way to ensure effective delivery is through contracts with sufficient financial incentives.

NB: a fully functioning teamwork approach has to include the RSCH.

Community health represents a vast bundle of differentiated, highly personalised, medical services

Every day, community health services have about 200,000 patient contacts – about 13% of all daily activity in the NHS.

Community health services cover an extensive and diverse range of activities, and hence can be difficult to define, with the precise range and configuration of services varying between local areas.

They commonly cover a wide range of needs across people of all age groups and are provided by many professional groups. In the NHS the term ‘community health services’ generally excludes specialist community mental health services.

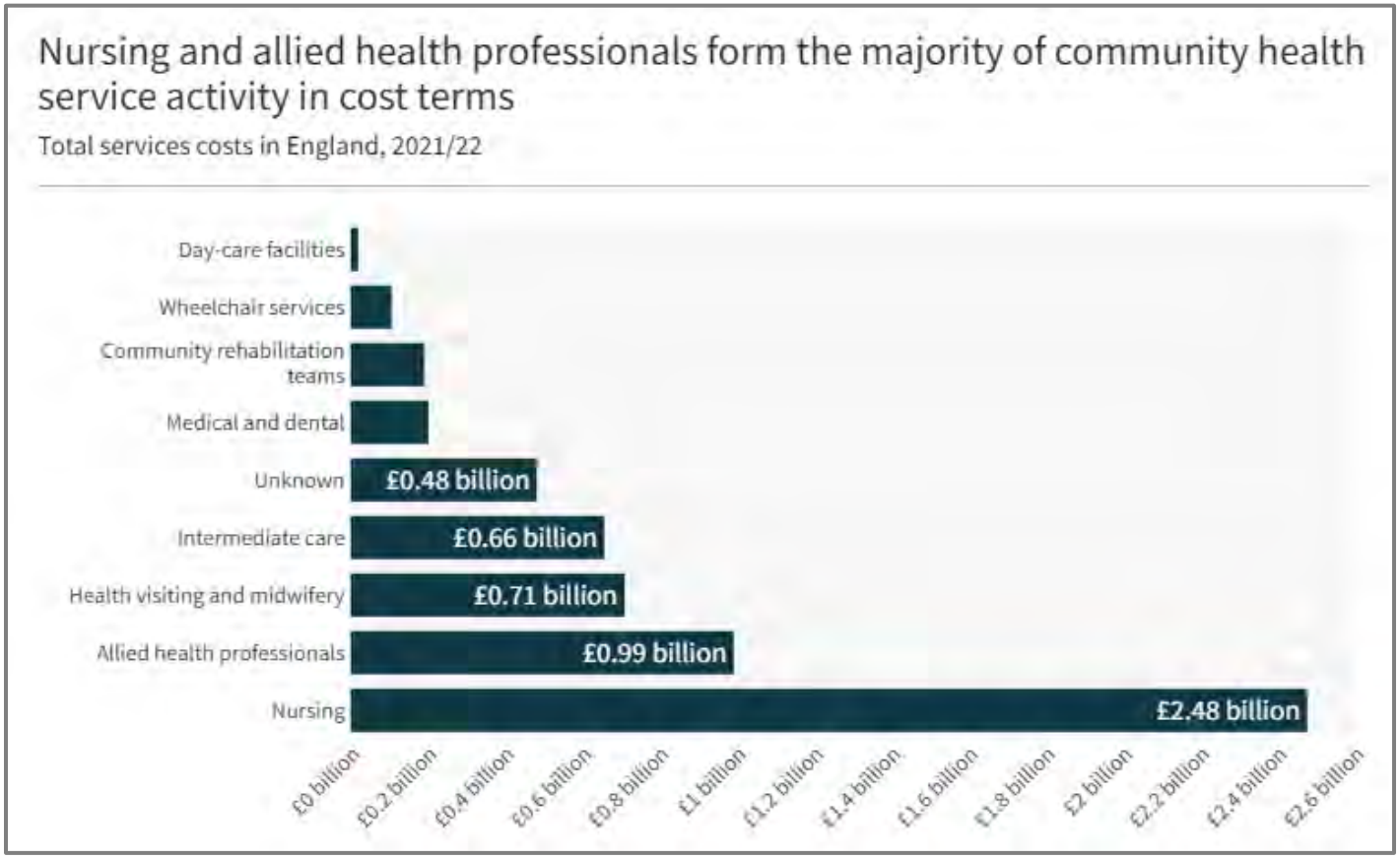
King’s Fund.

