NHS
County Durham
Clinical Commissioning Group

Summary of Opportunities as a result of the Primary Care Survey

In May 2020 NHS County Durham CCG undertook a survey of all primary care staff to understand what worked well and maybe not so well. 152 people participated. Respondents were a combination of primary care administrative and clinical staff and one pharmacist.

This document sets out opportunities for change in primary care going forward in light of the current Covid19 pandemic, equally focusing on the influence of rapid change in the way primary care has responded to the pandemic and the sustainability of those changes going forward.

The attached plan is based on the observations and responses from GP partners, salaried GPs, GP registrars, nurses, non-clinical staff (43% managers; 57% admin and reception). A more detailed analysis of the survey, which was undertaken by Dr James Larcombe is outlined towards the end of the report.

In order to achieve sustainable change and 'new' ways of working, this document considers six properties of care for durable change by Don Berwick (JAMA) who set out 6 principles below:

1) **Speed of learning**: will the tempo for learning and improvement be faster in the new normal than before? Assumptions are dissolving about how much time progress takes.

2) **The value of standards**: will the new normal embrace global learning, shared knowledge, and trusted authority as foundations for reducing harmful, wasteful, and unscientific variation in care?

3) **Protecting the workforce**: will the new normal address more adequately the physical safety and emotional support of the health care workforce in the future?

4) **Virtual care**: the office visit has become a dinosaur, and that routes to high-quality help, advice, and care, at lower cost and greater speed, are potentially many? Virtual care at scale would release face-to-face time in clinical practice to be used for the patients who truly benefit from it.

5) **Preparedness**: the foundations of preparedness have been allowed to erode or have never been laid in the first place. Several major reports in the past decade have tried to call attention to that lack of readiness, with only minimal response. (Berwick and Shine Mar 2020)

6) **Inequity:** a social and economic safety net would accomplish more for human health and well-being than any vaccine or miracle drug ever care

The comments and actions outlined below will be incorporated where possible into the Primary Care Strategy which is currently being refreshed in light of COVID-19.

Post Covid Primary Care Survey

Description	Opportunities for change	How will this be taken forward?
Remote Consulting and Working– Total Triage/Video and Online consultation		
Total Triage – to reduce footfall in practice During the pandemic all practices moved to a total triage model with telephone consultation. A positive note is that there has been a realisation (from both practices and more importantly, patients) that a large amount of patients can have their issue successfully dealt with remotely (phone, video etc.) and patients should only come to practices if they have a clinical need	• All practices to maintain a total triage model with clinical appointments being telephone and video • Improved quality of patient access • Create a better working environment for all staff • CCG/NECS procurement offer of support • Consider increase use of online/video/telephone consultation to support total triage. • Opportunity to work differently across primary and secondary care • Opportunity for at scale working to manage telephone calls	Primary Care Strategy and Primary Care work plan
Online/video consultation as part of total triage system It is acknowledged that Telephone/video appointments are not necessarily quicker than face to face so realistic expectations on efficiencies must be set, but they can be delivered from a clinician's home or other setting away from general practice	• Improved usage of online/video consultation • Better IT technology to support delivery • Supports home working where appropriate • Review which primary care services can continue to be delivered this way (nurse reviews, low impact health needs, initial GP consultations)	North East Primary Care Digital Strategy - Digital Workstream Optimising Resources Making best use of IT systems & processes to support practices to deliver high quality efficient care
Remote working to improve efficiency	• Practice would make the decision as to home / remote working and which parts could be delivered this way	Primary Care Strategy Primary Care to adopt

Description	Opportunities for change	How will this be taken forward?
	• IT support and equipment • Practice policies and procedures to be developed in order to create guidelines for each staff group	consistent ways of working with IT systems
Relationships Care Homes/TAP/ Social Care		
Better links and communications, through greater integration with primary care teams and attendance at team meetings (in person or virtual) It was acknowledged that relationships with TAPs has not changed in the eyes of admin staff	On-going development of PCN. Working together to ensure integration with the wider health care system. MDT's and Teams Around Patients have been in place for a number of years, this forum supports better links with teams. Opportunity to look at the TAPs model to ensure consistency across the County	PCN DES Primary Care Strategy
Social Care relationships improved for non-clinical staff	More integration with social care	Primary Care Strategy Integration agenda
Future changes in Primary Care		
Improved technology IT system improvements/ implementation such as use of 'ICE' and digital kardexes	Identify funding to improve IT equipment More available grants for the infrastructure improvements, enabling practices to get more screens, laptops and equipment to enable remote working	North East Primary Care Digital Strategy - Digital Workstream NHSE
Use of telephone consultation to review patients	Practice workload and staff rota planning	Primary Care Strategy
Telephone triage	Adapting to implement new ways of working	Primary Care Strategy
Increased use of AccuRx	Funding to be identified to increase the usage of AccuRx for all practices. This would support for example long term condition patient reviews which can be undertaken remotely	North East Primary Care Digital Strategy - Digital Workstream

