

Version 7.0

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 in Phase 3 of Scotland’s route map through the coronavirus pandemic1

It is likely that General medical services will be delivered in a different way for the foreseeable future.

We have made the following assumptions in preparing this guidance

1. the COVID pathway for symptomatic patients will continue until March 2021.
2. asymptomatic patients can be COVID +ve2 and patients with less common presentations will also likely be assessed by practices
3. Practices will experience episodic 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.

Some clinical activity will be modified or ceased as clinicians apply COVID ‘BRAN analysis’3 (Benefits , Risks, Alternatives, do Nothing)

NHS Lothian (NHSL), all 4 Health &Social Care Partnerships (HSCPs), GP sub-committee and Local Medical Committee (LMC) meet fortnightly to agree GMS Remobilisation plans and address issues not mentioned specifically in the Practice Action Plan - e.g. IT and premises.

## 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. GPs assess and treat large numbers of people who are ill or who believe themselves to be ill. The appropriate mode and level of assessment required to make a diagnosis / manage a problem is part of the complex decision-making process that GPs make.
	3. Most GP consultations will continue to be by phone or video with Face to Face (F2F) contact only for focused examination or investigation where this will change management.
	4. Asynchronous online 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 and manage the patient over the phone or video.
	2. Home observations may be possible with BP/temp/sats kit borrowed from the practice or bought by the patient and can aid remote consultation.
	3. Care homes may also have the facility for Near Me consulting and equipment to measure basic vital signs.
	4. Good team working with District Nurses / Palliative care nurses /other MDT members can reduce unnecessary additional house visits by a doctor.

## Shielded Patients

* 1. Shielding was paused on 1st August 2020, current advice can be found on <https://www.nhsinform.scot/illnesses-and-conditions/infections-and-poisoning/coronavirus-covid-19/coronavirus-covid-19-shielding> 5 .
	2. Former shielded patients who require F2F contact should be assessed and managed in the most appropriate setting following a risk assessment by the clinician considering clinical need and infection control.

## 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. Some practices have produced videos that are accessed by their patients via their website6
	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 previously 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 / BRAN3 need to be considered.
	5. See Appendix 2 for an initial review of Chronic disease management that are considered higher priority.
	6. A comprehensive guide *Rethinking Primary Care Chronic Disease Management in NHS Lothian after the COVID-19 Pandemic* *the Quality Planning Perspective*7 was published in July 2020 to support practices.

## Treatment Room Services / Community Treatment & Care Services (CTACS)

* 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 is a low priority activity, use eye protection if procedure deemed necessary.
	3. Phlebotomy will continue to be required to diagnose and monitor conditions managed by GPs (and pre- COVID secondary care work that has been agreed and funded).
	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.

## Minor Surgery / Joint injections

* 1. Minor surgery is a low priority activity but can be considered for significant problems.
	2. Only give a steroid injection if a patient has significant disease activity and/or intrusive and persisting symptoms, and there are no appropriate alternatives8.

## Enhanced Services

7.1 Monthly and quarterly payments for all enhanced services will continue based on 2019/20 payments as part of practice stability plan.

 7.2 NHSL and Lothian LMC have agreed that from 01/10/20 onwards all enhanced services can restart with the aim of achieving 25% of 2019/20 activity over the 2020/21 year.

7.3 The NHSL Primary Care Contractor Organisation (PCCO) and Lothian LMC have agreed a framework for enhanced service flexibility (Appendix 2)

## 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. Implementation of the NHS Lothian Hub and Spoke Travel Health Service has been paused due to the coronavirus pandemic. Scottish Government advice is that people should think carefully before planning any non-essential foreign travel and have stated that travel health is a low clinical priority. The WGH Travel clinic has limited capacity and private alternatives may be a better option for those who must travel.
	2. Where possible pneumococcal and shingle vaccine should be given but this is a lower priority than the 2020 Flu vaccine campaign.
	3. See Appendix 2 for further detail.
1. **COVID vaccine**
	1. At the time of writing there is no licenced COVID vaccine. However, preparations are being made for wave one of COVID vaccine implementation to be started in December.
	2. The target group in wave one is people aged 80+, care home residents, housebound and front-line health /care staff.
	3. Practices will be asked to vaccinate their ambulant over 80 population. Practice staff vaccination will likely be done by peer to peer vaccine as with flu campaign. A specific enhanced service is to be negotiated.
	4. HSCPs will be tasked with vaccinating housebound / care home residents
	5. Individuals cannot receive COVID vaccine within 7 days of flu vaccine
	6. Subsequent waves are being organised by our NHSL / HSCP colleagues for 2021 when larger supplies of vaccines are anticipated. A range of options are being explored including mass vaccination centres