Figure 1: Where do NHS community health services fit within systems that support health and care?

Community health services are most often used by children, older people, people living with frailty or with chronic, multiple and/or complex health needs, and/or people who are near the end of their life. Due to this complexity, community services work closely with other parts of the health and care system, such as GPs, hospitals, social care and pharmacies. The increasing numbers of people living with long-term conditions means that more people are likely to need support from community health services in the future.

Services are delivered in a wide range of settings – including people’s own homes, care homes, community clinics, community centres, schools and hospices.

£2.5 billion is spent on community nursing



The King's Fund, June 2024.

We can assume that the same proportions are present locally.

Community health care services are highly fragmented resulting in gaps in patients' care

'In the past two decades, there have been frequent reorganisations to how community health services are structured, resulting in a range of different provider types and sizes; this includes standalone NHS community trusts and combined community and acute or mental health NHS trusts.

It has been estimated that NHS providers hold around half of the total value of community service contracts, with the rest held by providers including community interest companies, local authorities, social enterprises, private providers, GP practices and pharmacies.

A single provider is often responsible for delivering most of the community services in an area, usually alongside other providers that deliver specific services under relatively small contracts.

Community services are delivered by a range of staff, including community nurses, district nurses, allied health professionals (such as therapists) and health visitors. There is limited reliable data about the community workforce, and NHS workforce statistics do not capture in a consistent manner where community-based staff work.

From the data available for community nursing, there are worrying trends that their numbers reduced between 2010 and 2022: community health nurses by 8%, health visitors by 23.5%, and community learning disability nurses by 46%.'

King's Fund.

Locally, there is a very long tail of community care providers. Each ICS may have 20

According to NHS Digital, 'there are over 100 million contacts made with community services each year – these could be a visit from a district nurse at home, a child attending a speech and language clinic, or a patient getting a blood test.

The provider landscape for community health services is made up of approximately 800 providers delivering services in the UK.

NHS England allocates approximately £10 billion annually to community health services,

Community health services are generally made up of physiotherapy, podiatry, nursing, intermediate care, virtual wards, discharge support, musculoskeletal (MSK) and rheumatology programmes, dermatology services.

Unlike the episodic nature of elective and emergency care, community care is often multi-layered and ongoing.

Community care support is often provided over the longer term, and most frequently to children, older people, and those with chronic conditions, or those nearing the end of their lives.

Services are delivered in a multitude of settings, including in people's own homes, community clinics, community centres, schools, and care homes, as well as hospitals.

As many as 70% of community health services are provided by non-NHS organisations, independent providers alongside voluntary groups and social enterprises'.

Community Health Services: what does good look like? Independent Healthcare Providers Network

We have no information as to how well the workforce is co-ordinated locally

‘Community health services employ a broad range of health professionals such as community nurses, district nurses, allied health professionals (including physiotherapists, speech and language therapists, occupational therapists, and podiatrists), health visitors and dentists.

The Nuffield Trust reported that combined community staff make up an estimated one-fifth of the total NHS workforce - 33% are registered nurses, 25% health care assistants and unregistered staff, 21% are allied health professionals, and 18% are other non-clinical staff.

One of the questions which remains about the wider elective waiting lists (over 7.7 million people waiting, Nov 2023), is the extent to which patients could in fact be seen or treated in a community setting’.

There are many case studies at: https://www.ihpn.org.uk/wp-content/uploads/2023/11/IHPN-Community-Services-Report.-22-November-2023.pdf

Given that so many organisations may be involved, we have no information about gaps or overlaps.

