
NOVEMBER 2015

Issue 199

How to Provide Primary Medical Care with Fewer GPs in the event of a Crisis

Introduction

It's 8.32 on Monday morning. You have one partner on sabbatical in Australia and you have just had a call from the husband of another to say she is in hospital with multiple fractures after a cycling accident. The third is even now vomiting in the staff toilet with presumed norovirus, and the locum agency cannot help. You are the total medical staffing of the practice for the day. What are you going to do?

Although this sort of thing has always happened, the likelihood of such a situation arising grows as the GP workforce gets ever tighter, so you need to have a plan. That plan should roughly divide into three phases.

- Immediate response – lasting up to 48 hours
- Continuity and planning – two days to two weeks
- Recovery – beyond two weeks

This Newsletter suggests some things you may wish to think about including in it.

Immediate Response – Adopting “Emergency Mode”

The essence of this is to sort out the genuinely urgent work from things that can safely be deferred for a couple of days. It is generally best to take a two stranded approach to this. First, use your remaining clinicians as efficiently as possible so they do only the tasks that only they can do, and second get the message out to your patients as efficiently as possible that you have a problem. We tend to assume that patient demand cannot be regulated, but when movement is heavily curtailed by, say, heavy snowfall, the phone lines are usually remarkably quiet. If patients know you are in trouble, most will be happy to wait a couple of days.

- Put a message on your main phone lines to say that due to accident/illness/whatever you are currently only able to provide an urgent service. Give an alternative phone number for patients to ring if they feel it is important they are seen in the next 48 hours.
- Give your most skilled receptionist or office manager the task of answering that phone, getting a one sentence history and phone number, and say that the GP will call the patient back.
- Your remaining clinician(s) will need to divide the day into blocks of telephone consultation and face to face appointments. If they are not used to telephone triage, two hours at a time is enough. The triage job is simply to decide if the patient needs to be seen that day or not. All other enquiries and requests should be politely declined.
- Face to face consultations can be run like an old-fashioned outpatient clinic, ideally with a nurse and a secretary/receptionist helping. Patients are ushered into separate rooms and the doctor moves between them, doing only core medical tasks, whilst the nurse/HCA and the secretary/receptionist do everything else. This can be very efficient, with 7½ or even 5 minutes per patient being manageable.
- Contact neighbouring practices and ask if they can help with visits – there won't be many, but a lot of time can be saved if the GPs do not need to leave the building.
- Tell NHSE and the CCG that you are in trouble, and why. They will certainly try to be helpful.
- Make sure you have enough non-medical people available, for example to help with the clinic sessions, and to deal with other routine matters, but the practice manager should have a strategic and co-ordination role and be free to deal with specific problems as they arise.

Continuity and Planning

Although patients, NHS England and other interested parties will understand if you need to run in emergency mode for a couple of days, you will need to pick up your routine work as soon as you can, not only because it is

contractual, but also to prevent the backlog becoming unmanageable. There will still be some things you can defer such as private medical reports, QOF/SPQS work and routine screening.

- Draft in management help. This will almost certainly be the first time you have had to do this but there are experienced managers with the skills and knowledge who can support you through this, talk to your Practice Managers group and approach SPH.
- Review everything the GP(s) do. Doctors should only be doing the things only doctors can do. Strip out every task that can be delegated. For example, get the GP to look at incoming results linked in with a staff member who can then contact patients, arrange repeats or file the results. Some of these things may increase your medico-legal risk, but not as much as would simply pouring more work on the GP.
- Ask neighbours for help. GP principals, being self-employed, can work in other practices so long as the right indemnity cover is in place. Don't forget they will need a new work location added to their Smartcards. Other staff can be "borrowed " or seconded, but check the employment position. Federations or GP collaboratives may wish to ask the Provider Support Unit for help planning for this.
- Flex your hours. You may not be able to get a locum from 9.00 to 12.00 but there could be someone available from 16.00 to 19.00. It is better to pay extra staff costs than fail to meet your contract.
- Extend review times. Patients ringing for a routine 6 monthly BP check because their repeats have run out can have another month or two of treatment authorized, but be aware of the double numbers you will have to deal with next time round.
- If it is not in the contract, don't do it. Most practices do some things because the GPs enjoy doing them or for patient convenience. Stopping non-contract work like ECGs and spirometry will clear some nurse time for more urgent clinical work.
- Review all your enhanced service activity. You may need to negotiate a suspension of this with the CCG, Public Health or the Area Team. In theory they could take a hard line on this, but in reality the last thing any of them want is for a practice to collapse.
- Talk to all the interested parties. Give your PPG and honest assessment of where you are and ask for their help in communicating with patients. Arrange to meet CCG and Area Team managers – the latter in particular will have been through this before.
- Thank all your team members frequently, brief them regularly and offer small tokens of appreciation. Most will be working harder and longer than usual, and they need to feel engaged and supported.
- Ask all the clinicians to commit themselves wholly to the practice for two weeks. That does not just mean working additional sessions, but also not attending educational events, external meetings or any other professional obligation that can reasonably be cancelled.
- Start to implement your recovery plan....

Recovery Phase

If you have met the first essential by having a recovery plan, you need to meet the second by using it. Although some of the things that triggered the initial crisis may have resolved, it is highly likely that you are going to have to operate in the future with fewer GPs than you would like. We think it is possible to provide primary care that meets the requirements of the GMS contract with about 2/3 of the current number of GPs, but only by making big changes in the configuration of the service.

