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# Primary Care

## JHOSC paper – 27 November 2020

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# Summary and contents

This paper includes an update to JHOSC on primary care in NCL during the Covid-19 pandemic, including details of what impact the pandemic has had on primary care and the measures we have put in place to respond to key issues. Key factors have been maintaining and encouraging access to primary care, learning from the first wave of Covid, the need to tackle health inequalities and improved support for care homes. The second section of the paper focuses more on primary care support for local people with long term conditions, and at the meeting Dr Katie Coleman, a local GP, will talk through in more detail what this means for patients with diabetes.

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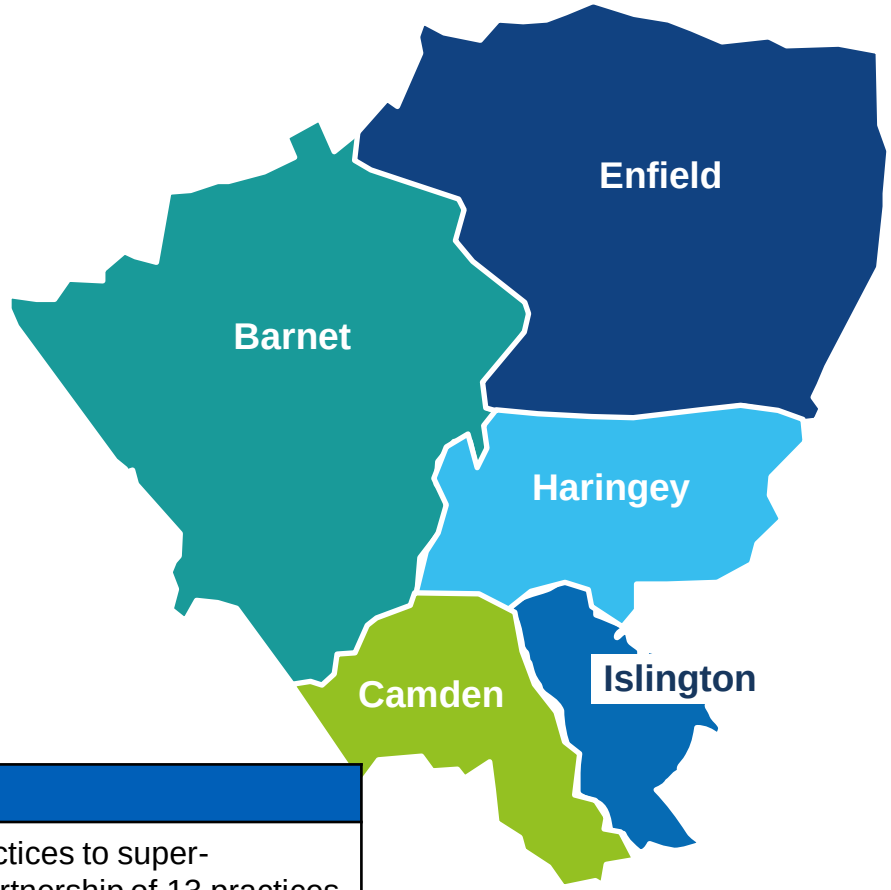
# Primary care in NCL

**Barnet**
Population: 425,395
Practices: 52
Clinical Lead: Amit Shah
Primary Care Networks: 7
Clinical Directors: 10
Federation: Barnet Federated GPs

**Camden**
Population: 303,267
Practices: 33
Clinical Lead: Dee Hora
Primary Care Networks: 7
Clinical Directors: 8
Federations: Haverstock Healthcare & Camden Health Evolution (CHE)




**Enfield**
Population: 425,395
Practices: 47
Clinical Lead: Fahim Chowdhury
Primary Care Networks: 4
Clinical Directors: 8
Federation: Enfield GP Federation

**Haringey**
Population: 298,418
Practices: 36
Clinical Lead: Gino Amato
Primary Care Networks: 8
Clinical Directors: 8
Federation: Federated 4 Health

**Islington**
Population: 257,135
Practices: 32
Clinical Lead: Imogen Bloor
Primary Care Networks: 4
Clinical Directors: 5
Federation: Islington GP Federation

