Lancashire and South Cumbria PCN Assembly

LMC

Lancashire and South Cumbria Primary Care Providers at Scale

Lancashire & South Cumbria PRIMARY CARE TRAINING HUB

NHS Lancashire and South Cumbria Integrated Care Board

Lancashire South Cumbria ICB:

Framework on Clinical/Professional Supervision and Support for Additional Clinical Roles in General Practice

September 2024

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Introduction

NHS Lancashire and South Cumbria (LSC) Integrated Care Board (ICB) has developed a framework on the role and scope of additional clinical roles in General Practice, in conjunction with representatives from NHS England, Lancashire & Cumbria Consortium of Local Medical Committees, LSC PCN Assembly and Primary Care Providers at Scale. The framework brings together guidance that exists nationally and from regulatory bodies, and is intended to be used as a benchmark to enhance patient safety and the delivery of high-quality care by:

- ✓ supporting local governance,
- ✓ assisting in good employment practices
- ✓ and providing a framework for expected levels of support and supervision that is required for these additional roles.

Background and context

The ICB recognises the importance of additional clinical roles in General Practice, such as, helping to increase the capacity of the primary care workforce, supporting new care delivery models, filling skill gaps and aiding the delivery of high-quality patient care. However, there are clear differences in the initial education and training of these different professions, and postgraduate training and development pathways for these additional roles are substantially different. Supervision, and a clear training framework, are therefore vitally important to support these staff transition into their role in General Practice, and if standards of patient care and patient safety are to be assured. In addition, effective supervision can contribute to the continued professional and clinical development of staff, support the development of healthy organisational cultures, enhance staff retention, and support staff morale and engagement.

The ICB is becoming increasingly aware of variations between organisations on the level of support, supervision and scope of practice (see Appendix 1) being undertaken by these additional roles. In some areas there are active concerns that scope of practice for some of these roles is being extended inappropriately and without support or supervision, with the resulting risk to patient safety.

There is no intention by the ICB to either diminish or negatively challenge the motivation, support contribution or commitment that employers and practices have for their additional clinical staff, however, it is paramount these staff are supported to work within their scope of practice by their employers and their practices, and they should not be pressurised to work beyond their competencies or scope of practice to safeguard the safety of patients. Any extension or development of these roles led by the employer or practice must be done in a structured manner and supported by appropriate training and competence assessment, including adhering to any frameworks/proficiencies set out by the relevant professional regulatory bodies.

Purpose

It is intended that this framework should be used as a benchmark to enhance patient safety and the delivery of high-quality care by supporting local governance, assisting in good employment practices and encouraging consistency in the level of support

and supervision offered to these additional clinical roles/posts. Furthermore, it aims to provide clarity, and improve the understanding, of the scope of these additional clinical roles.

It is a guide for both staff, practice/PCNs and employers.

Scope

This framework has been developed for all additional clinical roles in General Practice other than doctors, but also includes some specific considerations for the following roles: Non-Medical Prescribers, Paramedics, Nursing Associates and Physician Associates.

The ICB is aware that there are multiple employment routes for these additional roles e.g. additional roles reimbursement scheme (ARRs), directly employed, jointly funded etc. Regardless of employment route, employers and practices should ensure these staff are operating within the limits of their capability and that they are provided with appropriate supervision and training to enable them to do so. Therefore, the benchmark provided by this framework is generic, in that it applies to all additional clinical staff roles regardless of employment route.

Note: There are additional non-clinical roles in General Practice, for example, care co-coordinator and health and wellbeing coach, but these roles are out of scope of this document.

Additional roles in General Practice

NHS England have developed guidance and a quick reference summary of the additional roles employed in General Practice. These guides highlight key roles and responsibilities for each role, along with education and training requirements and recommended minimum supervision requirements.

This guidance and supportive summary should be used by employers and practices when considering these roles.

NHS England » Additional roles: A quick reference summary

NHS England » Expanding our workforce

The British Medical Association (BMA) guidance on safe working in general practice should also be used to preserve patient care and protect the wellbeing of staff.

As General Practice continues to grow and expand, so will the number of additional roles. This document has been developed based on current guidance and will be updated as new roles and guidance emerges.

Employment

Employing additional roles is desirable to build a team of people with diverse skills and competencies to support increased access to patients, alleviate pressure on existing staff and improve the quality of care and services. Employers and practices should however anticipate the learning and development requirements of individuals prior to authorising additional roles in their practices/Primary Care Networks (PCNs). And the following checks should be considered, in addition to standard pre-

employment checks, to better gauge the current working level/competencies of any staff:

- ✓ Clinical and practice experience, specifically within General Practice.
- ✓ Recent training and learning courses completed.
- ✓ Copies of employment passports, where available.
- ✓ Post qualification experiences.
- ✓ Copies of Continuing Professional Development portfolios.
- ✓ Examples of where a clinician has led in designing and delivering new care pathways and services.
- ✓ Evidence of autonomous working in practice.
- ✓ Current scope of practice.

Regulatory requirements – CQC

The Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations set out a provider's responsibilities. The CQC's guidance for providers on meeting the regulations explains that providers are responsible for the staff they 'employ'. The meaning of 'employed' in the regulations is wider than staff directly employed on an employment contract: it means anyone who works for the provider, under its ongoing direction and control.

Providers need to be assured about the 'fitness' of staff in these additional roles. Recruitment by another party may provide some assurance, but the registered provider should not assume that this guarantees fitness to practice; they must assure themselves that staff working under their direction and control have had the appropriate recruitment checks, are adequately supervised and are operating within the limits of their competency. This does not necessarily mean the provider themselves must carry out or repeat all the processes. However, it does need to reasonably assure itself that they have been done. Furthermore, consideration should be given for appropriate clinical/professional involvement in recruitment panels to assure the 'fitness' of any professional being recruited i.e. where a physiotherapist is being recruited an experienced physiotherapist should be part of the recruitment panel.

When the CQC assesses providers, it will look for evidence that providers have systems in place to ensure that staff are:

- Operating within the limits of their capability, scope of practice and competency.
- Provided with appropriate information, support and supervision to enable them to carry out their role.

GP mythbuster 106: Staff not directly employed by a GP practice

Guidance for providers on meeting the regulations

Supervision

NHS England defines supervision as:

a process of professional learning and development that enables individuals to reflect on and develop their knowledge, skills and competence, through regular support from another professional.

Supervision can have different forms and functions and there a number of terms used:

- **Clinic/practice supervision:** day-to-day support provided by a named/duty senior/more experienced clinician for issues arising in the practice. This is informal and could be hosted by practice/clinic and provide peer support/review.
- **Clinical/professional supervision:** regular support from a named senior/experienced clinician/Designated Prescribing Practitioners/Designated Medical Practitioners/practitioner to promote high clinical standards and develop professional expertise. This is formal/structured and could be hosted by the employer or practice/PCN, and could be in the form of a group supervision delivery model.
- **Educational supervision:** supports learning and enables learners to achieve proficiency.

Supervision is vital to enable a healthcare professional to develop their skills, knowledge and clinical abilities. Furthermore, it safeguards the safety of patients by ensuring staff only work within their scope of practice and competence.

