NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Primary Care Commissioning Committee (PCCC)

Date: 30th June 2020
Time: 9.00am – 11:10am
Location: Meeting to be held virtually

Agenda Number :	7
Title:	Primary Care Services from 1st July 2020
Purpose: Discussion	
Key Points for Discussion:	
This paper presents the current arrangements in place for Primary Care Services and proposes the approach to Quarter 2 and Quarter 3, noting the ongoing Covid-19 pandemic.	
Recommendations:	The committee are asked to discuss: The proposed delivery of Improved Access, Extended Hours, and Core Services going into Quarter 2, noting the ongoing Covid19 challenges
Previously Considered By and feedback :	Membership Engagement, Commissioning Executive Committee and Primary Care Operational Group throughout June 2020
Management of Declared Interest:	Not applicable
Risk and Assurance:	There are specific risks highlighted in this paper this month, outlined in Appendix 2.
Financial / Resource Implications:	There are no specific financial resource implications highlighted within this paper.
Legal, Policy and Regulatory Requirements:	There are no specific legal implications highlighted within this paper. Any agreed change requests will be considered via separate papers and will include any relevant legal implications.
How does this reduce Health Inequalities:	The change in the way Primary Care is accessed made necessary through Covid has highlighted the need to look more closely at health inequalities. Monitoring of Primary Care performance alongside practice demographic information will help to highlight areas of variation of services, which will then be addressed accordingly. An Equality Impact Assessment has been completed on behalf of the Primary Care cell and is connected to this programme of work.

How does this impact on Equality & diversity	The change in the way Primary Care is accessed made necessary through Covid has highlighted the need to look more closely at equality and diversity. Monitoring of Primary Care performance alongside practice demographic information will help to highlight areas of variation of services, which will then be addressed accordingly. An Equality Impact Assessment has been completed on behalf of the Primary Care cell and is connected to this programme of work.
Patient and Public Involvement:	Whilst there has not been consultation and communication with the public in the production of this paper, patient experience and public involvement is recognised as an important factor in reviewing and gaining assurance regarding primary care services. It is proposed that in line with recovery plans, and the Insights and Engagements team, patient views are gathered and understood in terms of any ongoing access challenges to ensure these can be addressed.
Communications and Engagement:	There are no specific communication issues highlighted as a result of this paper. Any change requests that require further engagement will be highlighted via separate papers.
Author(s):	David Moss, Head of Primary Care Contracts Geeta Iyer, GP Clinical Lead, Primary Care Development Stephanie Maidment, Senior Contracts Manager Jenny Bowker, Head of Primary Care Development Louisa Darlison, Senior Contract Manager
Sponsoring Director / Clinical Lead / Lay Member:	Lisa Manson, Director of Commissioning

1. Background

In the weeks following 16 March 2020, GPs across BNSSG explored opportunities to rapidly move to new models of care in response to Covid-19 and the wider societal lockdown across the UK. This included many changes to ways of working and the impact on patients was variable as summarised below: -

COVID adaptations to services

- Total triage
- Paused routine and low value services in order to prioritise care and safeguard patients and staff

Digital pathways and learning

- Staff adopted remote working with CCG support including deployment of laptops, webcams, Real VNC software, cross practice smartcard access and enhanced functionality of accuRx. This enabled:
    - Increased use of telephone consultations
    - Implementation and guidance for video consultations
    - Implementation of online consultations
    - Implementation of GP Connect for direct booking of Covid patients from the Covid Clinical Assessment Service into practice worklists

Contractual status summary for Quarter 1

- Protection of income offered to support response
- Contract reviews and performance monitoring paused

Care Homes

- Primary and community care Covid 19 support to care homes model implemented which will support PCN DES Enhanced Care in Care Homes commencing in October 2020

Locality planning

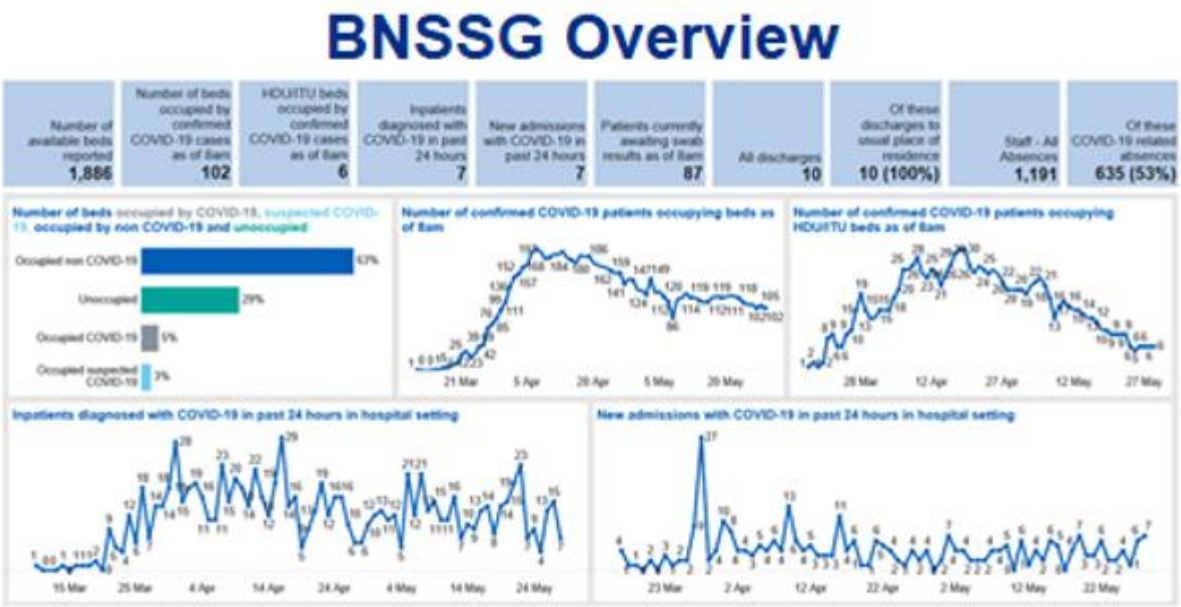
- Development of local practice resilience plans drawing on NHSE/I SOP and OneCare escalation tool - developed in partnership with OneCare, Sirona, LA, VSCE and other locality partners
- Hot and cold site proposals were rapidly developed
- Adaptions to working practises to support shielded patients
- Plans for greatly reduced workforce drafted, including proposals for site closures and hub working in case of significant initial peaks

