

Greater Manchester Primary Care Workforce Project (GMWF)

Report for Work Package 3: Integration of
New Roles into General Practice in
Greater Manchester



Working in collaboration with:

**Greater
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The 10 Clinical Commissioning Groups across Greater Manchester

Authors

Nelson PA, Brunton L, Ferguson J, Tazzyman A, Bradley F & Hodgson D
NIHR CLAHRC GM
University of Manchester

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Contents

1. Executive Summary	3
1.1. Background	3
1.2. Methods	3
1.3. Findings	4
1.4. Key Messages.....	6
2. Background.....	8
2.1. The Greater Manchester Workforce Strategy	9
2.2. Study aim	9
3. Methods	10
4. Findings	11
4.1. Participants	11
4.2. Distribution of new role types across GM.....	12
4.3. Targeted new roles (operational-level data).....	13
4.4. Strategic and operational-level stakeholder perceptions of new roles.....	14
4.4.1. Aims of new roles	14
4.4.2. Role definition/perception of roles	17
4.4.3. Challenges/enablers of implementing new roles	22
4.4.4. Measuring the impact of new roles	44
4.4.5. Funding and sustainability of new roles.....	47
5. Discussion.....	52
5.1. Summary.....	52
5.2. General factors affecting the implementation of skill-mix changes.....	53
5.2.1. Communication and engagement.....	53
5.2.2. Definition and differentiation of new roles	53
5.2.3. Training and employment of new roles professionals.....	54
5.2.4. Demonstrating the impact of new roles.....	55
5.3. Specific insights on the implementation of skill-mix changes	56
5.3.1. Care navigator role	56
5.3.2. Social prescribing link worker role	57
5.3.3. The influence of PCNs on future general practice skill-mix changes	58
5.4. Conclusions.....	59
5.5. Key messages.....	60
6. Appendices	61
Appendix 1: Summary information on the five new non-medical roles targeted in operational interviews	61
7. References.....	64

1. Executive Summary

This report presents a study of new non-medical roles in general practices across the Greater Manchester (GM) region, prepared in September 2018 by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care Greater Manchester (CLAHRC GM) on behalf of the Greater Manchester Health and Social Care Partnership (GMHSCP).

1.1. Background

The challenges of providing care for an ageing population living with increasingly complex health needs, alongside a corresponding shortage of GPs and nursing staff, has led to a new national policy focus to address rising workforce pressures in general practice. A key priority has been the integration of other health professionals (such as Practice Pharmacists) into primary care teams to redistribute the workload.

Regionally, the GMHSCP workforce strategy is prioritising the delivery of an integrated health and care model in primary care involving a multi-skilled, multi-professional workforce.

To inform the development of their primary care workforce strategy (and in particular the delivery of a multi-professional workforce), GMHSCP engaged NIHR CLAHRC GM to investigate the planning and operation of new non-medical roles in GM general practices and highlight learning.

1.2. Methods

The study was an in-depth qualitative exploration of the views of: 1) strategic lead staff (i.e. national and regional GP and primary care policy leads as well as regional CCG and GP provider leads), and 2) operational-level staff involved in five 'targeted' new roles across GM (i.e. training/service leads, role holders or host GP practice staff involved in the roles of care navigator, physiotherapist, paramedic, pharmacy technician and social prescribing link worker). The study was informed by previous NIHR CLAHRC GM research, including a rapid scoping review of the literature on skill-mix changes in primary care and an earlier local evaluation of new roles schemes in one area of GM. The study involved thematic analysis of 61 interviews (involving 74 participants) and one semi-structured focus group (with 13 practice managers).

1.3. Findings

In line with our previous local CLAHRC GM research, the study highlights that in the urgency to implement skill-mix policy changes, important discussion around planning, coordination and promotion of roles was often missed; however, adequate dialogue between stakeholders enabled roles to be implemented more smoothly. Engagement with skill-mix change was at different stages across GM and lacked regional consistency. Meaningful workforce data to underpin planning for new roles was lacking; some areas were hopeful that making efforts to engage practices in discussions about why workforce data was needed and how it could help them plan for the future would overcome this.

Confusion could arise when a role holder's scope of practice was not well defined and boundaries between roles were blurred, a finding which reflects our previous NIHR CLAHRC GM local evaluation on skill-mix changes in general practices. There were differences in relation to the five targeted roles examined, with the newer, unregulated roles of primary care-based social prescribing link worker and care navigator, bringing particular boundary issues into play. Where roles belonged to an established health care profession (e.g. physiotherapist), this could assist with implementation. That said, GPs, practice staff, and reportedly patients, were at differing levels of acceptance of new roles, with variation in staff's willingness to relinquish tasks that were previously under their own remit. Clearer role boundaries appeared to facilitate acceptance of roles by setting more realistic expectations about what they could achieve and helping them to be used more appropriately; however, this needed to be balanced with the needs of individual practices/settings.

The education and training of new roles professionals affected the feasibility of skill-mix changes. In line with our previous NIHR CLAHRC GM research, new roles practitioners regionally were reported to need a greater level of preparation for the general practice setting (where they would be expected to work more autonomously than before in a setting where uncertainty and risk were common). It was reported that capacity and time to plan training was often lacking, meaning that role holders often had inadequate periods of on-the-job training before being expected to function fully in their roles. GPs themselves were also said to need training to adjust to working alongside new roles professionals in order to optimise their own and other practitioners' skillsets.

Linked with education and training, new roles professionals were working under different employment models. Professionals employed directly with practices were seen to be more able to shape their roles to fit the requirements of general practice, but could miss out on the training and development opportunities afforded to role holders employed by larger organisations. It was noted that employing organisations needed clear HR procedures/support structures to govern the employment of new

roles practitioners and the capacity to provide continuing professional development, peer support and career development opportunities.

Our previous NIHR CLAHRC GM local evaluation of new roles schemes highlighted the difficulty of capturing evidence of the impact of roles due to the different goals associated with skill-mix changes, as well as a lack of appropriate mechanisms to fully capture these different outcomes. Regionally, there was wide agreement that evaluation of roles was needed to avoid unintended consequences; however, roles were often inserted rapidly into the system, sometimes without a clear understanding of the intended outcome, meaning there was no time to thoroughly plan evaluative approaches. It was also agreed that the main aim of new roles was to take the pressure off GPs by partially substituting for them on some tasks. Some new roles scheme leaders believed they were able to show time reductions; however, there were reports of work being duplicated by different professionals making net time-savings hard to gauge. Other participants believed that measuring reduction in GP workload was an impossible goal, as the work of GPs was so complex and multifaceted. Patient feedback on new roles services was also seen to be important, though recognised as equally difficult to capture in meaningful ways.

The ‘upskilling’ of reception staff as care navigators to provide active signposting to patients and direct them to the most appropriate source of help highlighted particular role boundary issues. The assessment and channelling of patients’ needs to appropriate help required a significant level of judgement and there were concerns that care navigators may be operating outside their realm of expertise with implications for patient safety. Directing patients who wished to see a GP to other services as part of this role could also reportedly involve stressful interactions. Additionally, a lack of planning and coordination across sectors appeared to impair the success of the role when other services were unable to take patients. This had implications for patient trust in general practice more widely.

There were mixed reports of the social prescribing link worker role. A lack of clarity about the role’s remit led some GP staff to make inappropriate referrals to link workers. Provider type appeared to strongly shape the role, with clinically based social prescribing link workers in primary care perceived to be operating in less patient-centred ways than those with in-depth knowledge of the community voluntary system. The potential for conflict between the dual goals of freeing up GP time and addressing patients’ needs was highlighted. The role also suffered from perceptions of inconsistency arising as a result of link workers from different backgrounds working in different ways. Standardised role frameworks and training specifically for the primary care setting could help embed the role more smoothly. Strong links across services in the system to develop in-depth knowledge of what is available and how services can best support patients enabled the role to function more successfully. While social prescribing link workers in primary care could be seen as a

threat to established link worker services in the community, with communication and engagement these difficulties could be overcome.

There were concerns about how the newly forming Primary Care Networks (PCNs) would shape the evolution of new non-medical roles in primary care, with some reticence about investing further as areas waited to see how set-up would affect roles planning. While PCNs were seen as potentially facilitating the sharing of roles, it was reported that PCNs might work against role shaping as roles would have to be strictly operationalised as specified in the new GP contract. There were concerns that the additionality rule under the Additional Roles Reimbursement Scheme (ARRS) penalised early adopters and would influence the type of roles seen in future general practice, as practices will be unlikely to invest in roles outside the contract. Other questions remained around the lack of legal status for PCNs and how this would affect inter-practice agreements and the employment of new roles professionals. More widely it was felt that practices faced the challenge of balancing their independent contractor status against the potential benefits of being part of a wider network. Given the difficulties highlighted around producing meaningful workforce data for general practice, it is uncertain whether PCNs will be able to link successfully with Integrated Care Systems (ICS) to influence workforce planning for new roles in primary care.

1.4. Key Messages

- Previous CLAHRC GM research at a local GM level identified key factors that maximise the potential of skill-mix changes in general practice and increase its sustainability; this study highlights that these factors also applied regionally and remain significant challenges to varying degrees across GM;
- Meaningful and timely communication and engagement between stakeholders for the coordination and planning of new roles can avoid unintended consequences;
- Engaging practices in discussions about why workforce data is needed and how it can help them with workforce planning may assist the development of skill-mix changes;
- Clarity around the definition and boundaries of new roles can assist roles to embed more smoothly, while recognising where emergent roles require some flexibility;
- Tailored training of new roles professionals for the general practice environment as well as employment models to ensure their continuing professional development are required;
- Robust measurement of the impact of new roles requires detailed attention to intended outcomes and availability of reliable data, particularly with regard to accurately assessing changes to GP workload;

- There are particular considerations for the implementation of the care navigator role. These include how the role functions across the wider health and social care system and whether staff are adequately prepared to assess/channel patients to different care options with possible implications for patient safety and trust in general practice;
- There are considerations for how social prescribing link workers funded under the new GP contract will affect existing services across the wider system and there may also be potential for conflict between duties of the role in providing personalised care to patients while aiming to release GP time;
- Which new roles will be sustained in general practice, and in what form, are questions that are strongly linked to the newly forming PCNs and associated funding streams;
- There is uncertainty around how PCNs might influence general practice workforce planning (including skill-mix changes) through the developing ICSs.

2. Background

Demand in general practice is currently exceeding capacity¹; the challenges of providing care for an ageing population living with increasingly complex health needs alongside a corresponding shortage of GPs and nursing staff has led to a new national policy focus to address rising workforce pressures in general practice. A key priority has been the integration of other health professionals (such as Physician Associates and Practice Pharmacists) into primary care teams to redistribute the workload. The drive to introduce a greater level of 'skill-mix' alongside GPs started with the General Practice Forward View² and has recently gained momentum. The NHS Long Term Plan³ and the new GP Contract Five-Year Framework⁴, both released in early 2019, are seeking to further expand the quantity and type of non-GP professionals in general practice over the next five years. Against the backdrop of GP shortages, the vision is for over 20,000 additional new roles professionals to be recruited across England to plug workforce gaps and enhance care.

From 1 July 2019 primary care networks (PCNs), made up of groups of general practices in the same geographical area, will provide care to populations of between 30,000 and 50,000 patients each. PCNs will be part of larger Integrated Care Systems (ICSs) that are planned to be in place by 2021 across the country⁵. ICSs will, among other things, be tasked with developing five-year workforce plans to inform national workforce planning, including plans for the number and mix of roles needed to deliver the NHS Long Term Plan⁶.

Funding for five specific new non-GP roles is being directed through PCNs⁷ under the Additional Roles Reimbursement Scheme (ARRS) in phases: from 2019, clinical pharmacists and social prescribing link workers; from 2020, physician associates and first contact physiotherapists; from 2021, first contact community paramedics. Seventy percent of salary costs will be covered for all these roles, except for social prescribing link workers whose salaries will be fully covered. Individual practices within PCNs will be expected to cover remaining salary costs of the roles. PCNs will be able to choose which roles they want to employ and have flexibility in setting job descriptions, though suggested job specifications have been provided for guidance.

Our previous NIHR CLAHRC GM research on skill-mix changes in primary care concluded that when new roles are introduced, it can be difficult to demonstrate their impact on the system. An extensive literature review in 2017⁸ highlighted the range of outcomes associated with new roles that had been measured in previous research and further, that these study designs were generally weak and their evidence unconvincing. Importantly, studies focused on measuring 'GP time released' (a key driver of the skill-mix at scale policy in primary care) were absent at the time of the review⁹. Our qualitative evaluation of three specific new non-medical roles in one area of GM, published in 2019¹⁰, additionally underlined that new roles are unlikely

to embed rapidly into primary care without some challenges, because 'substituting' other workers for GPs is not a straightforward transactional process.

2.1. The Greater Manchester Workforce Strategy

Regionally the Greater Manchester Health and Social Care Partnership (GMHSCP) 5-year plan identifies the need for the primary care workforce to change to enable reform to happen in a way that is sustainable for the future^{11,12}. The GM Workforce Strategy is seeking to explore new models of care that utilise the breadth of skills across primary care and put patients at the heart of services, requiring changes in how the future workforce is developed and sustained¹³. Key priorities for delivering an integrated health and care model in primary care, comprising a multi-skilled, multi-professional workforce, are to:

- Improve the recruitment and retention of a number of key roles and skills across primary care;
- Support the development of system leaders across primary care;
- Create a range of career pathways which cross boundaries and sectors;
- Ensure that all staff feel valued and have access to opportunities for development;
- Ensure that primary care is seen as the 'career of choice'.

2.2. Study aim

Recognising that piloting of workforce transformation in primary care, supported by evidence-based critical evaluation/learning, is essential to understand the process of innovation and help avoid unintended consequences, GMHSCP engaged the NIHR CLAHRC GM to investigate new roles in GM primary care. Building on prior CLAHRC GM research on skill-mix change in general practice⁸⁻¹⁰, the aim was to understand how new roles were being established in general practices across the region and how this might address current recruitment challenges in GM.

3. Methods

We conducted a qualitative process evaluation to understand how new roles were being established across GM. Ethical approval was obtained from a University of Manchester ethics committee. To gain a range of stakeholder views, participants were sampled purposively by professional role in the following groupings:

- 1) *strategic* interviews involving a) national/regional GP and primary care policy leads, and b) CCG/GP provider leads for each of 10 areas across the region of GM;
- 2) *operational* interviews involving staff working in some capacity in five 'targeted' new roles across GM (i.e. training/service leads; role holders or host GP practice staff).

