Bedfordshire & Hertfordshire
Local Medical Committee Ltd

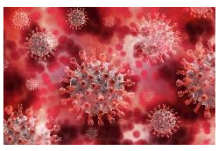
MOVING TOWARDS A NEW NORMAL

June 2020











INTRODUCTION

The response to the Covid-19 pandemic by General Practice in Hertfordshire and Bedfordshire has been exceptional. Services are rapidly transforming and adapting to ensure that the safety and needs of both staff and patients continue to be met.

This has involved adoption of a total triage model, utilisation of technology for phone, video and online consultations, resulting in a reduction of risk for staff and patients. Widespread use of PPE and infection control procedures, with development of 'hot' and 'cold' sites/zones has ensured the continuation of face to face patient contact has been as safe as possible.

Every General Practice has been affected by these service changes to a greater or lesser extent depending on existing infrastructure and community needs.

Looking to the future, we are now moving into what has been called the 'parallel' phase where General Practice must plan how to deliver services to our patients whilst we co-habit with Covid-19. This seems like a daunting prospect which is likely to last 12-18 months and many will mourn 'old' ways of working. However, there is little choice given the restrictions we are and will be living under into the foreseeable future. The LMC are here to help meet these ongoing challenges.

In order to support Practices, we have written this paper in collaboration with a large number of practicing GPs. It aims to provide examples of changes in ways practices are working, including their usage of workforce, premises, and implementation of IT solutions that we have seen both locally and nationally. Some of the areas covered may require more detailed operational support for implementation. Wessex LMC has produced some very detailed guidance aligned to the themes below which Practices may find helpful (click here).

We recognise that every Practice and Partnership is unique, so will have its own specific challenges to overcome. However, we hope that there will be something in here that will resonate with everyone and help in some shape or form the movement of local general Practice into the future. We have also developed the attached matrix as an aid to planning of activities.

Suggested Areas for Consideration

We have grouped these areas under the following five broad headings:

1. Workforce
2. Infrastructure (includes premises and IT)
3. Service Delivery (includes Covid-19 and non-Covid-19 work)
4. Business (includes how you function as a business)
5. Communication and working with other organisations

SECTION 1: WORKFORCE

Workforce has long been one of the key rate-limiting steps in the development and transformation of Primary Care. At this time of crisis, the focus should be on the efficient use of existing primary care employees and maximisation of the wider multi-disciplinary workforce within a locality.

- Review the skill mix across the practice and the additional roles reimbursement scheme from the PCN DES to expand the primary care team.
- Given the current work environment this might be the opportunity to recruit salaried GPs or partners into practices where gaps have previously existed. Review how you engage GP locums in the new service delivery within the Practice.
- Identify staff who have specific risk factors and work with them to find solutions so their skills and input can still be retained in the workforce.

  Example *– workforce risk assessments to guide safe, appropriate working environment.*

- Consider flexible working to help clinicians to continue to work whilst managing parental/carer responsibilities.

  Example *– remote working vs face-to-face activity.*

- Ensure that staff well-being is a priority. Staff that feel supported and protected will be productive and supportive to the running of the business.
- This is a time when small or single-handed practices need to consider the capacity of their clinical work force and reliance on small numbers of individuals. Many have organised 'buddying' arrangements in case of sudden illness of staff members or surges in patient demand.

SECTION TWO: INFRASTRUCTURE

a. Premises

An estate plan will be useful both at the practice as well as at PCN (scale) level to help you look at the resources available and ensure all are used efficiently.

Some key considerations might be:

- What is the "flow" of patients through the building? Can changes be made to reduce contact with staff and maintain social distancing i.e. using different doorways as entry/exit points, making drop off points, Perspex reception screens?

  Example *– one-way systems, zoning, staggering Clinical F2F sessions to allow social distancing in waiting room, entry phones.*

- "Hot" and 'Cold' site working can be considered at either practice, PCN or Locality level dependent on available estate, local mapping of anticipated demand and workforce availability for this work. It is important to consider how to build the ability to flex capacity to reflect surges in demand.