2. Purpose

This paper is intended to outline the current position and will propose the approach for the weeks and months ahead. It is recognised that the proposals contained in this paper will need to remain flexible to allow practices to adapt and manage future outbreaks and provide care within the constraints of appropriate access to Personal Protective Equipment (PPE) and Estates (maintaining social distancing). There will also be a requirement to set a consistent standard across BNSSG for our population and to ensure equity in access and a standard moving forward.

3. Pandemic status in BNSSG

The external environment within which services are being delivered has seen a reduction in those hospitalised with COVID 19 as set out below: -



Public Health efforts are now focused on identifying outbreaks and using new 'track and trace' systems to contain the spread of the virus.

4. NHS England Response May 2020

Ian Biggs, Director of Primary Care and Public Health, NHSE South West, reported on Friday 29th May 2020, that a new Standard Operating Policy (SOP) is being considered centrally using learning gleaned from national responses so far. In parallel it is anticipated that the wider national access review into primary care will be reignited. The review was originally due to be published in the Autumn of 2019 but was delayed due to the upcoming General Election.

It is not expected that there will be any information formally shared within the immediate future and therefore it remains sensible to engage the BNSSG CCG membership on the issues and considerations of how an access standard is created for our population.

5. Access Considerations Feedback from Primary Care Cell

The Primary Care Cell has observed and considered the experiences of GPs and their wider teams to capture some initial learning from the pandemic to support onward decision making in terms of changes to patient access, and the approach to a consistent offer of core general practice services and Improved Access and Extended Hours as we enter Quarter 2.

To date, the observations have included:-

- An initial drop in the volume of patients contacting their GP.
- Considerations of how one can build "trust", for a specific group of patients, when using telephone and video consultations.
- A growing appreciation that patients are more likely to contact their GP if the practice proactively contacts the patient to tell them what the arrangements are during the crisis or post crisis.
- An assumption that patients are more likely to trust the practice if changes to arrangements are made proactively rather than retrospectively.
- That there is a requirement to understand and highlight the inequity of moving to a more IT based general practice service.
- That all patients are entitled to register with primary care regardless of ethnicity, status and no fixed abode, among other vulnerable groups. While there are a few practices dedicated to serving these often hard to reach and atypical populations, many practices will have a patient population representative of these communities, registered with them. This raises questions of access, language (many will not have English as a first language) and confidentiality for these patients.
- Quality of communication on how to contact Primary Care remotely. Lack of materials available in alternative languages and ‘easy read’ guides. Video consultations may not be beneficial for certain patients and may take longer if an interpreter is required.
- In some cases, contact tracing may be required (e.g. infectious disease etc) and that can be very difficult to do if the only contact given is a phone number and will take some resource.
- Supporting the new models of hospital outpatients is going to require GPs to support holding patients in primary care safely using advice and guidance and other forms of monitoring.

- Not every GP / primary care intervention can be delivered remotely so, in any coordinated reopening there needs to be consistent processes in place to ensure that (for example) those with complex / long-term conditions who need certain interventions to manage their health can still access them, with the relevant safeguards in place. We should also take this opportunity to consider delivering some interventions at scale, for example, spirometry which is an aerosol generating procedure requiring more advanced PPE.

- Advantages of long-term ill / complex patients having one / possibly two regular GPs who can oversee their care noting (during a pandemic or not) it saves time and makes remote / telephone consultations more effective and less time-consuming.

- It is recognised that remote consultations are great in certain situations and should be part of the future offer, but must not necessarily become an automatic default. It is also noted that opportunities to build trust and discuss sometimes difficult messages are more value adding for all when attending in person.

- When considering primary care recovery a priority should be placed on high quality, high value activity.

6. Proposed Options to Respond to Access Requirements

Improved Access

For Quarter 1, practices were reimbursed for 45minutes of activity, and all performance metrics were relaxed in order to support income and initial Covid-19 response ahead of June engagement, options for Improved Access were proposed as below:

Option 1) Return to full service with reporting

Localities would submit plans to deliver as per usual process with One Care support. Plans should reflect seasonality of delivery in the usual way. A full service would mean plans support Covid-19 requirements including:

- Min 30 minutes per week (every week)
- A GP face to face offer somewhere in the locality at the time, then mixed with other skill mix, telephone, third party etc.
- An additional 1.5 hours every week day after 18:30 e.g. 18:30-20:00
- Available to all patients
- An offer on Saturdays / Sundays and Bank Holiday August

Risks:

- 3 weeks' notice to start of quarter 2 not enough to expect localities to organise full scale plans
- Covid-19 model not compatible with original aims of IA, e.g. face to face not a viable option

Option 2) Use additional hours for Core services

This option would allow the use of Improved Access to support the delivery of core services, noting the continued service pressures.

