Supervision for roles recruited through the Additional Roles Reimbursement Scheme (ARRS)

NHS England and NHS Improvement

Aim of this resource

Page 38 of the Network Contract Direct Enhanced Service (DES) outlines a number of requirements that every PCN must comply with, in relation to roles recruited through the Additional Roles Reimbursement Scheme (ARRS). This list of requirements includes a specific request for all additional roles to have "access to appropriate clinical supervision and administrative support."

This resource is not intended to be considered as contractual guidance or to be used as a lever for contractual enforcement, but is intended to support PCNs in developing their practitioners and providing both patient and practitioner safety through supervision. This resource offers examples of good practice in relation to clinical supervision, and provide PCNs with additional considerations on what good supervision looks like for each role.

This resource, developed in collaboration with Health Education England, offers:

- A further definition of what good supervision looks like in relation to the roles recruited through the ARRS.
- Advice on who can provide supervision to the roles.
- Example case studies from a range of PCNs who have developed innovative supervision practices that support their practitioners.

What is supervision?

- Supervision is considered a process by which one worker must work with another to meet professional, organisational and personal objectives, which together promote the best outcomes for the patient.
- For the purpose of the additional roles in the ARRS, it would be our recommendation that a PCN considers supervision in the context of the two types described below. These definitions reflect the latest HEE guidance on workplace supervision.

Clinical Supervision

- Provided in the clinical setting
- Aimed at all of the roles in the ARRS, particularly those in a clinical setting
- Purpose includes:
  - To offer debrief to ensure patient and practitioner safety
  - Undertaking work place based assessment
  - Reflecting and reviewing practice
  - Discussing individual cases
  - Supporting changes in practice where necessary

The frequency, structure and delivery of supervision and governance arrangements should be flexible according to the individual requirements and the complexity of their role; guided by the experience, capability and confidence of individual practitioners; the setting and their employer

CPD Supervision

- Provided by the employer or line manager
- Aimed at all of the roles in the ARRS
- This type of supervision is required to evidence maintained capabilities and continued professional development (CPD)
- Provided on a regular basis (for example six weekly)
- Purpose includes:
  - Touching base
  - Discussing ways of working
  - Developing teams
  - Identifying any learning needs, opportunities and support
  - Reflection on incidents/learning events
  - Peer review

What is the expectation per role in the ARRS?

It is our recommendation that in order to support both patient and practitioner safety, each clinical role recruited through the ARRS has access to the following types of supervision:

Clinical roles	Clinical supervision	CPD supervision	An appropriate named individual in the PCN to provide general advice and support on a day to day basis
Pharmacy Technician	☑	☑	
Physician Associate	☑	☑	
First Contact Physiotherapist	☑	☑	
Dieticians	☑	☑	
Podiatrist	☑	☑	
Occupational Therapists	☑	☑	
Nursing Associate and	☑	☑	☑
Trainee Nursing Associate	☑	☑	☑

What is the expectation per role in the ARRS?

In the case of Clinical Pharmacists, the PCN DES specifically requests the following levels of supervision:

- each clinical pharmacist must receive a minimum of one supervision session per month by a senior clinical pharmacist;
- the senior clinical pharmacist must receive a minimum of one supervision session every three months by a GP clinical supervisor;
- each clinical pharmacist will have access to an assigned GP clinical supervisor for support and development;
- there will be a ratio of one senior clinical pharmacist to no more than five junior clinical pharmacists, with appropriate peer support and supervision in place.

What is the expectation per role in the ARRS?

It is our recommendation that in order to support both patient and practitioner safety, each personalised care role recruited through the ARRS has access to the following types of supervision:

	Social Prescribing Link Worker	Health and Wellbeing Coach	Care Co-ordinator
A first point of contact for general advice and support and (if different) a GP to provide supervision. This could be provided by one or more named individuals within the PCN.	✓	✓	✓
It is recommended that link workers are also able to access clinical supervision as described in the Social prescribing link workers: Reference guide for primary care networks - Technical Annex (Annex F), which can be from their GP supervisor or another relevant health professional in the PCN.	✓		
Access to a GP (either their named supervisor or another appropriate GP) to provide advice on patient related concerns and to support with appropriate safeguarding procedures.	✓	✓	✓
Attendance at the peer support networks run by NHS England and NHS Improvement at ICS/STP level.	✓		
Access to regular supervision from a health coaching mentor, and individual and group coaching supervision from a suitably qualified or experienced health coaching supervisor.		✓	

What does good supervision look like?

- It is envisioned that good supervision will include the whole multi-disciplinary team, including clinicians and all three personalised care roles. We advise that all primary care staff recruited through the ARRS **meet regularly to reflect on their practice**, with the intention of learning, developing and providing high quality, safe care to patients. It is recognised that supervision can take a variety of forms to be effective.

