Capturing learning from Covid-19 Pandemic from the perspective of the primary care team

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Abstract

Objective To understand the changes that have taken place within primary care during the initial phase of the Covid-19 pandemic.

Design Survey and thematic analysis.

Setting Suffolk and adjacent counties.

Methods Email survey using survey monkey and semi structure conversations with primary care leaders.

Outcome Measures Reflection on care processes, what to stop, what to adopts and what to keep.

Results Changes occurs in weeks that usually take years, through improved collaboration, a reduced burden of regulation as a consequence of a clearly shared goals.

Conclusion Primary care proved able to adapt to the unique challenges associated with Covid 19 very rapidly, with the support of patients and regulatory bodies. Digital platforms enabled remote and asynchronous working, and implementation of demand lead solution to meeting patient's needs.

Strengths and limitations of this study

- Responses were received from a wide range of the primary care team.

- Senior clinical leaders' views were anecdotal, however these individuals shaped innovative services during the early phases of the pandemic, and the opinions expressed were echoed by many of the responses in the survey.
- The access to Healthwatch Suffolk patient feedback, has enabled the patients' voice to be heard.
- The survey was received by respondents possibly suffering from a degree of Covid-19 fatigue, at a time when practices were preparing for the post Covid-19 new ways of working, which may explain the low response rate.
- The survey answers were coded and coded for thematic analysis by one author. There was no rating of reliability for this coding.

Introduction

During the Covid-19 lockdown NHS policy was simplified and primary care was relieved from regulatory burden. Care Quality Commission inspections[1] and GP appraisals were paused[2], with quality payments guaranteed based on past performance[3], and Primary Care Network development slowed, all to enable primary care to focus on delivering Covid-19 related services.

The pandemic meant primary care had an opportunity to be strategic with fewer external constraints. Clinical leaders were able to work collaboratively with the organisations in a permissive "*can do"* environment that enabled rapid adoption of new consulting technology and new ways of working.

We wished to explore how these changes impacted on primary care managers and clinicians as well as the patients they served. We hope this paper may contribute the discussion regarding the future of general practice initiated by Marshall et al[4].

Methods

In order to better understand changes brought about by the pandemic in primary care, Ipswich and East Suffolk Clinical Commissioning Group (IESCCG) ran a survey of all primary care staff in Suffolk (Appendix A). The survey was sent to approximately 1000 health care workers via e-mail in May 2020 and was open for three weeks. 72 responded: 35 GPs, 13

managers, 13 nurses and 11 others, including paramedics, Physician Associates and mental health workers. The survey was accompanied by conversations with 12 primary care leaders in Cambridgeshire, Essex, Norfolk, and Suffolk.

The methodology implemented was thematic synthesis[5] where responses to survey questions were systematically coded and used to generate descriptive and analytical themes. This report provides a thematic analysis of the results; an analytical discussion about what they mean for primary care and a set of recommendations for the primary care sector.

Patient and public involvement

Patients or the public were not involved in the design of this study. Patients views were represented through consultation with Health Watch Suffolk.

Results

The raw data is summarised in Appendix B

System innovations

COVID-19 has resulted in innovative practice across the healthcare system. In all sectors there has been a shift to remote care, facilitated by a range of digital tools. Primary care has seen a proliferation of tools to enable online triage and video consultations which have been rolled out at pace. Not only this, but in response to the pandemic there have been changes to care pathways, job roles, and interdependencies with other sectors.

The desire to reduce routine patient contact led to a critical evaluation of some care pathways. E-prescribing for the Suffolk out of hours service was launched over the course of a weekend, which previously seemed an insurmountable hurdle. In Norfolk improved access to pathology ordering and results (ICE) was hugely valued and occurred through improved trust between organisations.

EConsultation and a reduction in demand, through more patient lead self-care, enabled some practice to operate a demand led service model.

The Suffolk GP Federation in conjunction with the hospices and the East and West CCG developed new clinical pathways for the community management of patients who were at the end of life with Covid-19 symptoms. The plan, which was innovative, based predominantly on transdermal medication and not consistent with usual guidance[6], was well received by clinicians and will be formally evaluated.

A clear common goal helped collaborative working between GP practices, Clinical Commissioning Groups, Suffolk GP Federation, and scaled GP organisations such as North Norfolk Primary Care (NNPC). This organisation instituted care home based Covid-19 testing very early in the pandemic to help protect residents and staff.

