RAPCI Final Project Report (5)

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Executive summary

The [Rapid Covid-19 Intelligence to Improve Primary Care Response (RAPCI) Project](#) examined the changing demands on GP practices across Bristol, North Somerset and South Gloucestershire during the COVID-19 pandemic. From 13 May to 29 July 2020, we held 87 longitudinal interviews with GPs, managers and nurses from 21 practices in four rounds. In [previous RAPCI reports](#) we reported separately on findings from each round. This final report contains a summary of the challenges identified in all rounds, plus lessons learned throughout the study.

Key findings

Demand and coping: Consultation volumes dropped substantially in March 2020. This gave time to switch systems to remote consulting, and practices coped well throughout the pandemic. Although an influx of patients was anticipated, this did not happen; volumes increased only moderately in June/July. GPs reported a slight decline in coping over the four rounds; face-to-face (F2F) consultations required more infection control procedures than before, telephone consultations were more complex, and total triage was draining.

Challenges:		Round raised			
	Challenge raised	**1**	**2**	**3**	**4**
1	Navigating guidance	■	■		
2	Managing shielding patients	■	■		
3	Implementing total triage system	■	■	■	■
4	Conducting remote consultations	■	■	■	◼(cyan)
5	Conducting F2F consultations	■	■	■	■
6	Managing staff well-being	■	■	■	■
7	Managing patient communications	■	■	■	■
8	Reaching vulnerable patients	◼(cyan)	■	■	■
9	Restarting services	◼(cyan)	■	■	■
10	Support from secondary care/mental health	◼(cyan)	■	■	■
11	Continuation of pre-COVID-19 plans			■	■
12	Using the advice and guidance service			◼(cyan)	■
13	Planning for flu clinics and winter			◼(cyan)	■

Thirteen related challenges were raised across the four rounds, as shown in the table.

Legend

■ Key topic in interviews

◼(cyan) Peripheral topic in interviews

Quantitative data summary

⇨ There was a reduction in GP consulting volumes in April 2020 of 17% from the previous year, increasing again by June to 5% higher than the previous year, coming close to normal levels in July.

⇨ The greatest reduction in the period April–July 2020 was in children and teenagers (33% lower) with no reduction at all in over 85-year-olds.

⇨ 90% of GP consultations were conducted remotely in April 2020 compared with 33% in April 2019. By July 2020 this had changed to 85% as practices lowered the threshold for seeing patients F2F.

⇨ Of the 90% of consultations conduced remotely, 88% were telephone consultations, and just over 1% coded as video. The true proportion of video is probably higher, as GPs often code telephone consultations which switch to video as telephone, but it is still substantially lower than telephone.

⇨ Nurse consultations dropped by 32% in April 2020 from April 2019. Nurses switched from doing 8% of consultations by telephone in 2019 to 46% in April 2020, reducing to 37% in July 2020 as routine procedures restarted. Nurse consultations in pre-schoolers reduced less than other age-groups.

⇨ Consultations in patients with poor mental health and with shielding status increased over the period April–July 2020 compared to the previous year, indicating a greater focus on these groups.

⇨ GPs sent three times more SMS messages to patients than the previous year and nurses four–five times more. Most SMS messages from April 2020 were sent on the same day as a consultation.

⇨ There was a spike in repeat prescriptions in March 2020. This was more pronounced in more affluent groups of patients and in white/mixed-race ethnic groups.

1. Introduction

This is the fifth and final report from the [RAPCI study](), which examined the changing demands on GP practices across Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) during the COVID-19 pandemic.

2. Data sources and methods

Twenty-one GP practices were recruited from BNSSG CCG to provide data to inform this report. Centralised BNSSG CCG data was also provided by One Care, the GP federation that represents and supports practices in BNSSG. The data analysed for this report are as follows:

Qualitative data: The previous four reports contained interviews with GP, practice/operations managers and nurses from 21 practices over the period 13 May to 29 July. Nurses were included in the fourth round only. For this report we have summarised the challenges faced in each of the four rounds and included the CCG response to this challenge. We have also summarised data on the lessons learned through the RAPCI project.

Quantitative data: For this report we analysed consultations with clinicians and SMS text messages sent by clinicians from 20 of the 21 practices from February 2019 to July 2020. We excluded one practice from the analysis, as the list size of this practice changed substantially from 2019 to 2020, and the consultation volumes in each year are therefore not comparable. For the prescriptions data, we used data from all

3. Qualitative findings

3.1 Interview rounds

Longitudinal interviews were conducted at four timepoints, as shown in Figure 1.

Figure 1: Dates of interview rounds for RAPCI study

We interviewed 41 participants over the four rounds: 21 GPs, 11 practice/operations managers, 8 nurses/nurse managers/advanced nurse practitioner (ANP). The practice managers and nurses were interviewed once at the start and end of the study respectively. The GPs and the ANP were all interviewed between two and four times. The interviews in each round are shown in Table 1.

Table 1: List of participating interviewees

Practice Identifier	List Size [a]	Deprivation Decile [b]	Round 1 [c]	Round 2	Round 3	Round 4
1	Medium - Large	1 - 2	2 (GP, PM)	1 (GP)	1 (GP)	1 (NM)
2	Small – Medium	3 - 4	2 (GP, PM)	1 (GP)	1 (GP)	1 (GP)
3	Medium	5 - 6	2 (GP, PM)	1 (ANP)	1 (GP)	1 (ANP)
4	Medium - Large	9 - 10	1 (GP)	1 (GP)	1 (GP)	1 (NM)
5	Small	1 - 2	2 (GP, PM)	0	1 (GP)	1 (NM)
6	Very Large	9 - 10	2 (GP, PM)	1 (GP)	1 (GP)	1 (GP)
7	Medium	9 - 10	1 (GP)	1 (GP)	1 (GP)	1 (GP)
8	Small – Medium	9 - 10	2 (GP, PM)	1 (GP)	1 (NM)	1 (GP)
9	Very Large	9 - 10	1 (GP)	1 (GP)	1 (GP)	1 (NM)
10	Small – Medium	9 - 10	2 (GP, PM)	1 (GP)	1 (GP)	1 (GP)
11	Small	1 - 2	1 (GP)	1 (GP)	1 (GP)	1 (GP)
12	Very Large	5 - 6	1 (GP)	1 (GP)	1 (GP)	0
13	Small	9 - 10	1 (GP	1 (GP)	1 (GP)	1 (GP)
14	Medium	9 - 10	2 (GP, PM)	1 (GP)	1 (GP)	1 (NM)
15	Small	9 - 10	0	1 (GP)	1 (GP)	1 (GP)
16	Small [d]	5 - 6	0	2 (GP, PM)	0	3 (GP, PM, NM)
17	Small – Medium	5 - 6	0	2 (GP, PM)	1 (GP)	1 (GP)
18	Small	1 - 2	0	2 (GP, PM)	1 (GP)	1 (GP)
19	Small – Medium	3 - 4	0	1 (GP)	1 (GP)	1 (GP)
20	Medium	3 - 4	0	1 (GP)	1 (GP)	1 (GP)
21	Small	1 - 2	0	1 (GP)	1 (GP)	1 (NM)
Total			**22**	**23**	**20**	**22**
Average "Coping" Score			**8.6**	**8.1**	**8.2**	**8.5**
Average "Coping" Score: GPs and ANP			**8.3**	**8.1**	**8.2**	**7.8**

a) Small: < 10,000; Small-Medium: 10 - 15K; Medium: 15-20K; Medium - Large: 20-25K; Large: 25 - 30K; very large: 30K+

b) 1 = most deprived and 10 = most affluent.

c) **GP** = general practitioner; **PM** = practice manager; business manager or operations manager; **ANP** = advanced nurse practitioner; **NM** = nurse manager or senior nurse.

d) This practice was excluded from the quantitative analysis.

