

Pandemic Flu:

Planning & Responding to Primary Care Capacity Challenges

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Introduction

The current swine flu pandemic is likely to present Primary Care Trusts (PCTs) and primary care services with increasingly significant capacity challenges: not only in terms of demand pressures from patients who present with influenza-like illness or secondary complications arising from swine flu, but also potentially in terms of supply pressures due to illness amongst primary care staff themselves.

This first practical guide to support PCTs in relation to primary care during a pandemic situation covers primary medical care: those services provided by GP practices, GP led health centres and Out of Hours Providers (OOH). Further practical guides will be produced for other independent contractors and to support any vaccination programmes that relate to this pandemic. A guide for pharmacy services and access to medicines is already in development.

PCTs will wish to consider how and when to collaborate with other local PCTs, particularly in urban areas, to ensure a consistent message to the public about where to access services. In line with national advice, PCTs will wish to work with practices and OOH providers to ensure appropriate high levels of take-up of both the seasonal and swine flu vaccinations by front line healthcare staff.

In order for PCTs to concentrate on delivering services whilst potentially short staffed, and to cope with increased patient demand during the pandemic and the anticipated seasonal flu, this guidance sets out:

- measures that PCTs are strongly advised to consider to support local primary care contractors over both the in-hours and the out-of-hours periods
- how PCTs should consider their responses to primary care capacity challenges in relation to their overall plan for managing a pandemic to focus activity within the system
- that there needs to be a key role for OOH providers as they have the infrastructure to make best use of scarce resources should the situation deteriorate
- that PCTs recognise the contribution made by OOH providers and provide appropriate help and support to sustain their role within the system
- that PCTs will not be making extra payments to practices, unless the practice clinical/administration staff are working demonstrably longer hours or the contractor is engaging significant levels of additional staff at the PCT's request (for example engaging additional staff so that they can cover the closure of a neighbouring practice)

The guide is structured around the following topics:

PCT level arrangements

- Escalation Strategy
- Dispensing practices
- Local contracts
- Out of Hours providers

Individual performer issues

- Employment of locums
- Retired GPs
- Doctors in training
- Indemnity cover
- Access to clinical records

National arrangements

- Emergency arrangements for GP practice income protection

Communications

Other primary care contractors

PCT level arrangements

Escalation Strategy

It is strongly recommended that every PCT Board should sign off a Primary Care Capacity Challenge Escalation Strategy as outlined on page 4, which sets out how the Trust will respond to inadequate clinician capacity, both in terms of individual practices and across the PCT area in general.

Critical to the ability of PCTs to manage a capacity crisis is their ability to prioritise services. This will include helping clinicians to prioritise workload, co-ordinate temporary re-provision of services, and establish an environment which promotes cooperation whilst minimising clinical risk and the risk of material financial loss to either practice or PCT.

Decisions on Suspension of Services

Although the QOF and DES can only be suspended if appropriate Directions are issued by the DH, there are potentially other services and activities that PCTs and primary care contractors could agree to suspend to help manage demands from pandemic flu, for example Local Enhanced Services (LES). Due regard will need to be taken for the nature of the service provided and its relative priority and needs of the population compared to the needs arising from the pandemic. Where LES are suspended it will be necessary to decide in each case whether any income normally associated with that activity should be protected, or whether it should be used to commission a defined activity to support the local response to the pandemic.

The DH is considering arrangements to enable PCTs to suspend certain DES if necessary, and will provide further advice on this shortly. PCTs 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 payments Directions being issued by the DH, the PCT will be unable to make the associated DES payment.

Decisions relating to the temporary suspension of services are not without significant clinical risk. PCTs are advised to 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 the following members:

- Senior Medical Advisor (e.g. PCT Medical Director or Director of Public Health)
- Non Executive Director
- Chief Executive or Director of Primary Care
- Designated Flu lead Director

- LMC representative
- Medical Director of the out of hours provider

The above would be supported and advised by a senior practising local GP and a senior primary care officer.