Supervision is also directly relevant to annual appraisal for all staff, and to revalidation or equivalent regulatory assurance (e.g. random CPD audits by Health and Care Professions Council) and to identifying concerns around fitness to practice.

The different types of supervision and example models can be found on the following link: NHS England » Supervision guidance for primary care network multidisciplinary teams.

The table below summarises what the ICB considers as best practice for the minimum frequency of structured clinical/professional supervision meetings and who can provide this supervision dependent on role. These recommendations are based on the requirements of the Network Contract DES, professional regulatory requirements and standards and is reflected in the NHS England guidance. Practices should use this table as a baseline to support their staff, but practices should be aware that some individuals may need additional support especially during the first 12 months of their role and if they are new to General Practice.

Practices should note that the below table highlights the frequency of **structured clinical/professional supervision meetings** and should not be mistaken for informal clinic/practice supervision i.e. the day-to-day support staff may need by a named/duty senior/more experienced clinician, for example, Physician Associates (PAs) are medically trained, generalist healthcare professionals, and will be registered on the basis that they will always work under supervision (https://www.gmc-uk.org/pa-and-aa-regulation-hub/information-for-employers). PAs

will require daily clinic supervision for any issues that may arise in the practice during the clinical day, but their structured supervision meetings can occur monthly.

Recommended frequency of structured/formal clinical/professional supervision meetings

Role	Recommended minimum frequency (dependent on experience)*	Recommended supervisor role
Clinical pharmacist	Monthly	Advanced pharmacist practitioner or senior clinical pharmacist. GP for support and development
Senior clinical pharmacist	Monthly	GP
Pharmacy technician	Monthly	Clinical pharmacist
General Practice Nurse	Monthly	Advanced Nurse Practitioner, GP, more experienced nurse
Mental health practitioner	Monthly	Local mental health trust (adult MHPs), local provider of children and young people's community mental health teams (CYP MHPs), employer where subcontracted by the trust, or a more senior/experienced MHP
First Contact Physiotherapist† (term used in the PCN DES to cover the ARRS physios)	Monthly	GP, consultant practitioner, recognised advanced practitioner or more experienced first contact physiotherapist
Dietitian†	Monthly	GP, consultant practitioner, recognised advanced practitioner or more experienced dietitian
Occupational therapist†	Monthly	GP, consultant practitioner, recognised advanced practitioner or more

Recommended frequency of structured/formal clinical/professional supervision meetings		
Role	**Recommended minimum frequency (dependent on experience)***	**Recommended supervisor role**
		experienced occupational therapist
Podiatrist[t]	Monthly	GP, consultant practitioner, recognised advanced practitioner or more experienced podiatrist
Paramedic[t]/trainee first contact paramedic	Daily debrief/reflection while in training Monthly for assessment	First contact paramedic, recognised advanced practitioner, GP.
Paramedic (working at master's level or equivalent capability)	Monthly	More senior/experienced first contact paramedic, recognised advanced practitioner or GP
Advanced practitioner	Monthly	GP, consultant practitioner or experienced recognised advanced practitioner
Trainee nursing associate	Monthly	Experienced nursing associate, registered nurse or advanced practitioner if a registered nurse
Nursing associate	Monthly	Registered nurse or other healthcare professional including advanced practitioner
Physician associate	Monthly	GP
Physician associate preceptee	Daily	Physician associate must work alongside their GP clinical supervisor during their day-to-day clinical practice
Trainee Advanced Clinical Practitioner	○ Throughout the period of training, there must be a minimum of one	

Recommended frequency of structured/formal clinical/professional supervision meetings		
Role	**Recommended minimum frequency (dependent on experience)***	**Recommended supervisor role**
	hour of scheduled supervision every week; of which one in four (once a month) is a scheduled hour with the co-ordinating education supervisor. ○ In certain practice contexts, where there is high risk, it will be necessary to debrief/provide daily supervision to ensure patient and practitioner safety.	Minimum standards for supervision - Advanced Practice (hee.nhs.uk) – supervisor can come from the multi-professional workforce and do not need to hold the same professional registration as the trainee.

* The ICB recognises the increasing demands on primary care and the recommended frequency of supervision stated in this table should not be considered as rigid. The frequency will, and should, vary depending on the supervisee's individual needs, and other factors such as their working pattern and the day-to-day operational demands. More frequent supervision may be required if the supervisee is newly qualified, or recently started a new role. Furthermore, new approaches to supervision to respond to operational demands or the needs of both participants may be required, which might mean that the supervision takes place at different times of the day, to accommodate shift patterns and the demands of the service, or the supervision sessions are triangulated with other colleagues in the Multi-Disciplinary Team, and/or the amount of supervision adjusted to respond to any challenges experienced. Ad hoc supervision, which can often occur outside of scheduled supervision sessions, is considered appropriate and an important part to effective supervision.
No learner is the same and from the outset, practices/employers should be willing to learn about their supervisee's needs, to help to identify the appropriate amount of supervision for them, and be flexible and willing to meet on an ad hoc basis, to respond to staff issues as and when they arise.

ǂ Allied Health Professionals (AHPs) who can typically work in a First Contact Practitioner (FCP) role include Dietitians, Occupational Therapists, Paramedics, Physiotherapists and Podiatrists. FCPs are often more experienced and have undertaken additional training and experience within a specified scope of practice (MSK, Dietetics etc) to be able to safely provide the first point of contact and assessment for defined groups of patients and presentations as aligned to their area of experience and training. Please see Appendix 2 for further information.

The mode of supervision

The mode of supervision can take several forms and does not have to be thought of as one-to-one meetings. Forms such as group supervision, peer supervision, virtual supervision or supervision built into existing meeting structures e.g. GP practice

meetings, or a combination of these can be considered. Each mode has different benefits and the mode used will depend on the supervisee's experience and learning needs. For example:

- remote supervision may be appropriate or even necessary when working in less accessible locations, where direct supervision is not available. This can also be helpful when providing more pastoral support and auditing of practice.
- peer supervision from others of the same professional background can help in reducing isolation and promoting profession-specific knowledge sharing.

There are already emerging examples of group supervision being delivered across the ICB. These models could be replicated by other practices/PCNs.

Group supervision models have included:

- Multidisciplinary or single profession groups.
- Members can have varying skill sets and/or members specialising in a field of practice; for example, diabetes / respiratory.
- The appointed supervisor must be present.
- Team members take it in turns presenting.

Group supervision has multiple benefits, including:

- It can be incorporated into existing team meetings.
- It is time efficient.
- It enables peer review.

Enablers to clinical supervision

Effective clinical supervision is important to reduce the time constraint and ensure effective learning and development. Practices/employers should consider the below enablers to supervision:

- ✓ Having a protected time slot, either at practice level or PCN level, for supervision.
- ✓ Practices/PCNs agreeing time frames and frequency of meetings. Practices/PCNs should consider the experience of staff members and if they work in isolation, and where necessary more frequent supervision should be provided.
- ✓ Recording supervision/training sessions. Recording sessions can enable staff to access the information later and ensure accessibility to all.
- ✓ Agreeing a shared purpose and boundaries of supervision that embed it within the organisation's culture.
- ✓ Providing support, time and training for supervisors to undertake their supervisory role. Time can be protected in job plans for activities relating to the supervisor role.
- ✓ Directing supervision on the needs of the staff member, allowing a greater focus on clinical issues and personal professional development.