## Contraception Services

* 1. Contraception reviews for POP 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 considered if 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. Cervical screening restarted in early July. This was a national decision and will therefore need to be accommodated.
	2. Screening people for hypertension have been paused by most practices. The rapid development of CTACs will be important to enable this activity to restart.
	3. National screening programmes for breast, bowel and AAA have resumed.

## Prescribing

* 1. Ordering of prescriptions should be done online whenever possible with collection of medicines direct via the pharmacy. Making full use of the Medicine Care and Review service (previously called CMS) will reduce footfall further in pharmacies and practices.

## 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 employers for absences of less than a week.

## 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

16.1 Phase 1 of implementation of GMS Contract in Scotland has restarted after a temporary pause. GP sub-committee representatives meet regularly with HSCP/NHSL partners at the GMS remobilisation group to ensure that resources ‘in direct support of GP’ are developed further to enable GPs to function in a sustainable way going forward11.

## Infection Control Measures

* 1. Remember FACTS9 in all settings including work.
	2. It is important to consider all processes that reduce footfall (see version 3 Practice Action Plan). Keep F2F encounters to the minimum necessary.
	3. Clinical spaces should be clutter-free with easily wiped down surfaces.
	4. Chairs should ideally be easily wipeable. Fabric chairs are acceptable but may deteriorate with repeated wiping.
	5. Hard surfaces in consulting rooms should be wiped down with appropriate disinfectant / detergent wipes between patients. Fabrics should be removed where possible to reduce need for cleaning (e.g. curtains)
	6. 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.
	7. Reception areas should be arranged to provide 2m 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.
	8. 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.
	9. Work clothes should be washed at the highest temperature they will tolerate in a half-filled load and not contained in a bag.
	10. 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
	11. 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 staff.
	12. NHS Lothian Infection Control policies, guidelines and information are available on NHSL intranet.
	13. HPS guidance for primary care is available at <https://www.hps.scot.nhs.uk/web-resources-container/covid-19-guidance-for-primary-care/> , this includes up to date guidance on PPE requirements

## PPE

* 1. Health Protection Scotland guidance should be followed <https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2930/documents/1_covid-19-guidance-for-primary-care.pdf>
	2. Posters for amber pathway PPE advice can be found at <https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3006/documents/4_covid-19-medium-risk-amber-a4.pdf>
	3. A mask can be used for a session (up to 4 hours continuous use), but the gloves and apron should be changed for each patient. Sessional use of masks is recommended.
	4. Hands must be washed before and after putting on/removing or touching PPE.
	5. PPE must be removed for meal breaks and before using the toilet.
	6. Refresher training on correct use of PPE is recommended using the attached video <https://vimeo.com/393951705>
	7. For the flu vaccine campaign there is no need to wear gloves nor plastic apron.
	8. Handwashing, wearing masks and social distancing are the key infection control elements.
1. **Communal areas**

19.1 Masks must be worn in all communal areas as per Scottish Government guidance <https://www.gov.scot/publications/coronavirus-covid-19-public-use-of-face-coverings/>

19.2 Communal areas such as kitchens, staff rooms and meeting rooms should be risk assessed. The number of team members congregating should be kept to a minimum.

19.3 Avoid sharing crockery, cutlery, food and drink.

19.4 Within all common areas (especially toilets and circulation areas) appropriate cleaning and disinfection must be in place. Particular attention should be paid to those parts that are frequently touched or handled by team members such as door facings, handles, taps, keypads or intercoms.

19.5 Share ‘Stop the Spread’ message within your team <https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3125/documents/1_covid-19-stop-the-spread-good-practice-points-poster.pdf>

1. **Test and Protect**

20.1 Practices should be familiar with Test and Protect. Ensuring that there is minimal contact at work as defined by national guidance should avoid the need for self-isolation of team members should a colleague have a positive coronavirus test. <https://www.gov.scot/publications/coronavirus-covid-19-test-and-protect/>

20.2 People who are have symptoms suggestive of COVID should go to [www.nhsinform.scot](http://www.nhsinform.scot) and follow the advice on how to get a test and how to seek medical attention if unwell.

