Covid Impact on London's Primary and Community Care Estates

London Estates Delivery Unit

July 2020

Introductions

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David Cox	NWL STP	Director of Estates
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Contents

Background

1. COVID has shifted the way in which health and care services are delivered
2. Many figures have started to be quoted in terms of % digital and potential estates space savings; need to understand what the future looks like and impact on space
   - HBN 11 draft refresh*: "Because of these changes, digital pathways and telehealth rollout may result in a consolidation of the estate. However, it is not inevitable that future primary and social care buildings will reduce in size. Space requirements should be service driven. Space should be used dynamically, with different providers of care making use of space at different times of day, or space being re-designated for different services as care pathways change over time."*
3. Why focus this review on Primary / Community?
   - COVID Capital spend has been prioritised for acute
   - Continued need for investment; The London Estates Board: Health and Care Estates Strategy, published July 2019

	Out of hospital / Primary Care (£M)	Mental Health (£M)	Total (£M)
NWL	217	33	250
NCL	44	137	181
NEL	318	10	328
SWL	167	251	418
SEL	156	0	156
London	901	431	1,332

Figure J: Estimated out of hospital/primary care and mental health capital investment requirement in London

- 1/3 of GP surgeries needing to be rebuilt and 44% needing repair
- a need for investment in the region of £1.3 billion over the next 10 years for out of hospital, primary care and mental health – see figure J

   - Business cases are in development which need to account for the new world
4. Issues raised from SEL discussions:
   - Mandated period in favour of adapting a "remote first" approach
   - Real opportunity for space consolidation but space still needed for alternative use / other services to manage Covid patients
   - Need for a clear strategy / guidance for future projects in London

"[Digital working] has transformed our day. We're getting through things much quicker." *Practice manager. March 2020*

"When we're over the worst of this crisis, we'll need to learn the lessons, keep what works and is sustainable for staff, providers and tech suppliers, and let go of what doesn't work." *Beccy Baird- The King's Fund, April 2020*

"My hope is that some people will become more able to self-manage…and this will be an opportunity to refocus primary care away towards those with the greatest needs." *GP in Lambeth, March 2020*

"It is also not clear how many services have been suspended. To release capacity for the critical care of Covid-19 patients, many services have been stopped, reduced, and or switched to telephone or video." *Richard Murray, Nigel Edwards, Jennifer Dixon – The King's Fund , May 2020*

"The bulk of NHS and social care services cannot simply be switched back on to their pre-Covid-19 state of February 2020." *The King's Fund, May 2020*

"This crisis may massively accelerate the timeline in the NHS long-term plan, which promised every patient the 'right' to digital primary care services by 2024." *Beccy Baird- The King's Fund, April 2020*

"One of the biggest changes in working practices is increased telephone and video consultations, which are proving shorter than standard ones, freeing up time. Video calls are not always suitable for patients without smartphones—home visits are still happening." *Jacqui Thornton, BMJ, March 2020*

"Some patients, users and carers will suffer and many professionals across the health and care system will have to make painful choices for many months to come." *The King's Fund, May 2020*

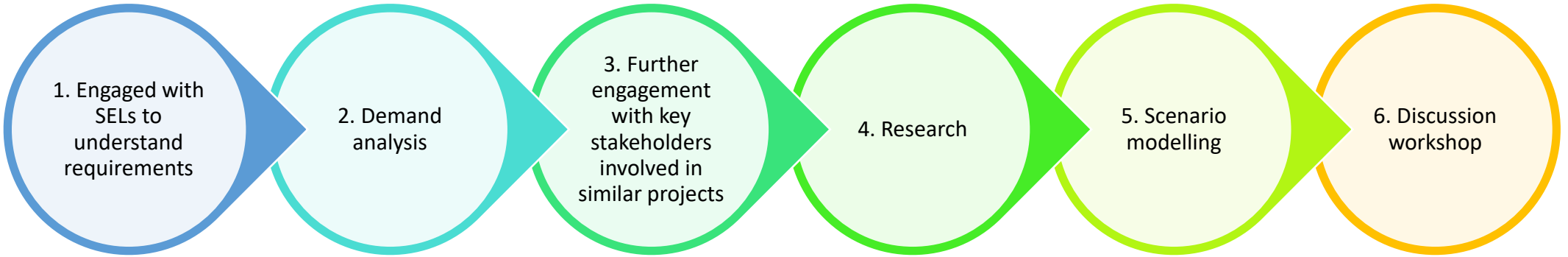
Scope

Purpose: Test theories relating to the move for space consolidation in primary care as a result of COVID-19, and provide clarification on space options for future projects in London

Key output: - Summary of findings from stakeholder engagement, data and research analysis which will inform tailored case scenarios on space in primary care.
- Space 'variables' will be created as a potential approach for testing space assumptions and investment in primary and community care across London.
- No figures will be prescribed with regards to the variables or space savings.

Timeframe: Output by end of July 2020

Process undertaken:



Demand Analysis

Appointments in general practice across London

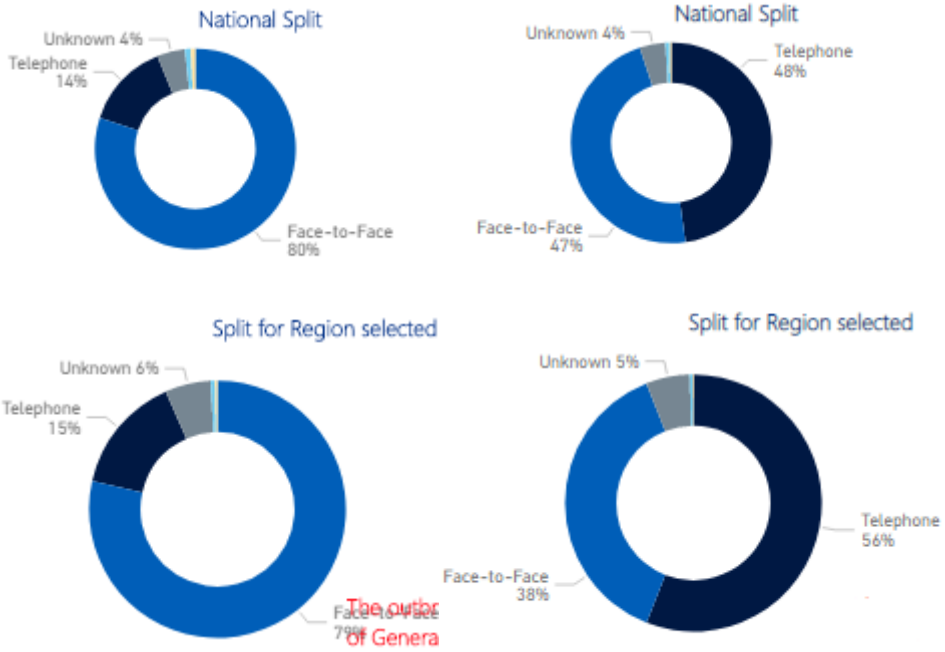
1. Total appointments in general practice

- London saw a sharp decline in total appointments in general practice compared to pre-COVID period
  - Total appointments in April were 35% less than Feb (pre-COVID month)
  - Total appointments in May were 32% less than Feb (pre-COVID month)
  - Update - June data shows England total appointments recovering to 14% below Feb baseline
- There was a marginal 4% increase in appointments in May compared to Apr
- These statistics mirrored the national changes

2. Total appointments by mode

- Reduction in Face-to-Face (F2F) appointments (Feb as the Pre-COVID month compared to May)
  - National 80% to 47%
  - London 79% to 38%
- Increase in telephone appointments (Feb as the Pre-COVID month compared to May)
  - National 14% to 48%
  - London 15% to 56%
- Use of video in general practice has remained low both nationally and in London (<1%)
- Update - June data shows F2F, telephone and video percentages almost unchanged from May despite recovery in total appointments
  - **Increases in remote consultations have been retained from April/ May into June**