⇨ Participants in each round were asked how they were coping with the changes resulting from the COVID-19 pandemic on a scale of 1 to 10. Average coping scores were calculated twice: once for all participants and once for participants who gave multiple interviews (GPs/ANP). The latter gives a better view of how coping changed over the four rounds; participants who had not been interviewed before (e.g. the nurses in round 4) tended to give coping scores which referred to the entire pandemic period, whereas participants who had been interviewed before gave their score in comparison to the previous round.

⇨ The average coping scores showed a slight pattern of decline over the four rounds for GPs/ANP. Clarifying this in qualitative interviews, most GPs said their practice had continued to cope well in terms of meeting the needs of patients, but some were finding it harder as individuals to cope with the demands of remote consulting/social distancing.

⇨ The increase in coping scores in round 4 when calculated across all participants may have been due to the inclusion of nurse managers as new participants in this round.

3.2 Table of challenges

Table 2: Challenges faced, innovative solutions and help required, and CCG/One Care action taken

	Challenges faced *identified by RAPCI participants*	Innovative solutions and required help *identified by RAPCI participants*	Action taken by BNSSG CCG/One Care *identified by CCG primary care cell*
1	**Navigating guidance (round 1):** Initially many practices found it challenging to keep abreast of the large amounts of guidance received from different sources. But they also sometimes lacked guidance for certain situations or found it to be contradictory.	**Solutions**: Creation of small teams to interpret guidance and lead practice response. Regular practice meetings to discuss issues as they arise. **Help needed**: More focused CCG bulletins (though bulletins generally viewed positively).	▪ Communications group formed in March 2020 of: the CCG, the Local Medical Council (LMC), Severnside and One Care. ▪ Substantial CCG and One Care resource spent collating and sharing guidance through the TeamNet site and email. ▪ Daily single system-wide COVID-19 bulletin sent out with a link to Teamnet. ▪ One Care initiated iterative FAQs with support from expert areas, e.g. LMC and Infection prevention Control (IPC). ▪ Reduced emails to three days per week in June as volumes of guidance reduced.
2	**Managing shielded patients (rounds 1 and 2):** ▪ Workload of managing list of shielded patients. ▪ Dealing with queries about shielding from patients not on list. ▪ Continual short notice changes to shielding criteria and lack of clarity at the outset on who is responsible (NHS England or GP practice). ▪ Addition of "cohorts" of patients added to the shielding list – often incorrectly. ▪ Deciding when and how to see shielded patients F2F. ▪ Concerns over how to manage patients going forward (phone calls very time-consuming).	**Solutions**: ▪ Single staff member (normally social prescriber) proactively contacting shielded patients. Provision of single 'clean' site, specific hours or home visits for shielded patients (see report 1) ▪ GP assigned to reviewing the shielding list and correcting allocations. Some practices chose to leave incorrect but borderline patients added to the list in June to avoid more confusion. **Help needed:** Guidance on how to manage shielded patients as workload increases.	▪ CCG specified a shielding EMIS search (prior to the national lists) to manage early shielding enquiries from patients. ▪ One Care provided technical support on EMIS searches for practices to identify shielded and vulnerable patients. ▪ Created "healthy shielding" resource in collaboration with voluntary sector (signposting info for shielding patients). ▪ Signposted practices to national shielding resources through TeamNet. ▪ IPC developed guidance on safe measures for seeing shielded patients (changing national guidance made this difficult to keep up to date. Practices often took local action). ▪ One Care provided translation/summary of messages for practice to track sequence of events and decisions.

Challenges faced *identified by RAPCI participants*	Innovative solutions and required help *identified by RAPCI participants*	Action taken by BNSSG CCG/One Care *identified by CCG primary care cell*
3 **Implementing total triage system (rounds 1–4):** ▪ Round 1: practices rose to the challenge of implementing total triage. ▪ Round 2: deciding on threshold for face to face (F2F) appointments as lockdown eased. ▪ Round 4: as patient demand increased, some practices started to find new systems unworkable (e.g. same day call backs). ▪ Practices were keen to keep some benefits of triage and avoid a return to unfiltered demand but were finding it a challenge to implement the right system to do this.	**Solutions**: In early rounds implemented new systems, e.g. ▪ Joint GP patient lists ▪ Closing bookable appointments ▪ Total triage and patient navigation at reception ▪ Reducing the need for F2F through risk stratification using Florey questionnaires. In later rounds, practices looked for ways to manage new systems with rising demand, e.g. ▪ Using online e-consultation systems to spread out demand. ▪ Freeing up pre-bookable phone appts to ease demand on same-day calls. ▪ Booking fixed time on-the-day phone apts. ▪ Creating slot types with different lengths – e.g. for first and follow-up phone appts ▪ Returning to personal GP lists ▪ Moving more work to ANPs (e.g. joint pains). ▪ Reducing unnecessary paperwork being sent to the GPs by admin staff. **Help needed:** ▪ Clearer guidance on when F2F is needed post lockdown easing (rounds 3–4) ▪ Practice community worker to assist patients with remote monitoring and technology. ▪ Information about local COVID-19 incidence.	▪ Commissioning Support Unit (CSU) support services were maintained and digital projects related to COVID-19 or remote delivery were prioritised with the CCG enabling rapid distribution of equipment to support remote consultations and home working. ▪ CCG/One Care set up the SitRep (situation report, launched 3 April 2020) for practices to provide a daily report on their resource needs so that needs could be monitored on a daily basis and assistance could be rolled out. ▪ Provided bespoke training and support sessions for implementing e-consultations. ▪ One Care provided expertise to practices utilising Bistech telephone functionality to spread route calls across PCNs and to work from home. The CCG funded additional phone licences to enable this.