**Practices & Primary Care Networks**

- 200 practices ranging from single-handed practices to super-partnerships e.g. Medicus (Enfield) - super-partnership of 13 practices
- Strong history of practices working together
- 17/18 NCL developed care and health integrated networks; 19/20 practices incentivised (NHSE) to formally form PCNs (30 in NCL)

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# General Practice: Summary of NCL Covid-19 Response

## Maintaining access to services

Support for general practice **and development of NCL model**, in preparation for both longer term Covid-19, and any increase in local incidence. Supported by/ **aligned with national Standard Operating Procedures** for General Practice, and Phase 3 guidance, the model includes:

- **Total Triage model –** following National GP SOP with all practices. Face to face appointments for patients who need them.
- **Roll out of online consultations** (99% of NCL practices); focus on digital inclusion as part of NCL GP Recovery programme
- **Maintenance of screening and immunisations** (including flu) and scaling of NCL referral support service
- **Patients to be managed remotely** as far as safely possible (from total triage to remote management with sats probes).

Model supported by access to staff testing and patient testing

## Supporting General Practice

**Range of tools developed to support general practice** in delivering care, based on principle that all patients seen in general practice will fall into high or medium risk Covid-19 pathways:

- Provision of **PPE**
- **Completion of staff demographic risk assessments** (practice sit reps for workforce related pressures)
- Roll out of **experiential infection prevention and control training (IPC)** to all NCL GP practices, and revised practice IPC self-assessment tool
- Confirmed **process for managing outbreaks in primary care**. Development of Covid-19-specific advice and guidance for GPs/ helplines for whole patient pathway from acute phase through to Long Covid, to assist primary care with complex cases
- **Maintenance of key communications** links with practices – weekly all practice webinars, GP bulletins, delivery of specialist training and education, and supporting communications for practices e.g. remote assessment e.g. sats probes, management of febrile children, end of life care, in collaboration with NCL Training Hubs

## NCL Covid Clinical Model

Face to face appointments where needed. **GPs follow appropriate and rigorous IPC procedures** to see all patients, including on home visits, whether patient has Covid-19 symptoms or not. Where a GP judges that their patient needs to be seen face to face, they will evaluate whether the patient requires assessment

- By specialist services - at hospital
- In the practice
- On a home visit

**Rapid mobilisation of Covid-19 symptom services** (April; initially site-based for confirmed/ suspected Covid-19 patients- CAG approved).

NCL's six GP federations **now delivering at-scale Acute Covid-19 service** with senior clinical triage, supported by remote assessment and monitoring (sats probes), and ability for GPs to refer for home visit, where own GP unable to see patients. Development of **agreed approach for scaling Covid-19-symptom services** up (or down) based on local incidence/ pressures

**At-scale service developed on basis of flexibility**, recognising possible requirement to scale up physical site-based services.

