Royal College of General Practitioners

BMA Scotland

# General practice priorities in remobilisation

## Background/situation

The purpose of this paper is to outline the priorities for general practice and wider primary care that are jointly agreed between the BMA and RCGP.

General practice has remained open throughout the pandemic - including during the spring public holidays. The pandemic has had enormous impact on general practice, this includes:

- Patient contact with general practice has fluctuated – in the early stages of lockdown there was a temporary reduction in the number of patients who sought care with their practices for non-urgent conditions. Indications are that this is now rapidly returning to normal levels of demand with a backlog of new and chronic disease requiring management.

- Necessary infection control measures such as reduction in footfall into practices, social distancing and PPE requirements have meant that patients are accessing general practice in different ways – there has been a marked increase in remote consultations, estimated to account for around 90% of patient contacts.

- GPs and their teams rapidly assimilated new ways of working with increased triage and learned to use new technology for video consultations under challenging circumstances.

- Practices undertook risk assessments of staff, made physical alterations to premises and redesigned patient and staff flow to reduce risk of infection.

- The reduction of many secondary care services has required patient journeys to be altered and curtailed – many patients have had existing out-patient appointments postponed and there is also now a significant backlog of new referrals from general practice waiting to be seen in secondary care. Many of these patients require active support in the community while awaiting definitive treatment.

- GPs contributed the majority of the workforce to the COVID-19 Hubs and COVID-19 Assessment Centres (CACs). In some cases, practice staff have also contributed time to these centres.

- GP practices undertook and continue to undertake considerable work associated with shielding patients.

- Rapid expansion of Key Information Summary and Anticipatory Care Planning for patients was delivered by GP practices within weeks[1].

- GP practices have experienced a significant increase in the number of mental health presentations during the lockdown period; this is a combination of new presentations and worsening of existing mental health problems.

- General screening programmes were paused nationally.

- Routine Chronic Disease Monitoring activities were largely paused in favour of prioritising urgent activity around Chronic Disease Management.

- Primary care MDT colleagues, were in many instances, withdrawn from practices to support other parts of the health service.

**Capacity in general practice is reduced, for the foreseeable future. This is due to a combination of**:

- social distancing requirements and the necessity of PPE and cleaning between patients, meaning longer appointment times and gaps between consultations

- GP and staff sickness absence, self-isolation, and shielding requirements

- backlog of GP and practice staff leave

- necessary personal recovery from the sustained efforts of responding throughout to the pandemic in all the ways presented above

- The increased length of time required to conduct appointments over the telephone or via video-link compared to face to face consulting. These consultations take longer because a more careful and detailed risk assessment must be undertaken for many patient encounters without the availability of visual information to maintain safe clinical care.

**There is a general expectation that the pandemic has resulted in a considerable growth of unmet health needs – that will present in the remainder of 2020 and beyond. The predicted economic downturn is also likely to further worsen existing health inequalities linked to socio-economic deprivation. The medical, psychological and social impacts of this will be experienced in frontline general practice more than any other part of the NHS.**

[1] Recent data indicates that the number of eKIS almost quadrupled from the start of the year and covered ~17% of all patients in Scotland in the high risk and very high-risk groups. That is an increase from 338,691 patients with a KIS in January 2020, to 1,185,749 by the start of May 2020.

## Overarching priorities going forward for general practice

The Scottish Government and the profession have agreed through the 2018 Scottish GMS contract that the people of Scotland will be best served by general practitioners as expert medical generalists focussing on:

- Undifferentiated patient presentations
    - Seeing patients who are unwell or believe themselves to be unwell

- Complex care in the community
    - Leading a primary care multi-disciplinary team to deliver care to patients with complex health needs – for example, multiple co-morbidity, general frailty associated with age, and those with requirements for complex care
- Whole system quality improvement and clinical leadership
    - Through GP advisory and representative structures and GP clusters to be fully involved in assessing and developing services intended to meet the needs of their patients and local communities

**These remain the guiding principles and inform the specific clinical priorities for general practice in the remobilisation of the NHS in Scotland.**

## Clinical priorities for general practice living with COVID-19

General practice capacity is reduced by COVID-19 and will remain so for an extended period. This requires prioritisation of services that are provided by general practice to where clinical need is highest. Scotland cannot afford to be wasteful of general practice capacity, which would risk both deterioration in patient health and increasing impact on acute services. Patients should have access to care from other health professionals where appropriate, especially where continuity of care is less important. This will allow GPs to support more complex patients in the community.

