RESETTING GENERAL PRACTICE IN THE TIME OF COVID-19

SOMERSET LOCAL MEDICAL COMMITTEE

June 2020

INTRODUCTION

General practice has responded to the Covid-19 (CV19) pandemic in an exceptional way, as befitting the worst public health emergency seen for generations. But how can we reset services as the Across the UK reflections like this one are being undertaken by NHSEI, CCGs, the BMA and LMCs. Each type of organisation will have its own perspectives. We will be able to collate and learn from each other's experiences just as we have seen an unprecedented level of collaboration between organisations since the declaration of a level four critical incident for the NHS in March.

Practices were diverted from work on the Quality & Outcomes Framework, Directed and Local Enhanced services and local contractual agreements to focus on CV19. To manage patients safely practices moved to a total "initial triaged system" which hitherto only a few practices in Somerset had adopted. Although mostly using the established use of telephones there has been a rapid expansion in other ways of managing care online and by video consultation such as with AccuRx and using Smartphone technology. Practices have been working in an organised way in Primary Care Networks (PCNs) set up in advance of the PCN DES to start this Autumn. Working with other community services has been key to their successes. Some practices have set up "hot" and "cold" sites to try to separate suspected CV19 from others either using their own facilities or pooling them within PCNs. Some of the former have plans to move to so called Primary Assessment Centres (PACs) if demand rises in future during a "second peak."

Initial modelling suggested that the pandemic would put extreme pressure on secondary care leading to care having to take extraordinary responsibility for clinical decisions that would never normally be made in the community. There was talk of a "rolling" alert status which would serially, week by week, rachet up criteria to decide who could and could not be admitted to hospital as rationing took hold. Mercifully, perhaps due to the unexpected enthusiasm with which the British public embraced social distancing and other lock down restrictions, and certainly in the South West because of much lower than expected infection rates, these worst-case scenarios never came to pass.

Now however we are presented with two overarching problems –

1. How to deal with the backlog of routine elective and acute general practice problems which are already coming back to be dealt with as well as the extra work that lock down is causing because of poorer outcomes with delayed hospital treatment and attendant psychological problems.
2. How to achieve this together with the continued existence of CV19 in the community albeit at lower levels than seen recently but without the prospect of a vaccine this year.

How we respond to these two questions will define general practice for years to come. The crisis has so far demonstrated the power of clinical leadership and the innovation that systems can make when presented with a problem to solve and, it must be added, when the "dead hand" of regulation is at least partially lifted.

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Sir Simon Stevens in his letter to primary care dated 29th April stressed some areas that the NHS expects primary care to focus upon.

- To ensure that patients can get primary care services for current concerns and that primary care is seen as being "open for business"
- To do as much routine and public health work as possible such as vaccination, immunisation and cancer screening
- To make referrals to secondary care as usual including two-week wait suspected cancer referrals
- To continue to develop video and digital consultation facilities which will be a contractual obligation from April 2021
- To contact high-risk or "shielded" patients to ensure their continuing effective care given the reduction in face-to-face consultations by using "clean sites" and Multi-professional Disciplinary Teams (MDTs) to reduce contacts
- To further support care homes (CHs), raising the standard as far as possible to the best possible for all by collaboration between general practices, other community teams together with secondary care colleagues.

Somerset LMC met on Thursday 14th to discuss what could be learned from the last two months and executive officers have held discussions with CCG, community and secondary care to refine these ideas. What follows owes a good deal to Wessex Local Medical Committees Covid-19-General Practice and the Future Report published earlier in May certainly as far as its admirable structure is concerned. The report has been commended for wider application by the BMA GPC. Its author, Dr Nigel Watson, was one of the most influential in setting out the need to maintain the best of independent general practice in the context of PCNs and the emerging Integrated Care Partnerships.

The report subdivides resources needed for the new ways of working into

1. Workforce
2. Infrastructure
3. Service delivery
4. Interfaces

Interfaces are defined as those with patients, with community services, with secondary care and with care homes.

Workforce: The need for the expansion of the primary care workforce is well known and documented over the years starting with the Five Year Forward View and, most recently the PCN DES which will now allow 100% of funding of teams under the Additional Role Reimbursement Scheme (ARRS). This was at least in part making a virtue out of the necessity of falling GP numbers for reasons far too numerous and well argued over to need repeating here. The present pandemic has both stressed the importance of pushing on with recruitment under the ARRS but also presented obstacles to it, not least preoccupation with day-to-day problems. The PCN DES is far from being without critics but we can only welcome more investment in primary care teams, whoever the ultimate employers may be, and this needs to carry on apace to help with the challenges of the next months.