Challenges faced _identified by RAPCI participants_	Innovative solutions and required help _identified by RAPCI participants_	Action taken by BNSSG CCG/One Care _identified by CCG primary care cell_
4 Conducting remote consultations (rounds 1-4): ▪ IT challenges in some practices (e.g. poor Wi-Fi, no webcams, old/slow computers). ▪ Managing risk and clinical uncertainty by phone/video, concerns regarding prescribing over the phone/video and concerns regarding missing problems in patients with long-term conditions that are not being seen F2F. ▪ Rounds 3 and 4: phone calls taking longer as complexity increased (including increasing mental health problems). ▪ Process of talking patients through video/SMS technology is time-consuming.	**Solutions**: ▪ In round 1: GPs using their own phones to conduct video calls. Some practices provided phone holders so GPs can video call hands-free. ▪ Peer support and consultation. ▪ Higher levels of follow-up. ▪ Following-up patients after remote prescribing. ▪ Increased use of SMS for app-based conversations prior to phone, video or F2F. _"We're doing a lot of stuff now like 'Can you send us a picture?' [accuRx allows] you to have an app-based conversation with the patient before you actually decide to talk to them. 'Have you looked at this leaflet? I think if you've got nits here is the leaflet that helps you to deal with that'."_ ▪ **Help needed**: Some practices would still like further IT support, including webcams on desktops and building upgrades to improve Wi-Fi.	▪ CCG facilitated roll out of accuRx functionality (video link, photo sending, unlimited use of accuRx Pathways.) ▪ CCG provided remote VNC /VPNs, 400 additional laptops, headsets and webcams (delayed because of international supply chain problems) ▪ CCG implemented an application programming interface (API) to allow patients to reply to practice texts directly. ▪ CSU developed information governance guidance on consent for photos and data security which was disseminated on Teamnet. ▪ CCG (in collaboration with practices and the local health and social care provider) assisted care homes with IT infrastructure. Included NHSNet, MS teams, ensuring adequate broadband. ▪ CCG facilitated sign-up for free/low cost boosts available from suppliers to NHS workers for phone and broadband.
5 Conducting F2F consultations (rounds 1–4): ▪ Keeping staff and patients safe. ▪ Separating COVID-19 suspected patients. ▪ Managing risk thresholds for F2F appointments and admissions. ▪ Early issues around the quality, cost and disposal of PPE, time to put on and take off PPE and disinfect between patients. Nurses had to do	**Solutions:** ▪ Repurposing physical environment to protect staff/patients (see report 1). By round 4, some practices were making these semi-permanent. ▪ Patients asked to arrive on time. ▪ F2F appointments spaced throughout day (though some practices found this disruptive)	▪ Estates principles for COVID-19 were disseminated with process for practices to apply to update estate. ▪ CCG Panel set up to review extraordinary requests. ▪ Initial problems with PPE in some practices resolved through the One Care system of PPE reporting and provision (which used SitRep). ▪ Hot hubs planning work carried out for Weston including digital advice to enable

Challenges faced *identified by RAPCI participants*	Innovative solutions and required help *identified by RAPCI participants*	Action taken by BNSSG CCG/One Care *identified by CCG primary care cell*
more of this than GPs and some found good infection control a challenge, e.g ○ Adhering to the protocol: "*it is extra brain power to think 'what do I do now'*". ○ Having enough time. ○ Physical demands: "*It's quite a lot of cleaning, and it's quite physical.*"	▪ Less experienced staff to discuss cases with the duty doctor before booking a F2F (this was relaxed in later rounds). ▪ Empowering patients to self-manage at home: e.g. wound care, blood pressure, self-administered contraceptive injections. ▪ Self Service station for chronic disease monitoring (with pulse oximeter, blood pressure monitor and scales.) ▪ Written protocol for infection control kept visible (e.g. on the wall) ▪ Dedicated appointment slots for cleaning ▪ In later rounds, some practices lowered the risk threshold for seeing patients F2F **Help needed:** In round 1 a minority wanted hot hubs but most GPs felt volumes did not warrant it.	access to records. Was approved but then was not required as the large number of anticipated COVID-19 patients did not arise. May be used for flu. ▪ One Care provided the names of suppliers who could fit Perspex screens to support infection prevention and control (IPC). ▪ Additional digital equipment (e.g. laptops, additional PCs) provided where needed to enable social distancing.
6 **Managing staff well-being (rounds 1–4):** ▪ In round 1, staff anxiety related to catching the virus was well-managed and staff rose to challenges. ▪ In round 2 new challenges emerged with staff home-schooling and caring for relatives. ▪ There was a concern in round 1 in some smaller practices about staff shortages due to illness and caring responsibilities. ▪ In rounds 3 and 4, after the initial "adrenaline", the model of consulting started taking a toll on staff. Some felt that, following an initial period of strong public support, there was a "backlash" against general practice among some of their own patients and in the media.	**Solutions:** ▪ Many practices immediately started vulnerable /self-isolating staff home-working or closed a site to patients for receptionists to man phones. ▪ Sharing weekly email for staff well-being. Greater inclusion of all staff in decision-making. **Later rounds:** ▪ Solutions included having regular catch-ups with colleagues so that affected staff know it is "not just them", many are feeling "COVID-19-fatigue". ▪ Continuing to educate patients. ▪ Some felt that more F2F appointments would help GP satisfaction as well as patient safety.	▪ Dissemination of NHS England well-being guidance through daily communications. ▪ Collated and disseminated staff risk assessment templates. ▪ Additional workforce coordination centre was launched, project managed by One Care using workforce SitRep reporting to aid practices. ▪ CCG Reimbursed self-isolating staff for 14 days. ▪ One Care proactively supported practices who were struggling with calls and advice to sustain their resilience.

Challenges faced *identified by RAPCI participants*	Innovative solutions and required help *identified by RAPCI participants*	Action taken by BNSSG CCG/One Care *identified by CCG primary care cell*
▪ Mandatory mask-wearing for all staff, which arose in round 3, was challenging for staff who hadn't been used to it.	**Help needed**: Some practices were aware of a new local workforce collaboration to provide a bank of reception staff and said this will be welcome.	
7 Managing patient comms (rounds 1–4): ▪ In round 1, participants were concerned about patients delaying contact with practice. ▪ In later rounds, as shielding guidance relaxed, the issue was managing patient expectations on referrals and appointments and maintaining social distancing standards (e.g. mask-wearing, coming alone, accepting telephone appointments).	**Solutions**: ▪ Communicating with patients via text (MJOG campaigns), signage, social media and local radio to let them know practice is 'open for business' but to wait outside. ▪ Making clear to patients at the point of referrals that the wait may be a long one.	▪ CCG comms and the COVID-19 comms cell developed a series of campaigns to support patient understanding of changes. Included managing expectations on referrals and remote appointments, mask wearing and social distancing. Mechanisms included social media, press and MP briefings, open letters to the public. ▪ CCG hosted information and resources for the public on their website. ▪ CCG-funded SMS text services to support patient comms (see 4 'Conducting remote consultations')
8 Reaching vulnerable patients (rounds 1–4): Some GPs expressed concern that remote consulting favoured a younger, more digitally literate demographic, and that some vulnerable patients were in danger of being missed. "*If we want to invest in anything to help general practice over the winter … it would be to deal with this problem [worsening access in certain groups].. the elderly, the shielded, perhaps a bit deprived, how can we deal with them without them having to come in and without the GP having to go out.*"	**Solutions:** ▪ Remote monitoring: e.g. phoning high-risk, diabetes patients and use of "sick day rules" ▪ Proactively phoning up patients on mental health learning disabilities register. ▪ Continuing to do multidisciplinary team meetings (MDTs) by video to discuss vulnerable patients.	▪ Held two waves of the citizens panel on health inequalities. Found specific localities who are not satisfied with digital routes. ▪ Are currently (August 2020) establishing how to identify people with barriers to digital access to ensure they get support from the voluntary sector. ▪ CCG sent out tool for practices so that they can proactively identify and manage vulnerable and shielding patients coming into winter.

