University of BRISTOL

Centre for Academic Primary Care

RAPCI Project Summary Report 1

5 June 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 first summary report presents qualitative findings from 22 interviews held with GPs and managers from 14 GP practices between 13 and 17 May 2020.

Key findings

Demand: The period from late March 2020 to mid-May 2020 was characterised by a drop in patient demand. Practices used the available time to reorganise services and implement social distancing:

> ***The drop-off in demand gave the practice time to plan and consider how to manage the changes. (GP)***

Innovation: Practices rapidly implemented innovations in this period, which included:

- Moving to a system of total telephone triage, closing online booking (some practices), operating a single GP list to better manage patients on the same day where possible (some practices).
- Patients emailing photos for static problems and using video calls for dynamic problems.
- For necessary face-to-face (F2F) appointments, reconfiguring working spaces to make them safe, including use of 'hot' and 'cold' areas, and spaces for shielded patients. Blood tests and consultations in car parks, or through patient car windows. Detail of arrangements varied across practices.

> ***We have turned on its head the way we are seeing patients. Every aspect of our consulting is different. (GP)***

Challenges: Key challenges faced in this period included navigating the sheer amount of information and guidance, implementing remote working, keeping staff and patients safe, managing shielded patients and patient communications. Some GPs also found the clinical uncertainty of remote consultations challenging and the relentlessness of telephone triage tiring. Practices have dealt with the challenges in different ways. These were underpinned by a co-ordinated practice response, e.g. creation of small teams to interpret guidance and lead the practice response and holding regular practice meetings.

Coping: Practices felt they had risen to meet challenges and were coping well at an average level of 8 to 9 out of 10.

> ***Change has been possible because of tremendous hard work, good will and effort by everybody. (GP)***

> ***As the weeks roll on it's starting to take its toll. (PM)***
>
> ***There's a feeling that a Tsunami is coming. (GP)***

Future: From mid-May practices reported an increase in demand, coinciding with national and local communications efforts to encourage patients to consult. This may be causing an increased level of stress among staff. Practices need guidance on how to restart routine work and manage the new working arrangements (e.g. physical distancing) in the context of increased workload.

Challenges, solutions and guidance needed

The following challenges, innovative solutions and help needed were raised in the interviews:

Challenges faced	Innovative solutions and help still needed
Navigating guidance: Initially many practices found it challenging to keep abreast of the large amounts of guidance received from different sources. But they also sometimes lacked guidance for certain situations, or found it to be contradictory.	**Solutions**: Creation of small teams to interpret guidance and lead the practice response. Having daily practice meetings (and sending updates to all sites) to discuss issues as they arise.
Shifting to remote working: Challenges in adapting to remote consultations, managing risk and clinical uncertainty.	**Solutions**: Peer support and consultation, sharing learning and talk through cases with others.
IT: Some practices have IT infrastructure challenges with remote working (e.g. poor Wi-Fi, no webcams, old/slow computers). In most cases GPs are using their own phones to conduct video calls.	**Solutions**: Some practices provided simple solutions like phone holders so GPs can video call hands free. **Help needed**: Some practices would still like further IT support, including Webcams on desktops and building upgrades to improve Wi-Fi.
Staff: Staff shortages in some smaller practices due to illness and caring responsibilities.	**Help needed**: Some practices were aware of a new local workforce collaboration to provide a bank of reception staff and said this will be welcome.
Managing F2F appointments: Keeping staff and patients safe, separating COVID-19-suspected patients, managing risk thresholds for F2F appointments and admissions.	**Solutions**: Repurposing physical environment separating COVID-19-suspected patients to protect staff and patients. Less experienced staff encouraged to discuss cases with the duty doctor before booking a F2F. **Help needed:** A minority wanted shared hot hubs to manage demand of COVID-19-suspected patients and free up under-utilised GPs in the red zone. In general, there was no appetite for this; most felt it would damage continuity and current volumes did not warrant it.
PPE: Issues around quality PPE, cost and disposal of PPE. Time to dress in PPE, undress, clean up for seeing patients F2F.	**Solutions**: Initial problems with PPE in some practices are felt to have been resolved now through the OneCare system of PPE reporting and provision.
Managing staff safety and well-being: Staff anxiety related to catching the virus at the start of the pandemic was well-managed. New challenges now emerging as staff juggle home-schooling, caring for relatives as demand is increasing. “As the weeks roll on it is taking its toll.”	**Solutions**: Many practices immediately started vulnerable/self-isolating staff home-working or closed a site to patients for reception staff to manage phones. Sharing weekly email for staff wellbeing. Greater inclusion of all staff in decision-making. **Help needed**: More efficient testing by PHE.