- For clinical supervision, **joint clinics with a GP and an AHP are an effective way to identify learning needs, build the skills and confidence of the AHP**, but also builds trust across the two colleagues. It can also be beneficial to host MDT sessions, in which practitioners from a range of roles come together to reflect on patients and consider any learning opportunities.

- In addition, **practices are asked to identify a named GP or verified and recognised advanced practitioner** who is available on the day to undertake debriefs and provide support and guidance to clinicians seeking further advice on a particular case.

- Putting the right level of supervision in place is **key for both staff and patient safety**. There are also additional benefits including staff retention - staff who feel supported in their role are also more likely to stay in post.

Who can provide supervision?

- **Clinical supervision** is primarily provided by a GP or by a verified and recognised advanced practitioner.

- **CPD supervision** is usually provided by a line manager, however this could also be offered by a senior professional from across the multi-disciplinary team.

- Where there are different employment models in place, such as rotational working across a PCN and an NHS trust, it is the responsibility of the employing organisation to ensure there is appropriate clinical supervision in place. For example, for a paramedic working in primary care, their host organisation (their local ambulance trust) must ensure there are suitable arrangements in place.

- HEE have developed further guidance on Workplace Supervision for Advanced Clinical Practice which can be found here: https://www.hee.nhs.uk/our-work/advanced-practice/reports-publications/workplace-supervision-advanced-clinical-practice

Examples of good practice

“Having worked in a range of primary care and practice settings, I have experienced a variety of supervision and support - initially as a paramedic, and then as an advanced paramedic. The best supervision experience, which enabled me to develop my competency and confidence within my role, was when I had regular joint clinics with a dedicated GP supervisor within the practice. Whilst there were more of these joint clinics at my initial start in primary care, as we developed trust in our supervisee-supervisor relationship, these clinics were then every four weeks. This worked well as, when I later undertook the prescribing course which mandated so many hours of direct supervision with a Designated Medical Practitioner, we were then able to implement these joint clinics more regularly. Because my GP supervisor and I had developed a relationship before this, and were used to this way of supervision, when we needed to do more for this course, it worked seamlessly.

I have also benefited enormously from the informal supervision and feedback in the surgery: Taking part in weekly practice meetings, which includes case based discussion, has been very helpful for my development - as well as building a relationship with other clinical members in the team. Both these elements together have ensured I have been able to keep a record of my practice development in my role and am able to evidence my competencies, crucial as part of my Continuing Professional Development requirements as a paramedic.”

Georgette Eaton,
Advanced Paramedic Practitioner

Examples of good practice

“As a First Contact Physiotherapist in primary care, having the right level of supervision is key to both my development and to providing safe patient care. Across my PCN, when a new FCP is appointed they are asked to complete an induction day at one of the practices in their PCN. On this induction day, they will be joined by a more experienced FCP who will share a competency document that we have developed locally (that outlines the role requirements and matches the HEE roadmap for FCPs), plus a second document we have developed that offers hints and tips on useful paths and processes for working across the local patch.

In the afternoon of the induction day, we’ll complete a join clinic together, to enable feedback and provide support to the new starter. We’ll then touch base again after two weeks in post, to go through any problem solving or concerns they have.

We offer formal clinical supervision every eight weeks, where we meet face to face at practice. There will be an observed clinic, after which we can discuss patients, concerns and any other elements such as wellbeing and annual leave requests. Each physiotherapist also has an FCP supervisor, plus a GP mentor for more specialist or medical development.

For day to day support, we have an FCP Whats App group for peer support or any on the day physio queries that we want to run past the group. If we have a medical or urgent query, there is always a doctor on duty at the practice to refer to.”

Emily Thomas,
First Contact Physiotherapist

Examples of good practice

“In Wirral, our acute trust have been supporting primary care by hosting clinical pharmacists, and latterly pharmacy technicians, and rotating them into primary care networks. As part of this collaborative approach to working across systems, we have set up a standardised supervision programme that aims to be both supportive of staff development and offer colleagues someone to talk to for advice.

Our supervision model is based on the model used by the acute trust, which we have tailored slightly to support colleagues working in primary care. Each PCN has an assigned PCN Lead Pharmacist, who has oversight of all the pharmacists working across their PCN.

The level of supervision they offer meets the requirements outlined in the PCN DES, and is tailored to the level required per banding/role. For example, with our band 6 pharmacists we offer daily check-ins, alongside weekly supervision sessions with the PCN Lead Pharmacist to enable teaching and education, as well as an opportunity to reflect and ask questions. Our band 7s meet less frequently, but we operate through a hub model that enables them to stay in touch with people and have access to more senior colleagues when support or guidance is required.