General practice must focus on undertaking work that requires expert medical generalists providing care to those patients with the greatest clinical need.

This will include:

- undifferentiated presentations and complex care as outlined above – although often through different ways of working and remote access

- high risk patients (including those identified by the considerably expanded ACP work)

- long-term conditions management such as diabetes, respiratory and cardiovascular disease

- potentially a new disease area of post-COVID-19 illness

## Supporting general practice to deliver the clinical priorities

The following must be put in place to enable general practice to deliver on the priorities outlined above.

- The time resource of general practitioners is our most important resource, we must not waste it on activities where self-care is available or other healthcare providers can safely and appropriately deliver the service. We must use the time wisely to provide the care that the system needs, that includes anticipatory care planning of the most vulnerable patients including those in care homes, managing the significant amount of unscheduled care that presents in primary care and overseeing chronic disease management programmes and other health protection initiatives.

- **Equity of primary and secondary care focus in future iterations of health board mobilisation plans.** Health and Social Care Partnerships must also be involved in the development of the next iterations of mobilisation plans and there must be meaningful engagement with GPs and GP representative and advisory structures.

- **Establishment of appropriate primary care representation on interface groups through GP subcommittees.** Establishing general principles that services must be respectful of capacity throughout the system - no part of the system should impose changes on other parts of the system. A pan-NHS response is required, such that remobilisation and recovery in one part of the system does not destabilise or negatively impact on another part of the system.

- **Rapid development of Community and Care Services as outlined in the 2018 GP contract and Memorandum of Understanding.** Quickly establish and strengthen CTACs to provide the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring and related data collection.

  Enabling access to monitoring services, particularly phlebotomy, to support remote working by secondary care. This will require considerable expansion to the presently planned CTAC service capacity and would require identified additional funding to support secondary care access to these services to avoid impacting on the commitment to provide these services to GP practices and their patients. Expanding CTACs in this way will allow for collaborative primary and secondary care development of patient pathways which make best use of clinician expertise across the whole system.

- **Joint system responsibility for vaccinations and cervical screening.** Remobilisation is an ideal opportunity to develop new models for the delivery of major immunisation programmes such as influenza. Given the capacity restriction explained above, without a whole-system approach there is a very real risk that vaccination and screening rates will fall – or that waiting lists might develop. As neither vaccinations nor cervical smears absolutely require the relationship-based care best provided by general practice, consideration should be given to alternative parts of the system contributing to this work, during these exceptional times.

- **Infrastructure improvements** – to support necessary premises adjustments for social distancing and infection control.IT hardware support for remote working and digital consultation.

- **Improved IT provision.** There is good evidence that improved IT can improve efficiency, and many solutions are available off the shelf. Making short term grants available to early adopter practices to adopt systems allows rapid uptake and assessment for larger strategic IT decisions in the future. Board IT teams will require resources to approve software and provide some support to practices during working hours that mirror clinical working hours.

- **Repatriation of the expanded MDT teams and acceleration of delivery on the MOU commitments** to improve the ability for patients to be signposted to services which were agreed as appropriate and necessary to reduce GP workload pre-COVID-19 and which are required even more now because of the reduction in GP and practice capacity. Delivery particularly in the short term can be enabled by enhanced remote working for MDTs to minimise risk and overcome premises restrictions.

- **Significantly increase direct patient access to mental health support from services attached to general practice**, if necessary, by exploring options for remote consultations. Better understanding of the use of Action 15 monies particularly in the light of increased use of new access models.

- **Realistic public messaging on 'the new normal' to manage expectations and to facilitate effective patient engagement in new ways of working which will persist**.

- **NHS Scotland restatement of commitment to the GMS contract transformation and delivery of the MOU including the assurance of agreed funding to HSCP**.

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