This is why having every patient on a risk assessed care pathway is critical.

Prompt interventions by community care staff is likely reduce many avoidable emergency admissions.

‘Based on August 2023 data, over one million people are waiting to receive community health services, with more than 208k waiting more than 18 weeks, and of that, nearly 32k have waited more than 52 weeks.

Approximately, 80% of people are being seen within 12 weeks, although there are problems in some areas - children’s speech and language therapy, where waiting times are far longer’. **IHPN**.

Also, just how well are Adult Community Services integrated with GPs' AARS work force?

'Adult Community Services for Guildford and Waverley are run in a joint venture between Procare and the Royal Surrey Foundation Trust.

This joint venture puts primary care back at the heart of patient care. It is the first contract of its kind in the country, with an acute trust partnering with a GP federation.

Adult community health services provide care to patients in the community; maintaining their health and independence and preventing unnecessary hospital admission.

They include services like district nursing, podiatry, rehabilitation beds, therapists and the Minor Injuries unit at Haslemere Hospital. They complement the services provided by GP practices, Royal Surrey County Hospital and other healthcare organisations.

Our ambition in running these services is to improve the integration between GP, Community and Hospital services so that they work more closely together. We know that we can provide a better service for the individual if the system works as one, allowing our teams work more closely together and the information to be available to support their patient throughout their illness'. **Procare.**

Is AARS effectiveness impared by a lack of space?

‘There is evidence that, so far, those new staff are being under-utilised due to insufficient and inadequate estate space. Traditionally, GPs conduct one-on-one consultations in examination rooms that sit within a practice premises.

MDTs work in different ways. Physiotherapists, for example, generally need more space to work with patients.

MDTs may also work with groups of patients as well as individuals. MDTs also need space to meet each other, co-ordinate care and collaborate.

The current estate is not designed to facilitate those ways of working.’

Delivering a general practice estate that is fit for purpose, Institute for Government, June 2024.

Where will the staff go? GP premises are not designed to house all these people

What are the implications for real estate?

Should there be one major site for the delivery of AARs community-led services?

Multi-disciplinary teams work best in a collegiate environment.

Many of the ARRS personnel need to be grouped in their own discrete spaces, but preferably in a single floor arrangement.

A significant amount of space would be required for a single point of access (SPA) and derivative services, like referral management.

Building a new culture would be a valuable by-product of shared premises.

The AARS scheme is immature and needs a more formal organisation structure

‘Ensure increased ARRS flexibility to allow primary care to determine their workforce needs and the flexibility to contract and deploy where most appropriate.

Greater investment in primary care capital for estate and digital funding to the rest of the NHS to ensure that primary care remains equipped to support a greater shift to out-of-hospital care.

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 scheme currently provides insufficient funding for supervision or training. By tackling workforce recruitment challenges in isolation (without structural enablers such as estates and digital or retainment/professional development) an opportunity for a more thorough intervention was missed.’

Assessing the impact and success of the Additional Roles Reimbursement Scheme, NHS Confederation, Feb 2024.

Logically, NHS community health care could be re-established by building out from the AARS initiative

The AARS programme is the first primary care initiative to invest beyond GPs' capabilities.

This represents a genuine move to reduce pressure on doctors and introduce a wider range of help to address patients' needs.

There are issues – particularly premises - which now need urgent attention.

We put forward a suggestion for consolidating the staffing allocations made for many of these roles to create more scale for the PCNs working within Places.

We identify a number of activities which might then be introduced or strengthened – a Single Point of Access and Referral Management, for example.

The next step would be to look to the ICS to help develop a process for more patients to be moved out of hospital to the community for their ongoing care.

This might mean putting more care under new contracts for which GPs and others might bid.

There might even be joint ventures with RSCH.

A longer-term move would be to consider running many discrete, condition-related care programmes as distinct service lines.

The Women's Hub operated by GPs in Shere might be a model.

Later, we propose a number of ways to strengthen technology to support these initiatives.

Is there true co-ordination between hospital community services and practice AARS schemes?