PCTs may:

- establish a new committee for this purpose
- use existing Local Flu Groups if they are appropriately constituted to fulfil this role
- strengthen existing Local Flu Groups so that they perform this function.

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

Escalation levels

PCTs are advised to have a defined escalation strategy to encourage practices to seek permission to suspend services, so that the PCT can co-ordinate an appropriate response and organise temporary re-provision if necessary. This is probably best achieved by agreeing not to stop/reduce contract payments if service suspension has been properly sanctioned. PCTs must follow the Statement of Financial Entitlements (SFE) until such time as it is revoked in their area by the DH. A key component of this strategy will be communications – including informing the public. Patients without flu-like illness may be expecting 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. It is important that professionals are encouraged to continue as much work as is practically possible and within the limitations of the capacity at any one time, taking into account other clinical priorities. The PCT will wish to be aware of the situation as reported in the pandemic flu monitoring and how this compares to usual Winter pressures in the area. PCTs will also wish to consider any HR information that considers the availability of clinical staff, including those in primary and community settings.

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 PCTs and their stakeholders locally to determine those activities and services delivered by their GPs which they do not regard as being core** i.e. can be suspended without immediate significant adverse health impact. “Core activities” are not necessarily the same as “essential services” under the contract. The criterion for identifying an activity as “non-core” relates to the immediate impact of its temporary suspension, and it may be that activities that are “essential services” under the contract are nevertheless identified as “non-core” when the PCT is obliged to prioritise activities during a pandemic. Early discussions on the types of services that might be included with stakeholders will be useful.

These activities might include non-urgent clinical services such as the minor surgery additional service, obesity management and non-clinical activities such as referral coding and reporting. However, PCTs should remember that where a practice withdraws from an additional service, it must make a deduction to the Practice's global sum as set out in paragraph 2.5 of the SFE.

At this level of action, specific non-core activities could be suspended across a PCT 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 LES.

Where suspending these activities would normally result in loss of income, PCTs could 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. This does not relate to additional services or any other SFE fees as far as paying against an assumed level of services is concerned. Redirecting money into a LES is fine.

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

The PCT executive team are advised to review all current arrangements by which the PCT engage clinical staff in commissioning activities, for example panel, committee and Practice Based Commissioning (PBC) activities. Such staff in all but essential roles could 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 PCTs to practices

The PCT executive team is advised to catalogue all planned visits to practices over the 6 months after the introduction of the strategy. It is recommended that all non-essential visits be postponed to allow practices to focus on more

immediate priorities. The possibility of any essential business being undertaken by telephone or with a more limited range of attendees could be considered.

Level 2: Managed suspension of services

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

The practice will need to request suspension of various enhanced services, for example suspension of LES, changes to surgery or opening times etc. This could be by a brief pre-prepared template email or fax to the PCT. The form should allow clear identification of the services that the practice wishes to suspend, and reasonably detailed reasons for the request.¹

These requests would need to 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. In other words, either where the suspension of the activity would otherwise result in loss of income practices should have the income protected, or the resources should be used to commission an alternative enhanced service from the practice.

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

These reports should be concise, but sufficient enough 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 PCT wide approach may need to be considered.

It is recommended that a similar decision-making process be followed for the recommencement of suspended services – this could be at the instigation of the committee or the practice.

¹ A sample form will be available soon at www.pcc.nhs.uk

Level 3: Full suspension of services

When circumstances arise such as it is not safe or possible for the practice to continue to provide services, normally due to the non-availability of clinical staff, it is recommended that the practice be required to submit a pre-prepared template by email or fax to the PCT providing notification & declaration of its decision. Practices may wish to consider how administrative or reception staff can start this process should all the practice clinical and senior staff become unavailable.²

It is recommended that the relevant decision-making committee consider all notifications. Where the committee considers that the closure was reasonable it could recommend accepting the practice closure. Alternatively, instead of accepting the practice closure request, the committee could seek to deploy PCT engaged locums and or other non-clinical staff to ensure that the practice remains open, then continue to monitor the situation through daily SITREPs.

