



29 October 2009

Dear Colleague

Pandemic Influenza: Guidance on Planning and Responding to Primary Care GP Practice Capacity Challenges

Summary

1. This Circular provides information and guidance to Health Boards etc. on how to plan and respond to Pandemic Influenza should demand on Primary Care Providers increase in their areas.

Information

2. Information to Health Boards is contained in **Annex A**.
3. The Scottish General Practitioners Committee, together with the Pandemic Influenza Co-ordination Team have agreed that the information contained in this Circular should be used as guidance and that Primary Care providers should adhere to the guidance as appropriate.

Action

4. NHS Boards are requested to bring this Circular to the attention of all relevant staff.

Yours sincerely

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Deputy Director, Primary Care Division

Addresses

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Pandemic Influenza: Planning & Responding to Primary Care GP Practice Capacity Challenges

Introduction

The current H1N1 Influenza Pandemic is likely to present Health Boards and primary care services with increasingly significant capacity challenges in terms of demand pressures from patients who present with influenza-like illness or secondary complications arising from H1N1 influenza and potentially in terms of supply pressures due to illness amongst primary care staff themselves.

This paper sets out measures that Health Boards should consider to support local GP practices and other primary care contractors during both in-hours and out-of-hours periods, allowing them to concentrate on delivering services whilst short-staffed, and to cope with increased patient demand during the pandemic and the anticipated seasonal influenza.

It is also important that Health Boards consider their responses to primary care capacity challenges in relation to their overall plan for managing a pandemic to ensure that activity is not inappropriately diverted around the system.

Out of Hours services will also play an important strategic role in the way that the primary care system responds to this pandemic. Therefore, it is essential that all Health Boards recognise the contribution made by out of hours services and provide appropriate help and support to sustain their role within the system. Examples include planning ways of quickly increasing capacity in local out of hours services during an outbreak cluster and identifying mechanisms to cope with any increasing demand for face to face consultations. The Out of Hours Operations Group is also feeding into the national planning considerations.

In general, Health Boards should not be making extra payments to practices unless the practice clinical/administration staff are working significantly longer hours or where the contractor is engaging significant levels of additional staff at the Health Board's request (e.g. engaging additional staff so that they can cover the closure of a neighbouring practice).

Emergency arrangements for GP practice income protection

NHS Employers on behalf of the four UK countries and the General Practitioners Committee (GPC) of the BMA agreed arrangements last year for protecting GP practices' income in the event of serious and sustained pressure from pandemic influenza, in particular by suspending the monitoring of the Quality and Outcomes Framework (QOF) and Directed Enhanced Services (DES) in order to enable practices to participate fully in national and local responses to pandemic influenza.

Scottish Ministers will issue Directions to Health Boards to bring in these emergency measures if required at the appropriate time.

The UK Government and the GPC are keeping under review the arrangements for deciding whether and when these emergency arrangements should be introduced and decisions will be made on a UK level.

The Directions to introduce these arrangements will build on the principles agreed by the BMA and NHS Employers in May 2008 under their *Principles for GMS practice payments during an influenza pandemic*. The general principle is that, in the event of some or all routine work having to be suspended; GP practices' NHS income from QOF and enhanced services will be protected in line with the previous year's earnings and Doctors' and Dentists' Review Body (DDRB) uplift in return for "command and control" by the Health Boards. Links to these documents are:

[http://www.sehd.scot.nhs.uk/pca/PCA2009\(M\)05.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2009(M)05.pdf)

http://www.nhsemployers.org/SiteCollectionDocuments/Principles_for_practice_payments%96flu_pandemic_cd_160209.pdf

http://www.nhsemployers.org/SiteCollectionDocuments/Costing_methodology-flu_pandemic_cd_160209.pdf

Employment of Locum GPs

Health Boards will be required to monitor the situation in their own area and take the appropriate action in determining the employment of locum GPs. The key stages as described below may differ across the country at different times.

It is recognised that Boards are best placed to directly employ locum GPs in their area. Thereafter, it would be for Boards to determine GP locum resources. For example, making effective use of such resources by directing locums to support Out of Hours services and/or GP practices most under pressure when dealing with the demands and effects of a pandemic.