FEB 2020 | **MAY 2020**



List of Post-COVID Primary Care Guidance

Title	Date Issued	Author / Organisation	Link	Summary of Advice
Letter to Primary Care	05 March 2020	Nikita Kanani, Medical Director for Primary Care NHS England and Improvement	https://cached.offlinehbpl.hbpl.co.uk/NewsAttachments/PGH/Preparedness_letter_primarycare_NK_5March2020.pdf.	Letter to Primary care recommending telephone or video triage to avoid patients coming into surgeries.
Novel coronavirus: RCGP guidance for general practice (including OOH)	13 March 2020	Royal College of General Practitioners	www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2020/covid19/RCGP-GP-guidance-march-2020.ashx?la=en	Interim guidance for general practices in managing Covid patients and operating telephone triage and conducting telephone or video consultations where possible.
Covid-19: interim guidance for primary care	19 March 2020	Public Health England	www.gov.uk/government/publications/wn-cov-guidance-for-primary-care/wn-cov-interim-guidance-for-primary-care. Now superseeded by https://www.england.nhs.uk/coronavirus/primary-care/general-practice/	Guidance on how to identify potential cases of Covid-19 and key actions to take
Covid-19: a remote assessment in primary care	25 March 2020	Trisha Greenhalgh, Professor of Primary Care health sciences British Medical Journal	https://www.bmj.com/content/368/bmj.m1182	Guiding principles on how to choose between telephone and video appointments, primarily focussed on COVID-19 patient consultations
Guidance and updates for GPs: at-risk patients	26 March 2020 and on-going	NHS England and improvement	https://www.england.nhs.uk/coronavirus/publication/guidance-and-updates-for-gps-at-risk-patients/	Up to date guidance and advice for Shielding patients, including letters from Professor Chris Whitty, Professor Stephen Powis, Ruth May and Matt Hancock
General Practice in the post Covid world: Challenges and opportunities for general practice	Jul-20	Royal College of General Practitioners	https://www.rcgp.org.uk/-/media/Files/News/2020/general-practice-post-covid-rcgp.ashx?la=en	A review of new ways of working, including what to expect with triage and remote consultations.

…guidance is continually evolving….

Engagement Summary

Discussions took place with the following stakeholders throughout June and July on the COVID impact on estates:

Stakeholder Group	Organisation	Summary of Engagement
External organisations	Murphy Phillips Architects Archus (healthcare estates consultancy) Nuffield Department of Primary Care Health Sciences, University of Oxford	• Design ideas to meet changing work patterns, evolving care models • Need for funding to align with new demands • Hospital outpatients - anticipated that the % of consults by video will remain small (maybe 10-20%) but depends on the specialty. There may be higher use of telephone especially follow up/ results.
NHSEI/ NHSX/ Property companies	NHSE/I NHSX NHSP CHP	• 'Digital first' agenda: 60% target for virtual appointments (in the New for Old scheme) – considering setting bar at 80%. • QOF (which requires face to face) review • CHP identified the Nelson Medical Centre telephone triage space as an exemplar.
STP/ commissioners/ clinical practitoner	North East London STP CNWL Consultant Connect North central London STP SW London STP Waterloo Health Centre Nelson Medial Practice (SWL)	• Digital expected to increase relative capacity • No % targets exist pre- or post-covid • Not suitable for all patient cohorts • Future planning for covid world: models of care, working practices/ social distancing, backlog of appointments, digital accessibility • Need to err on the side of caution with regards to % savings in space as the context is still constantly evolving • KCHFT identified at least 40% of community and mental health services should be delivered remotely, which may reduce occupied space by 20%. CNWL already maximised digital pre-COVID so unlikely to see any savings. • Telephone appointment times vary by practice – some as short as 5 mins, some as long as F2F.
LEDU	Strategic Estate Leads for all STPs Healthy Urban Development Unit (HUDU)	• Must respond to the challenge from the centre - 60%+ • Recovery period probably not representative of longer term • Local impact understanding will be needed to support developer contributions

Research Summary

Publication	Summary
BMJ	The landscape of how GPs function appears to have changed forever. GPs are now adapting to increased telephone and video consultations, which are proving shorter than standard ones, freeing up time. But video calls are not always suitable for patients without smartphones.
King's Fund	This crisis may massively accelerate the timeline in the NHS long-term plan, which promised every patient the 'right' to digital primary care services by 2024. In March, A&E attendances were 29 per cent lower than in March 2019. GP appointments fell by 30 per cent during March. Patients may be worried about contracting the virus, or burdening services. Five important challenges that will need to be addressed by leaders in government and the health and care system:
NHSE/I	• Approximately two-thirds of demand can be managed remotely. Early figures suggest that this proportion may increase to over 90% in response to COVID-19. • Online consultation systems allow about a quarter of all requests to be closed with an electronic message. • Research shows they also improve access for people with specific information and communication needs • During COVID, 80% consultations were closed remotely with less than 10% requiring of requesting F2F – balance of risk has changed.
British Journal of General Practice	• 2018 study - Overall, patient consultations by telephone triage were 2.37 minutes shorter than consultations • 2016 study - Telephone triage is not associated with a reduction in overall clinician contact time during the index day

London case studies

1. Tollgate Medical Centre, North East London, embedded the Online Consultation (OC) system into their business model before the pandemic, and found it fit for purpose for their patients ensuring they were getting the most appropriate care when needed.
   - Reduced F2F appointments from 86% to 42%
   - Reduction in DNA 8.4% to 2.1% (£3k saving in a 2-week period)
2. Nelson Medical Centre, South West London, have a dedicated telephone triage GP team established in 2015 when 2 practices merged (30,000 patients) and moved to their new premises.
   - They use a 30sqm open plan offices, originally for 2 navigators plus 6 GPs, now post-COVID only 2 navigators plus 2 to 3 GPs (due to social distance measures).
   - Only shielding GPs are working from home, however the partnership are looking at future 20% working from home.

Case Scenarios – Space Planning – Assumptions and Variables

We have taken a single practice with primary care appointments only, using the following key assumptions which remained constant across different case scenarios:

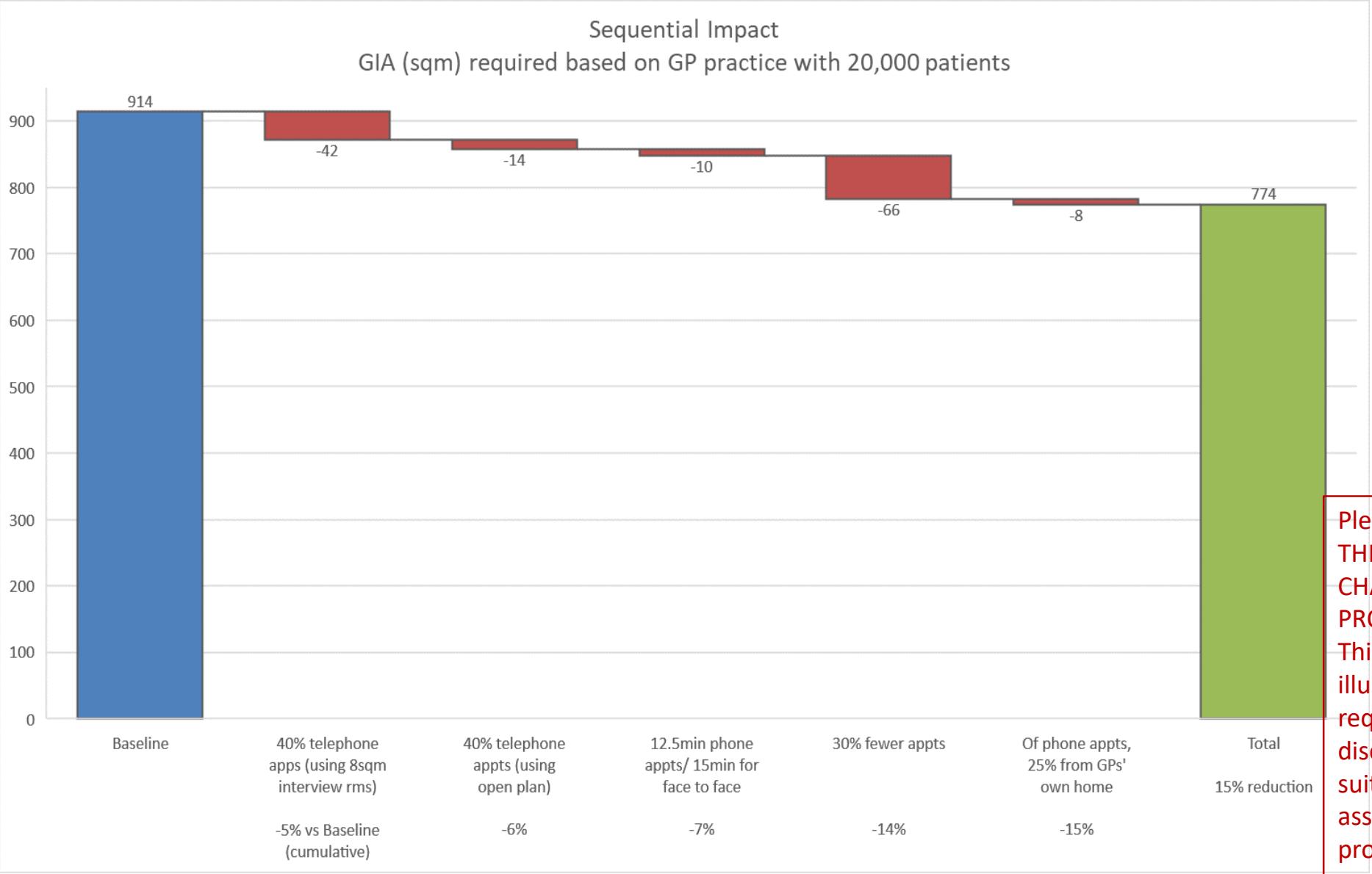
Constant	Value
Registered population	20,000
Total weeks per year open	51
Building operational hours per week	66
Room utilisation	80%
% of annual contacts needing use of a Treatment Room	20%

Please Note - THE VARIABLES USED IN THIS MODEL ARE NOT PROVEN CHANGES IN DEMAND OR SYSTEM PRODUCTIVITY.
This is a modelling exercise that illustrates the impact on space requirements of changing variables discussed in this presentation.
The suitability of each change should be assessed in the context of any specific project, alongside other uses and needs for space.

