The Strategy Unit.

Primary and Community Care Qualitative Insights

Third rapid cycle report

22/05/2020

NHS
Midlands and Lancashire
Commissioning Support Unit

Approach

- The notes from five interviews – two GPs and three nursing leads – in one STP between 06/04/20 and 26/05/20, were reviewed.
- Interviewer notes were imported into NVivo 12 software and the word cloud feature applied to look for patterns in the data. The main cluster of data related to 'working closely' followed by 'teams' and 'need'.
- Based on the findings from the analysis of the previous rounds of interviews, the interviewer notes were then coded according to the following overarching themes: 'patient-centred', 'new ways of primary care working' and 'system working'.
- Rereading and mind-mapping the coded data allowed for a summary against these overarching themes to be produced (slides 3-6). Note there is a 'new ways of community working' slide (5)
- Many of the findings of the previous two weeks (13/05/2020 and 20/05/20) were confirmed, here we report on newer/different findings.
- Summary findings from this week are reported in slide 7 in this report and the previous two weeks have been combined in slide 8.

Note:

- The interview data has only been partially analysed to provide rapid high-level findings whilst data collection is incomplete. For this STP there are plans to interview Mental Health and Cancer Services leads in the next few weeks and Care Homes and STP leads in the next months. Plans are also developing to engage with patient groups to capture patient perspectives.
- 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. A final report will be delivered within a month of data collection being complete.
- The format of the final report is to be agreed, but we expect to draw out differences in approaches by PCNs based on contextual information (e.g. number of GP practices in PCN, historical partnerships, patient demographics).

Patient-centred

"Right now, the nation is behind the NHS and not up for complaining just yet but over time that may change." *A Community Care Lead reflecting on current patient expectations and how these may change over the coming weeks.*

- The lack of formal complaints made by patients in both primary and community care was noted. Correspondingly, knowledge of the significant public support for the NHS at the time of the crisis has provided a morale boost for staff. Some interviewees cautioned for the collection of more patient data to gain a fuller understanding of patient experiences.
- The 'missing human element' inherent in remote consultations was viewed as a rationale for not changing primary and community services exclusively to this way of working, e.g.:
    - For those already socially isolated, it added to their loneliness.
    - For young people with low level mental health issues, it may inappropriately lead to a medical model of treatment.
- A rethink of waiting rooms in general practices was required to reduce footfall as lockdown eased (and possibly beyond), e.g. via:
    - Appointments spread through the day, so that there was limited use of a waiting room.
    - Text/email sharing of letters such as sicknotes to reduce physical presence at surgeries.
- Clinicians described a picture of need building, some of which implied risk of long-term harm:
    - Patients with COVID-19 who delayed health services contact – an example was given of a young patient who did not access care despite severe symptoms, until they had eased, for fear of hospital admission.
    - Colorectal disease patients who did not meet diagnosis and treatment criteria under new pandemic cancer guidelines.
    - Pain (including dental) and pain management with implications of painkiller overuse/addiction.
    - Gall bladder infections that would normally be treated as acute surgical cases.
    - One experienced GP reported two consultations for domestic issues (rape allegations), a career first.

New ways of primary care working

"This situation has accelerated two years' worth of innovation and transformation in the Networks. CDs have stepped up and shown real leadership and new leaders within the system." *A GP reflecting on the rapid action taken in response to the Covid-19 situation.*

- There was a strong view that restoration of primary care services should be local and GP-led, and not nationally directed. Local clinicians were perceived to have the relevant contextual knowledge to adapt and innovate as required based on the specific local care needs.
- New ways of working in primary care were perceived as this STP's 'Vanguard moment': the crisis had allowed primary care leaders to leverage existing Neighbourhood Teams and plans for PCN working. Using this infrastructure they were better able to collaborate and work as multi-disciplinary teams to respond to the crisis. Specific features of local collaboration included:
    - Joint-working with other PCN Clinical Directors, which was described to be 'excellent'.
    - Flexible working of all staff, not just clinicians. For example, administrative staff were also encouraged to work from home if possible.
    - Administrative support provided through CCG staff had been very helpful in the first weeks of the crisis especially.
- The specific aspects of primary care demand that needed addressing quickly included:
    - Routine services including blood tests, especially where these overlapped with chronic conditions monitoring.
    - Some long term condition (LTC) annual reviews, e.g. for diabetes, might have to move from every 12 months to every 15 months in the first instance to clear backlog.
- Telephone triage was expected to become business as usual in primary care as the cultural change (in patients and professionals) to establish this has now happened.
    - The need to look more closely at clinical risks of primary care triage was acknowledged; there was some concern that some priority patients had fallen through the gaps.
- GPs were finding remote consultations to be lengthy (longer than face to face consultations) as they were required to ask more questions in lieu of physical examinations.

