# General Practice During the Covid-19 Pandemic: The Role of the GP and Practice Team

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## Introduction

The GP and practice team have a key role in meeting the needs of patients with Covid-19 infections in the community. However, patients will continue to have other healthcare needs during the pandemic, which the general practice team must provide for. The purpose of this document is to consider how we will safely and effectively provide holistic care during the Covid-19 pandemic.

General practice services are essential to help maintain the health and wellbeing of our populations during the pandemic. The values of general practice have not changed and GPs must continue to offer high quality services and preserve continuity of care for their registered patients wherever appropriate. Practices, GPs and their staff must also maintain and understand their vital role in their local communities.

Practices as providers are truly clinical led, with a history of being innovative, adaptable, agile and flexible in how they best meet the needs of their local population; never before have these characteristics been more important.

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## Professional Context

**'There is arguably no more important job in modern Britain than that of the family doctor'**
(NHS England GP Forward View, 2016).

General practitioners (GPs) pre-date the creation of the NHS. The role of the GP has always been to provide holistic healthcare to individuals and to local communities. For most people, their GP is the first point of contact when they are concerned about a physical or mental health problem. In more recent times, this has extended to social concerns and even concerns of a cultural or spiritual nature. General practice care has been described as providing care from the cradle to the grave and, even in the current NHS, GPs continue to provide everything from antenatal/post-natal care through to end of life care with everything in-between. This relational continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes (as referred to by Freeman, 2010).

GPs operate in the complex space outside of disease-specific approaches, providing patient-centred care; they work in partnership with patients who have complex multiple co-morbidities to manage their physical and mental health conditions and to optimise the patient's wider well-being. Understanding patients' healthcare beliefs, values, and preferences is an important feature of this patient-centered care; this understanding predicts health behaviour, ensures treatment choices are more acceptable to the patient's expectations and needs, and is important aspect of compassion (as referred to by Kennedy, 2017).

Conditions that would have previously been outside the expertise of GPs, and under the exclusive remit of specialist hospital care, now form part of normal GP care. Over the last 20 years, the care of patients with long-term conditions (LTCs) has shifted so that the vast majority is now provided for by GPs and community teams. With the loss of the general physician in hospital practice, GPs have become the expert generalists. At a health-system level, general practice delivers efficient care by managing clinical risk through its front-line services, preventing over-medicalisation, facilitating appropriate access to specialist services and investigations (as referred to by Marshall, 2015).

At a population level, general practice serves defined local communities and offers prevention services and health promotion, in additional to treatment of disease. GPs understand their neighbourhoods, the local social capital and promote social inclusion, for example by linking patients to local groups and voluntary sector organisations.

GPs understand the specific needs of their local communities and have a long history of planning and delivering services to meet these needs, taking into account potential barriers to access, such as language and literacy, and ensuring delivery models that are socially and culturally acceptable. 'Taking into account the needs of different people' is a key line of enquiry for determining whether a practice's services are effective (CQC), and yet there is little mention of the importance of maintaining this localism at practice level in NHS strategy.

# Maintaining safe and effective general practice services during the Covid-19 pandemic

The main areas of care that GPs provide can be considered under the following headings:

**Emergency/urgent care**

- Diagnosis and management of patients presenting with acute illness.
- Risk assessing and triaging these presentations into those suitable for advice only, prescription, further investigation, referral for specialist advice or acute hospital referral.
- Referring cases of suspected cancer to specialist services in accordance with revised 2WW pathways.

**Long-term conditions**

- Diagnosis and management of many LTCs in general practice.
- Referral for secondary care for the diagnosis and/or initial management with referral back to GP for the long-term management.
- Referral to secondary care for the diagnosis and/or initial management and then ongoing joint management of the patient.
- Referral to secondary care for the diagnosis and ongoing management of patients.

**Prevention and health promotion**

- This includes vaccinations, immunisations, lifestyle modification (diet, exercise, smoking and alcohol).

**End of life care**

- Increasing numbers of patients with end stage disease or malignancy or choosing to die in the community with the GP being part of the multi-disciplinary team supporting them and their families through this event.

