## 4.17 Appendix A: Framework for a Memorandum of Understanding between GP Practice and Private provider (MH facility)

## Background

### 1.1. This Memorandum of Understanding sets out the understanding between the parties in relation to how [INSERT] “the GP Practice” will provide services to its registered patients who are resident at [INSERT] run by [INSERT] (“the Provider”). It does not require the GP Practice to provide any services above that which it is contracted to do under its contract with NHS England. Other services are the responsibility of the Hospital or the commissioning CCG.

## Duration

### This Agreement will commence on DATE and will be reviewed XXX years from this date

## Responsibilities

### The GP Practice shall provide all essential services as required under the terms of their contract with NHS England to its registered patients including, but not limited to the following:

1. appointments at the practice and [include description of when a visit may be required and for what reasons in a manner determined by the practice *(e.g. excluding organisational convenience which would be considered an enhanced service funded by either the CCG or the private hospital*);
2. Diagnosis and treatment plans in respect of conditions which are not directly related to the condition for which the Provider has been commissioned to provide care to the registered patient and/or which are not under the management of a consultant engaged by the Provider
3. Referral to other services as necessary;
4. Routine screening programmes

### 3.2. The provider shall provide necessary care and support to the patient including but not limited to the following:

1. Every opportunity for the resident to attend surgery during core hours
2. 24 hour psychiatrist cover which enables all mental health and behavioural problems to be covered “in house” with no need to consult GP.
3. 24 hour nursing cover including for any incidents arising as a result of the condition for which the patient is receiving treatment with the Provider for example in relation to self harm or other physical consequences of the condition or treatment.
4. Monitoring of medication prescribed by the Provider including through blood testing.
5. Access to psychology, OT and speech and Language therapy without recourse to the GP Practice
6. All aspects of MHA and MCA are covered by in house practice and training.

## Information

### [Insert an agreement around ensuring the GP has the necessary information in relation to each patient including contact arrangements should the GP require further information].

### Both parties recognise the importance to patient safety of ensuring that when the other party is treating the patient they are doing so in full knowledge of the care and treatment plans in place under the care of the other party.

### In order to achieve this, the parties will ensure that up to date and accurate information about the current treatment regime is communicated to the other party.

### Where new patients are to be registered the hospital undertakes to supply a full and accurate statement of the current clinical regime, and to update this where this changes. Where necessary when a patient is attending the practice the hospital will ensure that a competent member of the hospital staff accompanies the patient to provide information about the Treatment regime

## Date and arrangements for review

### The Parties agree that if one or more of the circumstances/assumptions on which this agreement is based should change, then the Parties agree that they should consult with each other in good faith as to how to reconsider the extent to which the provisions of this agreement are valid or need amending to meet the needs of the patient

## Signatories

**For and on behalf of the GP Practice;**

**SIGNED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For and on behalf of the provider;**

**SIGNED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**