Description	Opportunities for change	How will this be taken forward?
Better training for Nursing staff	Opportunity to ensure training needs of the workforce is understood Primary care workforce has appropriate training to maximise digital ways of working	Health Education England Central Training Hub North East Primary Care Digital Strategy - Digital Workstream
More cooperative working between practices in the PCNs	Practices are starting to work closer together , PCN development and maturity	PCN Directors Forum
Secondary Care		
Good telephone support from Consultants to avoid referrals	Work with Trusts to maintain the telephone support	Ensuring advice and guidance service within each clinical speciality is utilised to its full potential to avoid / reduce onward referral to secondary care. This work is reflected in the Restoration and Recovery planning Phase 3 letter Outpatient work stream
Restart of routine care including urgent pathways for two week waits	Work has commenced to ensure services can be “restarted” as safely and as quickly as possible	Restoration and recovery planning
Greater use of telephone and remote consultation for the reviews, MDT and nursing home	On going	Restoration and recovery planning
Improving relationships between Primary and Secondary care in respect of the	Transformational change of attitudes in Primary and Secondary care. Undertake a review in due course on	County Durham Place Based Delivery Plan

Description	Opportunities for change	How will this be taken forward?
ownership of problems tasks and monitoring, responsibility for cancelled activity, consultant-to-consultant referrals	relationships with Primary care and this has improved? Opportunity to develop closer working relationships between both sectors – Chief Officer working into CDDFT. Opportunity to look at secondary care outreach specialists nurses and professionals providing services such as spirometry, teaching HCAs about dietetics, using some specialists eg physios as the first point of call; managing 'multi-therapy' pathways	As above this is part of the Restoration and Recovery planning Phase 3 letter Outpatient work stream The 5-year Commissioning and Delivery Plan also an opportunity to work collaboratively along pathways and across organisational boarders
More effective communication - better information transfer, streamlined admissions, better discharge letters, use of e-prescribing, and a joined up approach to IT so that both sectors could communicate with each other more effectively	Work continues on the interoperability of systems, this would support: • Secondary care e-letters which go straight onto GP systems. • Secondary care to have access to primary care S1 patient records (more than just viewing recent medical history) • Secondary care to use electronic prescribing to reduce workload in primary care	North East Primary Care Digital Strategy - Digital Workstream
Care Homes		
Care Home alignment with GP practices	As part of the DES however was implemented at a rapid pace due to COVID	PCN DES
Dedicated nurse-led schemes eg the VAWAS or community matron schemes	Service currently under review	Primary Care Workstream

Description	Opportunities for change	How will this be taken forward?
Remote consulting, including virtual ward rounds and multi-disciplinary team discussions/ meetings, which may involve a range of primary care staff and community or hospital elderly care specialists	All care homes have been provided with IT equipment to allow them to undertake virtual wards with their aligned GP	Primary Care Strategy Enhanced Health in Care Homes North East Primary Care Digital Strategy - Digital Workstream
Relationships with Care Homes have improved across the clinical and non-clinical setting in practice	To continue this approach in order to develop stronger working links	Enhanced Health in Care Homes
Better training for care home staff, including feedback on admissions	To be led by Durham County Council. Opportunity for Care Home staff to link in with PCNs if appropriate via PCN development sessions/PLT	Developing the provider market – Led by Durham County Council
Extended Hours/In hours		
Hub-based model for externally-run extended hours	Opportunity to review the current service in line with feedback from the survey. Work has begun to look at other models across the Country.	Primary Care Strategy PCN DES
Most practice staff happy with current OOH arrangements		
Better communication by enabling IT systems and connections to avoid gaps in patient information		
What is to change in Practice Business Plans?		
Alteration of practice business plans with intention to add lessons learned from the pandemic	Opportunity for all practices to review business continuity plans, risk assessment documentation in light of COVID. Documentation circulated to practices and PCNs “COVID unlock plan for general practice”.	GP Practice led Restoration and recovery planning Preparedness for second wave
Plans should include remote working arrangements, and collaborative working arrangements		

Description	Opportunities for change	How will this be taken forward?
Provision of PPE, arrangements to manage staff shortages, and collaboration with other practices		
Cooperative working between practices in PCN in case of collapse of practice should be in plans		

CCG	
Description	**Opportunities for change**
Improved communication during the crisis	CCG Headlines was greatly appreciated during the pandemic. One frustration is a lack of a search facility on Teamnet
Allocated CCG link person well received	The Primary Care Team will continue to maintain the well-established links with practices
Improved relationships and openness in working together with the CCG.	On-going engagement
Zoom meeting very welcomed to save on travel	All meetings should be Zoom/Teams based. Respondents felt very strongly about this to save their time travelling, parking and costs on room hire.
More training required for Nurses re resilience	Opportunities through Health Education England and CCG Practice Link Nurses

ABSTRACT

Aims

To discover the opinions of members of practices in the Co Durham CCG area on the management of the COVID-19 pandemic and future changes to primary care in the light of recent experiences.

