University of BRISTOL

Centre for Academic Primary Care

RAPCI Project Summary Report 3

10 July 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 third summary report presents qualitative findings from 20 interviews held with GPs and managers from 20 GP practices between 15 June and 2 July 2020.

Key findings

Coping/staff fatigue: Practices are still coping well. However, despite giving high coping scores (8-9 out of 10), many of them commented on an increase in fatigue. As well as the continued stress of holding more clinical risk through remote consultations this is partly resulting from continual change. For example, after weeks of work on the shielding list, patients no longer need to shield. Old initiatives ending (e.g. shielding, hot hubs) and rapidly being placed by new initiatives (e.g. test and trace, updated risk assessments) are draining for staff. While acknowledging that most of these changes are unavoidable, some participants reported that this is dispiriting for staff.

> ***From an organisational point of view, this point presents the greatest risk in the pandemic so far. This is where the leaders have to motivate and retain staff, or there will be increasing levels of dissatisfaction and sick leave.***

Problems with continuation of pre-COVID-19 plans: Participants suggested that pre-COVID-19 plans (Integrated care providers (ICPs), CQC inspections, Quality Outcomes Framework (QOF), online triage/consultation, extended hours) should be reconsidered in a post-COVID-19 world, as energy needs to be directed to planning for COVID-19 recovery and for winter increase in demand.

Planning for the future in a COVID-19 world:

- Practices appreciated the support received in planning for the restart of routine care and re-emphasised a need for consistency in this across the CCG, and more support from secondary care.

> ***They [secondary care] just can't seem to re-open. There is this whole raft of patients that are just being left … We feel as if we're having to hold everything.***

- Practices are planning for more respiratory illness, when it will be difficult to distinguish COVID-19-infected patients from other viruses. There is some variation on how they plan to manage this.

> ***Is it more important to be fitting implants or seeing poorly controlled diabetics?***

Changing volumes and types of consultations: Participants reported a continued increase in complex and "stored-up" problems in non-COVID-19 patients including more mental health problems.

Challenges, solutions and guidance needed

Challenges faced in the last period included: rising demand; restarting services; prescribing remotely; managing long-term conditions remotely; delays in secondary referrals; managing patient expectations; mental load on staff; and the shielding list. New challenges identified in this period are:

Challenges faced	Innovative solutions and help still needed
Restarting services: This was reported previously, but has been included again, as it was repeatedly raised in this period. Practices emphasised the need for guidance and consistency across CCGs in relation to what routine care to prioritise restarting. e.g. *"Is it more important to be fitting implants or seeing poorly controlled diabetics [...] we all have things we want to be doing but we can't all be doing it"*	**Solutions (not including those raised last time)** ▪ Allocating one GP to work through the backlog of minor procedures, making sure appointments are spaced out throughout the day. ▪ Segmenting chronic conditions work, e.g. by inviting patients to visit for the physical aspects but doing the rest of the review by phone. ▪ Modifying existing templates for chronic disease reviews so they can be used over the phone or using online consultations ▪ Risk stratification – e.g. doing diabetic foot checks with a photo and only calling in those who need attention. Or using surveys sent via SMS, to determine whether patients require managing remotely or face-to-face, or if a patient is stable and can safely have their review deferred **Help needed:** Some participants felt there needs to be *"a discussion around what is reasonable in terms of workload and risks"* in the context of the RCGP guidance on workload prioritisation.
Continuation of pre-COVID-19 plans: Practices now need to plan not only for reopening of routine services, but also for Integrated Care partnerships, restarting of Care Quality Commission inspections, extended hours, and planning for 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.	**Solutions/Help needed:** Leadership (at all levels) to motivate and retain staff or *"there will be increasing levels of dissatisfaction and sick leave."* **Help needed**: Recognition that COVID-19 has created an exceptional situation, and there needs to be a *"pause for staff to regroup*" (which might include delaying some initiatives for longer). One GP commented that they would appreciate CCGs being *"as facilitative as possible"* as regards improved access and extended hours, so that practices can use their resources in ways that are needed, and not just to fulfil a requirement.
Online triage/consultations: Practices are anticipating challenges with using online triage/consultation systems. Some practices have already started and are finding it is an effective way to manage demand, but others are reluctant to start, feeling that it may create an extra stream of work on top of all the other demands.	**Help needed:** Guidance from the CCGs/NHS England on whether adopting online triage/consultations is contractual. Practices are aware that they are required to offer online consultations but have suggested that the interpretation of what constitutes an online solution should be revisited given recent wholescale changes. Could the requirement be met through the NHS App, Florey questionnaires, video consultations and email?

Challenges faced	Innovative solutions and help still needed
Planning for winter: Related to the above challenges, practices are planning for a time when there is more respiratory illness, and it will be difficult to distinguish COVID-19 infected patients from other viruses.	**Solutions (planned):** ▪ Removing waiting rooms, creating one-way systems and co-ordinating timings. ▪ Doing flu jabs at the weekend and flowing through the building without a waiting room. ▪ Remote pulse oximetry (some practices had planned this for COVID-19 and have suggested it may be more useful in winter). Continuing to hold more risk: e.g. asking patients who probably just have a respiratory infection to wait longer (e.g. 3 weeks instead of 1 for a non-COVID-19 cough) or prescribing more antibiotics by phone.
Support from secondary care: This was in the previous report, but included again, as it is having an increasingly detrimental effect on patients and GPs. There is no "read receipt", or similar mechanism for practices to know that a referral has been received and ownership taken. In some cases, patients who are already under the care of a consultant have stopped getting direct access for a flare-up and are instead deferred back into referrals services. Some tests (e.g. blood) which would previously have been done in secondary care are being done in primary care.	**Help needed:** Most participants were not clear on what the solution was, other than the need for more support from secondary care. One GP suggested that this was unrealistic but, at a minimum, there should be a set of principles agreed - e.g. referral requests will be responded to within X days, with clarity on whether investigations have been requested or not. Primary care would then know what a reasonable expectation was. *"They're [GPs] almost hoping that they're [patients] going to mention something that triggers off a two-week wait because they know it'll mean they'll get seen… because otherwise, well, forget about it."*
Drug manufacture and supply problems: Currently chemists find it hard to get hold of certain drugs, some of which might be related to over-ordering, but some is not directly related to COVID-19, e.g. Ranitidine. This takes time organising and explaining drug changes and is expensive for the NHS.	**Help needed**: Some participants suggested NHS England should drop QOF prescribing targets until this is resolved so practice pharmacist and GP time is not wasted on switching drugs to save minimal amounts of money. Instead of focusing on QOF, NHS England could focus on resolving the manufacturing and supply problems.
Test and trace and infection control: Initially concerned that test and trace could close down a practice, GPs now think this is unlikely. Mandatory mask-wearing has created additional stress for practices, who find it an additional pressure having to enforce mask-wearing among staff and other groups now coming in (e.g. podiatry, drug workers), especially when buildings do not allow for perfect isolation. Some participants felt that they had already addressed issues of contagion but must now *"hoop-jump"* to ensure compliance.	**Solutions:** ▪ More remote meetings to minimise staff contact. ▪ Mapping out floor plans to maintain distancing. ▪ Mask wearing at all times near another staff member.

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 3, 10 July 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