National/regional GP and primary care policy leads, as well as CCG/provider leads across GM areas who could contribute broad strategic views about new roles, were identified and invited to take part. To drill down to operational-level views, 'snowball' sampling was used in the strategic interviews to generate a sample of colleagues involved in up-and-running 'targeted' new roles that had not previously been researched by CLAHRC GM. The five individual new roles targeted were: care navigator, paramedic, pharmacy technician, physiotherapist and social prescribing link worker. We looked broadly at the five roles across GM areas rather than focusing in-depth on particular new role schemes. Participants involved in these roles as training/service leads, role holders or host GP practice staff were invited to take part.

Semi-structured interviews (and one focus group) were conducted with key individuals agreeing to participate. Strategic interviews with national/regional GP and primary care policy leads took place between August 2018 and May 2019. Operational interviews with staff involved in individual new roles initiatives across GM took place between April and July 2019. Interviews aimed to identify broad strategic and operational issues faced in implementing the new roles and how issues were being addressed. Interview/focus group topic guides were informed by our previous skill-mix change literature review⁸. Broad topics for discussion in interviews are presented in Table 1. Interviews/focus groups were transcribed and anonymised, before being analysed thematically using NVivo software¹⁴ and applying a combination of pre-determined and emergent codes¹⁵.

Table 1. Interview/focus group interview guide

Topics
1. New roles in place or planned
2. Changes needed to establish new roles
3. Steps so far
4. Communication of changes to staff/patients
5. Challenges encountered
6. Expected impact
7. Measuring 'success'
8. Sustainability of changes

4. Findings

4.1. Participants

A total of 87 participants (at both strategic and operational levels) took part in 61 interviews and one focus group (see Table 2 for final overall study sample). Operational-level interviews (on the five targeted roles) involved, in some cases, one professional from a particular new role scheme; in other cases more than one professional from the same scheme took part.

Table 2. Final overall study sample

Participant role	Number of participants	Targeted roles
Strategic interviews		
National and regional GP/policy leads	14	
Regional CCG/GP provider leads	26	
Subtotal	40	
Operational interviews		
New roles service leads	18	Care Navigator (3); Pharmacy Technician (3); Paramedic (1); Physiotherapist (5); Social Prescribing Link Worker (5)
New roles practitioners	9	Care Navigator (3); Paramedic (1); Pharmacy Technician (1); Physiotherapist (1); Social Prescribing Link Worker (3)
New roles host GP practice staff	7	Care Navigator (4); Pharmacy Technician (1); Physiotherapist (1); Social Prescribing Link Worker (2)
Subtotal	34	
Operational focus group		
New roles host GP practice staff	13	Care Navigator (13)
Subtotal	13	
TOTAL	87	

4.2. Distribution of new role types across GM

Several new roles were in place across the region at the time of interviews. Table 3 presents the distribution of new roles either in place or planned as reported by strategic leads (i.e. GM CCG or provider leads) over the period August 2018-May 2019, meaning that all roles were already in place before PCN arrangements came into force on 1st July 2019. New roles professionals were reported to be operating in all GM areas, though the distribution varied. Some areas had up to eight new roles, while others had only one. Every GM area was reported to have pharmacists in general practice covered by various funding sources. Three areas reported having physiotherapists (sometimes called musculoskeletal – MSK – practitioners) in place and two areas were planning on introducing this role. Social prescribing link workers with different titles were reported to be operating across GM in six areas, with one area working towards a social prescribing scheme. All social prescriber roles were in place prior to the forming of PCNs on 1st July 2019 and were operating both in primary care and the voluntary sector. Five GM areas reported having care navigators in place and six had paramedics, with one area planning to introduce this role into practices in the future.

Table 3. Distribution of new roles types reported by GM CCG/provider leads

Roles in place	GM Area	Planned roles	GM Area
Advanced practitioner	1, 4, 6, 8	Advanced practitioner	9
Care navigator	3, 4, 7, 9, 10	Care navigator (enhanced)	3
GP assistant	3	Counsellor (trainee)	3
Mental health practitioner	7	Mental health practitioner	1, 9
MSK practitioner/physiotherapist	1, 7, 10	MSK practitioner/physiotherapist	2, 9
Paramedic	2, 3, 4, 6, 8, 10	Occupational therapist (trainee)	3
Pharmacy technician	2, 7, 10	Paramedic	9
Physician associate	2, 6, 7, 10	Social prescribing link worker	9
Pharmacist (practice-based, neighbourhood or directly employed (various funding sources some NHSE scheme)	1-10		
Social prescribing link worker	1, 3, 4, 6, 7, 10		

4.3. Targeted new roles (operational-level data)

Operational interviews drilled down to examine the implementation of five targeted new roles that were operating in GM areas and that had not been researched previously by CLAHRC GM:

- care navigator;
- paramedic;
- pharmacy technician;
- physiotherapist;
- social prescribing link worker.

Social prescribing link workers had different titles in different GM areas and this is also the case nationally (e.g. community connector, community navigator, community health worker, with some workers based in primary care and others in the voluntary sector). For clarity, in this report the term 'social prescribing link worker' is used throughout as an umbrella term, since the core elements of the role - providing community-based support to patients through shared decision-making, personalised care and support planning - are purported to be similar.

For background, Appendix 1 presents short summaries of each role targeted in this study for operational interviews. Three of the roles (social prescribing link worker, physiotherapist, and paramedic) had also been identified for directed funding under the new GP contract; however, all roles investigated were up-and-running in schemes or initiatives before PCN arrangements came into force on 1st July 2019. One of the physiotherapy schemes included was part of the NHS England national first contact practitioner for MSK pilot¹⁶. The roles investigated and their areas of operation in GM can be seen in Table 4.

Table 4. Targeted new roles investigated in GM areas

Roles	Number of interview (i) or focus group (fg) participants	GM Area
Care Navigator	10 (i) 13 (fg)	Areas 3, 4 and 9
Pharmacy Technician	5 (i)	Areas 2 and 10
Physiotherapist	7 (i)	Areas 7 and 10
Paramedic	2 (i)	Areas 8 and 10
Social Prescriber	10 (i)	Areas 1, 4, 7 and 10
TOTAL	34	

4.4. Strategic and operational-level stakeholder perceptions of new roles

Stakeholders raised key issues in relation to their experiences of a range of new roles. Findings are presented in five categories:

- Aims of new roles.
- Role definition/perception of roles.
- Challenges/enablers of implementing new roles including:
 - preparation and training for general practice,
 - planning and coordination,
 - estates,
 - professional tensions/boundary issues,
 - regulatory issues,
 - communication and engagement,
 - factors influencing practice involvement in roles,
 - working across practices/employment and control.
- Measuring the impact of new roles.
- Funding and sustainability of new roles.

The presentation of findings under each of these categories is organised into results from strategic-level participants (i.e. national/regional GP and primary care policy leads and CCG/GP provider leads for each of the 10 GM areas) and views from operational-level participants (i.e. training/service leads, and role holders or host GP practice staff involved in the five targeted new roles across GM: the care navigator, paramedic, pharmacy technician, physiotherapist and social prescribing link worker roles).

4.4.1. Aims of new roles

Strategic

Participants viewed the introduction of new roles into general practice as fundamental to the re-design of primary care. Given the declining number of GPs, new roles were seen as a way to reconfigure how general practice works to ensure the 'right' professional skill-mix to meet patients' needs:

I think the aim in the long-term... is to reconfigure the way GPs and general practice works. And we've got what we've got, and we've got the workforce issue that we've got. One way is to just march on, until [GP] numbers go down and I don't think we can afford to do that. So, we've got to look at proactively shaping what general practice looks like. (Regional GP Lead 3, Interview 5)

Many reported that the aim of new roles was to take pressure off GPs but one expressed concern that plugging gaps in the declining GP workforce was not the best reason to introduce such practitioners; rather, this should be done with the primary aim of improving the skill-mix in general practice:

So I think the drive to multi-disciplinarity is coming from a negative thing rather than from a positive thing. So it's coming out of a stable that says, 'well, we can't get GPs...well, we'll get nurses, or we'll get physios'...they shouldn't be doing that; they should be using them because they are the right clinician to deal with the problem. (National GP Lead 2, Interview 6)

For some, new roles professionals were viewed as only temporarily important in general practice *'at least as a holding measure until new GPs come on board'* (National GP Lead 1, Interview 8).

Operational

The majority of participants across the five targeted roles agreed that the primary aim of these schemes was to address workforce pressure in general practice. Schemes were aiming to reduce demand for GP appointments and increase GP capacity, but with the possibility of developing more tailored services along the way:

...the summary of our work, really, is to support primary care and deliver services at scale that will allow us to take pressure off primary care and develop specialist services. (GP Lead Paramedic Scheme, GM Area 10, Interview 51)

There was a belief that through delegating tasks to new roles professionals, GP time could be saved. For example, pharmacy technicians were said to be able to focus on routine technical tasks appropriate to their skillset, enabling pharmacists to concentrate on work that required a higher level of skill, while physiotherapists could partially substitute for GPs, enabling them to focus on more medically complex patients:

[Pharmacy] technicians... will do all of that stuff that I feel isn't utilising my full skillset so that I can use my skillset in high level things. And that includes improving processes so there are less of these things where there are these repetitive tasks. (Lead Pharmacist, GM Area 2, Interview 55)

And a lot of GPs who don't have that MSK special interest, they really welcome, because they want to focus on something else; and that's what it is, it's freeing their time up so that they can focus on the complex medical conditions. (Lead Physiotherapist 1, GM Area 10, Interview 54)

Care navigators were reportedly in place to assess patients' needs and signpost them to the most appropriate service. A key part of this was to deflect those patients deemed not to need a GP appointment away from general practice to other community facilities, thereby saving GP time:

We need a mechanism to get that traffic away from general practice. But it's about freeing up GP time to deal with the cases. And actually care navigation is a really simple way to do that. And it's not about...telling people that they can't have an appointment [or]...stopping those ill people who do need to come to their GP. But it's about, you know, upskilling those reception staff or the administrative staff that are that first line, to spot that actually the carer who just needs a bit of support, who needs a group. It's that kind of thing. (CCG Lead, GM Area 9, Interview 29)

So, really, to try and ensure that the patient is seeing the right professional at the right time that they need to. And, if it's not a GP practice that they need to be in, then that is going to save time for the practice also...for them to be seeing the people that actually need to be there. (Lead Care Navigator Scheme, GM Area 9, Interview 32)

In addition to releasing GP capacity, new roles were also seen by operational-level participants as aiming to diversify the skill-mix in general practice to improve patient care. For example, first contact physiotherapy schemes aimed to provide patients with more expert advice, while social prescribing schemes were focused on addressing the wider social and psychological needs of patients in a 'patient-centred' way:

The key aim is to release capacity of general practice... with the unavoidable bonus that people get better advice, in general. So they get more expert advice on their condition, they get more follow up advice and it links to information, things to do, so the patient education is better. (GP Lead Physiotherapy Scheme, GM Area 10, Interview 64)

The GM understanding is we want holistic [care] – that's what we recognise as the social prescribing scheme... and the holistic is working with people for as long as they need it and the way they want it. (Regional Social Prescribing Link Worker Lead 1, Interview 41)

4.4.2. Role definition/perception of roles

Strategic

Among strategic-level stakeholders there was a general perception that GPs were beginning to accept new roles as part of general practice but there were reports of some remaining wary and unconvinced of the value of new roles:

I'm hearing feedback... in some instances there's a bit of a reluctance to do a patient-facing function from some of the roles, some pharmacist roles, and obviously patient-facing is kind of where they add value from a workforce perspective. Obviously they can do very valuable work as well in the back offices, but if they're not meeting some of that demand then there's a missed opportunity perhaps. (Provider Lead, GM Area 6, Interview 17)

There was concern over the 'deliverability' of new roles, centring on a perception that practices did not necessarily understand the remit of roles and how they would reduce GP workload on the ground:

...deliverability is the issue that we're facing all the time, I think, with new roles. So, it's not that we're averse to new roles, although you do sometimes have to sell it to practices, around, what's in it for them, but what they want to know is, how many patients will they see, how will they reduce my workload? (CCG Lead 3, GM Area 5, Interview 31)

'Risk averse' practices were said to be cautious about introducing new roles, often waiting to see how roles worked in other practices before committing to taking individuals on themselves:

Where there's any degree of uncertainty or risk, [practices will] shy away from it. They're just not prepared to go there, and I think that's a reflection of where they are operationally, so in terms of being 'maxed out', and not really wanting to take a risk on something, not having the capacity to try something out and test it. (CCG Lead, GM Area 6, Interview 16)

Participants in the strategic interviews mentioned some specific new roles in their accounts, mainly the physician associate (PA), paramedic, pharmacist and social prescriber roles (views on some of these roles were also gathered in operational-level interviews and are presented later).

There were mixed views on PAs among strategic stakeholders, though views tended to be more negative than positive. Concern centred on a lack of clear role description for PAs within general practice and a view that the role may better suited to secondary care. There was ambiguity about how the role could benefit general practice:

It's a new role; you're not quite sure what [PAs] can or can't do. There's relatively little information actually, even if you go searching for it, as to what they can and can't do, or should be able to do, and how you might get them up and running. (GP CCG Lead, GM Area 4, Interview 18)

Reportedly, there was wide disparity in clinical skill between individual PAs and views that the role required more support to assimilate into general practice (which could further increase the workload for already stretched GP practices) were expressed. PAs were not seen as offering value for money due to their restricted scope of practice, with reports that having a professional who '*can't prescribe was nigh on useless*' (Regional GP Lead 4, Interview 7)

By contrast, views of paramedics in general practice among strategic-level participants were generally positive with these professionals seen as having appropriately transferable skills to deal with home visits and assessment of acute conditions/falls. However, one participant described a previously unsuccessful paramedic pilot, where the experience and skillset of role holders had been reportedly incompatible with the requirements of primary care:

...we were looking at patients who were acutely ill, who we still wanted to hold in general practice, and actually what we found is the paramedics did not have the skill set to do that. They can't take blood... and really very simple things like that... you've got to be able to do all that diagnostic screening there and then, to make that decision about whether you hold or refer... yeah, so huge training needs there. (CCG Lead 1, GM Area 5, Interview 31)

Some strategic stakeholders described the initial response to pharmacists in general practice as mixed due to a lack of awareness of the potential advantages of this role. In the main however pharmacists were described positively, with a sense that any early resistance to the role had been overcome:

..So of all the roles, clinical pharmacists are the one they like... I think that one is one that is won over in (GM Area 6). (CCG Lead, GM Area 6, Interview 16)

Pharmacist roles could reportedly lack a clear role description however, at least initially. This was viewed by some as problematic but by others as advantageous because this ambiguity could allow individual practices to shape the role to meet their specific needs. This tailoring aspect meant that the practice pharmacist role reportedly varied greatly between practices and across areas in GM.