**Patient and local community advocacy**

- Identifying and referring vulnerable individuals, especially where there may be a safeguarding concern.
- Understanding the local communities being served.
- Providing holistic care, for example assistance with benefits.
- Linking with voluntary organisations.
- Providing patient support forums within the practice.
- Contribute to community cohesion.

When considering the delivery model for these services, it is therefore vital to consider how continuity of care and trusted therapeutic relationships with patients can be preserved, and how the place of the practice at the centre of communities can be maintained.

## Role of the GP and practice team during the pandemic

- The role of GP and practice team in meeting both reactive and proactive patient need has not changed.

- Patients need to be aware that they should continue to access emergency and essential services in a timely way.

- Clinical prioristisation has resulted in the need for practices to direct greater resource to the emergency management of acute illness, and away from routine care of conditions for which a delay is clinically acceptable and will not impact on mortality/significant morbidity. All other functions of general practice continue.

- However, decisions regarding the services and care to different cohorts of patients that can be safely postponed are more robust if informed by the duration of postponement. This is currently unknown, but it is reasonable to assume that the pandemic will last at least months if not years.

- Throughout the pandemic period, the demand on general practice created by Covid-19 will oscillate resulting in variation to the increased primary care emergency service demands.

- At times of waning demand, it is vital that practices re-direct capacity back into LTC care and health promotion. During these periods, practices need to consider how they prioritise the released capacity to best meet the needs of their patients.

- During the waxing periods, practices will need to manage the transition back to meeting high demand for emergency primary care Covid-19 services, and the diversion of an appropriate level of capacity away from LTC care and health promotion services.

- General practice has a long history of evolution, demonstrating an ongoing ability to implement considerable change in terms of the scope and nature of the services provided (as referred to by Baird, 2018). Practices are truly clinical led, with a history of being innovative, adaptable, agile and flexible in how they best meet the needs of their local population; GPs must draw on these strengths of their practice delivery-unit.

## Emergency/urgent care

### Ai. Emergency/urgent care for patients with suspected/presumed[1] Covid-19 infection: Covid-19-related emergency services

### Role of general practice:

- To provide an assessment and triage service with subsequent referral/ongoing monitoring/ management/end of life care to patients with Covid-19.

**1. Assessment and triage of Covid-19 severity**

- People presenting for Covid-19 care will either contact the practice as their first point of call for their first assessment or have been referred by the NHS 111 Clinical Assessment Service following a first assessment.
- People presenting directly to practices will need consideration whether an alternative diagnosis is likely and should be assessed and triaged into categories 1, 2a, 2b, 3 (as described by the London clinical networks) with consequent appropriate management.
- People who are referred by Clinical Assessment Service will typically be 2a symptomatic patients. They will require further clinical assessment and, as the disease progresses, the severity of their Covid-19 will need re-classification into categories 1, 2a, 2b or 3.
- Practices need to think about how they will deliver this assessment, triage and monitoring.
- Practices could consider setting up a designated practice-level 'GP Emergency Covid-19 Care Service'. This will involve:
  - Enabling the NHS 111 Clinical Assessment Service to refer eligible patients, as set out nationally, into the bespoke service that will operate until the end of the pandemic;
  - Repeated reassessment of patients as their disease progresses; the predicted frequency of review will depend on the category of severity at that time, with the facility for patients to access additional triage appointments if they deteriorate;
  - A booking system for ensuring patients can access ongoing patient monitoring, which may involve booking follow up reviews in advance. However, if demand outstrips capacity, there will need to be an additional mechanism of daily prioritisation according to clinical need. For example, daily patient self-reporting could support clinical prioritisation through identifying red/amber flags in the responses; we are working with AccuRx to develop a technological solution for this.
- In this case, patients are likely to have higher viral loads and present higher risk to health care professionals (HCPs). All triage should be conducted remotely, with use of video consultation if available, taking into account any vital signs (including oxygen saturations) that the patient has the means to obtain. Please see our guide on the assessment of Covid-19 patients.
- Remote triage poses no risk to HCPs and therefore the pool of staff available to provide the service is high, and relational continuity of care can be maintained at practice level.

