

Memorandum of Understanding between

Armagh and Dungannon

GP Federation of Family Practices

&

Member Practices

**Background**

The concept of the GP Federations was first introduced in Northern Ireland in 2013. A workforce crisis had developed due to insufficient training numbers to meet current and future service needs and the aging demographic of general practitioners. General practice has been changing rapidly also with more structured practice management as well as new IT systems and staff. Practices have been small businesses run as independent contractors. A new model was developed which allowed practices to work independently but take advantage of a unified service also – The Federation Model. This allowed practices to work to scale and maintain their sovereignty as an individual practice.

In 2013, GPs across the UK were exploring different models to enable them to work at scale. NIGPC, and the four LMCs, started exploring options and began to develop a model which would be best suited to NI. The primary principles in that development were that any model should:

1) Maintain the GP practice as the building block and ensure GPs were both responsible and accountable.

2) Ensure that any model would be able to employ staff and provide services and would not just be a discussion forum or advisory body.

3) Ensure that the model would maximise efficiency through economy of scale and reduce variance at practice level.

4) Provide effective and efficient management again through working together and maximising economies of scale.

5) Ensure uniform structures across NI so that any service developed successfully could be easily replicated elsewhere.

Currently every practice in NI is a member of a GP Federation. There are 17 Federations and 4 Federation Support Units, all with identical organisation structures, but again of varying size.

The GP Federation network in NI, supported by FSUs is unique in the UK.

By enabling GPs to deliver services at practice level, federation level, FSU level or regionally, it has successfully provided the opportunity to maximise resources, both financial and human, but has led to the opportunity to reduce variance between practices, whilst improving professional governance.

The structure to date has also allowed for the development of new services and ideas to the benefit of primary care. Examples include the successful roll out of the GP pharmacist scheme, the implementation of advanced nurse practitioners, GPNs , elective care, advanced paramedic practitioners and MDTS.

As per the Members Agreement signed on 13th October 2014, by all participating Practices, the ‘Board of Directors’ is the main decision-making body in respect of operational matters of the company which consists of both Member Directors and appointed Directors. They are responsible for strategic planning and direction, overseeing safe evidence-based services, partnership working, value for money and best use of available resources, corporate governance, openness and probity, MDT teamwork and ensuring that the interests of the local population and patients are at the centre of the Federations work. These members are elected on an annually at the AGM.

**Introduction**

The purpose of the MoU is to set the framework to primarily support the partnership between the Armagh and Dungannon GP Federation and its 23 Member Practices for the purpose of all Federation led projects/workstreams and employees within.

It sets out the parties’ respective responsibilities, identified areas of collaboration and mechanisms for sharing of information and joint working.

The partnership between all parties is necessary to support practices by progress the transformation agenda, to enable economies of scale and shared centralised business functions and to safeguard the interests of primary care.

It is an equal partnership for the mutual benefit of (HSC transformation), practice sustainability and patient wellbeing.

The MoU is not enforceable by law however all parties agree to adhere to its principles and to show due regard for each other’s responsibilities, activities, priorities, and views.

Each party will ensure their staff are fully aware of the content of the MoU and of the agreed responsibilities and functions set out within.

**Agreed principles of partnership working**

* Mutual respect
* Trust
* Consensus of decision making
* Accountability
* Regular communication
* Openness and transparency
* Flexibility of approach
* Willingness to change/adapt
* Shared goals & commitment to ensuring implementation of the MDT vision
* Involving users/carers and ensuring the adoption of co-production and community development methodologies where appropriate

**Scope**

Alongside the above partnership principles, the MoU covers:

• Due regard by all parties to Practice level and Federation Policies and

 Procedures applicable to Federation employed staff (including statutory leave,

 sickness reporting etc)

• Federation requirements of host Practices (Practice commitments)

• Practice requirements of Federation (Provider commitments)

**Services**

As the infrastructure and remit of the Federation has grown, so has awareness of responsibilities both as an employer and a service provider. With GPP implementation in its 7th Year, now is an opportune time to assess progress and strive for long lasting improvements in service delivery, interfaces and relationships going forward.

In addition, the Armagh & Dungannon Federation Members Agreement, outlined the need for ‘*Directors to operate a system of Integrated Governance in accordance with best practice and policy to ensure the highest standards of patient safety, service quality, delivery and value for money.*

Armagh & Dungannon Federation recognise the need for Directors to operate a system of Integrated Governance.

Job planning is an important way to link best use of resources with quality outcomes for patients. It allows managers and staff to better understand workforce capacity and to anticipate the needs of the organisation as it develops and grows thus helping the Federation to continuously respond appropriately.

Equally, in order to begin to tackle the workforce crisis facing primary care, it is imperative that Federation employed staff are not only attracted to Primary Care but retained. Efficient job planning which encourages professional development, helps health care professionals identify their contribution to the service, creates greater job satisfaction and will make the Federation and in turn its Member Practices ‘employers of choice’.

The following job plans define each service’s strategic vision, role composition and employer requirements of host Practices. Job plans have been formulated from regional benchmarking, adherence to professional guidance and CPD requirements for each discipline, feedback from staff, managers and leavers along with staff turnover rates to date.

For the purposes of job planning, the term “clinical work” has to do with whether the professional treat patients or provides direct patient care of any type. Non-clinical / professional time may support patient care, but the work does not provide direct diagnosis, treatment, or care for the patient.