Alongside the above supervision model, we ask our pharmacists to set objectives for each rotation they do. These objectives aim to provide staff with clarity on what is expected of them over the course of the rotation, and equally offers them opportunities to develop new skills and learn more about the wider system. To support with setting objectives and to offer an element of consistency in the quality of objectives set, the acute trust have developed a set of standard objectives (broken down by NHS AfC paygrade).

We also offer a range of additional networking and development opportunities, such as weekly all staff meetings, in which all our colleagues from across the acute trust and primary care can join, and regular “clinical bites” sessions, hosted by the PCN Lead Pharmacist, to share learning on focussed topics.

For us as a system, its really key that we work together to support colleagues to develop and provide safe patient care.”
Pippa Roberts,
Director of Pharmacy and Meds Optimisation and Pharmacy System Lead MO Wirral Place

Examples of good practice

The East Riding of Yorkshire social prescribing service is run by the Humber Teaching NHS Foundation Trust, with link workers in every GP practice in the area. Natalie Belt is the service manager who leads the social prescribing work. “As an early adopter of social prescribing we worked closely with our first GP practice in 2016 to understand how the integration between primary care taking on a role like a social prescriber would work. We knew that it was all about relationships, communication and connectivity. If the practice staff were not supportive of it then the patients wouldn’t benefit and be referred. From day one we felt it important to make staff part of the team which include ensuring they had an opportunity to shadow the practice workforce from reception to GP. The opportunity to sit with a GP and shadow an appointment really made a difference and allowed not only an understanding about how link workers could help to improve a patient outcome but also started a relationship and channel of communication. It was all part of the ‘getting to know you’ phase. The practice manager also plays a key role, acting as the invisible glue to bring social prescriber and practice team together as one. In all practices this has been achieved successfully and with impact.”

Natalie Pallant is one of the link workers with the East Riding Social Prescribing service. She said: “As a community link worker for the Humber NHS I have always felt like part of a big team despite working alone within GP practice. Within our team we have regular contact with our senior including one-to-ones and team meetings. The locality teams have regular MDTs to discuss cases and share ideas and contacts that may have helped clients in the past. Because of the process of integrating within general practices I have also felt welcomed by them and valued as a member of their practice.
“In case of challenging clients on being unsure of how you can help, the team regular share information so there is always help at hand. It is an extremely rewarding job.”

Natalie Pallant,
Community Link Worker

Examples of good practice

"Once a week we organise a peer supervision/support meeting where we take in in turn to chair the meeting and share our cases we have had from the week, sharing ideas on how we dealt with them and ask the other social prescribing link worker for support and advice on how they would deal with it. We also have a shared drive where we can shared advice, services and things we have found useful. Alongside this, we have a group chat where we can ask advice for numbers for services or support if we are struggling on how best to help a patient."
Anonymous,
Social Prescribing Link Worker

"My advice would be to support your social prescribing link worker and provide clinical supervision to ensure they embed into your network and practice. They will find some fantastic resources which are in your own community and provide sustainable and real solutions for your patients."
Dr Mohan Sekeram
GP

Resources and links

- Care Quality Commission.
  - https://www.cqc.org.uk/
- Chartered Society of Physiotherapy: First Contact Physiotherapy.
  - https://www.csp.org.uk/professional-clinical/improvement-innovation/first-contact-physiotherapy-0
- Chartered Society of Physiotherapy: Advanced Practice Physiotherapy.
  - https://www.csp.org.uk/professional-clinical/professional-guidance/advanced-practice-physiotherapy
- Delivering universal personalised care.
  - https://www.england.nhs.uk/personalisedcare/upc/
- Health Education England: Advanced Practice
  - https://www.hee.nhs.uk/our-work/advanced-clinical-practice
- Health Education England: Workplace Supervision for Advanced Clinical Practice
  - https://www.hee.nhs.uk/our-work/advanced-practice/reports-publications/workplace-supervision-advanced-clinical-practice
- Network Contract Directed Enhanced Service (DES) Contract Specification 2020/21 – PCN Entitlements and Requirements.
  - https://www.england.nhs.uk/publication/des-contract-specification-2020-21-pcn-entitlements-and-requirements/
- Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance.
  - https://www.england.nhs.uk/wp-content/uploads/2019/12/network-contract-des-additional-roles-reimbursement-scheme-guidance-december2019.pdf

Resources and links (2)

- NHS Long Term Plan.
  - https://www.longtermplan.nhs.uk/
- Social Prescribing Link Workers: Reference guide for primary care networks.
  - https://www.england.nhs.uk/publication/social-prescribing-link-workers/
- Society of Musculoskeletal Medicine.
  - https://www.sommcourses.org/
- The Association of UK Dieticians.
  - https://www.bda.uk.com/