Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY

NHS

Surrey Heartlands

Primary Care Guidance for COVID-19

15 March 2020

CONTENTS

ADDITIONAL RESOURCES

COVID-19 : guidance for health professionals

Primary Care SOP

NHSE IPC Guidance

Live case tracker

Poster resources / campaign resources

NHSE online consultations implementation toolkit

accuRx COVID Toolset (Including Video)

EMIS Video Consultations Guide

Rapid change to modes of care delivery, infection control and business continuity planning is needed for a resilient primary care response to the growing burden on the NHS caused by COVID-19.

Guidance from NHSE and PHE has suggested a number of operational changes that providers of services can make. While we do not have the remit to mandate directed change, we have aggregated best practice for dissemination to members.

CONSULTING MODEL

NHSE has advised total triage as the normal state of service provision for PHC. This means that no-one should be arriving for a face-to-face consultation at a surgery without prior triage. Appendix A contains a full implementation guide.

INFORMATION GOVERNANCE

IG concerns have been listened to by NHSX and primary care should be reassured that the need for immediate delivery of alternate services has been understood. Providers should use tools they have available, including off the shelf products such as AccuRX, as well as specific medical solutions. Full guidance here.

Included in the appendices are a guide to using total triage/digital and telephone consulting.

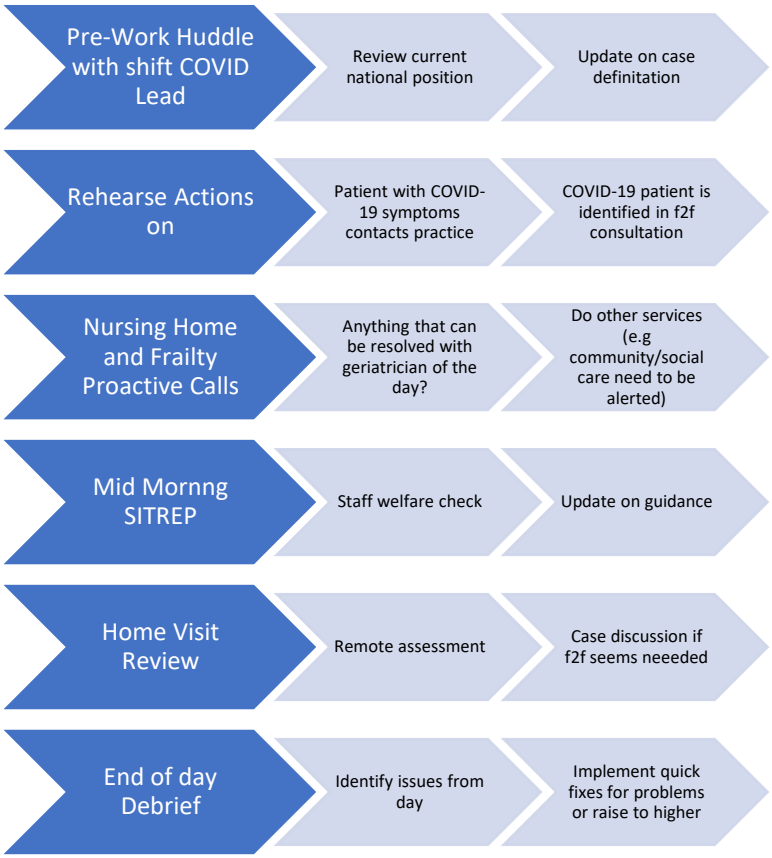
BUSINESS CONTINUITY PLANNING

It is likely that across Surrey Heartlands numbers of COVID cases will continue to rise with a consequent rise in exposure risk to practices. This will lead to practices at times being advised to temporarily close by PHE and staff being isolated either under direction or self-isolating. Preparing for this eventuality now will minimise service disruption. Some suggestions for how to approach this include:

- Name an overall COVID-19 practice lead who will monitor comms and brief staff
- Identify shift COVID-19 lead for each day
- Team separation:
    - A+B Teams who do not cross work (inc PM/Deputy PM)
    - Offsite working for staff where possible (including non-clinical)
    - Deputies for all critical positions who are briefed by the position holder in advance.
- Plan for possible practice closure and ensure there is a standard operating procedure for remote working to maintain as much service as possible
- Transfer prescriptions to EPS and eRD where possible
- Consider extending prescription lengths to a maxium of 3 months – our pharmacy colleagues are in the same situation we are, reducing footfall is helpful.