A full-time week is divided into 10 sessions: five morning and five afternoon sessions, as part of a 37.5 hour week, excluding lunch breaks. Job plans for part time, job share or split base staff will be worked on a pro rata approach.

Staffing Ratios

All Federation employed staff are allocated to Practices on the basis of list size, geography and practices ability to accommodate.

 **GENERAL PRACTICE PHARMACIST (GPP)**

*Background*

Medicines are the most common medical intervention and they account for £550 million per year of the HSC budget in NI, however, 30-50% of people do not take as prescribed. The Medicines Optimisation Quality Framework 2015 is a patient centered approach to the safe and effective medicine use to ensure best possible outcomes for patients. The model outlines what patients should expect when medicines are included in their treatment in different health and social care settings. The Strategic Leadership Group for Pharmacy stated that General Practice Pharmacists will help deliver the primary care component of the DoH Medicines Optimisation Quality Framework.

The concept of General Practice Pharmacists is to allow GPs to have more time to spend with patients and improve patient outcomes. The main aims of GPP are:

1. To improve safety and reduce the level of errors and waste by managing prescribing systems, carrying out medication reviews and medicines reconciliation associated with patient discharge.
2. To release GP time spent on prescribing activities to increase overall GP capacity and improve patient outcomes.
3. To improve prescribing quality through implementation of the NI Formulary
4. To ensure consistency of prescribing.
5. To reduce prescribing costs.

When the GPP model was created in 2016, the Armagh & Dungannon board agreed practices would be allocated a minimum of 5 GPP sessions per week, with larger practices receiving one additional pharmacist session for every 1000 patients up to a maximum of 10 sessions.

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| Practice List Size | Number of GPP Sessions  |
| <4000 | 5.0 |
| 4000-5000 | 6.0 |
| 5000-6000 | 7.0 |
| 6000-7000 | 8.0 |
| 7000-8000 | 9.0 |
| >8000 | 10.0 |

When assigning GPPs to a practice, Lead GPPs consider both the business needs of the Federation and the practice. From time to time this may mean reallocation of a GPP from one practice to another. A decreasing GP workforce, increasing practice list sizes and practice mergers has seen the Federation landscape change over the last 18months. In time the Federation may need to revise how GPP sessions are allocated.

NI LES General Practice Pharmacist - via Federations LES

The GPP service is commissioned by SPPG via the NILES General Practice Pharmacists - via Federations 2022/23. Each practice wishing to participate in this service will enter contractual arrangements with SPPG for service provision but the actual provision of the service (e.g., employment of GPPs) will be sub-contracted to local GP Federations. The objectives of the LES are detailed in the table below:

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| **Aim 1. To commission the General Practice Pharmacist (GPP) service from participating GP practices through GP Federations** |
| **Objective** | **Monitoring / Assurance** |
| Continue to maintain the GPP workforce within primary care | Annual end of year report: Number of whole time equivalent GPPs in postLES return / assurance statement |
| Develop the GPP workforce in line with training and service delivery needsand the Department of Health Pharmacy Workforce Review | LES return / Assurance statement |
| Develop a Federation Prescribing Action Plan based on service aims and objectives in conjunction with and on behalf of member practices. Developpractice level action plans from the Federation plan. | LES return / Assurance statement |
| **Aim 2. To focus on further improving the quality, safety and cost effectiveness of prescribing** |
| **Objective** | **Monitoring / Assurance** |
| Carry out an annual prescribing system audit and implement auditrecommendations as required | LES return / Assurance statement |
| Perform at least annual medication review for prioritised at risk patients e.g.polypharmacy, care home resident, frail and elderly | LES return / Assurance statement |
| Perform medicines reconciliation associated with patient discharge ormovement across interfaces | LES return / Assurance statement |
| Review medicine use in line with evidence-based guidelines and prescribingpolicy at a national and local level | LES return / Assurance statement |
| Support the regional Safer Medicines agenda with implementation of bestpractice recommendations as appropriate e.g., MHRA alerts etc. | LES return / Assurance statement |
| Support GP practices in reducing prescribing expenditure by 3% per Federation area | LES return / Assurance statement. Monitored via monthly prescribing statements. |
| **Aim 3. To achieve the aims and objectives of the service by optimising collaborative working between all key stakeholders** |
| **Objective** | **Monitoring / Assurance** |
| Encourage GPP involvement in joint review of practice prescribing with HSCB.Pharmacy and Medicines Management Team as necessary | Report: LES return / Assurancestatement. |
| Commit to participate in HSCB-led local joint working arrangements between Federations and relevant stakeholders e.g., HSCB PMMT, HSCTs, Community Pharmacy | Arrangements in place to develop joint working |

The LES requires the Federation to develop an annual prescribing action plan on behalf of member practices, based on the objectives set out in the table below. Each practice is responsible for developing a practice specific action plan for the year ahead. They should use the overarching Federation action plan to generate their individual action plan. The GPP will provide support to the practice to develop the action plan. The action plan should detail actions, as well as the intended outcomes to be achieved through the GPP working in conjunction with practice staff. On agreement of the action plan, a Lead GP should be assigned for each of the actions and the practice should discuss implementation with the GPP ensuring protected time is set aside for the GPP to complete agreed activities. It is not the sole responsibility of the GPP to ensure the action plan is completed.

