

RAPCI Project Summary Report 4

31 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 fourth summary report presents qualitative findings from 22 interviews held with GPs and managers from 20 GP practices between 3 and 29 July 2020 and quantitative data extracted from the patient record.

Key findings

Coping: Practices are still coping well with an average score of 8/10. The increase in fatigue, reported in [RAPCI report 3](#), continues for some participants, particularly GPs who are finding total telephone triage a strain. This is

exacerbated, in some practices, by a perceived “backlash” against general practice, from a minority of patients, due to changes in working practices and pay rises across the public sector which exclude nurses.

Organisationally, in terms of meeting the needs of our patients, we are well doing that ... But as individuals ... this [total triage] is not how we want to practise medicine.

Increased complexity and less support: Increased complexity, including more mental health problems is making many consultations more difficult to deal with over phone/ video. GPs are still struggling with a lack of support from secondary care and mental health services. The Advice and Guidance service is not always aware of what investigations GPs can access.

Today I had someone [on a phone] with a bit of abdominal pain, chest tightness, anxious, pain in feet, PR (per rectum) bleeding, you just think ‘where do I even start with this?’

Challenges in establishing new appointments systems: Practices are keen to keep some benefits of new ways of working and avoid a return to unfiltered demand but are finding it a challenge to implement the right system to do this. Practices are variously: introducing online triage to manage demand, new appointment slots and timed telephone appointments, encouraging greater receptionist triage.

Remote vs face to face (F2F) management: Practices are continuing to improve remote management to manage down F2F contact, e.g. self-service station for chronic conditions,

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encourage patients to self-management, use of Florey surveys to stratify patients. Nurses have found remote management for chronic conditions monitoring particularly useful. GPs are lowering their risk threshold for seeing patients F2F when the cases are complex and some are finding it difficult to establish a threshold for this.

Quantitative data summary: prescriptions

- ⇒ There was a spike in repeat prescriptions in March 2020, coinciding with the start of lockdown.
- ⇒ Analysis may indicate greater increases in repeat prescribing at the start of lockdown in more affluent groups of patients and in white / mixed-race ethnic groups (regardless of deprivation level).
- ⇒ Further qualitative research is warranted to indicate whether this resulted from an access issue and therefore led to health inequity.

Challenges, solutions and guidance needed

Challenges faced in the [last report](#) included: restarting services, implementing online triage/consultation systems (e-consultations), planning for winter, lack of support from secondary care, drug manufacturing and supply problems, and issues related to mask-wearing and test and trace. Mask-wearing is now more accepted by staff and by most patients. The lack of support from secondary care continues as a major challenge. Additional challenges raised in this period are:

Challenges faced	Innovative solutions and help still needed
<p>Creating an appointments system to deal with rising demand:</p> <p>In most practices, although demand is lower than pre-COVID-19 levels, it has increased in the last month and it is becoming more difficult to deal with all demand on the day. Some practices, still operating a system of same day call-backs, are starting to find this unworkable, and are frustrated by the number of unanswered phone calls. Practices are keen to keep some benefits of new ways of working and avoid a return to unfiltered demand but are finding it a challenge to implement the right system to do this. <i>“It’s a question of balancing the, what we’ve turned into, which is a doctor-first system; which is not [...] a model of care that we’d choose to use.”</i></p>	<p>Solutions: (These were implemented variously)</p> <ul style="list-style-type: none">▪ Using e-consultations to spread out less urgent demand over 48 hours and avoid the telephone bottleneck in the mornings (has challenges - non-urgent can end up on the duty doctors list.)▪ Receptionist triage: <i>“when we had more capacity it was fine for reception to throw everything on the duty doctor list, but they now need to start booking more on, or triaging.”</i>▪ Freeing up pre-bookable phone appointments to ease demand on same day calls. Some practices are instead asking patients to phone back in a week rather than release future appointments.▪ Booking on-the-day phone appointment slots with a fixed time which, if the patient misses, they miss the appointment (as with a F2F).▪ Creating slot types with different lengths – e.g. for first and follow-up telephone appointments▪ Returning to personal GP lists in most practices.
<p>Managing increasing GP workload:</p> <p>Telephone calls are taking longer as GPs are dealing with increased complexity and the process of talking patients through video/SMS technology is time-consuming. <i>“Why am I [GP] talking patients through how to set up their videos? ... if you think about that in terms a cost utilisation exercise and skill resource usage, it’s completely insane.”</i></p>	<p>Solutions</p> <ul style="list-style-type: none">▪ Moving more work to advance nurse practitioners (e.g. joint pains).▪ Reducing unnecessary paperwork being sent to the GPs by admin staff, for example, outpatient DNAs (unless children are involved) or COVID-19 negative test results. <p>Help needed: One GP suggested the CCG seek funds for a practice community worker to assist patients with remote monitoring and set up of technology. Identifying workers with customer</p>