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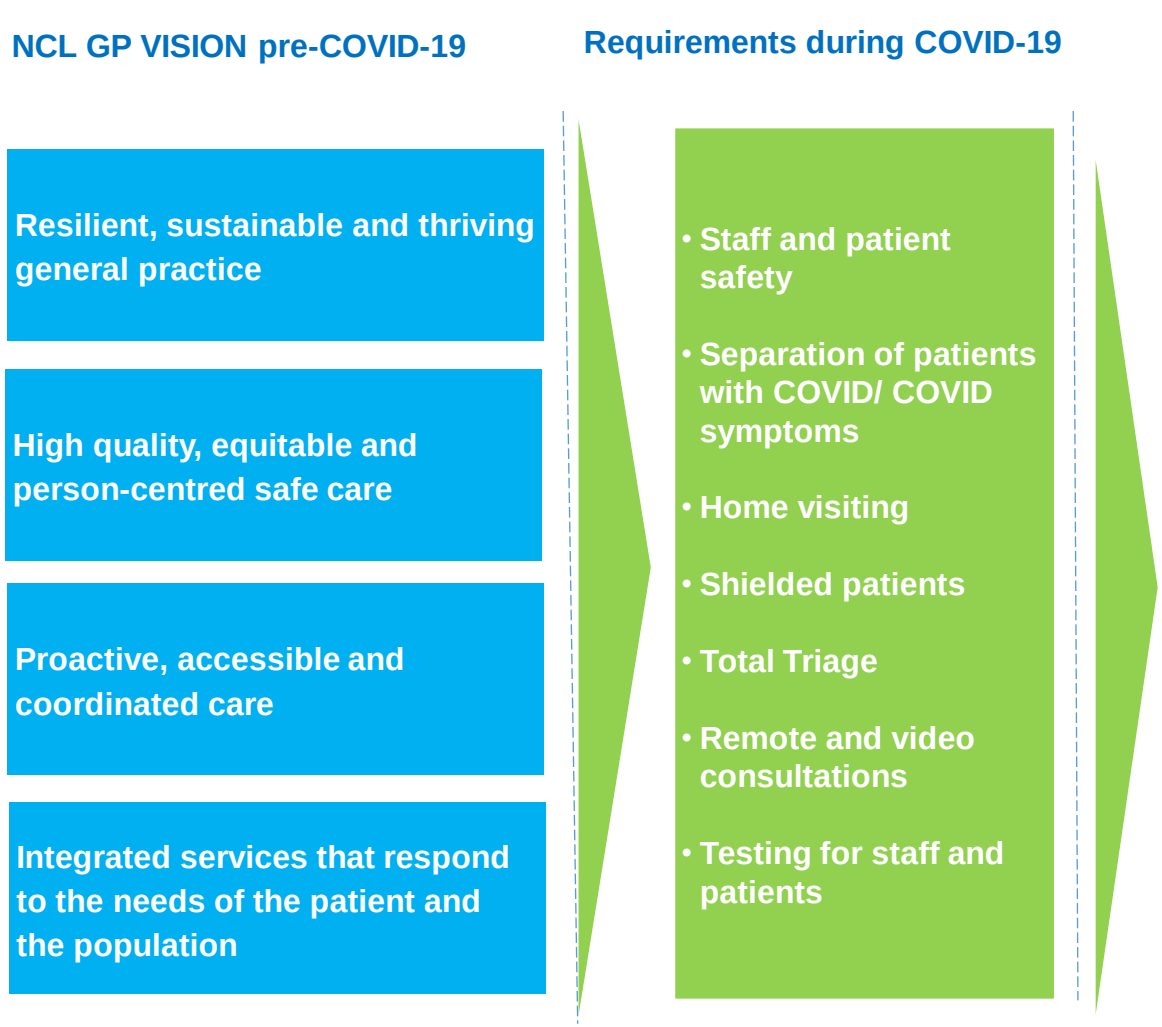
# General Practice: Learning from Wave One

## GP recovery

- Following the first wave of the pandemic, a GP recovery group for primary care was established.
- The group was tasked with drawing out the learning from the first wave of the outbreak.
- This identified three key areas of focus – ensuring patient access and patient experience, expanding multi-disciplinary working, supporting general practice and workforce resilience.
- These priorities reflect much of what was already a focus of the Strategy for General Practice (refreshed in 2018).