Each Health Board will need have to have a mechanism in place for determining when the local situation has reached a key stage and when responsibility for engaging locums needs to switch from individual providers to the Health Board.

The Health Board will wish to involve the LMC/GP Sub-committee of the Area Medical Committee in this decision. Until such time as the Pandemic Statement of Financial Entitlements (SFE) is in place, practices remain at liberty to source their own locums and claim under the current SFE. It is suggested that each Health Board takes this decision, having regard for local supply and demand conditions.

The GPC has expressed concern that, if a locum employed under 'call-off' contract arrangements were to die between contracts of employment, the locum's dependents would not be able to access death-in-service benefits from the NHS pension scheme.

The Director of Primary and Community Care from the Scottish Government Health Directorates has already written to Health Boards to ask that they avoid this possibility by offering contracts to locums during the period of the pandemic.

We believe a solution is for Health Boards to engage the services of GP locums on a longer-term, fee based and continuous contractual basis. This would afford GP locums Assistant Practitioner status under the Scottish NHS Pension Scheme Regulations rather than Locum Practitioner status.

Assistant Practitioners are afforded continuous (i.e. 24/7) death-in-service cover under the Scottish NHS Pension Scheme whereas death benefits awarded in respect of Locum Practitioners differ depending on the time of death. It would also be possible for GMS, Section 17C and Section 2C contractors to employ locums on this basis.

Also Assistant Practitioners are covered under the NHS Injury Benefits Scheme; GP locums are not. This does not mean that the locum GP needs to be contracted to work every day. The contract could be just for one day per week to maintain continuous NHS Pension Scheme Assistant Practitioner status.

Health Boards should ensure their lists of locum GPs is up-to-date and that they can offer contracts quickly if the pandemic escalates.

If more information is required in respect of NHS Pensions, death cover etc please contact: NHSPEN3@Scotland.gsi.gov.uk

Database of Active Locums

In readiness, Health Boards should also, if they do not already have a Locum Bank, prepare a **Database of Active Locums** with verified contact details, GMC number, defence union, availability, preferred locality to work etc of each locum GP. The easiest way to start the database is to contact all the GPs on the Health Board's Performers List who are neither GP "Principals" nor full-time.

Health Boards should see if Sessional Doctors in local practices are available for and willing to undertake additional locum work and may wish to add their details to the locum database. Health Boards could also contact part-time local GP Principals and Salaried GPs to establish if they would be willing to work additional locum sessions over and above their practice commitment. Health Boards should ensure that locums on the database are kept up-to-date with any communications regarding the Pandemic that are available to GPs and practices.

Health Boards should also consider appraising their local Bank of Nursing Staff in conjunction with their provider of community services seeking to build not only Community Nurse but also Practice Nurse reserve capacity.

Retired GPs

Health Boards should note that the BMA hosts a list of retired medical practitioners who have expressed an interest in returning to active service to support the NHS during a pandemic influenza outbreak.

Any Health Board wishing to access the list for their area should provide details of the postcodes applicable to their area of responsibility and complete a Data Protection Agreement form which is available from the BMA.

Please then e-mail the completed form to Alan Saddington at the BMA (asaddington@bma.org.uk) or fax a copy to 020 7383 6494.

BMA Scotland should be able to respond with the information within one working day of the request. Health Boards will then need to contact individual practitioners to ascertain availability.

Health Boards will need to ensure that retired GPs are competent and have the necessary skills and up-to-date knowledge of current medical services.

Health Boards will need to provide a contract to ensure that there is suitable indemnity cover from The Clinical Negligence and Other Risks Scheme (CNORIS)

and Central Legal Office (CLO) (i.e. retired practitioners have agreed to work in these circumstances for expenses reimbursement only).

Health Boards will wish to agree with the practitioner the scope of their work during this time which may include medical cover for call centres and death certification (should this become necessary). Should retired practitioners be required to provide primary medical services they will need to be included in a medical performers list.

Legislation has been introduced recently which will enable the GMC to register doctors temporarily in the event of a national emergency, such as a pandemic.

