University of BRISTOL

Centre for Academic Primary Care

RAPCI Project Summary Report 2

19 June 2020

The Rapid Covid-19 Intelligence to Improve Primary Care Response (RAPCI) Project is examining the changing demands on GP practices across Bristol, North Somerset and South Gloucestershire during the COVID-19 pandemic. It will investigate common challenges and innovative solutions that practices have devised to cope. This second summary report presents qualitative findings from 23 interviews held with GPs and managers from 20 GP practices between 28 May and 13 June 2020.

Key findings

Demand: Participants reported an increase in patient demand in this period. Problems are becoming more complex as patients have been "storing up" issues, however most practices are not anticipating an influx of COVID-19 patients. Practices are still coping well with demand at an average level of 8 to 9 out of 10.

Returning to a "new normal": The key challenge which practices are facing is establishing a "new normal".

- Practices are restarting routine services that have been stopped, including some chronic condition monitoring and routine minor procedures. This presents a challenge both in prioritising what needs to be done and the physical challenge of maintaining distancing and time-consuming donning of PPE. Some practices are making changes to buildings semi-permanent.
- GPs are adapting to managing clinical risk over the phone by doing higher levels of follow-up.
- GPs felt they were coping well only because they are managing a lot of demand over the telephone. There are concerns about how to manage future increased demand for face-to-face (F2F) consultations, for example if there is an increase in viral and respiratory illness as lockdown eases or over the winter.

Challenges: New challenges faced in this period included adjusting appointment slots to cope with rising numbers of F2F consultations. Practices are finding it challenging to manage patient expectations that services are restarting as normal, while some specialties are still not accepting referrals. Participants also reported that the current mode of operating is taking a toll on staff.

I think generally that the population are finding that their goodwill with this is fading.

"Secondary care needs to up their game …and find ways in which they can manage these patients too"

The government constantly gets it wrong about how many people are internet ready.

Impact on health inequalities: Some participants are concerned that the current mode of operating is increasing health inequalities. GPs noted, particularly in more deprived areas, that many of their elderly patients were unable to use smartphones and computers to send photos or connect to a video consultation, even if they had access to them.

Challenges, solutions and guidance needed

Challenges faced	Innovative solutions and help still needed
Rising demand: More consultations are being booked and problems are becoming more complex as patients have been "storing up" issues. The need to see more F2F patients coupled with social distancing and the time-consuming use of PPE is challenging.	**Help needed:** Some practices saw this as a problem requiring local planning. Others wanted clearer guidance on CCG expectation – e.g. maintain the telephone consultation but bring in more F2F? **Solutions**: Some practices are opening pre-bookable telephone appointments. Others see this as "pushing the problem into the future". Practices are starting online e-consults (though most do not expect this to help deal with demand). Some practices are introducing more "patient navigation" at reception.
Restarting services: *"It's easy to stop services, but hard to restart them safely."* Practices are restarting certain chronic condition monitoring (e.g. blood tests, diabetes checks, thyroid) and routine relatively 'minor' procedures that have been delayed. This presents a challenge both in prioritising what needs to be done, and the physical challenge of maintaining distancing and time-consuming donning of PPE.	**Help needed:** The list from the CCG (of red amber and green procedures) provides some clarity, but there are areas in need of more clarity, e.g. how long can practices delay on medication monitoring, less urgent diabetes checks and coil refits. **Solutions**: Practices are maintaining changes to building space described in report 1, and some are making these semi-permanent. Patients are being asked to arrive on time for appointments to reduce people in the waiting room. Bays in the parking areas are reserved for patients with booked F2F appointments. Practices are experimenting with spacing F2F appointments throughout the day, but some are finding this disruptive.
Prescribing remotely: Some GPs expressed concerns about prescribing over the telephone. *"It's almost like using the drug to make the diagnosis, which is backwards really in terms of how we're trained"*	**Solutions**: Higher levels of follow-up – proactively contacting patients to see if prescription has worked.
Managing long-term conditions remotely: Although some routine work is restarting, there is still a lot on hold. GPs expressed concerns about missing problems in patients that are not being seen or monitored.	**Solutions**: Remote monitoring: e.g. nurses are phoning diabetes patients more at risk, particularly the insulin-dependent ones and encouraging them to monitor their own sugars. Also texting out "sick day rules", how patients should manage their medication if they fall ill. Remote monitoring using pulse oximeters lent out from the practice is being done for some suspected COVID-19 patients.
Delays in secondary care referrals: Referrals were due to open again during this period, but some specialities have not opened. It is not clear which referrals will be accepted. This creates an administrative challenge of monitoring the referrals and a challenge managing people in primary care whose procedures have been delayed.	**Help needed:** Clear summary of what referrals are open and what are not. **Solutions**: Practices have created various solutions to track the referrals, e.g. "holding lists"; when the referrals are sent, they are removed from the list and, if bounced back, they are returned to the holding lists. Lists are intermittently checked, and referrals resent. It is hard work managing this.