DAILY RHYTHM

In times of uncertainty, flow of information and routine reduces anxiety and allows co-ordinated action by team members. A suggested pattern to be adapted is below:



BOOKING CONTROL

NHSE guidance has been that practices switch existing bookable face to face slots into telephone triage ones as part of a move towards total triage.

- Consider use of the AccuRX patient screening tool for existing face to face appointments
- Consider whether you should be continuing to bring in vulnerable patients for routine appointments (e.g. QOF)
- Review requirements for AHCP appointments e.g. is every nursing care appointment strictly required (spirometry e.g)
- Are there ancillary services that use your building that are non-essential (e.g health promotion clinics)?
- Are there staff at risk that you need to protect?

ARRIVAL CONTROL

There will be a portion of people who will need to be seen in person, despite the most careful screening at point of triage there should still be mitigation measures in place.

- Turn off self-arrival units (patients may ignore notices and check in even when at risk)
- Staff checking in patients briefed daily on case definition and questions to ask
- Clear signage is available here from PHE

MANAGING RESPIRATORY/FEVER CASES

There may well be occasions where clinicians feel that despite guidance to self-isolate respiratory cases or cases with an undifferentiated fever, they have to deliver patient assessment in primary care.

This is a decision for individual practices and clinicians, but we would encourage reducing risk as much as possible.

- See cases in a pre-designated area
- Have separate arrival areas or have patients sequestered in their own transport waiting to be called in.
- Patient to be masked on arrival and brought in through alternate entry
- Move all respiratory cases to the end of the day (if not clinically urgent).
- Use PPE for a designated clinician seeing cases
    - IPC guide is here, please note PPE guides are (at time of writing) for secondary care but adaptable to primary care
- Strict decontamination between cases
- EMIS practices can use the Surrey Heartlands COVID-19 template for assessment and data capture (see Appendix 4). SystmOne practices already have this template in their Resource Library.

STAFF AT RISK

Many people working in primary care have pre-existing LTCs and/or medications that put them in a high-risk category. Though we have no clear guidance on these groups yet, a pragmatic approach is advisable.

- Remove at risk staff from untriaged appointments
- Remote working if possible
- Stress handwashing to all staff, not just clinical

RESIDENTIAL HOMES / CARE HOMES / HOUSEBOUND

These patients represent a vulnerable set of patients. There is scope for both morbidity/mortality and secondary impact on acute hospital services if there is a spike of illness and subsequent admissions.

- Liaise regularly with care/residential homes to understand and be able to anticipate pressures
- Remote assessment where possible. Freedom has been given by NHSX to use novel methods to do so without being paralysed by fears over IG.
- If visits are required, consider whether PPE is appropriate in order to protect both vulnerable patients and staff.
- Complete Respect/PACE plans proactively where patients consent (these may be completed within a remote consultation).

REMOTE WORKING

Practice resilience can be maintained with use of remote working both as a proactive measure and as a response to staff self-isolation. EMIS can be run natively and securely from CSU laptops.

- As well as the approx. 250 laptops already rolled out, a further 300 will be ready for deployment from week commencing 6 April. An additional 300 are being ordered. The total number of laptops (including those already deployed) per Practice will initially be allocated based on list size with one laptop provided per 1500 patients e.g. a Practice with 12,000 patients will receive 8 laptops in total.
- Away from my desk licenses are also being procured and allow clinicians and non-clinical staff to access a computer in the practice from a home device. Please note; this is only an option when there is a spare computer in the practice.
- With regards to use of VPN tokens, the IG guidance mentioned above (link repeated here) covers use of personal devices, which can be used if necessary .
- Footfall can be used to access digital consulting platforms from home (or equivalent digital providers where already in use)
- A number of suppliers have offered Video Consulting platforms and are available for use now:
    - accuRx is deployed in many if not all practices already, with video functionality enabled since 9/3. A simple SMS to the patient iniates the consultation, there is no cost to the practice.
    - EMIS have released their video platform on a free basis for the next 12 weeks. Bookings are made through Patient Access, so the platform is only available to patients signed up for online services.