Methods

A questionnaire survey advertised through COVID headlines, a newsletter regularly posted on the GP Teamnet website during the pandemic. Both quantitative and qualitative analyses were undertaken on the first six questions. A qualitative analysis alone was undertaken on the next nine questions, all of which were free text comments. Responses were stratified by role: GP partners, salaried doctors, nurses, and non-clinical staff.

Results

There has been a marked difference in the use of remote consultation methods.

All groups had changed their methods of patient interactions and many felt they were likely to continue using these new methods in the future. Telephone and video were most likely to be continued, though just under a half indicated they would continue with total telephone triage and remote working from home. Several cautionary notes were added lest we forget those who are less able to access care or who are more vulnerable: mixed models of care would be most appropriate.

Relationships with Care Homes had improved markedly, and novel ways of working with this sector have been very successful. Clear lines of responsibility and continuity, provided by nurse practitioner or equivalent schemes, are likely to lead to the greatest benefits.

Relationships with other groups have been less successful. There were requests for secondary care to maintain new working arrangements and a plea to return to routine care as soon as possible, whilst not overburdening primary care. A small majority was pleased with CCG support, though practices collaboration with Primary Care Networks and federations didn’t appear to have been much enhanced during the pandemic.

Business plans are likely to be reviewed to include lessons learnt from the pandemic, but most felt that there was no need for major change in extended and out-of-hours arrangements.

Conclusions

The vast majority of primary care workers swiftly changed their working arrangements during the pandemic. They have adapted more easily than imagined and are receptive to maintaining changes. As COVID is likely to be with us for some while, there is a clear opportunity to test the alternatives more formally in the coming months.

Many relationships were tested by the stresses of the pandemic, and some were found wanting. Care Home relationships have, in particular, improved but it is unclear whether they can sustain the changes without greater support and funding.

BACKGROUND

SARS- CoV-2 better known as COVID19 or 'Corona virus' started in Wuhan, China in Autumn 2019 and in 2020 quickly spread globally. The first death on UK soil occurred on March 5th and as it escalated primary care quickly altered its pattern of consultation, moving from primarily a face-to face model to telephone triage and remote consultation.

In the year to Feb2020 81% of appointments in primary care were face-to-face. That is reported to have reduced to around 7-8% (BBC 11 April 2020), although Martin Marshall (RCGP) elsewhere has quoted that 15-20% of primary care consultations are still conducted face-to-face (Lessons from COV19 -MPS Webinar). Pre-Feb 2020 most of the rest were telephone appointments and only 0.6% were online or video consultations. Babylon Health has attracted many patients, reportedly mostly in the 18-45 age group, to 'remote consultation first' services over the last few years in London and more recently Birmingham. This model has been lauded as a force for disruptive innovation by the Department of Health.

A time of rapid change

Assumptions are dissolving about how much time progress takes (Don Berwick, 2020). Favourable innovations take years to reach scale; one often-quoted study claims that the average cycle time is 17 years. (Grant et al – BMJ; Balas and Boren, 2000), and it is unlikely that this has since reduced. In this pandemic timescales have reduced drastically. NICE, for instance, has moved from standard guideline production to rapid guidance in a matter of days, but have had to ditch its robust methods of evidence collection and analysis and widespread stakeholder engagement.

Rapid construction of new NHS facilities has been achieved using Army engineering and logistics skills, designed to rapidly react to situations on the ground: identify the problem, analyze it, find solutions, and decide the solution. It is based on a hierarchical command structure, and lacks the stakeholder engagement, which we strive for in the health care system, but it produces quick and workable results refined by action learning.

"No plan survives contact with the enemy" (Erwin Rommel)

Rapid decisions and change require us to forget previous norms and do come at a cost.

The ‘new normal’

“Anyone who knows what the ‘new normal’ will be is smoking something” (Don Berwick)

This term was first coined in economics literature at the time of the 2008 financial crash and is now used in a variety of other contexts to imply that something which was previously abnormal has become commonplace.

Don Berwick (JAMA) sets out six properties of care for durable change:

1) Speed of learning: will the tempo for learning and improvement be faster in the new normal than before? Assumptions are dissolving about how much time progress takes.

2) The value of standards: will the new normal embrace global learning, shared knowledge, and trusted authority as foundations for reducing harmful, wasteful, and unscientific variation in care?

3) Protecting the workforce: will the new normal address more adequately the physical safety and emotional support of the health care workforce in the future?

4) Virtual care: the office visit has become a dinosaur, and that routes to high-quality help, advice, and care, at lower cost and greater speed, are potentially many? Virtual care at scale would release face-to-face time in clinical practice to be used for the patients who truly benefit from it.

5) Preparedness: the foundations of preparedness have been allowed to erode or have never been laid in the first place. Several major reports in the past decade have tried to call attention to that lack of readiness, with only minimal response. (Berwick and Shine Mar 2020)

6) Inequity: a social and economic safety net would accomplish more for human health and well-being than any vaccine or miracle drug ever can.