[1] Household contacts of someone with suspected Covid–19 within the 2-week self-isolation period

2. **Advanced triage of Covid-19 severity – obtaining an oxygen saturation**
   - Following initial remote triage, it may be necessary to obtain an oxygen saturation reading to help ensure correct triage categorisation and manage the patient appropriately.
   - It is possible to achieve this whilst minimising risk of exposure of clinicians to Covid-19:
     - Pulse oximeters can be delivered to patients for the time period required and the patient can obtain the readings at home.
     - Alternatively, if space is available in the vicinity, patients can have their oxygen saturations measured in their cars, or after a brief period of exertion next to their car. If a blue tooth device is used, patients can put on gloves and apply the pulse oximeter whilst clinicians stand up to 10 metres away.
     - Please see our guide on the monitoring of oxygen saturations of Covid-19 patients.
   - If these means of delivering care without close face to face contact are instituted, along with appropriate infection control and personal protection measures, there will be low risk to clinicians and the pool of staff who could deliver this care will be higher. Therefore, relational continuity of care would not have to be sacrificed to ensure service continuity and this can be carried out at practice level.

3. **Arranging ongoing assessment/referral/prescribing for Covid-19**
   - In most cases, this can be carried out remotely at practice level.
   - If further primary care face to face assessment is required, this should be at an assessment centre until the patient's risk of transmitting infection is thought to revert to that of the general population. At this point, the patient can continue to be directly cared for by their practice.

## Aii. Emergency/urgent care for patients with suspected/presumed[2] Covid-19 infection: non-Covid-19 emergency services

## Role of general practice:

- Consideration of alternative diagnoses in patients presenting with Covid-19 symptoms, where appropriate.
- Consideration of an additional diagnosis, the assessment for which cannot be delayed until the patient has recovered from Covid-19.
- If considering a suspected cancer on the basis of the remote assessment, a decision will need to be made on whether further assessment/investigation can be delayed until the patient has recovered from their acute Covid-19 infection.

1. **Assessment, diagnosis, triage and management**

   **Remote assessment**
   - The first consultation should be remote and ideally be a video consultation.

[2] Household contacts of someone with suspected Covid–19 within the 2-week self-isolation period

**Further assessment/intervention required face to face**

- In exceptional circumstances, further examination, observations or primary care investigations may be required face to face in the primary care setting.
- These patients are likely to have high viral load and therefore pose higher risk to clinicians, who must use appropriate personal protective equipment (PPE) and infection control measures must be employed.
- There will be a more limited pool of clinicians who are low risk and willing to be exposed to higher viral loads. Furthermore, measures will need to be taken to ensure that these clinicians do not become vectors of disease when providing care to unaffected patients. However, with the correct eligibility criteria, the capacity required to deliver this service will be very low at practice level.
- Delivering this service, including allocating clinicians who are consequently unable to provide care to other patient cohorts, at practice level may not be an effective use of resources. Depending on predicted demand, it is important to consider whether primary care network (PCN) or borough-wide assessment centres may be an appropriate scale to deliver this care whilst maximising the effective use of the workforce resource.
- Service continuity considerations may mean that continuity of care is sacrificed for this small number of patients for the duration of their Covid-19 infection/self-isolation.

## B. Emergency/urgent care for patients without suspected/presumed[3] Covid-19

## Role of general practice:

- To recognise, triage and manage emergency/urgent care conditions including suspected cancer referrals in accordance with revised 2WW pathways. These vital services must continue. We must do all we can to prevent increased mortality and morbidity as an indirect consequence of the pandemic.

### 1. Assessment, triage and management

**Remote assessment, triage and management**

All initial assessment and triage and management, if possible, should be carried out remotely, ideally enabled by video consultation.

- This does not pose additional risk to clinicians nor patients, and therefore the pool of staff is likely to be sufficient for this to be carried out at practice level and continuity of care maintained.

**Further assessment required face to face**

- However, further examination, observations or primary care investigations may be required face to face in the primary care setting.
- These patients are less likely to be carrying high Covid-19 viral loads, although coronavirus can present atypically and be asymptomatic. PPE should be worn for all face to face interactions.
- Face to face interaction with a clinician may pose more risk to the patient, than the patient poses to the clinician. Clinicians who have been exposed to high viral load patients within the preceding two weeks should not deliver this care.

