Covid19 Community Pathway – Escalation (Practice Emergency Contribution)

Introduction

A whole system pathway for the management of Covid19 cases in the community was established in March. This is set out in further detail at Appendix 1.

This pathway supports two key aims:

- To maximise the numbers of symptomatic people who can be cared for in the community, reserving our hospitals for those with the most serious illness; and
- To minimise the exposure of patients using GP practices to Covid19, as these patients are most likely to be older and have multiple non-communicable diseases

The pathway is staffed and supported through a range of contributions from services across the Health Board and HSCPs. This includes engagement of a core group of GPs with a regular commitment to the Hub and CACs, nursing and HCSW staff provided by the HSCPs, administration and booking arrangements managed through the HSCPs and Board, and clinical and managerial leadership through the HSCPs and the GP Out of Hours service.

Every effort will be made to manage increases in demand over the winter through these routes, with planned increase in capacity across all sites.

However, in the event that activity rises to peak *possible* scenarios, the Hub and CAC model will not be able to be sustained without additional support.

In that event, all GP practices would be asked to support the pathway through provision of GP time to act as the senior clinical decision makers in the triage hub or CAC. The process for this is set out below.

Projected demand

The likely demand for the hubs and CACs has been projected taking account of both expected respiratory presentation and Covid19, with assumptions on the numbers requiring to be seen face to face.

At its peak, with 'worst case' assumptions on both prevalence and proportion requiring face to face assessment, numbers expected to be requiring CAC face to face assessment equate to the following.

	Peak weekly activity
Best case / core planning assumption	750
Step Up	1200
Scale up Phase 1	1900
Scale up Phase 2	2600
Scale up Phase 3	3700

Current face to face attendance is around 500 per week, well within the core planning assumption above.

In the event that activity is projected to rise to 750 per week or higher, this would not be sustainable under current arrangements. In that event, practices would be asked to provide GP time to the CAC in line with practice list size.

Escalation levels: Practice Emergency Contribution

There are 4 levels of escalation which would drive the contribution being sought from practices, in line with the activity set out above. It expected that the 'step up' level is most likely, with higher stages of escalation reflecting a position where there is exceptional pressure across the system which is likely to require a much wider range of actions.

Based on the gap between current regular staffing and what is required to meet these levels of activity, a contribution from practices would be sought on the following basis. This is shown for the first two bands of escalation / activity. Should levels three or four be reached, the contribution would rise in proportion and be confirmed at that time.

		Number of GP 3 hour sessions / Practice list size					
Escalation Level	**Trigger / activity**	**<2000**	**2-4,000**	**4-6000**	**6 - 8,000**	**8-10,000**	**10, -12,000**
Step Up	750-1200	1 per 6 weeks	1 per 3 weeks	1 per 2 weeks	2 in 3 weeks	4 in 5 weeks	1 per week
Scale Up Phase 1	1200-1900	1 per 3 weeks	2 in 3 weeks	1 per week	5 in 4 weeks	3 in 2 weeks	2 per week

Key principles/process

- The Level of Escalation (if any) will be agreed at the weekly Hub /CAC operational group in conjunction with Glasgow Local Medical Committee. The escalation arrangements will be kept under review on a weekly basis and stood down as early as possible.
- If escalation levels are reached and the meeting identifies that additional capacity is required with input from practices, there will be a formal communication to practices confirming which level is required. See attached flow chart.
- Practices to be notified one week in advance minimum of the start of this approach, or any changes to level of contribution sought.
- Practices may provide their contribution through sessions in any of the CACs (face to face) or in the triage hub.
- Practices should book sessions for the following 4 weeks in the first instance.
- Triage hub working can be done remotely and may be particularly suitable for GPs who are self-isolating or high risk and unable to see suspected Covid19 patients face to face.
- Sessions will be 3 hours.
- Practices can provide their session to the hub or any of the 4 CAC sites. The arrangements for booking sessions for each of the sites is as follows:

  Triage Hub and Barr Street CAC. Via rotamaster. To set up practice on rotamaster contact GPOutOfHours@ggc.scot.nhs.uk with practice name, address, email address and contact phone number.