Risks:

- Double payment may be being offered depending on the appointment type. e.g. care home visits are already funded through LES. There are possibilities here to use IA to support flu clinics, and potentially other vaccination programmes.
- If a full commitment is given against this option for 45 minutes, the CCG would retain none in reserve for winter and results in problems as we would have no 'surge' capacity or funding.

Option 3) Reimburse for 30 minutes IA for all practices

Practices would be paid for providing services up to 30 minutes per week and in return would be asked to prepare and return an IA plan. Appointments would be ring fenced as IA in system to allow OneCare to report. This option could:

- Offer flexibility on the times e.g. not just 18:30-20:00 but could be offered if preferred
- Mandate a Saturday offer but retain flexibility on Sunday provision
- Remove the requirement for a face to face GP offer
- Offer additional capacity if in core hours (with appropriate evidence to support this)
- Be used to support 111 direct booking
- Specifically recognise how the change in model has impacted the population by locality and demonstrate how this addresses the potential lack of access for certain populations and any widening in health inequalities that have arisen as a result of the pandemic; e.g. this could be some limited face to face appointments where safe

Benefits:

- Saves 15 minutes per week to reserve for surge and winter delivery and allows some demonstrable IA delivery.
- Opportunity to respond and support those most disadvantaged by Covid-19 model

Risks:

- Requires notice to stand up model, and an ability to thoroughly assess the patient impact noted above and develop an effective response
- Risk of double payment if activity is in core hours – need to be sure it is additional capacity

- Does not comply with current guidance on IA; there has as yet been no regional direction as a national steer is awaited. This means that there is potentially some flexibility we could apply

Option 4) Suspend IA Delivery for Q2

Continue to fund One Care management costs for Q2 but suspend IA practice based delivery.

Benefits:

- Allows CCG to reserve funding / minutes for a bigger Q3/Q4 response
- Time to develop what the Q3/Q4 model could look like for winter/covid
- Localities would have more time to work thorough plans and focus on other COVID related asks

Risks:

- Practice income, staffing considerations / liabilities
- Access could be poor for patients / particularly those who are disadvantaged by the new model
- NHS E assurance, we would not be delivering and links into overall CCG assurance process

Extended Hours

NHS England and the core contract have not suggested any changes to the Extended Hours during the Covid-19 response. For Quarter 1, this was protected within the local arrangements confirmed in the letter from Lisa Manson.

For Quarter 2 it is proposed that Extended Hours are offered and used to support Covid-19 response e.g. appointments for those significantly affected by shielding protocols. This could be used for early morning appointments to allow shielded patients to utilise clean sites prior to regular appointment sessions for non-shielding individuals.

To support this approach, PCNs would be asked to submit plans to confirm delivery of a minimum of 30 minutes per 1,000 registered patients per week:

Additional minutes* = the PCN list size** ÷ 1000 × 30

It is proposed that appointments would need to be:

- Available to all registered patients within the PCN
- Can be emergency, same day or pre booked

- Delivered by a healthcare professional or another person employed or engaged by the PCN to assist that healthcare professional in the provision of health services
- Held at times outside of the hours that the PCN core Network practices contract state.

Performance monitoring would remain light-touch to recognise the ongoing local challenges, but would support overall response to increases in demand.

PCOG considered the options outlined for Improved Access and noted the feedback from membership along with recommendations from the CCG Primary Care Contracting Team. Option 1 was discounted as not being realistic or appropriate given the current circumstances and not allowing enough flexibility for future outbreaks or resource constraints. Option 4 was discounted as it was felt that resuming IA in some way was necessary for our population and to support the recovery process. Option 2 was considered as a possible approach, but would not provide the winter planning aspect.

It is therefore recommended that we proceed with Option 3 to stand up delivery from August 2020 and this has been discussed with Locality Leads and PCN Clinical Directors.

The proposal for extended hours was approved pending further engagement.

Feedback from Membership W/C 15 June 2020

The primary care contracts team presented the preferred options to clinical membership and locality groups across the week. It was evident from the early sessions that the anticipated start date of July 2020 for extended hours was not possible. Members fed back that this was not nearly enough time to respond. Therefore it was proposed to the Primary Care Cell and Localities that both schemes recommence from August2020. A further relaxation of some of the contractual requirements for extended hours was also considered. This included removing the requirement for a practice to make appointments available to all patients within in a PCN. It was noted that asking to patients to travel across multiple sites may not be suitable at this time.

A full summary of the requirements proposed is attached at Appendix 1

Extended hours will give the opportunity to provide some capacity outside of core hours. Improved Access can be used to provide some services in hours as long as appointments are ‘ring fenced’ for Improved Access and not double counted with Extended Hours appointments. Practices are beginning to approach with innovative ways to use this additional capacity and we will work to facilitate where possible. One Care will provide managerial support to practices in planning for the delivery of Improved Access from August 2020. It was proposed that practices are paid for the full 45 minutes of delivery but consider ‘banking’ 15 minutes for a surge during the ‘winter’ period.

Nationally, the review of access is still intended to be published. This will describe in detail how both Improved Access and Extended Hours will fold together to become a single specification that will be part of the PCN DES from April 2021.