What about patients?

“In a very short space of time, patients have become used to accessing care in a different way: (McKenzie 2020)

There is a very limited amount literature at present on this subject. One study noted a reduction in time to access care, but other markers of patient satisfaction were a little lower (Newbould 2017). However, levels of satisfaction may depend on how the system is implemented (Ball, 2018)

In another study, patients reported benefits including convenience and access but some patients (and primary care workers) regard the face-to-face consultation as ideal. (Atherton 2017)

How do alternative consultation models affect primary care

There are few studies to base policy on, and the evidence that is available is not conclusive. Recent concerns about Babylon Health may be based around protectionism as well as evidence. However, previous assumptions have been recently turned upside down, and as the COVID 19 crisis is only likely to end when a vaccine is widely available, old assumptions may need to be disregarded.

Beliefs vary about which patients and health issues were suitable (Atherton H, 2017) for alternative arrangements for consultations.

A study in 2010 concluded that although telephone consultations are convenient and judged satisfactory by patients and doctors, they may compromise patient safety more than face-to-face consultations. Telephone consultations may be more suited to follow-up and management of long-term conditions than for in-hours acute management. (McKinstry 2010)

Studies of telephone triage found no overall benefits on patient footfall. Telephone triage is associated with an increase in the number of primary care contacts in the 28 days after a patient's request for a same-day GP consultation, with similar costs to those of usual care (Campbell 2014) but made no difference to the overall number of patients seeking medical intervention (Miller 2019). It can decrease delays to GP contact in a deprived urban setting (Miller).

Nurse triage reduces GP contact time but not overall clinician contact time. GP triage did not result in time-savings (Holt 2016). There are no overall cost benefits to a switch to telephone first models of care (Newbould 2017)

One study noted that e-consultations are very infrequent and their use may increase primary care workload and costs (Edwards 2017). Online consultations may only suit the management of single discrete problems (Casey 2017).

Experience of implementing alternatives to the face-to-face consultation suggests that changes in patient access and staff workload may be both modest and gradual. Practices planning to implement them should consider carefully their reasons for doing so and involve the whole practice team (Atherton H, 2017)

METHODS

A questionnaire (available separately) was developed to combine two needs: Co Durham CCG sought feedback on the management of the pandemic so far and future working patterns; the RCGP had distributed a questionnaire asking for opinions on planned changes to primary care structures post-COVID19.

There were 15 questions:

Q1-6 were yes/ no answers asking about changes to working patterns, future plans, what worked well, and collaborative working/ relationships with Care Homes, Social Care, and community teams during the initial phase of the COVID pandemic. There were opportunities to add free text comments for questions 1-3 individually and 4-6 as a whole.

Q7-14 were all free text responses on the wishes for future changes in primary and secondary care, Care Homes, community services, extended hours and out-of-hours services, business planning and the CCG. Q15 was 'any other comments'.

The questionnaire was advertised on 'COVID headlines', a CCG newsletter, which appears on the GP Teamnet website. In order to reply to the RCGP questionnaire we sampled GP only responses after the questionnaire had been live for one week. After this a reminder was posted in 'COVID headlines'. The final sample was taken at the end of the second week.

For the final sample responses were separated into GP partner, salaried GP, GP registrar, nurses, non-clinical (43% managers; 57% admin and reception).

Results for the first six questions are presented as bar charts. Comments attached to these questions and comments for questions 7-15 have been downloaded in full and thematically analysed.

RESULTS

Response rates:

A total of 152 replies were received, 120 in week1 and, after a single reminder, 32 in week2. From the 152 replies we have analysed over 1000 free text comments even after excluding those who replied 'not applicable', 'nil' etc.

75/272 (28%) of GPs in the CCG responded, though perhaps slightly higher: five people skipped or provided no response to the question on job role (patterns suggest these were people with a clinical background)

Apart from GPs, we are unable to formally assess response rates as the questionnaire was advertised on an open site viewed by all primary care practice-based staff.

Reliability, validity and bias:

It is unlikely that the respondents will be wholly representative of primary care, but themes were fairly consistent across all four groups of workers for the majority of questions. Early and late (GP) responders also provided similar responses for most questions. Nurse responses (17) were the lowest in number so will potentially be less reliable than other groups. We cannot assess whether individuals responded on behalf of whole practices or on their own behalf.

For a minority of questions there are significant differences in week1 and week2 (only GP results have been subject to interim and final analysis). A similar proportion of salaried GPs and partners replied in each week, so the observed difference in week2 responses is likely to reflect attitudes rather than a different perspective based on employment status.

I identified one pair of answers (logged at the same time) where criticisms looked very similar, suggesting potential for some co-dependency. Some questions e.g. views on the usefulness of GP headlines, where the study was advertised, may be less reliable as there is inherent self-selection.

Question 1/2/3

Have respondents worked differently?: unsurprisingly – a resounding "yes".