- It must be recognised that smaller practices or single-handed GPs may have more limited options with regard to effective use of their own estate and should consider how best to collaborate locally in order to be able to provide GMS services.
- Remote and flexible working might offer premises solutions – but consideration of the human resource implications and implementation needs to be made e.g. staff health and safety/IT access.
- Attention to infection control measures on site is paramount and may differ between different settings. Patients may need to be rescreened when attending for F2F appointments, doffing/donning of PPE takes time as well as environmental & equipment decontamination procedures which may have to be instigated.
- Consideration of the specific challenges faced by dispensing Practices may include increased footfall compared to other parts of the building and challenges of dispensary staff social distancing.

b. IT Infrastructure

The recent move to the new model of delivery of Primary Care that has occurred as a result of the Covid-19 pandemic is entirely dependent on adequate IT infrastructure for it to function.

Considerations include:

- The IT practices use must have the ability to share data and interact across organisations – with secure record sharing processes. Whilst our day to day IT needs of being able to provide appropriate clinical care remotely must be reliable and safe.
- With new models of consulting, consider what additional 'kit' is needed for staff efficiency and safety.

  Example *- headsets for consulting and charging points for mobile phones.*

- Select technology which is appropriate for the purpose of the appointment and is acceptable for the patient user. Ensure clear guidance exists on how to store attached photographs and documents.

  Example *– use of AccuRx for video consultation, but also sharing of photos and SMS.*

- Consider revision of the practice website. This could be an opportunity to use it to inform, direct and also manage your patients before they cross the practice threshold. This can include NHS app access, E consultation programs and electronic script requesting.
- Use of local Advice and Guidance systems can support remote interface working with specialist colleagues.
- Electronic prescription services including repeat electronic dispensing which is time efficient for practice and pharmacy teams.
- Minimise hot desking and sharing of keyboards to reduce infection risk.

SECTION THREE: SERVICE DELIVERY

a. Covid-19 related work

For Covid-19 specific work there are national reimbursement of costs (when costs are additional and exceeds other funding streams). The details of claiming are dependent on local processes. The main areas of work to consider are:

"Hot" clinics – acute suspected/confirmed Covid-19

- Consider how clinicians could work efficiently and at scale to deliver services (e.g. Covid-19 Home visiting, "hot" site work). This needs to be balanced against the needs of vulnerable staff members and your employer responsibility with respect to employee risk assessments.
- Try and predict the possible fluctuation in capacity needed, depending on community transmission of the virus. This understanding of need should be supported by local commissioners and Public Health and will ensure efficient usage of workforce and value for money. There may need to be consideration of the need for a hot site against the need to have adequate space to provide routine care for the future, depending on the local model of hot site delivery.
- Look at ways to reduce possible asymptomatic carriage of Covid-19 between staff and patients by considering staff movements between hot and cold sites through the day.

Shielded patients-clinically extremely vulnerable

- Practices should consider how they can support and provide shielded patients health needs, as it is likely that this intervention will need to continue until vaccination is known to be effective. It needs to be remembered that patients may not be able to interact with specialists or the practice in the same way as pre-Covid-19.
- Practices should risk assess shielding patients, considering where it may be appropriate to provide care on an individual basis. Some patients may need to be offered home visiting, others could be seen at a "cold site". Consider specific social distancing needs.

  Example *- first appointment in the morning, different entrances, no waiting time, care in cars.*

- Home visiting for shielded patients, although feasible, is likely to be demand dependent. Home visiting at scale could be a local solution.
- Shielding places additional psychological/social demands on patients. Opportunities to support shielded patients with regular remote health and wellbeing checks.

  Example *– reviews conducted by the social prescribers/community volunteers may be possible.*

- Routine care should be planned and coordinated, to reduce unnecessary clinical contacts.

  Example *– look at role of care planning.*

- Clear processes for this group to access acute same-day care should the patient need face-to-face review, e.g. home visit or dedicated 'cold' site.