Core GMS/PMS/APMS – Clinical Reference Group Review

System recovery principles have been agreed and shared with primary care and across the system. As we are now working together to recover as a system, a clinical reference group including CCG and LMC clinicians met and produced an iteration of a spreadsheet initially produced by the Royal College of General Practitioners and the BMA. The iteration attached at Appendix 2 incorporates local activity and initial feedback from wider primary care, Public Health, GP membership and Clinical Cabinet. We are not intending this spreadsheet to be used rigidly but rather as a flexible and helpful guide to support primary care recovery, and to provide some consistency of primary care services across BNSSG. It is anticipated that:

- The spreadsheet should ensure that health inequalities do not widen as a result of changes to the way primary care is delivered in Phase 2
- We need to give some consideration to the timing and method of review of this RAG rated activity; currently this is a weekly standing agenda item at Primary Care Cell
- We need to work with practices to map the activity across BNSSG and this will require co-ordination with the resilience work

Local Enhanced Services

It is anticipated that as activity recommences, the delivery of the majority of local enhanced services will return to pre-covid levels. Many of the requirements of the enhanced services are clinically appropriate and therefore activity will have continued during the covid-19 period. Guidance to support the delivery of each Local Enhanced Service during this phase will be circulated.

It has been agreed that the ADHD LES can be launched for delivery from 1 July 2020. Practices will be asked if they wish to sign up through an expression of interest exercise and the specification has been re-visited in light of covid. The requirement remains for the completion of an annual health check and a 6 month interim check. Once AWP are advised of the practices that have signed up they will begin to discharge appropriate patients. It is expected that the first patients will not be due for review until several weeks after the service commences. AWP have offered to host a training session for GPs to support sign up.

Primary Care Networks (PCN)

Primary Care Networks will be key to the onward delivery of services especially during the consideration and planning for future peaks. Income will continue to be provided as before Covid-19, and support from the CCG will be ongoing to recognise the benefits of the additional role reimbursement scheme and continue to recruit and respond to the DES specification where PCNs are able. Workforce planning templates are due to be submitted at the end of August 2020.

Quality and Outcomes Framework (QOF)

The National NHSE position on QOF for the remainder of the year has yet to be confirmed, however it would be encouraged that practices continue to support the framework wherever it is considered safe and an effective use of resource.

7. Feedback from Membership Engagement

Feedback from the PCN CDs/OneCare meeting has been described above but a more detailed summary is presented below, alongside CCG response:

- Concerns re timeline for EH and how we can flex this

It was agreed that the timeline would be moved from a July start date to August 2020 in line with Improved Access

- What is the approach for bank holidays

It has been agreed that August bank holiday model is not required through Improved Access. This may need to change if there is a national mandate.

- What if a practice cannot stand up weekend services for IA

We have relaxed the requirement around Saturdays and Sundays at this time though will support practices and PCNs that are able to offer this

- What is the flex for the flu vaccination programme to be delivered in IA

The delivery of the flu vaccination alongside the Improved Access programme will be discussed. This will require liaison and agreement with Public Health England and the CCG Medicines Management Team

- We need to be aware of the organisational challenge to stand up this work given the efforts of general practice during the pandemic
- How can we truly support the recovery work with IA and EH, bearing in mind the additional workload practices are incurring as the rest of the system phases into recovery as well, such as :

- Reviewing previously requested radiology investigations for up to date information at the request of secondary care
- Holding patients on a waiting list for referrals and reviewing this list regularly
- Alternative referral routes such as advice and guidance which may be higher value, but take more time
- Reviewing shielded patients lists and supporting patients with questions
- Covid-19 support to care homes response ahead of the PCN DES
- Patient demand now increasing to higher than pre Covid levels, balanced with constraints of social distancing, PPE and pressures on workforce

Innovative use of Improved Access and Extended Hours will provide a response and additional capacity to the challenges noted above. We are working with practices to hear their ideas and support where possible, whilst also being assured that we are addressing immediate issues around access to general practice.

Feedback on the core general practice activity spreadsheet has and continues to be collated, but the approach has been generally positively received; practices have also developed their own approach but this is largely consistent with this work.

Ongoing COVID 19 response

As we provide guidance for recovery of core and enhanced primary care services to practices we must continue to support the Covid 19 response. Key next steps are:

- Proposals for Primary Care Recovery to be shared with practices; specific barriers to rollout to be worked through
- Proposals for Primary Care Recovery to be shared with the wider system to ensure alignment with recovery in other key areas, such as urgent care, community services and outpatients
- Work to explore opportunities to undertake equality survey to assess those struggling to access services and tailor recovery accordingly
- Continue to support care homes and implement national guidance to support outbreak management
- Continue to support Covid Clinical Assessment Service (CCAS) developments
- Support 111 Direct Booking rollout
- Access – continue total triage but ensure that different modes of access are available dependent upon the needs of the individual
- Evaluate population health and consider the gaps and continue to measure population health and wellbeing throughout recovery

General Practice Resilience Programme

The General Practice Resilience Programme (GPRP) provides improvement plan development and implementation support for practices in greatest need. Practices participating in the GPRP will continue to be supported through the covid-19 recovery phase and what this entails in

terms of change and adaptation as required. The resilience of BNSSG CCG GP practices and the quality of care provided continues to be monitored via the Primary Care Quality and Resilience Dashboard as part of business as usual.