Challenges faced *identified by RAPCI participants*	Innovative solutions and required help *identified by RAPCI participants*	Action taken by BNSSG CCG/One Care *identified by CCG primary care cell*
9 **Stopping and restarting services (rounds 2–4):** ▪ In round 1, practices were concerned about how they would reintegrate routine work using new systems and were concerned about an imminent "flood" of patients due to delayed workload. ▪ In later rounds, workload was proving manageable, but practices emphasised the need for guidance and consistency across the CCG in relation to what routine care to prioritise restarting. ▪ Maintaining distancing and time-consuming putting on and taking off PPE continued to be challenging.	**Solutions**: ▪ From round 1, practices were planning for reopening services, writing referrals ready to go, using codes to identify deferred referrals. ▪ Allocating one GP to work through backlog of minor procedures with spaced appointments. ▪ Continued use of Florey surveys for risk stratification and segmenting chronic conditions work. **Help needed**: Guidance on: ▪ The prioritisation list from the CCG, based on RCGP list (of red amber and green procedures) needs more detail, e.g. how long can practices delay on medication monitoring, less urgent diabetes checks and coil refits?	▪ CCG adjusted RCGP/BMC prioritisation (red, amber, green) guidance early in the pandemic and sent out as a guide, with a clear message that this was a decision aid, which would need to take local circumstances into account. ▪ Further to this, CCG felt that prioritisation decisions were dependent on local practice circumstances, and more prescriptive guidance would not be appropriate.
10 **Support from secondary care and mental health services (rounds 2–4):** ▪ Referrals were due to open again during this period, but some specialities have not opened. ▪ There is no "read receipt", or similar mechanism for practices to know that a referral has been received and ownership taken. This creates an administrative challenge of monitoring the referrals and a challenge managing people in primary care whose procedures have been delayed. ▪ Some tests (e.g. certain bloods) which would previously have been done in secondary care are being done in primary care.	**Solutions**: Use of "holding lists" to track referrals. **Help needed:** ▪ Clear summary sheet on CCG website of what referrals are open or, at a minimum, set of agreed principles on when referrals will be responded to. ▪ Clarification of what counts as an "urgent" mental health referral.	▪ CCG are discussing work shift issue with consultants through Outpatients cell. Primary care cell and strategy board are mapping out pathway and primary care capacity as of August 2020. ▪ This mapping will be reflected in the recently developed primary care capacity planning tool, which will be rolled out to support practices. ▪ Setting up community phlebotomy hubs to reduce work shift to primary care. ▪ Datix tool on CCG website can be used to log problems with work shift. Processes being established to ensure that issues logged result in action being taken.

| Challenges faced *identified by RAPCI participants*	Innovative solutions and required help *identified by RAPCI participants*	Action taken by BNSSG CCG/One Care *identified by CCG primary care cell*
11 Continuation of pre-COVID-19 plans (rounds 3 and 4): Practices now need to plan not only for reopening of routine services, but also for Integrated Care partnerships, restart of Care Quality Commission inspections, implementing e-consultations, extended hours, and Quality Outcomes Framework (QOF). Staff are finding it hard to cope with these demands, combined with a continuation of COVID-19 related stresses like social distancing and holding more clinical risk.	**Help needed:** ▪ Leadership (at all levels) to motivate and retain staff. ▪ A *"pause for staff to regroup"* (which may involve delaying some initiatives). ▪ Relaxing of next year QOF targets (e.g. adjusted to be e.g. 2/3, given time lost during pandemic). ▪ Guidance from the CCG on whether e-consultations are contractual.	▪ QOF out of CCG control. ▪ Guidance was provided by the CCG on e-consultations.
12 Advice and guidance service (rounds 3 and 4): The service will often advise GPs to request investigations they do not have the ability to access/order.	**Help needed**: Clear communication should be provided to the advice and guidance service on what GPs are able to access/order, so that they can cater their advice appropriately.	▪ Clear communications for consultants were put on CCG website on what a good response looks like and what issues to consider. ▪ CCG did survey in July 2020 to see if this is a general issue. ▪ CCG are encouraging GPs to use Datix tool to log issues with responses.
13 Planning for winter and flu (rounds 3 and 4): ▪ **Winter**: Challenge to plan for a time when there is more respiratory illness, and it will be difficult to distinguish COVID-19 infected patients from other viruses. ▪ **Flu**: Administering flu jabs to more people, while maintaining social distancing, will require greater workforce and estates capacity. ▪ Challenges also include unrealistic expectations on measures needed to ensure both informed consent and	**Winter solutions planned** ▪ Removing waiting rooms, creating one-way systems and co-ordinating timings. ▪ Remote pulse oximetry. ▪ Continuing to hold more risk: e.g. asking patients with respiratory infection to wait longer or prescribing more antibiotics by phone. **Flu solutions planned**: ▪ Use of external venues. ▪ Bar-coding to improve recording. ▪ Moving from 1 to 3-minute slots. ▪ 2 nurses working in parallel. ▪ Using staff to marshal queues.	▪ The Prioritisation tool (see section 8, 'reaching vulnerable patients') also shows what vulnerable patients should be offered (e.g. flu jab, QOF Long Term Conditions (LTC) review, signposting to voluntary sector.) ▪ Sub-group set up to focus on primary care challenges and sharing best practice. ▪ Proactive FAQs set up for practices with both local and national information. ▪ One Care developed a TeamNet page to hold flu resources, guidance, FAQs and information.

Challenges faced *identified by RAPCI participants*	Innovative solutions and required help *identified by RAPCI participants*	Action taken by BNSSG CCG/One Care *identified by CCG primary care cell*
infection control (e.g. NHS England guidance on changing PPE)	▪ Fixed appointment times. **Help needed:** ▪ Some practices wanted guidance and others to do their own planning and then request help based on their local solution. ▪ Extra capacity – e.g. flight attendants to assist with the flu campaigns	

4. Quantitative findings

The quantitative analysis reported here is an update to the analysis presented in RAPCI report 3. Report 3 contained analysis from 15 practices up until May 2020 and compared the period April–May 2019 with April–May 2020. This analysis is based on 20 RAPCI practices, and the periods April–July 2019 and April–July 2020 are compared.