Do respondents intend to continue to work differently?: mostly yes

What worked well? CCG initiatives were rated most positively especially 'headlines' (which hosted the advert for this survey – see comment above) but also CCG support; and Zoom meetings. Up to 60% of respondents rated these as having worked well.

Remote consulting and working

Almost all members of the primary care team reported differences in the use of remote consulting, and the majority of those foresee greater use in the future.

Over 90% of GPs reported a change in their use of total triage and video consulting. It is unclear if the 5% of those who reported no change in video consulting had used the technique before or whether they had not taken advantage of this option. On the other hand, those reporting no change in total triage (8%) or telephone consulting (16%) might well represent numbers who already used these methods e.g. 'Doctor First'. Support for this view comes from the higher percentage of partners who will

continue telephone consultations than reported a change in use, and some comments e.g.:

“Already did plenty of tel consultations, much increase” (Q1-11)

Non-clinical staff responded very similarly, though it is unclear whether they were all answering for themselves or predicting how their clinicians/ practice would respond. Around 75% and 90% nurses and non-clinical staff also reported differences in the use of total triage and video consultations respectively. These two groups also reported the biggest changes in telephone consulting suggesting that remote consultations of all types were novel.

Although ‘total (telephone) triage’ was more likely to be seen as a response to a particular situation, it still has support for future use from around 50% of all respondents.

“Telephone triage is working really well. Limiting the number of footfall in the surgery” (Q2-14)

Non-clinical staff provided the most comments, possibly due to beneficial effects on workload. Salaried doctors were most likely to indicate that they would continue this in the future. GP partners, on the other hand, showed the greatest disparity in current use (92%) and likely future use (42%) and nurses the least disparity (71% currently using and 47% would continue). This might suggest telephone triage has been a revelation and relative success for nurses.

“I think I was worrying that working from home would be difficult as a practice nurse but during the pandemic I’ve noticed a lot more patients are open to having LTC reviews and advice over the phone.” (Q7-63)

This also supports Scott McKenzie’s opinion (see background) that patient attitudes to remote consultations have changed suddenly.

A number of commentators indicated that they didn’t see a return to past consulting styles, but the ‘new normal’ would be a hybrid model:

“Probably a mix of telephone and face to face” (Q2-8)

“Doctor first, remote consults but patients need F2F in between” (Q2-47)

A few specifically commented on providing a range of access options to suit particular groups:

“Video and photo use has been useful for some, and should continue as an option particularly for workers. But we have a significant population of vulnerable/ poor/ elderly patients who simply can’t access the technology for this at the moment – could there be a technology advocate to help them/ lend equipment?” (Q7-60)

In respect of the latter comment Dr Muir Gray has suggested that Utility companies, who are used to visiting the vulnerable in another context, could provide IT help and instruction.

Collaborative working

Different levels of cross-practice activity were reported by around 50% of total respondents. This is less than might be expected, unless they had high levels of collaborative activity pre-COVID. However, only 58% of salaried doctors, who are less likely to be directly involved in earlier cross-practice efforts, reported different (likely higher) levels of activity.

Most interestingly, a very marked dip in positive responses was clear when comparing the interim and final analyses: *64% of all GPs responding in week1 had worked more across practices → 18% of all GPs in week2 ($p< 0.001$)*. Did hot hubs, given as an example of collaboration, close, causing this pattern? Did practices collaborate in other ways? One comment suggested activity was more dependent on PCNs:

“We had not had need to work in hot hubs but always prepared to work with other local practices to meet the needs of the PCN population” (Q2-7)

Two further stats support this supposition: only 16% of all GPs (and fewer nurse/non-clinical) expect to continue the same level of collaboration long-term; 0/17 GPs responding in week two expected to continue working across practices compared to 12/59 in week one ($p<0.1$ – with Yates - so non -significant).

About half of GP partners reported working more closely with PCNs. Other groups reported much lower figures. Non-clinicians felt federations had been more supportive whereas clinicians were more positive about PCNs:

PCNs are about working together and that doesn’t seem the case” (Q15-50)

Remote working from home

More than 50% of non-clinical staff reported a change (presumably an increase) in remote working. This activity was reported most by GPs and least by nurses. As this quote shows, however, one nurse found working from home much easier than expected.

“I think I was worrying that working from home would be difficult as a practice nurse but during the pandemic I’ve noticed a lot more patients are open to having LTC reviews and advice over the phone.” (Q7-63)

20% of all groups (a remarkably similar pattern) reported that they intended to continue remote working from home long-term (ranging from 18% nurses to 53% of GP partners). Use of VPN links, however, means that this might not have been an uncommon activity in the past. The quote above (Q7-63) suggests that the type of work being undertaken at home has altered as well as the amount, but it is unclear whether such change is envisaged for the future.

Educational and organizational support

GPs reported more help from external providers – Red Whale was mentioned more than NB medical. Nurses and non-clinicians were more likely to have found national guidance helpful.