**GPP Workload**

GPP workload will depend on several factors. These include practice and regional priorities as well as the prescribing performance of the practice. The experience, expertise and qualifications of the GPP will also dictate workload. Activities completed must be in line with agreed practice protocols with referral to GP as required. GPPs will contribute to a variety of practice tasks which will evolve as the GPP becomes more experienced. There is currently no defined template to control the volume of work assigned to a GPP. Each practice should agree a system whereby the GPP can reassign outstanding workload to a GP at the end of the GPP session.

In the absence of a GPP workload should be reassigned to other appropriate members of the practice team. This would apply to days when there is no allocated GPP session or when a GPP is on annual leave, absent due to sickness or attending training. Work should not accumulate for the GPP to manage on their return to work.

The practice and GPP should regularly review workload to ensure assigned tasks are appropriate. Examples of appropriate GPP tasks can be found in Appendix 1.

**Prescribing**

GPPs with an Independent Prescribing (IP) qualification can prescribe medications within their competency (clinical area) provided the patient has a differential diagnosis. This qualification is annotated on their registration held by the Pharmaceutical Society of Northern Ireland. Activity must be in line with agreed practice protocols with referral to GP as required, and be commensurate with the level of experience, competency and parameters of prescribing set out in the “Standards and Guidance for Pharmacist Prescribers 2013” issued by the Pharmaceutical Society of Northern Ireland.

*Repeat Prescriptions*

GPPs can sign repeat prescriptions provided it is within their competency (clinical area) and they have assessed the patient or reviewed the clinical notes to ensure monitoring is up to date. They cannot sign repeat prescriptions printed by a receptionist or another HCP.

Due to restrictions with indemnity insurance at present GPP cannot:

* + Triage minor ailments (differential diagnosis)
	+ Manage acute prescription requests where diagnosis is required.

**Pharmacist-Led Disease Management Clinics**

Each GPP must complete the Independent Prescribing (IP) course in a specific clinical area for example hypertension, diabetes, COPD or asthma. Once this IP qualification is achieved, the GPP is a non- medical Independent Prescriber with competence to prescribe medication to patients within their chosen clinical area. The patients must have the pre-existing diagnosis. It is expected that the GPP will use their IP qualification to help manage a chronic disease register in the practice. The GPP must establish and agree parameters of prescribing (and READ codes) with the GP clinical line manager/governance lead. The GPP will develop a treatment plan and agree this with the practice. This will detail the condition to be treated, scope of practice, pharmacological and non-pharmacological interventions, monitoring and review of patients as well as referral criteria. A clinic should then be set up whereby the GPP is directly involved in reviewing and managing a specific cohort of patients.

**Attendance at Practice Meetings**

To support integration into the practice the Federation encourages the GPP to attend regular practice meetings. This provides an opportunity for the GPP to update the practice team on medication related matters. The GPP is also encouraged to attend the annual SPPG prescribing advisers meeting along with the GP Prescribing Lead.

**Education and Training**

Pharmacists in practice are a new concept in primary care, and over the past five years great effort has been made to ensure the training and development needs of GPPs are recognised and met on a regional basis. It is recognised that each GPP has different learning needs to fulfil the requirements of their post therefore ongoing GPP education and training will continue to be delivered in different ways.

*Professional Requirements and Indemnity*

Pharmacists are required to renew their registration with the Pharmaceutical Society of Northern Ireland (PSNI) and submit a Continuing Professional Development (CPD) portfolio record annually for assessment. The Federation is not required to provide time out for pharmacists to complete their own CPD but should support relevant training that meets agreed practice and Federation objectives. Federation Lead GPPs will consider each training request on a case-by-case basis in consultation with the GPPs in advance of the training.

Time away from practice will be agreed only where the training is relevant, appropriate and of high quality. Where approved training events occur outside of normal working hours, appropriate time in lieu should be agreed in advance with the Lead GPP. GPPs must ensure any planned time away from practice is communicated at the earliest opportunity.

Induction

Induction will be delivered by Lead GPPs, other GPP colleagues, members of the practice team and FSU staff as required. Induction can take place on-site in practice or elsewhere. GPP induction has been and will continue to be organised locally. It should provide the necessary information, support and training to enable the pharmacist to work as a GPP within the Federation. It is vital that GPPs are supported to develop strong relationships within the multi-disciplinary team and enhance their understanding of general practice.

Foundation Programme

Once in post new GPPs will be required to undertake the post-registration Pharmacist Foundation Programme provided by The Northern Ireland Centre for Pharmacy Learning and Development (NICPLD)

This programme is completed in two parts: FP1 and FP2 and incorporates professional requirements specific to working as a pharmacist in General Practice. It is work-based consisting of live workshops, webinars and the development of a portfolio to evidence developing competence against the indicators within the Foundation Pharmacy Framework. The programme aims to develop clinical proficiency within the GP practice setting. Participation in the programme will also help individuals to develop skills in relation to portfolio development, thereby preparing them for the Independent Prescribing (IP) programme.

Independent Prescribing (IP)

IP is an essential requirement of all Federation pharmacist posts. Staff who join without already being registered as an Independent Prescriber will be required to undertake the IP qualification in the early years of employment within a reasonable timeframe determined by their Lead GPP and Federation.