Existing staff must be retained using a flexibility to allow people to work to their strengths and, in some cases, giving extra protection from infection if they themselves are in vulnerable groups. Home working for those with childcare responsibilities or who are self-isolating must be a priority for a flexible approach to employment. It must also be realised that one needs "horses for courses" – some colleagues may miss real patient contact and so be better deployed seeing people as well.

The increase in flexibility offered by digital consultation must surely largely deal with the working age patient long professed problem of getting a GP appointment during working hours. This being the case, need we really need to continue with the anachronism of "extended hours" provision? This would save the NHS money and improve the welfare of staff.

To allow better collaboration across interfaces smaller teams have been posited (known as "clinical pods") to allow larger practices and integrated teams to gain proper local knowledge of their patients.

A perceptive comment was that the pandemic had demonstrated the need for information to teams to be conveyed at a "human" scale. There had been an information overload, but we can only hope that as NHSEI gets a grip, this impossible pace will slow.

Reductions in the traditional employment of sessional GPs as locums have been severe as holidays are cancelled and face-to-face consultations reduced. To a certain extent this is due to "market forces" and if it encourages sessional doctors into closer relationships with practices as salaried GPs or even as partners this cannot be regretted by the LMC as it will strengthen the independent contractor model. However, in the short term we have been disappointed by colleagues seeing their livelihoods vanish and welcome moves by the CCG to explore new ways of deploying this vital sector of the workforce. In time we trust that new models of working will be adopted by locums and those who introduce them to practices reflecting the new realities of primary care.

Infrastructure: this includes the IT needed to allow for the triage model of first contact to continue and, at its simplest, could mean the installation of more telephone lines in some practices. Existing technology developments must be escalated and so the LMC welcomed the commitment made by the CCG in May this year to use allocated funding for system licences and to support the delivery of online consultations in all practices including those with existing systems. It is to be regretted that the CCG is not permitted to go beyond the current financial year to secure funding which remains a national decision. IT infrastructure to support remote working will need to continue but the LMC recognises the superb efforts made so far by the CCG to greatly increase the number of business continuity laptops made available to practices. The LMC would welcome flexibility on how the CCG can use its digital funding application away from using it to employ a manager.

Digital platforms, notably Microsoft Teams and Zoom should continue to be funded as these have transformed MDT working, including practice and PCN "huddles" allowing social distancing to be maintained and reducing time spent travelling to meetings. The LMC was pleased to hear that CCG IT had invited expressions of interest in this. No doubt the information governance problems that have emerged can be easily overcome with the advice of the IT team and DPO.

With the emergence of PACs and "hot" and "cold" sites (and "red" "amber" and "blue" in some areas) premises have been as important as ever. The LMC was pleased to find that the CQC had made concessions to initial threats to enact regulations concerning change of use or provision of

additional services from certain sites. Funding from the CV19 fund should be made available to support changes in service delivery from some premises. Even as PACs are stood now we recognise that they may well need to reopen in the context of Winter pressures ahead.

There is however some concern that PACs may be a vehicle by which Urgent Treatment Centres (UTCs) will be foisted on practices and groups of practices where they would not be necessary or appropriate in order to satisfy central demands. Practices and PCNs will therefore be advised to pay strict attention to contractual obligations if they do not think an UTC is necessary or practical in their locality.

Service Delivery: the pandemic will change its trajectory, perhaps more than once, in the months ahead and so the flexibilities permitted, for example by the relaxation of some regulation (notably that of the CQC), must be allowed to continue. We note that the provisions of the Coronavirus Act 2020 are enacted for two years (with a six month Parliamentary review insisted upon by amendment passed in the House of Commons) but the LMC was concerned to hear of a programme of "supportive phone calls" to practices from CQC in the months ahead. This regulation cannot be allowed to restrict the flexibilities that allowed such good progress and patient benefits thus far.

The LMC also hopes that the CV Act 2020 provisions that introduced the new "28 day rule" for a GP having seen a person before death (including by video link) to issue a Medical Certificate of Cause of Death will be retained in future. We further hope that this will be extended to allow for an "attending GP" to include one who as part of an MDT was involved in supervising care. We do not expect the suspension of the second cremation form to continue, however.

As general practice returns to the back log of work created over the last two months, including that which will fall back on practices due to delays and cancellations of hospital outpatient appointments and elective procedures, recurring funding must be made available. Workload before the pandemic was unacceptable, as recognised by the PCN DES et al, but existing resources will not allow for the treatment of CV19 patients in the community, including those recovering from severe illness who will need support, as well as normal work as it returns. We look forward with interest to the development of visiting services in PCNs or countywide for respiratory disease including likely CV19.