Some stakeholders were eager for pharmacists to be working at the top of their scope of practice, focusing on patient-facing work and long-term medicines management (though this had caused concern among some GPs who had issues

around trust, competency, liability and indemnity). If pharmacists were confined to covering routine tasks for GPs, it was felt that retention could be an issue:

There are so many reasons [why pharmacists] are not here to do [GP] repeats [repeat prescriptions] for you... If you want them to do your repeats, they can maybe start doing that but we are not having them sitting in a dark room, no windows, doing repeat medication all day, because that's no good to anybody and they'll leave 'cause they will be bored basically. (Provider Lead, GM Area 7, Interview 13)

The social prescribing link worker role was mentioned briefly in strategic-level interviews and mainly in a positive light, as role holders were perceived to have the time to work with individuals in a holistic way to address underlying social or low-level mental health issues that GPs did not have the time deal with:

So, you know, you've got those kind of new roles, where it's looking at a person's holistic needs, rather than just medical needs, and saying, well, they've been off work for a year, because they're in debt, or because they've got this problem, and they're looking at the person's needs. (CCG Lead 3, GM Area 5, Interview 31)

Although, one national policy lead suggested that *'through the [GP] contract, the social prescriber networker role particularly, it's helpful'* (National Policy Lead, Interview 35), it was suggested by this participant that practices would need to operate the role as specified in the contract and not adapt it to suit their individual needs.

Operational

Perceptions of new roles in the operational interviews across the five targeted roles were largely similar to strategic views. For example, some roles were seen to be evolving in general practice. It was reported positively that with support, paramedics were developing their own unique role and identity in this setting:

...that's been the feedback that we've had from the paramedics...is that they're not feeling like they have to be GPs, necessarily; it's that they're being paramedic practitioners and that they are developing that role and that identity. (GP Lead Paramedic Scheme, GM Area 10, Interview 51)

Social prescribing link workers were new to general practice and service leads often described working towards developing their offer and shaping the role. One area with a well-established social prescribing service described how they had worked closely with their commissioners to shape their offer to specifically meet the needs of general practice:

We've worked very proactively; we've got a really close relationship with the commissioners...so yeah, it's very much been a collaboration with them in the hope that we give them what they need. And it seems to be because the GPs speak very highly of the service and the referrals are increasing. (Lead Social Prescriber Scheme, GM Area 1, Interview 44)

However, the social prescribing link worker role was often not well understood and this had impacted on its uptake in some areas, with particular concerns about giving these professionals access to patient information:

We didn't take on a [social prescriber]... I do think it's a really good concept. Our own experience when we were first asked, we went to a meeting for expressions of interest... and I said 'oh no, I'm not signing up for anything about yet, I don't know anything about it'. And they said 'this is such-and-such a body, she's coming to work with you on Monday, if you give her a desk and give her computer logins' - woah, woah! And they wanted full access to medical records which we weren't happy to do. (Practice Manager 4, Care Navigator Scheme, Focus Group 1)

The social prescribing link worker role could reportedly be heavily shaped by the provider organisation in charge of the scheme. Participants from services whose providers were based in the community voluntary sector (CVS) felt strongly that the success of their service stemmed from link workers being from a non-clinical background and having an in-depth knowledge of the CVS. There was concern however, that when social prescribing service providers were primary care based, this could lead to services being more likely to benefit the needs of general practice and become less person-centred:

And every single person within these walls, are so passionate... and I think that makes a big difference, you know? And that is the advantage again, of us being us, we're independent. So, we can challenge Public Health, we can challenge [County Council]. We can challenge the NHS... and that's an immense freedom. (Regional Social Prescribing Link Worker Lead 2, Interview 43)

In common with strategic views, operational interviewees reported some ambiguity among general practice staff about the remit of roles. For example, a number of service leads and social prescribing link worker staff described how they could receive inappropriate referrals (usually referrals from GPs and other practice staff of patients in mental health crisis or who were suicidal). This suggested that practice staff could be at least initially unclear about the remit of social prescribers, although participants reported that as services became more established, this became less of an issue:

...because it's a new service as well, we have had input on who we see and who's eligible and who's not eligible. So, it's like, if there are any people who are really depressed or anything like that, or suicidal, then we'd take that as an inappropriate referral. So, initially then, they shouldn't be referred. So, I think the GPs and reception are on board with that now, but at the beginning it was a little bit..."I've got this person" and it was like, "well, they're probably not suitable for our service because.." (Social Prescribing Link Worker, GM Area 10, Interview 66)

There were also concerns that social prescribing link worker service provision could be inconsistent where role holders came from different backgrounds. Link workers could often be employed from a variety of other services, such as debt management, benefits, mental health, dementia and housing. While this variation could bring a wide range of expertise to social prescribing teams, it could also lead to variation in what role holders and services could offer:

...we've been very focused... on equity of provision...across GM Area 10, so...that to us is very difficult to meet, not just in terms of the number of hours we have, but also in terms of the worker that we offer. So [one link worker] might lean more on mental health, [another] might lean more into supporting with debt and might, so she might signpost the mental health issue out, but manage someone with debt issues. And from my point of view as a Service Lead that's very, very difficult to manage because I can't actually say that we're delivering exactly the same thing in each neighbourhood to each clinic. Whereas if they asked the physio team, they're all delivering physio or the pharmacy team are all delivering medication reviews. (Lead Social Prescribing Link Worker Scheme, GM Area 10, Interview 34)

Some social prescribing teams had consequently developed (or were working towards) competency frameworks to ensure consistency of service delivery across all link workers and services in an area.

In terms of patients' perceptions, it was reported that although some still struggled with the concept of seeing an alternative practitioner rather than their GP, patients were beginning to understand new roles:

...and as we go along we're seeing that the patients are then getting on board with it as well, and they're becoming more aware of what those roles look like. (GP Lead Paramedic Scheme, GM Area 10, Interview 51)

4.4.3. Challenges/enablers of implementing new roles

4.4.3.1. Preparation and training for general practice

Strategic

Participants in the strategic interviews identified that new roles professionals needed specific training to prepare for general practice, however there were concerns that there was often no capacity or workable plan to operationalise such training. Paradoxically, it was suggested that areas most in need of new roles were the least able to support these professionals because they were 'under-doctored' to begin with:

One of the things that we've thought about is there is areas where they need quite a few [roles] but they are not necessarily the areas for them to train in. ...So, where the greatest need is isn't necessarily the easiest place to try and [train them]...So, we perhaps need to choose other areas to train and, you know, where they have got the time, the information and the good practice, and take that to the areas that we need. (CCG Lead, GM Area 8, Interview 24)

It was highlighted that workforce plans did not factor in the capacity to train new roles. With many areas regionally assuming that new roles' practitioners came ready-made and prepared for general practice, this was seen to be based on unrealistic assumptions:

...all the workforce plans I've seen... none of them include the capacity to train those groups of people, it's all on the assumption that there's a shelf there, you're just going to pick them straight off, they're going to arrive and they're going to deliver 100% workload according to that theoretical model. Rather than actually, even if you pick a qualified PA, they will need two to five years building up to deliver the sort of work you think you're going to get from them. (Regional GP Lead 1, Interview 1)

Strategies to improve preparation and training for new roles that were suggested included moving from schools of 'GP training' to schools of 'primary care training' to ensure training hubs developed a remit for workforce planning that would not be solely focused on attracting more GPs, and developing a primary care competency list to inform curricula for staff entering this setting from different clinical backgrounds. Ensuring that new roles professionals were employed by organisations that could provide access to Continuing Professional Development (CPD) and peer support to provide career development was seen to be important, as were efforts at the national level to engage with practices about how they could host new roles practitioners and afford them developmental opportunities and a clear direction for progression:

...when we had a national programme to bring them in, the pharmacists had a training programme from us, so skills to work in primary care as well as independent prescribing... working with the practices on how they could appropriately host and give the clinical supervision and maybe even mentoring, support and such like. (National Policy Lead 3, Interview 35)

In particular, there was a view that current PA training was not adequate and had led to low uptake of the role across GM. One participant believed that PAs were being 'set [up] to fail' (GP Provider Lead, GM Area 3, Interview 11). Improving PA training would, in their view, need closer working with local universities to develop primary care focused training that is co-designed with primary care involvement. Enabling prescribing rights for PAs with regulation and a career pathway was also seen as important in having this role accepted in general practice:

...we're working with [universities] to look at how we develop their primary care module again, because we don't think it's fit for purpose at the moment, how it's done, and the fact that they only do eight weeks. It's not a realistic... overview... and it should be a placement in first and second year with a lot longer in it and we should have a couple of blocks so they get to see everything. (Provider Lead 2, GM Area 3, Interview 11)

More generally, it was suggested that GPs themselves required training to help them adjust to working alongside new roles colleagues to embed them, including support to manage their expectations of new roles and guidance on how to optimise practitioners' skills:

I would doubt, as we go forward, whether we would have all the skills in primary care... the GPs, sorry, would have all the skills to cement or to professionally develop the various new roles. And I think that's where the GP... federations would probably be helpful at holding that ring. (GP Provider Lead, GM Area 9, Interview 40).

In terms of supervision, there was a general sense that the infrastructure to provide this to new roles employees in general practice was lacking across the GM area:

...it's also usually a case, where it's a new role, that the person coming into general practice... needs to be mentored, and it's the time that it takes to provide them with the supervision that they require, and it's also, a lot of these are small businesses under quite a lot of pressure, and if they can't see a benefit from day one, then they won't necessarily want to take it on board. (CCG Lead 3, GM Area 5, Interview 31)

However a regional participant highlighted that the training of GPs to clinically supervise new roles staff was important and being addressed:

So, there's quite a lot of active work going on and [we] are trying to help with training the GPs, who are going to clinically supervise these people. So we've just started, we've just done our day one, of our two day course, to develop generic clinical supervision skills for these people to train in GP, with a view to them working in GP. (Regional GP Lead 3, Interview 5)

Operational

Challenges were also raised in operational interviews for the five targeted roles, relating to the preparation and training of new roles professionals for the primary care setting. Across the different roles, education and training delivered at university was described as being geared mainly towards secondary care, with little, if any, focus on primary care. Additionally, there were few opportunities to experience practice in this setting before role holders began their careers and this could present a steep learning curve:

I've obviously been involved in the recruitment and training of [pharmacy technicians] and induction... they come in from wherever their background is and the first six months are like, they're in shell shock because it is so different. And I remember feeling that myself. It's, you can't prepare yourself for it, and I just say to them, the first six months don't worry about what you don't know. (Pharmacy Technician Scheme Lead, GM Area 10, Interview 30)

Risk management in the general practice setting was highlighted as a particular area of concern among operational scheme leads due to the perception that the previous training of non-medical practitioners prioritised more standardised types of working. Training staff to manage the uncertainty inherent in primary care was therefore seen as important to successful implementation of new roles in general practice:

Understandably it's scary going into that different environment where... the level of uncertainty that we have to deal with and manage in our job. Things can be more protocol-driven [for non-GP staff] and that's not just paramedics... things can be a lot more uncertain, and there are more grey areas. So managing that uncertainty has definitely been something that we've been helping them develop on. Their confidence has just gradually grown with these things; so yeah, initially it was definitely a very steep learning curve, and it continues to be. (GP Lead Paramedic Scheme, GM Area 10, Interview 51)

Some roles were seen to need supervision and mentoring of a more qualified professional in order to overcome concerns about risk management. For example, pharmacy technicians were generally only introduced into practices where a qualified pharmacist was available to provide guidance and support, checking the work of the technician to make sure they were not carrying out duties outside of their scope of practice. However, there were reports of these professionals working alone in primary care and this was said to present a potential risk to patient safety:

I believe there are surgeries that have qualified technicians in place without a pharmacist being there and I'm not sure that that would work as well. I think they need to work under that expert, personally. (Pharmacy Technician Lead, GM Area 2, Interview 55)

Similarly, some GPs working with first contact physiotherapists insisted on seeing patients first, despite the aim of the system being to direct patients away from GPs. This was said to be due to GPs' concerns about risk, but it caused work to be repeated by different practitioners rather than reducing workload:

Some GPs still like to see the patient first and then refer in to the MSK practitioner, but that's individual preference really... that's duplicating the time, so that's what we're working with them at the moment. It's building that confidence and trust that these GPs will have with the practitioners. (CCG Physiotherapist Scheme Lead, GM Area 7, Interview 65)

New roles practitioners were expected to work more independently than in other settings and those who already had experience in primary care were more prepared than others for this way of working:

I've been a paramedic for 17 years, when I started the role I really didn't know where to start, it's massive, and, basically, the role is quite autonomous. (Paramedic Practitioner, GM Area 8, Interview 53)

I suppose you'd kind of struggle if you didn't know the primary care setting and background ... you've got to be used to working on your own to an extent 'cause sometimes physio teams are set up where you're all sat around a desk and working together, whilst this is, you're kind of behind a closed door at a GP room, so you've got to be used to that kind of independence, and being able to manage that diary independently. I suppose that there's that responsibility to that really. (Physiotherapist Practitioner, GM Area 10, Interview 61)

Some schemes had focused a great deal of effort on consulting with GP colleagues to plan, agree and deliver structured training for their new roles practitioners. In the case of first contact physiotherapists for example, this approach enabled them to extend their roles and carry out duties traditionally carried out by GPs:

They [physiotherapists] are able to order bloods and we've recently agreed an x-ray protocol with the radiology department, because beforehand, our... ANP [Advanced Nurse Practitioner]... couldn't order x-rays directly and it had to all go through the GP.... we still have to have some kind of protocol that our GPs have signed off to say that they are happy for the practitioners to take

responsibility for ordering these x-rays, a list of conditions, you know, that sort of thing. So we've done that, so now they can order x-rays, they can do bloods, and they can order ultrasound scans as well. (CCG Physiotherapist Scheme Lead, GM Area 7, Interview 65)