4.1 Change in consultation volumes over time

Figure 2: Monthly GP and nurse/paramedic consultations from February–July 2019 and February–July 2020 per 1,000 patients registered: stacked bar charts
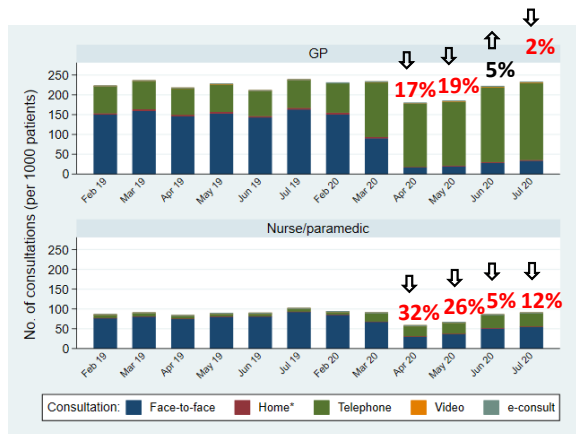
⇨ GP consultations reduced in April 2020 by 17% from the previous year. By June 2020 consultations were back to above the previous year. Overall, from April–July 2020, GP consultations were 8% lower than the same period in the previous year.

⇨ Nurse consultations reduced by 32% in April 2020, increasing again in June 2020 to nearly the same as the previous year. Overall, from April–July 2020, nurse consultations were 19% lower than the same period in the previous year.

Figure 3: Monthly GP and nurse/paramedic consultations from February–July 2019 and February–July 2020 per 1,000 patients registered: line charts
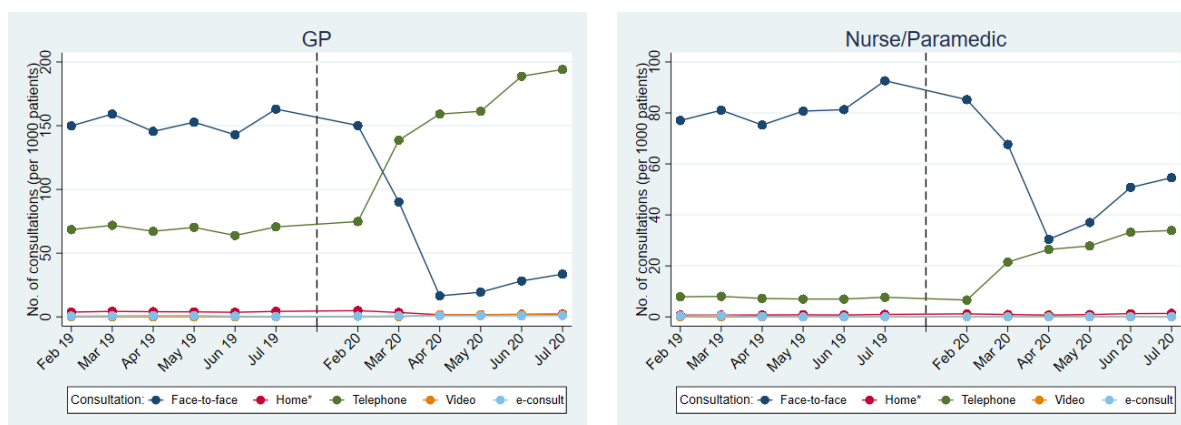
⇨ The profile of F2F/remote GP consulting changed in April 2020 from F2F representing 67% of all consultations (April 2019) to only 9% (April 2020). Nurse consultations changed from being 90% F2F to just over 50% F2F. The proportion of F2F consultations increased from May–July 2020, but were still much lower than previously, especially for GPs.

⇨ Remote consultations were nearly all telephone. Just under 1% of GP consultations in April-July 2020 in this dataset were video consultations. The true number may be higher than this, as it was difficult to identify video consultations in the data as some telephone consultations switched to video, but were only recorded as telephone.

⇨ Less than 0.5% of consultations in April–July 2020 were e-consultations. This only includes e-consultations done by GPs – consultations added by administrators are not included in the data.

4.2 Change in consultation volumes by age

Figure 4: Monthly GP consultations in April–July 2019 and April–July 2020 per 1,000 patients in each age group
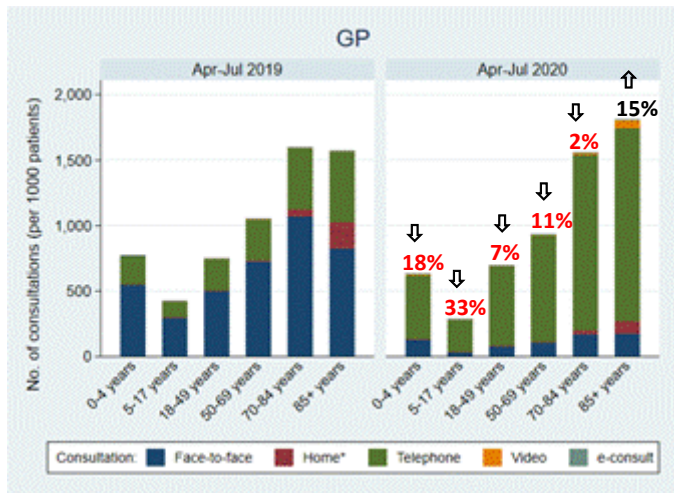
⇨ Telephone consultations have increased in all age groups, but particularly in older age groups.

⇨ Total GP consultations in 85+ patients have increased, although home visits and F2F have decreased substantially.

⇨ GP consultation rates have shown the greatest drop in children aged 5–7.

⇨ Video calls are used most in the age group 85+ (3.6% of all consultations. This may be nursing home ward rounds).

Figure 5: Monthly nurse consultations in April–July 2019 and April–July 2020 per 1,000 patients in each age group
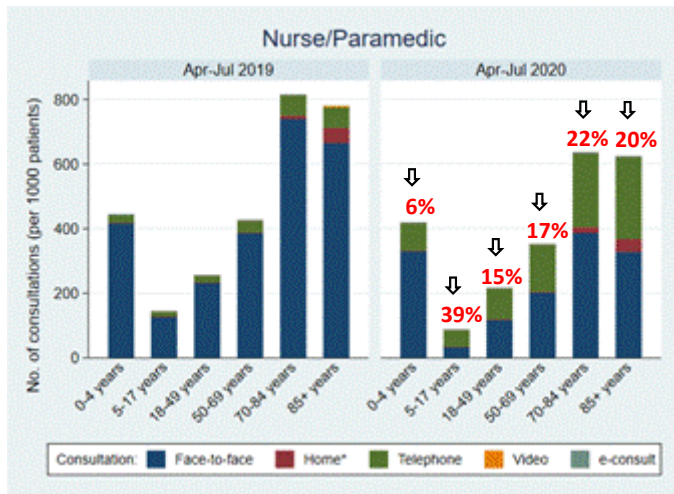

⇨ Total nurse consultation rates among 0–4 year-olds decreased less than other groups.