8. Investment and Impact Fund

In light of the Covid-19 pandemic, NHS England have postponed the introduction of the Investment and Impact Fund (IIF) for at least six months.

IIF Indicators	National Funding (£'000K)	CCG Share of Funding (£'000K)		Current Commitments (£'000K)	Year to Date Expnditure (£'000K)
Flu Immunisations	£8,000.0	£127.8	postponed		
LD Health Checks	£6,250.0	£99.8	postponed		
Number of patients referred to social prescibing	£6,250.0	£99.8	postponed		
Prescribing Incentives	£20,000.0	£319.5	postponed		
PCN Support Fund				£259.60	£86.53
Network DES Total Funding	**£40,500.0**	**£647.0**		**£259.6**	**£86.5**

40% of the funding previously earmarked for the IIF has been recycled into a PCN support funding stream, which is being paid on the basis of a PCN's weighted population at 27p per weighted patient for the six month period to 31 September 2020.

As yet, there has been no formal communication from NHSE as to the future requirements of PCNs in terms of delivery, and how the remaining IIF funding may be allocated from 1st October.

9. Engagement

Patient Facing

The CCG communications team are working with regional colleagues and with national team around shared messages for the public, but it is likely that this will need tailoring to each area and we will need to develop our own messages. The Communications team have updated PPGs to help them understand the changes implemented in primary care. This will be revised to pick up any changes presented in this paper. The primary care cell and primary care strategy programme board are working with the communications and insight teams to understand intelligence from the citizens' panel about how people are feeling, how they access care, and which groups may need a more tailored approach. We are also planning to work closely with the Patient and Public Involvement Forum sub group which has been established, and all of this will inform our future engagement plans.

GPs and practices

To ensure the proposals were proportionate and inclusive the issues presented in this paper were shared with membership and other fora as laid out below before coming to PCCC for approval.

Meeting	Date
Commissioning Executive	11th June
Membership	9th June (Bristol x3) 10th June (SG & NS)
PCOG	11th June
Primary Care Locality Sub Group	18th June
PCCC	30th June

9. Financial resource implications

There are no specific financial resource implications highlighted within this paper.

10. Legal implications

There are no specific legal implications highlighted within this paper. Any agreed change requests will be considered via separate papers and will include any relevant legal implications.

11. Risk implications

There are specific risk implications associated with this paper and these are outlined in Appendix 3.

12. Implications for health inequalities

The change in the way Primary Care is accessed made necessary through Covid has highlighted the need to look more closely at health inequalities. Monitoring of Primary Care performance alongside practice demographic information will help to highlight areas of variation of services, which will then be addressed accordingly. An Equality Impact Assessment has been completed on behalf of the Primary Care cell and is connected to this programme of work.

13. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

The change in the way Primary Care is accessed made necessary through Covid has highlighted the need to look more closely at equality and diversity. Monitoring of Primary Care performance alongside practice demographic information will help to highlight areas of variation of services, which will then be addressed accordingly. Recommencing Improved Access and Extended Hours is an opportunity to identify and address issues particularly affecting Access for patients. An Equality Impact Assessment has been completed on behalf of the Primary Care cell and is connected to this programme of work.

14. Consultation and Communication including Public Involvement

Whilst there has not been consultation and communication with the public in the production of this paper, patient experience and public involvement is recognised as an important factor in reviewing and gaining assurance regarding primary care services. It is proposed that in line with recovery plans, and the Insights and Engagements team, patient views are gathered and understood in terms of any ongoing access challenges to ensure these can be addressed.

15. Recommendations

The Committee are asked to support the approach outlined above to Primary Care Recovery.

Report Author: **David Moss, Head of Primary Care Contracts**
Geeta Iyer, GP Clinical Lead
Stephanie Maidment, Senior Contracts Manager
Jenny Bowker Head of Primary Care Development
Louisa Darlison, Senior Contract Manager
Report Sponsor: **Lisa Manson, Director of Commissioning**

Appendices

Appendix 1 – Improved Access and Extended Hours Proposal Presentation
Appendix 1 - Core work Q2 Recovery proposals as reviewed by GP Clinical Leads and Clinical Cabinet
Appendix 2 – Recovery Risk Register

Glossary of terms and abbreviations

DES	Directed Enhanced Service
QOF	Quality and Outcomes Framework
ARRS	Additional Roles and Reimbursement Scheme

Appendix 1 - Improved Access and Extended Hours Proposal Presentation

EH IA.pptx

Appendix 2: Core work Q2 Recovery proposals as reviewed by GP Clinical Leads and Clinical Cabinet

