Template PCN Contingency Plan

This template, prepared by one of our PCN's has been shared for others to adapt and use. You may wish to adapt or use as a starting point for your own plan.

Potential Novel Workloads and Risks to Service:

- Cat 2 COVID-likely patients where face to face assessment is desirable to stratify risk.
- Patients who are presenting complaints warrant face to face assessment but who potentially have COVID-19 on the list of differential diagnoses. (for example "tonsillitis", "asthma exacerbation", "COPD exacerbation", "SOB")
- Rapid Discharge Patients. Covered in document: "COVID-19 Hospital Discharge Service Requirements" 29 March 2020. Increased social care and community nursing needs identified and mitigated. Increased speed of discharge is likely to yield a patient with greater than usual medical needs.
- Patients with frailty who are unlikely to benefit from hospital admission. Increased volume of care planning, review and palliation.
- Reduction of clinical staff and capacity due to illness/isolation/caring
- Reduction of non-clinical staff and capacity due to illness

Baseline

- Current member practices are…..
- Dedicated "Hot" facilities are……..
- Current cross practice working details…..
- Use of other premises/organisations for Hot facilities……
- Other governance arrangements are……

Contingency A (Hot Sites Live)

Likely contingency within 7-10 days.

Identification of need to move to contingency A via SitRep and alert via PCN WhatsApp group. Practices are free to determine when "Hot Site" working is desirable. Data sets and collection do not provide a threshold mandating or limiting use of hot sites. Contingency A relies upon sufficient residual capacity to provide telephone triage and "cold" operations within individual practices.

Upon activating Contingency A the Core Practice Board (Or Clinical Director on behalf of the board) will appoint one Tactical Lead and One Clinical Lead for each Hot Site. This is imperative to provide clear leadership. Tactical and Operational leads work together to open hot site alongside Clinical Director who will provide accountability. In the absence of the CD Tactical Lead assumes seniority.

Tactical Leads Responsibilities (anticipate this would be a PM):

1. Contact CCG to request permission to open site
2. Ensure adequate signage and direction for patients. Directions from site entrance to Hot Site. Identification and marking of segregated parking bays.
3. Ensure IT facilities and permissions are operational
4. Identify potential limitations or risks to service provision and work with/instruct operational lead in mitigating these

Operational Leads Responsibilities (anticipate this would be PM, GP or Practice Nurse):

1. Ensure PPE transferred to Hot Site
2. Ensure Cleaning and Decontamination products are available at the Hot Site
3. Identify clinicians to staff the site and ensure they have the permissions to access clinical systems.
4. Work to mitigate limitations or risks to service provision under the direction of the tactical lead
5. Once set-up is complete manage day-to-day needs of site including clearing and decontamination supplies and clinician requirements.
6. It may be desirable for tactical lead to assume some of these responsibilities or take turns covering these requirements in order to manage practice workloads.

Standard Operating Procedure

1. Phone triagers to ensure that patients booked into Hot Site have mobile phone number and car registration in booking information. Advise patients to remain in their car until retrieved by Hot Site staff.
2. Clinician dons PPE and leads patient from their car to the clinical room
3. Clinical assessment
4. Wash hands, change gloves and apron
5. Escort patient out of the building
6. Decontaminate room

7. Remove PPE as directed and decontaminate hands
8. Operational lead to consider SOP and amend as per emerging or changing guidance. If both hot sites operational this could be done by one Operational Lead and implemented bilaterally.

Contingency B (Insufficient capacity to maintain organisational integrity)

Unlikely contingency within 10-20 days. Amalgamation of practices or sites to form separate hot and cold sites.

Contingency B comes into force in the event that a practice identifies insufficient capacity to provide adequate service such that risk to patient safety is compromised or suboptimal. The decision to request activation of this measure is at the discretion of the partners of the practice pursuant to their Partnership Agreement. Activation of this measure also requires they agreement of a host practice pursuant to their Partnership Agreement and it is recommended this decision be made in advance via discussion at a partners meeting at the earliest opportunity. Communication of this decision would be desirable.

For the purposes of the below description Practice A has the closing premises and Practice B has the receiving premises. The “requesting practice” contacts the “paired practice” in order to request amalgamation.