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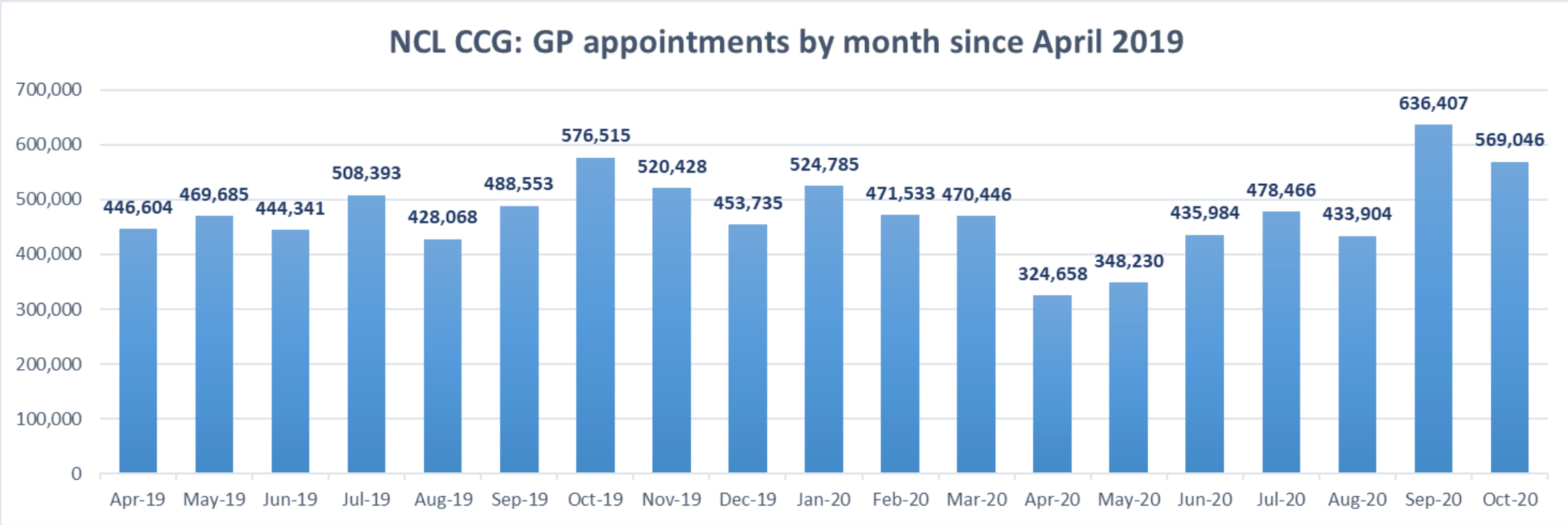
# Impact of Covid-19 on GP appointments

The reduction in GP appointments during April and May accruing from the Covid pandemic has reversed with appointment levels returning to pre-Covid levels, as practices reinstated planned care and chronic disease management work in line with national guidance, and people become more willing to make appointments. Whist appointment levels fell in April and May practices reported that this was offset by the acuity and complexity of patients being seen.



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# Patient access to general practice

- NCL **GP practices have remained open throughout the covid-19 pandemic**. The GP model of access has been shaped by national guidance - practices must operate a 'total triage' model i.e. patients triaged by telephone, video or online consultation and managed remotely wherever safely possible. Face to face appointments continue to be offered for those who need them.

- NCL Healthwatch data highlighted that the majority of residents were able to find required support and information during the first wave. **Many local people reported a positive experience of using digital health services***. However digital services are difficult for people who are not IT savvy, for whom English is not their first language or who have additional access needs e.g. learning disability or hearing loss.

- Further work is required to **enable digital inclusion**. All practices were asked to proactively contact vulnerable patients throughout the summer, and a pilot project is underway in Haringey which focuses on digital inclusion.

- Childhood immunisations, 8 week baby health checks and other essential GP work has continued throughout. National cancer screening programmes were restarted over the summer. All NCL GP practices have resumed cervical and other cancer screening activities. The NCL cancer alliance is running webinars to support primary care with updates on national cancer guidance and local pathway changes.

*Healthwatches in Camden, Enfield, Haringey and Islington surveyed patients in June 2020.

# Encouraging access to general practice

- iPlato message sent to all NCL residents over 16 years plus registered with a GP practice:
  Don't ignore new symptoms, your GP is here during lockdown to help and can offer telephone, video consultations and at the practice if required**.**
- NCL CCG social media, Accessing services - GP practices and importance of attending diagnostic appointments, Antenatal/Childhood Vaccinations, getting possible cancer symptoms checked
- Healthwatch Q&A in Camden with questions from public about general practice recovery and how we are dealing with covid-19.
- Camden Council Covid update in Camden New Journal. - If you're worried about your mental or physical health, need to speak to your GP, or have a scheduled appointment coming up, please know that local health services are still here for you.
- Forthcoming event with Healthwatch Enfield. Q&A with clinicians and the public on the impact of covid-19 and what services are open
- Self-Care Week event in Barnet – covers NHS is open and encouraging attendance at routine and hospital appointments, including vaccination and screening appointments
- Barnet First Magazine – Article reminding Barnet residents that the NHS is open and encouraging attendance at routine and hospital appointments, including vaccination and screening appointments

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# Responsive primary care – provision for care homes

**Implementing national guidance on primary care support to care homes –** clinical lead for CQC registered care homes. Provided enhanced clinical support to all care homes. Included development of new Barnet locally commissioned service and care homes clinical support team to deliver multi-disciplinary team reviews. Significant increase in primary input to care homes; many GPs undertaking daily virtual reviews. System working (including LAs, CCG, GP federations, PCNs and community providers) required to provide national service specification for *Enhanced Health in Care Homes* since October 2020.