This Post-Graduate Certificate course is divided into four modules and runs over a ten-month period. This programme requires eight days out of practice to attend mandatory training days, as well as twelve days supported practical learning in practice, overseen by the GP Designated Medical Practitioner (DMP). The pharmacist may complete their learning in practice at any point during the ten-month period. The GPP will also need to dedicate a significant amount of time outside of working hours to undertake the necessary CPD to attain the IP qualification. Whilst most GPP prescribe initially within one clinical area, this can continually be built on to meet the needs of the practice.

On successful completion of the course, the GPP’s registration will be annotated accordingly, and a prescribing role undertaken as required and as appropriate. This role will be advised by the Lead GPP and Federation.

Clinical Diplomas (levels 5 to 7)

Lead GPPs will consider GPP participation in clinical diplomas in consultation with the GPP. Time away from practice will be agreed only where the training is relevant, appropriate and of high quality. Where funding is required, contributions from the Federation and the individual pharmacist will need to be agreed. Examples include asthma/diabetes diplomas.

The Advanced Pharmacy Practice (APP) Programme

This programme develops the knowledge, skills and understanding required to deliver ‘Excellent’ practice as an Advanced Pharmacist Practitioner. The programme is delivered through a combination of workshops, self-directed learning and practice activities and a portfolio of evidence is required to demonstrate competence. This programme is delivered by Ulster University. Time out of practice is required to attend the taught component but like the FP and IP programmes attainment of this qualification requires the GPP to dedicate time outside of working hours to undertake the necess

 **ADVANCE NURSE PRACTITIONERS (ANP)**

The primary role of the qualified ANP is to provide general practice services to patients from birth to end of life. They will see, assess, diagnose and treat patients including prescribe appropriately as independent prescribers. The exception is seeing and treating patients with pregnancy related issues and will not be authorised to sign off fit notes. The Advanced Nurse Practitioner (ANP) will use their expert knowledge and complex decision-making skills, guided by The Nursing and Midwifery (NMC) Code in all situations. The ANP is accountable for the total episode of care for patients with undifferentiated and undiagnosed needs and is shaped by the context of their clinical practice. ANPs must be registered nurses with the NMC and must also register their prescribing qualification with them. The ANP will link with the MDT GP in their practice or a nominated GP for support on clinical issues and participation in their annual appraisals etc. The ANP will be able to demonstrate competence across the four key areas of the Advanced Nursing Practice Framework and in addition the ANP must demonstrate the ability to work at an advanced level and be able to apply the competencies in the key areas of their scope of practice. The ANP will be able to:

* + Assess individuals, families and populations with an undifferentiated diagnosis, holistically, using a person-centred approach and a range of different methods, such as physical assessment and history taking, ordering, performing and interpreting diagnostic tests or advanced health needs assessments.
	+ Use their expert knowledge and clinical judgement to decide whether to refer patients for investigations and make diagnosis. • Decide on and carry out treatment, which may include the prescribing of medicines, or referring patients to an appropriate specialist. • Ensure streamlined episodes of care.
	+ Assess and evaluate, with patients and/or carers, the effectiveness of the treatment and care provided and make changes as needed.
	+ Work autonomously within a wider health care team.
	+ Work across professional, organisational and system boundaries and proactively develop and sustain new partnerships and networks to influence and improve health, outcomes and healthcare delivery systems.
	+ Communicate and work collaboratively with the Primary Care team to meet the needs of patients, supporting the delivery of policy and procedures and providing nurse leadership as required.

 The qualified ANP working full time (37.5 hours) will work 9 clinical sessions to include time for clinical administration with 1 session for non-clinical work generally described as professional development activities. The ANP is a salaried member of staff who may work full time or part time, in recognition that there may be times that an ANP will work more hours than they are salaried for. There should be a localised arrangement in respect of how additional hours worked can be given back to the staff member. The allocation of time for the non- clinical work includes a range of opportunities such as time for appraisal, preparation for revalidation, education and training, staff meetings, quality improvement activities.

For those ANPs who work part time the 9-1. split will be agreed on a pro-rata basis. It is also important to recognise that while 1 session is allocated for non- clinical work as described above there may be occasions when more time will be required for training and development. For example, where a practice and an ANP identify a specific course of training which will require a longer period of non-clinical activity on a weekly or fortnightly basis for a defined period of time then agreement needs to be made how this time out of work will be granted.

Such decisions will be tripartite being discussed with the Lead Nurse, the GP practice or and the ANP. The ANP workforce will undertake non-clinical work on Wednesday afternoons to facilitate tutorials, team meetings and other professional development activity.

**House Calls**

ANPs are able to undertake appropriate home visits and are capable to provide care in the home of a patient who is housebound with acute and/or long-term health problems. Exceptions to ANP Practice ANPs cannot provide care to pregnant women if this involves assessment of the pregnancy, unless they are also a practising midwife meeting the NMC requirements of registration. Other non-pregnancy related conditions may be treated, however, the RCN would recommend that you advise all pregnant women to seek advice from their named midwife at the earliest convenience, even if the condition appears to be unrelated to the pregnancy. The RCN believes that nurses who are non- medical prescribers working in general practice should not prescribe folic acid to a woman who is pregnant. They should be seen by a GP or midwife as this is prescribing in relation to a women's pregnancy. A suspected post-pregnancy sepsis should be referred to the GP or appropriate medical care.