[3] Household contacts of someone with suspected Covid–19 within the 2 week self-isolation period

- For any face to face encounter, whether through visiting or not, appropriate infection control processes must be in place and PPE must be available to protect the clinician and the patient.
- If staff capacity allows, shielded patients (who are at the highest risk of developing severe Covid-19 disease) could be offered home visits for face to face assessment, so that they are not exposed to additional infection risk through leaving their homes. If this is not possible, practices may wish to consider whether there is benefit in designating a room or site for face to face care to shielded patients.
- For lower risk patients, this care can be delivered in the practice setting with appropriate infection control and personal protection. Practice could consider designating specific consulting rooms for this purpose. Each patient should encounter the minimum number of staff, ideally just the clinician delivering the care.
- As these patients are much less likely to carry viral loads than patients with Covid-19 symptoms, it should be possible to maintain a sufficient pool of staff able to safely deliver the care at practice level, maintaining relational continuity of care.

2. **Arranging ongoing assessment/referral/prescribing for emergency presentations in those without suspected or presumed Covid-19 infection**
   - The management of non-Covid-19 emergency illness will not change during the pandemic period. However, the operating procedures must minimise the risk of Covid-19 disease transmission. Secondary care services may also be re-configured.
   - For patients who require acute admission to hospital, a direct discussion between the referring clinician and the accepting clinician will help to ensure that the risk: benefit of hospital attendance is in the patient's best interest.
   - If required, primary care follow up of the patient should be through phone/video consultations, unless there is a specific reason that would require a face to face appointment.

## Long-term condition care, prevention and health promotion

### Role of general practice:

- To diagnose and provide maintenance care to people with LTCs.
- To provide prevention and health promotion services, including vaccinations, screening and lifestyle modification (such as diet, exercise, smoking and alcohol).

**We need to minimise the risk of harm to patients through delays to routine care.**

1. **Prioritisation**
   - There are some patients for whom any delay in the delivery of LTC care may result in harm, and essential services should continue to these patients, even at times of high Covid-19 care demand (as referred to by RCGP, 2020):
     - T2DM with HbA1c>75, recent DKA, disengaged;
     - COPD with a hospitalisation in last 12 months and/or two or more exacerbations in last 12/12 requiring oral steroids/oral antibiotics, patients on LTOT;
     - asthma with a hospitalisation in last 12 months, ever been admitted to ICU, two or more severe exacerbations in last 12 months (needing oral steroids), on biologics/maintenance oral steroids;
     - significant mental health with concerns regarding suicide or deliberate self-harm risk or currently unstable mental health.
   - There are some services that should continue being provided by the commissioned service provider, irrespective of Covid-19 care demand (as referred to by RCGP, 2020):
     - essential injections – eg, Prostap, Aranesp, clopixol, testosterone*;
     - blood monitoring for high risk medications eg, INR, DMARDS, immunosuppressants etc;
     - wound care.
   - There are prevention and health promotion services for which delay may result in harm, and these services should continue throughout the pandemic (as referred to by RCGP, 2020):
     - childhood immunisations;
     - routine vaccinations, such as seasonal flu, pneumococcal etc for all patients where they are recommended, with prioritisation of vulnerable patients in high risk groups;
     - postnatal checks – combining these with childhood immunisation to reduce patient contact.
   - At times of high Covid-19 care demand, we are likely to also to experience significantly increased rates of staff sickness absence, creating considerable challenges in maintaining LTC diagnosis, maintenance care and prevention, and health promotion services. At times of reduced capacity, care to people for whom a delay in LTC care is very unlikely to result in harm should be de-prioritised to direct resources to those with more acute need.
   - However, the pandemic period is likely to last months/years, and patients will come to harm if LTC care is suspended for prolonged periods.
   - Throughout the pandemic period, the demand on general practice created by Covid-19 will oscillate and when, Covid-19 demand allows, LTC diagnosis and maintenance and health promotion services should be resumed.

- In order to minimise the risk of harm to patients due to delays to routine LTC care and prevention and health promotion services, practices should consider how they stratify their services and patients to ensure that the clinical value to the patient population is maximised.

