

Version 4.1

Disclaimer

The following guidance is developed by the xxxx Medical Practice and does not represent expert advice. We are working with the available information in a proportionate and pragmatic way, minimising risk to staff and patients. Anyone who follows this guidance does so at their own risk and their own volition. This plan is subject to change

coronavirus disease (COVID-19)pandemic  
PRACTICE Action PLan

Xxxxxx Medical Practice

# Background

We are moving to the mitigation phase of management of the pandemic1

Until an effective vaccine is developed general medical services will be delivered in a different way

We have made the following assumptions in preparing this guidance

1. the COVID pathway for symptomatic patients will continue.
2. that asymptomatic patients are assumed to be COVID +ve2
3. Practices will experience chronic reduced capacity due to team members self-isolating.
4. Practices will have reduced capacity to assess and treat problems due to the challenges of F2F assessments and reduced availability of investigations, out-patients etc.
5. Practices will provide essential services only until further notice and may need to change again at short notice should circumstances change

Some historic clinical activity will need to cease as clinicians will apply COVID ‘BRAN analysis’3 (Benefits , Risks, Alternatives, do Nothing)

This guidance aims to help practices adjust to the ‘new normal’

## GP Appointments

* 1. Signposting to a modified 3 Before GP4, MDT and 3rd sector resources is vital to ensure there is enough GP capacity to manage demand.
  2. The vast majority of GP consultations will be phone or video with Face to Face (F2F) contact only for focused examination or investigation where that will change management.
  3. eConsult consultation by email may be used by some practices.

## Home Visits

* 1. As with all F2F contact, home visits should be avoided if it is possible to safely assess the patient over the phone or video.
  2. A relative or carer may be able carry out observations if they are already in contact with the patient using BP/temp/sats kit borrowed from the practice and can facilitate video consultation. This should not be done if it would be introducing a new person to the household.
  3. This sort of approach should also be used when assessing care home patients. Care homes may have the facility for Near Me consulting and equipment to measure basic vital signs.
  4. District Nurses / other MDT members requesting a GP opinion should speak to GP directly to discuss problem. E.g. consider ‘Near Me’ whilst team member there

## Shielded Patients

* 1. Shielded patients who require F2F contact should be assessed and managed in the most appropriate setting following a risk assessment by the clinician taking into account clinical need and infection control. This will normally take place in a ‘super -clean’ area of the practice or ‘drive – through’ facility (see later)

## Chronic Disease Management

* 1. In the initial phase practices postponed chronic disease management clinics but the key element of this work is the discussion around lifestyle and self-management which can be done via phone or video.
  2. This is an opportunity to think about how you manage patients with chronic diseases and make sure that any testing and monitoring is actually adding value and done in conjunction with the patient rather than continuing to pursue the rigid metrics based review system encouraged by QOF.
  3. Hypertension can be monitored remotely if the patient has access to a BP machine or can be loaned one. The Florence texting service may be useful in encouraging patients to self-manage. <https://vimeo.com/389976964> is a useful video to share with patients by text/ put on your practice website/Facebook page.
  4. Some monitoring bloods may still be required but thought should be given to whether the results will change management and the principles of Realistic Medicine / BRAN need to be considered.

## Treatment Room Services

* 1. Some F2F wound management will be necessary, but it may be possible to train patients or their families to change dressings.
  2. Ear syringing should be avoided as non-essential.
  3. Phlebotomy will be required in many cases and care needs to be taken to do this in as safe a way as possible as many of these patients will be vulnerable.
  4. Liquid nitrogen for warts/verrucae should not be done as other treatments are available which do not require F2F contact. This should not be restarted in the future and any necessary cryotherapy services should be commissioned by IJBs
  5. Vitamin B12 injection advice is available via refHelp. We need to pursue oral B12 treatment as an alternative once supplies are available.

## Minor Surgery

* 1. Surgery for lesions which are clearly benign should be avoided.

## Enhanced Services

All non-essential Enhanced Services will remain suspended until 30/9/2020. Monthly and quarterly payments for all enhanced services will continue based on 2019/20 payments as part of practice stability plan (see Appendix 1 )

## 6-8 Week baby checks

* 1. These are felt to be essential and should continue to be done.
  2. If the 8-week immunisations take place at the practice, then it would make sense to schedule the baby check at the same time to avoid two visits.

## Immunisations

* 1. Immunisations apart from travel, pneumococcal and shingles vaccines are essential and should continue. These will continue to be managed by the vaccines team but with modified processes to ensure minimal contact between patients.