Clinical supervisors should ensure they:

- ✓ Have the appropriate knowledge and skills to undertake the role within the context they are supervising. Wherever possible professionals should be supervised by an individual from their own professional background, this is

important for safe/effective practice as well as professional identify/belonging, retention, career planning/progression

- ✓ Receive regular feedback on their practice and engage in continuous professional development.
- ✓ Always uphold the relationship, trust and professionalism of the role by maintaining confidentiality.
- ✓ Provide feedback on common themes to managers to enable service improvement whilst protecting the confidentiality of supervisees.

The ICBs position is that all supervisors should have completed the following training course, funded by the training hub, to assure the quality of supervision:

GP and Advanced Clinical Practitioners (ACPs)	Recommended to undertake the Wider Workforce (and FY2) Clinical Supervision Training (provided by Greater Manchester Training Hub on behalf of all 3 NW Hubs)	https://forms.office.com/e/V3xMPvv0aH
General Practice Nurse (GPN)	Recommended to undertake the Training Hub delivered Nurse Clinical Supervision Training	https://www.lscthub.co.uk/events/list/?tribe-bar-search=clinical+supervision+session
Pharmacist	ProPharmace fully funded, Supervisor training programmes: • **Training for Educational Supervisors including Designated Supervisors (DS)** Both pharmacists and pharmacy technicians can apply for the educational supervisor training. • **Training for Designated Prescribing Practitioners (DPP)** Designated Prescribing Practitioners (DPP) supporting supervision of learners in the pharmacy workforce.	Educational Supervisor Training for the Pharmacy Workforce
Allied Healthcare Professional (AHP)	TALC (Teaching and Learning Consultation Skills) *First Contact Practitioners (FCP):* The route to becoming a supervisor for First Contact Practitioners (FCP) Roadmap education and training is	Contact your local Primary Care Training Hub who will advise which training course(s) should be completed.

	integrated into NHS England Workforce Training and Education process for the approval of multi-professional educators.	
Physician Associate (PA)	None currently – under revision by national team	

Staff training and development opportunities

The ICB is committed to supporting employers/practices with training opportunities for their staff. To create a standardised approach to upskilling staff in their leadership skills and clinical skills, the following courses/training opportunities should be considered, and time protected in job plans, for staff to attend/sign up following needs identified in staff appraisals/Personal Development Plan (PDP) meetings.

Clinical, Leadership and Management training opportunities:

Quality Improvement, Leadership and Management – Lancashire and South Cumbria Training Hub (lscthub.co.uk)

Preceptorship

Giving additional clinical staff the best start in their General Practice journey is vital to ensure staff retention, support staff health and wellbeing, reduce anxiety and stress and enhance job satisfaction.

Lancashire and South Cumbria Primary Care Training Hub offer Nurses and Allied Health Professionals a fully funded preceptorship programme. The programme is designed to provide support, guidance and development for new primary care practitioners ("preceptees") to build confidence and competence as they transition towards being an autonomous professional.

Preceptorship is not a replacement for basic induction, mandatory training or supervision. It involves commitment from the practice, utilising experienced practitioners for the first 12 months of new-to-practice practitioners commencing employment.

The ICB would encourage practices to engage with the offer of preceptorship as investment has been proven to provide triple returns: it improves retention, it increases skills and confidence, and it produces economic value (NHSE, 2022). It also ensures patient safety, stability and satisfaction with local Primary Care services.

More information about preceptorship for Nurses and Allied Health Professionals can be found at Preceptorships – Lancashire and South Cumbria Training Hub (lscthub.co.uk).

Preceptorship for Physician Associates: As part of the nationally agreed funding model introduced in 2018, NHS England (NHSE) funds a £5,000 incentive payment through a preceptorship model for each physician associate trainee employed in a primary care provider after completing education. This is paid to the primary care provider (GP Practice/PCN) with the expectation that the employer will provide preceptorship support and supervision in return. Further details can be found on the training hub website: https://www.lscthub.co.uk/physician-associates/.

The email address for any queries about preceptorship is: mbpcc.preceptorship@nhs.net.

Additional considerations for named roles

Nursing Associates

A nursing associate is a member of the nursing team in England that helps bridge the gap between health and care assistants and registered nurses.

Registered nursing associates are registered professionals who are academically qualified and registered with a professional body (NMC).

Registered nursing associates will work to the NMC Code and Standards of Proficiency and are subject to regulatory requirements including revalidation and fitness to practice.

Like nurses and other healthcare professionals, registered nursing associates can expand their scope of practice through further education and experience. This will usually be after a period of consolidation and preceptorship which supports the transition from student to registered professional.

Nursing associates work with people of all ages, in a variety of settings in health and social care. The role contributes to the core work of nursing, freeing up registered nurses to focus on more complex clinical care.

The Nursing and Midwifery Council (NMC) has established standards for proficiency for Nursing Associates which align to the six platforms below (NMC, 2018c). The NMC code states that all registrants must work within their scope of practice. The Royal College of Nursing's position is that Nursing Associates must not work beyond the framework of the six platforms and the associated standards of proficiency: Nursing-associates-proficiency-standards.pdf (nmc.org.uk).

6 platforms:

- Being an accountable professional
- Promoting health and preventing ill health
- Provide and monitor care
- Working in teams
- Improving safety and quality of care
- Contributing to integrated care

General Practice Nurses

General Practice Nurses are qualified and registered adult, child, mental health or learning disability nurses. Nurses cannot legally practise in the UK unless they are registered with the Nursing and Midwifery Council (NMC). A GP practice that employs nurses must make sure they are registered before they begin work. Practices need to check their registration regularly throughout their employment, including locums and temporary staff.

If a nurse is an independent prescriber, this qualification should be on the NMC register. The employing practice should use the up-to-date NMC registration confirmation service, as any paperwork the nurse provides is only valid on the day it was issued.

The General Practice Nurse will work as part of the practice multidisciplinary team, delivering care within their scope of practice to the entitled patient population.

The practice nurse will be responsible for a number of clinical areas such as health promotion, chronic disease management, health prevention, well women and well man clinics, as well as supporting the management team in the reviewing of clinical policy and procedure.

Lancashire and South Cumbria have developed a *General Practice Nursing Resource Pack*, which includes additional information around clinical supervision and should be referred to, in addition to this document and the NMC standards and professional code for nurses, to ensure General Practice Nurses are well supported in their role.

Mental Health Practitioners (MHPs)

Mental Health Practitioners contribute to the NHS Long Term Plan ambition to develop new and integrated models of primary and community mental health care, to support adults and older adults with severe mental illnesses to live well in their communities.

MHPs provide GPs and other primary care staff with timely support and advice, helping to relieve pressure on workloads and build stronger relationships with mental health services.

Lancashire and South Cumbria NHS Foundation Trust, in collaboration with the ICB, have developed a *Primary Care Mental Health Practitioner Handbook*. The aim of the handbook is to help bring clarity to the jointly employed Primary Care Mental Health Practitioner (PCMH Practitioner) roles within Primary Care Networks (PCNs), funded via the Additional Reimbursement Roles scheme (ARRs). The handbook includes information around job planning and supervision and should be used alongside this document to ensure these practitioners are well supported in their roles.