Maintaining existing Locum arrangements in General Practice

Payments are made by Health Boards to practices for the purposes of contributing to the costs of locum cover whilst a GP, Partner or Salaried Doctor is absent from the practice due to sickness. The SFE sets the minimum obligations that Health Boards have in respect of locum sickness payments that would normally commence if leave of absence is more than one week.

NHS Employers and the General Practitioners Committee have agreed a payment rate for locums during a pandemic period. This rate will be set at an hourly rate applicable to the time of day worked for the local out of hours service as averaged over the previous three months.

N.B. Health Boards should review their Section 17C contracts to establish their obligations to pay for locums to cover the sickness absence of Section 17C doctors, Principals and Salaried Doctors.

In most cases, it is likely that Section 17C contract clauses will reference the GMS SFE and therefore Health Boards will probably need to treat Section 17C practices in the same way as GMS.

If not, then Health Boards should consider the implications of any difference in policy and address this if necessary, including any requirements for contract variation to be agreed.

Medical Indemnity for Non- Contractual work

Doctors who are asked by the NHS to undertake additional sessions or work outside their usual duties for the duration of the pandemic, for example GPs doing triage in an A&E department, are advised to inform their Medical Defence Organisation.

It is expected that most additional work, including non-primary medical care, should be NHS indemnified and that all the other benefits of Medical Defence Organisation membership should operate in the usual way in respect of any medico-legal problems arising from such work.

Liability cover in the event of Influenza Pandemic

The most up-to-date advice with regard to cover for NHS employees and volunteers is that: *“All staff employed by members of our schemes, including authorised volunteers, are treated as being “engaged” by the member for the purposes of CNORIS*

Access to Clinical Records

Whilst this is not normally a significant issue when practices are organising their own locums to cover occasional sickness, Health Boards should recognise access to clinical records is at significant risk (in the extreme circumstances of a pandemic) when they are stepping in to direct locums into a practice or arranging for patients to be seen at a different surgery. Under such circumstances, unless prior arrangements have been made, it may not be possible for the alternative GP to access a patient's medical records due to Clinical System security measures. Although it may be acceptable to see urgent patients without medical history for a few days, any longer periods of practice cover cannot be provided safely without access to clinical records.

Health Boards should consider whether there are any suitable technical measures they can take to either allow remote access to clinical records or to secure onsite access through local security systems.

In the absence of any technical solutions, Health Boards may wish to arrange for multiple additional log-in identities to be created and assigned to each locum GP as required, rather than a shared identity as this will preserve the value of the audit trail. Where practical the Board will want to engage the practice as well as LMC in these arrangements. Boards may also wish to consider training on unfamiliar systems. Practice managers may already have induction-style packs that are used by short-term locums within the practice.

Escalation Strategy

Every Health Board should sign off a Primary Care Capacity Challenge Escalation Strategy which sets out how the Board will respond to inadequate clinician capacity both in terms of individual practices and across the Health Board area in general.

Critical to the ability of Health Boards to manage a capacity crisis is their ability to prioritise services in a managed way.

Decisions on Suspension of Services

Although the QOF and DES can only be suspended with the approval of Scottish Ministers, there are potentially other services and activities that Health Boards and primary care GP contractors could agree to suspend to help manage demands from pandemic influenza. Local Enhanced Services (LES) are one example. Health Boards will need to enter into discussions with Local Medical Committees to agree in each case whether any income normally associated with that activity should be protected, and whether it should be used to commission a defined activity to support the local response to the pandemic.

The Scottish Government is also considering arrangements to enable Health Boards to suspend certain Directed Enhanced Services if necessary and will monitor the situation as it develops.

Health Boards should bear in mind, that subject to relevant contractual arrangements, a practice can choose to withdraw from any DES arrangement. However, if this is done prior to the introduction of revised Directions being issued, the Health Board will be able to withhold the associated DES payment.

Decisions relating to the temporary suspension of such services are not without significant clinical risk. Health Boards should have a defined committee or other decision-making body to consider such actions in the context of local health priorities and needs. It is suggested that this committee could include:

Senior Medical Advisor (e.g. Director of Public Health)
Non Executive Director
Chief Executive
Designated Flu lead Director
LMC representative
OOH Medical Director
PC Contracts person

Supported and advised by a senior local GP and a senior primary care officer.