Attitudes towards remote consultations

Some practices had been operating an eConsulting model prior to the Covid-19 pandemic whilst others moved very swiftly, in just a few weeks, in order to adopt technology so they could provide a virtual service to patients and enable their own workforce to contribute to this service in a safe and effective fashion.

There was broad endorsement of the rapid change to digital methods among GPs – specifically remote consultation of patients (n=11), triage tools to enable only seeing those that need it (n=9), and the use of solutions to access clinical systems remotely (n=6). Remote consultation as a first option was endorsed by 6 GPs. However, when asked what new practice they would like to stop, eight GPs said they would either like to stop or do fewer remote consultations. Some outlined that these consultations can take more time and that patients should be seen face-to-face unless a patient chooses otherwise, or there is a good reason to the contrary. Four GPs also identified their concerns about patients not accessing healthcare services.

The shift to digital and remote means of working was also a significant feature of positive nurse responses, with six identifying the positive elements of seeing patients for virtual consultations, two benefitting from remote access to clinical systems, and two identifying benefits from attending meetings with other professionals remotely.

However, four nurses identified their concerns about patients not accessing healthcare services, an over-reliance on virtual consultations, and the lack of proactive long-term management that was occurring.

Other clinical staff also noted the advantages of triage to ensure only seeing those patients who needed appointments (n=6). However, the preference for remote consultation was much more mixed in this group, with three identifying that remote consultations were positive and three wishing to do fewer remote consultations. Two staff noted the advantages of digital changes within prescribing and issuing sick notes.

Finally, practice managers were generally in favour of remote consultations (n=8) and a small number noted the positive effects of the ability to triage patients to ensure clinicians only see those in need of a face-to-face appointment (n=2).

Learning points

eConsulting can effectively enable remote delivery of care with risk management for face-to- face contacts when clinically indicated.

Digital forms of consultation are not a panacea across all sections of the population – practices will need to consider who they are not enabling to access services through the promotion of digital first approaches.

Impact on staff roles

The response to the pandemic led to a significant change to job roles for some. While the reduction of paperwork and bureaucratic tasks caused by CQC visits, appraisals and QOF tasks among other things was particularly welcomed by GPs (n=14) and practice managers (n=4), some changes were not so positive. Some GPs (n=6) expressed concern about the delegation of work from secondary care (such as ordering tests for example) while three nurses felt they were being overused as phlebotomists.

However, this period also allowed time for professionals to identify how their roles could be improved in the future. Five GPs identified opportunities to manage long-term conditions differently, with two recognising that increased use of remote consultations may enable practices to offer longer appointments to those who need them.

Four GPs wished to continue with fewer care home and home visits and two proposed that such visits could be done by teams external to a specific GP surgery (an idea also shared by four practice managers). Two GPs specifically identified that they wished to lose specific clinical duties such as fitting IUDs.

Three nurses recognised that they only saw patients that needed to be seen during the pandemic and that there were increased opportunities to promote self-care. Two nurses wished to change what they saw as bureaucratic annual reviews of patients and a further two identified how they had used quieter periods of work to undertake remote CPD modules and to chase patients who were overdue screening or annual review appointments.

Learning points

A reduction in bureaucratic tasks was particularly welcomed.

Staff have identified a number of ways in which their roles could be improved, and this should not be lost when returning to business as usual.

Roles should be reviewed and staff supported, ensure everyone is working to the top of their ability and performing appropriate tasks to make the best use of their skills.

Support for staff working remotely

In terms of coping with the covid-19 pandemic, GPs most frequently identified that the support they received from their immediate colleagues through messaging apps, daily briefings, or remote meetings was helpful. Three GPs reported that they increased their exercise to combat the impact of so much computer working, and four GPs noted helpful support from external professionals (including Suffolk GP Federation, CCGs and volunteers supporting personal protective equipment (PPE) distribution).

Similarly, four nurses, four other clinicians and 8 practice managers reported value from regular virtual team support. The practice manager group also advocated the value of support when shared across all members of the practice team.

Learning points

Virtual team support via a range of mechanisms appears particularly effective in supporting primary care staff to work remotely.

Buildings and infection control

Five GPs wanted to be able to enforce their own interpretation of PPE and infection control guidelines rather than having this externally dictated.