Using outputs from demand data analysis, engagement summary and research, we designed cases which vary based on the following 'variables'

Variable	Value	Could this be varied for scenario testing of COVID impact?	Notes
Access rate (per 1,000 registered)	6,000	Yes, reduce by 30% to 4,200	Reflects reduction in demand for appointments in April and May 2020. However, early indications show that demand of appointments is picking up.
% face to face (F2F) versus telephone	100%	Yes, reduce to 60%, with 40% assumed as telephone.	NHSE/I quoting 40% F2F. May data showed 38% F2F in London. However, this incorporated loss of QOF and other F2F appointments which GPs are concerned about. Therefore 60% has been assumed for the purposes of scenario testing. As the use of video remained low pre and post COVID at <1%, we have not used video as a variable as this would be negligible in terms of space.
Appointment time (mins)	15mins consult, 20 mins treatment	Yes, telephone appointment time at 12.5mins	Research identified consultations by telephone triage were 2.37 minutes shorter than F2F. However, other research showed there was no reduction in overall clinician contact time.
Consult space	14sqm consult room	Yes, use 8sqm interview room OR open plan with 6sqm workstations for telephone appointments	8sqm interview rooms as per conversation with Murphy Phillips Architects. Open Plan as per telephone triage room at Nelson Medical Centre – 6 sqm per workstation plus 1 x 2p office for every 5 GP workstations.
% of telephone appointments taken from GPs homes	0%	Yes, assume 25%	Reflects conversation with Nelson Medical Centre re some working from home opportunities.

Scenario Analysis



Baseline scenario assumes

- 100% face-to-face
- all consultations use 14sqm consult rooms
- 15 min appointment length
- No working from home

All other scenarios have constant space assumptions with the exception of the following areas which change compared to the baseline by flexing variables:

- Consult space
- Waiting space in reception
- Plant area
- Circulation
- Internal partitions/ engineering

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Group Discussion and Conclusions

Variables

- Review opportunities and challenges of each variable
- Are there any variables we have missed?

How do you feel about this approach…

- What do you think is good about this approach?
- What challenges do you foresee with this approach?
- Can we use these variables as the basis for future space planning in primary care?

Next steps

- Summarise the discussion and share PowerPoint pack
- How to share this work more widely?

Any Questions?

Variable
Access rate (per 1,000 registered)
% face to face (F2F) versus telephone
Appointment time (mins)
Consult space
% of telephone appointments taken from GPs homes

Group Discussion and Conclusions - page 1

Variable	
Access rate (per 1,000 registered)	• Demand was suppressed during the covid period, likely to be followed by uptick; • Greater need for consultation for older people. • Unlikely that the need is lower now than before covid.
% face to face (F2F) versus telephone	• Demographics are an important driver here - granular data is needed to support negotiations with developers and borough planners. **[See research appendix]** • Nelson Health Centre established remote first approach - is there data on health outcomes over the 5 years since it opened? • London GP suggesting they will no longer see 90% of their patients - seems ambitious. • Patient voice – needs to be reflected in this work, and ensuring patient care is not compromised • Telephone triage generally driven by necessity i.e. lack of consultation space for growing patient list; video is preferred to telephone but much concern that conditions will be missed with reduced face to face appointments. • More patient engagement is needed – many are not coming out because they don't want to/ afraid. Need to factor in having the right space to engage and treat patients (eg cancer care) - not always possible to do from home with distractions. • If there is a change in the demographic of face to face consultations (age, health condition), does this impact design of health space? • Wider service model of PCNs requires additional space or increased productivity within existing - digital enablement of services may facilitate this, and is part of NE London's planned response to significant population growth. • Telephone triage often driven by need to cover more patients, or to manage demand. • Video works well for students (sent home by covid but staying registered with university practice). • Video may be more prevalent than the NHSE data suggests. • Concern over missed diagnoses from phone triage, video better. Face to face is preferred.

Group Discussion and Conclusions - page 2

Variable	
Appointment time (mins)	• Age demographic is also a factor in consultation duration. • 12.5min - is this more triage than consultation proper?
Consult space	• Too early to say if waiting space can be reduced - social distancing. • Important to get the balance right. Can't leave GP's short of space and having to re-plan later. • What is the required mix between treatment vs consultant? Might need to think more about flexible treatment rooms rather than smaller interview rooms, and this would feed into integrated care/ more activity in local settings. • Possibility of using consulting rooms as telephone triage office with two or three occupants - as economical as open plan? • Consider introducing telephone pods rather than reconfiguration. • 8sqm interview room is not suitable for alternative uses where 16 or 20sqm rooms are. • With remote triage, balance might shift towards treatment over consulting rooms. This is also more flexible for other uses - admin, social care, private sector use if surplus to NHS in the future.
% of telephone appointments taken from GPs homes	• Consideration of patient and clinician needs, especially in sensitive conversations - no distractions, background noise.
General	• Chart is useful and persuasive visually; • HBNs/ ICP may respond to covid with hot/cold delineation. This would e.g. protect community services from displacement by hot hub designation. • PCNs pushing for more space to accommodate additional staff they are expected to hire, additional services delivery.

Appendices

1. Design ideas
2. Scenario model
3. Research summary
4. Demand analysis - primary care

Appendix 1 - Design ideas

The Nelson Health Centre, Merton - Background

1. The Nelson Health Centre is a CHP facility in Merton, South West London.

2. It was built in 2015 with the following tenants:
    - Nelson Medical Practice (from 2 merged practices)- 30,000 patients
    - Pharmacy
    - Outpatients (St George's)
    - Diagnostics (St George's)
    - Community health services (CLCH)
    - Community mental health services (SWLSTG)

3. Since 2015, the Practice have run a telephone triage service and the facility was designed to enable this. The service involves the following:

✓ 2 Navigators who receive and decide where to guide the patient e.g. telephone GP/ Nurse, Face to Face, Pharmacist, NHS111, etc
✓ A dedicated space for up to 8 GPs taking telephone consults

4. Post-COVID the setup has evolved as care has shifted towards telephone first, and social distancing requirements have been established.

Nelson Health Centre – GP Telephone Triage Space

The Practice uses one large 29.5sqm Admin Office (Room 9.24), split as follows and shown in orange on the floorplan:

1 – 2 desks for Navigators
2 – One large bench with 6 workstations for GPs to take calls (GPs use headsets to ensure privacy)
3 – Further standing desk for GPs

4 - PLUS adjoining 4.2sqm video consult room.

COVID impact:

- Only 2 GPs can sit at the long desk (previously 6 GPs sat here) due to distancing rules. A third GP can use the standing desk. A fourth can sit in the 4.2sqm consult room. Other consult rooms are also used for telephone consults. Some offices have also been used for telephone consults.
- Very few appointments require video – usually only for dermatology concerns.
- March to May – GPs were advised to do 100% telephone consults, with F2F by exception. In June, advice changed to allow for 3 out of 14 appointments in person per session…. a GP does 3 sessions per day – therefore would currently have 9 face-to-face and 33 telephone consults per day.
- Only GPs who are shielding are working from home currently. There are some early discussions around 'GPs working from home' in the future, based on only one session per week for telephone consults.