New ways of community working

"In terms of reviewing caseloads there have been some positive changes which I believe teams will want to continue with for example switching warfarin to a different type of anticoagulant" A *Community Care Lead reflecting on changes in community working that have been beneficial.*

- The demand for most community services was described to have fallen but was expected to revert to normal. The view was that in the long-term patients' needs and expectations would be unchanged. Nursing leads also expressed concern for specific patient cohorts:
    - The frail elderly who were at risk of falls, as referrals for falls and OT equipment had decreased.
    - Those hard of hearing, as they would struggle without visual cues from caregivers.
- Discharge from community/intermediate beds at the time of the crisis were described to have been lower than expected, the observation being that patients occupying these beds were more poorly than usual.
- A number of community nursing services had made use of the capacity freed up to address long-standing service improvement plans:
    - Community teams had planned for an expected increase in demand for End of Life Care services working with the STP End of Life Care Group. The experience of putting this into practice had identified areas for improvement such as more responsive GP/medical review of case notes; there was concern that some people were being classified as COVID-19 when they were not.
    - The previous backlog of musculoskeletal (MSK)/physiotherapy appointments had been addressed through a review of the patient caseload, followed by a video/telephone clinical triage and assessment. This opportunity to redesign the service was welcomed and virtual consultations for MSK services were viewed as 'here to stay'.
    - Managing essential care for priority patients, i.e. those that needed daily/weekly management. For these patients, a regular remote clinical contact was set-up, using either video or telephone as appropriate. Where possible the mode of medicine administration had switched from IV to oral e.g. VitB12 and warfarin. The need for an audit on the long-term effects of changed medicines management was acknowledged.

New ways of system working

"PPE, don't get me started, we're still reaping that whirlwind. We had some really scared staff; it's been very hard as an employer…It's been really difficult when messaging from the centre has changed so often." *A GP/PCN Clinical Director reflecting on the national arrangements for PPE and impact on staff.*

- Management of the PPE situation required clinical leaders to personally relieve the anxieties of their staff; they did this via sourcing PPE privately and then checking-in routinely with staff members.
- The CCGs were explicitly praised as providing crisis support, above and beyond any national support and guidance (most GPs were dismissive of the national support).
- Community nursing leads were hopeful that new ways of system working would increase confidence in community-based integrated working, delivering care at/closer to home. The expected consequence of this increased demand in multi-disciplinary team (MDT) delivery of care was viewed to be a decrease in emergency/hospital activity.
- There was some redeployment of community nursing staff to other parts of the healthcare system, either to match supply of expertise to where there was demand (for example to Neighbourhood Teams to provide community nursing input), or because clinical staff were unable to deliver face-to-face care due to their own shielding status.
- Care home support from the local system was perceived to have stepped-up following national identification of care home challenges. There was a desire that this system support for care homes should be maintained in the future.
    - Currently the support was limited to virtual consultations by primary care clinicians; in the future face-to-face support was warranted as virtual support was not perceived to compensate for this cohort of patients.
- Increased value of the voluntary sector was being observed, e.g. Age UK was working with Neighbourhood Teams to support those isolating.
- Pause in the activities at the Acute Trust was increasingly queried, e.g. given the status of empty beds and available theatre capacity, it was felt that some surgical procedures could be reinstated.

"The system changed didn't it to allow it to run as it is running now? There is a massive benefit and job satisfaction."

Third report summary

During COVID-19	Post COVID-19: Stopped	Post COVID-19: Started
Started	**END (Changes specific to COVID-19)** Remote consultations for the vulnerable (socially isolated, mental health issues); Limited medical responsiveness/review of deaths.	**AMPLIFY (Changes that show promise)** Process improvements to change physical space use to reduce patient footfall in GP surgeries; Primary care led local innovations of community based integrated health care delivery; Local commissioning support for primary care innovation; Virtual consultations for MSK services; Delivery of care as multi-disciplinary teams as a priority to reduce acute activity; Redeployment of clinical staff according to role and need.
Stopped	**LET GO (Unfit for purpose)** Nationally directed/mandated change; Holding on to empty beds in the acute hospital.	**RESTART (Stopped due to COVID-19)** Explore patient experience of health services; Acute services (surgery, pain clinics); Planning for routine primary and community services; Review of the telephone triage process to learn; Clinical risks audit e.g. for medicines management.

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

Combined rapid reporting summaries

During COVID-19

	Started	Stopped
	END (Changes specific to COVID-19) Care backlog caused by prioritising for COVID-19, cancer and chest pain; Remote consultations for the vulnerable; Clinical risks (through identification) of primary care triage; Staff anxiety caused by lack of nationally available PPE in primary care settings or its guidance in community settings; Limited medical responsiveness or review of cause of death.	**LET GO (Unfit for purpose)** Working in silos resulting in inefficient patient pathways; 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) or mandated change to allow local innovation in meeting system challenges; Reliance on locums/agency staff.
Started	**AMPLIFY (Changes that show promise)** Working at scale, across commissioners and providers, making use of PCN footprints; 7-day MDT working across organisational boundaries; Primary care led local innovations of community based integrated health care delivery; Dynamic use of available skill mix, further matched to need; System-wide technology adoption for routine patient care; Support for patient self-management of health conditions; Delivery of enhanced services for mental health in primary care settings.	**RESTART (Stopped due to COVID-19)** Explore patient experience of health services; Planning for routine primary, community and acute services; Patient choice for continuity of care especially in the management of LTCs; Clinical risks auditing; Staff training for technology use and ways of team/network working; Service improvement based on learning from staff experiences.

Stopped — Post COVID-19 — Started

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