The most recent version of the handbook can be found: Mental Health Practitioner – Lancashire and South Cumbria Training Hub (lscthub.co.uk).

Any MHP employed directly by General Practice surgeries'/PCN's will need to ensure supervision requirements are met in accordance with the guidance in this document and the practitioner's professional body/scope of practice.

Physician Associates (PAs)

The NHS in England is committed to supporting PAs to work effectively and safely as part of the multi-disciplinary team and to supporting doctors in their supervision responsibilities, and they have developed some supporting guidance which practices/employers should follow:

- NHSE Ensuring safe and effective integration of physician associates into general practice teams through good practice

- NHSE Summary of existing guidance on the deployment of medical associate professions in NHS healthcare settings

Please note: Additional guidance from the Royal College of Physicians (RCP) is in development, and this document will be updated once the final RCP guidance is published.

Background

Physician Associates (PAs) are healthcare professionals who work as part of a multidisciplinary team under the supervision of a named senior doctor (a General Medical Council (GMC)-registered consultant or GP). While they are not medical doctors, PAs can assess, diagnose, and treat patients in primary, secondary and community care environments within their scope of practice. PAs add to the breadth of skills within multidisciplinary teams, to help meet the needs of patients and enable more care to be delivered in clinical settings, and have been part of the healthcare workforce for 20 years in the UK.

The education and training requirements, supervision, and scope of practice for PAs are developed, determined and reviewed by the General Medical Council (GMC), National Health Service England (NHSE), Faculty of Physician Associates (FPA) and the Royal College of Physicians (RCP) in collaboration with all relevant stakeholders across the four nations of the UK. Through stakeholder engagement, proposed peer review and transparent authorship, the FPA is in the process of writing a suite of guidance documents on supervision, scope of practice, and career development.

PAs are in no way a replacement for any other member of the general practice team. They work in conjunction with and are complementary to the existing team. Therefore, it is important that practices ensure that there is a single coherent explanation of the PA role utilised by all practice staff to ensure patients understand the role is distinct from that of a doctor. Practices should use the FPA title and introduction guidance to ensure there is clarity in all communications to patients that PAs are not doctors, and to be clear about their specific roles and responsibilities.

Because Physician Associates await statutory regulation, employers are strongly advised to be diligent in their recruitment process. Any job description advertising for the role must state that it is essential for applicants to hold a PG Diploma or MSc in Physician Associate Studies from a recognised UK programme, and that they have passed the UK Physician Associate National Exam. Please note: Physician Associates will need to be regulated with the GMC from December 2024. Regulation will help assure patients, colleagues and employers that PAs have the knowledge and skills to work safely and that they can be held to account if serious concerns are raised.

Until the GMC register for PAs becomes open in mid-December 2024, the ICB, in line with the FPA recommendations, advises employers/practices to only recruit physician associates who are registered on the Physician Associate Managed Voluntary Register (PAMVR). This is a register, managed by the FPA, of fully qualified Physician Associates who have been declared fit to practise in the UK. It therefore enables supervisors and employers to check whether a PA is qualified and safe to work in the UK.

Supervision

To provide assurance that a PA is working safely, and to ensure patient safety, all practices should have a supervision policy in place.

The level of supervision and support will vary depending on the individual PA and their experience. During preceptorship year, NHSE guidance stipulates daily supervision for PAs, requiring a debrief of all patients, this may be after every patient or at the end of a clinic. As the PA and supervisor relationship grows and the PAs competence and confidence develops, this often progresses to the PA selecting patients as required for debrief. Adjustments to support and supervision should be made on an individual basis through discussion with the PA and using the PA portfolio to evidence their development and acquisition of knowledge and skills.

For the supervision model to work effectively, there should be safeguards in place by the supervising GP to cover the identification and management of the PA's 'unknown unknowns' as part of a defensible model of supervision. A suggestion includes the supervisor reviewing a sample of the patient's notes not brought to debrief as per Drennan et al. (2014). This would be good practice to monitor the PA's scope of practice, and to document this in the patient's notes for audit purposes. The FPA have stated that there is no 'one size fits all' approach. Ultimately it is up to the practice how they wish to proceed, but the ICB would recommend a two-way approach in which the PA feels able to seek support when they need it, in addition to the practice reviewing patients not brought to their attention by the PA.

Named supervisor

A PA should be allocated one or two overarching GP supervisors. Practices should ensure only those who feel comfortable supervising are allocated where feasible. Furthermore, it is recommended that the supervisor has undertaken formal training in education and supervision.

Formal supervisory meetings and annual appraisal

Formal supervisory meetings should occur a month into the newly appointed PA seeing patients, and then subsequently at months three and six, dependant on the individual PA.

Appraisal should occur annually with the named supervisor(s).

Prescribing rights

Finally, PAs are currently not permitted to prescribe, however the ICB is aware that some PAs have previously held prescribing roles and are registered healthcare professionals, and this means that they personally retain those prescribing rights. This adds a layer of confusion for patients, practices and employers. The ICBs position on this is that we support the statement from the Royal College of Physicians and the Faculty of Physician Associates which recommends that PAs do not currently prescribe i.e. people who are qualified to supply medicines or who are registered prescribers from previous roles cannot use these responsibilities in their PA role.

More helpful resources to support PAs in primary care can be found via the following link: Physician Associates – Lancashire and South Cumbria Training Hub (lscthub.co.uk).

Paramedics

Paramedics have been part of the wider multi-disciplinary healthcare team for many years, providing emergency medical care within the Ambulance service.

Whilst paramedics may be primed to work well in General Practice, the ICB is aware that there have been challenges/conflicts in relation to paramedic job titles, roles and responsibilities. Furthermore, clinical gaps in areas such as biochemistry, urinalysis, imaging, wound care and pharmacotherapy, need to be filled to ensure successful transition of paramedics into General Practice. Paramedics should therefore follow the Health Education England (HEE) Roadmaps to Practice to evidence their capability as first contact practitioners (FCPs) or advanced practitioners (APs). The Roadmap provides a clear educational pathway from undergraduate to advanced practice for clinicians wishing to pursue a career in general practice, and the capability framework clearly articulates capabilities so that employers can understand what the clinicians can offer the multi-disciplinary team (MDT) (NHS England » Paramedics in general practice). Clinical supervision is also important to enable paramedics to feel supported and develop these clinical skills.

In addition to clinical supervision the ICB would encourage practices/employers to adhere to the College of Paramedics checklist for potential prescribers and/or organisation introducing prescribers, found in Annex F of the guidance document *Improving Patients' Access to Medicines: A Guide to Implementing Paramedic Prescribing with the NHS in the UK* (Appendix 3). Best practice is that paramedics should be working at an advanced level of practice before they apply to become a Non-Medical Prescriber.

Occupational Therapists

An Occupational Therapist helps people of all ages overcome challenges completing everyday tasks or activities.

Occupational Therapists see beyond diagnoses and limitations to hopes and aspirations. They look at relationships between the activities people do everyday, alongside the challenges they face and their environment.

The Royal College of Occupational Therapists have stated that when an Occupational Therapist is line managed or supervised by someone from another profession, or an Occupational Therapist line manages/supervises someone from another profession, the manager needs to be aware that they are still responsible for ensuring that the practitioner is competent to carry out any tasks (whether clinical or otherwise) that they delegate to them.