Appendix 1 - Design

Extract from Room Data-sheet

ADB	Room Data Sheet	M0278-02R2

Project:	2537	Nelson LCC		
Department:	9	GP Cluster 2		
Room:	M0278-02R2	GP Administration area: 6 workstation		
Room Number:	9.24		Revision Date:	20/05/2013

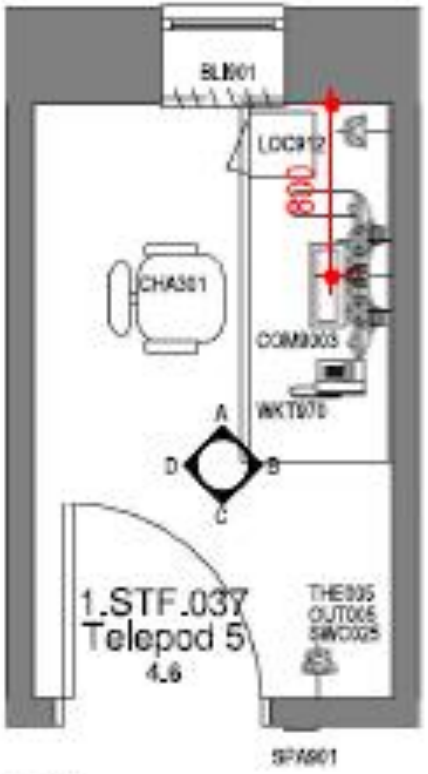
Activities:	1) Clinical administration. 2) Computer workstation(s) may be used. 3) Telephone(s) may be used. 4) Information on computers may be accessed. 5) Printer may be used. 6) Staff notices, information and/or messages may be displayed. 7) Patient records may be reviewed and recorded.			
Personnel:	6 x staff.			
Planning Relationships:				
Space Data:	Area (m^2):		Height (mm):	
	For areas refer to MPA General Arrangement Floor Plans (00 series). For heights refer to MPA drawings within Ceiling Package (34 series).			
Notes:				

ADB	Schedule of Components by Room	M0278-02R2

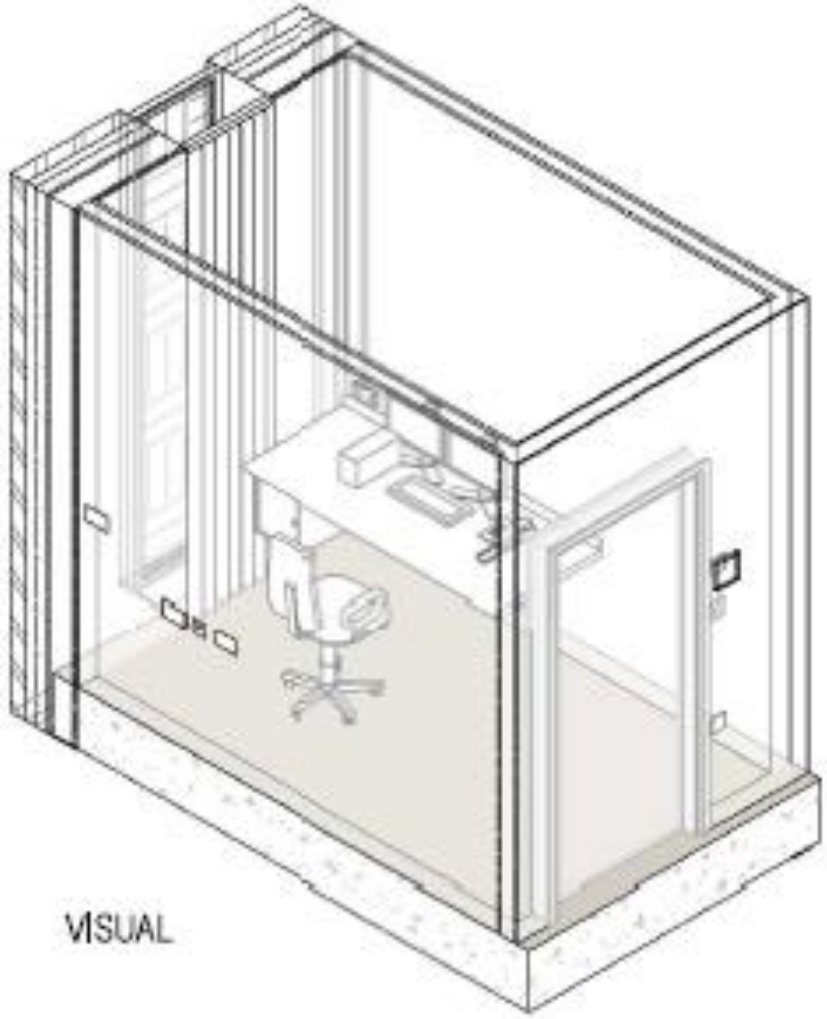
Project:	2537	Nelson LCC		
Department:	9	GP Cluster 2		
Room:	M0278-02R2	GP Administration area: 6 workstation		
Room Number:	9.24		Revision Date:	20/05/2013

Quantity			Code	Description	Alt. Code	Grp
New	Trans	Total				
2		2	BLI000	BLIND, window		1
4		4	MPA007	CABINET, base unit, 1 door, 500W		1
2		2	MPA013R1	CABINET, base unit, 1 door, 600W, under 720H table		1
2		2	MPA018	WORKTOP, cantilevered from wall 800D, as drawing		1
1		1	MPA020R	WORKTOP, to base units, length as drawing		1
1		1	OUT005	SOCKET outlet, switched, 13 amp, single		1
21		21	OUT010	SOCKET outlet, switched, 13 amp, twin		1
15		15	OUT133	SOCKET outlet, computer data, double		1
3		3	SHE221R3	SHELF, fixed, 300D, length as drawing		1
1		1	SWC025	SWITCH, light		1
1		1	BOA013	BOARD, display/notice, wall mounted, 900H 1200W		2
1		1	BOA037	BOARD, marker, whiteboard, dry-wipe, with pen holder, wall mounted, 900H 1200W		2
1		1	CLO001	CLOCK, wall mounted		2
4		4	BIN9001	BIN, waste		3
7		7	CHA301	CHAIR, swivel, height adjustable, high back, with arms, wipeable, 5 star base, on castors		3
7		7	COM031R	STANDARD IT SETUP: computer, monitor, keyboard, telephone		3
2		2	DES026	DESK UNIT, cantilever, cable management, adjustable legs, 1400W 800D		3
6		6	DRA056	DRAWER UNIT, 2 drawer, lockable, on castors, 600H 410W 600D		3
1		1	PRI015R1	PRINTER, desktop		3
1		1	SCN001R	SCANNER, desktop		3
1		1	TAB005R	TABLE, 720H 1600W 600D		3

Telepod - stand-alone telephone booth



PLAN



VISUAL

Emerging ideas in health architecture

- Architects are exploring new design ideas however this is still evolving and principles-led.
- Less space is needed due to moving towards virtual, but more space is needed to enable social distancing measures to be effective.

	Emerging Design Ideas and Considerations
1	Fewer 14sqm consult rooms (with couch and sink) to more 8sqm interview rooms
2	Move admin staff to a 'work-from-home' model, which releases admin space for clinical use or telephone triage
3	Sound attenuated telephone type booths
4	Open plan telephony areas – with adequate space standards and dividers etc. that allow privacy / reduce distraction – similar to ones used by telephone-based talking therapies.
5	Work from home - privacy and data protection considerations required - seems to be a requirement / standard practice for mental practitioners when working from home or are on-call responders.
6	Consideration for patient and staff flow to allow for social distancing and infection control e.g. in and out flows
7	Tech infrastructure often is practical limitation to flexibility rather than enabler due to use of HSCN servers limited to particular providers and acting as the secure access point to the health network system. Secure access now being enabled in devices rather than the router allows connection to any network - supports sharing of space, mobile working elsewhere, more efficient deployment of routers and much less expensive router equipment etc.
8	PCN level call centre for GP telephone appointments
9	Dedicated PPE/ gowning room

Appendix 2 - Scenario model

Case Scenarios – Space Planning

Please Note - THE VARIABLES USED IN THIS MODEL ARE NOT PROVEN CHANGES IN DEMAND OR SYSTEM PRODUCTIVITY. This is a modelling exercise that illustrates the impact on space requirements of changing variables discussed in this presentation. The suitability of each change should be assessed in the context of any specific project, alongside other uses and needs for space.