## Contraception Services

* 1. Contraception reviews for POP are not required or can be done remotely.
  2. COCP reviews can be done remotely with height and weight measured by the patient and blood pressure recorded on patient’s own monitor or loan monitor.
  3. Change of Implants and IUD/IUS can be delayed for a year as per FSRH advice but new coils or implants should be avoided unless no alternative is suitable – clinicians will make individual risk assessments based on patient circumstance.
  4. Sayana Press can be used in place of nurse administered depot injections.
  5. Emergency contraception is still available at community pharmacies. Emergency coil may be the only option in some cases and would be done in the usual way.

## Screening

* 1. The majority of screening programmes have been paused; we await word on when screening that affects practices will recommence. Cervical screening will significantly increase F2F activity for nursing teams.
  2. Screening systems for hypertension will need to be set up remotely. CQLs may take a lead to support practices / HSCPs develop effective systems.

## Prescribing

* 1. Ordering and collection of prescriptions should not be in person. Making full use of the Medicine Care and Review service (previously called CMS) will reduce the administrative burden in issuing stable regular prescriptions.

## Fit Notes

* 1. Fit notes for self-isolation are available from NHS 111 website
  2. Fit notes for other conditions should be posted rather than collected in person
  3. Self-certificate forms are available from the gov.uk website

## HGV Medicals

* 1. Patients due HGV medicals will be issued with a one-year license without the need for a medical examination or D4 form. They just send their renewal without the D4 form. The exception is diabetics on insulin.

## The 2018 GMS Contract in Scotland

15.1 Although the pandemic has led to a temporary pause Phase 1 of GMS Contract in Scotland, we have an opportunity to design services that support practices through the pandemic and beyond. GPs through their GP sub-committee need to co-design systems with our HSCP/NHSL partners to ensure that all these F2F services are sustainable and effective

## 

## Infection Control Measures

* 1. It is important to consider all processes that reduce footfall (see version 3 Practice Action Plan). Keep F2F encounters to the minimum necessary.
  2. Clinical spaces should be clutter-free with easily wiped down surfaces.
  3. Chairs should be wipeable, not fabric.
  4. Hard surfaces in consulting rooms should be wiped down with appropriate disinfectant / detergent wipes between patients.
  5. Team members should wash or decontaminate their hands frequently throughout the day, and particularly between each patient consultation. Hand hygiene should be extended up the arm.
  6. Reception areas should be arranged to provide 2 M physical distance between patients and staff. A screen can be used, or staff should wear a surgical face mask if physical distancing cannot be maintained. Patient self-check-in systems should not be used.
  7. Staff should also maintain 2M physical distance from each other during work. Staggering hours of work may facilitate this. Staff may be able to work from home at times. Break times should be staggered, people should use their own cup and avoid communal food. Open food storage should be avoided. Clean surfaces regularly in communal areas.
  8. Work clothes should be washed at the highest temperature they will tolerate in a half-filled load and not contained in a bag. Clothes or uniforms should be tumble dried or steam ironed.
  9. Equipment loaned to patients should be cleaned in line with the manufacturer’s instructions or using detergent wipe, chlorine (e.g. ChlorClean 1000ppm) or alcohol wipes on return. All equipment must be stored dry and in a way which prevents contamination from the environment. Any equipment which is more difficult to clean and if visibly contaminated may have to be used as single patient use and disposed of after use
  10. Patient waiting areas – increased environmental cleaning is advisable. Twice daily cleaning with monitoring/vigilance by staff is sufficient. As a suggestion, this could be achieved at the end of 2 distinct ‘sessions’ – morning and afternoon. The first clean should address any debris/obvious contamination and cleaning of frequent touch surfaces (chairs, keypads, door handles etc). The second/final clean at the end of the day is a more thorough clean by domestic staff6.
  11. NHS Lothian Infection Control policies, guidelines and information are available on NHSL intranet.
  12. HPS guidance for primary care is available at <https://www.hps.scot.nhs.uk/web-resources-container/covid-19-guidance-for-primary-care/>

## PPE

* 1. Droplet PPE – plastic apron, gloves, fluid resistant surgical mask plus eye protection (e.g. visor or goggles) should be worn when seeing all patients including shielded or vulnerable patients.
  2. The mask and eye protection, if worn they can be used for a session (up to 4 hours continuous use), but the gloves and apron should be changed for each patient.
  3. Masks are required when in shared spaces where 2M physical distancing with colleagues difficult is unachievable and at all times when seeing patients.
  4. Sessional use of masks is recommended
  5. Masks and eye protection should be disposed of if removed for any reason, or if it becomes wet, visibly contaminated, damaged or uncomfortable.
  6. Hands must be decontaminated before and after putting on/removing or touching PPE.
  7. PPE must be removed for meal breaks and before using the toilet.
  8. Refresher training on correct use of PPE is recommended using the attached video <https://vimeo.com/393951705>

1. **COVID Pathway (Hubs and assessment centres)**

18.1 PLEASE READ SEPARATE COVID PATHWAY GUIDANCE – only use COVID pathway if COVID is the primary condition causing concern (e.g. abdo pain with mild respiratory symptoms should be assessed by practice and seen F2F as appropriate by practice)

18.2 Patients with COVID symptoms causing concern should be signposted to 111.

18.3 Some triage by COVID Hub clinician may signpost patient to practice (e.g. request for possible house visit) This will be done via Adastra communication with practice during the day.