Public Health

- General Practice has a statutory responsibility to notify public health, of confirmed and suspected cases. What internal processes are needed to support this? Processes may change depending on numbers of cases.
- Ensure robust coding of potential cases and have systems in place to recall and potentially follow-up patients for Covid-19 specific care, depending on agreed local pathways.

b. Non-Covid-19 related work

Management of the consultation

- A total triage model continues to be recommended in the latest Standard Operating Framework. The aim should be for the "right" professional to deal with the request at an appropriate time. This requires effective triage at reception level and has workload and workforce benefits.

  Example *– triage by internal Care Navigators or Social Prescribers.*

- A "digital first" online platform might be an appropriate initial step, where the patient completes additional detail about the request, allowing a disposition to be determined. Practices need to consider processes to ensure how the onward care is managed (e.g. appointments offered and communicated).
- If needed, a face-to-face consultation should be risk assessed. This risk assessment considers:

  - Which professional is best placed to see the patient?
  - Where are they appropriate to be seen?
  - What the focused assessment will contain (e.g. only needed interventions, but reduce patient needing to reattend for other service if can be co-delivered).
  - What resources are needed (e.g. equipment, PPE, room layout) to allow easier infection control procedures.

Consulting in different ways

- There are many different options for mode of consultation i.e. F2F, video, telephone, e-consult, as well as skill mix to deliver the care which may be dependent on available resource. This may include pharmacists conducting medication reviews, paramedics doing minor illness clinics and home visits and first contact specialists (e.g. physiotherapy teams).

  Example *– 1-month audit of consultation undertaken to assess balance of different modes and skill mix to ensure efficient setting of Clinical appointments going forward.*

- Some of the skill mix for these ways of consulting are available at practice level but can also be found at PCN or community service level. Practices need to be aware of and make use all available workforce resource.

Chronic disease management

There is an opportunity to do this in a new way, to avoid duplication and to reduce appointment burden.

- Identify your chronic disease priorities at a practice/PCN level. Consider which care is best delivered by the practice and which could be locality/PCN delivered.

  Example *– use of EA appointments for provision of virtual Diabetic/asthma reviews.*

- Removal of disease specific individual follow-up, moving to a more holistic review based on patient needs, delivered by the most appropriate health professional based on co-morbidity/complexity.

  Example *– patients seen for one annual holistic review covering all QOF indicators/local incentive scheme actions.*

- Encourage patient submitted metrics/measurements to assist with decision making.

  Example *– BP, SaO2, blood sugars.*

Public Health

Primary care delivers numerous public health activities – either through Local Authority commissioned services or Enhanced Services. Some have continued to be high priority throughout the crisis, amongst those that have been paused some may be seen as higher priority to restore i.e. Smoking cessation.

Areas to consider:

- Screening, e.g. 6-week baby checks, Health checks, Smoking cessation. Consider where best to provide these interventions with prioritisation dependent on capacity. Be mindful to ensure F2F contact is minimised as much as possible.

  Example *- performing at baby checks on a "cold" site with immunisations, remote health checks with self-reported BP*.

- National cervical screening program. Additional clinics may be needed to catch up with deferred smears and recall for those at high risk of changes.

  Example *– Cervical smear clinics provided by local EA services.*

- Immunisations, e.g. childhood immunisations, influenza. Social distancing will add a level of complexity never seen before to the provision of mass immunisations. Local discussion of flu planning is strongly recommended as additional modes of delivery and capacity issues (both workforce and vaccine numbers) will need to be taken into account.

  Example *– drive through clinics, PPE requirements.*

- Consider how to maximise the self-help behaviour that practices began to observe during the crisis phase.
- Consider the cost impact/availability of PPE in provision of services.

  Example *– PPE requirements for coil fitting may make the service unviable at this time.*

SECTION FOUR: BUSINESS

a. Partnership functioning

Traditionally partnership decision making has been largely by committee, involving multiple face to face meeting to discuss issues before decisions are reached. This pandemic has moved Partnerships into a more dynamic, fast changing environment where big decisions have had to be made quickly, often with incomplete information, and usually not all sat round a table. This is likely to continue and will result in the need for a new approach to partnership decision making.

- Consider how best to use remote video technology to connect partners and practice managers – selecting the platform which works best, look at frequency and contents of meetings.