ANPS can sign fit notes (awaiting further guidance from DOH ).

**Working without GP in the Practice**

ANPs should not be left in the GP practice seeing and reviewing patients without a GP being present. Their indemnity does not cover planned periods of absence by GPs. However, the indemnity does cover emergency situations that can arise ie a prolonged home visit which runs over the planned start time of the next clinic. In cases such as these the ANP can continue to work providing the GP is available via mobile for advice if the need arises

Prescribing ANPs are all non-medical prescribers holding the V300 prescribing qualification and have this recorded with the NMC. As such ANPs can prescribe the full range of medications normally prescribed in general practice

**Repeat Prescriptions**

ANPs can sign repeat prescriptions but are responsible and accountable for ensuring the patient is assessed as required and should not issue repeat prescriptions outside the agreed number until the required investigations are completed e.g blood pressure or blood investigations.

**Acute Prescriptions**

ANPs should sign their own acute prescriptions. They should not sign off prescription for patients they have not seen or assessed.

**Governance**

Effective governance enables the employer to assure the public that nurses are deployed to advanced roles in such a way that their fitness to practise can be verified as purposeful, planned, and underpinned by appropriate education that is both measurable and safe. It is essential that the Federation and practices have mechanisms in place for quality assurance of the role of the ANP to include the provision of safe effective person-centred care. The following governance mechanisms are being developed and put in place: - Agreement that the newly qualified ANP will have support and mentoring from the clinical lead GP or a nominated GP in the practice - Job plan which outlines the working week of an ANP in General Practice - Annual appraisal and personal development plan (PDP). This appraisal process will be completed in a tripartite approach with the clinical lead GP OR nominated GP of the Practice, the ANP and the Lead Nurse and will reflect the needs of the practice and those of the ANP and the training and development required to ensure delivery of these.

A rolling audit programme is being designed, will run every three months and will in the first instance include: - Audit of prescribing - Audit of referrals to a range of services –Revalidation

Training needs framework to support (mandatory and specific to practice) - 360-degree feedback - Patient satisfaction - A range of clinical tutorials. - Video Consultations and recording.

**Allocation of Leave**

The Federation is responsible for calculating an ANPs annual leave. The Federations Annual Leave Policy advises all staff to 50% of their allocated leave taken by the mid- point of the leave year.

**Requesting Leave**

Annual leave is to be requested through the Practice. Where requests for leave cannot be granted due to service pressures in the first instance the employee and the Practice Manager should work out an agreed alternative. Only in exceptional circumstances would the Lead Nurse become involved.

 **Recording and Monitoring Annual Leave**

The ANP lead is responsible to have a system in place to review annual leave to ensure smooth flow of leave in line with the Federation. A/L should be reviewed in May September and December. Any complaints or concerns involving an ANP should be raised in the first instance with the ANP Lead

**GPN**

The primary role of the qualified GPN is to provide general practice services to patients from birth to end of life.

The role of a GPN includes the delivery of nurse led clinics for a range of long-term conditions and public health activities including Diabetes; Asthma & Chronic Obstructive Pulmonary Disease;Cardio-Vascular Disease; Chronic Kidney Disease and Hypertension

The GPN also participates in a range of public health initiatives to improve the health of the practice population which includes health promotion, prevention of ill health and accidents.

The GPN will also contribute to the provision of treatment room services as appropriate.

The GPN is required to maintain their professional registration with the Nursing and Midwifery Council (NMC) and will practice adhering to the NMC Code of Professional Conduct in all situations.

GPNs who hold a non-medical prescribing qualification must register this with the NMC.

The GPN will:

* Provide person-centred nursing care which encompasses the core HSC values of Compassion, Openness and Honesty, Collaboration and Excellence ( DoH 2018) (NMC The Code 2018).
* Assess individuals, families and populations holistically, using a person-centred approach and a range of different methods, such as physical assessment and history taking as appropriate and within their scope of practice, ordering, performing and interpreting diagnostic tests to support planning care
* Use their knowledge and clinical judgement to decide whether to refer patients for onward investigations to other health care professional eg General Practitioner/Tissue Viability/Diabetic Nurse Specialist.
* Assess and evaluate, with patients and/or carers, the effectiveness of the treatment and care provided and make changes as needed in line with their scope of practice.
* Work across professional, organisational and system boundaries and proactively develop and sustain new partnerships and networks to influence and improve health, outcomes and healthcare delivery systems.
* Communicate and work collaboratively with the Primary Care team to meet the needs of patients, supporting the delivery of policy and procedures and providing nurse leadership as required.
* Keep accurate and contemporaneous records in accordance with the General Practice policies, GDPR (2018), General Practice IT systems, NMC requirements and current regional standards for nursing and midwifery record keeping practice.
* Contribute to General Practice Team Meetings and other multi-disciplinary forums.
* Report any adverse incidents, accidents or near misses to the General Practice Manger and Lead Nurse in a timely manner and undertake an investigation as directed completing all relevant paperwork.
* Adhere to Federation Policies and Procedures and local GP policies and procedures as required raising any conflict between both sets of documents with the Lead Nurse for discussion as appropriate.
* The GPN will be supported with one day per month ( or in instances could be two eg if training courses run over two) for professional, continuous development activities to meet the regulatory requirements of supervision and revalidation alongside education and training which is funded by the GP Federation .
* The GPN cannot see and review patients without a GP presence in the building as the Federation indemnity does not provide this level of cover.