Reciprocal/Buddying arrangements and financial implications

PCTs may wish to prepare for Level 3 requests for full suspension of services by supporting or setting up buddying or reciprocal arrangements between practices.

This is particularly important for PCTs 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 affect the ability to provide a safe service. This could be one of the priority areas for PCT retained/employed locums.

As a contingency against such eventualities, PCTs may:

- seek agreement with the Primary Medical Care Contractors (generally the GP workforce), working with the LMC, to have reciprocal arrangements in place between practices for covering patient care where capacity is lost or significantly reduced
- wish to consider the role that Primary Care Trusts Medical Services (PCTMS) practices play in providing cover for urgent consultations
- 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 OOH providers (see below).

In the event that

- the PCT 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 PCT accepts such an application,

it is suggested that the PCT uses a time limited LES to secure services for groups of patients with the alternative provider(s) so as to establish clear

² A template will be available soon at www.pcc.nhs.uk

responsibility for clinical care. The PCT will also wish to ensure suitable access to patient records (see earlier section).

It is expected that the PCT will have to make payment to the alternative provider or 'buddy' and it is suggested that the following funding formula could be used:

- $\text{Global sum} \times 1000/52 = \text{cost per week per 1000 patients}$

This should approximate to £1250 per week per 1000 patients.

Provided the practice seeking to fully suspend its services does so in accordance with the agreed protocols (Level 3) the PCT 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 (as above), 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.

PCTs may wish to record the periods where practices assume responsibility for patients registered with other practices, so that additional expenditure can be accounted for in their prescribing and PBC budgets.

Where patients are managed by another practice following a practice closure, the PCT is advised to ensure that appropriate contractual procedures are followed to ensure the legality of the arrangement. The PCT will wish to be mindful not to create a bureaucratic burden on 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 PCT and the practice temporarily managing the patients. The agreement should state that the practice '...has agreed to provide services under contract to' and that Schedule 7 (Payment Schedule) has been varied to include the agreed payments of £x associated with this arrangement.

A similar signed agreement could be drawn up for PMC contractors confirming the contractors agreement to provide services to a particular group of patients.

Contractual implications of service suspensions

The pre-prepared templates for temporary suspension of services³ can be prepared in the form of a time-limited LES. The PCT will wish to involve the finance team in this level of planning. This would serve to clarify the arrangements agreed between the two parties in order to avoid potential future disputes.

³ A template will be available soon at www.pcc.nhs.uk

Dispensing practices

Specific requirements for dispensing practices in rural communities

Special arrangements will need to be put in place for dispensing practices to apply for full suspension of services at level 3. Not only will any alternate provider need to cover the provision of urgent consultations, the PCT may need to ensure adequate medicines supply and pharmaceutical services are available through other providers. Amendments are being made to current pharmaceutical regulations to enable PCTs to respond flexibly to the demands of the pandemic. Separate guidance will be available shortly on these changes. Alternative arrangements may need to be considered for the issue of medicines by supplementary pharmacy services.

Communications between PCTs and providers

PCTs are advised to consider establishing a dedicated telephone number for primary care providers to contact the PCT during any period of pandemic activity, which would need to be staffed between the hours of 08.00 to 18.30. Outside of normal working hours the on-call director will need to be the first port of call – arrangements will need to be considered for decisions to be made for OOH providers. This will be particularly important if any provider needs to reduce the level of service or suspend services at short notice, when contacting the PCT via their normal routes is not possible.

In addition, as part of the PCT pandemic planning arrangements, it is recommended that 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 PCTs are advised to define key messages and information that can be provided to all primary care contractors for dissemination to their patients. This will help ensure that a consistent message is given to the public, and help foster public confidence in local services.

Redirecting Patients

The PCT is advised to 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 PCT staff tasked with managing the closure
- posters redirecting patients
- wording of a message to go on the practice answer phone.