It was generally GP reception staff who had undergone training aimed at extending their role to that of care navigator. Care navigators expressed that they were (at least initially) concerned about taking on this role, because they were not clinically trained and did not feel qualified to signpost patients to other services. While some stated that they got used to signposting '*at first it was a bit scary but now, you just get used to it*' (Care Navigator 4, GM Area 3, Interview 58), even experienced staff remained concerned that by taking on this 'triaging role' without clinical training, it was only a matter of time before important signs and symptoms of patients' illnesses were missed with safety implications:

I feel that somewhere along the way...it's going to have consequences for somebody, because something that somebody clinical might pick up, won't be picked up by us... touch wood, it hasn't yet, but you just... you've just always got that feeling that, ooh, are you [making] the right decision and... that's after doing the job for a long time, so I don't know about new people, how they feel when they're doing [it]...it must be awful. (Care Navigator 5, GM Area 3, Interview 59)

Care navigators were also often in the position of having to have challenging interactions with patients who resisted their attempts to signpost away from GP appointments. It was felt that more training was needed to prepare staff for these eventualities:

...you get a range from 'well, no, of course I want the doctor, otherwise I wouldn't be here' and all those sorts of things. So I think that we would need more training of receptionists in change management, sort of to encourage...you know, have a difficult conversation with patients, et cetera, so that they are more comfortable in doing that. (Care Navigator Lead, GM Area 4, Interview 39)

4.4.3.2. Planning and coordination

Strategic

There was general acceptance among strategic stakeholders that for new roles to successfully embed in general practice, planning and coordination were crucial. A lack of consistency in how new roles had been planned and rolled out across GM was reported, however, with different things being done in different areas. While the 'vision' for workforce including new roles was seen to be strong in GM, some felt that their area was not taking on enough new roles, with practices working in '*different*

lanes at different speeds' (CCG Lead, GM Area 5, Interview 31) in their level of engagement with skill-mix change. This was considered in part to result from a lack of clarity around whether the responsibility for planning/implementing new roles lay at a local or regional level and which organisation/s ought to be leading the processⁱ:

I've got companies at the moment who've got physios that could be put in place tomorrow. I could run a physio service, I could run a clinical pharmacy service tomorrow... but I don't know who to turn to. So, I go to the CCG and say, we've got a transformation plan. I go to [regional body] and [they] say, well your CCG's got this transformation money, go to them. So, all I see is this spiral going around, and I'm watching it going around, and I've got people walking through the door, and I'm sitting here, and in our patch at the moment, I know doctors out there are struggling. (GP Provider Lead, GM Area 5, Interview 33)

There was evidence of attempts to work across neighbourhoods and practices to coordinate and share new roles. However, neighbourhood working could be complex and influenced by power, politics and relationships, with variation in the willingness of practices to work with and learn from each other. While there was a sense that individual practices often found it difficult to grasp how they could allocate work differently, national policy leads saw PCNs as a vehicle to assist with this:

And actually, if we have the discussion at 30–50,000 population size... Whilst as a practice you can't employ one diabetic specialist nurse, one frailty specialist nurse...you could employ one person, your practice down the road can employ the other and the practice down the road can... employ the third one, and you could share that resource and everybody get the benefits. So there's the primary care networks which will hopefully help us with that. (National Policy Lead 4, Interview 38).

More fundamentally there was recognition that meaningful workforce data to grasp the nature and spread of the existing general practice workforce across GM areas and underpin plans for new roles was lacking:

...the [workforce] data we have doesn't lend itself either to working in a collaborative way and understanding what the needs are, or what impact any innovations or changes in roles have. So, we're almost doing innovations and testing things blind without truly understanding the impact. (CCG Lead, GM Area 2, Interview 12)

Some areas had attempted local exercises to map their general practice workforce but these efforts had brought several challenges. For example local tools, while

ⁱ GMHSCP report that they are currently addressing this issue

marketed as free to use could have hidden costs, and were often inflexible. Areas were also reluctant to duplicate effort by completing both national and local workforce returns:

...there was a problem with the [local] tool as well... because they were already reporting it. And they were saying well, why should we have to report it twice?... there are a lot of teething problems. (CCG Lead 5 GM Area 1, Interview 20)

A solution to this was making efforts to engage practices in discussions about why workforce data was needed and how it could help them plan for the future:

...what we're trying to do, is develop both the extent and the quality of conversations around workforce planning, in practices and neighbourhoods... that would be owned, that would be understood. (CCG Lead, GM Area 6, Interview 16)

Operational

Similarly to strategic stakeholders, operational level participants across the five targeted roles described a lack of consistency in how new roles had been planned and rolled out across GM:

There was a very loose service spec with some quite generic targets that were pulled from guesses, I suppose. Because there wasn't really anything preceding us to give us an idea of what that might look like. So from there we've tried to build the structure of the service and develop the service spec. We're still in development... because I think that the, the way that the service looks now maybe wasn't how... it was originally envisaged to look. (Lead Social Prescribing Link Worker Scheme, GM Area 10, Interview 34)

In terms of planning and preparation for taking on new roles, providers outside general practice who were able to demonstrate clear HR processes and support structures were often seen as more likely to be able to stand as host organisations for practitioners working in general practices:

Obviously general practices were keen and willing to take [the physiotherapist] role on. We did receive a few expressions of interest to take on the practitioners themselves, but we felt that the neighbourhoods that put the bids in were not well enough established and they didn't show a clear sort of employment/HR function, you know, all that sort of thing. Whereas I think the [hospital Trust] say that they've already got that structure, they've already got a governance structure. The practitioners would sit within an MSK block type department, so they've got that peer support as well, rather than sitting in

isolation in a neighbourhood with no peer support. (CCG Physiotherapist Scheme Lead, GM Area 7, Interview 65)

PCNs were seen by some as a way to improve coordination and better plan across practices to support the work of new roles. It was hoped that working in a PCN may, for example, assist care navigator staff to function optimally because networks would enable a more systematic capture of all the health and wellbeing services available across an area:

I think this is one of the benefits that we'll get from networks, because one of the assets of each network is you map your assets. And your assets are voluntary and community sector, aren't they, so you'll be able to build that picture of what is available. Because like you say, you book somebody in and then the following month you book somebody else in and they're talking about the same thing. (Practice Manager 3, GM Area 3, Focus Group 1)

A particular issue raised among operational stakeholders involved in the care navigator role was a perceived lack of planning and coordination between primary care and other parts of the health and social care system. For example, there were instances of patients being signposted to other services that could not take them and it was highlighted that care navigation could only be successful when other services had capacity. When patients were referred to services that were not available, it could erode patients' trust in care navigators:

The patient loses faith in the call handler because they think that [they've] just been fobbed off. (Practice Manager 2, GM Area 3, Focus Group 1).

4.4.3.3. Estates

Strategic

Estates issues were raised among strategic leads only. Practices often had limited space to accommodate extra staff. While some buildings were described as simply not having the space, those in private buildings were limited by needing to pay to use the spare rooms available, which was an additional financial burden, or not financially viable in some cases. Some stated that CCGs needed to support the implementation of new roles by providing funding for space, something which was described as not having occurred to date. This meant that while practices were potentially willing to take on new roles they felt restricted from doing so by the lack of space available:

We don't have an estates strategy, so the thing that limits me taking training into my practice isn't people to do the training...it's actually having room space available. (GP Provider, GM Area 10, Interview 25)

One area was hoping to overcome space restrictions by using community buildings rather than accommodating new practitioners in general practice premises.

4.4.3.4. Professional tensions/boundary issues

Strategic

Among strategic level participants there was a general consensus that new roles may overlap with other roles leading to blurred boundaries and possible inter-professional tensions:

So, I have a thing about role adjacency, so where a role is more adjacent to the other, I think that's a source of tension in practice, rather than things where there is a lot of differentiation between what people do. So the closer they are to what they do, the more tension (CCG Lead, GM Area 6, Interview 16).

It was suggested that one way to reduce professional tensions/boundary issues was to define new roles more clearly, while allowing for flexibility to suit individual practices. One participant argued that defining new roles should be done collectively at a strategic level (e.g. involving higher education institutions and regulatory bodies to agree role definitions and governance provisions) and ensure that professionals did not work outside their scope of practice:

...a really important message that I would send is that when we look at paramedics and all the other things coming in... I think there needs to be some guidance and governance at the higher level, [otherwise] people start getting people to do things they shouldn't be doing. (GP Provider Lead, GM Area 8, Interview 19)

Establishing professional forums across practices was also seen as important to prevent new roles practitioners from feeling isolated and losing their professional identity:

...we have practice manager forums... we need to have forums for the other skills as well. Only last week, I was having a discussion with a paramedic that's now in general practice, and he was saying exactly the same thing, that he's aware that we've got five but they're not linked up, they're not networking, so they're feeling a bit isolated. So straightaway, I've got to do something about putting some support network in place, because otherwise I'm going to lose them as well. (Policy Lead, Non-GM Region 5, Interview 3)

In addition, it was suggested that GPs needed to take a less 'romanticised' (GP Provider Lead, GM Area, 9, Interview 40) view of being a GP and be 'less precious'

(Provider Lead, GM Area 2, Interview 10) to make room for new roles. This involved being open to negotiating with new roles professionals about ways of working which would involve them giving up some tasks:

And then how do we embed the new roles? And I'm not sure there is a really good understanding out there of what they can and can't do and what the implications there are then, therefore, for GPs and how they need to change what they do. (GP Provider Lead, GM Area, 9, Interview 40)

Operational

Boundary issues and professional tensions were also highlighted in the operational interviews across the five targeted roles, but especially in relation to roles that were newer and less familiar.

For example there were boundary issues in relation to the care navigator role. 'Upskilling' practice receptionists to the role of care navigator involved changing the job description and consequently the boundaries of what a receptionist role entailed. Some receptionists were said to have resisted these changes while others were enthusiastic; however, receptionists were reportedly not given a choice to take up the role but rather were tasked with the role by a GP or practice manager. Some receptionists saw this as an opportunity for career development; however, the role was said to involve more work and the possibility of confrontation (and sometimes even receiving abuse) from the general public. This was important particularly as receptionists were not necessarily paid more for the widening of their role. While upskilling of staff was seen to be a good thing in theory, the lack of financial recognition for this in practice was viewed as problematic:

When you look at what the HEE [Health Education England] guidance says about enhanced care navigating, I didn't think that role really fitted with the receptionist, I thought it was probably better to do it something like a HCA [Health Care Assistant]. But then there was a bit of a backlash from practices that you're upskilling staff, they'll want more pay...to put the proper enhanced care navigator in practice needs some funding, because it's a different skillset and a higher level than our receptionists. (GP Lead Care Navigator Scheme, GM Area 3, Interview 49)

There was also apprehension among some care navigators who felt unprepared for the widening of their role from receptionist to care navigator with perceived expectations that they must make judgements about the health and care of patients. There were consequently worries among role holders about patient safety:

It was the CCG that brought it in, it certainly wasn't our decision to do it... we all still feel a little bit that we may be making the wrong decisions for the patient because we aren't clinical... there should be somebody clinical doing

this triage and signposting, because it's easy for somebody to miss without clinical knowledge. (Care Navigator 5, GM Area 3, Interview 59)

Boundaries of the scope of practice of other roles were sometimes unclear. For example, there was a lack of understanding about the pharmacy technician role and how this was distinct from the role of a pharmacist:

...it was blurry, because I don't think [practice staff] knew what a pharmacy technician was to be honest. They'd just learnt what a pharmacist does! (Trainee Pharmacy Technician, GM Area 2, Interview 37)

It was reported that pharmacy technicians could sometimes be asked to carry out duties that were inappropriate to their role due to practice staff being unfamiliar with their remit and viewing them as fully qualified pharmacists. Pharmacist leads described a process of 'muddling through' with practice staff to sift and allocate technician tasks more appropriately:

Sometimes the [pharmacy technicians] are asked to do... things that are above their competence... but then if they do start to do a task, reach their level of competence, then they'll pass it back on to our [task] list... because people like the receptionists have less of an idea about what is and isn't appropriate for them. And to be honest we don't always know until we start doing it and find out. It's all a pilot, it's all learning. (Pharmacy Technician Lead, GM Area 2, Interview 55)

However, this practice pharmacist participant also described a process of passing the less interesting and more repetitive work down a hierarchical chain, from GP to pharmacist to technician. This was viewed as potentially improving the job satisfaction of those nearer the top of the hierarchy:

[GPs] just pass it off...sometimes it can be a bit of a dumping ground, like here, you do that... and at the same time I do the same thing to the admin staff – please call this patient, tell them their prescription's ready, please call them to get them to book in with me... I have felt more satisfaction since I've had the [pharmacy] technicians, because they will do all of that stuff that I feel isn't utilising my full skillset so that I can use my skillset in high level things. (Pharmacy Technician Lead, GM Area 2, Interview 55)

This cascading of work could mean that pharmacy technicians might often work below their skill level due to staff shortages however:

...there's sometimes grey areas but we would never step up, but we often have to step down because of staff shortages or just because it works to do it

then, as oppose to wait for somebody else coming in. (Pharmacy Technician Lead, GM Area 10, Interview 30)

There was a sense that primary care based social prescribing link workers could be seen as a threat to other established services because of potential overlap. However, there were also examples of close collaborative working with other services, particularly in GM Area 1, where link workers were part of the multidisciplinary team meetings to meet the needs of the local population:

So, we have a [link worker]...who has just, I think, done so much for the practice and the community really. He's really got engaged with all of our work in the community... he really has become part of the team, and somebody that the community trusts as well [...] [patients] love him. Absolutely – it's somebody that's listening to them. It's somebody that has time to spend, he can just listen to them, he can help them set targets, he can help make phone calls for them. (Practice Manager, GM Area 10, Interview 63)

There were reports of professional tensions between GPs and some new roles professionals. This was perceived to centre on concerns that bringing in new roles to general practice may actually increase rather than reduce GP workload, but more fundamentally over the question of who would have jurisdiction and control over certain tasks. A key solution to this involved new roles professionals making great efforts to build relationships with GPs:

...you have to have that personality where you're able to go into the different practices, and build that on a one to one basis. Why was there some reservations about it? Well, part of it, they didn't know if we were going to increase their workload... and then there's a bit of, who takes control of that imaging, if there was something serious found on it...? Like who's responsible for the blood tests, the referrals, for example. (Lead Physiotherapist 3, GM Area 10, Interview 61)

Professional tensions could also arise when the introduction of new roles represented a perceived shrinking of remit for GPs. For example, it was reported that some GPs had concerns about relinquishing control to non-medical professionals and becoming de-skilled, although they were having to acquiesce to this due to GP shortages:

So, there has been first contact [physiotherapy] services running in Britain for at least 15 year... but taking a long time to get off the ground... and I think... there is that difficulty to shift cultures – a bit of a hangover too, as doctors like to keep everything close to their chests and, to some extent not wanting to see services be fragmented, and not possibly be de-skilled themselves. But then, of course, landscapes change over the last ten years and there are not

enough GPs and there is less and less. So, I think there has been some acceptance that we are going to have to let other people in. (GP Lead Physiotherapy Scheme, GM Area 10, Interview 64)

It was felt by others in a physiotherapy scheme that this initial resistance had been overcome due to scheme leads and role holders working hard to have their professional expertise recognised and assimilate into practices:

Lead Physiotherapist 2: Initially they [GPs] thought, oh, [physiotherapists] are going to de-skill us; but we're only seeing one in five of their patients with MSK problems, because of our capacity issues. If we had a full-time physio in each practice that would be a lot different. And I think that will come, but this is just baby steps really.