Your plan will contain both medium and long term items, but here are some you might include:

- Triage all access requests. Triage has a chequered reputation from its role out of hours where it is used to decide who needs to be seen and who can safely be deferred. During the daytime you should not be putting people off, but deciding on the best solution to their problems, which is completely different. The essential requirement is to have enough capacity in the system for everyone who calls to have their needs addressed, not necessarily by seeing a GP. Start with a standard message on the phone to say that because there is a national shortage of GPs the practice is having to work differently to keep everyone safe. When the caller is put through, please can they tell the receptionist the reason for the call. This gives the patient a chance to think about what they want to say, and the receptionist can then give them a

suitable appointment or make a call back arrangement with a clinician or other staff member – for example, questions about hospital appointments can go on to a call back list for the admin staff. Clinical triage (by call back) should be undertaken by a GP or senior nurse, and experienced triagers suggest that something like 60% of calls do not need a GP appointment if an alternative is available.

- Widen your skill base. Primary care clinicians do not have to be just GPs or nurses. Physiotherapists, mental health nurses, counsellors, pharmacists, health coaches and social workers can all be part of the practice team.
- Don't expect GPs to work in isolation. Doctors work much more efficiently if there is another team member available to work with them. That may be a HCA, a secretary, or an admin assistant, but all analyses of current GP work show they are doing far more non-medical work than they should.
- Watch GPs job weight. If the GPs end up dealing only with risky diagnostic decisions, unresolvable psychosocial problems and complex multi-morbidity they will soon burn out. Appointment times will need to be longer, refreshment breaks and professional discussion timetabled in and some lighter and more immediately satisfying work included.
- Organise on a larger scale. Providers of 25,000+ are more resilient in every way. This crisis may give you the impetus you need to get on with it.
- Be radical about patient flow. Acute "on the day" demand is different to long term condition management and dealing with problems for which long term knowledge of the patient is helpful. Intolerable and unsafe "duty days" are a major source of GP stress, so split off immediate work to a team that is only responsible for this on any particular day. Think about using the clinic model for this.
- And while we are at it, you could centralise call handling for several practices.
- Go through everything that is done within the practice and map it across to a contract requirement. Send a list of everything that does not to the CCG and the AT and tell them that unless they can prove that the work is contractual you plan to stop doing it forthwith. (The BMA publishes a convenient check-list)
- Look critically at all your enhanced services contracts. It is likely that some are not profitable enough to continue. Give notice on these as soon as you can.
- Review all the non-patient contact tasks GPs do. Are these all necessary? Can any be delegated? Will the support proposed in bullet point 3 help?
- What are you doing about the wellbeing of your GPs and clinical staff? Does everyone have a compatible "buddy" or mentor? Do they have access to debriefing or supervision sessions, especially after an adverse event or a complaint. Do they know how to get counselling? Is there recovery time built into the working week? Does everyone get some flowers on their birthday?
- Changing working practices will buy us time but it does not resolve the problem of meeting rising demand under an open contract, with little prospect of more resources. What is your plan for two years and five years from now, and how often are you reviewing it?

Conclusion

Although there are many things being planned that will improve recruitment and retention of GPs and other primary care clinical staff in Somerset, these will take time to bear fruit. For the moment it would be wise to be ready for the problems we must anticipate over the next couple of years.

LMC/CCG Clinical Staff Survey

Sorry, another questionnaire, but this one is really important!

The CCG, the LMC, and other interested parties are meeting regularly to see what practical things we can do to improve GP and Practice Nurse recruitment and retention in the county. Although we have some information about the clinical workforce in primary care, there are some things we just don't know that are essential if we are to devise an effective plan. In particular, we need to know about current GP vacancies and what practices plan to do if they cannot be filled. We will be very grateful for your help with this. Please look out for it - we anticipate that it will be sent to you in the next few weeks.

Somerset GP Provider Support Unit

A developing resource for Practices and GP Collaboratives that needs funding

You do not need to be told how busy you are. The demands on general practice – both clinical and regulatory – ratchet up each winter and never really go down again. With clinical and management staff already working at the limit the LMC is fully aware that however much practices understand and agree that working at a larger scale is probably essential, nobody can pull themselves up by their own bootstraps.

By now most will be familiar with the idea of a Provider Support Unit (PSU) which is the slightly grand title for a virtual assembly of specialist resource that practices can draw on when considering collaborative options. Like a box of Lego, it includes a number of building bricks that can be used to assemble different models.

So far, with the LMC's own resources and some modest funding from the GP Defence Fund, we have started to build a library of legal and financial template documents and recommendations, and there is a growing list of FAQs that we will make searchable to provide quick answers to simple questions.

But to really move things on we need to have some skilled people, ready and able to guide potential groups through the change management process, and also more capacity to collect and collate the mass of information that will make this easier.

Practices have already seen the proposal from SPH for the appointment of a Project Manager and the funding that this will require, but co-ordinating the PSU will also require additional staff time in the LMC office. We estimate that £10,000 - £12,000 would cover this, which is the equivalent to about 2p per patient over and above the LMC levy. We are therefore asking Federations to consider allocating part of their Provider development resource from the CCG to help pay for this work. The sums involved are fairly modest but we anticipate that the investment will pay dividends for the whole county.

Bridgwater Bay Health	£1516.06
Central Mendip	£398.02
Chard Crewkerne and Ilminster	£944.42
East Mendip	£874.02
North Sedgemoor	£965.06
South Somerset	£2462.64
Taunton Deane	£2381.72
West Mendip	£1016.26
West Somerset	£668.44
Total	£11226.64

Dr Whimsy is on holiday but promises to return for the Christmas Edition bearing gold, frankincense & myrrh.

SMALL ADS... SMALL ADS... SMALL ADS

For current practice vacancies please see the adverts on our website at: <https://www.somersetlmc.co.uk/jobs/>