Challenges faced	Innovative solutions and help still needed
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<p>Deciding on the threshold for F2F appointments: Some GPs are more uncertain about when remote management is necessary, given wider relaxation of lockdown/social isolation measures.</p>	<p>service and first aid skills (e.g. like flight attendants who were due to help in the Nightingale) would mean they could also assist with flu campaign (see below).</p>
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<p>Managing rising nursing F2F workload: As RAPCI report 3 showed, more than 50% of patient contact with nurses is still face-to-face. Much of this is treatment room work which requires hands-on contact with patients. Practices have sought innovative ways to manage down the amount of face-to-face contact.</p>	<p>Solutions: Lowering the risk threshold for seeing patients F2F. <i>“When it started it was very clear that your primary goal was not to have people enter this building. Whereas now, there isn't any clear NHSE message to guide on your threshold for bringing people in, so I think it's hard for us to know what you should be doing.”</i></p>
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<p>QOF: There was some variation among participants as to whether they saw the reintroduction of QOF as a challenge or not. Some GPs pointed out that QOF items contravene COVID-19 guidance e.g. spirometry for COPD, F2F review for rheumatoid arthritis patients (most of whom are shielding, and should therefore be offered home visits, but there is not enough capacity for this). Most participants were, however, unconcerned: <i>“We're not obsessing about QOF”</i></p>	<p>Solutions: Previous solutions included doing reviews by phone, stratification of patients into high and lower risk, use of patient surveys. Additional innovative solutions raised this time included:</p> <ul style="list-style-type: none"> ▪ Encouraging patients to manage their own health at home: e.g. wound care, blood pressure monitoring, self-administered contraceptive injections. ▪ Self-service station for chronic disease monitoring (with pulse oximeter, blood pressure monitor and scales.)
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<p>Practising infection control: Although they felt they were meeting the challenge well, some nurses interviewed reported that they have sometimes found it challenging to practise good infection control. Challenges include:</p> <ul style="list-style-type: none"> ▪ Adhering to the protocol: <i>“it is extra brain power to think ‘what do I do now’”.</i> ▪ Having enough time: <i>“we're needing so much more time with cleaning and putting on PPE that that puts on more pressure”.</i> ▪ Physical demands: <i>“It's quite a lot of cleaning, and it's quite physical.”</i> 	<p>Solutions: Some practices have used this time as an opportunity to change systems for the better, e.g. changing recall date to date of birth (many practices were doing this anyway).</p> <p>Help needed: Some practices suggested relaxing of next year's QOF targets (e.g. adjusted to be e.g. 2/3, given time lost during pandemic).</p>
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<p>Solutions:</p> <ul style="list-style-type: none"> ▪ Having a clear written protocol: e.g. responsibilities, criteria, processes (including mask-wearing etc.) ▪ Keeping protocol visible: One participant kept NHS England guidance on the wall as a reminder. ▪ Allowing additional time between appointments for cleaning. <i>“It's a challenging time for me as a nurse manager. They're [nurses] worried that they haven't got enough time to practise the infection control things which I think they do, I think some of it's psychological”.</i>