Health Boards may:

- Establish a new committee for this purpose;
- Use existing local influenza groups if they are appropriately constituted to fulfil this role; and
- Strengthen existing local influenza groups so that they perform this function.

NB. The committee needs to be able to meet at short notice and additional backup members of staff should be nominated to ensure that the committee can still operate if any of the substantive members of the committee are absent.

Escalation levels

Health Boards are advised to have a defined escalation strategy to encourage practices to seek permission to suspend services so that the Health Board can co-ordinate an appropriate response and organise temporary re-provision if necessary. This is probably best achieved by agreeing not to stop or reduce contract payments if service suspension has been properly sanctioned. Health Boards must follow the current SFE until such time as it is revoked. A key component of this strategy will be communications, including informing the public. For example, patients without influenza-like illness may expect the same high level of service from their GP practice that under these conditions they might not receive.

This paper suggests **three levels** of escalation and it is important that professionals are encouraged to undertake these areas of work when practically possible and within the limitations of the capacity at any one time and taking into account other clinical priorities.

Level 1: Suspension of non-core activities

There is no contractual definition of non-core activities and this guide does not seek to establish such a definition. It will be for Health Boards and their stakeholders locally to determine those activities and services delivered by their GP practices which they do not regard as being core (i.e. can be suspended without immediate significant adverse health impact).

Health Boards should bear in mind that contracts for services to registered patients must include the provision of essential services. Regulations stipulate that essential services cannot be sub-divided into services that are delivered and those that are not.

At this level of action, specific non-core activities are suspended across a Health Board area until further notice. These activities might include non-urgent clinical services (such as additional minor surgery which equates to 0.6% of global sum), obesity management and non-clinical activities such as referral coding and reporting. At a technical level this would usually involve suspension of various local enhanced services.

Where suspending these activities would result in loss of income, Health Boards may then continue to pay practices for such services against an assumed level of performance in lieu of the alternative workload being undertaken, or use the released funding to commission an alternative enhanced service from the practice to help respond to the pandemic. Any change to practice funding must be discussed with the Local Medical Committee as any service for which funding has been removed will cease.

Temporary release of all non-essential clinical staff engaged by the Health Board

The Health Board Executive team should review all current arrangements by which the Health Board engage clinical staff in the planning and implementation of services, for example clinical involvement in the management of Managed Clinical Networks (MCNs) Integrated Care Pathways and others. Such staff in all but essential roles should be released back to their practice to focus on more immediate clinical priorities. Some of these activities will need to continue in some form but a pragmatic approach is suggested.

Temporary suspension of all non-essential visits by Health Board to practices

The Health Board Executive Team should catalogue all planned visits to practices over the next 6 months. All non-essential visits should be postponed to allow practices to focus on more immediate priorities. These may include Health Board visits related to QOF, payment verifications, internal audit etc.

The possibility of any essential business being undertaken by telephone or with a more limited range of attendees should be considered. One-off visits may be required in situations where there are genuine clinical governance concerns. Such visits should be agreed locally with the Local Medical Committee.

Level 2: Managed suspension of services

At this stage the Health Board recognises that it is not possible for the practice to continue to provide all core services to patients.

Practices may need to request suspension of various services (e.g., suspension of booked appointments, changes to surgery opening times etc). This could be by a brief pre-prepared template, e-mail or fax to the Health Board. The information should allow clear identification of the services that the practice wishes to suspend

and reasonably detailed reasons for the request. Guidance and copies of the template are available at:

www.sehd.scot.nhs.uk/publications/DC20091014form.doc.

The requests should be considered on a case-by-case basis by the designated decision-making committee. It is recommended that any request granted by the committee should not result in a financial penalty to the practice.

Where practices have been permitted to suspend services it is recommended that they be required to submit daily SITREPs until the suspension is lifted.

These reports should be concise but sufficient to allow the designated decision-making committee to determine whether the suspension should be lifted or whether circumstances at the practice are getting worse and further action is likely to be needed. Where incidence of pandemic demand is similar across a geographical area, a Health Board-wide approach may need to be considered.