**Co-created NCL tiered model of clinical support to care homes** – outlines basic, good and excellent clinical support to care homes, based on local knowledge and experience and national recommendations to develop the standard of care for NCL. Model focuses on personalised care plans and multi-disciplinary team working.

**Gap analysis: clinical support to care homes –** response to the Enhanced Health in Care Homes mobilisation. Collated quantitative and qualitative data identifying gaps in clinical support to care homes against guidance, and areas where significant clinical support is already provided.

**Establishing virtual consultations** – digital maturity assessment to establish additional requirements to deliver virtual consultations; how the Facebook Portals can be used to support. Equipment being procured for care homes. Development of training for care home staff and governance for care homes to undertake observations. Significant increase in care homes who have access to NHS Mail (now 190/225 or 84% at time of writing) – which enables safer information sharing. 300 Facebook Portals disseminated to NCL care homes, enabling residents to maintain family contact.

**Implementation of remote care home support/supervision –** Significant challenge to support care homes workforce. NCL training hubs developed a remote care home support/supervision offer to all care home workers from care home staff to GP clinical leads. Collaboration with HEE, NCL clinicians supported to develop facilitation skills, offer regular supervision sessions, and identify ways to ensure succession planning to ensure a legacy is in place.

**Pharmacy and medication**–medicines management teams developed policies on medication re-use in care homes, and stocking end of life medications in nursing homes to facilitate supplies and timely administration of medications. Pharmacy Cell and Care Homes Task Force supported implementation of structured medication reviews into care homes.

**NCL Webinars for primary care -** set up a series of fortnightly webinars for NCL GPs around Covid-19 and End of life care. Each webinar co-hosted by a borough GP and a consultant from one of the community palliative care teams. Subjects included updated guidance, advance care planning, death verification, PPE and supporting care homes. These have been transformed into monthly training and information sessions.

**Community Palliative Care teams -** Community services moved to remote patient support; phone via video consultation. Almost all Covid End of Life Care patients died in hospital so community teams focused on non-Covid patients at home. All community service teams increased weekend capacity during the Covid peak, available for phone advice seven days a week. Also offered virtual ward rounds to all care homes, assistance relating to death verification, supported clinicians and family members that had to do this. Daily meetings with district nurses to fully support patients at home, and that services supported each other.

Reviewing adoption and roll out of pan-London symptom control medicines authorisation and administration records (MAAR) chart

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# Health inequalities

**Outlined below are a few examples of how primary care services are tackling health inequalities.**

**Flu vaccination campaign**

- Higher national vaccination targets for 2020/21 flu campaign due to covid-19 context.
- Also national drive to increase uptake amongst BAME population and other cohorts that are more vulnerable to covid-19.
- NCL GPs have been given additional funding to support targeted approaches to those populations at greater risk of health inequalities.
- NCL communications team have worked with local GPs who speak other languages to translate materials into most frequently spoken languages in NCL.

**Enhanced health in care homes**

- There has previously been significant variation across NCL in the level of support offered to care home residents by GPs. E.g. Barnet, which has the highest number of care homes in NCL, did not have a borough wide GP service to support care homes.
- During wave one of the pandemic, an NCL steering group with local authority, CCG and GP membership to support rapid mobilisation of support to care homes.
- Since October, primary care networks in NCL are now delivering a national specification for enhanced health in care homes. This includes a regular virtual home round, personalised care and support plans, structured medication reviews and hydration and nutrition support.

**Digital inequalities pilot project – Haringey**

- The CCG and Healthwatch are setting up a pilot project in Haringey to train volunteers to take tablets/ smart phones to patients homes, allowing them to access GP, community health, mental health and acute outpatient appointments. This will be particularly targeted to patients who would otherwise be unable to use online services.