20.3 Practice team members who have symptoms suggestive of COVID should self – isolate and organise a test via Occupational Health via your practice manager.

20.4 GPs and their teams see people who are ill and will do tests as appropriate to the clinical situation.

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

21.1 Please see refHelp guidance <https://apps.nhslothian.scot/refhelp/covid-19#tabs-1> and only use COVID pathway if there are respiratory symptoms that are likely to be due to COVID and the patient needs assessment for possible hospital admission

21.2 Patients with classic COVID symptoms should be signposted to 111.

21.3 Some triage by COVID Hub clinician may signpost patient to practice. This will be done via Adastra communication with practice during the day.

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

#  Clinical areas within the practice

22.1 Patients no longer walk into practices without initial assessment. This is to keep everyone safe. Practices usually do this by phone initially. Practices arrange F2F assessment when required and manage demand on waiting areas appropriately through the day to keep patients and practice teams safe.

**The RED zone**

* Most practices have ‘mothballed’ their Red zones as we moved into Phase 3 of the route map1 .
* This may change if circulating levels of coronavirus in Lothian increase.
* Many still operate a ‘drive in area’ for essential finger prick bloods from car window e.g. INRs and HSCPs and practices are planning drive through flu clinics to reduce footfall indoors wherever possible.

**The AMBER zone**

This is an area where clinicians may see all patients F2F in Phase 3.

* 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, patients should be asked to wear a face covering (if able to ) when attending the practice.

         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.

         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 discouraged. Legionella risks associated with infrequently used outlets should be mitigated by ensuring that all sanitary areas are cleaned and flushed daily.

PPE should be worn for any F2F encounter that breaks the 2m physical distancing rule, consulting rooms should be cleaned after any F2F encounter

**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 should 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 / TOILETS

# 23 Team Morale

The 2020 pandemic is hopefully a once in a lifetime experience for us all. We should aim to be kind, supportive and empathic with colleagues across the whole system.

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 regularly.
* Regular team meetings for all
* Consider a WhatsApp group for all team members for important updates
* Open door policy for anyone to speak about concerns and anxieties around COVID-19
* Use Wellbeing resources10

# 24 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.
* Consider using the video produced by RCGP Scotland Chair Dr Carey Lunan MBE <https://www.youtube.com/watch?v=JRNYWdNba14&feature=youtu.be>
* 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 information5
* Using SMS messaging to make sure any messages get out properly
* Reassurance that services are available but in a different way.
* Reassurance that priority services will be maintained and due to reduced capacity in the system the management of lower priority problems may need to be deferred.
* 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.

# 25 COVID coordination group

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

This will be important for coordinating shared use of communal areas and of Red, Amber and Green zones.

# 26 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.

*Advice from NHSL Occupational Health (OH) Team when a team member tests positive for coronavirus is as follows*

*0 cases – ensure safe working practices, practices and behaviours when on meal break, team meetings, travel, and socialising away from work*

*1 case – revisit all of the above, heightened awareness, actively monitor staff issues for 14 days*

*2 cases  - as above, OH aim to make contact to check and reinforce the above*

*>2 cases – likely problem assessment group (PAG), +/- visit from OH*

\*\*\*If there are a significant number of team members self-isolating such that the practice cannot function normally you must call your HSCP emergency line immediately on the number shown below/follow the guidance for your area as shown below; \*\* **PLEASE DELETE AS APPROPRIATE\*\***

**EDINBURGH**

David White       07974185419

Eileen McGuire  07980734775

E mail: EdinburghPrimaryCareSupportTeam@nhslothian.scot.nhs.uk

**WEST LOTHIAN**

|  |  |
| --- | --- |
| **HSCP**General Manger: Isobel PenmanHead of Health : Fiona WilsonClinical Director: Elaine DuncanChief Nurse: Mairead Hughes | Office: 01506 281011 (07815 504679)Office: 01506 281017 (07896 969663)Office: 01506 281012Office: 01506 281003 (07664 512626) |
| Director on Call – Primary Care  | 01506 523000 / 0131 537 6000 |
| Health Protection(Emergency & Service Continuity Response as well as PH medicine) | 0131 465 5420/54220131 242 1000 (ERI switchboard) |
| NHS 24 | nhs24providerupdates@nhs24.scot.nhs.uk |