Non-Medical Prescribers

Non-Medical Prescribers, regardless of profession, employers and practices should adhere to the ICB Policy for Non-Medical Prescribing in General Practice. The policy brings together best practice and regulatory and profession specific standards. The

policy aims to standardise the approach to Non-Medical Prescribing practices across General Practice in Lancashire and South Cumbria.

Furthermore, all Non-Medical Prescribers should have an annual appraisal. As part of the appraisal discussions the ICB encourages practices/employers to include prescribing and ensure the ICB Approval to practice/Annual Declaration Form (found in Appendix 3 of the ICB Policy for Non-Medical Prescribing in General Practice) is completed to assure a prescribers ongoing competence in clinical areas.

Individual prescribers should perform an annual audit of their prescribing practice, and audits should be reviewed at a prescriber's annual appraisal.

The ICB is committed to supporting Non-Medical Prescribers in becoming confident and competent clinical practitioners and have created opportunities to support prescribers in their development:

- ✓ Prescribing data reports – these are shared quarterly with Non-Medical Prescribers, Clinical Supervisors and Practice Managers and are an opportunity to reflect on current prescribing practices and identify learning needs.
- ✓ Bitesize education and training sessions – these sessions are held for 30 minutes via MS Teams and covers topics which support both clinical and professional development.

The ICBs position is that practices/employers should encourage their Non-Medical Prescribers to act on their data reports and attend a minimum of four out of the 12 education and training sessions held each year.

Summary

NHS Lancashire and South Cumbria ICB recognises that a robust induction and access to supervision is integral to providing an effective and safe healthcare service and is committed to supporting General Practice to ensure that additional clinical roles, irrespective of their level of practice and experience, receive quality supervision on a regular basis which supports not only clinical development, but also professional development and reflective practice.

This framework highlights the ICBs position in relation to national and regulatory body guidance for additional clinical roles in General Practice, and offers employers/practices with a framework for the expected levels of support and supervision that is required for these additional roles.

The ICB recognises that there are multiple employment models across Lancashire and South Cumbria, however, this framework is all encompassing, recognising the increasing demands of these additional roles in General Practice and the importance of safeguarding the safety of patients across Lancashire and South Cumbria.

Whilst this framework is not prescriptive in nature, it aims to support employers and practices in understanding their responsibilities when employing these additional roles. Employers and practices may choose to separate out the roles and responsibilities over support, supervision and education and training of these additional roles by a Memorandum of Understanding (Appendix 4).

Finally, it must not be forgotten that staff in these additional roles also hold a level of professional responsibility, in that they are accountable for their practice and, where applicable, subject to their professional body regulations/code e.g. NMC Code for nurses. Some must also undertake revalidation in line with their professional body requirements. Therefore, staff should be encouraged to openly discuss their competencies and any challenges they face with their employers/practices and be provided with opportunities to undertake further training and education to achieve additional knowledge, skills and enhance competencies.

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Appendices

Appendix 1: **Scope of practice**

Scope of practice is defined as:

"the limit of your knowledge, skills and experience and is made up of the activities you carry out within your professional role."
(How can scope of practice be described and conceptualised in medical and health professions? A systematic review for scoping and content analysis)

Health and care professionals must keep within their scope of practice at all times to ensure they are practising safely, lawfully and effectively. This is likely to change over time as they acquire knowledge, skills and experience.

Below are links to guidance on scope of practice for each role/profession and an example scope of practice form which professionals may wish to use to evidence learning.

Guidance on scope of practice

- For all Allied Health Professionals (paramedic, dietician, physiotherapist, occupational therapist, chiropodist/podiatrist) registrants:
    - Guidance from the Health and Care Professions Council

Additional guidance for specific professions:

- Physiotherapist: Chartered Society of Physiotherapy guidance on scope of practice.
- Paramedic: College of Paramedics guidance on scope of practice.
- Occupational Therapist: Royal College of Occupational Therapy guidance on scope of practice.
- Dietician: British Dietetic Association guidance on scope of practice.
- Physician Associates: Faculty of Physician Associates - quality health care across the NHS (fparcp.co.uk)
- Nursing Associates: Annexe B of Standards of proficiency for registered nursing associates - The Nursing and Midwifery Council (nmc.org.uk)
- Nurses: Annexe B of Standards of proficiency for registered nurses - The Nursing and Midwifery Council (nmc.org.uk)
- Non-Medical Prescribers: Expanding Prescribing Scope of Practice (rpharms.com)
- Pharmacist: GP mythbuster 81: Pharmacy professionals in general practice - Care Quality Commission (cqc.org.uk) and Pharmacists in GP practices | RPS (rpharms.com)

Example scope of practice form

Example Primary Care Focused Scope of Practice Form

Purpose

This document can be used with your practice/organisation to specify areas of clinical competence that fall within your knowledge and skills as a clinical staff member. If you are a Non-Medical Prescriber this form can also be used in combination with your Annual Declaration/Approval to Practice form to evidence your competencies based on your training, qualification, experience and skills.

Competency

The scope of your clinical practice defines the current extent of your competencies. Knowing where these are is a vital component of risk management.

These competencies should be 'sense checked' with your clinical supervisor/mentor in your place of work.

Competency will increase over time after formal training or experience so this document should be updated on a regular basis.

How to Use:

1. **List all areas of current competence with the following advice:**
    - Area of practice:
        - List the area(s) of practice that you will be covering within your practice and are competent in, this can be a clinical area such as diabetes or a practice system process such as medicines reconciliation or repeat authorisation.
    - Prescribing:
        - State if you will be prescribing in this area of practice, you can refer to your Annual Declaration/Approval to Practice form if necessary.
        - Write any specific requirements such as 'only for patients reviewed by yourself' or 'only patients over 18 years of age' etc.
    - Evidence of Competence:
        - List the criteria that makes you competent in this area of practice e.g. completion of external training, 2 years' experience in endocrine ward of hospital, post grad diploma, supervised practice etc.
    - Guidelines or protocols employed:
        - Refer to any relevant local or national policies that you will be working to in this area of practice e.g. ICB pathways, NICE antimicrobial guidelines, neuropathic pain pathway, NICE Hypertension guidelines, practice repeat prescribing policy, ICB policies etc.
    - Exclusions to competency:
        - List areas/patient groups that would not be covered by your competency, e.g. diabetes – exclude pregnant women, under 18s etc.

- Clinical review beyond competency boundaries – escalation:
  - Identify who you would go to for support/review and approval of decision, advice or referral if it was beyond your competence e.g. a patient suspected of having an acute problem such as a COPD exacerbation – refer to duty GP, Level 3 medication review – refer to senior pharmacist or GP at practice/service.

2. **Review your scope of practice with your clinical supervisor/mentor. This should be done for <u>each</u> practice/service you work at. Note: competencies can be transferred between practices/services as it is attached to the practitioner.**
3. **You and your clinical supervisor/mentor agree on competencies and resolve any disagreements. Both parties then sign the agreement for each practice.**
4. **The document should be kept under review and any new competencies, developed through training or experience, added.**
5. **If an area of practice is identified by the clinical supervisor/mentor as an area that would be beneficial for both the practice and its patients, but the clinician does not currently have the relevant skills to be competent in this area, a plan should be agreed (by both parties) to develop the clinician's competency in this area, through relevant training and supervision.**

Scope of Practice Agreement Form

Area of practice	Prescribing	Evidence of competence to prescribe/ practice in this area	Main guidelines or protocols used	Exclusions to competency	Clinical review beyond competency boundaries - escalation	Agreed with clinical supervisor/ mentor

Competency Development Plan

If you are planning to extend your clinical competencies to other areas, complete the table below.