Barr Street CAC (additional contacts)
Ann Forsyth, PCIP Programme Manager & PCIP Service Manager
Ann.Forsyth@ggc.scot.nhs
Janet Tobin, Covid19 Response Service, Operational Manager
Janet.Tobin@ggc.scot.nhs.uk

Linwood CAC
Carol Graham, Telephone: 0141 618 7665, Email: Carol.Graham2@ggc.scot.nhs.uk

Inverclyde CAC
Gwen McBride, Mobile: 07385 367158, Email: gwen.macbride2@inverclyde.gov.uk

Renton/Clydebank CAC
Anna Crawford, Mobile: 07811247708, Email: anna.crawford@ggc.scot.nhs.uk,

- Practices are only expected to cover sessions during core GMS hours (8am – 6pm); however, practices may opt to cover sessions at other times if that is more convenient.
- Existing practice contribution to the CAC and Hub staffing will count towards the contribution described.
- Practices who are currently at level 3 escalation would not be expected to provide additional input to the CACs.
- Clearly some practices will be unable to offer their requested contribution over the time period in question, for example as a result of significant staff absence. It would be possible to make a contribution at a later time.

Support and Induction
It is recognised that the Hub and CACs may be an environment which is unfamiliar to GPs who work the majority of their time in practices. Standard Operating Procedures and Induction will be available to anyone providing sessions in the centres, which are run as a supportive team. Online videos and induction will be available prior to any sessions to show how the centres and hub would operate and the GP's role as senior decision maker.

Indemnity
GPs providing sessions in the CACs and triage hub will be covered by the Board CNORIS

Payment
It is recognised that practices will be continuing to provide GMS services throughout this time and may require backfill when covering the Community Pathway sessions. Practices will be paid for these sessions (via practitioner services) based on the current hourly rate.

Core GMS activity and escalation
The CAC and hub model is intended to support ongoing provision of GMS by ensuring that practices remain Covid19 free as far as possible and providing an alternative pathway for suspected Covid19 patients. During the winter period, it is possible that a significant amount of respiratory demand may be managed through this route due to the overlap in symptoms and case definition. However, it is acknowledged that provision of GP time from practices to the CACs will impact on practices' ability to provide a full range of GMS services at all times.

The General Practice escalation plan is attached and sets out the flexibilities which practices have within existing contractual arrangements to provide essential services.

On the day / short notice escalation

This paper sets out arrangements when there is an expected rise in activity over the following week and beyond. It is recognised that there may be individual days when there is an unexpected peak in demand which cannot be managed within existing capacity and standby arrangements.

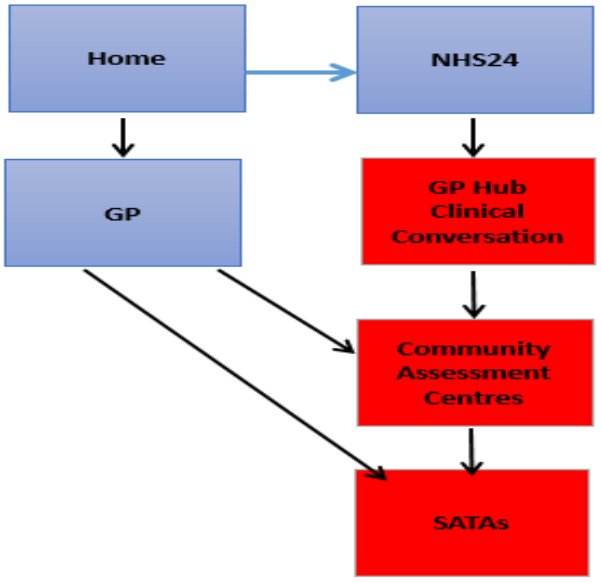
Even before escalation beyond 750 per day happens, it would be invaluable if some practices were willing to act as standby support for escalation on particularly busy days. This would help ensure the maintenance of the community pathway.

Even if the larger service escalation (Practice Emergency Contribution) is triggered, practices will also be able to opt to be available as a standby practices on designated days. Further arrangements for this are being developed and will be shared shortly.