⇨ Nurses have continued to do more F2F consultations in 0–4 year-olds than other age groups (this may be immunisations and baby checks).

⇨ Nurse consultation rates in all other age groups have decreased.

⇨ As with GP consultations, the change was greatest in the age group 5–17 years.

4.3 Change in shielding patients and patients with poor mental health

Figure 6: Monthly GP and nurse/paramedic consultations in April–July 2019 and April–July 2020 per 1,000 patients registered in patients with good mental health and poor mental health
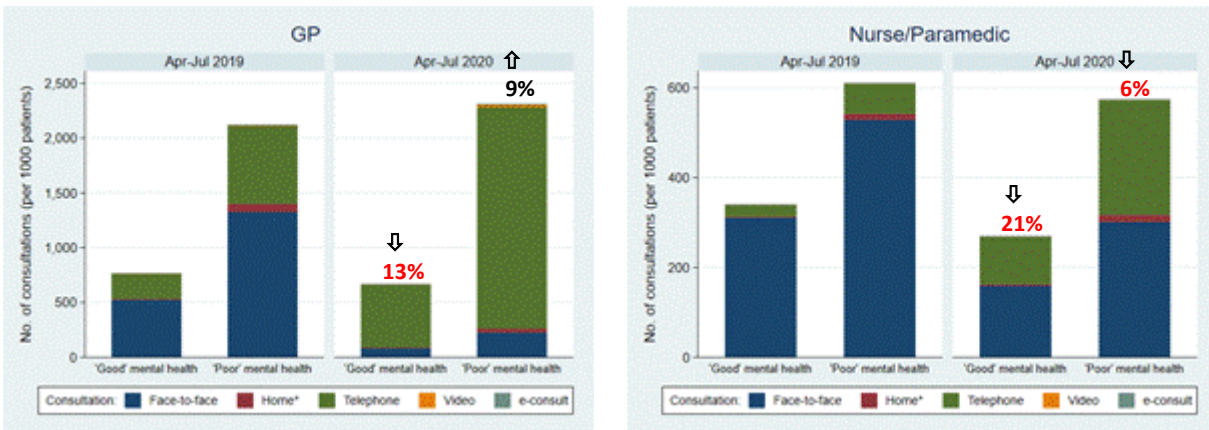
⇨ In the period April–July 2020, GP consultations decreased by 13% from the previous year in patients who had good mental health but increased by 9% in patients who had poor mental health.

⇨ Nurse consultations declined in both groups, but the decline was greater in patients with poor mental health.

Figure 7: Monthly consultations in April–July 2019 and April–July 2020 per 1,000 patients registered in patients with shielding and non-shielding status
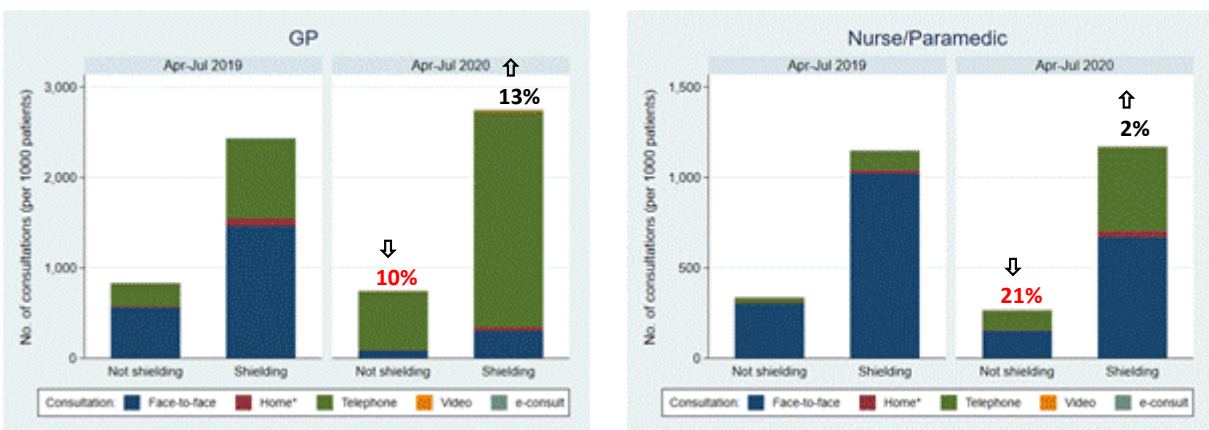
⇨ In the period April–July 2020, GP consultations decreased by 10% from the previous year in patients who were not advised to shield but increased by 13% in patients who were advised to shield.

⇨ Nurse consultations remained similar in patients who were advised to shield and decreased by 21% from the previous year in other groups.

4.4 Change in SMS messaging

Figure 8: SMS messages sent from February–July 2019 and February–July 2020 per 1,000 patients
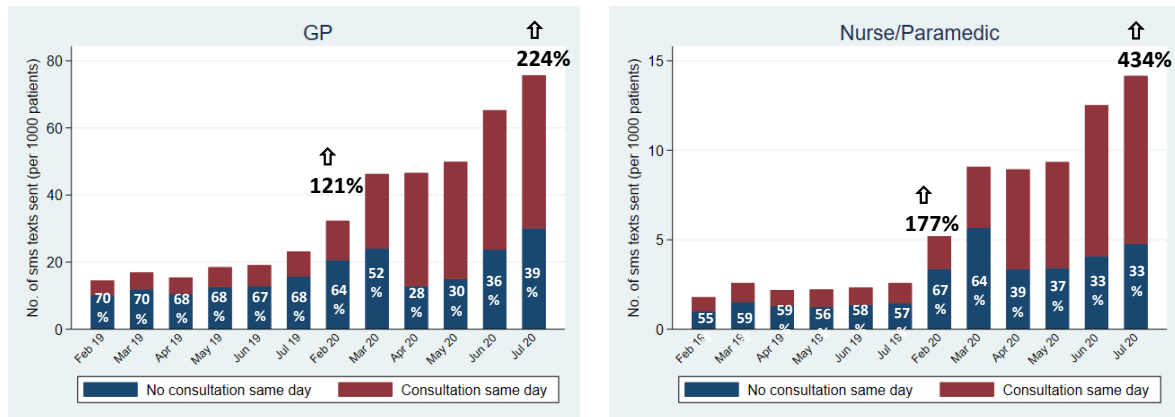
⇨ Both GPs and nurses communicated with patients substantially more by SMS. By July 2020, GP SMS message sent to patients had increased by 224% from July 2019, an SMS messages sent by nurses had increased by 434%.