There were mixed views on PPE and infection control amongst nurses, with two nurses identifying that they preferred the increased ability to clean while two noted that PPE rules were detrimental to how they perceived delivering patient care.

Learning points

A review of PPE requirements and how it is applied should be carried out to ensure it is keeping patients and staff safe, without negatively impacting on patient care.

The patient perspective

The patient perspective has primarily been informed by a conversation with Healthwatch Suffolk who have shared the essence of relevant comments received at their feedback centre. Generally, patients have valued having their enquiry triaged quickly and that phone back has reduced the need to visit the surgery. Continuity of care particularly for ongoing episodes of care is highly valued.

Online technologies are perceived to have improved access to health professionals and fitting in with patient lifestyle, and it is hoped by some patients that these perceived improvements will continue.

From the clinician's perspective a willingness on the part of patients to self-care and a clear understanding that the Covid-19 pandemic required the public "*behaving sensibly and not calling 999 and 111 for petty complaints*" reduced demand on the day time and out of hours service. It was a theme across the different staff groups in the primary care survey that patient contacts had varied with now only seeing those that needed to be seen and that there were increased opportunities to promote self-care. However, it is important to also reflect on the impact of those who have required healthcare input but who have avoided

seeking it for the fear of catching Covid-19. A theme in the primary care survey was that many staff groups reported their concerns about patients not seeking healthcare services during the pandemic.

Not all patients are happy to contact surgeries online, which must be remembered. Attendance at surgery for non-Covid-19 issues has been predictably difficult for some patients, and there are those in vulnerable groups such as the homeless, who have experienced even greater difficulties in accessing services.

Healthwatch Suffolk are exploring the effectiveness of e consulting from a patient's perspective and will collaborate with Suffolk Primary Care.

Learning points

Self-care reduced demand

Practices delivered timely virtual consultation appreciated by patients

Some patient groups find eConsultation services difficult to access

Discussion

Main findings

Our survey showed that many professionals moved quickly to adopts online tools and see the benefits of online tools for remote consultations and total triage, and guidance for implementation was published[7]. Not only do remote tools enable social distancing during the COVID-19 context, they can also facilitate the shift to a demand-led service.

A demand-led service model understands what the demand is, recognises that it is consistent and predictable, and ensures that the service provision is designed to match. There is less churn in the system, less distress on the behalf of patients, who have greater confidence knowing that they can access the service they want, when they need it. Prior to the Covid-19 pandemic many practices were moving towards this model of service, combining it with digital platforms such as askmyGP (https://askmygp.uk) or econsult

(https://econsult.net) to enable them to stream demand to appropriate providers of care within their skill mix team.

With total triage, practices can flex their time and focus on the most needy[8] - as long as they have processes to support this - and eConsulting provides a useful way to do this. However, there also needs to be flexibility: whilst many patients do not want face-to-face contact, there can be clinical needs for face-to-face appointment particularly for more complex consultations[9] and groups of the population who are not able or willing to use digital tools to access their healthcare needs. We agree innovations should be co-produced with patients[10] and recognise concerns regarding the efficacy and safety of video consultations have been raised[11].

It is not always clear which technology (SMS, Video or email) is best to fulfil the needs of various consultations. Personal observations from a respondent has highlighted that eConsulting can generate the occasional 'super-user' that likely means there is an unmet need, citing an individual with 29 contacts in a period when most patients had a maximum of 2 or 3 contact.

With regard to the workforce, two key changes occurred during the height of the Covid- 19 pandemic: the workforce was physically separated, and some clinicians had a reduced workload.

Our survey identified that the support staff received from their immediate colleagues through messaging apps, daily briefings, or remote meetings was particularly helpful. The ability to access meetings remotely – both those for support and other professional meetings – was an area of practice that staff wanted to continue.

With some staff having reduced clinical contact they had the time to meet virtually, think, and then act strategically, rather than be reactive as is often the case. This pandemic brought a common objective which enhanced collaborative working, with a willingness to get things done in time frames previously unheard of, prior to the pandemic. These collaborations have crossed boundaries, with beneficial impact, and a sense that these working practices should continue.

Care home staff were supported with teaching in some areas, alongside more regular virtual contact with care homes. There are also examples of where care homes were less well supported. The primary care staff survey highlighted mixed responses about the role of GP surgeries in supporting care homes and home visits moving forward. A theme of responses included having an externally commissioned primary care home visiting service.