**Working environment**

To successfully undertake the role of the GN in General Practice the GPN should have access to a room with an examination couch, sink, desk chair and computer.

**Allocation of Leave**

The Federation is responsible for calculating an GPNs annual leave. The Federations Annual Leave Policy advises all staff to 50% of their allocated leave taken by the mid- point of the leave year.

 **Requesting Leave**

Annual leave is to be requested through the Practice Manger. The Lead Nurse will monitor and approve on Cascade.

Where requests for leave cannot be granted due to service pressures in the first instance the GPN and the Practice Manager should work out an agreed alternative. Only in exceptional circumstances would the Lead Nurse become involved.

**Training**

The qualified GPN working full time (37.5 hours) will work 10 clinical sessions to include time for clinical administration per week. There will be 1 day out of practice monthly which will be pro rata for part time staff. This will involve professional development activities to include education and training, supervision, appraisal, revalidation, team meetings and quality improvement activities. It is also important to recognise that there may be occasions when additional time may be required for training and development. For example, where a practice and a GPN identify a specific course of training e.g cervical screening, spirometry, which will require a longer period out of practice either weekly or fortnightly for a defined period of time then agreement needs to be made how this time out of work will be granted.

Such decisions will be tripartite being discussed with the Lead Nurse, the GP practice and/or the GPN.

**Job Planning**

In order to begin to tackle the workforce crisis facing primary care, it is imperative that Federation employed staff are not only attracted to Primary Care but retained. Efficient job planning which encourages professional development, helps health care professionals identify their contribution to the service, creates greater job satisfaction and will make the Federation and in turn its Member Practices ‘employers of choice’.

The following job plan defines a service’s strategic vision, role composition and employer requirements of host Practices.

The Job plans have been formulated from regional benchmarking, adherence to professional guidance and CPD requirements for nurses and includes feedback from staff including leavers along with staff turnover rates to date.

For the purposes of job planning, the term “clinical work” has to do with whether the professional treat patients or provides direct patient care of any type. Non-clinical / professional time may support patient care, but the work does not provide direct diagnosis, treatment, or care for the patient.

A full-time week is divided into 10 sessions: five morning and five afternoon sessions, as part of a 37.5 hour week, excluding lunch breaks. Job plans for part time, job share or split base staff will be worked on a pro rata basis Appendix A

**Complaints procedure**

Any complaints or concerns involving a GPN should be raised in the first instance with the GPN Lead/s.

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| **Federation** **GPNs****Weekly schedule** | **90%vs 10%****Morning session** **Minimum of 20 minute appointments -half hour for full diabetic patient review.**9.00-11.20 am patients -face to face and or \*triage calls appropriate for GPN.**Coffee 11-20**11.40 - 12.40 patients -face to face and or \*triage calls appropriate for GPN 12.40 clinical admin -1.30 clinical admin/ referrals **Lunch 1.30-2.00pm** 20 min appointment 2.00-4.20pm 4.40pm clinical admin referrals etc.**\*Triage of patients relates to those patients with differential diagnosis of chronic disease processes** | **CPD 1 day per month**  Clinical updating Professional supervision Revalidation Mandatory training  Quality improvement  |

**Salaried GP’s (Locums)**

The purpose of the salaried GP (Locum) is the provision of care for GP practices in the Armagh & Dungannon, Craigavon and Newry and District Federations with sessions being booked in advance through the website.

Practices would be expected to have a ‘Locum pack’ and provide the locum with all the necessary log in details eg for EMIS, CCG referrals, Sectra x-ray requests, Docman etc on their arrival.

Locums should be able to discuss any specific concerns about a patient / issue, with one of the GP partners in the practice or discuss any practice issues with the GP Lead.

Session length would be considered to be 4hrs, dividing the day into 2 sessions - usually 9-1pm and 2-6pm. Times should be agreed in advance with the practice. Appointments are usually a range of telephone and face to face appointments - the number of each will vary from practice to practice. Locums would need to have a certain degree of flexibility depending on the needs of the practice.

Locums would not be expected to action blood results, post or complete reports for the practice. The exception to this may be if the locum is covering a single-handed practice -they may have to have sight of blood results to ensure there are no grossly abnormal results that need to be actioned urgently the same day.

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| **Discipline** | **Clinical v non clinical** | **No of appts per day** | **Appt time** | **Weekly cap on appts** | **CPD** | **Supervision** |
| **GPP** | **Clinical work plan to include:*** clinical administration: medication reconciliation, medication review, reauthorisations, queries etc
* clinics: Direct patient interaction and consultation either face to face or virtual e.g. diabetes, respiratory, cardiovascular, osteoporosis, pain, medication review (i.e. brown paper bag face to face) depending on pharmacist’s competence.