**2. Stratification**

**a. Long-term condition maintenance**

In order to stratify LTC maintenance by therapeutic clinical value to the patient, practices may wish to consider factors such as:

- **Control of the condition**
  Practices may wish to prioritise patients whose LTC control is unstable or variable. Patients who have historically well controlled disease are at lower risk of developing long-term complications if their control deteriorates over a short period of time.
- **The need to avoid harm due to treatment**
  This includes medication monitoring. Some treatments have a narrow therapeutic window (lithium) or variable availability (warfarin) so need to be prioritised over treatments that are monitored for long-term benefit (statins).
- **The time frame for development of complications if maintenance care suboptimal**
  The risk of developing complications from treatments such as anti-coagulation can occur acutely so would need to be prioritised over other conditions such as diabetes, hypertension etc. where, with exceptions, complications are more likely to occur over a prolonged period of time.

**b. Medication reviews**

In order to stratify medication reviews by therapeutic clinical value, practices may wish to consider factors such as prioritising review of the following medications over routine medication reviews:

- drugs that need essential monitoring;
- drugs of potential abuse;
- polypharmacy.

**c. Prevention and health promotion services**

In order to stratify population prevention services and health promotion, practices may wish to consider factors such as:

- **Long-term impact to the population**
  For example, there's a requirement to continue immunisation programs to maintain herd immunity.
- **Long-term impact on the individual**
  For example, national screening programs increase the likelihood of early detection of conditions, reducing morbidity and mortality.
- **Health promotion that can be delivered by other methods**
  For example, smoking cessation can be done remotely, by smoking cessation advisors or pharmacist or patient facing online resources and tracking apps and remote feedback can help support lifestyle change such as increasing exercise, eating healthily and losing weight.

## 3. Delivery model

**Remote assessment**

- All clinical interactions should be remote wherever possible, with video consultations when required.
- Practices should consider reviewing our LTC pathways to consider which components can be done remotely. All members of the GP team in developing remote consultation techniques.

**Face to face for assessment or delivery of essential interventions, such as essential injections and blood monitoring**

- Face to face care should only be carried out if the benefits outweigh the risk to the patient.
- Asymptomatic patients receiving routine care have low risk of carrying high viral load. However, all face to face interactions require appropriate infection control measures and personal protection to protect both clinicians and patients.
- In order to minimise the risk of asymptomatic transmission, ideally care should not be delivered by clinicians who have been exposed to patients with suspected Covid-19, and consequent potential high viral loads, within the preceding two weeks.
- The risk of harm to a patient from a face to face interaction with a clinician and the additional risk of leaving their home will depend on the medical risk of the patient.
- If staff capacity allows, practices could consider offering their highest risk patients (shielded patients) care in their own homes through visiting. If this is not possible, in order to minimise the risk in delivering essential face to face care to asymptomatic shielded patients, practices may wish to consider designating a room or site which has been set up for the purpose of seeing shielded patients without suspected or presumed Covid-19 infection.
- It may be possible to carry out more self-testing blood monitoring for investigations that traditionally have required phlebotomy services, e.g. HbA1c, GFR. This would reduce risk to patients, especially our highest risk patients, and release staff capacity but needs more exploration regarding the risks and benefits.
- Patients, for whom the risk associated with leaving their own homes is lower, can be seen in a practice setting.
- Practices may wish to consider whether there is any benefit in designating a room or site, for the delivery of essential face to face care, to asymptomatic patients who do not meet the criteria for shielding but are at higher risk of developing severe Covid-19 infection.
- This work should pose low risk to clinicians and therefore the pool of staff who can deliver this care should be sufficient to enable this to continue to be delivered at practice level, maintaining the continuity of care that is of considerable benefit to patients with LTCs and those receiving health promotion.

## End of life care

### A. For patients with suspected/presumed[4] Covid-19

### Role of general practice:

- To work as part of a multi-disciplinary team to ensure that patients remain as comfortable as possible, and supporting patients, their careers and families to meet their psychological, social and spiritual needs.