Lead Physiotherapist 1: I think [GPs] have realised now though that also we have integrated into practice...so it's become very much working together. And they ask us questions, we ask them questions, and so...I think they realise it's not about us just coming in and taking patients away, it is about them having more time to see the more complex medical ones and they will see an MSK caseload. (GM Area 10, Interview 54)

4.4.3.5. Regulatory provisions

Strategic

Employment and indemnity for new roles staff were regulatory issues raised by strategic participants only. It was noted that there could be confusion about which organisations were employing new roles' professionals and directing employment through NHS Trusts' HR departments was seen as a way of overcoming indemnity issues:

I think the indemnity, the wages, how you pay people, that's one of the big difficulties to try and share any of that work...I think the local Trust also... they are a huge employing organisation... the local Trust, why can't they employ them in terms of providing HR and occupational health? So to make them feel like even though you've transferred your HR into the Trust, you belong to the health economy. It's not a Trust job or a GP job or a community job. (GP CCG Lead 1, GM Area 1, Interview 20).

Linked to indemnity was the further challenge of affording new roles staff full access to patient records; without this, some continuity of care could be lost:

For the wellbeing and self-care [staff], current legislation means that it's actually quite difficult to make a case for [those roles] to access the full GP record, because they're not clinical themselves. So we've actually had to take

them off the GP record and buy in a different product which is a kind of social prescribing software, which means that you're losing some of that continuity on the record, but it's kind of where we are now. So I think, you know, given that social prescribing's really been pushed in the sort of new contract announcement, we're going to have to think about how we bring them in so it doesn't feel like a kind of disjointed service that you're referring into. (GP Provider Lead, GM Area 10, Interview 25)

While PCNs were not legal bodies and therefore would be unable to (directly) employ new roles staff, some participants believed that GP federations would be useful to them in the set-up and governance of staff into new roles:

So where we've got to in GM Area 9, we will have four networks, so all practices will be involved and the whole area will be covered. They are asking the federation... to money-hold, be the banker basically, and also the recruiter for the extra posts, which I think is probably the model that most areas will go down. And then we may or may not offer the services depending on what the individual networks feel they want to do... certainly in the initial stages, whilst [PCNs] are building up their relations and the governance and things like that, I think it's helpful if a neutral body outside of that holds all of it. (GP Provider Lead, GM Area 9, Interview 40)

4.4.3.6. Communication and engagement

Strategic

Among strategic level participants there was a general concern that the public, patients and staff of GP practices were not sufficiently informed about new roles and their potential value:

I think that we don't actually publicise what [are] all the [new] roles in the health service. Everybody knows about nurses and doctors... they don't know about all the other things, they don't know. Yeah, so I think that we need... some work needed there. (Provider Lead, GM Area 2, Interview 10)

However, there were examples of local engagement where scheme leaders had visited practices individually over an extended period to establish their GP pharmacist service and local events to showcase new roles. National policy leads spoke of a country-wide campaign to prepare patients for receiving care from professionals other than GPs:

So the comms team have got a national campaign that talks about the new roles coming into general practice. Because I guess part of the conversation is patients being prepared to receive care from somebody that isn't a GP,

sometimes people are happy to see a nurse but these new roles feel less familiar to people. So we've got a national campaign that introduces what the roles are, who they are and actually when you go to your GP, your PCN, when you go to receive [care] in your community there might be somebody else who's better placed to offer care to you and a GP isn't necessarily always the right and the best person for you to speak to. It's a two way thing to demonstrate what the roles can do and should do so that they're delivered and received on an equal basis. (National Policy Lead 3, Interview 35)

The importance of learning from early-adopter practices about the benefits of new roles was emphasised with some citing GM work to get local hubs and CCGs working together to share ideas and experiences of new roles. It was suggested that GPs were more likely to listen to other GPs and persuade colleagues to get on board with changes in general practice:

...actually it only takes one positive voice within your GP partnership or your GP practice to actually then sell the benefits to others. GPs listen to GPs, GPs don't listen to managers. Within NHS England obviously we have a large number of jobbing GPs or indeed, you know, GPs who have worked as GPs but perhaps don't do so much now, within our different directorates, and they are the ones that actually are saying, this is my experience in general practice, this is how it worked for me. And that's been very powerful, whereas in the past we've always said, the Department of Health want you to do this therefore you have to do it, and that's not gone down so well. (National Policy Lead 4, Interview 38)

Building trust with practices and focusing efforts on greater public engagement were perceived as factors that would encourage new roles to be accepted and taken up; this included educating the public about the changing nature of the GP role:

It's trust and relationship and you have to...some of the mistakes I think we made across GM Area 8 was too much preaching rather than building a relationship, building trust and just talking one-to-one. (GP Provider Lead, GM Area 8, Interview 19)

And then the other bit that I probably haven't mentioned but I think really needs to be addressed is the public engagement and the public acceptability of the new roles and the change in GP role. (GP Provider Lead, GM Area 9, Interview 40).

Operational

Among operational participants there were also concerns that the public, patients and staff of GP practices were not well informed about new roles with implications for

their success. Not all GP practices were willing to take on new roles and overcoming this resistance often required a lot of effort from scheme leads:

It was about getting the word across to GPs ...we had some that were more on board than others. And really, I would say to a lesser extent, that's still the case with some practices. (Social Prescribing Link Worker Scheme Lead, GM Area 1, Interview 44)

Other participants also spoke about the cynicism among GP colleagues about social prescribing link workers in particular and how these entrenched views were difficult to change and could hamper the uptake of new ways of working in practices:

Some just were very sceptical...a GP colleague in my own health centre would say 'are you going off 'singing'? Some of us are practising proper medicine!' And I just kind of thought well proper medicine only accounts for 10% of population health, 90% of population health is based on those wider determinants of healthcare! My conscience was clear with that one. So, I think, there is some scepticism, I think, there is some cynicism. (GP Lead Social Prescribing Link Worker Scheme. GM Area 10, Interview 50)

There was reportedly also a lack of engagement among some GPs in relation to the care navigator role in particular. It was suggested that promoting the role more effectively to GPs would help to overcome perceptions that introducing the role would increase GP workload. In the meantime this resistance meant that it was difficult to implement the scheme in some practices:

Certainly the biggest frustration...was the lack of GP support, and them not valuing it. And that needs a bit of marketing with the GPs really and stuff, because if you haven't got the people at the top of the chain engaged, it's not really going to work. So yeah, we still need to work on that, and we keep chiselling away and chiselling away at it and stuff, but it's like an oil tanker, you wouldn't believe that this was actually part of the 10 Point Plan to help you! (GP Lead Care Navigator Scheme, GM Area 3, Interview 49)

While some patients were accepting of having consultations with another type of practitioner, others were less accommodating, due in part to a lack of understanding of wider changes happening in the health system:

...there's nobody telling the patients 'the face of your NHS does have to change because we can't cope with health at the moment'. And they don't see it. (Practice Manager 2, GM Area 3, Focus Group 1)

It caused a lot of complaints at the beginning because, one, it was ‘them nosy receptionists, they think they’re doctors!’ (Practice Manager 4, GM Area 3, Focus Group 1)

One practice pharmacist participant described that some patients were not curious at all about the different healthcare professionals they were seeing in general practice because they generally assumed that they were GPs anyway:

I think it's how we present ourselves. A lot of patients they don't know the difference, they just all refer to everybody as ‘doc’. They'll talk to me like that – ‘I don't know, doc, right, okay’ – they just see us as a healthcare professional sat in front of you and they're not bothered really. (Lead Pharmacist, GM Area 2, Interview 55)

However, there were reports of patients becoming perplexed and even frustrated/angry at times about being directed away from their GP to alternative services by care navigators. National campaigns to increase awareness of other services and why patients may be referred to them would likely help patients better understand and accept the role:

...one of the biggest bugbears is patient education because we really don't feel there is enough education for patients on the availability of other services because I think historically the default action has always been to go to your GP. But the amount of people that need to see a GP these days has increased massively and we've had an increase in the population and a shortage of GPs. So, you know, having the additional services available is great but I think there does need to be more education for patients to make them aware of it... I think it's something nationally that the government needs to do myself. (Practice Manager, Care Navigator Scheme, GM Area 3, Interview 46)

As a result of patients' lack of familiarity with this new way of working, staff felt they often needed to take a firm stand when navigating patients to alternative services, with variation in staff ability and/or willingness to tolerate patient resistance to this:

I think the most important part of it is standing your ground with it. You know, trying to be firm with patients and say, no this is the option that you've got. And, making sure that everybody [care navigator staff] is working from the same page as well, because obviously if [patients] get one receptionist one day, they are firm with them, they tell them ‘no, this is what you have got to do’, and then they get another one the next day ‘oh yeah, come in and see one of the GPs’... (Care Navigator 1, GM Area 3, Interview 47)

However, it was felt that having a new role supported by a well-respected GP could increase patient acceptance. For example, it was suggested that patients were more likely to accept being triaged by care navigators when GPs were involved in promoting the role:

I think our message on the phone... it's the senior partner, she gives a lot of messages about why we're asking and hopefully if we can refer you onto somewhere else then we will...So, I think having that little message there at the start, because, everybody loves [GP] at the practice, so because it's her that's putting it across, they think 'oh, okay'...I know some of the doctors, if a patient doesn't accept care navigation and they insist on seeing the doctor [they] will try and educate the patients and say, 'well actually, what the receptionists were telling you was right'. (Care Navigator 1, GM Area 3, Interview 47)

4.4.3.7. Factors influencing practice involvement in roles

Strategic

Strategic level participants highlighted factors that influenced practice involvement in new roles schemes. However, it was emphasised that the policy drive of re-designing primary care with skill-mix changes left practices no option but to engage with new roles and workforce issues more generally, especially because a major tranche of funding was attached to these initiatives:

[Practices have] been able to carry on pretty much as they have before, whereas now that emphasis is changing, and unless you change how you work, unless you look at your workforce, look at working differently in groups, then life as an individual practice, is going to become increasingly tricky, because the funding streams are moving in that direction. (CCG Lead 1, GM Area 5, Interview 31)

Some participants however, felt that more financial support was needed for practices to help them train and take on new roles. The contrast was drawn between medical students who came with substantial sums of money and new roles trainees who often came with less funding; for practices this could signal that new roles were less of a priority for CCGs:

So, therefore, we value our medical students because there's a lot of money attached...it makes it very hard to place students who obviously we don't value because we don't get paid anything for – it really makes me cross – and paramedics, they only come out for a week and they are something like £100. (Provider Lead, GM Area 2, Interview 10).

In particular, small practices were often impeded from taking on new roles professionals because of concerns about the amount of support they would have to provide to the new role. It was suggested that NHS Trust HR departments could have a role in helping to organise support for smaller practices. Giving practices an opportunity to try out new roles without taking on the risk of permanently employing staff was a national incentive designed to encourage practices to engage with new roles:

So even though [practices]... as small business owners, will have to take on the employing of these people, or they could do it through their primary care network or through another route, actually providing the direct funding for them is a massive benefit, and I think that it removes some of that risk. And... if you were a GP you could employ somebody on, for example, an 18-month fixed-term contract, to limit your liability in terms of redundancy etc., but at the same time have the benefit of that individual that's paid for through this direct enhanced service. (National Policy Lead 4, Interview 38)

4.4.3.8. Working across practices/employment and control

Strategic

There were issues raised in strategic level interviews about the challenges of finding employment models that would enable the sharing of new roles practitioners across practices. One participant described having been unable to find a way of sharing a valuable paramedic practitioner between practices in their neighbourhood:

...as a paramedic, she would see the disasters that would happen... and go and give really good falls advice, dare I say it, better than a GP would, because she'd know who to refer to and what to look out for and that's really, really good. We loved it as an individual practice, but we never quite worked out how she could work across different practices and she's now doing other work... (CCG Lead 2, GM Area 8, Interview 24).