Variables	Scenario A Current health planning method	Scenario B	Scenario C	Scenario D	Scenario E	Scenario F	Scenario G	Scenario H	Scenario I
Access rate (per 1,000 registered)	Same as pre-COVID – assume 6 appointments per reg patient	Same as current post-C19 demand Assume 30% reduction ie 4.2 appointments per reg patient	Same as pre-COVID assume 6 appointments per reg patient	Same as current post-C19 demand Assume 30% reduction ie 4.2 appointments per reg patient	Same as pre-COVID assume 6 appointments per reg patient	Same as current post-C19 demand Assume 30% reduction ie 4.2 appointments per reg patient	Same as pre-COVID assume 6 appointments per reg patient	Same as current post-C19 demand Assume 30% reduction ie 4.2 appointments per reg patient	Same as current post-C19 demand Assume 30% reduction ie 4.2 appointments per reg patient
% Face to Face appointments	100%	100%	60%	60%	60%	60%	60%	60%	60%
% Telephone appointments	0%	0%	40%	40%	40%	40%	40%	40%	40%
Assumed telephone consult space	Same as F2F – 14sqm consult rooms	Same as F2F – 14sqm consult rooms	Use 8sqm interview rooms	Use 8sqm interview rooms	Use open plan admin room for telephone triage stations - 6sqm per workstation. Plus 1 navigator office per 5 telephone workstations.	Use open plan admin room for telephone triage stations - 6sqm per workstation. Plus 1 navigator office per 5 telephone workstations.	Use open plan admin room for telephone triage stations - 6sqm per workstation. Plus 1 navigator office per 5 telephone workstations.	Use open plan admin room for telephone triage stations - 6sqm per workstation. Plus 1 navigator office per 5 telephone workstations.	Use open plan admin room for telephone triage stations - 6sqm per workstation. Plus 1 navigator office per 5 telephone workstations.
Appointment time (telephone)	Same as F2F – 15mins	Same as F2F – 15mins	Same as F2F – 15mins	Same as F2F – 15mins	Same as F2F – 15mins	Same as F2F – 15mins	12.5 minutes	12.5 minutes	12.5 minutes
% of telephone apts taken from GPs' home	0%								25%
TOTAL SQM GIA	**914**	**828**	**872**	**799**	**858**	**789**	**848**	**783**	**774**
% reduction compared to Scenario A	**0%**	**9%**	**5%**	**13%**	**6%**	**14%**	**7%**	**14%**	**15%**

These scenarios have not accounted for any future potential additional space required for social distancing or PPE/ gowning in primary care.

Appendix 2 - Scenario model

Appendix 3 - Research Summary

1. Survey of on-line consultations - NECS for NHSE Feb 2019
2. Total Triage model in general practice - NHSE/I advice
3. Telephone triage publications - BMJ
4. Case study - Tollgate Medical Centre NE London
5. Covid-19: how coronavirus will change the face of general practice forever - BMJ March 2020
6. How has the General Practice responded to the Covid-19 outbreak? - The King's Fund April 2020
7. Delivering core NHS care services during the Covid-19 pandemic and beyond - The King's Fund May 2020
8. Lessons for Hospital Building programmes - HSJ July 2020
9. Letters from Simon Stevens and Amanda Pritchard to the NHS - April and July 2020

Research summary – surveys on online consultations

Online consultations research February 2019 Publishing approval reference: 000795

https://www.england.nhs.uk/wp-content/uploads/2019/09/online-consultations-reserach-summary-of-findings.pdf

North of England Commissioning Support (NECS) first undertook a period of research with members of the public, GPs and GP practice staff over a three month period from May to July 2018. This provided an in depth understanding of views and feelings and strengthened the development of key messages that have now been developed into a suite of collateral for general practice and patients

GPs views

When considered by job role and practice size:

- GPs are significantly more likely to **resist** the idea of offering innovative new online services (57%) compared to any other job role.
- Large, or group sized practices (25,000+), are likely to be more **willing** to offer new services compared to any other list size.

Incentives

- The availability of funding to support new online approaches was the key motivator, higher amongst those who are 'possible';
- Being able to test 'in situ' and reassurances on information security were next highest;
- Support and training were also important factors supporting the adoption of new service;
- Concerns around technology and broadband infrastructure were mid-level concerns; and
- Choice amongst suppliers was not a high-ranking issue for any of the groups.

Barriers

Major concerns from professionals around offering 'new' online services centred around:

- Creating more work.
- Concerns around misdiagnosis/lack of observation and the potential to exclude patients who do not have access to, or ability to use the internet.
- Information security and confidentiality also scored high as concerns.

Patients' views

When asked "Would you be interested in having an online consultation with a GP/other health professional in the future?"

- **Most respondents (67%) said they would.**
- A further 69 respondents (2.3%) said their practice already provides this.
- A minority of 566 respondents (19%) said they would not be interested, 365 (12%) respondents were unsure.
- Seventeen (0.6%) said they already use a paid for private provider.

Barriers in detail

- When considered by gender women are more likely to distrust, dislike or have no confidence in using the internet.
- Women are more concerned than men about getting an online response from 'any doctor'.
- Those aged 55-74 also see the lack of face-to-face contact as a barrier.
- Confidence, trust and dislike of the internet are the most significant barriers for respondents over 85.
- Carers also cite confidence, trust and dislike of the internet as their most significant barriers.
- Respondents who consider themselves disabled are generally concerned with security and confidentiality as well as citing confidence, trust and dislike of the internet as their most significant barriers.
- Respondents with parental or guardian responsibility are most concerned with security and confidentiality as well as being concerned that they will not understand the information provided in an online consultation.

Research Summary - Total Triage Model in general practice

NHSE/I Advice on how to establish a remote 'total triage' model in general practice using online consultations Apr 2020

https://www.youtube.com/watch?v=sczwFG6fxZM&feature=youtu.b

- Data shows approximately two-thirds of demand can be managed remotely. Early figures suggest that this proportion may increase to over 90% in response to COVID-19.
- Online consultation systems allow about a quarter of all requests to be closed with an electronic message. They can capture the patient's history and symptoms asynchronously automatically, allow patients to send pictures and offer signposting to self-help or local services. They increase resilience by enabling more adaptable working patterns (i.e. customised appointment lengths) and giving staff more control over managing their time and workloads (e.g. prioritising activities to free capacity and working flexibly).
- Staff working remotely (e.g. if they are self-isolating) can use digital triage systems from home.
- Research shows they also improve access for people with specific information and communication needs, including those with a disability or hearing loss, carers and people who feel apprehensive about accessing health services – e.g. for a mental health, sensitive or embarrassing problem. Telephone functionality helps ensure equity of access for non-digital users.
- Pre-COVID, only 24% of patients wanted a F2F, 44 practices with 450,000 list size. During COVID, 80% consultations were closed remotely with less than 10% requiring of requesting F2F – balance of risk has changed. Professionals have departed from established procedures to care for patients, supported by the use of professional and clinical judgement.

- 50% of patients complete the online consultation themselves, 50% have help from relatives or reception staff
- Review by NIHR showed that clinicians often make the wrong assumptions about who can or can't use the system
  - *Who has access to the internet were not evidenced*
  - *Who should be using online consultations are not evidenced*
- Online does not replace telephone or SMS, though
  - *Staff guiding patients through OC important for equity*
  - *Frees up time for patients who can't use online*

Research summary - telephone triage

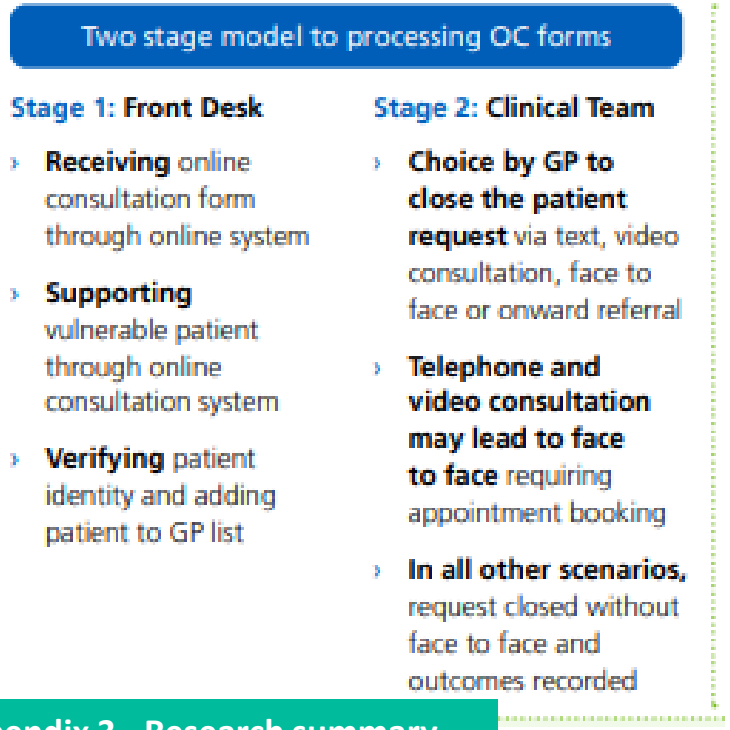
Title	Journal/ source	Date	Conclusions
Impact of telephone triage in managing patient demand for same-day appointments? A before-after study in a UK general practice	British Journal of General Practice 2018; 68 (suppl 1): bjgp18X697361. DOI: https://doi.org/10.3399/bjgp18X697361	2018	Telephone triage was able to manage majority of patient problems by telephone alone, with significant reduction in consulting time per patient episode. Overall, patient consultations by telephone triage were 2.37 minutes shorter than consultations under its predecessor (P <0.001). Telephone consulting was not shown accountable for the increase in unplanned re-consultations.
Telephone triage systems in UK general practice: analysis of consultation duration during the index day in a pragmatic randomised controlled trial	British Journal of General Practice 2016; 66 (644): e214-e218. DOI: https://doi.org/10.3399/bjgp16X684001	2016	Telephone triage is not associated with a reduction in overall clinician contact time during the index day. Nurse-led triage is associated with a reduction in GP contact time but with an overall increase in clinician contact time. Individual practices may wish to interpret the findings in the context of the available skill mix of clinicians.
Evaluation of telephone first approach to demand management in English general practice: observational study	BMJ 2017; 358 doi: https://doi.org/10.1136/bmj.j4197 (Published 27 September 2017)	2017	The telephone first approach shows that many problems in general practice can be dealt with over the phone. The approach does not suit all patients or practices and is not a panacea for meeting demand. There was no evidence to support claims that the approach would, on average, save costs or reduce use of secondary care.