**Remote care**

- The risk of transmission from patients to clinicians is high, and therefore, as above, options to deliver end of life care remotely should be thoroughly explored. End of life care should continue to be holistic, paying heed to a patient's physical, psychological, social and spiritual needs. The needs of the family/informal carers should also be very carefully considered, especially as the usual support networks will not be available during the pandemic period. Furthermore, the social circumstances may be precarious if other members of the household are unwell with Covid-19 infection.

**Face to face care**

- In the end of life setting, patients may require face to face interventions through home visiting.
- With the right pathways in place to support the delivery of effective remote end of life care, and with the input of specialist palliative care services, the need for face to face interactions can be minimised.
- These patients are likely to have high viral load and therefore pose higher risk to clinicians. Appropriate PPE must be worn, and infection control measures employed.
- There will be a more limited pool of HCPs who are low risk and willing to be exposed to higher viral loads. Furthermore, practices should endeavour to take measures to ensure that these clinicians do not become vectors of disease through also providing care to unaffected patients.
- For patients who are household contacts of people with covid disease, if they do not develop symptoms of the disease, they can be considered low risk to the clinician after their period of self-isolation.
- There will be a cohort of patients at the end of life who develop a cough as a result of their end stage non-Covid-19 condition. This may unnecessarily increase the number of patients considered to pose higher risk to clinicians. Putting in place unnecessary self-isolation precautions at home will also potentially impact on the quality of interactions between the patient and family members. This could be overcome if community Covid-19 testing were available.
- Delivering a visiting service to people at end of life with suspected Covid-19 may not be effective at practice level. Service continuity considerations may mean that relational continuity of care has to be sacrificed for this small number of patients. For patients who are household contacts of people with Covid-19, this would only be for the duration of self-isolation.

[4] Household contacts of someone with suspected Covid–19 within the 2 week self-isolation period

## B. For people without suspected/presumed[5] Covid-19

### Role of general practice:

- To work as part of a multi-disciplinary team to ensure that patients remain as comfortable as possible, and supporting patients, their careers and families to meet their psychological, social and spiritual needs.

**Remote care**

- The risk of clinicians to patients should be considered, although this may be less pertinent at the last stage of life.
- The risk of clinicians to other household members should be considered.
- Therefore, care should continue to be delivered remotely wherever possible, including non-conventional options. For example, there are resources to teach and support carers to deliver subcutaneous medications. End of life care should continue to be holistic paying heed to a patient's physical, psychological, social and spiritual needs. The needs of the family/informal carers should also be very carefully. considered, especially as the usual support networks will not be available.

**Face to face care**

- Patients may require face to face interventions through home visiting, and appropriate PPE should be worn, and infection control measures employed.
- Ideally, care should not be delivered by clinicians who have been exposed to suspected high viral load patients, or Covid-19 household contacts, in the preceding two weeks. This will pose risk to family members and, depending on the stage of end of life, may hasten death of the patient through asymptomatic transmission. Clearly, this additional risk to the patient diminishes as the patient enters the final phase of end of life.
- These patients are unlikely to pose high risk to clinicians.
- Therefore, there should be a pool of staff sufficient to enable this to remain at practice level, especially given the significant benefits of continuity of care during these distressing periods.

[5] Household contacts of someone with suspected Covid–19 within the 2 week self-isolation period

## Patient advocacy and community capital

### Role of general practice:

- To offer holistic care, taking account of physical, mental, social, spiritual needs.
- To have a thorough understanding of local communities within our practice population, including commonly held values and beliefs.
- To understand the social capital of the local practice community.
- To be at the heart of the communities we serve.
- To understand our influence as respected leaders in our local communities.