Prepared by Dr David Triska, Digital First Primary Care Lead for Surrey Heartlands & GP Partner, Witley & Milford

v1.4 15 March 2020

APPENDIX A

SCOPE:

Pressures from COVID-19 mean that practices need to look at remote consultation models to both protect patients and staff from disease spread, provide resilience in their operating model and allow flexibility for future situational change.

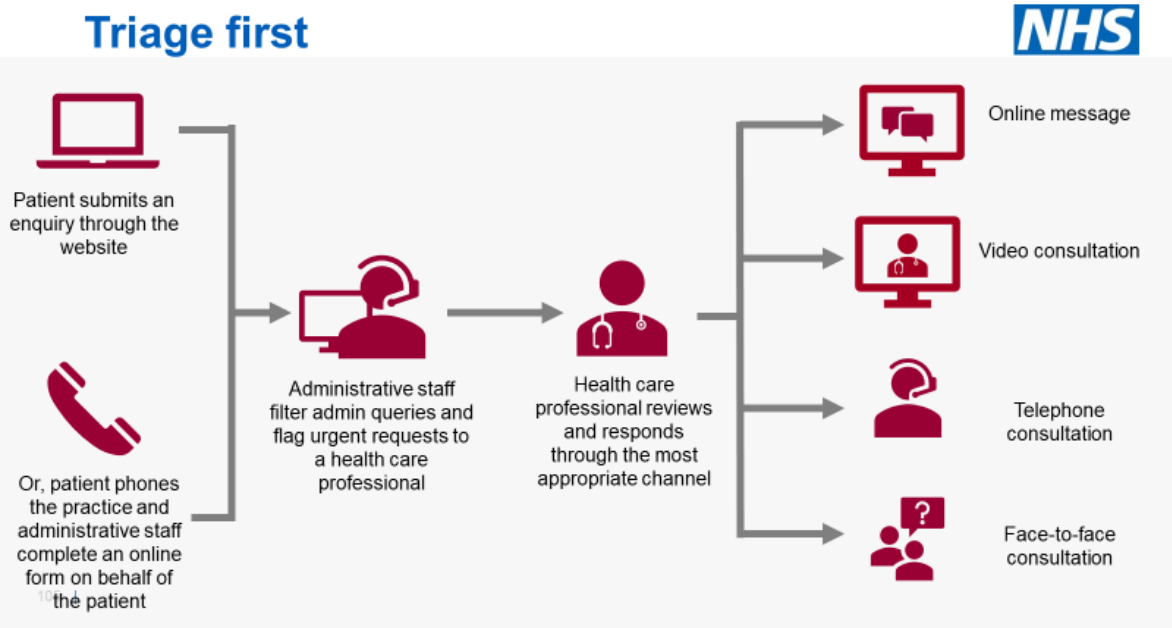
This document provides an overview of rollout phases, consulting models and practical implementation support.

PHASE 1: MODEL DECISION

1. ***Digital and phone total triage**:* offers equality of access for digital and non-digital users, efficiency for practices and in-built resilience by enabling more flexible remote working patterns and adaptable working patterns (i.e. custom appointment lengths etc). Does require rapid training of staff.

2. ***Phone total triage:*** Requires no additional equipment and can be implemented with minimal change. Allows adaptable working patterns (i.e. custom appointment lengths etc). Doesn't offer the scale of increased efficiency of digital models or the flexibility for remote working.