Challenges faced	Innovative solutions and help still needed
<p>Educating the public about managing risk: Now that shielding guidance has relaxed, some practices find patients' standards are slipping (e.g. mask-wearing, coming alone, accepting telephone appointments). Many participants felt it was hard to get patients to "strike a balance" between complete isolation and moving back to pre-COVID-19 behaviours.</p>	<p>➔ Solutions: Public education needs continual repetition, or the new habits lapse back into old. <i>"Patients seem to think things have gone back to normal, but obviously they're not back to normal."</i></p>
<p>Backlash against general practice: Some participants felt that, following an initial period of strong public support, there is a "backlash" against general practice, both among some of their own patients and in the media. One GP noted an increase in minor complaints. <i>"There is a lot of GP-bashing on social media, which is hard to deal with"</i></p>	<p>➔ Solutions:</p> <ul style="list-style-type: none"> ▪ Solutions included having regular catch-ups with colleagues so that affected staff know it is <i>"not just them"</i>, many are feeling <i>"COVID-19-fatigue"</i> and avoiding social media. ▪ Continuing to educate patients (see above)
<p>Advice and Guidance service: The service will often advise GPs to request investigations they do not have access to, e.g. haematologist asking for blood tests they can't request, cardiologists suggesting they request 24-hour tapes. <i>"I don't think they've quite twigged what we have access to and what we don't."</i> (GP)</p>	<p>➔ Help needed: GPs are making frequent use of this service to avoid making referrals. Clear communication should be provided to the Advice and Guidance service on what GPs are able to access/order, so that they can cater their advice appropriately.</p>
<p>Increased mental health problems: GPs reported increased anxiety from patients who had been isolating, returning to work/life and COVID-19-related stress <i>"catching up with people"</i>.</p>	<p>➔ Solutions: Practices did not feel there were any innovative solutions or help needed to deal with this problem, other than increased support from mental health services (see below)</p>
<p>Lack of support from mental health services: Despite the increase in mental health problems, mental health services support is lacking. Guidance suggests urgent referrals should be accepted, however GPs reported referrals they felt were urgent being returned (e.g. worsening depression and suicidal thoughts).</p>	<p>➔ Help needed: Clarification of what counts as an "urgent" mental health referral. <i>"There was some talk about whether we should ring people on the mental health register and whilst I think sometimes that would make us feel better, it could end up making them feel worse... what are you offering?"</i></p>
<p>Planning for flu clinics: Most practices feel the key challenge is administering flu jabs to more people, while maintaining social distancing, which will require greater workforce and estates capacity. Some practices suggested challenges also include unrealistic expectations on measures needed to ensure both informed consent and infection control.</p>	<p>➔ Solutions:</p> <ul style="list-style-type: none"> ▪ Use of external venues (church halls / car parks). (Although larger practices mostly plan to use a surgery site - better for safety and recording.) ▪ Some practices looking at use of bar-coding to improve recording. <p>Detailed plans include, e.g. moving from 1-min to 3-min slots; having 2 nurses working in parallel, using staff to marshal queues and ensure patients to stick to appointment times.</p>

Challenges faced

Innovative solutions and help still needed

Help needed: Opinion differed on whether more guidance on this in advance is required. Some participants thought written guidance is required: *“Some demonstration of how they [CCGs] would expect a flu clinic to run would be really great.”* Others thought that practices first need to do their own planning, and then request help based on their local solution: *“Top-down, ‘this is what you will do’, would be very unhelpful, because every practice is different [...] A response to ‘this is what we require’ would be helpful, once we know what we require”* One GP suggested deploying flight attendants to assist with the flu campaigns (see managing increased GP workload).

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

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