Few reported that connections with secondary care, mental health trusts, or public health (including infection control) had worked well. However, this is likely to be an overall assessment, and some elements (see later) were positively rated.

Q4-6 Have relationships improved?

Relationships with Care Homes had significantly improved but comments and scores suggested that the majority thought that relationships were unchanged with TAP teams. Few felt relationships with social care had improved. Several responses said that relationships with Care Homes and district nursing teams were already good. For some, rejigging of community teams had disrupted relationships.

Overall, nurses were the group most positive about relationships with the three identified groups; non-clinicians were the most positive about social care. GPs showed the greatest variation (partners 6% positive response on social care v 78% for Care Home relationships)

GP respondents were a little more positive about relationships with TAPs in week two compared to week one. Although statistically non-significant it might indicate that cooperation is developing. The other two relationships were unchanged in week two.

Q7-10 Future changes

Primary care, community and social care

This section reiterated and strongly emphasized the planned changes to the ‘new normal’ methods of communication expressed in question2.

“We need to adopt technology faster and keep moving with the times. We should not go back to the pre-CV19 situation.” (Q7-124)

“More and continued remote working. This should be accepted across all levels of the NHS/NHS England/CCG and at patient/community level.” (Q7-2)

Free text comments were very plentiful on the use of telephone, video, email consultations, text reminders, remote triage, virtual meetings, and IT in general. If we exclude those who skipped this question, an absolutely remarkable statistic emerges. 70% of every individual group (GP partners, salaried doctors, nurses, and non-clinical staff) spontaneously commented positively on future technological developments, suggesting that there is wide support throughout all core primary care team members.

GP partners commented most on the use of video; salaried doctors and non-clinical staff on the use of telephone; nurses on telephone triage and video. This may give a hint about which technological aspects are most important to each group. The interest in virtual meetings seems important to GP partners, but, less to other groups, as they commented infrequently?

Specific comments included using photos to complement telephone triage (as current video quality may be insufficient for fine examination); use of telephone to review patients; the use of AccuRx pathways (I am unfamiliar with this but presume from the name it is a prescribing decision aid tool? – although one reply comments that it generates text messages?)

As well as the comment on the video quality, there others reminding us that funding and provision of equipment will be necessary to make the most of the developments:

“Continued use of technology to allow remote consulting, would be helpful to have higher quality equipment available.” (Q7-102)

No-one spoke directly against an increase in the use of technology, though there were several words of caution:

“I fear that the ‘powers that be’ at all levels are excited by some of the developments that have been adopted during the crisis and keen that things continue to develop but on the ground there will be a huge amount of work to catch up with and this needs to be factored into further developments.” (Q7-16)

“limited move to remote consulting, but only if appropriate to problem, and in order to improve access for patients. NB remote consulting is no more efficient than face to face consultations and not as effective for many problems.” (Q7-56)

“Whilst telephone and video consults have been useful in the context of a Covid Outbreak they should not be seen as a miracle solution going forward. They risk driving up demand, widening inequalities in health care and exhausting GPs as they are not as safe or efficient as traditional consulting.” (Q7-86)

One respondent emphasized the need for adaptability of our response and others suggested that face-to-face access will still be needed for those without access to suitable IT and vulnerable patients. Although there were no comments in this survey, there have been regular comments in the media about the risks of domestic violence and child abuse during COVID, both of which may be more easily missed in remote consultations. This suggests that a nuanced approach to technical developments will serve us best. Others felt that face-to-face was often a necessary step in ongoing consultations, although this could be intertwined with the use of technology. It is likely to be an individual learning exercise and clinicians will approach this at different speeds.

“Option to tailor how we work to local needs rather than being imposed on us by NHSE or CCG.” (Q7-112)

Efficiency and reducing, rather than adding to workload was in the forefront of several commentators’ minds:

“This has highlighted how many patients have f2f appointments when they could be dealt with more efficiently using other options.” (Q15-23)

“A better systems and lean approach to patients attending acutely so that opportunistic pull mechanisms are in place for patients to receive as much of their annual care as possible at any one visit to the practice.” (Q7-110)

“Have a say in what aspects of our work are meaningful and which merely tick box exercises.” (Q7-115)

Several commentators felt that triage had not only helped the current crisis but would continue to reduce demand. Triaging had appeared to filter out inappropriate requests:

“Not to revert to old ways- we need to manage demand as COVID has shown that demand is patient led and often inappropriate” (Q7-28)

I think telephone triage reduces the number of inappropriate appointments and would like to see that continue.”(Q7-40)

A couple suggested that appointments made by 111 should also be triaged, which would be logical in the context of a ‘doctor first’ model.

In contrast to the frequent comments about technical solutions to consulting and access, there was almost total absence of comments about remote working from home despite, in question2, 1/3 of all respondents (and ½ GP partners) indicating that they would continue to do this in the future. It is unclear whether the three brief mentions by non-clinical staff related to their own or practice ways of working.