**Implementation of Practice Action Plan in collaboration and agreement with practice. Examples include:*** QI project
* Improving the medication review system
* Improving high risk drug monitoring/amber drugs and NOACs
* Actioning drug alerts and MHRA alerts
* Audits
* Improving formulary compliance
* Reviewing compass
* Improving antibiotic prescribing
* Annual repeat prescribing audit and implementing changes
* Cost Efficiencies

**Professional Practice to include:*** Team meetings
* Peer supervision/reviews to share best practice,
* Appraisal including preparation
* 1-1s
* Performance development planning
* Updating boundaries of clinical practice for independent prescribing, expanding prescribing into other areas
* Training including mandatory and CPD
* MDT/Practice meetings
* Audits and QI
* Clinical and social care governance
 | Difficult to quantify due to diversity of role and individual practice needs For clinic: 20-30 min appt depending on clinical area.For follow up: 10-15min | Set individually at practice level |  | Pharma Society NI: 30 hours per year submitted online and assessedOther training as agreed with Lead GPP based on Education and Training detailed above. | Annual appraisal1:1 with Lead GPP as needed |
| **ANPs** | **85% v 15%****Morning session**15 minute appoints from 9.00-10.45Coffee 10.45 – 1115 minutes appts 11.00-12.0012.15 -1.30pm (clinical admin, acute and repeat scripts plus or minus a house call) **If a house call is required then afternoon session should start at 2.15 to allow for travel time etc and lunch break.****Lunch 1.30-2.00pm**Afternoon Session15 min appointment 2.00-4.154.30 onwards clinical admin referrals etcPlease note as agreed by the Fed Board ANPtelephone consultations and or face to face appointments for the qualified ANP must be scheduled for 15 mins and should not exceed more than 11/12 in a morning session and ten in the afternoon.ANP trainees start with much longer patient appts i.e.30 mins reducing to 20 while in training. | 20 per day11 am/ 9pm *(Plus or minus a house call)* | 15min appointment s | Approx. 20 per day | 1.5 sessions per week for FTE*NMC**Revalidation requirements**=35 hours**CPD over 3 years (exec mandatory training)**20 of these hours must be participative &**15 can be didactic training* | Regulatory & Supervision activity, CPD, quality improvement work, audits etc are all undertaken in the 1.5 sessions per week Anything over andabove 1.5 session needs to be agreed locally with practice |
| **It is important to note that ratios are notional and there will undoubtedly be times when staff members fail to achieve the desired breakdown due to personal, patient or Practice circumstances.** |

**Provider Commitments**

The Armagh and Dungannon Federation will fully or in part cover indemnity costs for all staffing groups and commit to the best of their ability, to the following:

1. Timely notice of any staffing changes to include new starts / leavers/ maternities

/ planned sick leave or absences.

1. Completion of training needs analysis for all new starts within the first 3 months of taking up post.
2. Fair distribution of annual leave, study leave and training absences across Practices, where staff have split base. This will also involve co-operation between Practices.
3. Frequent, timely, meaningful, 2-way communication between Practices and service managers.
4. Joint Clinical and Social Care Governance across disciplines and employers. Such is required to (1) provide assurance that a robust framework for the management of key critical clinical systems and processes is in place from an employer’s perspective and (2) develop a culture of learning and an ethos of fair and proportionate accountability for all Federation employees. Proactively promoting a culture of openness underpinned by a no blame culture.
5. Maintenance of a risk register.
6. Ongoing MDT implementation.
7. Joint discussion and resolution regarding any staffing issues between Practices and service managers.
8. Timely communication of staff training and team meetings, along with the rationale for such by service manager/staff (please note all training requests will come to a joint training committee for sign off).
9. Timely recruitment and replacement of any leavers where budget permits.
10. Timely and appropriate response to any staffing, performance or conduct related issue raised by Practices.
11. The opportunity for Practices to feed into staff supervision and yearly appraisal processes.
12. Provide appropriate feedback from any Quality Improvement audits or clinical and social care governance investigations.
13. Fully or in part cover employer costs including training deemed to be appropriate to the needs of the service. Training requested by Practices, outside of training priorities identified by leads, will be the responsibility of the Practice to fund, with attendance taken out of Practice time.
14. Adherence to all professional regulatory obligations from employer’s perspective.
15. Assist or action any complaints arising from services provided by staff/Practice as appropriate (please refer to relevant complaints processes previously shared).
16. Ensure that all mandatory training requirements are fulfilled.
17. Facilitate the training of staff on appropriate clinical system and in the completion of MDT data capture templates where necessary.
18. Jointly agreed annual leave (in accordance with previously shared annual leave processes).
19. Mediate where necessary any annual leave disputes between Practice and staff member via service managers.

**Practice commitments**

Member Practices will commit to the best of their ability, to the following:

* Commitment to the principles of partnership working outlined.
* Proactively welcome and assist all members of the MDT (including ANP and GPP) to integrate into the wider Practice team. Regular MDT team meetings and huddles can greatly assist with this.
* MDT role division as described including release from Practice.
* Mandatory engagement with the Federation Clinical and Social Care Governance structure, including risk management namely identifying SAEs and open, two-way communication into the investigation of such, including access to notes for investigation purposes.

Clinical and Social Care Governance is necessary to:

* + - To provide a Forum that reports on all aspects of Governance in relation to the Primary Care MDT.
		- To develop a culture of learning and improved performance.
		- Ensure that clear lines of accountability and responsibility exist within all roles for the overall quality of care.
		- Ensure the co-ordination and prioritisation of risks and provide reports to the Federation Governance structure when required.
		- To monitor the incident reports, complaints and compliments and ensure that all staff are supported in learning from incidents, complaints and compliments.
		- To compile reports including examples of good practice, audit and innovation and agree the way forward for any future recommendations and actions.
		- Ensure all staff are provided with adequate governance information, training and education.
		- To promote an open and participative culture of partnership working with clients and the wider community.
		- Ensure compliance with statutory functions.
		- Engagement with management led QI audits for the benefit of service provision and development.
		- Input and engagement with Federation service managers regarding staff supervision and annual appraisal.
		- Advise Federation of any complaint arising from a member of the MDT team
		- Timely response to annual leave requests.
		- To seek agreement from Federation Service Managers regarding any Practice specific training and to directly fund.