18.4 Some triage by practice clinician may signpost patient to COVID assessment centre (someone with concerning COVID like symptoms) – referral through FLOW CENTRE

# Clinical areas within the practice

19.1 The practice will be divided into discreet areas to allow proportionate infection control measures to take place. All patients will require triage by phone initially

**The RED zone**

* This area will be for essential face to face appointments with shielded patients.
* It will have a ‘super clean’ focus. If there is only one clinical area available, then consider seeing Shielded patients at the start of the day.
* This zone consists of ……….ENTER CLEAR DESCRIPTION OF ZONE OF PRACTICE TO BE USED.
* Patients entering this zone should enter through …xxx….DOOR – *usually a separate door where possible leading directly to the designated zone*
* Within this area it shall be mandatory to see patients whilst wearing PPE
* Open window in room may improve air change rate in room. Do not do this if AC/negative pressure ventilation in operation.
* Put PPE on before entering the RED zone
* Wherever possible patients will be admitted to the building when the clinician is ready to see them (e.g. patient called from their car by mobile). A small waiting area with 2 m spacing and masks should be available where this is not possible - patients should be seen within 5 minutes of arrival in this area.
* Upon arrival to the RED zone, there is an alcohol hand gel dispenser and instruction poster of how to wash their hands.
* Patients will not be able to use the practice toilet whilst in the building (will be reminded to go before they attend the practice)
* Use minimum required equipment.
* Consider a ‘drive through area’ for essential finger prick bloods from car window e.g. INRs

**The AMBER zone**

This is an area where clinicians may see non-shielded patients F2F.

* This zone consists of ……….ENTER CLEAR DESCRIPTION OF ZONE OF PRACTICE TO BE USED.

         Where possible – develop a one-way system for patients attending for consultation (check in with receptionist, wait, called forward to consultation room) to minimise opportunity for contact/cross over of patients

         Maximise the existing waiting area space – to ensure that a minimum of 2M is provided between waiting patients – remove leaflets / tables/ toys etc.

         In line with recent Scottish Government advice, many patients may elect to use a face covering when in a public space

         Ensure patients have access to alcohol-based hand rub and are encouraged to use this on entry to the practice. Hand hygiene by patients and staff is the most important control measure in managing risk.

         At this stage we are not advising that carpets are replaced with hard flooring- NHSL IPCS will advise re appropriate cleaning of carpeted areas following discussion with domestic and HPS colleagues

         As a general principle, all areas should be clutter free. It is acceptable to display appropriate posters/patient information in waiting areas. This should be clean, intact and changed/disposed of if tatty/visibly soiled.

         Use of patient toilets is currently discouraged – however – this may create Legionella risks associated with infrequently used outlets (and reduced water use across the buildings with reduced on-site clinical activity). Ensure all sanitary areas are cleaned daily – this will ensure these are clean and ready for use and achieve water flushing.

PPE should be worn for any F2F encounter that breaks the 2m physical distancing rule, consulting rooms should be cleaned after any F2F encounter (as per section 16.4)

**The GREEN zones**

* This area consists of ENTER CLEAR DESCRIPTION OF ZONE OF PRACTICE TO BE USED.
* This area represents a PATIENT-FREE AREA
* Stocked daily with handwashing equipment
* These areas shall be used exclusively for telephone and video consults and administrative tasks.
* All staff in this area shall follow infection control procedures (e.g. Bare below the elbow)
* Clean equipment used regularly (keyboards/telephones etc)
* Ensure physical distancing (2m) and where this is not possible consider sessional use of masks throughout the building including green zone. If masks are worn ensure correct use.
* Maintain infection control throughout – ESPECIALLY KITCHEN / STAFF ROOM

# 20 Team Morale

It is vital that morale is upheld during this time of great anxiety for the staff.