Challenges faced	Innovative solutions and help still needed
Managing patient expectations: Managing perception that as lockdown eases practice is opening back up as before**.** Managing expectations re referrals, complaints about lack of seating and ability to be able to pre-book appointments arising.	**Solutions**: As before, using different ways of communicating with patients. Videos and messages on social media / website. Lots of signage over surgery to encourage people to wait outside. Making clear to patients at the point of referrals that the wait may be a long one.
Mental load on staff: Participants reported that, after the initial "adrenaline" of having to quickly make changes, the current mode of operating is taking a toll on staff: *"As demand is increasing it becomes a little bit more monotonous ... not having that patient contact becomes less satisfying"*	**Solutions**: Some practices pointed out that introducing more F2F appts would help GP satisfaction as well as patient safety. Others pointed to initiatives to "try to keep the team spirit going" with for example coffee mornings on the lawn.
Additions to the shielding list: Dealing with late additions to the shielding list has been challenging. A cohort of patients were sent letters in June. Identifying immunosuppression is not clear-cut and explaining to the borderline cases that they should not have received a letter is difficult.	**Help needed:** Lesson for the future; all big national data extraction requires local validation, ***before*** letters are sent to patients. Post-hoc validation causes anxiety, particularly in borderline cases. **Solutions**: Practices assigned doctors to reviewing the shielding list and correctly allocating patients. Some practices have chosen not to remove borderline patients added to the list in June as this would be likely to create confusion and anxiety.

Perceived impact on health inequalities

GPs expressed concern about health inequities widening due to the new ways of working, for example:

- **Delays in seeking care:** Participants noted that the people delaying contacting the practice, or not wanting to visit the practice, include some of those with the greatest health problems. GPs felt that some elderly patients need to be persuaded to come to the practice when they need to be seen. Moreover, multiple GPs have noted a reduction in the number of requests for home visits, which they worry means people are delaying reporting problems.
- **Difficulties communicating by phone:** GPs and some other practice staff felt this affects those who are hard of hearing and those with English language difficulties the most. While this is an obvious truism, some participants felt it was greatly exacerbated by so much change happening at a time when face-to-face access is limited. For example, one GP commented that incorrect additions to the shielding list were much more difficult to communicate to patients in this population than another population.
- **Lack of access to technology:** GPs pointed out that many of their population might initially appear to have access but lacked IT literacy. One GP explained that, pre-COVID-19, many in his population found it very difficult to do online prescription ordering, despite having access to a computer. Others suggested that the elderly and the shielded are often the worst affected if good IT literacy is a requirement for access. One GP gave an example of a shielded patient who tried for 24 hours to get help with sending a photo from a mobile phone, before sending a relative to the practice with a poor-quality photo on an old digital camera.

- **Missing out on care provided through shielding:** Some participants pointed out that the additional support given to shielding patients may not have been equitably distributed among the vulnerable population. In most practices a social prescriber, or other staff member, contacted everyone in the shielding list to check they had enough support. One participant pointed out that many of these patients, although immunosuppressed, were physically able with a strong social network and did not need or want any more support. Another GP pointed out that the focus on shielded patients may have been at the expense of the socially vulnerable and frail.
- **Missing out on face-to-face contact:** Some participants suggested that F2F provides a better way to manage care, for example, for people with chaotic lives (who are also difficult to contact).

Mitigating negative effects

GPs described various measures that they had put in place to try to minimise the negative effects of changes to access to care, including:

- Proactively contacting vulnerable, shielded, and at-risk patients to ensure all is well and assess any needs for support.
- Offering home visits to vulnerable/shielded patients.
- Keeping 'we are open' message (e.g. on practice Facebook, twitter and website) and encouraging people that they must get in touch if they become unwell, to minimise the impact of missing things from patients staying away.
- Lending user-friendly devices, such as "Grandpads" to some patients to enable them to communicate with the practice. (This was mostly combined with remote pulse oximetry for COVID-19 suspected patients).
- Other GPs made the point that they are not necessarily in a position to observe some health inequalities, because they don't know what they are not seeing, but the best they can do is make the practice as accessible as possible. GPs were interested in finding ways to make digital technology work for these groups.

The reason I am interested in this piece of work [the RAPCI project] is, 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. (GP, Practice 21)

Report authors: Mairead Murphy, Andrew Turner, Rachel Denholm, Lauren Scott, Anne Scott, John Macleod, Chris Salisbury, Jeremy Horwood.

Acknowledgements: We would like to thank all study participants. This research was funded by the National Institute for Health Research (NIHR) School for Primary Care Research with support from NIHR Applied Research Collaboration (ARC West) at University Hospitals Bristol NHS Foundation Trust and OneCare. The views expressed are those of the authors and not necessarily those of the NIHR, the Department of Health and Social Care.

How to cite this report: Murphy, M. Turner, A. Denholm, R. Scott, L. Scott, A. Macleod, J. Salisbury, C. Horwood, J. RAPCI Project Summary Report 2, 19 June 2020. Centre for Academic Primary Care (CAPC), University of Bristol.

Find out more about COVID-19 research at the Centre for Academic Primary Care, University of Bristol