 **Incident Review Policy**

Armagh & Dungannon Federation to be informed when an incident/no harm event/near miss involves in any way a staff member employed by the Federation.

All GP practices are required to have an Incident/Adverse Event Management Policy.

**Monitoring**

All parties commit to ongoing monitoring, with the aim of ensuring accountability and performance against key milestones / developments required to achieve full embedment.

The Armagh & Dungannon Federation Board of Directors will coordinate the

monitoring of such.

 **Duration and Review**

The MoU is not time limited and will continue to have effect unless the principles described need to be altered of cease to be relevant. The MoU will be reviewed in three years although it may be reviewed at any time in advance, at the request of either party. Changes to the MoU will require agreement by all parties.

 **Approval**

|  |  |
| --- | --- |
| **NAME & TITLE:**Dr Deirdre ClearyChair of Armagh & Dungannon GP Federation | **SIGNATURE:****Date:** |

**Approval by Member Practices**

|  |  |  |
| --- | --- | --- |
| **Member Practice** | **Director** | **Date of approval email** |
| Stewartstown Health Centre |  |  |
| Abbey Court Surgery |  |  |
| Mid Ulster Health Care |  |  |
| The Valley Medical Practice - Fivemiletown |  |  |
| Campbell Surgery |  |  |
| Coalisland Health Centre |  |  |
| The Archway Surgery |  |  |
| Richhill Health Centre |  |  |
| The Friary Surgery |  |  |
| Parkview Surgery |  |  |
| Ardmore Medical Practice |  |  |
| Tandragee Medical Practice |  |  |
| Dr Watters |  |  |
| Aughnacloy Health Centre |  |  |
| Willowbank Surgery |  |  |
| Dr. McShane & Partner |  |  |
| Errigal Medical Centre |  |  |
| Dr. Herron & Partner |  |  |
| Moy Medical Practice |  |  |
| Dr Cleary & Partner |  |  |
| Markethill Health Centre |  |  |
| Tynan Surgery |  |  |
| The Medical Centre Coalisland |  |  |

**Appendices**

Supporting documentation for Practices regarding each role are available from Leads if required.

* 1. GPP Tasks

**Appendix 1 - GPP Tasks**

The following information is intended as a guide to the tasks that General Practice Pharmacists (GPPs) may carry out within a GP practice. All tasks carried out should be agreed in advance with the practice and Lead GPP and be commensurate with the level of experience, competency and parameters of prescribing. Competency may vary depending on therapeutic area. Activity must be in line with agreed practice protocols with referral to GP as required. This task list will evolve as the role of the GPP progresses.

|  |  |  |
| --- | --- | --- |
| **No/little previous** | **At least 1 year** | **Experienced** |
| **experience of** | **experience as** | **General Practice** |
| **working as General** | **General Practice** | **Pharmacist (at** |
| **Practice Pharmacist** | **Pharmacist +/-** | **least 2 years) and** |
|  | **Independent** | **an Independent** |
|  | **Prescriber** | **Prescriber** |

**Day to day medicine related queries: GP, Community Pharmacist, Nurse, Receptionist, Hospital , patients**

**To provide advice on prescribing of licensed vs unlicensed medicines**

**Signpost to other HCP Eg Community Pharmacy Minor Ailments Scheme**

**Prescribing System Audit and Review Development of prescribing and medication related protocols**

**Administration of repeat dispensing scheme**

**Communication of Medication changes for patients whose medication is supplied in a compliance aid (i.e.inform pharmacies, synchronise medications)**

**Review adherence to medicines and uncollected Prescriptions**

**Medicines Information Tasks**

|  |  |  |
| --- | --- | --- |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |

**Prescribing Systems**

|  |  |  |
| --- | --- | --- |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |

**Management of high risk medicines (Amber List Drugs) including ensuring bloods up to date**

|  |  |  |
| --- | --- | --- |
| Yes | Yes | Yes |
| Review, manage queries, implement actions, documentinterventions | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |

**Support practices with medication review & reauthorisation for Care Home patients**

**Practice Formulary set up and Implementation**

**Responding to Medicines Alerts eg MHRA safety alerts**

**Clinical Review**

**Clinical audits (with implementation of findings)**

**Identify and implement prescribing priorities eg from COMPASS report**

**Generic switches**

 **Cost effective switches**

**Training and Clinical education for HCP / practice staff**

|  |  |  |  |
| --- | --- | --- | --- |
| **Triage minor ailments Differential diagnosis** | **No** | **No** | **No** |
| **Acute prescription requests where diagnosis is required** | **No** | **No** | **No** |

*The following tasks cannot be undertaken at present due to restrictions with indemnity insurance.*

**Cost Effective Prescribing**

|  |  |  |
| --- | --- | --- |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |

**Training**

|  |  |  |
| --- | --- | --- |
| Yes | Yes | Yes |

*.*