⇨ There had already been a substantial increase in SMS messages in February 2020, before the national mandate to reduce F2F consultations, so there may have been an upward trend in SMS messaging anyway, unprompted by the COVID-19 pandemic.

⇨ In 2019, most SMS messages were sent to patients on days that they did not also have a consultation (e.g. 68% for GPs and 59% for nurses in April 2019). In April–May 2020, GPs and nurses started to send most of their SMS messages to patients on the same day that they also had an appointment (e.g. 72% for GPs and 61% for nurses in April 2020).

⇨ This may indicate different reasons for SMS messages from April 2020. SMS messages in this period may be more directly related to the consultation which the patient had on the same day, for example SMS video links, accuRx questionnaires to triage patients, or follow-up texts.
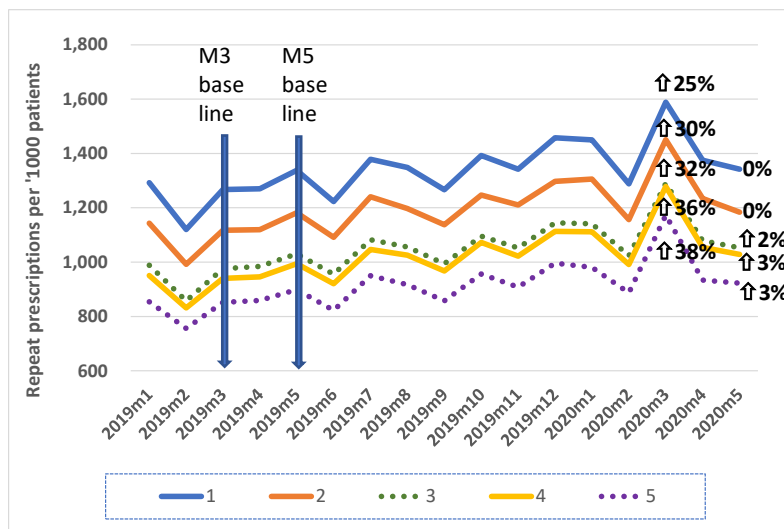
4.5 Change in repeat prescribing

There was a sharp increase in the number of repeat prescriptions issued in March 2020, coinciding with the start of lockdown. The figures below show this by deprivation and ethnicity.

Figure 9: Monthly repeat prescriptions from January 2019 – May 2020 by ethnicity per '000 patients registered in May 2020 in each ethnic group – all practices in BNSSG CCG
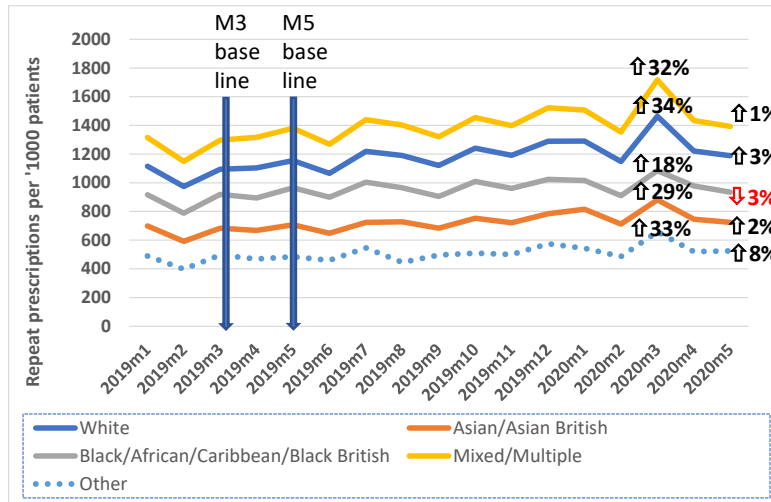
⇨ The increase from March 2019 to 2020 was greatest in white (34%) and mixed/multiple (32%) groups and lowest in Black/ Caribbean / African and Black British groups. (18%)

⇨ White and mixed/multiple ethnicities also had more repeat prescriptions at baseline.

⇨ By May 2020, repeat prescription rates were only slightly higher than the previous year (but slightly lower for Black/African/Caribbean and Black British ethnic groups).

Figure 10: Monthly repeat prescriptions from January 2019 – May 2020 by deprivation quintile per '000 patients registered in May 2020 in each group – all practices in BNSSG CCG

⇨ The increase in repeat prescribing from March 2019 to 2020 was greater in more affluent groups (36% and 38% at deprivation quintiles 4 and 5 respectively) and lowest in the most deprived (25% and 30% a deprivation quintiles 1 and 2).

⇨ By May 2020, repeat prescribing was only 3% higher than the previous year in more affluent groups (deprivations quintiles 4 and 5) with no increase at quintiles 1 and 2.

⇨ More deprived deciles had more repeat prescriptions at baseline.

4.6 Change in consultation follow-up rates

Table 3 shows the proportion of consulting patients who had another consultation within two weeks, firstly for the period April–July 2019 and secondly for April–July 2020. This is broken down by the initial consultation type (shown in the rows) and the type of the first follow-up consultation (columns).

"Follow-up" consultations are just the second consultation in this period. They could be follow-ups from the initial consultation or could represent a new episode of care; we don't have information on what the index consultation is in each episode.

We have investigated follow-up for every consultation, so some consultations will count as both an initial consultation and a follow-up consultation. A similar table produced in RAPCI report 2, for 15 practices for April–May 2020 included failed telephone consultations. These have now been excluded for this analysis. The results still show that more follow-up is being carried out.

Table 3: Proportion of patients with consultations of each type who have a follow-up consultation within two weeks, by type of first follow-up

Initial consultation type	Follow-up consultation type			
	F2F %	Tel %	Home %	Any %
APR-JUL 2019				
Face-to-face	29.4%	8.8%	0.2%	38.5%
Telephone	34.0%	16.5%	1.9%	52.6%
Home*	12.5%	22.3%	22.3%	57.2%
Total	**30.3%**	**10.9%**	**1.0%**	**42.2%**
APR-JUL 2020				
Face-to-face	23.3%	26.0%	0.3%	49.9%
Telephone	13.3%	34.7%	0.7%	49.1%
Home*	8.5%	39.5%	18.0%	67.3%
Total	**15.6%**	**32.6%**	**0.8%**	**49.4%**

In April/July 2019, 42% of consultations were followed by another within 14 days. In April/July 2020 this had increased to 49%.

F2F after telephone consultations has substantially *decreased*. In April/July 2019, 34% of patients who had a telephone consultation had a subsequent F2F within 14 days as their next consultation. In 2020, only 13% did.

Follow up by telephone has substantially *increased*. In April/May 2019, 11% of patients who had a consultation of any kind had a telephone consultation within 14 days as their next consultation. In 2020, 33% did.

5 Lessons learned throughout the RAPCI project

In this section we summarise lessons learned through the RAPCI project on 1) remote consulting 2) other innovations implemented 3) leadership.