Everyone in the practice has a responsibility to make the team

* Feel safe
* Feel supported
* Feel part of #team xxxxx *practice name*
* Feel they are making a difference for the safety of our community

To do this, team engagement and communication are vital

* Senior Management Team to meet each morning at xx am (COVID meeting) with standing agenda items (reviewing up to date guidance and stats)
* Team appraisal cycle paused until further notice
* GPs encouraged to postpone appraisals until further notice
* Regular team meetings for all
* Consider a WhatsApp group for all team members for important update
* Open door policy for anyone to speak about concerns and anxieties around COVID-19

# 21 Patient and Stakeholder Comms

Keeping our community of patients informed and our local stakeholders informed is key to avoiding problems and complaints. We should aim to provide comfort and confidence to the people we serve.

This can be avoided by

* Making sure that the message to patients is about the practice wanting to protect them, their family, their friends and their community.
* Making sure the message is consistent across all patients and stakeholders (no mixed messages and fair / equitable treatment)
* Website updated with practice information complemented by national information
* Using SMS messaging to make sure any messages get our properly
* Reassurance that service available but in a different way.
* Contact with HSCP and PCCO regarding potential problems in maintaining service (see separate guidance)
* Keep Facebook updated with latest practice and national information
* React quickly to complaints with a full explanation of why the service is different and restricted currently but try to deescalate wherever possible.

# COVID coordination group

In larger buildings with multiple users there will be a need for a larger Covid coordination group to consider the issues raised

This will be important for coordinating shared use of Red zone and Amber zones

# Business Continuity Plan (BCP)

*As per practice business continuity plan. Suggest review to ensure that it reflects current potential risks and maintain contact with Buddy practice.*

**References**

1. <https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30128-4/fulltext>
2. <https://www.nejm.org/doi/full/10.1056/NEJMe2009758>
3. <https://www.aomrc.org.uk/choosing-wisely/>
4. <https://www.rcgp.org.uk/campaign-home/updates/2018/january/3-before-gp-england.aspx> - we will need to develop ‘COVID signposting’ for step 3 of ‘3 before GP’
5. <http://lothianlmc.co.uk/assets/presentations/Chair%27s%20Report%20-%20Drummond%20Begg%20%28AGM%202020%29.pdf>
6. Infection control advice from NHSL Infection Prevention and Control Services

**APPENDIX1**

**Enhanced services**

|  |  |  |
| --- | --- | --- |
| *Type* | *Service* | *Essential Y / N* |
| DES | Challenging Behaviour Practice | Y |
| DES | Childhood Immunisations | - |
| DES | Child Seasonal Flu Vaccination | - |
| DES | Extended Hours Access | N |
| DES | Influenza > 65 | Y |
| DES | Influenza < 65 at risk | Y |
| DES | Minor Surgery | N |
| DES | Palliative Care | N (meetings) |
| DES | Pneumococcal > 65s | N |
| DES | Pre School Boosters | - |
| DES | Rotavirus Vaccination | - |
| DES | Shingles Vaccination | N |

|  |  |  |
| --- | --- | --- |
| NES | Anti-Coagulation (INR) | Y |
| NES | Disease Modifying Drugs | Y |
| NES | Drug Misuse | *Y* |

|  |  |  |
| --- | --- | --- |
| *SESP* | *Adults with Learning Disabilities* | *N (administrative)* |
| *SESP* | *Child Health & Wellbeing* | *N (administrative)* |
| *SESP* | *COPD Pulmonary Rehabilitation* | *N* |
| *SESP* | *Patient Safety* | *N* |

|  |  |  |
| --- | --- | --- |
| *LES* | *Alcohol Brief Interventions* | *N* |
| *LES* | *Anticipatory Care (Care Homes)* | *Y* |
| *LES* | *Diabetes Type 2*  *Diagnosis and Management* | *N* |
| *LES* | *Hepatitis A&B* | *N* |
| *LES* | *Hepatitis B for foster carers (Edinburgh only)* | *N* |
| *LES* | *Hepatitis C (BBV)* | *N* |
| *LES* | *Human Papilloma Virus (HPV)* | *-* |
| *LES* | *Influenza: GPs and their staff, Home Care Staff and Care Home Staff* | *Y* |
| *LES* | *Influenza: Primary School children at risk* | *Y* |
| *LES* | *Men ACWY for university Freshers and young people aged 16-18yrs* | *Y* |
| *LES* | *Minor Injuries* | *N* |
| *LES* | *Minor Surgery* | *N* |
| *LES* | *MMR* | *Y* |
| *LES* | *Phlebotomy 1 / domiciliary based* | *-* |
| *LES* | *Phlebotomy 2 / practice-based* | *Y* |
| *LES* | *Pneumococcal < 65 at risk* | *N* |
| *LES* | *vLARC* | *Y* |