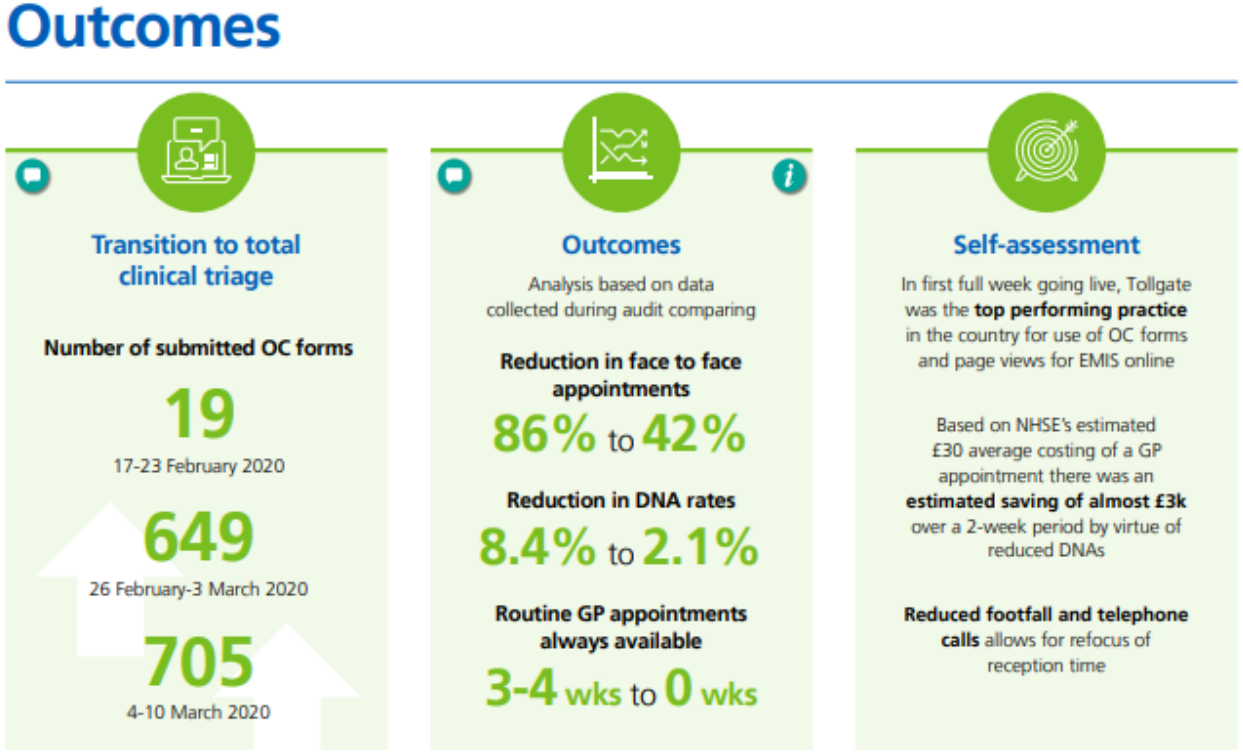
Research - Online Consultation Case Study

Tollgate Medical Centre, NEL

- Tollgate Medical Centre, North East London, embedded the Online Consultation (OC) system into their business model before the pandemic, and found it fit for purpose for their patients ensuring they were getting the most appropriate care when needed.
- Despite the availability of OC forms, internal audits showed that number of patient requests had not increased
- Simpler online requests could be dealt with more rapidly, leaving more time for more complex requests

https://www.eastlondonhcp.nhs.uk/downloads/ourplans/digital/Remote%20Clinical%20Triage%20Model.pdf





British Medical Journal

"Covid-19: how coronavirus will change the face of general practice forever" by Jacqui Thornton, March 2020

https://www.bmj.com/content/368/bmj.m1279

- The landscape of how GPs function appears to have changed forever.
- GPs are now adapting to increased telephone and video consultations, which are proving shorter than standard ones, freeing up time.
- But video calls are not always suitable for patients without smartphones.
- Some GP's have been frustrated with the lack of clear central direction, or a clinical care model, from clinical commissioning groups (CCGs).
- Primary care networks (PCNs) have been left to make their own decisions.
- GPs have reported personal challenges with home working. (Issues with IT / slow NHS laptops, unable to use personal laptops for security reasons or no access to the Electronic Patient Record. Quickly becomes a cost implication for surgeries as they must fund compatible computers

The King's Fund:

"How has General Practice responded to the Covid-19 outbreak?" by Beccy Baird, April 2020

https://www.kingsfund.org.uk/blog/2020/04/covid-19-general-practice

- Digital consultation in general practice is not new, yet take up has been patchy and slow. Since Covid, almost every practice is doing remote consultation.
- Clinicians on social media have been overwhelmingly positive about the experience of remote consultations, and there's certainly a view that this will now become part of the core offer for general practice.
- This crisis may massively accelerate the timeline in the NHS long-term plan, which promised every patient the 'right' to digital primary care services by 2024.
- GPs are exploring options such as hot hubs and are organising these hubs in partnership with local councils. Some are reviewing the use of marquees and other open-air facilities with lots of parking to provide good ventilation and allow patients to be seen in their cars if necessary.
- Primary care networks have come into their own as they bring together GPs across an area to plan and share resources together.
- WhatsApp groups and other forms of social media have been used to enormous effect to collate and share useful resources across these networks.
- New collaborations within and across organisations are forming.

The King's Fund

"Delivering core NHS care services during the Covid-19 pandemic and beyond: a letter to the Commons' Health and Social care select Committee" by Richard Murray (King's Fund), Nigel Edwards (Nuffield Trust) and Jennifer Dixon (The Health Foundation), May 2020
https://www.kingsfund.org.uk/publications/letter-to-health-and-social-care-select-committee-covid-19

- The House of Commons Health and Social Care Select Committee launched an inquiry to better understand the impact the crisis has had on core NHS and care services during the pandemic and beyond.
- As part of that inquiry, The King's Fund, Health Foundation and Nuffield Trust submitted a joint letter to the Committee highlighting key areas to consider.
- There has been some national guidance around which types of surgery should continue or which patients should be identified as vulnerable – but for the most part, judgements about who gets services and how, have been made locally.
- In March, A&E attendances were 29 per cent lower than in March 2019. GP appointments fell by 30 per cent during March.
- Patients may be worried about contracting the virus, or burdening services.
- Five important challenges that will need to be addressed by leaders in government and the health and care system:
  - How and when will appropriate infection prevention and control measures be available for all settings delivering care, and what impact will these have on capacity to re-open?
  - How will the system understand the full extent of unmet need?
  - How will the public's fear of using NHS and social care services be reduced?
  - What is the strategy for looking after and growing the workforce?
  - Can the system improve as it recovers?