Local Medical Committee consultation

It is strongly recommended that the PCT discusses all its proposals with the LMC which 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.

Local Contracts

Should the national arrangements be brought into force for GMS practices, PCTs will need to work with local providers as a matter of urgency to secure their agreement to similar contract arrangements. Current contracts may have to be suspended or varied by arrangements acceptable to both parties, that protect providers' income and secures their maximum participation in caring for patients with 'flu symptoms.

We would expect that in the case of PMS contracts, which often mirror GMS and will have been in place for some time, PCTs will probably wish to follow the GMS model where this is applicable.

APMS contracts, many of which are comparatively new and may not have previous year's earnings as a benchmark for income protection, will require more consideration. These contracts, like other primary medical care contracts, will have detailed requirements and associated sanctions. A contractor who is cooperating with the PCT's local pandemic flu plan will almost invariably find itself unable to comply with these requirements. It is not envisaged that PCTs will wish to activate any such contractual sanctions or financial penalties where the breach is directly associated or caused by the contractors continued cooperation with the PCT as part of its influenza pandemic plan.

Out of Hours Providers

Core GP practice hours cover less than a third of the hours in a week, and the onset of illness has no regard for 'normal' opening hours. It is clear that OOH providers have faced very substantial increases in demand for their services whilst at the same time running exactly the same risks in terms of reduced supply of both medical and call handling staff.

OOH providers are playing a critical role in the delivery of primary care services in the pandemic. For this reason, PCTs are advised to seek to involve their OOH providers in both strategic and operational planning at every stage, and ensure that communication flows are as efficient and effective as those established for core hours general practice.

PCTs will need to plan effectively for out of hours provision during the pandemic; early and continued conversations with providers are required to ensure that capacity remains available.

In order to safeguard this critical role it is important that PCTs ensure OOH providers do not become the default provider for activity that is not handled by other services during normal hours. Just like A&E, OOH providers 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.

In order to support their Local OOH provider to meet the demand and supply challenges of the flu pandemic PCTs may wish to explore the following approaches.

- Practice-based GPs need to be encouraged to step up their contribution to OOH services. PCTs would need to consider what is the best use of local GP resources – access to GPs at their own surgery or additional resources provided centrally to the whole population by the out of hours provider.
- PCTs could review how GP Led Health Centres interface with local OOH services and, where possible, negotiate more effective integration and efficient utilisation of resources; for example encouraging OOH providers to direct patients to GP Led Health Centres at busy times, or redeploying GP Led Health Centre staff to provide additional capacity for OOH telephone consultations.
- It will be necessary to ensure that Patient Group Directions (PGDs) are in place to allow nurses to dispense Oseltamivir (Tamiflu) as per Health Protection Agency guidelines. In addition, they also need to ensure that procedures are in place for Non-Medical Prescribers to be able to authorise supply of Tamiflu. The simplest solution is to use the same PGD as PCTs. These guidelines may change with the introduction of vouchers or unique reference numbers.

- PCTs could agree that OOH providers have the freedom, where necessary, to elongate front-end messages from beyond the mandated 30 seconds to allow them to direct patients to the National Pandemic Flu Service (NFLS) where appropriate.
- PCTs could support the increase in caller handler trainer capacity so that when necessary it can fast track the training of new OOH and other local call handlers.
- The PCT could review its current staff complement (administrative & clinical) and identify staff in non-essential roles that could be released or redeployed on to support enquiry lines/OOH providers.
- PCTs could confirm that OOH provider 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.
- PCTs could confirm that OOH provider staff are defined as 'frontline healthcare staff', including call handlers and drivers, and offered vaccination.
- PCTs could permit OOH providers to split National Quality Requirement (NQR) reporting requirements into flu and non-flu. Non-flu cases could continue to be reported as per NQR, but flu cases would not. Once cases have been triaged into uncomplicated flu and complicated (or high-risk) flu, the latter category could be managed as per non-flu call back standards. Uncomplicated cases could be called back within 4 hours.
- PCTs could consider whether the current situation is an example of force majeure, in contract terms, and contribute to the increased service costs incurred. PCTs are advised to meet with their OOH providers regularly in order to review both OOH demand and clinician/call handler supply, reviewing analysis of increased costs. It is important to be aware of the risk of providers being forced into insolvency, and in this respect the PCT may need to take action to ensure prompt payment of bills or improve cash flow.
- PCTs are advised to ensure that antiviral collection points are available 7 days a week, with late opening up to 10pm. Particular attention needs to be paid to the August, and subsequent, bank holidays.
- If there are inadequate Anti-viral Collection Points (ACP), the OOH provider may become the OOH ACP by default, further adding to the demand.

