PRIMARY CARE UPDATE – 15 DECEMBER 2020

TO BE ISSUED VIA LOCAL INCIDENT COMMAND CENTRES AND COPIED TO MEMBERS OF THE PRIMARY CARE BOARD

RECOVERY AND WINTER PRESSURES

Work to resume services continues to progress across the whole of primary care.

In general practice, action plans are being developed and local standards refreshed to address the backlog in relation to screening, immunisation and management of long-term conditions, with the focus on those with the highest clinical need. There are examples of good practice with practices sharing resources across primary care networks and using the sitrep to flag any issues. There is work ongoing to target patients at increased risk if they were to contract Covid-19, as well as those with a history of poorly managed long-term conditions and/or missed reviews. Practices are also working hard to support care homes, including virtual ward rounds, identified leads and streamlined end of life processes.

However, practices are coming under increased pressure with reduced capacity due to staff members going off sick or isolating and increased demand alongside the flu vaccination programme and roll out of the covid vaccine. CCGs are working closely with providers to explore a range of support options that aim to support resilience in general practice. These include strengthening business continuity arrangements, sharing prioritisation guidance and stepping down reporting requirements to reduce the administrative burden. A standardised Greater Manchester approach to prioritising care is being considered, for example using a set of shared principles. There are risks to this approach as prioritisation decisions mean further delays in some types of care, which could lead to future health risks and local pressures.

Additional funding via the recently announced General Practice Covid Capacity Expansion Fund will see £8m coming to Greater Manchester. Each STP will also receive extra funding to support the recruitment of GPs.

In community pharmacies, work is underway to roll out the revised Greater Manchester Minor Ailments Service, which was paused in a number of areas. We have been identifying optometry providers that are not yet offering the full range of services and working to understand the reasons behind this.

Work continues to further develop phases two and three of the recovery plan, which look at embedding what has worked well so far and accelerating new ways of working.

CAPACITY AND DEMAND PROFILING

Work is continuing to map capacity and demand across primary care. Having a clear picture of capacity and demand in primary care is an integral part of primary care recovery, not only to ensure patients are able to access services but also to support primary care providers to manage their workload. It can also inform local discussions of how to address/manage additional work resulting

from changes in other parts of the system. This piece of work is initially focusing on general practice.

A data set has been developed using existing data sets such as QOF disease registers, eligible population and uptake of screening, vaccination and immunisations and prescribing data. It also incorporates secondary care activity such as urgent and emergency care data and referrals. This goes some way to illustrating demand in general practice but is not necessarily a full, real time picture.

Following a discussion at GP Board, we are now looking at the possibility of conducting an audit of demand and supplementing this with data from the AskmyGP online platform. A small group has been formed to consider this further with practices from Tameside and Glossop, Trafford, Wigan, Manchester and Bury agreeing to act as 'marker practices' to undertake a manual audit to provide an initial indication of demand. This will inform the development of an automated process which could be rolled out across all general practice. In addition, Wigan Borough CCG is compiling a report on AskmyGP data for the past 12 months as a testbed for other areas.

There are discussions ongoing around incorporating capacity and demand data into the overall OPEL reports to provide a broader perspective of practice resilience.

PHLEBOTOMY

In response to a number of issues with the delivery of phlebotomy reported by CCGs during the COVID-19 pandemic, the Primary Care Cell requested a review into these services. The aim was to identify if this was a widespread issue or only affected a few areas. The situation has been further exacerbated by the recent Roche issue affecting both MFT and Trafford.

Provision of community-based phlebotomy, particularly during COVID, has been a challenge to a number of localities but, in the majority of areas, this has been responded to by commissioning additional activity.

A recurrent theme from the audit was the cause for concern with respect to clinical responsibility when a patient sits between primary and secondary care, particularly highlighting the point if that responsibility should be held by the referring clinician. However, this point gets challenging when primary care are undertaking blood tests on behalf of secondary care.

In view of the number of CCGs looking to undertake a review of their community-based phlebotomy service, the Primary Care Cell considered if it would be appropriate to develop a Greater Manchester wide service. However, it was felt that the service would be best commissioned at a locality level.

COMMUNITY DEATHS

The Enabling Safe Certification of Deaths in the Community (ESCDC) service was established in March to provide increased capacity to support the rising demand to attend, verify and certify expected and reasonably foreseeable deaths in the community. It was stood down on 30 June and this work reverted back to general practice. A support pack was provided to practices with full details of this change.

Since the ESCDC service stopped there has been a gap in community death data. Extracting the data from GP practice systems via Graphnet and into Tableau looks to be the most appropriate solution.

There other issues emerging too. Feedback from the police and coroners suggests some deaths are requiring police attendance and being referred to the coroner that could have been managed

within the community/general practice. This is leading to increased pressure in the wider system. Some care homes have been calling 999, instead of general practice, when one of their residents dies. It has also been noted that out of hours providers are not issuing a medical cause of death certificate.

There have been calls to reinstate the ESCDC service but there must be strict criteria to trigger this move as it is expensive and not all localities would welcome it. Some actions have been identified that improve the management of deaths in the community, including refreshing and reiterating the guidance to GP practices, out of hours providers and care homes.

The following have been identified as potential triggers to prompt a system wide discussion as to whether the service should be mobilised:

- Mortuary capacity reduced to 30%
- Infection rates in care homes reaching 25%
- Notable pressure in the GP system – OPEL 3 level
- Marked increase in police attendances

There will also be discussions with the provider to understand minimum length of time required to reinstate the service and different models of delivery (e.g. out of hours, sector/locality basis).

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