Example *– move to more frequent shorter meetings to enable more rapid responses to system changes.*

- Decision by committee may no longer be possible to be able to function efficiently, consider delegation of tasks/areas of responsibility to enable rapid responses.
- Be prepared to review decisions and changes in response to feedback, local situations and National policy.
- Good partnership working is heavily reliant on a good Practice Manager. Much of the deluge of information and drive to change processes has fallen on their shoulders. Consider what support and additional resources may be needed in order for them to continue with their vital work.

b. Income generation

The practice is a business and must make money in order to survive and develop. During the pandemic, some income generating work has stopped. While there have been guarantees from NHS England and CCGs about continuing funding at historic levels during the pandemic, it is not clear how long this will continue and does not take into account any increases in activity you had planned for this year. It also only covers a proportion of your income generating activity. It does not cover most of the Public Health commissioned work and covers none of the private work such as insurance medicals.

- Make sure you are claiming for all your financial entitlements.

Example *– you are entitled to claim locum cover for GPs who are off sick, including where the locum sessions are provided by current partners or salaried GPs.*

- Be aware of requests to take on additional work for which you are not reimbursed.

SECTION FIVE: COMMUNICATION AND WORKING WITH OTHER ORGANISATIONS

a. Communication

One of the key themes in the response to Covid-19 is the importance of collaboration between practice staff, practices, PCNs and wider providers to ensure efficient use of available services, reduction in unnecessary contacts and responsive service delivery to rapidly changing needs. This is all predicated on effective communication at all levels, something which now needs to be done remotely using technology largely previously unused in Primary Care.

- Use of remote video technology (e.g. Zoom, MS Teams, WebEx, WhatsApp) can help a team feel connected whilst maintaining social distancing.
- Traditional practice communication may need to be reviewed in light of:
    - Ensuring isolated and shielded staff contribute to business, clinical discussions, and practice education opportunities.
    - Recognising the need to consider staff emotional as well as clinical support.
    - Facilitating MDT and complex patient reviews (including health and social care and secondary care colleagues) whilst social distancing.

- Keeping patients informed of the rapidly changing ways in which services are being delivered is vital in order to ensure effective service usage, minimise the risk of complaints, support access to services and improve the patient experience.

  Example *– a local practice has developed a service delivery plan which maps services to the Government 1-5 Covid-19 categories. This is shared with their patients on their website.*

- Consider how to keep your PPG updated and how to make best use of their support as General Practice services change.
- Large volumes of communications are sent to Practices on an almost daily basis - how can this be effectively disseminated to the practice team and stored in a way that allows easy access to specific information. Encourage practice managers to share local solutions.

b. Locality/PCN Working

- Develop clear communication strategy which allows dissemination of information and support for staff working in new localities/cross site working.
- Given the fledgling status of most PCNs, good communication channels will support agreed in service delivery as well as provide a forum to share ideas and problem solve.
- Review and engage with wider locality/PCN resources that can be harnessed to support your patient population.

c. Secondary Care Interface

- Look at any changes in referral pathways implemented as a consequence of Covid-19 and how they can they best be used. Ensure staff are aware of changes to ensure efficient referral pathways within the practice.
- Use of local Advice and Guidance systems can support remote interface working with specialist colleagues.

d. Care homes

- The expectation is that practices move to a single practice covering each home, with a named clinical lead. Consider the most appropriate individual for this role.

  Example *– in West Herts the named clinical lead for Care Homes is a member of the Community Nursing Team (it should be noted that this is possible under the care homes specification that runs from May to September, however, under the PCN DES specification starting in October the lead must be a GP or GPs).*

- Weekly check-in should be delivered remotely, look at utilising aligned MDT staff to perform assessments and consider distributing workload based on clinical priority and patient need.
- Ensure there is support from CCGs and community providers as to the delivery of Enhanced Care in Care Homes – it is a local system responsibility to deliver, not just a General Practice responsibility.
- Consider how to support the introduction and use of remote monitoring in the Care Home setting, which would assist your reviews. This could include pulse oximetry which may be beneficial in the assessment of the clinical needs of suspected Covid-19 patients and/or other equipment which

would facilitate remote working. Equipment may be supplied directly to Care Homes or could be funded through the practice as reasonable reimbursements related to Covid-19.