**Supporting the vulnerable during the pandemic**

- We need to consider if the patient is socially vulnerable, medically vulnerable or both.
- Shielding and social distancing is not free of risk. Everyone has basic needs for food, social interaction and a sense of belonging.
- Patients who are at most risk of severe covid disease, our shielded patients, currently have an offer of volunteer support and additional social and health care.
- However, some patients are likely to be at risk of harm from the impact of social distancing because their basic needs are not met, for example an inability to access food and social interactions. These people may not have the means to reach out. General practice is well placed to identify those at increased risk and reach out through our link workers, and match need to the volunteer offer.
- Social distancing and loss of existing social support mechanisms may pose increased risk of exacerbation of pre-existing mental health difficulties. GPs and practice staff often have longstanding therapeutic relationships with their patients and are likely to be able to identify those whom they feel may be at particular risk, and who may not reach out despite requiring increased support during the pandemic period.
- Some patients may be at increased risk due to their living circumstances and may need the input of specialised services and support. For example, GPs are trained to identify safeguarding concerns early and respond appropriately to any signs or allegations, working effectively with other organisations. Social isolation and distancing is likely to increase vulnerability to domestic violence in some families.
- The pandemic will also have a significant impact on the socio-economic wellbeing of our populations and practices have a key role in signposting to support.
- Practice professionals can also signpost to wider services of support and draw on the local community social capital, for example matching need to volunteers, local groups and voluntary sector organisations.
- The pandemic has increased geographic community cohesion in many areas, with people reaching out and volunteering to support their close neighbours for the first time. Volunteer support is important in non-pandemic times too, bridging the support provided by practices and the community (as referred to by Gilburt, 2018).

- Communities are vital building blocks for health and wellbeing (as referred to by PHE, 2015). Practices are well placed to support this community-led movement in their local areas and help their local community to maintain and develop this when the pandemic has passed. This is essential to the wellbeing of our practice populations (as referred to by King's Fund) and may reduce reliance on health and social care services moving forwards (as referred to by Buck, 2008) – both of which have importance post pandemic.
- We will endure as communities, we will rally as communities, and we will heal as communities. Our practices are at the heart of our neighbourhoods, and clinicians must not underestimate their influence as local leaders.

## Key messages

### The role of general practice

- The pandemic has not changed the role of GP and practice team in meeting both reactive and proactive patient need, nor have the values of general practice changed.
- Practices must do what is within their gift to minimise the risk of mortality and morbidity as a direct and indirect consequence of the pandemic. Emergency care, LTC care, end of life care, health promotion and population healthcare must all continue.
- The pandemic has changed the way we work and resulted in us spending more of our time managing emergencies than undertaking routine and preventative care.
- The pandemic will oscillate over months/years and practices need to be agile to flex their services to match patient need with changing levels of staff capacity.
- LTC and health promotion services, and the patients they serve, can be stratified so that practices deliver the maximum clinical value with the staff available at any given time.

### How we deliver our services

- Practices should consider the best ways of providing their different services during the pandemic. They should also consider the scale – practice, PCN or borough – that would maximise the safety and effectiveness of each service.
- Practices should continue delivering care at practice level wherever possible and appropriate, thereby maintaining the therapeutic trusted relationship with GPs and the primary health care team.
- Careful consideration of how care can be delivered safely and effectively will maximise the number of services that can continue to be delivered at practice level.
- PPE and infection control measures should be used for all face to face interactions, although the level of risk due to viral load will be variable.
- All face to face interactions should involve interaction with the fewest number of clinicians and other practice staff as possible.
- All face to face interactions should be for the briefest duration as possible.
- However, all practices will need to have business continuity plans. Maintaining care at practice level throughout the pandemic may be more challenging to practices that are vulnerable due to their size or staff shielding. Clinicians who are concerned that their practice business continuity is at higher risk may wish to share resources with another practice or across a PCN.
- In determining how and where different aspects of care should be delivered, consider:
    - The balance between the level the risk posed by the patient/HCP and the level of risk posed to the patient/HCP;
    - The balance between the level of patient demand for the service and the size of the staff pool available to deliver the service;

  - The balance between continuity of care by the normal practice and the need to provide care in the safest setting.

- Continuity of care for a particular service/patient cohort at practice level may need to be compromised if:
  - The pool of staff available to deliver the service is insufficient to meet demand and maintain service continuity;
  - Deploying practice staff to deliver the service would destabilise other key practice services/be an ineffective use of clinicians' time and practice resources; and
  - Care can be provided more safely in another healthcare facility.