Challenges faced	Innovative solutions and help still needed
Managing patient communications: Concern about patients delaying contact with practice, despite need to be seen. Managing patient frustration that routine work is put on hold.	**Solutions**: Communicating with patients via text, signage, social media and local radio to let them know practice is 'open for business'
Managing shielded patients: Workload of managing list of shielded patients. Dealing with queries about shielding from patients not on list. Continual short notice changes to shielding criteria and lack of clarity at the outset on who is responsible (NHS England or GP practice). Deciding when and how to see shielded patients F2F. Concerns over how to manage patient list going forward (phone calls very time-consuming).	**Solutions**: Single staff member (normally social prescriber) proactively contacting shielded patients. Provision of single 'clean' site, specific hours or home visits for shielded patients. **Help needed**: Guidance on how to manage shielded patients as workload increases. (Participants were not keen on using extended hours for shielded patients, as current footfall does not require this, and shielded patients will often not be in favour of early mornings.)
Recovery: Challenge to reintegrate routine work and implement medium and longer-term solutions to booking systems, conducting remote and F2F appointments. How to manage workload if there is a "flood" of patients and referrals due to delayed workload. Managing risks of patients being missed due to large workloads.	**Solutions**: Practices have been planning for reopening services, writing referrals ready to go, using codes to identify deferred referrals. **Help needed**: Guidance on: ▪ Routine referrals. These opened in late May, but some specialities have returned referrals. ▪ Restarting and managing routine work (e.g. diabetic testing, flu jabs) ▪ Information about local incidence.

New consultation models implemented

There is wide variation among practices in the new models they have implemented to book appointments, manage GP lists, consult with patients remotely and face-to-face.

Booking process and list management

- **Booking**: All practices closed the ability for patients to walk in to book an appointment. Patients booked via phone (all practices) or online, via patient access (approximately 50% practices). Although COVID Clinical Assessment Service (CCAS) slots are available, none of these had yet been used. Some practices have same day bookings only, and other have opened booking for up to two weeks ahead (but still have a lot of availability in this time). All practices have a short receptionist triage protocol.
- **GP Lists:** In some practices GPs are retaining their own lists, and the duty doctor is operating two lists, one for COVID-19 and one for other urgent problems. Other practices are operating a single list, with GPs/nurses are picking patients off the list sequentially or (more rarely) dividing the patients up at the start of the day.

Using telephone and video consultations

- **Telephone**: Most consultations are now done by telephone. For problems which require visual assessment but are not dynamic (e.g. a rash) most GPs prefer asking a patient to send a photo via AccuRX or email and scheduling a follow-up telephone consultation or confirmatory text.
- **Video**: All practices are using AccuRX for video calls/sending photos. Consultations are sometimes booked as video but mostly GPs transition from phone to video call mid-consultation, if they decide they need to see the patient (e.g. to assess a sick child, or gait/breathing/movement).

Consulting with patients face to face

Practices have entirely reconfigured their working space to make it safe. This has included creating separate routes through building for different patients, designating specific rooms as isolation rooms, spacing F2F appointments through the day and setting up hot and cold areas within building. Smaller practices tend to find this more challenging because of the relative lack of space and multiple building entry points.

- **Low-risk patients:** Patients are triaged to check red-flag symptoms before coming in. Most practices are asking patients to wait in their cars and the GP brings them in when ready. A few practices are allowing low risk patients in waiting rooms (with spaced out chairs). Car parks are frequently used for blood tests.
- **COVID-suspected patients**: All practices have a "red zone" for COVID-19 patients: either a dedicated room in the building (which is disinfected each time) or a space in the car park (which does not require disinfecting). Patients are taking their own SATs readings from their car where possible. PPE is changed after each patient. A few practices have shared hot rooms with other practices. Some practices have a dedicated COVID-19 "duty team", including a doctor and "helper".
- **Shielded patients**: There is variation in how practices are dealing with F2F appointments for shielded patients. Some practices have specific rooms or have a separate site for shielded patients, others have specific times of day and others have designated staff members. Some practices only see shielded patients at home. Others are bringing shielded patients to the same treatment room as routine patients while taking care to ensure they are distanced.

Follow-up

Because of the extra uncertainty and risk around remote management, GPs have been doing more phone call follow-up. AccuRX Florey surveys are being used by some practices to follow-up suspected COVID-19 patients. A small number of practices are doing remote monitoring of COVID-19 suspected patients with pulse oximeters and blood pressure monitors.

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