There was a view among some strategic leads that PCNs had a central role to play in enabling the sharing of new roles between practices so that new roles practitioners could work at a neighbourhood level. That said, there was also a recognition that it was important to strike a balance between practices' independent contractor status and enabling them to benefit from being part of a wider network:

I think it makes it much easier looking at, like you say, that sort of neighbourhood level to see how these additional roles can work. I think if it was just at a practice level it would be much more difficult because you wouldn't need some of these roles on a sort of full-time basis... I think so long as we get the balance right between the practice as an independent contractor to retaining its sort of autonomy and the ability to manage its

practice and the way that it's delivered, but also being able to take the benefit as being part of this broader network and the opportunities that brings to getting an additional pharmacist, or whatever, who does a certain number of sessions. I think that's hopefully going to be an ideal mix. (National Policy Lead 1, Interview 27)

Tensions had arisen in one GM area where some practice pharmacists were employed by a CCG and some by the GP provider organisation; this arrangement had, for example, worked against the integration of pharmacy services into one employment model in GM Area 10, even though the individuals were beginning to function well as an overall team:

Currently, we have a cohort of staff employed by the CCG and a cohort of new staff that are employed by the Federation, and we're trying to merge them into one integrated team.... they have two different employers, which has caused some issues in terms of... the CCG offers Agenda for Change, the Federation doesn't. So we're trying to bring those together... so some of those little nuances we're working through and trying to align contracts, but actually the team really feels like it's coming together. So we want to get to the point in the near future where you shouldn't know who employs the member of the staff. But the next phase with the CCG is formally transferring those staff so you get one team. (GP Provider Lead, GM Area 10, Interview 25)

Operational

In operational interviews, different employment models were reported to be operating within and across the five targeted new roles. Some role holders were employed directly by the practices they worked in, while others were employed by a CCG or provider organisation. There were positive and negative aspects to both arrangements. While directly employed professionals were seen to have more scope to shape their roles, they may also be less likely to keep abreast of national guidelines and receive training/peer support:

I think if you employ directly, the technician doesn't have as broad a spectrum of knowledge... I think in terms of the national and local guidelines and directives, they're not always aware of them. Because we're employed by the NHS or GP federation, we have to be aware of all the current local and national guidelines. I mean, registered technicians obviously have to do CPD but it wouldn't necessarily be some of the regular training that we have to have and the knowledge we have to build... so... that's a con in a way... but on the other hand, if you're employing your own tech you can give them exactly what you want them to do and you're employed by the practice. (Pharmacy Technician Lead, GM Area 10, Interview 30)

Some felt that being employed and based in a non-primary care host organisation while being shared between general practices could overcome the professional isolation that new roles practitioners could face:

I think [physiotherapists] being in a team of their peers has really helped them. I know that the feedback that I've had from the practitioner that was originally employed a couple of years ago... he just worked in [one] neighbourhood. He did his own sort of CPD and his own self-development and he was very well mentored by the GP at the practice that he was working in. But I think since he's moved into the MSK team, he's felt a lot more confident in the role and he's learnt a lot more, he feels that he's got more support with his peers and with obviously the MSK leaders at the Trust. (CCG Physiotherapy Scheme Lead, GM Area 7, Interview 65)

However, working across practices meant that only part of a practitioner's time could be spent in any one practice, bringing the potential for fragmented working and reduced continuity of care:

I'm probably working in about six different GP clinics over four days... you're there once a week, then you're not there until a week later. So, if there are things to be picked up on, you've maybe got that delay in between... when, if you've got one physio who's there all day, you could see that might be a bit more, the continuity would be a bit easier for them. (Physiotherapist Practitioner, GM Area 10, Interview 61)

Not having a role working in the practice every day could mean practices were reluctant to become reliant on a service that was only available for a proportion of the week:

We always struggled first of all with the what can we give them to do that we don't become reliant on, because they're not here every day, so you can't have a system on a Monday that gives work to [pharmacy staff] but on a Tuesday and a Wednesday it has to go back to the GP. (Practice Manager, Pharmacy Technician Scheme, GM Area 10, Interview 52)

Working across larger geographical areas could make building relationships and trust between GPs and new roles staff more difficult and consequently influence the success of roles. It was suggested that smaller or more contained areas were more conducive to good relationships:

[GM Area 4] is a much smaller area than [GM Area 8], it's contained... there's a trust that has to be built up in primary care for doing home visits. So, the GP Trainer Lead knows me now, he knows what I'm capable of...he understands what my level of training is... [but] within [GM Area 8] I've got 41 or 39 GP

practices, so it's very difficult for me. (Paramedic Practitioner, GM Area 8, Interview 53)

The success of certain roles was heavily reliant on inter-relationships between services and systems and not only individual staff or practices. This was the case for social prescribing and care navigation. For social prescribing link workers to successfully embed in general practice, it was felt that strong partnerships were necessary between general practices that referred patients, the link workers supporting patients and the voluntary, community and social enterprises (VCSEs) that were providing services. However, VCSEs sat outside the jurisdiction of primary care and were often funded from a different part of the system or commissioned by a different funding stream (for example, local authorities). This meant that patients could be referred to services that were unable to support them appropriately. This in turn had a negative impact on patient perceptions of social prescribers:

How does the wider VCSE link into social prescribing? What are the relationships like? How resilient is it? How ready are groups to take referrals? How strong and resilient are they? How much funding goes into those groups? It's, and all of that is social prescribing. We generally look at the link worker alone, primary care alone. The whole thing, without any of those three things it doesn't work. (Regional Social Prescribing Link Worker Lead 1, Interview 41)

There was a couple of issues with one particular service... patients were quite grateful to be signposted to that service not knowing it was available, but when they've actually rang that service, the service has told them, 'no, sorry, we've got no appointments', which obviously had a bit of a negative impact... (Practice Manager, Care Navigator Scheme, GM Area 3, Interview 46)

Successful social prescribing link worker schemes were regarded as those with pre-existing strong relationships between primary care organisations and the voluntary sector; one participant described how they had integrated sectors by seconding members of staff from the voluntary sector to work between organisations. This meant that there was a good understanding of what services were available and how patients could be supported to access services:

We are right across GM Area 7... we have a really good understanding of what's available in the community voluntary sector, because of our organisations that are seconded as members of staff. Their expertise and knowledge, the best part of 20, 30 years, that those companies have been in established in GM Area 7, in the community voluntary sector... (Lead Social Prescribing Link Worker Scheme, GM Area 7, Interview 45)

4.4.4. Measuring the impact of new roles

Strategic

The challenge of measuring the impact of new roles in primary care was recognised by strategic leads. Reasons for this included being under pressure to insert new roles rapidly, meaning that the opportunity to evaluate early schemes was not prioritised and learning missed:

We need these new roles; we want these new roles in general practice to support our workforce currently that are under a lot of pressure. So, because we need to get them in there so much, you lose that time where being able to afford yourself the time to step back and say, 'right, that's been in there, and in six months we'll evaluate it, we'll do a proper evaluation, and then, you know, we'll roll it out, and all of that'. We haven't got that luxury at the moment and it's almost like as soon as they're qualified, 'right, we need you in there, we need you working, and all of that'. And like I say, we're not affording ourselves the time to learn the lessons, to evaluate it, and then to get those messages out there, and it's almost as if we're moving at such a fast pace, we've got to do it whilst we're running, sort of thing. (Policy Lead, Non-GM Region 5, Interview 3)

However, evaluation was considered necessary to avoid unintended consequences and to build up an evidence base to encourage practices to sustain new roles once funding assistance ceased:

And it's about building up the evidence of being able to demonstrate that that role has made a difference, so that it is financially viable for the practice to then employ and take that person on, on a fulltime basis. (Policy Lead, Non-GM Region 5, Interview 3)

Strategic leads highlighted that some evaluations were taking place, mainly in relation to pharmacy schemes with efforts focused on identifying how many patients were being seen by a pharmacist. It was emphasised by some, however, that these figures offered no certain way of knowing that roles had made a difference to the workload of GPs:

...we produce a monthly report between us – KPIs – so it's a bit widget-counting at the moment. There is a lot of – so what? 'Well, they've made this many contacts.' And what happened as a result of that? Do we know? Do we not know?... the phase one pharmacists [in GM Area 7]... the KPI we got was 'how many GP hours have you replaced?' And, I was – 'OK, where do you want me to start with what a stupid question that is?' (Provider Lead, GM Area 7, Interview 13)

It was recognised that gathering patient feedback on new roles was important, though involved a lot of effort to capture:

I've insisted that the CCG does... develop patient feedback. So, it's not to the level of PROMS [patient reported outcome measures] or anything like that, but it is – 'how was it today, how did you feel?' – some of the sort of fairly standard stuff – 'have you got any feedback on, was it worth you doing, did you feel the benefit of?' Because I try – it never works – but I try and get feedback from every single patient we see. And I've always done it, and you never get it because people forget and it's difficult, or they don't fill it in or whatever, can't be bothered – it's fine, I was in there for five minutes. But, if you don't do that then you don't know how people are actually experiencing the service. So, the CCG are still working on doing that. (Provider Lead, GM Area 7, Interview 13)

Operational

Operational scheme leads for the five targeted roles aspired to show the impact of new roles initiatives on the system, particularly in terms of freeing up GP time and demonstrating cost-effectiveness; it was unclear in some cases whether there were mechanisms to this adequately at the current time however:

...I suppose it's important that while we're doing this work, and we know that subjectively we've got some excellent examples of admission avoidance, it's important that we capture real demonstrable outcomes to, again, be able to deliver that feedback back to the stakeholders who have invested in the service, and be able to demonstrate our activity being, I suppose, cost-effective. (GP Lead Paramedic Scheme, GM Area 10, Interview 51)

I'm trying to think of a way that... I can maybe put a question in there that says – 'how many appointments has your MSK practitioners delivered this week, and how many appointments has that maybe freed up for your GP?'... and it might be that in that audit we might see that the GP has a clinic with longer appointments for the more complex patients, so that would say, well, they've been able to do that because the MSK practitioner has seen X number of people that the GP would have normally seen. (CCG Physiotherapist Scheme Lead, GM Area 7, Interview 65)

Some operational scheme leads believed that they had found ways to measure GP time saved and/or prove the cost-effectiveness of their services; the first contact physiotherapy service in GM Area 10 was for example, part of the national scheme and took its KPIs from the larger audit:

[Audit] is showing massively that we're actually managing about 70% of the people we see we are managing ourselves; so, they don't go and see a consultant, they don't go down more physio or off somewhere else; so that's massive really. We've very low numbers on investigations, so we're not actually creating another cost, and we're seeing most people within one or two session. (Lead Physiotherapist, GM Area 10, Interview 54)

So there's lots of my work that is technical and can be done by a technician, leaving more time for me to be able to do more high level things. And then in turn more time for the GPs to be able to concentrate on what they're looking at while I'm managing things like the high risk drugs. So, yes, we do measure things in GP time. When I started everything that was quantitative was measured in GP time. And then we stopped doing it once it was very well established that this is 100 per cent worth it. (Lead Pharmacist Lead, GM Area 2, Interview 55)

However, the lack of comparative baseline measurements prior to the implementation of new roles made it difficult to be sure that new roles might be reducing GP time.

Operational leads from social prescribing schemes reported that impact was often measured by collecting activity data (e.g. number of patients referred into schemes per year/number of appointments conducted) alongside assessing clients' wellbeing using different questionnaires at different time-points across schemes. There were reports of some coordinated efforts to collect data across GM as a region to show a body of evidence for social prescribing; for example, development of a GM outcome measure for social prescribing and an online platform to collect data across schemes. However, it was recognised that it was difficult to attribute impact (such as cost savings in the NHS or improvement in wellbeing scores) directly to social prescribing services and this potentially impeded the scale-up of services:

Some schemes are recording usage data by NHS numbers – so what was the usage 12 months before? What was the usage the two years after? – or attempting to. It's not easy with the systems at all to capture that. Some schemes are starting to look at using... [the] Patient Activation Measure [PAM]. There's stuff coming out the national network is they want to use PAM and the ONS [Office for National Statistics] wellbeing measure. And then it's hard, isn't it? Because there's so many initiatives, you can't easily put any change that might be seen in the system down to social prescribing, because it's in conjunction with integrated neighbourhood, with pharmacy, da da da. You can't, it's really tricky to do it. (Regional Social Prescribing Link Worker Lead 1, Interview 41)

Therefore, some social prescribing schemes had chosen to focus on capturing 'case studies' in an effort to show impact, as these were regarded as more meaningful than quantitative outcome measures and had reportedly resulted in buy-in from GPs and increased referrals into services:

The video case [study] that we've got, is actually one of the nurses there, saying that this individual now doesn't come into the GP as much...there's some good quotes as well, from the actual people who've been referred in, to say, 'I'm not going back as much now, I'm sort of feeling more connected, I've got a positive spin on life...so thank you so much for building my confidence back, it was amazing speaking to you... I'm hopeful about the future for the first time in years'... they're just in there, and sort of say the impact that the programme's having. (Social Prescribing Link Worker Lead, GM Area 7, Interview 45)

For the care navigator role, capturing data to show impact was reported as problematic by one CCG due to difficulties in getting practices to complete a care navigation template (as receptionists/care navigators felt this delayed the appointment process). In addition, the tool they had purchased to capture this data was not compatible with the data sharing agreement that they had with practices, meaning that it had not been possible to show whether care navigation had any impact on reducing GP appointments:

....it very quickly became apparent when we looked at the figures, that [practices] weren't coding to say that [care navigators had] referred [patients] on to the chemist, or wherever, because the figures were so low... [the] tool, we couldn't use it because the data sharing that we have with our practices, is at a certain level, and the tool... extract[s] actual names of staff, so that you can say, receptionist did this many...So the thought of then going back to all our practices and saying, we need to change the data sharing agreement, and it just became not worth the outcome, particularly given that the practices weren't using the template much anyway. (CCG Care Navigator Lead, GM Area 4, Interview 39)

4.4.5. Funding and sustainability of new roles

Strategic

Existing new roles schemes were generally being supported via transformation funds, GP Federation, CCG or NHS England funding, with fewer examples of individual practices taking on directly employed professionals. One participant described how pharmacist services in general practice in her area were funded by transformation funding with the primary aim of reducing secondary care use; it was

reported they had not yet made a difference to GP workload because, in contrast to directly employed pharmacists, this was not their aim:

I think there's quite a mixed response to clinical pharmacists across the CCG and I think it depends on how they're being used... some [practices] are employing directly their own, and getting them to do a variety of different things, so some of that is taking admin workload off GPs and freeing up GP time... locally with GM Area 4 [clinical pharmacists are]... employed by the hospital and work on a neighbourhood basis... I think it's difficult, because they're transformation funding, and [that] is aimed at trying to reduce secondary care input I think, is the reality. Do they make much difference to primary care and our workload? They haven't done so far. (GP CCG Lead, GM Area 4, Interview 18)

The future of schemes could be uncertain and the decision to continue would be in the hands of newly forming PCNs, compounding uncertainty. There was confusion about how new funds through PCNs to support the development of new roles would flow (whether directly to each neighbourhood, through GP federations or some other way), and a concern that organisations had not thought about the reality of who would employ new roles since PCNs were not legal bodies. A further concern expressed was that practices directly employing staff at the time of the baseline audit to assess additional money needed for new roles, would be penalised for already having staff in place. There were suggestions that this may be being re-considered at national policy level after significant pushback:

...the issue now about the additionality is important, because some of these roles... are from the transformation fund, which isn't permanent funding, but we have to say that they are there in practice in this baseline audit, which means then that we don't get funding for them going forward. We've got to show that it's over and above that and it's always been a 'what do we do going forward?'... we hope that [new roles will] continue, but then to be faced with this where funding's there for those that haven't been quite so ahead of the curve, it feels a bit... that can't be fair, can it?... so there's some thought to be put into that I think, and the pushback's been enough to I think get at least NHS England thinking about it again hopefully, hopefully. Because there's not just us, but there are many that haven't done what we've done and not got these people out there and they'll benefit from that. So, yeah, it's difficult. (CCG Lead, GM Area 7, Interview 23)