Principals:

1. Request to activate Contingency B made to Core Practice Rep Board via PCN WhatsApp group or email followed up by telephone call to the paired practice.
2. Paired practice confirms receipt of the request and seeks urgent decision
3. Communicate decision promptly and seek to identify and define who is Practice A and who is Practice B
4. At least clinical staff begin operating from one location and assume joint responsibility for both lists.
5. Clinicians in this instance are encouraged to maintain telephone triage and utilise the available staffing to prioritise clinical activities depending upon demand and in view of available estates.
6. Non-clinical staff could remain at their base surgery if they are not required to manage clinical care (for example reception staff are required to manage clinical care whereas administrators or secretaries may be asked to stay in their base surgery).
7. If possible ensure dispensaries remain open so as not to suddenly overload already struggling community pharmacies. Utilise any non-clinical staff remaining at base surgery to support this where appropriate.
8. It is likely to be impractical to utilise a single clinical system in this instance. Practice management would need to arrange requisite permissions as a matter of urgency. Train, delegate and discuss in anticipation of this contingency. It would be sensible to build redundancy into these plans to account for possible absence of senior practice management staff.

Practice A responsibilities:

1. Identify a named lead individual accountable for discharging the below responsibilities
2. Communicate and transfer staff and clinicians

3. Allow access/permissions to clinical notes system
4. Divert telephone calls
5. Communicate with CCG
6. Arrange transfer of medical supplies, PPE or equipment as deemed appropriate.
7. Once operational retain employment and management responsibilities for employees. Conscript and offer payment to Locums or salaried clinical staff providing extra cover as required.

Practice B responsibilities:

1. Identify a named lead individual who is accountable for delivery of the below responsibilities. (NB accountable for delivery does not mean accountable for the decisions taken. This accountability rests ultimately with the partners who will need to be consulted where appropriate).
2. Becomes de facto “lead practice”. Practice management to assume leadership in delivering and maintaining service for both lists in close association with Practice A.
3. Identify clinical space and/or workstations for incoming staff. Bear in mind comparatively little space may be required for face to face assessment at the “cold” site compared to the need for telephone and computer workstations needed for telephone consultation.
4. Identify shortfalls in medical supplies, PPE or equipment and liaise with Practice A
5. Liaise with CCG if IT/Comms issues arise.
6. Retain employment and management responsibilities for employees. Conscript and offer payment to Locums or salaried clinical staff providing extra cover as required.

Stand-down of Contingency B is at the discretion of the partnerships pursuant to their Partnership agreements.

Contingency C (Collapse of services and National catastrophe)

Highly unlikely contingency within 21-48 days. Called in the event of an inability to maintain two contingency B services adjacent to the PCN resulting in the need to rationalise into single PCN-wide service covering all patients. Highly unlikely scenario but with potentially highly significant consequences where decision-making would need to be very decisive and responsive in order to maintain any degree of service. Commensurate with “worst-case” scenario levels of infections if delay measures are unsuccessful.

The core principal of this contingency is to quickly identify a structure for governance and decision-making given the context will be highly unpredictable in terms of both supply and demand for healthcare.

1. Decision to move to Contingency C is likely to be made by the residual partners operating out of the cold sites. Consideration must be given to the Partnership agreements but the decision may need to be made in the absence of quoracy if insufficient partners are contactable.
2. It is suggested that one partner and one practice manager is identified to take the lead.
3. This process could be a simple nomination, second and vote or left to residual Core Practice Reps to make the decision.
4. The Nominated Partner would assume strategic accountability. Discussion with other partners would be imperative but the Nominated Partner would need to provide clear, direct and rapid leadership.
5. The Nominated Manager would take tactical accountability in liaison with other practice managers or senior practice management staff in order to deliver the tactical and operational responses needed.

Decisions and Priorities:

1. What is to be the main site of operation. Consider size of residual workforce, capacity of estates, location of site (central vs peripheral).
2. Need a rapid ICT and comms solution.
3. Is there any available workforce not yet conscripted
4. Given our geography which satellite estates could be utilised (e.g. could the hot sites still run, does this need to be rationalised to 1 site, can a clinician provide some limited face to face cover satellite to the main site to reduce patient travel .)
5. Communication and liaison with CCG.

Consider standard Critical Incident Response principles of Strategic, Tactical and Operational. The small numbers of residual staff does not allow for separate commands however the above proposal allows Nominated Leaders to stratify decisions and effectively delegate. Think of Strat, Tac and Ops as ABCDE in resuscitation. Allow it to provide structure to decision-making if we hit crisis point.

Contingency X

Not unlikely within 7 days onwards. One practice, Contingency B cold site or Hot site is well staffed where others are not. Although this is identified it is not possible to formally plan for this.

It is anticipated that this scenario would be picked up via SitRep, via discussion on the PCN WhatsApp group on NHSMail. If a discrepancy in workforce is identified offers of clinical help or support could be made. Similarly practices could self-identify as in need of extra staff and others could consider whether they have spare capacity or whether they have clinicians not at work who might offer to provide extra work. There may be self-isolating clinicians working from home who may be able to provide telephone consultations or triage.

Humberside LMCs

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