- PCTs could consider introducing buddying arrangements between OOH providers. Given the commercial complexities of the contractual arrangements, PCTs and/or SHAs would need to work with providers to develop effective solutions.
- PCTs may wish to consider developing contingency plans for OOH call centre provision, possibly in collaboration with social services.
- Given that many OOH providers cross PCT boundaries, there is a role for collaboration between PCTs or the SHA in supporting effective OOH provision.
- SHAs may wish to consider how OOH provider networks or buddying arrangements link with other regional forums to provide mutual support, strategic surveillance and as a sentinel for triggering escalation procedures to support variation in demand between PCTs and provider greater resilience.
- PCTs may wish to consider using SITREPs for all OOH providers in order that capacity for these services can be effectively monitored and appropriate contingency plans escalated as appropriate.
- PCTs may wish to review the reporting requirements and KPI arrangements they have in place within contracts for these services. PCTs might wish to consider allowing flexibilities within payments where KPIs have not been achieved due to pandemic activities.
- In addition PCTs 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 'flu-like' symptoms. It is also possible for A&E services to provide telephone access to NPFS, or commission NHS Direct to provide access to its services within the waiting room.

Individual performer issues

Employment of Locums

Guidance to PCTs recommends key stages during a pandemic when PCTs will be best placed to directly employ locum GPs in their area⁴. By making most effective use of locum resources, PCTs will be able to direct them to support organisations (OOH providers or GP practices) under most pressure dealing with the demand and effects of a pandemic.

Each PCT Board will need have to have a mechanism for determining when the local situation has reached this key stage, when responsibility for engaging and employing locums needs to switch from individual providers to the PCT. The PCT is advised to involve the LMC and OOH providers in this decision process. Until such time as the pandemic SFE is in place practices remain at liberty to source their own locums and claim under the SFE. It is suggested that the Primary Care Priorities committee (see below) of each PCT 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. Ian Dalton wrote to PCTs on 3 August 2009 to ask that they avoid this possibility by offering contracts to locums during the period of the pandemic. We believe a solution would be for PCTs to engage the services of GP locums on a longer-term, fee-based, continuous contractual basis. This would afford these GPs Type 2 (Assistant) Practitioner status under the NHS pension scheme regulations rather than Locum Practitioner status. Type 2 Practitioners are afforded continuous (i.e. 24/7) death in service cover under the 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, PMS and APMS contractors to employ locums on this basis.

Also Type 2 (Assistant) Practitioners are covered under the NHS Injury Benefits Scheme whereas GP locums are not.

This change of status does not mean that the GP needs to be contracted to work every day. The contract could be just for one day per week in order to maintain continuous NHS Pension Scheme type 2 Practitioner status.⁵

PCTs are advised to set this in motion now, establishing template contracts so that they may be quickly issued to locum GPs should it become necessary if the pandemic escalates.⁶ When setting up template contracts please note

⁴ [Pandemic Flu – Human Resources guidance for the NHS](#)

⁵ more information on NHS Pensions, death cover etc is available by emailing practitioners@nhspa.gov.uk

⁶ A sample template will be available soon at www.pcc.nhs.uk

that under direction 7 of the "Directions to PCTs in relation to their functions relating to primary medical services", the PCT is directed to offer employment terms that are no less favourable than those contained in the BMA/NHSE model contract when employing general practitioners.⁷

In readiness, if they do not already run a locum bank, PCTs are advised to prepare a **database of active locums** with verified contact details and availability, either singularly or across a wider geography (counties or by OOH provider). The easiest way to start the database is to contact all the GPs on the PCT's 'performers list' who are not either GP principals or fulltime salaried doctors in local practices to see if they are available for locum work. PCTs 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.