- Example – use of pulse oximetry, temperature checking, blood pressure monitoring – taking into consideration staff training needs.

WHEN TO CONTACT THE LMC

The Beds & Herts LMC is there to support general practice. Occasions when you may find it helpful to contact the LMC include

- Queries about your income – we can clarify or remind practices about national and local agreements about funding, and we can take queries on your behalf to the CCGs.
- Queries about any aspect of your GMS contract – the contract changes annually and it can be hard to keep up with what is or is no longer required. The LMC office keeps itself up to date with all the changes, and no question is too small or too daft. If we aren't able to answer your query ourselves, we can contact GPC or LMC Law for clarification.
- Queries about practice mergers, PCNs, premises, etc – as above, we can usually answer most queries and sometimes just talking through an issue can help. If we aren't able to answer your question we can seek advice from elsewhere.
- Training needs – if you identify staff training needs that aren't being met by local training availability, you can contact the LMC to see if this is something we can develop for you.
- Legal advice – through the retainer we have with LMC Law, practices in Beds & Herts can have access to some free legal advice and, if further advice is needed, receive this at greatly reduced cost
- Support for GPs – the LMC runs a free, confidential pastoral care support service for all GPs in Beds & Herts.

CONCLUSION

Given the above, it must be remembered that the major challenge is one of capacity. The knowledge practices' have of their local population is essential in enabling them to deliver a quality service. The general practice workforce is already stretched, and this crisis has highlighted the need for robust continuation of care delivered by experienced GPs.

GPs are being asked to deliver Primary Medical Services, vital prevention activity such as immunisations, cancer identification and support, along with service delivery changes for 'shielded' patients, and enhanced support to Care Homes. None of this is inappropriate, however, it needs to be considered against the background of the well-articulated General Practice workforce crisis which remained unresolved pre-Covid-19.

Covid-19, itself, also has workload implications. There is increased workload due to Covid-19 illness, both management of the acute illness, any resulting rehabilitation/chronic illness needs and the new care needs of shielded patients. There is also the unquantified potential burden of delayed, deferred, or consequential results of non-Covid-19 related conditions which have worsened during the Crisis phase. This increase in workload needs to be met by an already inadequate workforce with Covid-19 further impacting on the practice workforce by reduction in staff not able to perform roles due to illness or risk factors. Notwithstanding workforce and workload pressures, it must also be acknowledged that the infection control procedures practices must now employ routinely increase the time taken to deliver care and add inefficiencies into the mix.

The BMA has produced a paper outlining 10 principles that need to be considered in the approach to the restart of non Covid-19 work. https://www.bma.org.uk/media/2487/ten-principles.pdf These are:

- A realistic and cautious approach to balancing Covid-19 and non-Covid-19 capacity is needed.
- There must be adequate PPE for health and care workers, and measures in place to prevent the spread of the virus within the NHS.
- Decisions about staffing levels and redeployment must be safe and made in consultation with employee representatives.
- Measures must be taken to safeguard staff well-being.
- Clarity must be given to healthcare workers about their future contractual position and plans to restore training and career development.
- There must be effective and transparent public communication so that patients understand what they can and cannot expect from the NHS at this time.
- Increased remote working, where clinically appropriate, and use of technology to empower patients should be supported.
- Local decisions must be guided by clinical expertise and the experience of those working at the frontline.
- The government must support and significantly enhance local public health services and ensure there is adequate capacity to test, trace and quarantine.
- A strategy is needed to ensure that restarting non-Covid-19 work does not exacerbate health inequal.

Whilst some of these are more applicable to Secondary care and much is under national control, these are worth bearing in mind when assessing your practices ability to deliver services within this new world.

Lastly in preparing this paper we were asked by the committees to consider suggesting some timelines for these activities. This has been a challenge as there are so many variables to consider such as timing of political decisions, seasonal variations in demand, differences in availability of locality resources, lack of available modelling data for future peaks and inherent practice variabilities across all aspects of service delivery. Thus, it is suggested that practices take an approach that fits their business model, workforce availability and patient needs.