5.1 Remote consultations

Telephone consultations
▪ Telephone consultation is effective for many patient problems. Clinicians vary in their ability to consult by telephone; it is a skill which takes training and practice.
▪ Telephone consultation makes flexible working and managing sickness cover easier.
▪ Nurses can successfully carry out some chronic conditions monitoring by phone.
▪ Telephone consulting may result in less problems being introduced by the patient at the end of the consultation. (This has downsides as well as positives).
▪ F2F is often seen as the "gold standard" while telephone is seen as more efficient. However, neither statement is always true. F2F is not always superior to telephone: some clinicians feel their patients are more relaxed over the phone and it is easier to build a relationship. Telephone is not always more efficient than F2F because information can be gathered more quickly in a F2F.
▪ The rapid move to telephone consulting was implemented because there was a necessity to reduce risk of potential exposure to SARs-COV-2, not because it was the most appropriate in all cases. Although more consultations can be done by phone than previously thought, the ideal balance of telephone/F2F is higher in favour of F2F than observed in the RAPCI data.

Video consultations

▪ Video consultations are most useful for:
  ○ Children (getting a "feel" for how ill children are by visually assessing).
  ○ Reassurance and relationship building with adults.
  ○ Multidisciplinary team (MDT) meetings.
  ○ Virtual ward rounds in nursing/assisted living homes.
  ○ Problems which require dynamic assessment (e.g. gait, respiratory monitoring for asthma/COPD, although these can also be achieved through questioning by phone).

▪ Video consultations are most useful when there is an imperative to reduce F2F contact (e.g. during the COVID-19 lockdown). When there is no such imperative, video calls are less useful, as they take time to set up and are technically more problematic than phone calls. Many GPs prefer to see patients who require visual assessment F2F to ensure they don't miss anything.

SMS messages
▪ SMS for long-term conditions management can be effective. Patients with long-term conditions can be sent questionnaires and prioritised for review using their responses.
▪ It can be efficient for GPs/nurses to have SMS exchanges of information before conversing.
▪ Photos sent via SMS are often preferable to video for static problems (e.g. rash).
▪ Paperless working (e.g. sick notes and prescriptions) is efficient and valued by patients.

e-consultations
▪ Most RAPCI practices started e-consultations during this period. Unlike phone, video and SMS, this was driven by national mandate, not by the need to implement remote consulting. It was therefore implemented less rapidly, and it is too early to note lessons learned.

5.2 Other innovations

New practice systems
New systems which were implemented effectively during the pandemic were manageable because of reduced demand, and a strong imperative across general practice to make the new systems work, despite risks. Practices are finding it challenging to find a system for a post-pandemic period which retains the benefits of triage but mitigates the risks.   **Practices should use the benefits of remote consulting** to better manage chronic disease patients, to gather as much information in advance of the consultation, and book flexibly to manage patient care according to need, rather than demand (i.e. giving patients the time they need, rather than everyone getting 10 minutes).   - Systems can be implemented to **rationalise patient visits to the practice** – e.g. baby measurements, immunisations and the six-week check being done by different health professionals in the same room; or blood tests and other chronic conditions checks being done in the same visit.   - Remote management suits some patients better than others. As it is not necessarily more efficient, **remote consulting should be by patient choice**, combined with GP clinical judgement, not used as an efficiency measure.
Patient empowerment
Self-monitoring can be effective for patients with long-term conditions. This is easier in more affluent practices, where many patients who need their blood pressure monitored already have their own blood pressure.   **Self-testing stations** can be used in waiting rooms (with a blood pressure monitor, scales, pulse oximeters) for patients with long-term conditions or on the contraceptive pill.   **Supplying** high-risk patients with "rescue packs" provides reassurance.   **Wound care** can be done over the phone through patients sending pictures of wounds, nurses training relatives over the phone and leaving dressings for patients to pick up.   **Patients can be trained to do self-administered injections** (e.g. Sayana Press injectable long acting contraception) over video and use of a training podcast/online training guide.   The above initiatives take time to set up. This was possible because of the initial drop in demand. *"We've been given time to do that work that otherwise would never have been done."*

5.3 Leadership

Practice level leadership
- Listening to staff, involving them in decisions and keeping them informed through regular meetings resulted in a perceived flattening of hierarchy from staff and buy-in to the changes.   - Setting up practice teams to interpret guidance and cascade within the practice was effective.   - Acting early (before national mandate) to protect staff builds confidence and a positive organisational culture.   - Under strong leadership, times of crisis can result in positive organisational changes, including improved teamwork, peer support and trust.   - Practices need to find the balance between waiting for advice and acting. The national and regional responses will necessarily be slower than a local response. Early response may involve taking manageable financial risks (e.g. buying PPE equipment, paying staff overtime before assurances that this will be reimbursed). *"Almost from day one we've had a manager and a few clinicians who've co-ordinated everything, it's felt really well-led."*
CCG/GP federation level leadership
- In times of rapid change, a focused, daily communication is highly valued by practices.   - Investment in infrastructure (webcams, Wi-Fi, quality computers and phones) is essential for effective implementation of remote consulting.   - Supporting high quality IT infrastructure is a priority, as this infrastructure is important for the success for remote consulting.   - Investing in PPE and setting up a system for supply was key to building practice confidence and trust.   - Putting resource into tools or guidance that is scheduled to come via a national route (e.g. shielding) may not be the best use of CCG time. Supporting practices to make practical choices might be more helpful.
NHS England/Government level leadership
- Rapidly changing guidance is confusing and erodes confidence.   - Big data extraction (e.g. list of shielding patients) requires local validation before it is acted on.   - Basing guidance on what NHS England believe is pragmatically achievable (rather than best practice in an ideal world) can be seen as political and erodes confidence.   *"Before COVID I completely trusted NHS England advice, post-COVID I don't trust it as much anymore … the guidance changed so much with PPE to balance the fact that there was high demand. ….. Were we supported? I don't really think we were ... particularly when we were buying our own PPE…. I've been enlightened to the fact that it's very political, before I thought it was very evidence-based." (Nurse)*

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List of abbreviations

ANP	Advanced Nurse Practitioner
API	Application Programming Interface
CCG	Clinical Commissioning Group
CSU	Commissioning Support Unit
F2F	Face to face
FAQ	Frequently asked Questions
GP	General practitioners
IPC	Infection Protection and Control
IT	Information Technology
LMC	Local Medical Council
LTC	Long term conditions
MDT	Multi-disciplinary team
MS Teams	Microsoft Teams
NHS	National Health Service
NHSE	NHS England
NM	Nurse Manager
PCN	Primary Care Network
PM	Practice Manager
PPI	Personal protective equipment
QOF	Quality and Outcomes Framework
RAPCI	Rapid COVID-19 intelligence to improve primary care response Study
RCGP	Royal College of General Practitioners
SitRep	Situation Report
SMS	Short message service
VNC	Virtual Network Computing
VPN	Virtual Private Network