Actions might include:

- Formal qualifications.
- Other forms of training, for example study days or on-line courses.
- Self-directed study.

- Shadowing.
- Supervised practice – for example, where all decisions are reviewed by a supervisor / mentor.

Area of competency	Actions required to achieve this competence	Target date

<u>Declaration:</u> I declare that I am competent in the area(s) of practice described above

	Name	Signature	Date
Clinician			
Clinical Supervisor/Mentor			

<u>Example of Completed 'Scope of Practice Form'</u>

Area of practice	Prescribing	Evidence of competence to prescribe/practice in this area	Main guidelines or protocols used	Exclusions to competency	Clinical review beyond competency boundaries - escalation	Agreed with clinical supervisor/ mentor
Depression	*Yes*	*e.g. Completion of Certificate in Psychiatric therapeutics at Aston University in 2013 and 2 years' experience in running clinics*	*NICE guidance: Depression in adults CG90,*	*Depression in older adults. Children, pregnancy.*	*Mental health specialist pharmacist*	*Yes April 2021*
Level 2 and 3 medication review	*No*	*Clinical diploma and 4 years' experience in primary care. Ongoing CPD.*	*Local med review protocol.*	*Discuss complex patients (poor control, frequent admissions, polypharmacy) at practice MDT. Pregnancy, children with complex needs.*	*Dr Smith (GP partner), MDT.*	*Yes October 2020*
Clinical Examination Skills - Ears, eyes, nose and throat	*No*	*Clinical Examination Skills course at University of Bradford. Supervised practice in clinics.*	*NICE guidelines*	*Paediatrics*	*Dr Smith (GP)*	*Yes October 2021*

o auroscope *o hearing/ tuning forks* *o neck examination*						

Example Competency Development Plan

Area of competency	Actions required to achieve this competence	Target date
Prescribing following COPD patient review	• CPPE package training on COPD • Spirometry Training package • Inhaler technique training • Shadowing COPD Lead Nurse • Joint clinics with COPD Nurses	July 2025

Declaration: I declare that I am competent in the area(s) of practice described above

	Name	Signature	Date
Clinician	J. Bloggs	*J. Bloggs*	08.07.2024
Clinical Supervisor/Mentor	Dr Smith	*Dr Smith*	08.07.2024

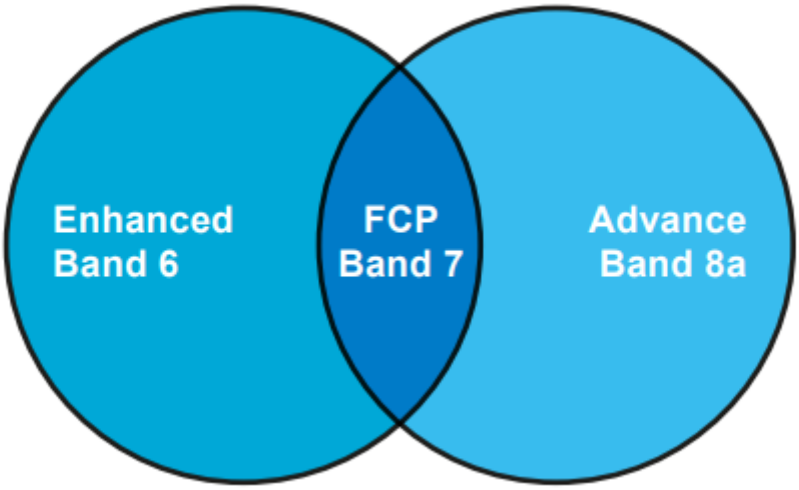
Appendix 2: **First Contact Practitioner**

First Contact Practice FAQs | NHS England | Workforce, training and education (hee.nhs.uk)

What is a First Contact Practitioner

A First Contact Practitioner (FCP) is a diagnostic clinician working in primary care at the top of their clinical scope of practice at Agenda for Change Band 7 or equivalent and above. This allows the FCP to be able to assess and manage undifferentiated and undiagnosed presentations.

- ✓ It is the minimum threshold for working as a first point of contact with undifferentiated undiagnosed conditions in primary care. With additional training, FCPs can build towards advanced practice.
- ✓ To become an FCP, recognition is required through NHSE (formerly Health Education England), whereby a clinician must have completed a taught or portfolio route.
- ✓ The clinician must have a minimum three years postgraduate experience in their professional speciality area of practice before starting primary care training to become an FCP.
- ✓ FCPs refer patients to GPs for the medical management of a patient with presentations and pharmacology outside their agreed scope of practice.



First Contact Practitioner (FCP) Roadmaps to Practice

The First Contact Practitioner (FCP) Roadmaps to Practice were written as guidance documents which set out nationally agreed education and training standards for AHPs moving into FCP roles in primary care. They described the educational supervision and governance to safely support practitioners through the process.

The first Roadmap was developed in response to the 2018 Musculoskeletal (MSK) Core Capabilities Framework, which set out nationally agreed standards of practice for practitioners who were in a first point of contact role diagnosing and managing people with MSK conditions.

FCP Roadmaps were subsequently developed for the other specific professions - Dietetics, Occupational Therapy, Paramedics and Podiatry - which were aligned to relevant capability frameworks.

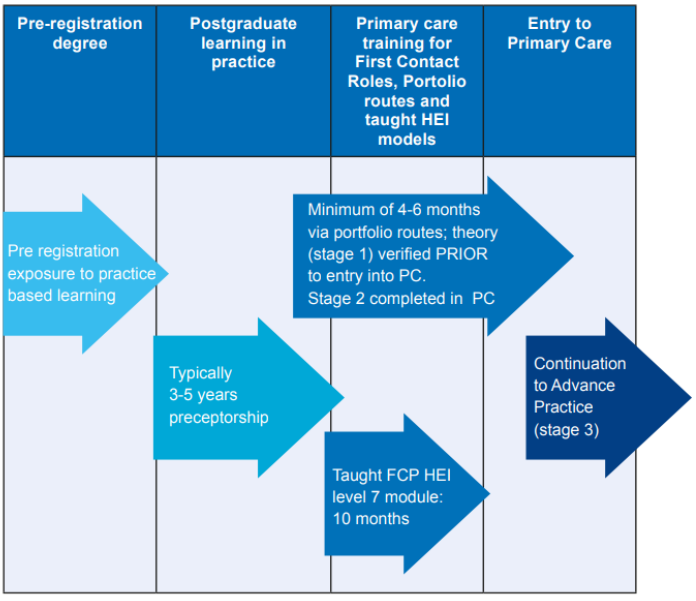
FCP education and training that has been nationally commissioned, meets agreed standards providing AHPs with the framework to demonstrate skills and knowledge needed to practice safely and effectively in a FCP role in primary care.

