The Strategy Unit.

Primary and Community Care Qualitative Insights

Second rapid cycle report

22/05/2020

NHS
Midlands and Lancashire
Commissioning Support Unit

Approach

- The notes from six interviews of primary care leads in one STP between 06/04/20 and 15/05/20 were reviewed.
- Interviewer notes were also 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 'practice(s)' closely followed by 'patient(s)'.
- Based on these clusters and the findings from the analysis of the previous round 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 3-5).
- Many of the findings of last week (14/05/2020) were confirmed, here we report on newer/different findings.
- A summary of the findings, relating to this analysis of 'practices' is mapped to the 'understanding crisis-response measures' template (slide 6).
- Summary findings in slide 6 in this report and the previous have been combined in slide 7.

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.
- 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 PCN based on contextual information (e.g. number of GP practices in PCN, historical partnerships, patient demographics).

Patient-centred

"It's inevitable that demand will increase and reach similar historic levels – patients want to see specific doctors in a time and place to suit them and who knows them – these patients are holding fire." *A GP/ PCN Clinical Director reflecting on the expected return to usual high demand, when the pandemic eases.*

- There were differences in opinion on whether the reduced demand for primary care appointments and services would be sustained An increase in demand for primary care consultations was being observed in the last few weeks as recent NHS media messages (including local social media) of 'general practice is open' took effect.
    - GPs were hopeful that patients had learnt to exercise self-management of conditions and symptoms, even in the case of long-term conditions, and as a result the foot-fall in practices post-COVID-19 was expected to be lower than pre-COVID-19 levels.
- The process of sharing information of COVID-19 test results with practices was in need of improvement. Currently, it depends on patients informing their practice; GPs would prefer that practices were directly informed by test providers.
- It was suggested that the balance between offering patients a convenient appointment (i.e. same day appointment) versus an appointment that provided continuity of patient care (consistent care provider) could be met through same day access to nursing services (within PCN model) in future primary care.
- Concerns were rising around specific cohorts of patients not presenting:
    - The elderly and the very young, challenges of neglect and safe-guarding expected in the future
    - Management of conditions (e.g. cancer) facing a delayed diagnosis, e.g. waiting list for colonoscopy was becoming a local issue.
- A better than expected uptake of virtual consultations was reported, including in those previously presumed to be less receptive (e.g. older generation). Given the choice, GPs preferred video consultations over telephone as they provided non-verbal cues.
- Driven by the need to err on the side of caution during the pandemic, GPs were noting that they were overprescribing antibiotics in remote consultations.
- The designation of red, amber and blue/green sites needs to be reviewed for future PCN working to ensure it provides equity of access for patients (e.g. some patients had quite some distance to travel to access the relevant site for their need).

New ways of primary care working

"Primary Care needs to deal with mental health issues at source rather than patients waiting 6-9 months for psychology services"

A GP/ PCN Clinical Director reflecting on the need for timely access to mental health services, given the current covid-19 situation.

- Early planning for future primary care services was emphasised by many, especially to address the pandemic related additional need.
    - It was suggested that future planning should consider meeting mental health needs in primary care rather than awaiting community referrals for psychological therapies which would be facing escalated demand.
    - Existing services such as Healthy Minds and social prescribing routes could be strengthened to meet increased future demand.
- PCNs that were rapidly maturing were able to respond rapidly to COVID-19 due to established relationships between practices which provided peer-support (e.g. for clinical decision making) and were able to leverage the skill mix available to them (e.g. use of Physicians Assistants in triage has been enhanced)
- Providing a primary care response as PCNs has highlighted future resource implications:
    - The GP shortages can be addressed by practices working at scale
    - The reliance on locums/agency staff can be reduced by arranging cover for sickness/leave within the PCN
    - Provision of some services across the PCN e.g. nursing services may be more costly in the first instance.
- Staff morale remains high, driven by the recognition of the benefits of working as a team (within individual practices) and responding to a crisis as an MDT (within PCNs) and management of staff anxiety at an early stage.
- The need for training all staff, but most notably practice admin staff, in new ways of working (e.g. working from home) and using new technologies (e.g. using AccuRx to communicate with patients) was identified.
- Practices had noted that where nurse telephone triage was already routine, nurses were now more likely to triage patients to a GP consultation, as they felt less confident of managing clinical risk.
- There was anxiety around performance measures (e.g. QoF) being reintroduced too quickly once full primary care services resumed.