A similar decision making process should be followed for the recommencement of suspended services and this could be at the instigation of the committee or the practice.

Level 3: Full suspension of services

When circumstances arise that it is not safe or possible for the practice to continue to provide services (normally due to the non-availability of clinical staff or levels of demand mean that the normal level of service is unsustainable) the practice is required to submit a template by e-mail or fax to the Health Board providing notification and declaration of its decision. Guidance and copies of the template are available at:

www.sehd.scot.nhs.uk/publications/DC20091014form.doc.

Practices may wish to consider how administrative or reception staff can start this process should all the practice clinical and senior staff become unavailable.

The relevant decision-making committee must consider all notifications. Where the committee considers that the closure was reasonable it should recommend accepting the practice closure. Alternatively, instead of accepting the practice closure request, the committee may seek to deploy Health Board engaged locums and/or other non-clinical staff to ensure that the practice remains open, and then continue to monitor the situation through daily SITREPs.

Reciprocal / Buddying arrangements and financial implications

Health Boards may wish to prepare for Level 3 requests for full suspension of services. This is particularly important for Health Boards with significant numbers of small or single-handed GP practices where the absence of one or two GPs and failure to secure a locum will impact on the ability to provide a safe service. This could be one of the priority areas for Health Board retained or employed locums. As a contingency against such eventualities Health Boards may:

- seek agreement with the Primary Medical Care Contractors (generally GP workforce) working with the Local Medical Committee (LMC), to have

reciprocal arrangements in place between practices to cover patient care where capacity is lost or significantly reduced.

- wish to consider how GP led Health Centres can provide cover for either urgent or routine consultations to create additional capacity.
- wish to consider how better integration and efficiency is achieved working with Out Of Hours services.

In the event that:

- The Health Board appoints another practice to undertake the provision of care for another practice list or
- a practice applies to the Board for an alternative provider or a 'buddy' to undertake the provision of care for its practice list and the Health Board accepts such an application.

it is suggested that the Health Board use a time-limited LES to secure services for groups of patients with the alternative provider(s) so as to establish clear responsibility for clinical care. The Health Board will also wish to ensure suitable access to patient records.

It is expected that the Health Board will have to make payment to the alternative provider or 'buddy' and it is suggested that this payment should be based on what the 'buddy' practice would be paid if the patients from the other practice registered with them, i.e. on a capitation basis calculated from the global sum of the practice suspending its services.

Provided the practice seeking to fully suspend its services does so in accordance with the agreed protocols (Level 3) the Health Board should not take any action under contract to recover monies paid during the period that the practice is closed.

Any practice taking on the provision of care for another practice list, may wish to consider a move to level 2 in order that they can suspend provision of non-urgent care for patients on their lists, thereby releasing time and capacity required to undertake additional urgent consultations.

Health Boards may wish to record the periods where practices assume responsibility for patients registered with other practices so that any additional expenditure can be accounted for in their budget.

Where patients are managed by another practice (following a practice closure) the Health Board will need to ensure that appropriate contractual procedures are followed to ensure the legality of the arrangement. The Health Board will wish to be mindful not to create a bureaucratic burden for practices in this situation and bear in mind that the circumstances may be temporary.

The most effective way of achieving this is through a simple signed agreement between the Health Board and the practice temporarily managing the patients.

The agreement should state that the practice 'has agreed to provide services under contract to' in accordance with clause 161.6 of its GMS contract and that

Schedule 6 (Payment Schedule) has been varied to include the agreed payments of £69 per capita associated with this arrangement.

Note: similar clauses should be present in Section 17C contracts.

Contractual implications of service suspensions

The pre-prepared templates for temporary suspension of services can be prepared in the form of a time-limited local enhanced services. This would serve to clarify the arrangements agreed between the two parties in order to avoid potential future disputes.

Specific Requirements for Dispensing Practices in Rural Communities

Where a practice is a dispensing practice, special arrangements will need to be put in place where this practice applies for full suspension of services at level 3.

Not only will any alternative provider need to cover the provision of urgent consultations, alternative arrangements may need to be addressed for the issues of dispensing medicines by supplementary pharmaceutical services.