Some comments highlighted the opportunity for us to build on encouraging self-care, the use of social prescribing, and pharmacist support, though perhaps in expanded roles.

Whilst clinicians commented little in this question about relationships with federations and PCNs, it was spontaneously brought up by 15% of non-clinical staff, second only to IT developments. Two separate comments added in a later section asked for stronger PCN leadership. On the other hand, specific schemes e.g. VAWAS, run by PCNs, were cited as positive aspects of the relationship.

Although this is largely beyond the influence of CCGs (better through LMCs/ BMA?) there several calls for the suspension of targets (e.g. QoF), bureaucratic processes, and regulatory oversight e.g. CQC, appraisals.

Q8 Secondary care

A good few commentators had appreciated email and telephone support from secondary care consultants and this is a service that they would like to be continued. They believe that this saved referrals and admissions.

A few comments reminded us that a restart to routine care is important, including pathways for urgent and 'two week rule' cases. One asked that routine referrals shouldn't be automatically bounced during COVID:

"In particular they shouldn't be passing referrals back to us to do once COVID is over. " (Q8-78)

This brings up two issues: firstly, how is primary care going to reassess all these referrals as workload increases after restrictions are eased and, secondly, when will this actually occur – I presume there will be a staged return to outpatient activity?

"Moving forward I have concerns about the fall out of this pandemic. We may have a huge rise in demand for referrals…I hope secondary care will support us with this" (Q15-16)

Several commented that secondary care could make greater use of remote and telephone consultations. Reviews and where examination is not a necessary part of the assessment were thought to be suitable examples, as well as nursing home assessments and multidisciplinary virtual rounds. Some pointed out that outpatient attendances can be a poor use of resources, and that changes would be patient-friendly. There were a few remarks of caution in that remote consultations may increase requirements for pre-and post-investigation by primary care – perhaps, causing further transfer of responsibility to primary care.

There were very many comments on interface relationships between primary and secondary care though it was rarely clear if these were worries going forward or an expression of the wish to use the post-COVID period as a time to reset relationships.

Issues raised included taking ownership of problems, ‘dumping’ tasks and monitoring, responsibility for cancelled activity, consultant-to-consultant referrals.

There were quite a few pleas for respect in general. In addition there were specific requests for secondary care to better recognize the roles and responsibilities of non-doctors in the primary care system.

There were several requests for better information transfer, streamlined admissions, better discharge letters, use of e-prescribing, and a joined up approach to IT so that both sectors could communicate with each other more effectively.

“The realization that we are all working towards the same goal and we are all one NHS. This view applies to primary care as well.” (Q8-75)

For all the negativity about community deaths during this crisis one comment suggest we reflect on a previous marker of quality end-of-life care:

“being proud- not ashamed of the fact that care home patients died /are dying in their preferred place of care, rather than hospital in county Durham.” (Q8-31)

Q9 Community services

A good few suggested that teams already work well (GP partners were more likely to state this than salaried doctors or non-clinical staff). On the other hand, many others asked for better links and communications, through greater integration with primary care teams and attendance at team meetings (in person or virtual). CSPs were mentioned quite a few times:

“Better understanding of CSPs – where are they, what do they do. The need to be part of practice teams.” (Q9-15)

There was less emphasis on remote consulting, although several did comment on the benefits of video calls when a district nurse wants to liaise with a GP about a patient they are visiting. District nurse and nurse practitioner (community matrons/ VAWAS nurses) could also liaise from Care Homes.

Commentators would like to see IT system improvements/ implementation such as use of ‘ICE’ and digital kardexes.

A couple commented on the ‘disappearance’ of mental health support, which might be a major issue post-COVID if the media reports of a ‘tsunami of mental illness’ comes true!

There were specific comments (relevant to secondary care outreach specialist nurses and professionals allied to medicine?): providing services such as spirometry, teaching HCAs about dietetics, using some specialists eg physios as the first point of call; managing ‘multi-therapy’ (rather than single disease?) pathways.

Q10 Care Homes

Across the board there were calls for more funding and /or more support.

Alignment of care homes to practices was a very strong theme. No-one argued against this point of view although, one commentator felt it was a matter of organization rather than alignment. Dedicated nurse-led schemes eg the VAWAS or community matron schemes were highly valued. There was a plea for these schemes to be shared widely.

“Aligned care homes to each practice. Dedicated community matrons for each care home.”(Q10-12)

“I am very happy with our current situation- but that is because we have the privileged position of 2 elderly care homes that are all our patients and an excellent VAWAS nurse with whom I do regular MDTs” (Q10-33)

Remote consulting was highly valued, including virtual ward rounds and multi-disciplinary team discussions/ meetings, which may involve a range of primary care staff and community or hospital elderly care specialists. The quality of Care Home communication systems, however, was a very significant concern: poor organization; poor wifi; inability to access homes directly on the phone.

One respondent suggested giving homes access to Systm1. There were also several requests for the provision of equipment to enable remote examination.