The criteria for new roles being funded under the new GP contract included that the role was 'new' and role holders were able to consult with patients, address the prevention agenda and be available in sufficient numbers to work in general practice. According to national policy-makers, by pledging financial support for particular new roles, there was no implication that these were the only roles needed in general

practice. However, in reality, general practice would be less likely to invest in new roles that were not funded through PCNs under the contract, because interest in new roles often dwindled once funding came to an end:

And then Primary Care Networks have come along saying they're going to fund this role, this role, this role, this role. I mean why would anybody invest in anything else that isn't on that list?...by the end of five years it's three quarters of a million pounds a year for new roles, a huge amount, per neighbourhood and there's [several neighbourhoods] in GM Area 6, so it's a big number. Far bigger than we would have got from the CCG in terms of investment, I think. (Provider Lead, GM Area 6, Interview 17)

One participant highlighted a previously problematic cycle of short-term new roles' funding which ended before practitioners could embed, followed by the removal and re-badging/reintroduction of new roles a few years later. Although PCN funding for new roles removed some of the risks for practices, which was seen as a positive development, it was suggested that this might also lead to reduced priority on gathering an evidence-base to underpin new roles. Another participant highlighted that the planned introduction of PCN funding for social prescribers had complicated the roll-out of an existing service in their area with a lack of clarity about how the two funding streams would work together, if at all:

So the other role that we've got ready to roll out ...would be the voluntary sector, for us to have the social connector roles. So we've got to the point of we've got the job description, and really in GM Area 9 it was the voluntary sector that were going to employ them, and this was also a means of getting funding into the voluntary sector on the transformation plan. And they were going to work within neighbourhoods and connect... the practices to... assets... in the community. So obviously now we've got this [primary care] network and the social prescriber role, so we're just trying to see how the two fit together... and a little bit of negotiation will need to happen with practices because obviously... what we would prefer not to have is practices employing a whole bunch of staff when... we'd already made a decision that it would be good for the voluntary services to hold that role. (GP Provider Lead, GM Area 9, Interview 40)

Operational

Operational leads across the targeted roles reported that new roles schemes were at different stages of roll-out. For example, a scheme to place pharmacy technician trainees into practices was seeking further funding to extend from one practice where it had been successful to other practices that were different in set-up:

...this model's worked here, I'm hoping to start another group of practices in September with a new batch of students; I'm just trying to get funding.

Because I want to show is that... it can work in another practice as well as it's worked in that practice. Because I don't know, this practice might be unique and because of how it had all been embedded and everything with the [pharmacist team], so it might be why it's worked so well. (Pharmacy Technician Lead, GM Area 2, Interview 36)

Some participants felt that schemes and services that had been able to provide evidence of effectiveness and impact were more likely to be regarded positively and sustained and supported in the future by practices and commissioners. Capturing feedback on how new roles had made a difference to reducing GP workload in struggling practices in particular was seen as important, to encourage these type of practices to look at different ways of working:

Touching back on the performance and outcomes: we want to look at how our activity has freed up those GP hours in the surgeries, and what they've then been able to do with that. And it might actually be that practices or GPs felt like they were at absolute breaking point, and under so much strain, and with us being able to take those hours of visits and seven day access appointments away, that allows them to then just leave on time, or closer to when they were supposed to leave; or another example, being able to concentrate their work on their more complex patients, or administration within the surgery. And again, that's feedback that we're capturing, as well. (GP Lead Paramedic Scheme, GM Area 10, Interview 51)

In common with the views of strategic leads, in operational interviews the introduction of PCNs was also said to be bringing uncertainty about the funding of some roles. Social prescribing service leads, in particular those funded via transformation funds, were unclear about the sustainability of existing schemes. Concerns were raised that efforts to build a business case to fund social prescribing from core budgets would be lost now that PCNs were to receive monies for social prescribing link workers. This led to questions regarding what model of social prescribing would develop in the future, with questions around how future schemes would sustain and secure the VCSE sector which was perceived to be vital for offering a holistic model of social prescribing:

They could end up having a social prescriber in each GP practice, being part of the clinical team with the consequences of that... if you work within a clinical team, you are going to become more clinical... I'd like to see that [social prescribing] stays with community organisations, to keep the roots where the roots need to be. And to make a place like us sustainable... because if we're not here, then a lot of those service offers that they're going to need will suffer (Regional Social Prescribing Link Worker Lead 2, Interview 43)

In terms of the sustainability of social prescribing services, some operational-level participants were also concerned that the intelligence and community links built over the time of existing schemes could be lost, as in some areas PCN-funded social prescribing link workers were being employed without any input from the service leads of existing schemes:

... it's very much for us, at this moment in time, having those conversations to see what's going to happen after the funding, how are we going to pass all this information on, if more funding doesn't come in? How can the PCNs learn from what we've learned? Here's like, I say, x, y and z, sort of take that, do whatever you want with it, don't just leave it in a cupboard, because it's valuable, and what sort of learning, and carry on the good work that we've done, and let's see how we can support you, and ultimately sustain social prescribing in GM Area 7. (Social Prescribing Link Worker Lead, GM Area 7, Interview 45)

Only one social prescribing scheme participant reported that their service had been recently recommissioned for a further five years and therefore the introduction of PCN link workers did not appear to threaten the sustainability of their service.

Another concern among operational participants was the retention of staff they had in new roles in the future; the introduction of PCN monies meant that PCNs would be looking to employ new roles across the country and this would increase demand. Participants who were leads of pharmacy teams and first contact physiotherapy services saw this as a particular problem; they cited previous struggles to recruit pharmacists into general practice and the shortage of qualified first contact physiotherapists across the country as reasons for their concern:

...there was only 800 qualified [first contact physiotherapists], as I understand it... in Britain... so, obviously everybody wants them... and, I say to my team, this is a really good time to be you, because you are going to be in demand and your wages are going to have to go up because there are so few and it takes several years to train up from band 6. (GP Lead Physiotherapy Scheme, GM Area 10, Interview 64)

I mean one of the big dangers now though is that with every network in the country looking for pharmacists, are they going to stick around, or...am I going to go through lots of change and struggle to recruit... GM Area 10 has struggled to fill all its vacancies in the pharmacy service. And that's only going to get worse because it's a big undertaking to get this many pharmacists in general practice. (Practice Manager, Pharmacy Technician Scheme, GM Area 10, Interview 52)

Thus the sustainability of new roles was seen as largely to be influenced by the currently forming PCNs and the funds that would flow through them to practices under the new GP contract.

5. Discussion

5.1. Summary

Findings from this study reflect and build on those of our prior CLAHRC GM research on skill-mix change in primary care⁸⁻¹⁰. The issues raised in our previous local evaluation of non-medical roles in one area of GM¹⁰ were also found to broadly apply to new roles across the region. In this study, views gathered in operational and strategic-level interviews were largely similar; however, drilling down to examine five targeted roles in more detail offered a greater level of insight on how particular roles were operating across GM than would have been possible from strategic views alone.

In summary, in line with previous research, four general factors that affected the implementation of roles were identified.

- 1) Communication and engagement between stakeholders enabled roles to be planned, coordinated and implemented in general practice more smoothly.
- 2) Clarity around role definition/professional boundaries was reported to enhance the acceptance and embedding of new roles.
- 3) The infrastructure to support appropriate training and employment of new non-medical practitioners in general practices appeared to be crucial to their success but was often lacking.
- 4) Although some evaluation was taking place, measuring the impact of new roles remained challenging, particularly in accurately assessing changes to GP time as a result of introducing new roles professionals.

This research also extends what is known already about the implementation of skill-mix changes by offering specific insights on how the social prescriber and care navigator roles were operating, as well as highlighting the extent to which the sustainability of new roles was reported to hinge on the newly forming PCNs and associated funding streams.

These findings are discussed in more detail in the sections below.

5.2. General factors affecting the implementation of skill-mix changes

5.2.1. Communication and engagement

In line with our previous local CLAHRC GM research¹⁰, this study has highlighted that in the urgency to implement skill-mix policy changes, important discussion around planning, coordination and promotion of roles was often missed; however, adequate dialogue between stakeholders enabled roles to be implemented more smoothly. Unintended consequences could arise as a consequence of inadequate engagement and expectations management between stakeholders prior to and during implementation.

Engagement with skill-mix change was at different stages across GM and lacked regional consistency. The need to share roles across clusters was often recognised, but hinged on underpinning good relationships and trust. Meaningful workforce data to underpin planning for new roles was lacking; some areas were hopeful that making efforts to engage practices in discussions about why workforce data was needed and how it could help them plan for the future would overcome this. Engaging GP champions to promote skill-mix change was seen as particularly important in communicating the potential benefits of roles to primary care staff and patients. It was also highlighted in particular, that educating patients about both the changing GP role and changes in the wider health and social care system was not currently happening and might help new roles to assimilate.

If new roles are to be sustained in general practice, it is therefore vital that time is set aside for dialogue between stakeholders (CCGs and primary care provider organisations, policy-makers, training leaders, HEIs, general practice staff and patients), to plan these changes and ensure a realistic vision of what might be achieved within a reasonable timescale.

5.2.2. Definition and differentiation of new roles

Confusion could arise when a role holder's scope of practice was not well defined and boundaries between roles were blurred, a finding which reflects our previous local evaluation on skill-mix changes in general practice¹⁰.

There were differences here in relation to the five targeted roles examined. Pharmacy technicians, for example, were often confused with pharmacists, with reports of technicians being asked to carry out tasks inappropriate to their role. It required significant effort on the part of practitioners to challenge these perceptions. The newer, unregulated roles of primary care-based social prescribing link worker and care navigator were the most unclear, bringing particular boundary issues into play (these are discussed in more detail in sections 5.3.1 and 5.3.2 below). Though more familiar in secondary care, the roles of physiotherapist and paramedic were

already recognised as regulated professionals in their own right. Being seen to belong to an established health care profession enabled practice staff to have a certain level of confidence in these roles to begin with; this could assist with implementation of the role. That said GPs, practice staff (and reportedly patients) were at differing levels of acceptance of new roles in general, with variation in staff's willingness to relinquish tasks to new roles professionals that were previously under their own remit. This resistance could dissipate with time and a growing understanding of the value of the role which often rested upon trust in individual role holders.

Ambiguity around role definition contributed to confusion at least initially, but could also allow roles to evolve to fit the general practice setting. However, clearer role boundaries appeared to facilitate acceptance of roles by setting more realistic expectations about what they could achieve and helping them to be used more appropriately. The challenge for policy-makers, regulatory bodies and training organisations will be to define and differentiate the purpose and scope of new roles more clearly while allowing flexibility to suit the needs of individual practices/settings.

5.2.3. Training and employment of new roles professionals

General practice is characterised by presentation of a wide diversity of signs and symptoms¹⁷ meaning that the management of diagnostic uncertainty is common¹⁸. The education and training of new roles professionals as well as the way they were employed regionally therefore affected the feasibility of skill-mix changes.

In line with our previous local research¹⁰, new roles practitioners regionally were reported to need a greater level of preparation for the general practice setting than was currently provided. In general practice, they would often be expected to work more autonomously than before, being required to recognise and deal appropriately with risk and uncertainty when presented with wide-ranging health problems. Accessing support and mentoring from more experienced colleagues from their own professional background was seen to be important and some new roles practitioners in this study were able to do so. However, it was reported that capacity and time to plan training was often lacking, meaning that role holders often had inadequate periods of on-the-job training in general practice before being expected to function fully in their roles. A new insight from this study was the suggestion that GPs themselves needed training to adjust to working alongside new roles professionals in order to optimise their own and other practitioners' skillsets. Regulatory bodies, training organisations, higher education institutions (HEIs) and general practice leaders must work to ensure that new roles professionals are supported to develop the skills they need for general practice if roles are to be sustained.

Non-medical professionals were functioning in their roles under different employment models; each model offered positive and negative aspects. Professionals employed directly with practices were seen to be more able to shape their roles to fit the

requirements of general practice, but by the same token, could miss out on the training and development opportunities afforded to role holders employed by larger organisations. Larger bodies often employed non-medical practitioners on a shared basis, which could be protective for the practitioner in terms of reducing isolation and maintaining professional knowledge/identity, but less positive for individual practices because care could be fragmented through part-time working across practices. It was noted that employing organisations (be they NHS Trusts, CCGs, primary care provider organisations, individual practices or organisations in the voluntary sector) needed clear HR procedures and support structures (such as mechanisms to obtain professional indemnity) to govern the employment of new roles practitioners. It was also seen as important that employing organisations had the capacity and a commitment to provide CPD, peer support and career development opportunities to practitioners. As new roles embed into general practice it will be important to balance these competing demands.

5.2.4. Demonstrating the impact of new roles

Our previous local evaluation¹⁰ highlighted the difficulty of capturing evidence of the impact of roles due to the different goals associated with skill-mix changes, as well as a lack of appropriate mechanisms to fully capture these different outcomes. Regionally, there was wide agreement among participants in this study that evaluation of roles was needed to avoid unintended consequences; however roles were often inserted rapidly into the system, sometimes without a clear understanding of the intended outcome, meaning there was no time to thoroughly plan evaluative approaches.

It was also agreed that the main aim of new roles was to take the pressure off GPs by partially substituting for them on some tasks. Some service leads were part of national initiatives designed to channel patients away from GPs to other types of professional. For example, MSK practitioners working as part of the first contact practitioner for MSK scheme¹⁶ were collecting standardised KPIs tied to the national pilot and believed they were able to accurately assess GP time saved and show time reductions. However, although this scheme was designed for patients to self-refer to a physiotherapist in their own general practice without having to see a GP first, some GPs involved in the scheme reportedly insisted on seeing patients before passing them to MSK colleagues, thereby duplicating work and making net time-savings hard to gauge. Other participants believed that measuring reductions in GP workload was an impossible goal, as the work of GPs was so complex and multifaceted. Patient feedback on new roles services was also seen to be important, though recognised as equally difficult to capture in meaningful ways.

Improving patient care by diversifying the skill-mix available in general practice was cited as another goal of new roles (i.e. introducing social prescribers with expertise in managing the wider social needs of patients; physiotherapists with expert knowledge of MSK problems or paramedics in assessing acute conditions). However, it was

also recognised that it would be difficult to attribute any impact (such as cost savings in the NHS or improvement in health/wellbeing) directly to new roles, as many different components of services were operating simultaneously. In the absence of robust measures, some stakeholders were relying on case studies alone to promote positive messages about roles and encourage them to be sustained or more widely taken up.