Vaccination programme: Capacity issues

Health Boards need to work closely with their GP practices to ensure effective systems are in place to deliver the programme.

Some of the additional activity related to this programme will include the issuing of call/recall letters for the H1N1 programme which for this year will be in addition to the annual seasonal flu call/recall letters. This will present an increase in the volume of letters which GP practices are required to issue.

There will also be a need for GP practices to update patient records with data gathered by local Occupational Health providers where health and social care staff have been vaccinated within this setting. This will present a challenge for Boards in processing this information timeously to ensure records are up to date as quickly as possible.

Health Boards will also need to ensure that vaccine supplies are not wasted through lack of cold storage capacity at different levels, including GP practices. Waste should also be minimised through efficient use of the multi-dose vials and appropriate forward planning of the vaccination of patients. There will be other areas which will require joint working between the Health Boards and GP practices to successfully deliver this challenging programme.

GPs will be paid a fee of £5.25 for each dose administered to patients in the priority groups.

It has been agreed that Community nurses will be responsible for vaccinating housebound patients in the priority groups. GPs will be expected to inform Boards of those patients on their lists who are in these groups but to whom they will not be offering vaccinations and to liaise closely with Boards to ease delivery.

Health Boards should ensure that such patients are referred to the appropriate community nursing service for vaccination, especially when they are not currently on an existing caseload.

Where GPs are willing to continue with effective local arrangements under the seasonal flu programme to assist with, for example, the housebound in care homes, they should inform their Board and enter into local arrangements.

More generally, it is recognised that the wider vaccination programme represents additional work. The per dose payment of £5.25 is designed to cover the costs of this new activity in terms of contacting patients, administering the vaccine and taking on extra staff. In particular, this fee paid to GP practices will go in part towards additional work required of staff, whether practice employees or NHS Board employees. It will be for individual practices to agree with local Boards how reimbursement should be made to Boards for this use of NHS staff. This reimbursement will not apply to the vaccination of housebound patients as detailed above.

Where individuals are in both an at risk group and a relevant occupational group, the expectation is that, subject to patient preference, they will be vaccinated by their GP practice.

Whilst GPs are normally responsible for the occupational health arrangements of their own staff, Boards have agreed that Occupational Health services will be responsible for vaccinating eligible practice staff who are not in clinical at risk groups. However, practices may agree to vaccinate their own staff provided details are provided where appropriate to the GP practice where such staff are registered. This work will not qualify for the £5.25 fee.

The Scottish Government and the Scottish General Practitioners Committee underline the exceptional nature of this vaccination programme, which does not set a precedent for future arrangements.

Communications

Health Boards should consider having a dedicated telephone number for Primary Care contractors to contact the Board during any period of pandemic activity, which would need to be manned between the hours of 08.00 and 18.30.

In addition, as part of the Health Board pandemic planning arrangements, an alternative dedicated number should be publicised for use by patients who may need to access advice regarding service provision in the event that services have either been reduced or suspended at the 'usual' primary care provider.

All Health Boards, working in conjunction with the Scottish Government, should define key messages and information that can be provided to all Primary Care contractors for dissemination to their patients.

Information materials for professionals will be provided by the Scottish Government which will help ensure consistent messages are conveyed to the public and help foster public confidence in local services.

Re-directing Patients

The Health Board should establish a protocol and related products for the re-directing of patients from a closed surgery to an alternative local provider. This might include preparing:

- a checklist for the practice manager or for Health Board staff tasked with managing the closure;
- posters re-directing patients to other surgeries or providers; and
- the wording of a message to go on the practice answer phone.

Local Medical Committee Consultation

It is essential that the Health Board should discuss all its proposals with the Local Medical Committee who will be able to advise and make valuable recommendations. These discussions should take place in a timely fashion with sufficient time for a considered response.

Out of Hours Services

It is clear that Out of Hours services, who provide primary care for a significant number of hours in the week, have faced very substantial increases in demand for their services during the current H1N1 pandemic whilst at the same time running exactly the same risks as GP practices in terms of reduced supply of both medical and call handling staff.