Health Service Journal

"Covid-19: Lessons for Hospital Building programmes" by Nigel Edwards (Nuffield Trust), July 2020

https://www.hsj.co.uk/policy-and-regulation/covid-19-lessons-for-hospital-building-programmes/7028049.article (paywall)

- In the last major round of hospital building, the programme was all about planning individual hospital developments as opposed to a system-wide approach allowing for community and primary care services across a defined area, or for social care infrastructure.
- We currently have an overstretched hospital estate with bed occupancy exceeding 90% or even 95%
- The pandemic has reinforced the need to plan for integrated health and social care services – and to end any notion that care outside hospital is someone else's problem.
- New hospital building programmes should incorporate designs with a greater proportion of reconfigurable /convertible space, allowing clinical areas to be moved or re-equipped to much higher specifications without major building works.
- "Loose fit" and adaptable space where rooms are designed to change or accommodate multiple functions, and the ability to segregate different activities and to create "hot/cold" or infectious/non-infectious flows of patients, will be valuable.
- "Soft space" such as storage and administrative offices can be built around high-tech departments to enable them to expand with minimal upheaval and cost. Future electrical and engineering costs can be contained by deploying interstitial floors, and/or building shell space that allows for expansion or alternative use.
- Outpatient departments are likely to be smaller and more orientated to procedures, but there will be a greater need for well-equipped space to do remote consultations.
- Administrative work can be done remotely, but there may be an opportunity to reduce the over one million square metres of administrative space in the NHS.
- The present pandemic is a lesson for us to start building flexibly and wisely for the future.

NHS Response to Covid19 - Letter to the system, April 2020

Key elements from letter from Simon Stevens and Amanda Pritchard on 29 April 2020 re SECOND PHASE OF NHS RESPONSE TO COVID19:

Community, Primary Care and Mental Health

*"We are going to see increased demand for Covid19 aftercare and support in **community health services, primary care, and mental health.** Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex. General practice will need to continue to stratify and proactively contact their high-risk patients with ongoing care needs, including those in the 'shielding' cohort to ensure they are accessing needed care and are receiving their medications."*

Emergency Care

***"Emergency activity** has sharply reduced in recent weeks. Last week emergency hospital admissions were at 63% of their level in the same week last year. This is likely due to a combination of: a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes (e.g. ambulance 'see and treat', online appointments)."*

Digital

*"We should also take this opportunity to **'lock in' beneficial changes** that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations."*

NHS Response to Covid19 - Letter to the system July 2020

Elements from letter from Simon Stevens and Amanda Pritchard on 29 July 2020 re THIRD PHASE OF NHS RESPONSE TO COVID19:

Shared focus:
A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter
B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.
C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

Secondary care

Trusts should ensure their e-Referral Service is fully open to referrals from primary care. ***To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical outpatient appointments where a clinically-appropriate and accessible alternative exists****. ... This means* ***collaboration between primary and secondary care*** *to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties.* ***Where an outpatient appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments****.*

Primary care

CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. ***All GP practices must offer face to face appointments at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate*** *– whilst also considering those who are unable to access or engage with digital services.*

Mental health

In addition, we will be asking systems to validate their existing LTP ***mental health service expansion*** *trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:*
- IAPT services should fully resume
- the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working

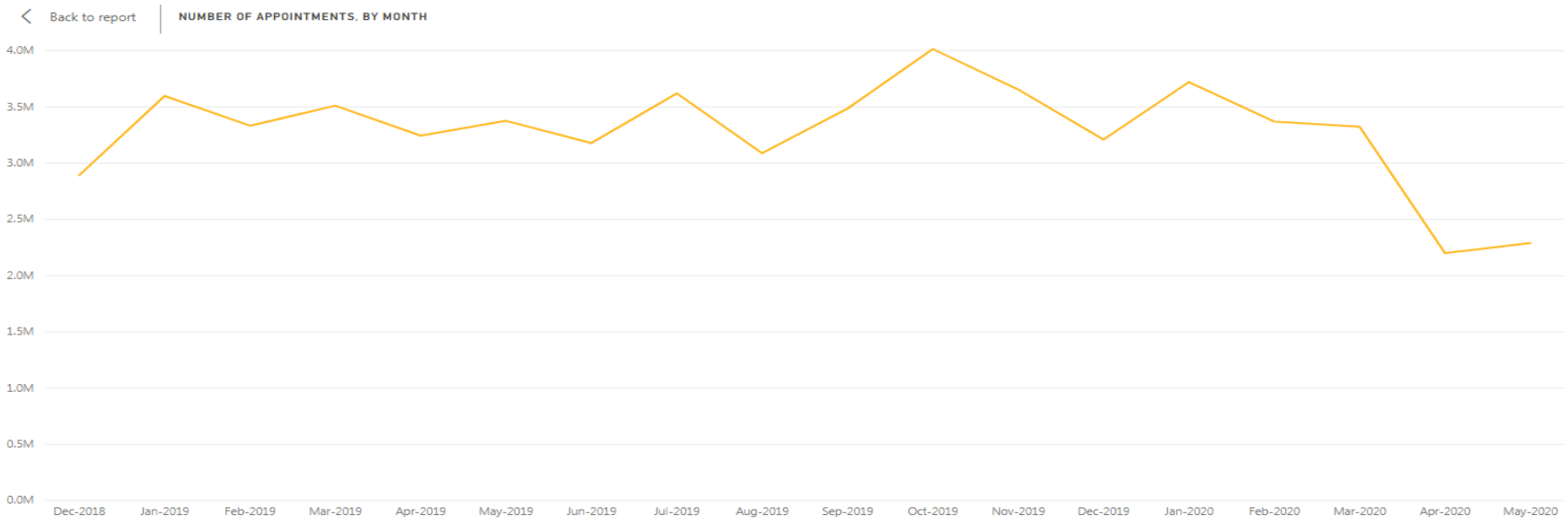
Impact of COVID on General Practice: Appointments in General Practice London Data Analysis

London Estates Delivery Unit

Marwa Al-Memar, Regional Delivery Director

30 June 2020

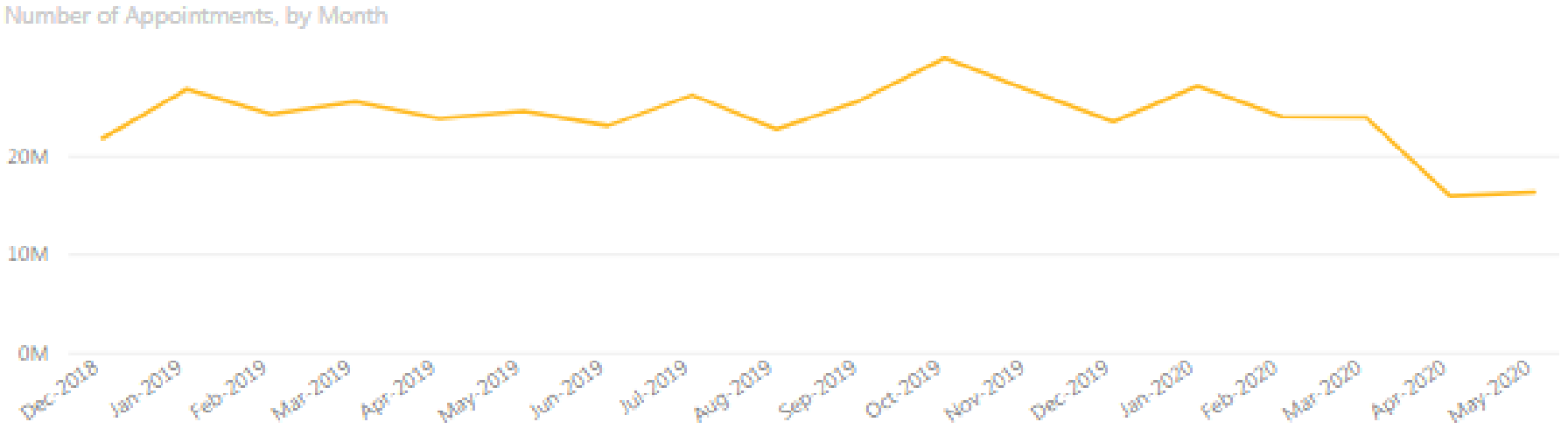
Total appointments in general practice - London



- London saw a sharp decline in total appointments in general practice compared to pre-COVID period
  - 35% Apr vs Feb
  - 32% May vs Feb
- There was a marginal 4% increase in appointments in May compared to Apr

Month	Number of appointments by month	Percentage change from previous month	Percentage change compared to Feb 2020
Feb 2020	3,369,734		
Mar 2020	3,323,371	-1%	-1%
Apr 2020	2,200.426	-34%	-35%
May 2020	2,289,710	4%	-32%