**Quality Outcomes Framework (QOF)**

- The QOF is an annual incentive scheme for general practice by which GPs are funded to deliver targeted activities e.g. annual healthchecks for patients with specific long term conditions such as diabetes, hypertension etc.
- The 2020/21 guidance requires GPs to take a population stratification approach to identify and prioritise the highest risk patients for proactive review – this includes those patients most vulnerable to harm from covid-19 such as patients from BAME groups and those from the 20% most deprived segments of the population.
- In NCL, GPs have been encouraged to use a range of risk stratification tools developed by UCL Partners to ensure that we are proactively targeting those parts of our population that particularly need support.

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# Long term conditions and Covid

People with long-term conditions are disproportionately affected by covid-19. It has also exposed a number of health inequalities that we need to address as we respond to the needs of patients with LTCs in primary care.

Since the end of wave one of the pandemic, an immediate priority has been supporting routine care, and ensure that primary care and community services, working together, reach out proactively to clinically vulnerable patients, particularly those whose routine care has been delayed or disrupted.

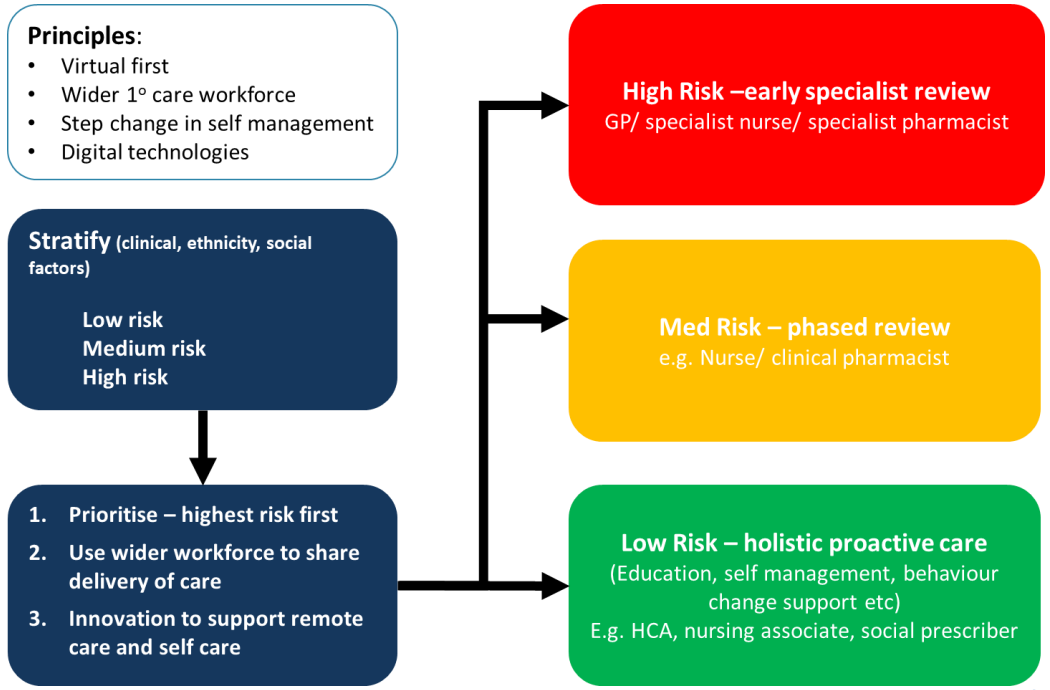
Doing this has required ensuring that primary care multi-disciplinary teams (MDTs) have the tools and skills required to do this work, drawing on expertise across the system, and making best use of enablers like data, risk stratification, workforce and technology.

UCL Partners developed a series of frameworks for local adaptation to support proactive management of long-term conditions in post-COVID primary care.

These frameworks were rolled out across NCL, and UCLP and the NCL training hub ran a series of training webinars for GP practices to support with proactive management of long term conditions within the Covid context.

NCL CCG has also recently launched a new project to support GP practices to increase patient self-management through virtual group consultations and remote blood pressure monitoring.