**EAST LOTHIAN**

For East Lothian Practices, in the event that staff shortage results in a situation where the practice is unable to open, the pre-agreed business continuity plan, which includes buddying arrangements should be followed. These plans remain in place for the present time, though are currently under review to ensure they remain secure, and any necessary changes will be communicated to practices directly

**MIDLOTHIAN**

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Hamish Reid  - 07946 706832 – HSCP Clinical Director

Grace Cowan – 07890 388633  - Head of Older People and Primary Care

**References/useful resources**

1. <https://www.gov.scot/publications/coronavirus-covid-19-phase-3-staying-safe-and-protecting-others/> (accessed 2/11/20)
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> - Step 3 of ‘3 before GP’ is the new Pharmacy First initiative.

1. <https://www.nhsinform.scot/illnesses-and-conditions/infections-and-poisoning/coronavirus-covid-19/coronavirus-covid-19-shielding> (accessed 2/11/20)
2. <https://www.harbourspractice.co.uk/>
3. <http://lothianlmc.co.uk/assets/presentations/NHSL%20Chronic%20Disease%20Quality%20Planning%20EXECUTIVE%20SUMMARY%20final.pdf>
4. <https://www.rheumatology.org.uk/Portals/0/Documents/COVID-19/MSK_rheumatology_corticosteroid_guidance.pdf> - accessed 16/8/20
5. <https://www.gov.scot/publications/coronavirus-covid-19-facts-poster-including-translations-and-accessible-formats/>
6. <http://lothianlmc.co.uk/what-we-do/> - a comprehensive list of supports locally and nationally.
7. <http://lothianlmc.co.uk/assets/presentations/Chair%27s%20Report%20-%20Drummond%20Begg%20%28AGM%202020%29.pdf>
8. Infection control advice received from NHSL Infection Prevention and Control Services
9. RCGP video on ‘**What to expect when you make and appointment with your GP practice**’ to upload on to your website / Facebook page <https://www.youtube.com/watch?v=JRNYWdNba14&feature=youtu.be>

ADB/Nov20

**APPENDIX 1 Chronic Disease Management.**

Practices will have reduced capacity so previous levels of activity will not be sustainable. Some historic clinical activity will need to cease. Clinicians will need apply COVID ‘BRAN analysis’3 (Benefits , Risks, Alternatives, do Nothing) to triage people who will gain the most from a Chronic Disease review.

We would suggest that if capacity permits, practices focus on the following areas of Chronic disease monitoring / management. We recommend that practices use videos on their website to provide advice to all their patients6

1. **Blood pressure** monitoring /management

People on IHD, stroke, PVD, CKD and hypertension registers should be given the opportunity to monitor their blood pressure at home.

There are two main remote systems.

1. One week of blood pressure readings recorded on a paper chart once a year
2. Florence telehealth – blood pressure readings texted every month.

Most practices are aiming to use a mixture depending on what their population can manage. There is a significant amount of work required to ensure people have access to blood pressure monitors. Florence telehealth is currently used in less than 5% of the total population requiring monitoring.

We await guidance on the evidence on risks and benefits of monitoring UEs with long term diuretics/ACEi/ARAs during the pandemic. Most practices have paused annual monitoring until more definitive evidence of benefit vs test every 2 years.

1. **Diabetes**

Most people with diabetes will need some level of monitoring (e.g. annual bp) but there may not be capacity to do blood tests on those who have the least requirement. A person with a HbAc1 46 may be lower priority.

1. **Thyroid**

For people on a stable dose of thyroxine, TSH can be checked every 2 years or sooner if the person has symptoms.

1. **Asthma / COPD**

We recommend that practices develop web-based information for their patients to access advice on Asthma and COPD self-management5. In practices that feel that they have capacity then targeted review of higher risk groups is advised.

1. **Lithium /DMARD monitoring**

Lithium monitoring advice remains unchanged. Some relaxation of DMARD monitoring frequency has been agreed.