3. ***Current duty doctor/routine model with pre-booked converted to video (if no examination needed and/or it could safely be delayed):*** Most recognisable way of working with minimal change needed. Little resilience in this system with least efficiencies and less scope for remote working.



Both digital and/or phone total triage models share a common workflow design

PHASE 2: CAPACITY PLANNING

There will be provision to each practice of a predicated activity model customised to the chosen mode of delivery. This will allow foresight to the planned contacts per day and whether or not practices can meet the demands of their chosen model.

Should the operating model change at the practice's request the capacity planner will be reworked and provided again.

PHASE 3: REALLOCATION OF STAFF

Changing models of working will very likely cause shift of demand around the week. There is a fairly clear pattern of activity per day when working both in the total triage model and the more traditional model, if there is a significant change from a practice's current way of working they should be prepared to look at where sessions are needed to meet patient flow throughout the week.

PHASE 4: APPOINTMENT REALLOCATION/BLOCKING

Total triage (either digital and/or phone) :

- Select a date to stop taking forward bookings from.
- For any outstanding routine bookings that fall beyond this convert to video (comms to affected patients needed)
- Prepare staff to brief patients on why this is happening
- Adjust website / SMS messaging to frame why this is happening

PHASE 5: STAFF TRAINING RESOURCES

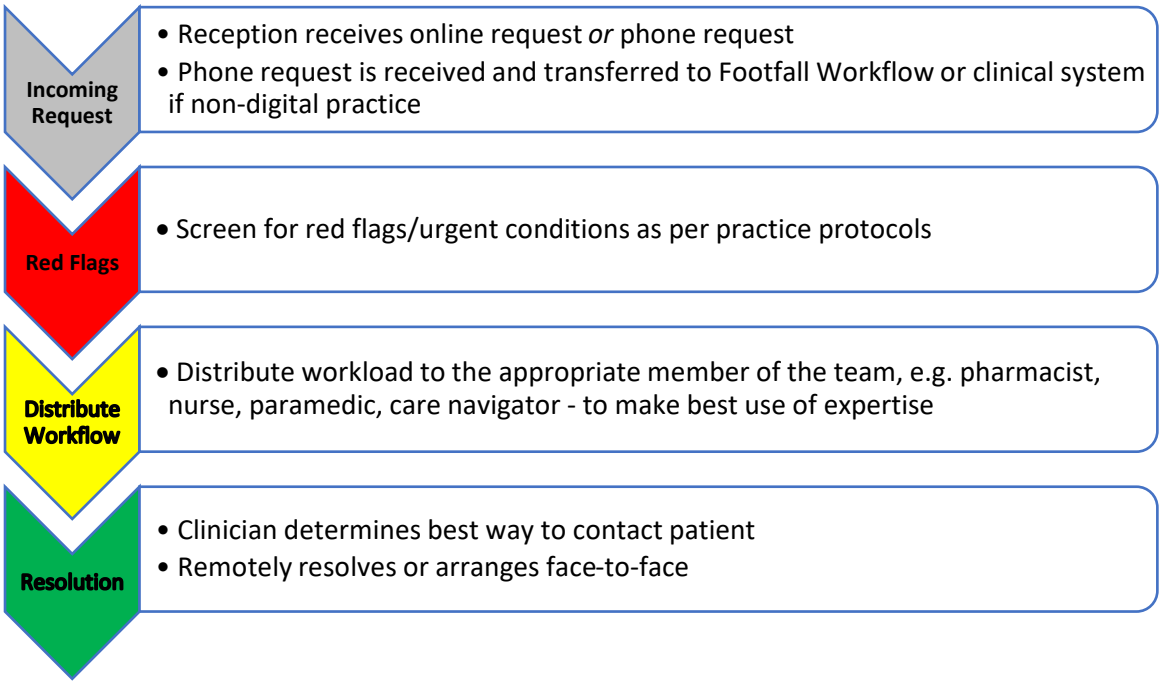
Rollout will be at a fast pace and resources are available online to start staff training right away. Links are provided below to training and resource videos.