All registered healthcare professionals are accountable for their practice. The FCP programmes support AHPs moving into primary care to engage with relevant continuing professional development and supervisory activity, supporting them to maintain their skills and knowledge and to re-enforce their need to act within their scope of practice and governance framework.

As the independent regulator for health and social care in England, the Care Quality Commission (CQC) will look for evidence that employers have systems in place to recruit staff appropriately. For employers that recruit AHPs in FCP roles, the CQC expect to see evidence of completion or plans for completion of FCP education and training.

Roadmap process

Practitioners proceeding through the FCP Roadmap will need to be supported by a verified roadmap supervisor to complete required general practice recognition (Stage 1 on the road map below) this can be started and completed prior to entry into an FCP role and completed either in practice or through HEI modules. For paramedics, roadmap supervision is likely to be delivered by the ambulance trust though this may differ depending upon the geographical area. Some paramedics may already be working in general practice at academic level 6, to ensure standardisation of the role and effective governance, paramedics may complete and evidence their clinical practice using a portfolio to achieve stage 1 and 2 of the portfolio with support of their road map supervisor (Please note the timeline for stage 1 can be amended by the local commissioner i.e., take 12 months as opposed to 6 months).



Practitioners proceeding through the FCP Roadmap can access one of two educational routes to complete the specific requirements of a FCP education and training:

- FCP Supported Portfolio route – the practitioner works with a supervisor and education provider to create a portfolio of evidence to meet the knowledge, skills and attributes outlined in a FCP Roadmap and to demonstrate they have applied these in clinical practice. The education provider will work with the practitioner to assess their portfolio of evidence and, if required, oversee and deliver additional learning to support them to meet the requirements of Stage 1 and Stage 2.
- FCP Taught route – the practitioner undertakes a level 7 master's level module(s) at an education provider, which is mapped to the knowledge, skills and attributes in a FCP Roadmap. Stage 2 is completed as part of a level 7 module delivered in clinical practice.

There is no central place where evidence / proof of portfolio completion is stored. The FCP Taught route will have a certificate of completion.

NHS England Workforce, Training and Education will not provide additional confirmation of completion. Once a practitioner has successfully completed their portfolio of evidence, it will be reviewed and signed off by their supervisor.

Regardless of whether a practitioner completes the FCP Supported Portfolio route or FCP Taught route, their supervisor will work in collaboration with an education provider throughout to support the practitioner to meet the appropriate level 7 learning outcomes. Once the supervisor has signed-off the practitioner's evidence and the education provider assured itself that the learning outcomes have been met, the provider can issue a certificate or other form of evidence to the practitioner to indicate that they have completed the requirements of the applicable FCP training.

Roles with Roadmaps

Physiotherapists

First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal)

Occupational Therapists

First Contact Practitioners and Advanced Practitioners in Primary Care: (Occupational Therapy)

Paramedics

First Contact Practitioners and Advanced Practitioners in Primary Care: (Paramedics) (hee.nhs.uk)

Dieticians

First Contact Practitioners and Advanced Practitioners in Primary Care: (Dietitian)

Podiatrists

First Contact Practitioners and Advanced Practitioners in Primary Care: (Podiatry)

Appendix 3: **College of Paramedics Checklist for Potential Prescribers and/or Organisations Introducing Prescribers**

Annex F: Checklist for Potential Prescribers and/or Organisations Introducing Prescribers

The following checklist provides a list of pre-requisite features required in order to move towards prescribing, and provides a link to the associate standards and legislation which may form part of your Professional Development Plan needed to ensure you meet the minimum criteria (and to maintain this). This checklist may be used regularly after qualification as an independent prescriber to ensure you still fulfil the requirements necessary to undertake independent prescribing. **You MUST be able to answer *YES* to all topics before considering non-medical prescribing.**

Topic	Evidence	Self-Assessment			Standards and Guidance Documents	Your Evidence
		Yes	Needs Development	No		
Your Clinical Role	Your employer provides clinical services which require independent prescribing (do you have a clear prescribing role)					
	Your role is currently limited by not being able to independently prescribe, or is a requirement of the role you are training for					
Your Professional Qualification and Post-registration experience	You are registered with the HCPC and have no sanctions or conditions applied					
	You have (or are working towards) an advanced practice qualification (typically MSc/other study at Masters level which fulfils the HEE definition of Advanced Practice) and have achieved the award within the last 6 years, or have evidence of continuous practice at that level if achieved to longer than 6 years ago.				HEE - definition of Advanced Practice	
	You are, and have been, practising in your area of expertise for at least 12 months					
	You have been qualified and registered for at least 5 years					
	You have evidence of post-registration study (for example, DipHE or PGDip)					
	You have a qualification, experience and evidence of competency of diagnostics, physical examination and decision making skills relevant to your area(s) of prescribing practice.					

Topic	Evidence	Self-Assessment			Standards and Guidance Documents	Your Evidence
		Yes	Needs Development	No		
Your Organisation	You are employed by an organisation which is providing clinical services, and which has recognised a need for prescribing roles.					
	Your organisation has access to a pharmacist who is familiar with non-medical prescribing, and a Non-medical Prescribing Lead.					
	Your organisation has an established non-medical prescribing policy, governance processes, and prescribing budget which meet the minimum best practice standards					
	Your organisation employs a Medical Director or other Clinician delegated to oversee non-medical prescribing					
	Your organisation has sufficient access to a Designated Medical Practitioner (DMP) who meets the criteria (NPC, 2005), and who can supervise trainee non-medical prescribers.				Web Link - NPC 2005	
Your Prescribing Education	You meet all educational requirements for entering an approved non-medical prescribing programme and you have experience and competence in using medicines legislation for administration, possession and supply of medicines					
	You have read and understood the Royal Pharmaceutical Society's competency framework				RPS - A Competency Framework for all Prescribers	
	You have read and understood the Allied Health Professionals Federation Outline Curriculum Framework for independent and supplementary prescribing				AHPF Outline Curriculum Framework	
	You have access to funding for non-medical prescribing education, or you are able to self-fund.					
	You have access to a DMP who can support your prescribing training					
Your CPD Plan and Opportunities	You have a detailed professional development plan which includes development as a prescriber. You can demonstrate attendance at relevant events, and a clear plan to take CPD opportunities in the future as a prescriber.				HCPC standards for continuing professional development. HCPC Standards for Prescribing	

Topic	Evidence	Self-Assessment			Standards and Guidance Documents	Your Evidence
		Yes	Needs Development	No		
Your Supervision Plan and Opportunities	You are able to identify a suitable non-medical prescribing supervisor (buddy system), and have liaised with your non-medical prescribing lead (if available) to discuss supervision needs.					
Your Local Prescribing Network	You are aware of your local prescribing network and have discussed with your non-medical prescribing lead the role and function of this group.					
Your Ongoing Role and Career Plans	A clinical role is part of your career plan and you should seek to undertake prescribing as a core aspect of your clinical career for at least 3 years					
	You understand the implications of ceasing to prescribe as part of your practice within your role.				HCPC - prescribing training	
Your Regulator	You understand the guidance issued by your regulator (HCPC)				HCPC Standards for Prescribing	
	You understand and follow the Standards of Performance, Conduct and Ethics issued by the HCPC				HCPC Standards of Conduct, Performance and Ethics	
	You understand and follow the Standards of Proficiency for Paramedics issued by the HCPC				HCPC Standards of Proficiency for Paramedics	
Your Professional Body's Practice Guidance	You understand the role of the professional body – the College of Paramedics, and understand its role in relation to practice guidance, indemnity, CPD and professional standards					
	You have read and understood the Practice Guidance issued by the College of Paramedics				College of Paramedics: Practice Guidance for paramedic supplementary and Independent Prescribers	

Appendix 4: **Memorandum of Understanding (MoU) example**

MEMORANDUM OF UNDERSTANDING

PCN DES Additional Roles Reimbursement Scheme (ARRS) Deployment

BETWEEN:

XXX

AND

Name of Practice

Date:

Review Date:

Version:

1. Background

1.1 A PCN is entitled to funding as part of the Network Contract DES to support the recruitment of new additional staff to deliver health services. This element of the DES is referred to as the "Additional Roles Reimbursement Scheme".