APPENDIX
Community Pathway – overview of arrangements and criteria

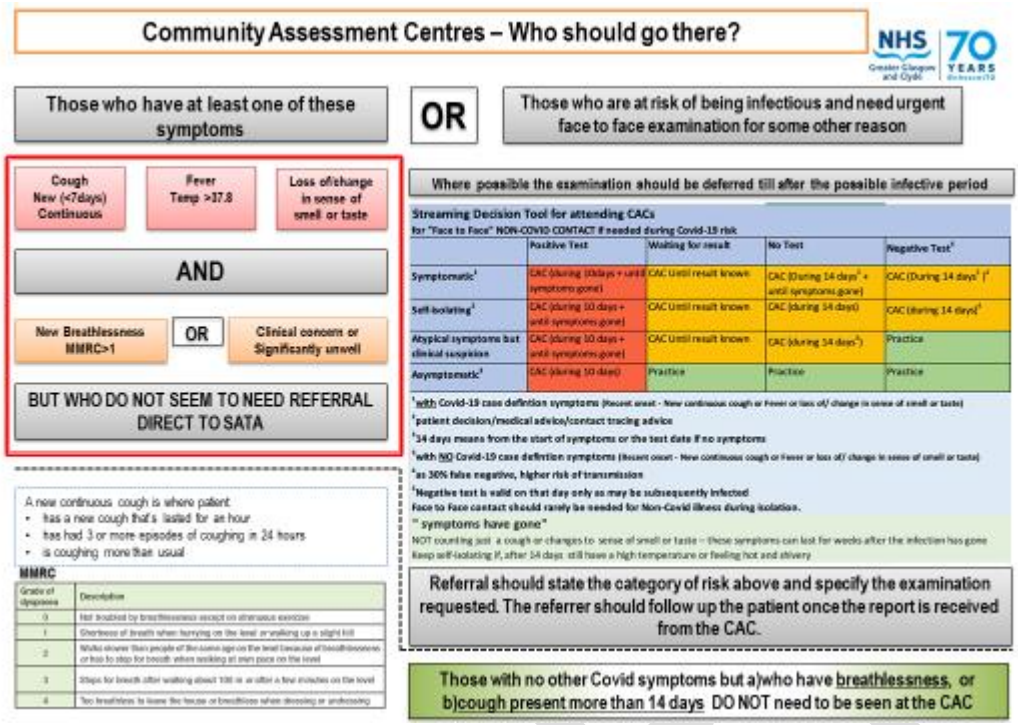
Whole system pathway
The CACs were established as part of a pathway with the following components:

- First contact for patients with Covid19 symptoms through NHS24 rather than GP practices
- Hub for clinical triage of potential Covid19 cases requiring assessment following NHS24 contact, and to manage cases where possible without face to face assessment
- Community Assessment Centres where face to face assessment is required
- SATAs within acute hospitals for assessment of patients who may require admission
- GP Out of Hours providing home visiting and face to face assessment in the period when CACs are not open



While the recommended patients' pathway is for patients with Covid19 symptoms to contact NHS24 in the first instance, it is acknowledged that many patients will still contact their GP. The pathway therefore allows for GPs to refer directly to CACs and SATAs following initial telephone or NearMe consultation. Around 40% of onward referrals to the CACs have come through the Covid19 hub, with 60%+ from general practice.

A further underlying principle across the Covid19 pathway is that patients should be managed by phone or Near Me assessment wherever possible, with face to face assessment only where there is no alternative. The key role of the CACs is to determine whether or not a patient needs to be admitted to SATA or continue with ongoing care in the community provided by the patient's own practice.



NO CHANGES ARE PROPOSED AT THIS STAGE TO THE OVERALL MODEL AND PATIENT FLOWS

These are summarised above and in the six triage advice cards (links below). As has been the case to date, the case definitions and referral criteria will be continually kept under review and any changes communicated. This will include specific exceptions or guidance on particular groups (e.g. management of post immunisation fever; arrangements for children).

Covid-19 GP Advice Cover Note

Covid-19 GP Practice Child Triage GP Advice 5

Covid-19 GP Practice Cleaning Advice GP Advice 2

Covid-19 GP Practice Clinical Distancing GP Advice 6

Covid-19 GP Practice Home Visit GP Advice 4

Covid-19 GP Practice Respiratory Appointment GP Advice 3

Covid-19 GP Practice Triage Pathway GP Advice 1

Home Visits

Home visiting will remain part of the CAC and hub response; however, it is recognised that this is very resource intensive and should be kept to a minimum where possible. The Hub or GP practice who is carrying out the initial triage should make every effort to perform a comprehensive assessment via telephone or NearMe and only refer on for home visit where absolutely necessary.