APPENDIX 1: PRACTICE PLANNING MATRIX

Workforce				
Area to consider	**Current situation**	**Problem**	**Proposed plan**	**Considerations**
Care of Shielded/High risk colleagues	*Quantify* *Risk assessments*	*Effect on remaining workforce and distribution of workload* *Consider needs of shielded colleagues*		*Roles and limitations of remote working*
Recruitment/Retention Issues	*Current situation and future potential issues*	*Future potential issues*		*Potential for better long-term work force planning*

Workforce				
Area to consider	**Current situation**	**Problem**	**Proposed plan**	**Considerations**
Making best use of PCN, locality, community resources *Pharmacists, link workers, physios etc*	*Quantify availability of aligned PCN, locality, CCG, Community team workforce*			

Premises / Safety				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
Social distancing measures *Waiting rooms* *Reception* *Back office etc*				*Be consistent in application of measures*

Infection Control Measures • PPE *availability, suitability, storage* • Oxygen therapy *Aerosol generating procedure* • CPR *Aerosol generating procedure*				
Care of possible/suspected Covid-19 patients (Hot sites/zones) *Physical Capacity* *Site Management*	*Consider current situation and potential issues with forthcoming flu season*			
Care of non Covid-19 patients (Cold sites/zones) *Physical Capacity* *Site Management*				

IT Infrastructure				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
Hardware needs *Webcams, headsets, laptops*	*Mapping of laptop allocations and id numbers*	*Need for all clinicians and managers to have remote working enabled*		
Software needs *EPS* *E-consult* *NB Consider training needs*				*Consider the added value of standardisation of ways of working*
Record sharing *Between Practices, across PCNs* *My Care Record*				
Telephone Access/capacity *Call volume* *Contract issues*				

Covid-19 related work				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
'Hot' sites/zones *Workforce issues* *Clinical Capacity* *Seasonal needs*				
Care for shielded patients *Workforce issues* *Clinical Capacity*				

PH related covid-19 activities *duty of general practice to notify PH of confirmed or suspected cases – coding, call and recall systems if f/u needed – any experience so far?*	*Use of current resources , such as Ardens*	*Consider - coding, call and recall systems if f/u needed*		

Non Covid-19-related work				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
Management of Consultations *efficient triage model* *use of pre bookable appointments* *use of digital first* *management of F2F consultations*	*Use of clear 'traffic light' systems of work that can be implemented dependent on peaks and capacity issues*			*Consider use of partner time / other Dr roles*
Different ways of Consulting *wider MDT/PCN resources (pharmacists, link workers, physios),* *remote consultations* *group consultations*				

Restarting routine work *Coils* *Implants* *steroid injections*				
Chronic disease Management *Planned restart of QOF related areas* *Local incentive schemes* *Virtual checks* *Use of MDT*			*Use of templates completed prior to review with information from e consults*	*Consider impact of patient ability to engage in new consultation methods*
Public Health Activities *Screening - baby checks, health checks* *Immunisations* *Cervical screening* *Winter flu clinics* *Self care* *Health promotion*				

Partnership functioning				
Area to Consider	**Current Situation**	**Problem**	**Proposed Plan**	**Considerations**
Decision making *Speed* *Data/Information needed* *Forum*				
Review of decisions *Response to change in local/national positions*				
Practice Manager support *Personal wellbeing* *Practical support*				

Communication				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
Business Meetings				
Clinical Communications *Clinical discussions* *Significant event/complaints*				

Communication with PPG				

At scale working				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
PCN activities/support/resources *Resources* *Communication*				*Differing levels of maturity of PCNs influence impact – consider development needs.*
Locality activities/support/resources *Resources* *Communication*				

Secondary care Interface				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
Referral processes *Communication with secondary care*				*How do we improve and rebalance the relationship with secondary care?*

Care Homes				
Area to Consider	**Current Situation**	**Problem**	**Proposed plan**	**Considerations**
Wider Community Support *Availability* *Communication*		*What are we trying to achieve?*		*Where are the GP skills most needed?* *What is the role to be played by wider Community Services?*
Remote consultations *Implimentation issues* *Training*				