Implications of changes to routine service provision

Under the GMS contract, practices have a responsibility to provide services to their registered patients and it is for practices to decide how best to provide these services. The emergence of COVID-19 does not in any way negate this requirement.

General practice has rapidly, and rightly, changed its working patterns in order to cope with this national emergency, and demand on general practice for routine care has changed. There are early signs that a short-term reduction in routine clinical activity, although replaced by significant work on system change, is now reversing as patients begin to contact their practices more frequently again. This will lead to routine clinical work returning more toward normal, in addition to increased workload to manage the COVID emergency.

Practices are responding to the needs of patients with, or suspected of having, COVID-19, by admitting them when clinically appropriate and managing them in the community in the way they would for many other patients (including palliative care), often supported by community nursing and other primary care teams. These arrangements, including the establishment of hubs or zoning in a practice building, have been established by practices or between practices as a way of managing patients to whom they have a responsibility to provide essential services.

Remote consultations have become the norm, protecting patients and staff, but there will be instances where a face to face consultation is required. Practices who do not provide any access to face to face consultations when a clinical examination is required may make clinical errors and therefore could be open to medico-legal and contractual risks, so practices need to ensure patients can access services appropriately.

NHS England has committed to maintaining practice income while practices replace normal routine care with new ways of providing this care, and provision of COVID-related care. Additional costs accrued by these new models should be covered by additional funding, from the national COVID-funding announced by government. Many CCGs are also providing additional support.

For example, if the system deems that a group of people (eg shielding patients) who are not normally housebound must be visited, then that should trigger a discussion about how that new additional work is paid for or commissioned.

For patients who require care not related to COVID-19 (whether they don't have COVID-19, they are asymptomatic, they are shielding, or they have COVID-19 but have other health needs) – practices will provide the routine care to their patients in the way they decide is clinically appropriate. If the patient is already under specialist care (ie not general practice care) for specific health needs, then this specialist care should continue to be provided.

For patients who require COVID-related care in the community, NHSEI has stated that it is for the locality to agree how this is to be delivered – with input from all providers within the locality. A practice cannot be forced to operate in a specific way, or deliver care that is outside their scope of expertise, but we would expect all parties to work collaboratively to ensure patients receive appropriate care. Localities may agree additional funding is required, especially if the new model of care delivery creates additional costs to practices.