Task delivery status (RAG) Green - To be delivered Amber - To be delivered if possible Red - Suggest not delivered	Assessment as at 12/05	Considerations	Resources / Enablers (RAG) Green - In place Amber - Support Required Red - Significant challenge / barrier
Patients believing themselves to be unwell if requiring medical attention following initial remote consultation, including immediately necessary patients	Yes	Patients with possible COVID-19 should be separated from patients who do not fit case criteria.	Hot / Cold Sites localities work
Medication/problems that cannot be dealt by community pharmacy.	Yes	Remote review should be the norm unless there are overriding reasons that a face to face assessment is necessary. If possible recommend utilising PCN pharmacist if available. Consider 6-12 months repeat prescribing of 28 day supplies to prevent supply issues. Avoid lengthening supplies of repeat medication unless clinically indicated.	Remote access PCN Workforce
Investigations for immediately necessary conditions such as serious anaemia.	Yes	For patients on warfarin, if appropriate consider switching to DOAC.	Assume this needs to be face to face, hot cold sites
Symptoms consistent with cancer that may require referral.	Yes	Can this be performed remotely e.g. skin lesions by photo and postmenopausal bleeding for immediate referral	Remote access
Palliative care including anticipatory care and EoL conversations	Yes	Proactively complete Respect/ DNAR forms and prescribe anticipatory medications in advance of a worsening spread of disease	keep electronic prescribing, carer SOP, remote verification of death, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881838/medicines-reuse-in-care-homes.pdf
Wound management/dressings.	Yes	Encourage patients to self-care, providing dressing where possible	Patient Information
Acute home visits to housebound/residential or nursing home patients BUT only following remote triage and when clinically necessary	Yes	Encourage homes to purchase pulse oximetry probes, thermometers and electronic sphygmomanometers and use video calls to assess if possible	Remote access Supply of kit
Childhood immunisations. (inc those delivered in school?)	Yes	The aim is to avoid an increase in preventable diseases estates/model of care eg drive through	Face to face, hot and cold sites Hubs clinics
LTC reviews for those at higher risk, Review remotely where possible.	Yes	• T2DM with HbA1c>75, recent DKA, disengaged* • COPD with a hospitalisation in last 12 months and/or 2 or more exacerbations in last 12/12 requiring oral steroids/oral antibiotics, patients on LTOT time stratification - system pathways - greatest gain in shortest time - resp/diab (inc those hard to reach, medium HBA1C values), then CVD/HTN - Value. Also Mental health - not tick boxes (PTSD) • Asthma with a hospitalisation in last 12 months, ever been admitted to ICU, 2 or more severe exacerbations in last 12months (needing oral steroids), on biologics/maintenance oral steroids • Significant mental health with concerns regarding suicide or deliberate self-harm risk or currently unstable mental health (Consider using social prescribing teams for help) time stratification - system pathways - greatest gain in shortest time - resp/diab (inc those hard to reach, medium HBA1C values), then CVD/HTN - Value. Also Mental health - not tick boxes (PTSD)	Need advice from meds management Patient Information
If a commissioned service from general practice, blood monitoring for high risk medications eg INR, DMARDS, immunosuppressants etc	Yes	Depending on financial model	Need advice from meds management Patient Information

Dispensing , if a dispensing practice.	Yes		No issues noted
If commissioned, essential injections – e.g. Prostap, aranesp, clopixol, testosterone**	Yes	Consider teaching patients to self-administer if appropriate Patient Education	Need to check
Smears with previous high risk changes/treatment to cervix or on more frequent recalls	Yes	may need designated clinics Do all smears dependant on PPE and colposcopy clinics- GW to highlight disruption PPE	Locality working Hubs / Clinics
Postnatal checks – where possible combine with childhood immunisations,	Yes		Locality working Hubs / Clinics
Blood results review and filing	Yes		Remote Access
Routine vaccinations, such as seasonal flu, pneumococcal, shingles etc for all patients where they are recommended. Prioritise vulnerable patients in high risk groups, such as	Yes	patients with a solid organ transplant • undergoing active chemotherapy or radical radiotherapy for lung cancer • with leukaemia, lymphoma or myeloma at any stage of treatment • having immunotherapy or other antibody treatments for cancer • having other targeted cancer treatments which can affect the immune system • had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs • severe respiratory conditions • with rare diseases and inborn errors of metabolism that significantly increase the risk of infections • on immunosuppression therapies sufficient to significantly increase risk of infection • pregnant with significant congenital heart disease think about delivery, access, availability of vaccines - and equity	Locality working Hubs / Clinics
Med3	Yes	Med3 for first 7 days not required. No Med3 should be provided by General Practice for self-isolation past 7 days. Advise patients that a self-isolation note is available here: https://111.nhs.uk/isolation-note	Meds Management to comment
Contraceptive services	Yes	Be aware of the possible risk of increased pregnancies following isolation periods. Consider extending pill prescriptions for low risk patients without review. Specific advice is given by Faculty of Sexual and Reproductive Health https://www.fsrh.org/documents/fsrh-position-essential-srh-services-during-covid-19-march-2020/ Sam to forward table top doc - dept on PPE - FPC availability and extended advice as per FSRH	Meds Management to comment Patient Information
Complaints	With Support	Consider a standard response to delay formal response during COVID-19 outbreak Define complaint thresholds and process - to be thought through	Template response letter would be useful
F2F reviews of routine care for most at risk groups and those LTCs who do not meet the green criteria.	Yes	Remote review is strongly recommended, wherever possible. Depending on value and ?PIFU, likely to happen by default in time	Remote consultations