PCTs are also advised to consider appraising its local bank of nursing staff in conjunction with its provider of community services seeking to build not only community nurse but also practice nurse reserve capacity. Again, this could be shared across more than one PCT.

Maintaining existing locum arrangements in general practice

Payments will be made by PCTs 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 sickness. The SFE sets the minimum obligations that PCTs have in respect of locum sickness payments that would normally commence if leave of absence is more than one week.

NHS Employers and the GPC have agreed a payment rate for locums during a pandemic period. This rate will be set at the normal hourly rate for the local OOH service as averaged over the previous three months.⁸

N.B. PCTs are advised to review their PMS contracts to establish their obligations to pay for locums to cover the sickness absence of PMS doctors. In most cases it is likely that PMS contract clauses will reference the GMS SFE and that therefore PCTs will probably need to treat PMS practices in the same way as GMS. If not, then PCTs are advised to consider the implications of any difference in policy and address this if necessary, including any requirements for contract variation to be agreed.

⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4081201

⁸ This rate applies to the normal hourly rate applicable to the time of day worked.

Retired GPs

PCTs 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 flu outbreak. Any PCT wishing to access the list for their area should provide details of the postcodes applicable to their area of responsibility and sign, scan and return a copy of the Data Protection Agreement in Appendix 1 at the end of this document, to enable a search of the database⁹.

Please email the completed form to Alan Saddington, at asaddington@bma.org.uk or fax separately to 020 7383 6494.

It is also important to note that retired practitioners have agreed to work in these circumstances for expenses reimbursement only.

However, the Department is currently developing guidance regarding temporary re-registration of doctors in times of emergency with a view to publishing this in the near future. This will include further information on issues relating to the provision of primary medical care and the performers list. It will be important for PCTs to consider this guidance carefully before contacting retired practitioners. In particular, unless or until their emergency powers of temporary re-registration are activated, volunteers can offer their support to employers but must not hold themselves out to be registered medical practitioners, or undertake duties which are reserved to registered medical practitioners (including prescribing or certifying deaths).

Doctors in Training

PCTs may, in conjunction with the post graduate deanery for primary care, consider the use of doctors in training should local capacity be depleted. Early plans for the numbers and skills available, and the areas that they may be able to work should be considered.

⁹ Appendix 1 - Data Protection Agreement form, p24

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 (MDO). Additional work, of a non primary medical care nature, must be NHS indemnified through NHSLA because the clinical liability aspects of such work will not be covered through the traditional GP MDO route. Other benefits of MDO membership should operate in the usual way in respect of any medico-legal problems arising from such work.

Liability cover in the event of a flu pandemic – NHS Litigation Authority¹⁰

The most up to date advice with regard to cover for NHS employees and 'volunteers' states;

'All staff employed by members of our schemes, including authorised volunteers, are treated as being "engaged" by the member for the purposes of CNST (Clinical Negligence Scheme for Trusts) and as "relevant persons" for LTPS (Liabilities to Third Parties Schemes), where those staff are working for the NHS in support of other NHS bodies and (provided that this is on a non fee-paying basis in the case of LTPS) other healthcare organisations.'

¹⁰ www.nhsla.com

Access to Clinical Records

When PCTs are stepping into direct locums in a practice or arranging for patients to be seen at a different surgery they should recognise that access to clinical records is a significant risk in the extreme circumstance of a pandemic, even though it is not normally a significant issue when practices are organising their own locums to cover occasional sickness. Under such circumstances it may not be possible for the alternative GP to access patients' medical records due to clinical system security measures, unless prior arrangements have been made.