Each practice that elects to use Footfall Digital Triage will have intensive individual support from both the Footfall team and Surrey Heartlands; we would encourage practices to utilise the online training resources prior to these inputs in order to make the most of the time.

1. Why use Digital First? - Introductary ideo from Dr David Triska
2. What Is Footfall? – Introduction to the Footfall website from Silicon Practice
3. How to use your Footfall Dashboard? – Introduction to the practice dashboard
4. What is Digital Triage and How to Use It? –Using Footfall to manage all patient requests

PHASE 6: WORKFLOW DESIGN

The final section before deployment is to determine how you process incoming requests. This will vary depending on your local protocols but should follow this general format:



Appendix B

GUIDE TO TOTAL TRIAGE FOR CLINICIANS

1. Remain calm when looking at your workflow. Remember that a list of consultation requests can actually be done very quickly. Use messaging where possible and if phoning patients keep the calls short if you know you will need a face to face review as a result.

2. Don't forget the online- patients lose confidence in using it if they don't get a quick response, try to keep responses timely and do not make online messaging worse than phone (they should be equitable). Efficient response times encourage as many as possible to keep using it as the most efficient method).

If there will be a delay to a response, let the patient know they have been heard with a pre-formatted message or you may find there is re-work through a subsequent phone call to the practice by the patient.

3. Do today's work today. Pre-booking things with others for the next day just makes the system grind to a halt and is the biggest cause of stress for most of the team. Try not to push things back, if a patient needs to be seen, ideally see them later on in the same session rather than booking later in the day wherever possible- this is a more efficient and sustainable way of working than having a surge of face to face appointments later on.

You can pre-book clinical reviews, but ask yourself is it really necessary? Often giving the patient a call on a day in x days/weeks time suffices- they may be fine and not wish to be seen and if they do, they can minimise the risk of DNA by agreeing a good time.

Utilise recall services like accuRx's Pathways to remind patients that you wanted to check in with them at a pre-set review duration.

Pre-booking lots of face to face ahead into your own clinics also just increases stress as your workload goes up. Look after yourself as well as your patients.

4. Structure your day how you like it, but find out what works best. The busiest part of the day for incoming requests is 08.00-1000. Only see emergencies face to face in this time if possible, or patients that need the convenience- but only for quick things.

Booking a predictably complex patient early in the day this time will set you up for a stressful session as you will be playing catch up. As a routine pattern of working, start seeing F2f at 10.30 onwards.

Space patients out allowing both adequate duration of appointment (e.g. 30 mins for a complex mental health patient) and time between appointments to allow you to catch up with referrals, calls and messages.

5. Utilise the other staff- ACHPs can see cases where appropriate and you can direct to the pharmacy or minor injuries for cases that are not appropriate to primary care. You do not need to see every patient the requires a f2f appointment.

6. Add value to the consultation for both the patient and practice. You can add NHS choices links to your replies online/sms to cut down on typing out lots of info. Don't forget to code advice given if it relates to QoF and to update any outstanding QoF items whilst speaking to the patient.

7. Make sure the patient knows about their appointment. If you are booking an appointment online for a patient, send them an SMS to make sure they know about it or consider a quick call. Some people don't check their emails and then inadvertently DNA.

8. Protect yourself from overwork. Do offer convenient appointments, but try offering specific slots first that would be good to fill- If a patient prefers afternoon, say 'I can fit you in at 2.30pm' rather than say 'what time would you like to be seen'

Appendix C

TELEPHONE TRIAGE GUIDE (COURTESY OF EGPLEARNING.CO.UK)

1. Before you start:

- Use a headset – it will provide better audio both ways (especially if you have a mic) and you hear your own typing less and will have free hands so you are more likely to document during the consult and hence save time.
- Check the reason for the call – look at the records briefly before you make the phone call, it really helps ie alerts, past medical history, recent contacts etc.
- Limit interruptions – ensure other staff are aware you are on the phone, we recommend having screen messages to pass information rather than knocks on the door as it will fluster you and make things longer.
- Establish the mindset of why you are calling. If using to assess the reason first and confirm an appointment is needed, this should be your endpoint. If it is to not see the patient, have routes in place to manage this first and the tools to help you like weblinks (ie nhs.uk or patient.info links, knowledge of which services can deal with appropriate conditions, leaflets etc. If it is just a review, focus on the issue you are reviewing.
- if you have a list with pre-triage information (via admin team or patient-generated) then screen for the cases that require your urgent attention either based on clinical need or likely to need to come down hence get them booked in first like children who most would have a lower tolerance for bringing in.