1.2 To be eligible for the Additional Roles Reimbursement Sum, PCNs must comply with the principle of additionality and with the role requirements set out in the Network Contract DES Specification including:

- access to other healthcare professionals,
- access to admin/office support and training and development
- access to appropriate clinical supervision and administrative support
- having a review and appraisal process

2. Purpose

2.1 To support a collaborative relationship between XXX and The Practice to support ARRS deployment.

2.2 To promote a common understanding of the roles, responsibilities and accountabilities between the Parties in relation to the supporting of the ARRS postholders.

2.3 This Memorandum is not intended to be legally binding but is intended to document the expectations of each Party.

2.4 Each Party respectively is expected to act in good faith in accordance with this Memorandum.

3. Statement of Intent & Scope of Co-operation

3.1 The Parties will act in good faith and will use their best endeavours to achieve the Purpose and to give effect to the Terms of this Memorandum.

3.2 The Parties hereby acknowledge and agree that they will each respectively perform all acts and execute all documents as reasonably required in order to give effect to the terms of this Memorandum.

3.3 Each Party agrees to cooperate in the spirit of mutual understanding and goodwill in order to develop the Parties' relationships with one another and in order to pursue the Purpose.

3.4 The Parties will work in an open and transparent fashion, acknowledge each other's respective responsibilities and take these into account when working together.

4. Responsibilities & Accountability

4.1 XXX

XXX have a responsibility to:

- Advertise and recruit roles as directed and agreed by PCN Clinical Directors
- Undertake all pre-employment checks
- Provide a clear job description and contract of employment
- Record and monitor annual leave/other leave once practice approved
- Provide full HR services for postholders in accordance with XXX policies
- Ensure relevant data sharing agreements are in place
- Provide lap tops
- Provide a full induction, including EMIS training, smart cards, IT
- Ensure all mandatory training is completed and a record of this sent to the practice for their records
- Work with the practice to support and embed each role
- Confirm with the practice what days & hours the staff member will work for the practice
- Provide line management and an annual appraisal and PDP
- Provide a minimum of one supervision session per month for clinical pharmacists and technicians
- Provide all training required to undertake minimum role requirements for all ARRS roles
- Provide peer support
- Audit quality of consultations and include in quality improvement programs
- Ensure that all role requirements are performed in accordance with the DES Service Specification
- Provide quarterly submissions of ARRS staff details to NHSE and NWRS
- Provide all contractual reporting and forecasting requirements of the DES
- Whilst all ARRS staff are covered by the state-backed GP indemnity scheme for activity provided as part of general practice NHS services (Clinical Negligence Scheme for General Practice), XXX will also provide additional 'wrap around' cover for regulatory defence in the wider aspects of the roles.

For any defined PCN projects undertaken outside of the practice, XXX is accountable for ensuring their clinical and information governance processes are followed.

4.2 The Practice

The practice has a responsibility to:

- Provide a practice induction
- Embed roles in the Practice and ensure full integration within the multi-disciplinary team
- Provide access to electronic 'live' and paper-based records
- Ensure appropriate work space is allocated. If the practice allows occasional WFH, then practice information governance processes must be followed
- Be responsible for day to day attendance and management

- Provide appropriate clinical supervision
- Provide uniform if required and any other equipment required to undertake role in practice
- Ensure practice IG processes are followed
- Release staff for training sessions (dates agreed in advance)
- Understand that some roles may work remotely for the PCN on defined projects
- Inform XXX of any HR matters/concerns
- Agree all annual leave requests and inform XXX for their records

The practice is accountable for all clinical and information governance relating to any work undertaken by ARRS staff within, and on behalf of, their practice.

5. Disputes

5.1 Should there be a dispute involving the MoU document from any one of the Parties, a meeting of all Parties is to occur to discuss the issue raised to ascertain an amicable outcome.

5.2 Notwithstanding the existence of a dispute, each Party will continue to comply with this MoU except as otherwise expressly provided by this MoU.

6. Confidentiality

6.1 XXX will ensure that strict confidentiality policies are adhered to and maintained. Subject to all legal rights of access to information, all parties will respect the confidentiality of all matters arising in connection with this MoU. All parties will consult with the other before responding to any requests for information connected with this MoU under the appropriate UK legislation.

7. Changes to Memorandum

7.1 This Memorandum will only be amended by agreement of both Parties.

7.2 Any changes to this Memorandum must be made in writing and signed by both Parties

8. Status

8.1 This MoU is not intended to be legally binding and no legal obligations or legal rights shall arise between the Parties from this MoU. The parties enter into the MoU intending to honour all their obligations.

8.2 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the parties, constitute either party as the agent of the other party, nor authorise either of the parties to make or enter into any commitments for or on behalf of the other party.

9. Termination

9.1 This Memorandum will commence on INSERT DATE

9.2 This Memorandum will remain in effect for 1 year unless terminated by the Parties.

9.3 The Parties may terminate this Memorandum by written agreement of both Parties

SIGNED BY THE PARTIES

Signed for and on behalf of XXX

…… Date: ……

[Insert NAME]

[Insert Job Title]

Signed for and on behalf of The Practice

……..

Date:……

[Insert NAME]

[Insert Job Title]

Appendix 5: **Professional body standards/code of conduct**

- **Nurses and Nursing Associates:**

  Nursing and Midwifery Council:

  - The Code (nmc.org.uk)
  - Standards for nurses - The Nursing and Midwifery Council (nmc.org.uk)
  - Standards for nursing associates - The Nursing and Midwifery Council (nmc.org.uk)

- **Pharmacists:**

  General Pharmaceutical Council:

  - Standards and guidance for pharmacy professionals | General Pharmaceutical Council (pharmacyregulation.org)
  - Guidance for pharmacy professionals | General Pharmaceutical Council (pharmacyregulation.org)

- **Allied Healthcare Professionals:**

  Health and Care Professions Council:

  - Meeting our standards | (hcpc-uk.org)
  - Standards of conduct, performance and ethics | (hcpc-uk.org)
  - Standards of proficiency | (hcpc-uk.org)
  - Prescribing | (hcpc-uk.org)

- **Physician Associates**

  Royal College of Physicians:

  - Faculty of Physician Associates - Code of Conduct
  - Future regulation of PAs and AAs - GMC (gmc-uk.org)
  - GP mythbuster 82: Physician associates in general practice - Care Quality Commission (cqc.org.uk)