Working from home and being able to access clinical systems reduced the need for staff to be physically present in the practice whilst still delivering a good service. There is a varying appetite for this style of working.

The success of flexible, remote working challenges the traditional model of General Practice. Clinicians do not need to be in the same building, and many patients are having their health need met remotely. Whilst this suggests that space can be used more efficiently, social distancing and infection control procedures in the workplace may generate different space issues. Apart from some nursing staff within the staff survey, who welcomed opportunities to increase cleaning, many other staff identified that PPE and infection control processes were too burdensome and were problematic in their clinical practice.

This new way of working for health, and for many businesses, is dependent on effective broadband, still problematic in many parts of East Anglia.

The support provided by team working cannot be underestimated too; the staff survey identified that support from within the practice was a key factor in enabling effective working during the pandemic.

Strengths

We have reached out to a wide range of members of the primary health care team in order to learn how the Covid-19 pandemic has impacted on them, and what their views are regarding working practice in the new-normal. We have been able to hear the patient's voice via Healthwatch Suffolk, and the views of clinical leaders who were directly involved in shaping the primary care response to the pandemic.

Limitations

Our survey was received as a single email, at a time of high work load and possible 'Covid-19 fatigue", which we believe may account for the low response rate. The usual multidisciplinary team meeting, where the study could have been promoted were not taking place due to Covid-19. The survey responses were analysed by one author (SR), similarly the semi structure conversations with primary care leaders were recorded and interpreted by the other author (SVR) and are therefore subject to interpretational bias.

Conclusion

The Covid-19 pandemic unlocked a "can-do" attitude and liberated primary care organisations to be more innovative. Going forward, at every level of decision-making, a positive effort needs to be made to not lose this momentum, to remain agile with bottom-up creativity and lighter touch regulation and bureaucracy. This must combine with an organisational culture that demands productive meetings. There is excitement regarding the positives from the Covid-19 pandemic, evidenced in this study. The new normal is living with Covid-19. Our goal must be to perpetuate the best examples of innovation described. We hope to use evidence gathered from on-going, and proposed survey work with clinicians and patients to evaluate the digital triage and consultation, then provide both clinical and operational guidance on future use. We believe there is a need to collaborate with secondary care to help them evaluate their learning from lockdown, and share primary care learning. Although we may experience a second wave, or ripples, the unmet clinical need across pathways is an enormous future challenge that can be best addressed by closer working. Covid-19 has emphasised the importance of resilience planning for mass casualties and major incidences. The primary care teams who adapted most quickly to Covid-19 did so because of their existing resilience planning. Effective resilience planning may be beyond the scope of individual practices. The collated learnings from our response to Covid-19 may form the basis for a resilience template to be held at a Primary Care Network level. Sadly, it the authors concur with Oliver[12] that all this will be difficult to achieved without addressing the funding and manpower concerns within the NHS.

Footnotes

We wish to acknowledge the contributions of Shelley Hart , Partnerships Programmes Officer, IESCCG, Mark Shenton Professor of Integrated Care, University of Suffolk Chair IESCCG and Andy Jacub CEO Healthwatch Suffolk

Contributors: SVR and SR helped design the survey with IESCCG. SVR developed the semi structures health leader conversations. SVR interpreted these, whilst SR analysed the survey responses. Both author drafted and critically reviewed the manuscript.

Funding: No funding was available, the IESCCG set up and hosted the survey.

Competing interests: SVR is the Chair of Suffolk GP Federation

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Appendix A

Primary care - innovation survey

Your Patients and Your Primary Care Need You 👉

Covid-19 has caused a sea change in how we work as individuals and as practices both individually and collectively. The work with our communities, care homes and patients had to alter to manage the risk to us all. Your ability to organise and adapt, adopt and use technology, manage the ever changing guidance and new ways of doing normal practice has been amazing

Heartwarming stories, practical advice shared rapidly, pragmatic change with a “can do”, “thinking differently” team approach have been clearly demonstrated, but, what matters most to you?

What do you want to share?

What did you hate that is now changed or stopped?

What would you want to see more of or less of?

Thank you for your time, we know how valuable it is.