2. Consultation

Opening

Confirm who you are speaking with first:

- 3 point identification – name, date of birth and address.
- Check they are somewhere private to talk. If a parent or guardian speaking, confirm who (document) and that you have consent where applicable to speak to them. Use a macro to help document this.

Example standard opener

- *Hello, I believe you are expecting a call from the practice?*
- *May I just confirm your name, date of birth and address to confirm I have the right notes?*
- *Thank you, I am Dr X from Y Practice, how can I help you?*

Establish the history

Golden half minute – listen to what they are saying, jot down things if needed so you do not lose track.

When they stop check for other reasons for consulting. It enables a better structure for the rest of the consultation.

Establish what you are dealing with on the call and repeat back to the patient to set expectations.

Clarify the bits you need. The important decision you are making is 'do I need to see you or not'. Your aim should be to answer this question first.

If you make a decision to see early, check safety and appropriateness and book an appointment. Don't spend lots of time consulting on the phone

Clarify deeper–if short of breath – what does that mean? If not drinking – how much? If they have vomiting, how many times/what/when etc? **Be specific**.

If the patient is giving unclear answers – go to closed or yes/no questions to get the info you need.

Listen and check for 'hard' evidence – the way they breathe, speech flow etc. If able check pulse /stand on foot etc.

Do not feel rushed. Many see telephone consultations as a quicker route. IT can be, however, I still have had 20 min telephone consultations as it was the most effective way of dealing with the patient.

Plan

Summarise and repeat back-it makes a massive difference later.

Repeat for each issue before going to plan.

Explain your plan based on the information they have given.
If you have options state how many first then explain.

'You said….. So my advice is…..'
Most patients will accept the information you give if you have done the above. Some will want something different. This is where the summarise and repeat back is invaluable as you can refer to this with facts relating to the patient.

Where possible summarise plans to patients using an SMS service to avoid confusion and provide Patient Information Leaflets/Links for safety netting

3. Tips

- Establish the boundaries of convenience vs urgency. It is great when both work but do not be afraid to challenge issues relating to patient need vs want.
- If you are not planning on seeing the patient that day – give plan and safety net. Be specific. Document this clearly.

- Be clear on safety netting. Saying “Call back if worse” is unclear advice – what does worse mean? Use links/PILs via SMS where possible to better advise the patient and protect yourself medicolegally.
- Use accuRx or equivalent to send standardised COVID-19 Florey (questionnaire) and patient information leaflets in line with latest guidance.

Appendix D

COVID-19 CLINICAL TEMPLATE

Please find below an EMIS COVID-19 template and protocol contained in a zip folder. Please note, SystmOne practices have an equivalent template available to download from their Resource Library.

Surrey Heartlands
COVID 19 EMIS Resou

EMIS template installation instructions:

1. Double click on the embedded zipped folder and save it to the desktop or an easy to find location
2. Right click the folder and select “Extract All”
3. Save the file to the desktop or easy to find location
4. Go to EMIS Web, click the EMIS ball, go to configuration and select template manager/resource publisher
5. Select a folder. On the ribbon bar click “Import”
6. Navigate to the folder you saved earlier and import both the template and the protocol. It tells you that things will be overwritten, this is fine
7. Once both are imported, the protocol will need to be added to every relevant staff member’s F12 protocol launcher
    a. Press F12 on the keyboard
    b. Select an empty slot
    c. Right click and select add
    d. Locate the imported protocol and press OK