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.

Practices are likely to have business continuity plans that deal with internal escalation processes, accessing locums and access to IT systems.

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

In the absence of a technical solution, PCTs may wish to arrange for multiple additional login identities to be created and assigned to each locum GP as needed, rather than a shared identity as this will preserve the value of audit trails. Where practicable the PCT will want to engage the practice as well as the LMC in these arrangements.

PCTs may also wish to consider training on unfamiliar systems. Practice managers may already have induction-style packs for their systems that are used by short-term locums within the practice.

National Arrangements

Emergency arrangements for GP practice income protection

NHS Employers 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 flu. In particular by providing income protection for payments that are based on number of patients, 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 flu. This will require the Department of Health (DH) to issue Directions to PCTs.

The DH and the GPC are keeping the arrangements for deciding whether and when these emergency arrangements should be introduced under review. It is possible that the DH will introduce the arrangements in some regions or PCTs before others. These decisions will be made nationally once the PCT(s) have made a case for such arrangements with their SHA, usually via the designated Director for Pandemic Flu. Information required will include levels of demand for services balanced with capacity in system to manage the demand. Further work on staff and provider capacity is planned for early Autumn.

The Directions to introduce these arrangements will build on the principles agreed by the BMA and NHS Employers in May 2008¹¹. 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.

¹¹ [*Principles for GMS practice payments during an influenza pandemic*](#)

Communications

PCTs will have clear plans for managing the pandemic locally, and will wish to effectively communicate these plans internally with the wider NHS and other stakeholders. They will also wish to use local media to direct people towards the national pandemic flu service, within the current guidelines, to reduce queries and enquiries to practices and OOH providers. A shared approach with LMCs, OOH providers and the Director of Public Health or Pandemic Flu lead will lead to most effective local communications.

Other Primary Care Providers

General dental services

The PCT 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. A level of income protection has been agreed for NHS dental contracts in the event of a pandemic situation.¹²

General ophthalmic services

The PCT will not need any specific planning in relation to this service. PCTs that commission local enhanced services, for example diabetic retinopathy, will need to consider the local contractual implications.

¹² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_087736

Appendix 1 – BMA Data Protection Agreement

The British Medical Association has a policy to comply fully with the Data Protection Act 1998 and it is essential that proper security measures should be taken against unauthorised access to, or alteration, disclosure or destruction of personal data and against accidental loss or destruction of personal data. This data security policy applies to personal data held on computer-based records and in written form.

In view of the Association's liability in this respect, it is essential that you safeguard the personal data, including e-mail addresses, pertaining to any members of the BMA that is forwarded to you in connection with your duties as
(please insert your role here)

Failure to do so will result in your access to such information being withdrawn. In particular, your attention is drawn to the following conditions of access:

1. Computer-held or produced information should only be discussed or communicated with other staff of the Association whose duties require them to receive such information, or with the particular subject whom the data concerns.
2. No computer-held or produced data should otherwise be discussed or communicated to any third party without the prior written approval of Alan Saddington (or one senior member of staff nominated to oversee data protection for the Association). Under no circumstances may personal data be disclosed to any third party that might use it for the purposes of marketing.
3. You should ensure that computer-held or produced lists of personal information on members, including lists of personal information on members and lists of names and addresses (including e-mail addresses), are held securely and are properly destroyed if no longer needed in the completion of your responsibilities.
4. You may have access only to personal data relating to BMA members that are allocated to the Flu Pandemic Database.

If you require further guidance on the conditions specified in this agreement, you should contact the Head of Membership and Professional Records at 020 7383 6494 (asaddington@bma.org.uk).

Signature of Applicant Requiring Access to BMA Membership Data

I agree to adhere to the terms and conditions of the BMA as specified in this agreement.

Signature

Surname

Forename

Date