**UCL Partners Long Term Condition Frameworks for Local Adaptation**



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# NCL long term conditions programme

- Covid-19 has shone a light on some of the health and wider inequalities that persist in our society. Like nearly every health condition, it has become increasingly clear that Covid-19 has had a disproportionate impact on many who already face disadvantage and discrimination, and has a chronic trajectory that is only now beginning to become apparent. The impact of the virus has been particularly detrimental on people living in areas of greatest deprivation, on people from Black, Asian and Minority Ethnic communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations. Covid-19 risks further compounding inequalities which had already been widening. We need to mitigate these as far as possible.

- Developing a population health approach to improving outcomes for people with long term conditions will enable us to:
    - understand the needs of people who have long term conditions
    - Understand where inequalities exist
    - design and deliver improved models of care that span traditional service siloes and organisations.

- A whole system approach will enable collaboration across NCL providers and commissioners, learning from others to improve outcomes and to ensure service delivery is as effective and efficient as possible.

- The phase three implementation plan of the NHS response to the Covid-19 pandemic contains priority actions directly relating to the care of people with long term conditions. Over the past few months, a NCL long term conditions steering group has developed a response to Covid-19 in primary care and community settings to support patients with long term conditions who are most at risk from Covid-19. The NCL Local Care Forum has approved the formation of an long term conditions programme which brings together existing work (e.g. Diabetes transformation programme)

- Our proposed model of working has borough CCG, provider and public health teams leading on the development of different areas of long term conditions provision across NCL:
    - Barnet – Respiratory
    - Camden – Chronic Kidney Disease
    - Enfield – Cardio Vascular Disease
    - Haringey – Multi-morbidity
    - Islington - Diabetes

- Using the following model, and a population health approach, we will map existing provision and opportunities for improvement / spreading of best practice. We are testing this approach in Camden, who are currently carrying out this work for Chronic Kidney Disease, in acknowledgement that stage 5 patients have recently been added to the list of people who are clinically extremely vulnerable during the Covid-19 pandemic.

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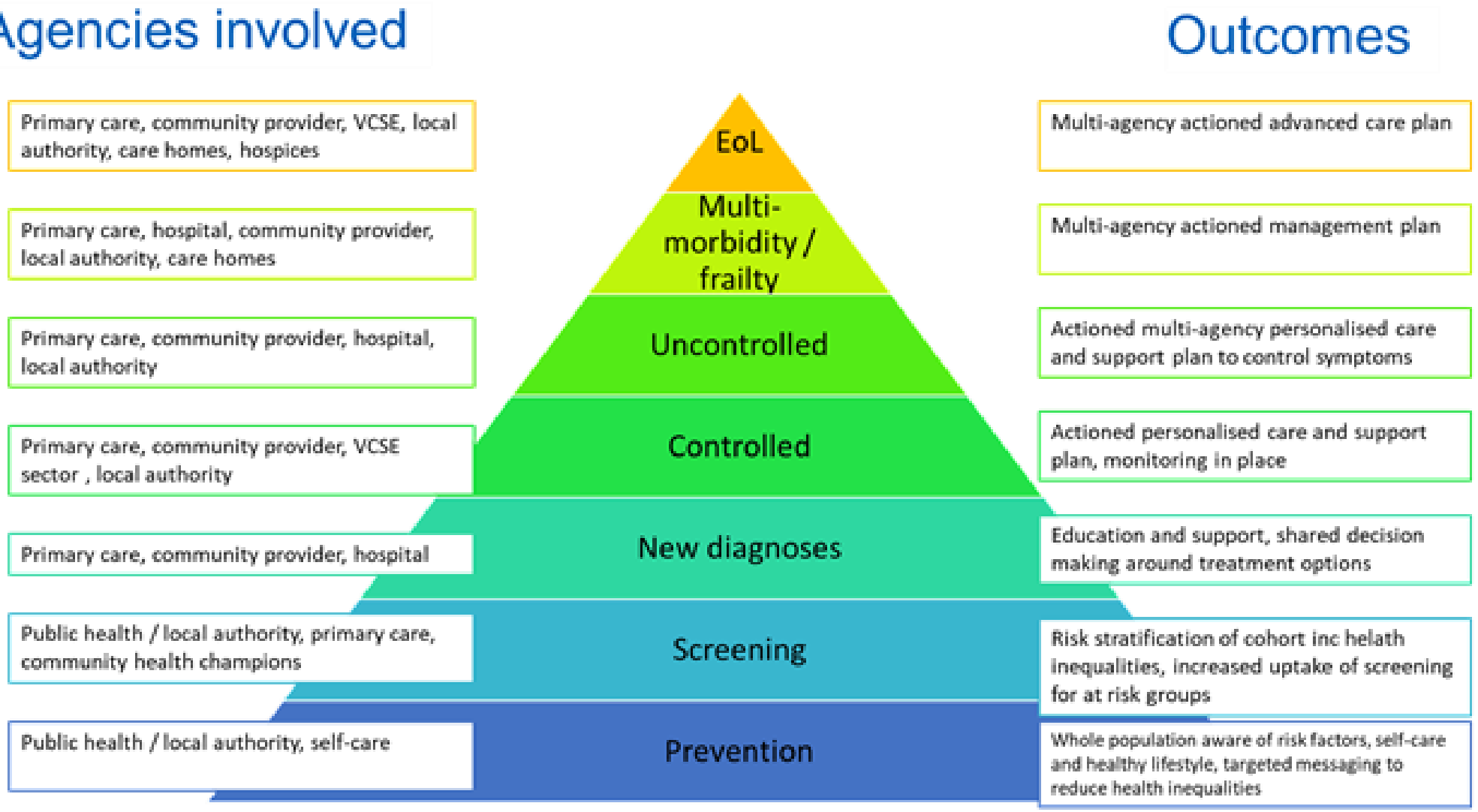
# NCL proposed long term conditions model of care