Many commentators felt that there should be more and better training for care home staff, including feedback on admissions. In the spirit of remote consulting some suggested this might be delivered remotely. A few suggested standardization of policies (or even nationalization!) across Care Homes.

“Closer working with primary care. Better education for care home staff and continue video links.”(Q10-84)

Q11-15 What changes would you like to see in…?

Q11) Extended hours and Q12)out-of-hours (OOH)

Some felt it was unclear whether this was an opportunistic question or related to COVID. With respect to extended hours it was clear that some comments related to a practice’s own internal arrangements, whereas others commented on the shared hub-based arrangements. Where shared, a hub-based model for externally-run extended hours seemed to be favoured.

Most who made a relevant comment were happy with current OOH arrangements but there were more GPs who questioned the value of extended hours than expressed satisfaction. On the other hand, non-clinical staff generally commented favourably on the extended hours service, perhaps reflecting that the arrangements are felt to take some pressure off primary care appointments? A few asked for the Federations or PCNs to take over the running of these services. Some were concerned that the OOH workforce wasn't resilient. It was also noted, however, that arrangements are due for review nationally next year.

In this section there were also calls for Increased use of remote consultations.

Duplication of effort is a bugbear:

"It would be good if we could improve appointment utilization between extended hours, general practice and out-of-hours so the right patients are seen more consistently in the right setting" (Q12-46)

There were a few comments asking for greater simplicity in the management of non-standard hours' services, though not at the expense of passing this back to primary care providers. Comments for both (extended and OOH) asked that the clinicians exercise increased decision-making so that patients aren't asked to re-contact their GP practice the next day to complete management.

"Take some management decisions and stop telling patients to see their GP in the morning." (Q12 –37)

Communication may be sub-optimal, and some IT systems in OOH don't connect with primary care leading to gaps in patient information, and potential for abuse e.g. opiate requests.

Q13 –Business plans

It was implied that several practices had already altered their plans, and some that hadn't intend to add lessons learned from the pandemic. Non-clinical staff were the most sceptical group regarding the usefulness of current plans (43% of these respondents were practice managers who are often primarily responsible for these plans).

Plans should include remote working arrangements, and collaborative working arrangements. I assume pandemic planning was not at the forefront of minds when plans were drawn up, but it was clear that the current crisis will change that balance. Provision of PPE, arrangements to manage staff shortages, and collaboration with other practices were common topics that are likely to make it into at least some revised plans.

"remote working much more prominent in plans and cooperative working between practices in PCN in case of collapse of practice should be in plans." (Q13-10)

There were several calls for standardization via PCN, federations, and regions, but not CCGs. There was only one suggestion that plans should remain individual.

Q14/ 15 CCG and other comments

On the whole, there were more positive than negative comments about the CCG, its response and its leadership, though it may initially look otherwise as critics have helpfully provided detail of where improvements could be made. The overall 'result' reinforces the results in Question 3 'what worked well', where the CCG scored highest of the organizations.

"Noticed a step up in communication during the crisis which has allowed non-partners to be included which has been welcomed" (Q14-78)

"very slow to make (actions) and feedback during this pandemic." (Q14-18)

GP partners were the most positive about CCG communications. Non-clinical and salaried doctors were split, and nurses didn't comment. Some felt supported but at the same time found telephone support checks intrusive. A majority felt that the CCG had managed to chart a course that dispelled some of the confusion, chaos, and conflicting advice.

"The handling of CV19 has been chaotic. It was a predictable event." (Q15-77)

"CCG have been responsive and supportive, guidance from several sources is difficult to manage and quite often conflicting leading to confusion" (Q3-16)

Non-clinical staff valued closer links and, in particular, the allocated CCG support person. Others would welcome greater 'visibility on the ground' and greater openness. GP partners asked named directors to be allocated to collaborate with PCNs.

Zoom meetings were a positive feature and several were greater of the travel time saved. All groups would like these to continue. A couple wanted fewer meetings, but it wasn't clear whether these wishes would be met by providing better remote access or only by reduction per se.

Nurses in particular want better training. They especially, but all groups, asked for clear guidance going forward, and resilience of PPE supplies. Nurses were also the only group who wanted the CCG to take a lead on pay and conditions.

A couple of voices felt the CCG was becoming too large and requested "no further mergers"

Adaptability of the medical workforce was praised, though some were worried whether second waves, and subsequent staff shortages through illness/ self-isolation would be manageable (recent figures suggest 25% of hospital staff have COVID antibodies, but it is thought that ‘immunity’ in primary care will be significantly less)

Conclusions

The vast majority of primary care workers swiftly changed their working arrangements during the pandemic. They have adapted more easily than imagined and are receptive to maintaining changes. As COVID is likely to be with us for some while, there is a clear opportunity to test the alternatives more formally in the coming months.

Many relationships were tested by the stresses of the pandemic, and some were found wanting. Care Home relationships have, in particular, improved but it is unclear whether they can sustain the changes without greater support and funding.