New ways of system working

"I suspect people will die because they mucked up shielding." *A GP reflecting on the national arrangements for PPE.*

- The lack of adequate national supply of PPE is of significant concern for staff in the system; there is much anxiety and fear surrounding this. Practices are continuing to rely on local routes to access equipment including schools and companies.
- GPs are continuing to provide remote support for the care homes they cover (e.g. via virtual ward rounds and regular dial ins). Care homes were supplied with the digital technology to support this (e.g. iPads) although more support/training to utilise them was required.
- GPs are also providing cover, in person, to community hospitals, undertaking regular ward rounds.
- CCG/STP support has been well received especially for financial reassurance, guidance and decision-making, and digital working purposes. Daily calls between commissioners and primary and community trust leads has enabled action-oriented problem solving.
- A strong spirit of collaborative system working was noted between primary, community and acute care as well as local authority, care homes, voluntary sector and patients, expecting it to be sustained. Key things to note:
    - Community nursing teams were recognised as being empowered to work effectively within MDTs (e.g. through higher staffing ratios and EMIS use (shared care records between primary and community care)
    - Public Health involvement as system partners was described to be poor as a result of their Local Authority (non-NHS) affiliation
    - The system could be more proactive for the management of future demand, learning from the current crisis and addressing historic inefficiencies in clinical pathways, e.g. secondary care demand could be met through virtual outpatient appointments.
    - There was some criticism of different sectors' responsiveness to the crisis, some GPs felt that primary care had to absorb the additional risk, e.g. mental health appointments had been postponed indefinitely rather than telephone consultations being provided
    - The differences in ways of working between geographical areas of the system could be removed.

“We've had system-wide change, adaptation and review.”

Second report summary

During COVID-19

	Post COVID-19: Stopped	Post COVID-19: Started
During COVID-19: Started	**END (Changes specific to COVID-19)** Overcompensation for clinical risk by triaging preferentially to GPs Staff anxiety caused by lack of nationally available PPE	**AMPLIFY (Changes that show promise)** Support for patient self-management of health conditions Delivery of enhanced psychological therapies/services in PCN settings Voluntary sector and social prescribing involvement Technology adoption for routine patient care in the wider system Local system working across commissioners and providers Dynamic use of available skill mix, further matched to need
During COVID-19: Stopped	**LET GO (Unfit for purpose)** Reliance on locums/agency staff Inefficiencies in patient pathways, especially elective treatments	**RESTART (Stopped due to COVID-19)** Patient choice for continuity of care Adherence to clinical guidelines for antibiotic prescribing Staff training for technology use and ways of team/network working

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

First and second summary combined

During COVID-19

	Started	Stopped
	END (Changes specific to COVID-19) Referral backlog caused by prioritising for COVID-19, cancer and chest pain Overcompensation for clinical risk by triaging preferentially to GPs Staff anxiety caused by lack of nationally available PPE in primary care settings	**AMPLIFY (Changes that show promise)** Working at scale, across commissioners and providers, making use of PCN footprints. 7 day MDT working across organisational boundaries 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
Stopped	**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) - to allow local innovation in meeting system challenges Reliance on locums/agency staff	**RESTART (Stopped due to COVID-19)** Preventative care (e.g. screening, smoking cessation clinics) Patient choice for continuity of care especially in the management of LTCs Adherence to clinical guidelines for antibiotic prescribing Staff training for technology use and ways of team/network working

Stopped — Started

Post COVID-19

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

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