NHS 24 is the first point of contact for Out of Hours in Scotland and clinical services are provided under contractual or other arrangements made by Health Boards with GPs.

GPs delivering Out of Hours services will continue to play a critical role in the delivery of Primary Care Services in a pandemic situation. For this reason, Health Boards should seek to involve these GPs in both strategic and operational planning at every stage, including ensuring efficient and effective communications, similar to those in the core hours of general practice.

In order to safeguard their critical role, it is important that Health Boards ensure Out of Hours services do not become the default provider for activities that are not handled by other services during core hours.

Similar to A&E, Out of Hours services have to respond to the needs of all those who contact them and their ability to do this may be severely compromised if they are faced with a surge in demand when other services close.

Following the same principle, Out of Hours services should not defer the triaging of patients who are put in contact with them in the out of hours period by waiting to refer them to their GP practices in hours (unless it is clinically appropriate to do so).

Out of Hours services also have an important role working with the Scottish Flu Response Centre (SFRcC) in assessing patients passed on from the NHS 24 core service.

In order to support their local Out of Hours services to meet the demand and supply challenges of the influenza pandemic, Health Boards may wish to explore the following approaches:

- GPs should be encouraged to step up their contribution to support Out of Hours services. Health Boards will need to consider what is the best use of local GPs, including sessional GP and locum resources. Health Boards should also take into consideration that GPs working additional hours during a pandemic will require sufficient rest and may be unwilling to work additional shifts.
- The Health Board should review its current staff complement (administrative and clinical) and identify staff in non-essential roles that could be released or redeployed to support Out of Hours services.
- Health Boards need to confirm that OOH staff are defined as essential users on lists for fuel if access is restricted. This is especially important in rural areas with poor public transport. These measures should avoid the situation where OOH mobile cars are full of fuel but staff are unable to get into work.
- Health Boards should ensure that the team involved in providing Out of Hours services are offered H1N1 vaccination as “frontline healthcare staff”.
- Health Boards need to ensure that they have arrangements in place to make antivirals available, where appropriate, to symptomatic patients and for prophylaxis. This includes the activation of antiviral collection points. Particular attention needs to be paid during public and bank holidays.

In the event that the Flu Line Solution is activated, NHS Boards will also need to ensure that Out of Hours services are able to deal with any “speak to doctor” dispositions which will be transferred electronically to the local hub from SFReC / NHS 24. Boards will need to increase their monitoring capacity, especially daytime, in their OOHs hubs to continue to support the primary care response.

Health Boards may wish to consider using SITREPs for all Out of Hours services in order that capacity for these services can be effectively monitored and appropriate contingency plans escalated as appropriate.

In addition, Health Boards may wish to consider, as part of their contingency planning, reducing pressures at A&E by retaining GP services within the A&E environment or to be available to attend when large numbers of patients are presenting with influenza-like symptoms. It is also possible for A&E services to provide telephone access to NHS 24 to provide access to its services, within the waiting room.

Communications

Health Boards will wish to use local media to direct people towards the most appropriate disposition e.g. NHS 24, SFReC, Flu Line (if activated) or their GP practice within the current guidelines and should consider future communication routes when it become necessary to reduce queries and enquiries to GP practices and Out of Hours Services. A shared approach with LMCs, Out of Hours services, the Director of Public Health and the local Pandemic Influenza Team will lead to the most effective local communications.

Other Primary Care Providers

NHS Pharmaceutical Services: Specific guidance has been developed in relation to NHS pharmaceutical services. Please refer to this guidance when considering any local strategies and responses to planning and responding to primary care capacity issues.

NHS Boards should, in their planning, take into account any subsequent impact on community pharmacy contractors and services in their responses to wider primary care capacity challenges and, in particular, GP practices.

General Dental Services: The Board will need to consider how to deal with increased dental emergency demand in the event that local dentists are forced to close due to staff shortages. The Board will also need to consider how to re-deploy staff that are not busy delivering usual dental services to support other areas of primary care.

General Ophthalmic Services: The Board will not need to consider any specific roles that can be undertaken by optometrists to protect hospital services, including A&E. The Board can consider how and where any staff not busy with the usual optometry services can be re-deployed to support other areas of primary care.