Blood monitoring for lower risk medications and conditions eg ACEi, antipsychotics, thyroid disease.	Yes	Consider increasing the interval of testing if clinically safe to do so	Meds management to comment
Vitamin B12 injections	Yes	Recent meds management advice released regarding lengthening intervals and converting to oral meds	Meds Management to comment Patient Information
Routine smears that are considered to be low risk	Yes	may need designated clinics Do all smears dependant on PPE and colposcopy clinics- GW to highlight disruption PPE	PPE
Mild self-limiting illness and worried well	No	advise to use NHS choices or seek local pharmacy advice first signpost, never see	Patient Information
Coil checks/change	No	(consider starting POP as an interim measure (also for those with contraceptive implant changes or needing depo injections)) Specific advice is given by Faculty of Sexual and Reproductive Health https://www.fsrh.org/documents/fsrh-position-essential-srh-services-during-covid-19-march-2020/ teach checks and see above	Patient Information
Ring pessaries	Maintain (Yes?)	I think we discussed this and agreed you would see these but please clarify	Patient Information
Minor surgery/joint injections	Yes	dependent on pt need - steroid risk and covid	Patient Information
Advice re self-isolation or information for employers and schools etc. Guide patients to national websites.	No	Websites	Patient Information
Travel vaccinations, insurance reports, medicals, non-urgent paperwork, DVLA medical examinations	Yes	dependent upon patient need - SARS and insurance reports deprioritise? Support not high value for pt	Patient Information
Ear syringing	No	(can advise to continue use of olive oil or arrange privately at a high street provider) dependent upon pt need/secondary care services/self care/PPE - context of covid. Aerosol Generating Procedure??	Patient Information
ECGs			
Spirometry	No	PPE/QoF/referrals - wider pathway discussion with Sirona/hubs	Patient Information
New patient registration medical examinations, unless clinically indicated.	No	don't do them specifically	Patient Information
Stop smoking clinics	No	Rename / rebrand, Could be held Mostly virtual/ Health promotion / Alcohol - PH - recovery phase	Patient Information
New patient checks, NHS health checks	No	split out - don't do new patient checks	Patient Information
meds reviews	Yes	DES - meds reviews, frailty, link with care homes and frailty MDT	Remote consultations
Frailty and >75s annual reviews	Yes	DES - meds reviews, frailty, link with care homes and frailty MDT	Remote consultations

For those socially isolated or more vulnerable, e.g. elderly, carers, learning disabilities, refer to social prescribing teams for help	Yes	Prioritise	Patient Information
Friends and family test and engagement with PPGs	No	split out - PPGs (OneCare and PPIF) engaged with service devt; FFT lower value	Patient Information
Engagement with PPGs	Yes	split out - PPGs (OneCare and PPIF) engaged with service devt; FFT lower value	No issues noted
Data collection requests unless related to COVID-19, DESs/LISs/LESs, audit and assurance activities, routine CQC inspections and reviews, appraisal and revalidation work	No	Unless guidance changes nationally	No issues noted
PCN Des Participation	Yes	Sign up not disrupted by covid work continuing	CCG support
Enhanced Health in Care Homes	Yes	Continuing with current timescales	CCG support
Early Cancer Diagnosis	Yes	Continuing with current timescales	CCG support
Extended Hours	Yes	Following National webinars, EH has been outlined as a Contractual expectation. However, we recognise the value in flexible delivery to support Covid-19 response and recovery	CCG Support to define ask
Learning Difficulties Health Check	yes	Advised to continue as per NHSE	CCG support
Minor Surgery	No	Assume not happening income is protected - indemnity cover?	CCG support / PPE
QOF Asthma	With Support	care homes, QOF QI	CCG Support
QOF COPD	With Support	care homes, QOF QI	CCG Support
QOF Heart Failure	With Support	care homes, QOF QI	CCG Support
QOF Non diabetic hyperglycaemia	With Support	care homes, QOF QI	CCG Support
QOF Early Cancer Diagnosis	With Support	care homes, QOF QI	CCG Support
QOF Learning Disabilities	With Support	care homes, QOF QI	CCG Support
Anticoagulation Basic	Yes	Assume continue due to patient safety	Telephone triage, online consults, PPE
Anticoagulation Advanced	Yes	Assume continue due to patient safety	Telephone triage, online consults, PPE
Specialist Medicines Monitoring	Yes	Assume continue due to patient safety	Telephone triage, online consults, PPE
DVT	Yes	Assume continue due to patient safety	Telephone triage, online consults, PPE
Insulin Initiation	With Support	Not sure if this is happening although should be clinically required -online training being developed to support	Telephone triage, online consults, PPE
GP Support to Care Homes	Yes	Assume continue due to patient safety	Telephone triage, online consults, PPE
Dementia	No	virtual? Equity of access? Carer input? Pt choice re modality	Telephone triage, online consults, PPE
ADHD	No	Not yet started dependant on AWP	AWP to discharge appropriate patients

LARC	With Support	Funded and commissioned through IA	Not CCG Commissioned / PPE
Improved Access	No	Delivery relaxed across quarter 1 - income protected	CCG Support to define ask

Appendix 3 – Recovery Risk Register

Name of Cell managing the risk	Description of change that risk relates to	Date logged	Description of Risk As a result of… There is a risk that…. Which may result in…	Mitigating Actions as described by the Cell managing the risk	Risk Owner (for updates)	Initial risk score (probability x severity)	Current risk score (probability x severity)	Date of Clinical Cabinet when change approved / discussed	Clinical Cabinet assessment of risk and subsequent decision	Date of Gold when approved / reviewed if appropriate	Clinical Cabinet Review Date	Notes
Primary Care Cell	Primary Care Recovery	26/05/2020	If primary care recovery does not have a consistent approach across BNSSG, there is a risk that health inequalities will widen	Developing approach to recovery involving wider primary care	Dr Geeta Iyer	4x4=16		TBC				
Primary Care Cell	Primary Care Recovery	26/05/2020	If primary care recovery activity is not aligned with system recovery plans, there is a risk that patients will experience delays in treatment with no mitigation	Discussion at Clinical Cabinet to ensure alignment with system recovery plans	Dr Geeta Iyer	5x4=20		TBC				
Primary Care Cell	Primary Care Recovery	22/06/2-2-	Recovery may be impacted or suspended by a localised Covid outbreak	NHS E Covid outbreak sitrep will be required when local outbreaks occur, practice will be supported accordingly	Dr Geeta Iyer	3x4=12						
Primary Care Cell	Primary Care Recovery	22/06/2020	A Practice individual resilience needs may impact on their ability to participate equally in the recovery programme	The Primary Care Development team to continue to work with practices to support resilience	Geeta Iyer	3x4=12						