**Practices may wish to consider working at a larger scale to deliver face to face care to patients with suspected Covid-19 and to patients who are household contacts of people with suspected Covid-19:**

- Face to face care to patients with suspected Covid-19 and patients who are household contacts of people with Covid-19 may pose greater challenge to safe and effective delivery at practice level.
- There must be provision for essential face to face care (through home visits and in the healthcare setting) to patients with covid disease and to patients who are household contacts of people with Covid-19.
- With appropriate eligibility criteria and alternative means for measuring oxygen saturation, there is likely to be very low demand for face to face services to these two cohorts of patients at a practice level. However, patients will continue to need:
  - Consideration of a non-Covid-19 diagnosis that cannot be carried out remotely;
  - Consideration of an additional diagnosis that cannot be carried out remotely, and for which a delay until the patient has recovered from Covid-19/completed the isolation period would cause harm; and
  - End of life care that cannot be delivered remotely.
- Clinicians providing face to face care (including visits) to people who are likely to be infectious, should be low risk for severe Covid-19 and be working with this cohort of patients through choice. This is likely to be a small pool, especially at practice level.
- Therefore, maintaining business continuity for these services may not be possible at a practice level.
- Furthermore, in order to minimise the risk of asymptomatic transmission, clinicians providing this care should ideally avoid providing care to non-infected patients, especially those patients most at risk of severe Covid-19, until two weeks have passed. This may compromise delivery of other services with higher demand.
- Providing these services at larger scale – PCN or borough- may offer further opportunities to maximise the effectiveness and safety of the service through:
  - Utilising the most appropriate facilities for infection control procedures;
  - A bespoke operating model;
  - Staff becoming experienced in working in the environment;
  - Less professional isolation in providing care for this cohort of people.

## Summary

This document recognises how the role of the GP and practice team has changed during the Covid-19 pandemic. General practice services are essential to help maintain the health and wellbeing of our populations during the pandemic but must be delivered differently in order for services to be safe and effective. GPs must continue to offer high quality services and preserve continuity of care with their registered patients wherever appropriate. Practices, GPs and their staff must also maintain and understand their vital role in their local communities.

Practices as providers are truly clinical led, with a history of being innovative, adaptable, agile and flexible in how they best meet the needs of their local population; never before have these characteristics been more important or more clearly apparent.

The response of general practice to the Covid-19 pandemic has been truly exceptional. All GPs and practice staff should have a sense of immense pride and appreciate that the public gratitude to the people of the NHS is truly deserved.

We thank you for all that you are doing in serving our communities.

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## References

Baird, B. (2018). Innovative models of general practice. *Kings Fund*, 6-10.

Buck, D. (2008). Communities and Health. *Kings Fund*, https://www.kingsfund.org.uk/publications/communities-and-health.

CQC. (n.d.). https://www.cqc.org.uk/guidance-providers/healthcare/taking-account-needs-different-people-healthcare-services.

Freeman, G. (2010). Continuity of care and the patient experience. *Kings Fund Research Paper*, https://www.kingsfund.org.uk/sites/default/files/field/field_document/continuity-care-patient-experience-gp-inquiry-research-paper-mar11.pdf.

Gilburt, H. (2018). Volunteering in general practice: opportunities and insights. *Kings Fund*, www.kingsfund.org.uk/publications/volunteering-in-general-practice. .

Kennedy, B. (2017). Healthcare provider versus patient's understanding of helath beliefs and values. *Patient experience journal*, 29-37.

Kings Fund. (n.d.). https://www.kingsfund.org.uk/projects/improving-publics-health/strong-communities-wellbeing-and-resilience.

Marshall, M. (2015). A Precious Jewel - The role of general practice in the English NHS. *New England Journal of Medicine*, 372:893-897.

NHS England. (2016). *General practice forward view. https://www.england.nhs.uk/gp/gpfv/.*

PHE. (2015). A guide to community-centred approaches for health and wellbeing. A full report. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768979/A_guide_to_community-centred_approaches_for_health_and_wellbeing__full_report_.pdf.

RCGP. (2020). *RCGP Guidance on workload prioritisation during Covid-19.* https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2020/covid19/RCGP%20guidance/202003233RCGPGuidanceprioritisationroutineworkduringCovidFINAL: version 8.