Researchers and policy-makers will need to work together to generate better ways of evaluating outcomes associated with new roles including economic impact of these changes^{19,20}, and, in particular, capturing changes in GP workload (though some recent work in this area is promising²¹). It is also currently unknown whether skill-mix changes are meeting patients' needs. Addressing this will be an essential step towards a sustainable multi-professional system of general practice.

5.3. Specific insights on the implementation of skill-mix changes

The study also offers specific insights on the operation of the newer roles of care navigator and social prescribing link worker and highlights stakeholder perspectives on the rapidly forming PCNs and their potential influence on the evolution of new roles in primary care.

5.3.1. Care navigator role

Active signposting is one of the 10 High Impact Actions that aspire to help general practices release time²⁷. Nationally funding has been provided to train first point of contact reception and clerical staff as care navigators with the aim of signposting/navigating patients to the most appropriate source of help (i.e. a range of health professionals and services across the health and care system or self-care). The assessment and channelling of patients' needs to 'appropriate' help requires a significant level of judgement and this study highlighted particular boundary issues associated with 'upskilling' receptionists to take on the care navigator role. There were concerns for example that as non-clinical staff, care navigators may be operating outside their realm of expertise and this may have implications for patient safety. Not all role holders welcomed being trained as a care navigator and some reported feeling pressurised to shift the boundaries of their role and take on this extra responsibility. In particular, as the purpose of the role was to free-up GP time, directing patients who wished to see a GP to other services as part of this role could reportedly involve stressful and even combative interactions. There was consequently potential for conflict between the dual goals of freeing up GP time and addressing patients' needs appropriately. Additionally, receptionists/care navigators were not remunerated for assuming this higher level of responsibility.

A lack of planning and coordination across sectors (e.g. primary care and the voluntary sector) also appeared to impair the success of the role. For example, care navigators could signpost patients to services that were overloaded and unable to take them and this had implications for patient trust in general practice more widely. Measuring impact of this role was particularly problematic because of a lack of standardised outcome measures for signposting and low engagement from care navigators in completion of measures.

5.3.2. Social prescribing link worker role

Social prescribing is being widely advocated and implemented although it is currently an unregistered/unregulated role. It broadly aims to provide community-based support to patients through personalised care and support planning, using community and informal support and freeing up GP time. There were mixed reports of the link worker role in this study. A lack of clarity about the remit of the role could lead some GP staff to make inappropriate referrals to these professionals, for example, of patients with serious mental health issues that link workers were not qualified to manage.

Providers of social prescribing link worker services were found in both the primary care and voluntary sectors. Provider type appeared to strongly shape the role, with clinically based social prescribing link workers in primary care perceived to be operating in less patient-centred ways than those with in-depth knowledge of the CVS system. In a similar way to the care navigator role, this was reported to centre on a perceived conflict between prioritising the goals of general practice (i.e. freeing up GP time by deflecting patients away from GPs) and addressing patient needs in a 'holistic', personalised way. Further, there were questions around whether the holistic nature of the link worker role can be sustained if services become split off from previously longstanding voluntary sector schemes and come to be primary care-based (and potentially more 'clinical' in focus) under PCNs. Potential conflict between the dual aims of providing holistic patient care while taking pressure off general practice may have implications for service delivery and role sustainability more generally, and suggests that more dialogue and planning is required around the aims and delivery of social prescribing services.

The role also suffered from perceptions of inconsistency arising as a result of link workers from different backgrounds working in different ways. Standardised role frameworks and training specifically for the primary care setting could help embed the role more smoothly and indeed regional attempts were being made to develop these but were at an early juncture. Strong links across services in the system (e.g. primary care, social care and the voluntary sector) to develop in-depth knowledge of what is available and how services can best support patients enabled the role to function more successfully. While social prescribing link workers in primary care could be seen as a threat to established link worker services in the community, with communication and engagement these difficulties could be overcome. Indeed, pre-

existing relationships between sectors were seen to assist the integration of services; in addition, the design of roles that enabled staff to work across the boundaries in health and care system also reinforced this.

However, it has been highlighted previously that evidence for improvements in health and well-being and reduction in usage of health services as a result of social prescribing is lacking^{22,23}. Outcome measures to assess the impact of these roles therefore need to be developed; however, given that the role aims to holistically address a wide range of patient needs, it will be challenging to adequately capture this in a way that attributes changes in the system to this role alone.

5.3.3. The influence of PCNs on future general practice skill-mix changes

There were concerns about how the newly forming PCNs, being established to incentivise collective working between independent general practices²⁴, would shape the evolution of new non-medical roles in primary care. At the time of the interviews there was some reticence about investing further in new roles as areas waited to see how the setup of PCNs would affect planning for new roles. While PCNs were seen as potentially facilitating the sharing of roles and planning of services across an area, there were also concerns that these new bodies might work against role shaping as roles would have to be strictly operationalised as specified in the new GP contract, giving practices less autonomy in role development.

There were concerns that the additionality rule under the ARRS scheme⁷ (whereby practices that had new roles professionals in place prior to the start of PCNs would be ineligible for earmarked future funding) penalised early adopters. The ARRS scheme may influence the type of roles seen in future general practice, as practices will be unlikely to invest in roles outside the contract. More broadly the future of new roles in general practice remains uncertain after the current five year funding streams come to an end.

There was also a suggestion that the availability of funding for the new roles under the contract might encourage a rather 'tick box' approach to the employment of new roles professionals, hampering the need for evidence and discouraging implementers from robust evaluation of new roles schemes. Other questions remained around the lack of legal status for PCNs and how this would affect inter-practice agreements and the employment of new roles professionals. The role of pre-existing GP federations in PCNs was also uncertain. There was also a lack of clarity about how future new roles funded under ARRS would operate alongside existing schemes on the ground, or whether long-standing schemes would become defunct as a result. Early adopters of new roles were concerned that the contract would increase demand for certain named roles and increase the likelihood that staff they had already invested in would leave.

More widely under PCNs it was felt that practices faced the challenge of balancing their independent contractor status against the potential benefits of being part of a wider network. Learning from past reorganisations of primary care suggests that progress is best achieved through paced development alongside training, support and assessment; this would seem to be applicable also to the formation of PCNs²⁴.

It is planned that PCNs will be part of larger ICSs across the country by 2021. Part of the remit of ICSs is to develop five-year plans to inform workforce planning, including plans for the number and mix of roles needed to deliver the NHS Long Term Plan^{6,25}. Given the difficulties highlighted in this report around producing meaningful workforce data mapping (and by extension, onward workforce planning for general practice), it is uncertain whether PCNs will be able to benefit from this shift of responsibility and work with ICSs to influence workforce plans for new roles in primary care.

5.4. Conclusions

The re-design of general practice into a multidisciplinary workforce with new roles professionals as a key tenet is set to continue. The ‘People Plan’ (a government strategy to guide the implementation of skill-mix and wider NHS workforce changes) is expected in late 2019. Meanwhile the learning from this study could assist stakeholders involved in new roles initiatives across GM with planning to maximise roles’ potential and increase their sustainability in general practice.

Implementers could focus attention on key factors to enable the smoother implementation and embedding of roles: communication and engagement between stakeholders to coordinate and adequately plan skill mix changes, including engaging practices about the need for underpinning workforce data; clarity around role definition and role boundaries; specific training of role holders for the general practice environment; employment models to enable continuing professional development; and robust ways of measuring the impact of new roles, particularly in accurately assessing changes to GP time.

There are particular considerations for the implementation of the roles of care navigator and social prescribing link worker including: 1) how the roles function across health and social care and the voluntary sector, and 2) the potential for conflict between the two goals of freeing up GP time and addressing patients’ needs in a person-centred way with implications for patient safety.

Lastly there are considerations for skill-mix changes linked to the influence of the newly forming PCNs and associated funding streams. These include implications for which new roles will be sustained and in what form, and how PCNs might influence workforce planning for general practice through the developing ICSs.

5.5. Key messages

Key messages from this study:

- Previous CLAHRC GM research at a local GM level identified key factors that maximise the potential of skill-mix changes in general practice and increase its sustainability; these factors also apply regionally and remain significant challenges to varying degrees across GM;
- Meaningful and timely communication and engagement between stakeholders for the coordination and planning of new roles can avoid unintended consequences;
- Engaging practices in discussions about why workforce data is needed and how it can help them with workforce planning may assist the development of skill-mix changes;
- Clarity around the definition and boundaries of new roles can assist roles to embed more smoothly, while recognising where emergent roles require some flexibility;
- Tailored training of new roles professionals for the general practice environment as well as employment models to ensure their continuing professional development are required;
- Robust measurement of the impact of new roles requires detailed attention to intended outcomes and availability of reliable data, particularly with regard to accurately assessing changes to GP workload;
- There are particular considerations for the implementation of the care navigator role. These include how the role functions across the wider health and social care system and whether staff are adequately prepared to assess/channel patients to different care options with possible implications for patient safety and trust in general practice;
- There are considerations for how social prescribing link workers funded under the new GP contract will affect existing services across the wider system and there may also be potential for conflict between duties of the role in providing personalised care to patients while aiming to release GP time;
- Which new roles will be sustained in general practice, and in what form, are questions that are strongly linked to the newly forming PCNs and associated funding streams;
- There is uncertainty around how PCNs might influence general practice workforce planning (including skill-mix changes) through the developing ICSs.

6. Appendices

Appendix 1: Summary information on the five new non-medical roles targeted in operational interviews

Care Navigator: a role which involves helping patients navigate their care across sectors and health/social care boundaries²⁶. The role is based on ‘active signposting’, one of the 10 high impact actions to release GP time included in the General Practice Development Programme²⁷. Care navigation aims to provide patients with a first point of contact which signposts them to the most appropriate source of help (e.g. a particular health professional, voluntary sector service or web/app-based self-help resource) with the underpinning aim of freeing up GP time. National investment of £45 million via CCGs was made available for training of reception staff to play an increased role in active signposting of patients. NHS England case study research (e.g. <https://www.england.nhs.uk/wp-content/uploads/2017/10/west-wakefield-general-practice-case-study.pdf> and <https://www.england.nhs.uk/gp/case-studies/active-signposting-frees-up-80-inappropriate-gp-appointments-a-week/>), and one small-scale peer-reviewed study²⁸ state that care navigation schemes have shown a positive impact on reducing the need for GP appointments/telephone consultations, though robust evidence for the impact of the role on the wider system is needed.

Paramedic: a professional who typically works in emergency care but who could work as part of the primary care team, assessing and managing patients with minor conditions²⁹. Paramedics are regulated and registered through the Health and Care Professions Council (HCPC) and have their own professional body, the College of Paramedics³⁰. The college oversees specialist training for the primary care setting under its Diploma in Primary and Urgent Care (<https://www.collegeofparamedics.co.uk/publications/diploma-in-primary-and-urgent-care>). From 1st April 2018 an amendment to the Human Medicines Regulations allows some paramedics eligibility for independent prescriber training (http://www.legislation.gov.uk/ukxi/2018/199/pdfs/ukxi_20180199_en.pdf).

Paramedics as partial substitutes for GPs in responding to and assessing urgent requests for care and home visits have been piloted in England in recent years but evaluation is currently limited³¹. The first contact paramedic role is eligible for 70% funding under the Additional Roles Reimbursement Scheme (ARRS) from 2021⁷.

Pharmacy Technician: a role that typically works in community or hospital pharmacy, which became regulated in 2011 by the General Pharmaceutical Council (GPhC). They usually work alongside and support pharmacists with the supply of medication and/or delivery of care to patients. As the role of the pharmacist has become more clinically focused, the potential for pharmacy technicians to take on

additional responsibilities has opened up in all sectors, to varying degrees. About 5% of these professionals work in primary care³²; pharmacy technician roles in this sector are the most diverse and include: data analysis and report writing on prescribing, incidents, usage, wastage; medicines switches; investigating and reviewing incident reporting; reviewing patients' medicines; and medicines management in nursing homes³³. There is no formal training pathway for pharmacy technicians entering primary care/general practice (as there was for NHSE scheme pharmacists). Due to their small numbers and the recent emergence of the role, little is known about their training and support needs (though concerns about the relevance of training and education for the role in other sectors may also apply to pharmacy technicians in primary care³⁴).

Physiotherapist: a role which is HCPC registered/regulated and has its own professional body, the Chartered Society of Physiotherapy (CSP). Physiotherapists may operate in primary care in a range of ways, e.g. assessing, diagnosing or triaging musculoskeletal (MSK) problems, taking direct MSK referrals, offering support for particular issues such as falls or neurological/respiratory conditions and acting as a bridge between primary and secondary care. They are autonomous regulated professionals and since 2014, some have been qualified to prescribe independently under restrictions and order tests¹. First contact (i.e. self-referral) physiotherapy appears to be safe and comparable to care delivered by a GP with high levels of patient satisfaction and indications that patients may need fewer return visits or referrals^{8,35}. However, the impact of these services on the overall general practice workload is unknown²⁶. The role is eligible for 70% funding under the Additional Roles Reimbursement Scheme (ARRS) from 2020⁷ and physiotherapists in primary care are being widely promoted by the CSP³⁶.

Social Prescribing Link Worker: a role which aims to provide holistic, community-based support to patients through shared decision making/personalised care and support planning, and making the most of community and informal support³⁷. The role is not regulated by a professional body and there is no generally agreed definition of social prescribing, with a number of different models being adopted within primary care³⁸.

The NHS Long Term Plan commits to 1000 new social prescribing link workers by 2020/21 rising beyond this figure by 2023/24³ and the role is earmarked for 100% funding through the Additional Roles Reimbursement Scheme (ARRS) from 2019⁷. Social prescribing is part of a wider commitment to implementing the NHS England comprehensive model for personalised care³⁷; a reference guide and technical annex has been produced to support PCNs to introduce the role into primary care (<https://www.england.nhs.uk/publication/social-prescribing-link-workers/>), including a sample job description. There is a lack of robust, quality evidence to show the effectiveness of social prescribing schemes^{23,39} as this is currently limited to small-scale, poorly designed evaluations²². However, some qualitative evidence suggests

that social prescribing schemes may be viewed positively by users, primary care workers and commissioners⁴⁰. Studies have shown that link workers positively influence the management of long term conditions and that the link worker role is essential for users' ongoing engagement in social prescribing schemes^{41,42}. Future evaluations require a more robust, transparent (reporting both success and failure) approach with both qualitative and quantitative methods to assess impact, compare across studies and share learning^{22, 23,39}.

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