	Risk Assessment scoring matrix					
likelihood of happening	Almost Certain = 5	5	10	15	20	25
	Likely = 4	4	8	12	16	20
	Possible = 3	3	6	9	12	15
	Unlikely = 2	2	4	6	8	10
	Rare = 1	1	2	3	4	5
		Insignificant = 1	Minor = 2	Moderate = 3	Major = 4	Catastrophic = 5
		Impact				

Current Status

	Extended Hours	Improved Access
National Position	No relaxation	No relaxation but recognition that current model not fit for COVID climate
Local Position	Payment protected (letter from LM 19 March 2020) requested that staff continue to be paid	Delivery suspended for Q1 payment protected, pragmatic approach to access requested
Delivery Requirement	30 mins / 1000 registered PCN population per week	45 minutes / 1000 weighted population per week
Current Funding	Paid monthly £1.45 per patient / 12 (£0.121 per patient per month)	£6 per head for 45 minutes per week delivery with management cost passed through to One Care, currently paid monthly
Proposed Re-start	July 2020	August 2020
Proposed Funding Level	No Change to above	Pro rata depending on delivery from August 2020. July payment at 30 minutes ??
Considerations	Local support of some relaxation to the contractual requirements (see slide) EH and IA coming together from April 2021	Local support for design of delivery noting existing aims not suitable. Opportunity to specifically address access issues relating to those disadvantaged to digital models / improve access to mental health support

Extended Hours

- **Deliver 30 minutes / 1000 PCN registered population per week**
- Appointments should be available to all registered patients within the PCN
- **May be for emergency, same day or pre booked appointments**
- **Are with a healthcare professional or another person employed or engaged by the PCN**
- **Are held at times outside of the hours that the PCN core network practices contracts require e.g. outside of core hours**
- **Must be distinguishable from IA appointments**
- Held at times having taken into account patient expressed preferences
- **Provided in continuous periods of at least 30 minutes**
- Are provided on the same days and times each week with sickness and leave of those who usually provide covered by the PCN
- **May be provided face to face, by telephone, by video or by online consultation** provided that the PCN ensures a reasonable number of appointments are available for face to face consultations where appropriate

Extended Hours – Opportunities

- Opportunity to deliver services outside of core hours
- Early morning sessions may be an opportunity to bring in cohorts of patients in a ‘clean’ environment if estate doesn’t allow clear segregation between hot / cold sites
- Slots could be used to provide face to face appointments if practices wish or could be used to deliver additional online capacity
- Local temporary relaxation of the rules could mean that slots are targeted at particular cohorts of patients for the benefit of supporting COVID response

Improved Access

- **Deliver a minimum of 30 minutes per 1000 weighted patient list per week** (no more than 45, consider banking for 'winter')
- Deliver weekday access at an additional 1.5 hours every evening after 18:30pm e.g. 18:30-20:00
- Deliver access to pre bookable and same day appointments on both **Saturdays** and Sundays
- Patients must be able to see a GP face to face
- **Some capacity can be provided in core hours** if supported by robust evidence of need
- Services must be clearly advertised to patients on practice websites / waiting rooms

Improved Access - Opportunities

- Relaxation of the face to face requirement would allow localities to plan services making use of the technological advances / models that have come about at pace due to covid
- Opportunity to use some IA to deliver services in core hours if demand is sufficient and to support covid response.
- Delivery plans should focus and address access challenges that have come about due to covid 19, for example a response for those who are disadvantaged due to the digital initiatives rolled out
- Plans could focus on the increased need for access to mental health services and could be designed to focus on those particularly disadvantaged due to covid
- Opportunity to ‘bank’ minutes for later on in the year, e.g. winter. Delivery should be no less than 30 minutes per week and no more than 45 minutes.

	Extended Hours	Improved Access
July		Develop plans for August delivery that take into account and address access issues in relation to COVID -19
Aug		• 30 mins / 1000 weighted • Additional appointments in core hours if required • Slots targeted and tailored to those who are disadvantaged through online models • Slots targeted and tailored to support MH needs of those particularly impacted by Covid-19 • Slots can be used to offer digital models of care • Slots can be in the evenings if desired
Sep	• 30 mins / 1000 registered PCN patients per week • Outside of core hours • Mix of same day / pre bookable • Mix of clinician or professional employed by PCN e.g SPLW • Face to face / online / telephone • Separate from IA slots	
Oct		
Nov		
Dec		• 45 mins / 1000 weighted plus any minutes 'banked from Q2' to support surge capacity (if needed) • Additional appointments in core hours if required • Slots targeted and tailored to those who are disadvantaged through online models • Slots targeted and tailored to support MH needs of those particularly impacted by Covid-19 • Slots can be used to offer digital models of care • Slots can be in the evenings if desired • Slots to support winter initiatives
Jan		
Feb		
Mar		
Apr	National plan still in place to merge both schemes to create 'Enhanced Access' into the PCN DES from April 2021	