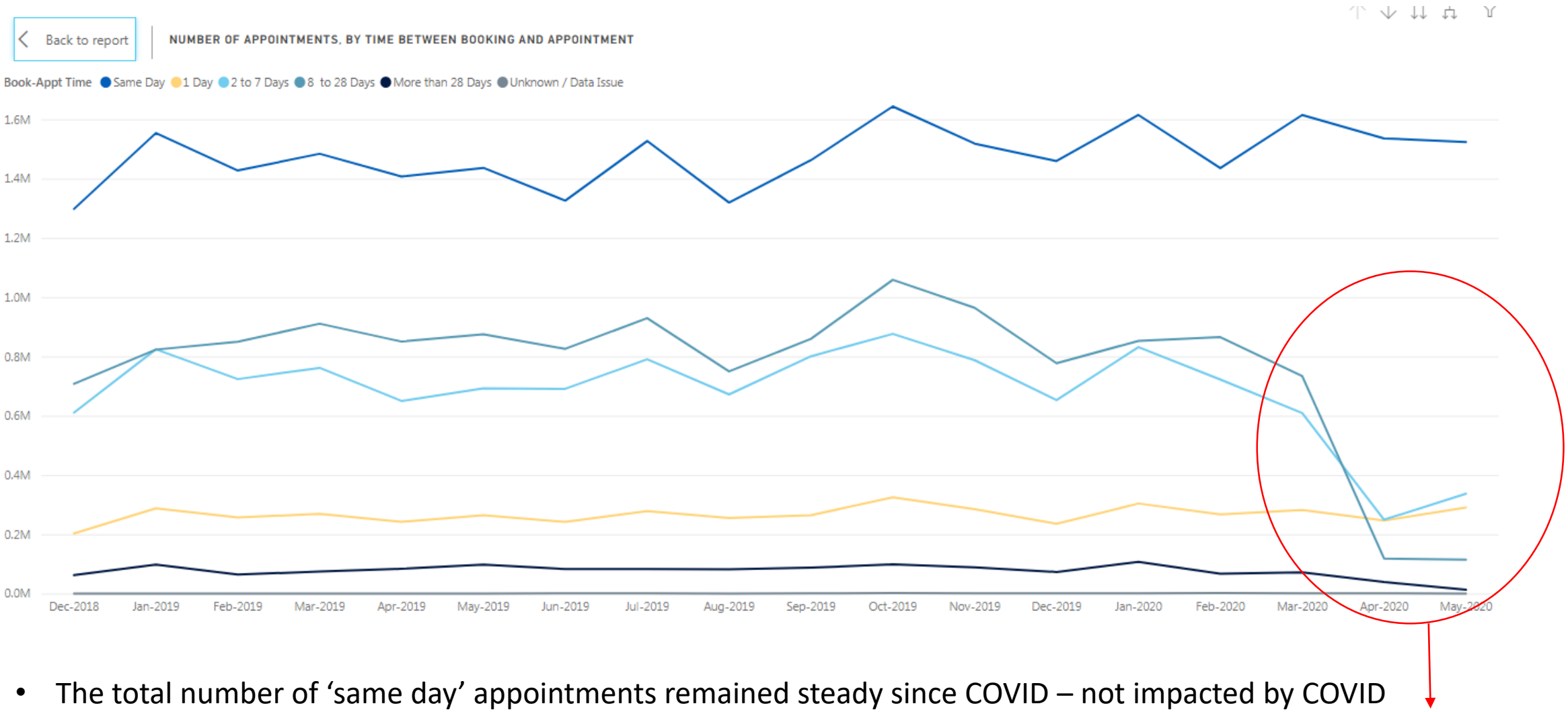
Total appointments in general practice – National



- A sharp decline in total appointments in general practice was seen nationally – similar statistics to London
- There was a marginal 3% increase in apts in May compared to Apr nationally – in line with the London experience

Month	Number of appointments by month	Percentage change from previous month	Percentage change compared to Feb 2020
Feb-20	24,034,223		
Mar-20	23,982,915	0%	0%
Apr-20	15,964,834	-33%	-34%
May-20	16,375,240	3%	-32%

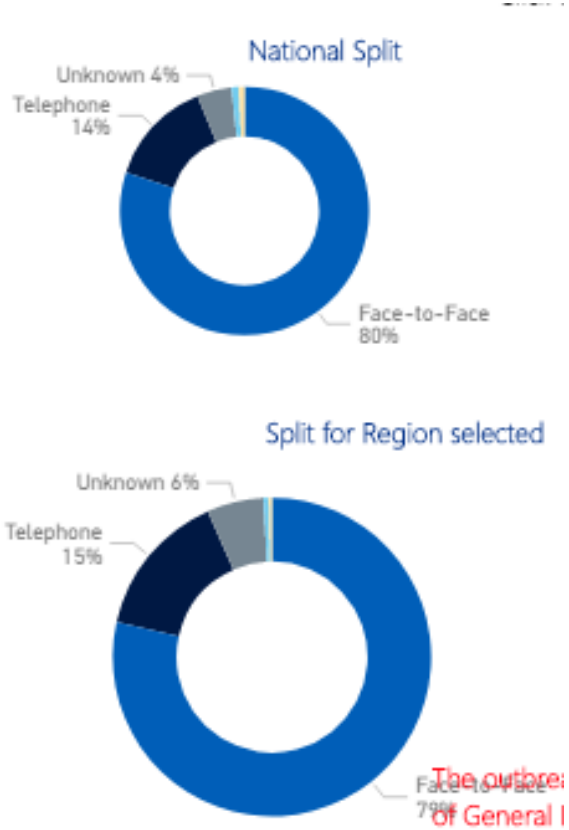
Total appointments by time between booking and appointment - London



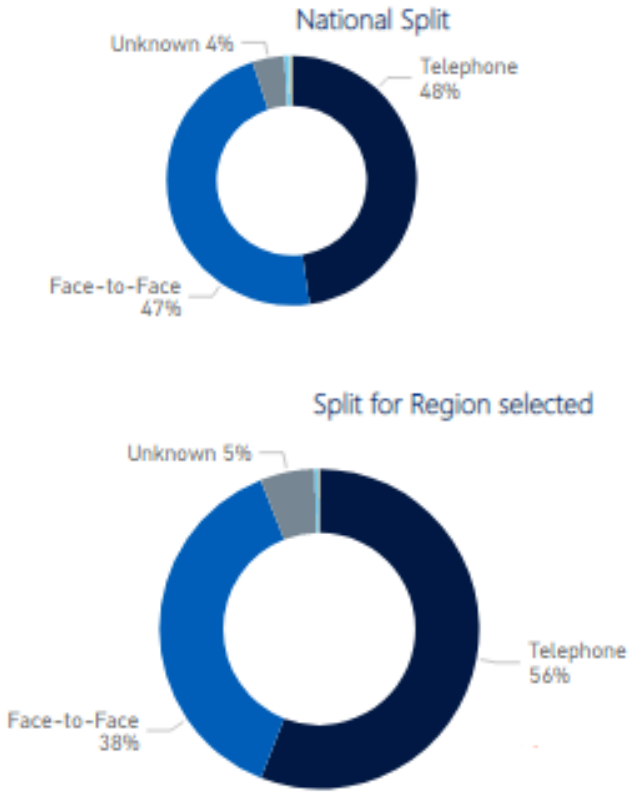
- The total number of ‘same day’ appointments remained steady since COVID – not impacted by COVID
- COVID had the most impact (reduction) on appointments with wait times between 8 to 28 days, and also for 2 to 7 day waits

Total appointments by mode – London and National

FEB 2020



MAY 2020



- Reduction in F2F appointments (Feb vs May)
  - National 80% to 47%
  - London 79% to 38%
- Increase in telephone appointments (Feb vs May)
  - National 14% to 48%
  - London 15% to 56%
- Use of video in general practice has remained low both nationally and in London (<1%)

Source of data

https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/may-2020

June 2020 data to be published on 30 July 2020

Glossary

	Organisation
BJGP	British Journal of General Practice
BMJ	British Medical Journal
CHP	Community Health Partnerships
CLCH	Central London Community Health NHS Trust
DNA	Did not attend - missed appointments
F2F	Face to face
HSJ	Health Service Journal
HUDU	Healthy Urban Development Unit
LEDU	London Estates Delivery Unit
NECS	North of England Commissioning Support
NHSPS	NHS Property Services
OC	Online consultation
PCN	Primary Care Network
PPE	Personal Protective Equipment
RCGP	Royal College of General Practitioners
SEL	Strategic Estates Lead
SQM GIA	Square metres gross internal area
STP	Sustainability and Transformation Partnership
SWLStG	South West London & St George's NHS Mental Health Trust