1. Please tell us who you are (* required)

   ☑ Receptionist/Care Navigator/Admin Team member
   ☑ Nurse
   ☑ GP in practice salaried, locum, partner
   ☑ GP in Suffolk Federation
   ☑ Dispenser
   ☑ Manager
   ☑ Paramedic/Physician Associate/Mental Health worker/Physio
   ☑ Other (please specify)

2. What two things do you want to see continue?

   Enter your answer

3. What two things do you want to stop doing?

Enter your answer

4. What two things would you like to start doing differently now?

Enter your answer

5. What else have you done to help you cope that others would benefit from?

Enter your answer

Appendix B

72 professionals completed the survey. Of these, 35 identified as being a general practitioner, 13 as a practice manager, 13 as a nurse practitioner, and 11 were from other clinical staff groups including physiotherapy, HCA, paramedic, and physician associate.

General practitioner themes (n=35)

In terms of coping with the covid-19 pandemic, most GPs identified that the support they received from their immediate colleagues through messaging apps, daily briefings, or remote meetings was most helpful. 3 GPs identified that they increased their exercise to combat the impact of so much computer working, and 4 GPs identified helpful support from external professionals (including Suffolk Fed, CCG, volunteers supporting PPE distribution).

There was broad endorsement of the rapid change to digital methods – specifically remote consultation of patients (11), triage tools to enable only seeing those that need it (9), and the use of solutions to access clinical systems remotely (6). Remote consultation as a first option was endorsed by 6 GPs with only 2 responses relating to the issues of having so much

remote consultation. 4 GPs identified that they wished to see improved interoperability between primary care and secondary care.

There was broad endorsement (14) of the reduction of paperwork and enforced bureaucracy that had occurred during the pandemic (examples included CQC visits, appraisals, QoF tasks). 5 GPs identified with a wish to be able to enforce their own interpretation of PPE and infection control guidelines rather than having this externally dictated.

There was reflection on work duties with 4 wishing to continue with fewer care home and home visits and 2 proposing that such visits could be done by teams external to a specific GP surgery. 2 GPs specifically identified that they wished to lose specific clinical duties such as fitting IUDs. There was a significant theme about the wish to stop the delegation of perceived secondary care tasks (6).

GPs in this survey identified their wish to utilise opportunities to now manage LTCs moving forward differently (5), seeing that the increased use of remote consultation would offer opportunities to offer longer appointments to those who need it (2).

4 GPs identified their concerns about patients not accessing healthcare services.

Nursing staff themes (n=13)

Again the shift to digital and remote means of working was a significant feature of nurse responses, with 6 identifying the positive elements of seeing patients for virtual consultations, 2 benefitting from remote access to clinical systems, and 2 identifying benefits from attending meetings with other professionals remotely.

There was reflection on changes in work duties, with 3 identifying that they felt overused to as a phlebotomist and 2 reflecting on the wish to change what they saw as bureaucratic annual reviews of patients. 3 recognised that the patient contacts had varied with now only seeing those that needed to be seen and that there were increased opportunities to promote self-care. 2 nursing staff had identified how they had used quieter periods of work to undertake remote CPD modules and to chase patients who were overdue screening or annual review appointments.

There were mixed views on PPE and infection control with 2 nurses identifying that they preferred the increased ability to clean with 2 identifying that PPE rules were detrimental to how they perceived delivering patient care.

4 nurses identified their concerns about patients not accessing healthcare services, an over-reliance on virtual consultations, and the lack of proactive long-term management that was occurring. 4 staff identified that like the GP group they had perceived benefit from the virtual support they had received from colleagues.

Other clinical staff themes (n=11)

A key theme of responses within this collective group of staff was the advantages of triage to ensure only seeing those patients who needed appointments (6). The preference for remote consultation was much more mixed in this group, recognising low numbers with 3 identifying that remote consultations were positive and 3 wishing to do fewer remote consultations. 2 staff noted the advantages of digital changes within prescribing and issuing sick notes.

4 staff identified value from regular virtual team support. This was not a staff group that reported their concerns about patients not seeking healthcare services during the pandemic.

Practice Manager themes (n=13)

5 practice managers identified the benefit of being able to remotely access clinical systems and the ability to remotely meet with other professionals (5). The easing of paperwork and perceived bureaucracy was also a feature in this group (4). The respondents were in favour of remote consultations (8) and an ability to triage so that staff only saw those that needed it (2). 4 staff wanted an external service to undertake care home and home visits.

8 staff identified value from regular virtual team support, and this was a staff group that advocated the value of support when shared across all members of the practice team.