Part of the answer will be provided in organised general practice through PCNs but the LMC must point out the anxieties that exist about how realistic NHSEI expectations on primary care. The outrage which greeted the release of the draft specification in December led to significant concessions, but these seemed in doubt when Simon Stevens announced the "bringing forward" of the CH part of the DES to deal with the CV19 pandemic. This has now, of course, been "clarified" but there is still concern that practices and PCNs will be made to "just do" what is required of them without remuneration and so the LMC welcomes the CCG's pragmatic stance on the NHS supporting CHs.

Practices and PCNs will need to work together to decide what services need to be delivered and at what level of organisation but CV19's continuing to circulate requires an approach summarised as "one team, one touch" to ensure the right intervention is made at the right time by the right person. This is of course the principle behind MDT working but CV19 should accelerate the move away from "silo working" and artificial contractual barriers that get in the way of good, safer patient care.

Interfaces – Patients. People will need helping through this reconfiguration of care provision to ensure equity of access and to understand that, more than ever, a GP may not be the right person to help them get what they need. There is currently an acceptance largely bourne out of the unexpected response to lock down restrictions – the most severe seen in British civil society since the Second World War (and in many cases exceeding those then) – and it is possible that as "six weeks is enough to make a habit" some of this will last. However, it is more likely that engrained expectations will be part of what will be looked for when an equilibrium is reached. We are already beginning to see early signs of "Covid complaints" where patients or families are blaming practices for adverse outcomes which they at least partially attribute to the fact that they did not "see a GP." It is noteworthy that GMC, the medical defence organisations and NHS Resolution have all made statements about somehow allowing clinicians leeway for the limitations placed upon the Law Courts' "gold standard" clinical practice of seeing, questioning, listening to and EXAMINING every patient. The LMC welcomes the long-delayed encouragement in people taking more responsibility for their own health and welfare after decades of infantalisation of the population (but more in hope than in expectation). Patients taking their own blood pressure and reporting it to nurses as well as using My Diabetes My Way and similar online schemes for COPD must be boosted by lock down?

Community Services. Alignment of health and social care across Neighbourhoods allowing MDT working to break down barriers must continue. Social care has often complained over the years at the poor level of involvement by GPs with case conferences often called at short notice. If these are, from now on always conducted by conference video call surely involvement will increase?

Secondary Care. The LMC welcomes the assertion from NHSEI that primary care must be allowed to continue to refer to secondary care and that it is for secondary care to hold any extra waiting lists that accrue owing to delays from the pandemic. The LMC deplores moves such as Diagnostic Imaging requiring to review and categorise referrals already made: the information contained in the request process should be used by the hospital to prioritise cases with clear direct communication with patients to inform them of any decisions made that affect them. The expansion of Consultant Connect has been widely welcomed as showing just how foolish it was to separate colleagues in primary and secondary care by artificial contractual boundaries that got in the way of good patient care. The LMC would encourage commissioners to make sure that secondary care providers are aware of the requirements in the latest NHS standard contract that internal referrals are now permitted without further reference to primary care. The present situation also makes the reliance on paper communication look more of the anachronism it undoubtably is and urges commissioners to insist on e.g. mental health and MIU providers to move towards routine electronic communications instantly. Patients who visit "outlying hospital trusts" should also not be disadvantaged by their hospital letters being sent to practices by Royal Mail.

Care Homes. CV19 has brought society's focus on to elderly care as never before and, frankly, this has been long overdue. The present author will never forget speaking to two Filipino carers at an excellent CH who said how much they enjoyed their work and their residents but how astonished they were by the way the British often treat their elderly relatives. The LMC regrets the confusion caused by Simon Stevens subsequently retracted "bringing forward" of the Enhancing Health in Care Home moiety of the PCN DES but welcomes the CCG's pragmatic approach to the present "ask" that it feels it deserves to be mentioned twice. Although NHS services are generally only a part, albeit an important one, of what it makes to ensure a CH resident has a good a life as can be it is important

that practices remain involved with their patients' care. It is therefore with some concern that we note that patients should be "supported to re-register" on admissions to a CH with a practice within the local PCN. We recognise the benefits of zoning for homes and for practices as well as often for patients but sometimes this will not be right and patient choice must be available for all. We therefore welcome the recent clarification on "a lead practice" or similar for care homes.