The RSCH says it delivers the range of community services in the first column.

AARS services, delivered by PCNs and based in GP surgeries are in column two, but local allocations are not known.

How well are the two organisations' services co-ordinated?

Proactive care

- District Nursing
- Proactive Care Service
- Tissue Viability Service
- Multiple Sclerosis Specialist Nurse
- Parkinson's Nurse Specialist
- Heart Failure Service
- Continence Nurse Specialist
- Speech and Language Therapist

Intermediate care

- Urgent Community Response
- Hospital at Home
- Community Therapy Team

Place based care

- Milford Integrated Care Hub (MICHub)
- Musculoskeletal physiotherapy
- Podiatry service

- Clinical pharmacists
- Pharmacy technicians
- The social prescribing link worker
- Health and well-being coaches
- Care co-ordinators
- Physician associates
- First contact physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Nurse Training Associates
- Nursing Associates
- Community Paramedics
- Advanced Practitioners
- General Practice Assistant
- Mental Health Practitioners (Adults and children)
- The Digital and Transformation Lead

The RSCH has a control centre for community care. Does Procare have a separate one?

Community Co-ordination Centre:

'The Community Co-ordination Centre (CCC) is a single referral point for health and social care professionals to refer local residents registered with a GP in Guildford and Waverley.

Once we have received the referral, we will assess each individual and co-ordinate the appropriate community services to support the patient's health and wellbeing to enable to patient to remain in their own home and to prevent any unnecessary admissions to hospital.

To access the service would be through a referral from your GP, health or social care professional or following a discharge from hospital.

You are able to refer yourself by calling the Community Co-ordination Centre on 01483 362 020

When your referral is received either by email or phone, an administrator will ensure we have taken a detailed history of your health concern to enable the clinician to identify the appropriate services to support you.

The identified service will then contact you to arrange an appointment.' **Procare.**

Procare says: 'We provide adult community nursing services 24 hours a day, 7 days a week, 365 days a year.

Our Community Matrons, District Nurses and Community Night Nursing Team provide nursing care, support, advice and treatment for people in their own homes.

To contact the service, your GP or hospital will refer you into the community co-ordination centre.

The referral will then be processed by our team of clinicians and prioritised according to urgency and clinical need.

If you need to contact the CCC please call 0300 303 9513 from 8am - 8pm. Between 8pm - 8am please contact 07771 772180.'

The organisational challenge of community care is that this highly federated business has to be coordinated

Every day, patients in the poorest health are being seen by a wide range of specialist care providers.

Many have complex needs requiring personalised care across a number of conditions.

But how well is the care coordinated and meeting the patient's unique needs?

These people are easy to identify through current NHS systems.

The neediest are about 10% of the local population and represent about £300 million of local health care costs.

This then is a significant, subdivision of the Guildford population.

Their costs are distributed between hospital, community care providers (physical and mental health) and GPs.

As we explain elsewhere in this presentation, it is relatively easy, given current technology and available patient data to build a care pathway for each of them.

The starting point of re-organising their care might be to group them into a single population overseen by a single management.

This would be the basis of a new community care organisation.

An expanded community care capability will need its own organisation

A merger of traditional ‘community care’ and AARS teams seems inevitable, and a good idea.

AARS is expanding under PCN and GP control.

GPs have never been expected to run large, complex businesses.

The main enablers of integrated care [are] the organisational skills of health and social care professionals who [are] actively able to contribute to inter-professional collaborations by bridging task-related gaps and overlaps, and a growing interest in co-production in health care services to improve information sharing and reduce duplication.

‘Despite PCNs now delivering new services, their development has not been uniform, with success often being dependent on local factors. This means that systems have a role to play in promoting integration in Places through primary care leadership, providing supporting infrastructure and committing to transformation both in empowering PCNs themselves and in recognising that PCNs – as the ‘building blocks’ of ICSs - are the transformation that underpins all others’. **NHS Confederation**

But these are operating units with their own limited, separate managements.

Who will bring it altogether and pay for it?

Especially, as ICBs’ future structures are uncertain.