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Brief to practices and CCGs / NHSE

Re the Third Phase of NHS Response to COVID-19

This letter published on the 31st of July will no doubt now have found its way into your inbox. We wanted to comment as your LMC on the aspects of this letter relevant to general practice.

We recognise the severe pressure that you have all been under in responding to COVID and now dealing with the increasing demands placed on you for non COVID activity. We are worried about the lack of understanding there may be within the rest of the health service about these pressures and, as so often, most of the attention appears to be on the acute sector. There are sections of this Phase 3 letter that give guidance on initiatives that will relieve pressure on secondary care, or allow them to address their backlog, but this can't be at the expense, intended or otherwise, of increasing the workload in general practice.

The language in the letter can also be interpreted as exerting pressure to return to "normal working." We know this is not going to be possible and you will have to continue using clinical judgement to address the most pressing and priority needs of your patients. The LMC will support you wholeheartedly in following this line and will resist any measures to pressurise you into doing more than is possible. We have a good working relationship and understanding with CCG and NHSE colleagues and will continue to work with them to sustain this message.

Regarding the specifics of the letter:

Cancer

> *To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.*

The LMC will take it that "work with GPs" means that we will liaise on your behalf with the Cancer Alliance and Local Trusts to ensure that there is no extra burden placed on general practice. We have had a number of instances where proposals from Trusts have blurred their clinical governance responsibilities and placed extra responsibility on practices. We have successfully challenged this and will continue to do so.

Elective Activity

> *Trusts, working with GP practices, should ensure that, between them, every patient whose planned care has been disrupted by Covid receives clear communication about how they will be looked after, and who to contact in the event that their clinical circumstances change.*

As in the case with Cancer referrals, any patients on a hospital waiting list remain the responsibility of the consultant. Any communication should therefore come from the hospital and if the patients condition changes, then they should get in touch through a hospital contact number supplied to them. Of course, the GP should be copied into any correspondence, so they are aware of the patient plan.

To further support the recovery and restoration of elective services, a modified national contract will be in place giving access to most independent hospital capacity until March 2021.

An unintended consequence of this initiative may be that GPs get used as an intermediary because of difficulties in direct communications between Trusts and private hospitals. The LMC will work with local systems to minimise such risks.

Collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties

Whilst advice and guidance is a useful tool to promote dialogue between primary and secondary care clinicians it is not a substitute for an outpatient referral and should not be used as such. In addition, certain specialities are less suited to advice and guidance as it can result in GPs having to interpret complex diagnostic results that are the province of the specialist. The burden and time-consuming nature of advice and guidance will result in an impossible pressure on already overstretched GPs if it is used as a vehicle for transferring outpatient work to general practice.

Restoring Primary Care Services

*General practice services should **restore activity to usual levels where clinically appropriate** and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed.*

We recognise that capacity is constrained but will support practices to deliver as comprehensive a service as possible.

The emphasis we as the LMC will pursue is the term “where clinically appropriate.” We will support all GPs to prioritise their work based on clinical judgement and the needs of their patients. The term “usual levels” is meaningless in this world of social distancing, stringent control of infection measures and constrained capacity. We will reinforce the fact that telephone and remote consultation is not quicker, or an easy option. They are more time consuming and involve more risk that face to face consultations.

We are also unclear on what “reach out proactively” means and will seek clarification from CCGs.

We will explore with the ICS and local CCGs what is going to be offered under the banner “support practices to deliver as comprehensive a service as possible.”

In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood immunisations and cervical screening through specific catch-up initiatives and additional capacity

Again, practices will already recognise this as a priority but may be constrained in their ability to make "rapid progress." We will enter into dialogue at ICS and CCG level to explore what additional capacity may be available and support with initiatives.

All GP practices must offer face to face appointments at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate

We as an LMC interpret this, and will support practices accordingly, as offering face to face appointments where clinically necessary. Remote triage / consultation should remain the norm to protect patients and staff from the risk of infection.

There is a separate issue of patients wearing face masks when they do come to the surgery for a face to face appointment. NHSEI has issued guidance that practices cannot refuse entry to patients who refuse to wear face coverings. The LMC strongly disagrees with this position and will support practices following a "no mask - no see" policy. Face coverings are intended to protect clinicians and staff from potential COVID-19 infection. There is no evidence that wearing a face covering can cause physical harm to patients, even those with respiratory or cardiovascular disease.

Practices should educate patients regarding the importance of wearing a face covering and should protect their staff from patients who do not wear them. Staff, including clinicians, are at risk of infection if they are within two meters of a person not wearing a face covering. Additionally, it keeps other patients attending the practice safe (including vulnerable and shielding patients).

Impact of Hospital Discharge Initiatives

There are a number of other initiatives where the impact on general practice is either not recognised or been ignored. We will work with the ICS to ensure that any impact is minimised, quantified and funded.

Community health services crisis responsiveness should be enhanced in line with the goals set out in the Long-Term Plan and should continue to support patients who have recovered from the acute phase of Covid but need ongoing rehabilitation and other community health services.

It is inevitable that those recovering from the acute phase of COVID will require ongoing medical support.

*From 1 September 2020, hospitals and community health and social care partners should fully embed the **discharge to assess** processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.*

We will be seeking clarification within each health community as to what this means and where clinical responsibility for patients in the initiative lies. There is no capacity within general practice to take on this clinical responsibility with all else that is being asked of general practice.

Admission Avoidance Schemes

There are two initiatives that give us cause for concern as they are likely to place a further strain on GP services.

Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly.

Whilst general practice is not cited as a potential disposition of these patients (it talks about Same Day Emergency Care, speciality 'hot' clinics and Urgent Treatment Centres) we are all aware of a long history of patients being inappropriately disposed of by 111 into general practice. The LMC will maintain vigilance on this to minimise any impact on general practice.

Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

Whilst we accept the concept of ringing before turning up at an A&E Department we await the result of local pilot schemes to test its feasibility. An unintended consequence, if barriers are erected around A&E access, is that more patients may revert to seeking an urgent appointment at their surgery.

Vaccination Programmes

Deliver a very significantly expanded seasonal flu vaccination programme for DHSC- determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

This is a very big 'ask' and general practice will need significant strategic leadership and support to harness the capacity, workforce and infrastructure to deliver these programmes in a COVID environment of stringent infection control measures, social distancing and inadequate estate. We will work with local flu groups and the ICS to ensure as much planning and support is given to practices in delivering these programmes.

Conclusion

Any one of the initiatives in this Phase 3 letter, requiring all parts of the health service to restore services, has the potential to put a severe pressure on general practice. We are aware of the 'extra mile' that GPs and their staff are already doing and have been for the last four months. It is difficult to see how this can be maintained for a longer period even without the new ask. Taken together they would appear to place an impossible burden on general practice - a 'Perfect Storm.'

We will be working through the Primary Care Cell across Lancashire and South Cumbria and with colleagues in North Cumbria to keep a tight rein on the situation. We are also active in each ICP area addressing interface issues between secondary and primary care.

Plans are developing in each CCG to be sensitive to the situation in each area as COVID takes its course and the normal winter pressures start to apply, so that services can be stepped down, or up in the light of circumstances, pressures and capacity to address priority issues. We will continue to be involved in this work to protect general practice and their staff.

We are always receptive to hear issues at first hand from you so do not hesitate to contact us if you have an issue or need help.