This shows the different health and care professionals involved and expectations for the different stages of the patient pathway for people with long term conditions and we'll talk through what this means for patients in more detail at the meeting.

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# Developing post-Covid Syndrome pathways

- Supporting people to recover from Covid-19 is a priority for the health and care system in North Central London – we are currently mobilising post-Covid syndrome (or Long Covid) pathways to meet the needs of people with symptoms of post-Covid syndrome. This has been designed with input from clinicians from across the health system, including General Practice, mental health services, hospitals and community rehabilitation providers.

- The pathway, approved by North Central London's Clinical Advisory Group, will cover everything from the identification of symptoms of Post-Covid syndrome, the investigations and assessments patients with suspected Post-Covid syndrome will need, through to attendance at post-Covid clinics and referral to specialist rehabilitation for those who need it. Patients' post-Covid mental health and social care needs will also be overseen as part of this pathway.

- Many services needed to deliver the post-Covid pathway already exist in all of our boroughs, and though they may differ in scope and availability, hospitals are already running post-Covid clinics in many areas. The focus is to make sure there will be a consistent offer for all patients in North Central London, so everyone receives the highest quality care based on latest clinical evidence, and that everyone who needs to be seen in a post-Covid clinic is identified and referred to one.

- A post-Covid Syndrome task and finish group formed to mobilise the pathway and report progress updates to NCL's Clinical Advisory Group and to our Local Care Forum. The key areas of work for this group are:
    - Modelling current demand for post-Covid Syndrome services in each borough based on available public health and hospital datasets
    - Rollout of a standard approach to managing post-Covid Syndrome in primary care, advising on assessment, investigations and symptom management
    - Development of a local care post-Covid multi-disciplinary team who will pick up complex cases either through primary care or hospital discharge and oversee their care planning and treatment
    - Engagement with acute providers to design a standardise advice and guidance offer to primary care and community services and to consult on delivery models for post-Covid clinics
    - Work with community providers, led by Central North West London NHS Trust on a safe and standardised rehabilitation offer in all boroughs

- NHS England/ Improvement have recently published national guidance on post-Covid clinics which we are incorporating into our standard operating procedures for the post-Covid Syndrome pathway. We will report our plans for post-Covid clinics to them as a condition of receiving future post-Covid Syndrome funding as a system. They will be monitoring delivery of the services through agreed service outcomes.

- As our understanding of PCS is still rapidly evolving we do not yet have data on expected prevalence within NCL but are working with public health to understand what the potential need for these pathways might be, and to ensure that patient care is provided equitably.