The Strategy Unit.

Primary and Community Care Qualitative Insights

First rapid cycle report

14/05/2020

NHS
Midlands and Lancashire
Commissioning Support Unit

Approach

- This first report draws on interviews from one STP.
- The notes from 10 interviews of primary and community care leads between 27/04/20 and 05/05/20 were reviewed.
- Interviewer notes were also imported into NVivo 12 software and word cloud and auto coding features were applied to look for patterns in the data.
- The main cluster of data related to 'patient(s)'.
- Rereading and mind-mapping of the data which related to patient(s) revealed further subthemes of patient choice, prioritisation of care, demand, referral, delivery of care, safety of care, support for new ways of working.
- A summary of these subthemes is provided in slides 3-5, synthesised for overarching themes of: patient-centred, new ways of primary care working and new ways of system working.
- A summary of the findings, relating to this analysis of 'patients' is mapped to an 'understanding crisis-response measures' template, is provided in slide 6.

Note:

- The interview data has only been partially analysed to provide rapid high-level findings whilst data collection is underway.
- More in-depth data analysis and deeper insights, linked to topic guide themes (changes to services, wider impact, support and future), will be developed (and reported) over time.

Patient-centred

"I think a real advantage of this experience is that patients are appreciating the NHS as a pressured and precious resource. This is key, that they stop and think before they're picking up the phone."

GP reflecting on the change in patient behaviour in accessing GP/NHS

- Stopping face-to-face general practice appointments initially received a mixed reception, but was quickly understood by patients, with no formal complaints reported.
- Fear of catching COVID-19 led to dramatic decrease in appointment request; community nursing appointments were declined in some instances, but is now slowly picking up. Some patients are restless, some apologise for getting in touch with practices.
- 'Worried well' are no longer presenting to GPs; people are beginning to understand that some illnesses (e.g. coughs and colds) resolve on their own without need for medical intervention (e.g. antibiotic prescription)
- Practices are offering telephone triage in the first instance, prioritising the acutely unwell, according to national guidance: COVID-19, cancer and chest pain. Routine work of managing long-term conditions was switched off, but now resuming (practices appear to have made different progress with this). Preventative work (e.g. smears) remains paused.
- Clinical concern that a new cohort of vulnerable patients is emerging and their care needs planning. Mental health issues most frequently mentioned but also expecting challenges of increased severity of physical health issues for long-term conditions (as had to deprioritise care) and new diagnosis (patients refusing scans and tests due to COVID-19 concerns). Also expecting increased prevalence of combined health issues (e.g. alcoholism).
- Different ways of communicating with patients: at one practice the Patient Partnership Group produced a video for patients; one PCN had clinical leads promoting general practice services on Facebook when primary care demand fell.

New ways of primary care working

"I'm now more than happy for those GPs to see my patients - when I review their decisions, they seem quite good which is pushing us towards working as a larger unit."

GP/PCN Clinical Director reflecting on other GPs in PCN providing care for patients not usually in their care.

- Working as red, amber and blue/green sites to provide primary care services during the pandemic is aligned to the PCN footprint, has been put into place rapidly and is positively received.
    - National guidance has been rapidly interpreted for local purposes and communicated in a streamlined way (e.g. GPs are now accessing information from a single PCN source)
    - Practices are covering for one another when need arises (e.g. due to staff sickness) and providing moral support for one another (e.g. through use of local WhatsApp groups)
    - PCN leads can attend regular meetings via Teams and Zoom, can therefore participate without travel need
- Most primary care leads were in favour of virtual appointments, some expressed desire that they become the mainstay of primary care consultations, based on local context/demand (not directed by national guidance)
- Those less keen on virtual consultations gave reasons of personal preference, inability to provide holistic care, and patient inequities in access (e.g. non-smartphone users are unable to submit photographs for clinical review).
- Early and quick access to new laptops and digital technologies, e.g. AccuRx and EMIS, provided by the CCGs) has supported the rapid change to remote delivery of care
- Inability to refer patients is causing anxiety around the backlog building up. Practices have developed their own ways of noting the patients in need of a referral. There is some tension to resolve as to 'who holds the responsibility' when clinical risks are being identified. Where available, access to consultants for advice and guidance over email has been helpful.

New ways of system working

"Life is so much easier without talking about who is responsible, its a more integrated way of working for the team."

Community Nursing Lead reflecting on system-wide multi-disciplinary working

- A new model of hospital Discharge to Assess is now in place, staffed by complex discharge nurses, CHC and adult social care. There is much enthusiasm for working as one team seven days a week with a desire to continue this way of working post-COVID-19 and making use of the tools developed (e.g. discharge assessment template).
- Community nurses are not doing any administration, can concentrate on nursing duties (e.g. the complex discharge team have added end of life care coordination to their role rather than relying on ward nurses)
- Move towards feeling like one team across GP, hospital, community and patients – a more 'trusted system'
- Care homes: GPs are providing remote support for the care homes they cover. There are dedicated video conferencing slots with care home staff and access to GPs outside of these times. In the main, GPs are satisfied by the care being delivered to residents, one clinical safety concern has been reported to the CCG.
- Safety of staff remains an issue.
    - Access to PPE is not universal and there are staff morale issues linked with that. Many have resorted to their own networks, for example one practice had a family member who could provide visors; staff in another practice were making their own masks and sewing filters inside.
    - Community nursing teams were disappointed with the lack of national guidance around PPE for aerosol generating procedures, had to provide local guidance (but only because of expertise in this area) and then tackle the logistics of sourcing the appropriate PPE locally too.
- CCG/STP support has been well received especially for digital working purposes, compares unfavourably with NHSX guidance (there is expectation of a national digital policy document) which is 'shamefully slow'.
- National command model, e.g. of performance measurement, can stifle local innovation and decision making appropriate to population need.

"COVID has been the single biggest drive to cultural change in the NHS, achieving more in 3 to 4 days than in 3 to 4 years."

During COVID-19

	Post COVID-19: Stopped	Post COVID-19: Started
During COVID-19: Started	**END (Changes specific to COVID-19)** Referral backlog caused by prioritising for COVID-19, cancer and chest pain Local, uncoordinated access to PPE	**AMPLIFY (Changes that show promise)** Working at scale, making use of PCN footprints. Increased virtual consultations (based on patient demographics/need) Telephone triage to book appointment with appropriate professional Remote monitoring of frail elderly Digital access to care records for all healthcare professionals 7 day MDT (across organisational boundaries) approach to hospital discharge
During COVID-19: Stopped	**LET GO (Unfit for purpose)** Working in silos; collaborative team working across professional and organisational boundaries has now proven worth. Admin burden for clinical staff – e.g. nurses freed up to do nursing duties, practices freed up from QoF National central command (e.g. for performance) - to allow local innovation in meeting system challenges	**RESTART (Stopped due to COVID-19)** Management of LTC patients (e.g. routine reviews) Preventative care focus (e.g. screening, smoking cessation clinics) Mental Health focus (including for COVID-19 trauma)

Table template adapted from https://www.thersa.org/discover/publications-and-articles/rsa-blogs/2020/04/change-covid19-response

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