The Strategy Unit.

Herefordshire and Worcestershire COVID-19 Response

Primary Care Interviews: Interim Findings

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Contents

1. Executive Summary 1

2. Introduction 3

3. Method 4

4. Findings 5

4.1 Need, Demand and Behaviour 5

4.2 Primary Care Delivery in Response to COVID-19 7

4.3 Working as a Primary Care Network 15

4.4 System Working to Support Primary Care 18

4.5 National Support for the Primary Care Response 21

4.6 Future Ways of Working 24

5. Conclusions 27

6. Appendix A: Analysis 29

7. Appendix B: Topic Guide 30

8. Appendix C: Further Activities 34

1. Executive Summary

As part of a wider evaluation of the COVID-19 system response in Herefordshire and Worcestershire STP, the Strategy Unit conducted an in-depth analysis of 14 interviews that were conducted with primary care leads (13 GPs and 1 Managerial Lead). The findings provide a rich account of the experience of primary care over a six-week period of rapid change, beginning at the end of April.

In this report we discuss the main themes that have emerged in the context of changed demand and the transformation of delivery of primary care in a crisis (see Section 4). We found reduced primary care demand to be a result of public anxiety; and despite system efforts to encourage primary care appointments, there was still a significantly lower than usual number of consultations reported in early June.

As a response to the crisis, primary care had reorganised into Hubs to deliver services based on urgency of need and COVID-19 status. Individual practices had to rapidly adapt to this changed way of working, and they did so willingly and with strong team spirit. This collaborative team working extended to the emerging Primary Care Networks infrastructure, which allowed primary care to be more responsive and resilient.

The GPs described how primary care felt let down by national agencies on all aspects, including safety and guidance. Practices had to resort to personal networks to resource PPE, shielding lists were not fit for purpose and national guidance was late and/or confusing. In contrast, local CCG support was reported to be, in the main, proactive to expected need, responsive to emergent need, and effective.

A collective primary care voice and strengthened primary care leadership has emerged from the crisis, with confidence in assuming responsibility of future services. The GPs requested improved support, from both the centre and their local system, to sustain energy for change, especially in dealing with the healthcare backlog and acuity of need.

The lessons learnt by primary care (captured in Figure 1, using an adapted RSA framework[1] to recommend next steps in learning from the COVID-10 response) echo the recently published British Medical Associations five key principles for GP-led change[2]:

1. Capitalise on the greater autonomy provided to general practice
2. Significant reduction in the level of regulation within the system.
3. Significant reduction in the level of bureaucracy and duplication
4. Increase the level of digital and technological support for practices
5. Empowered as clinical leaders in their communities.

[1] Understanding crisis response measures: collective sense-making. April 2020 RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce)
[2] Trust GPs to lead: learning from the response to COVID-19 within general practice in England June 2020 BMA

Figure 1: Recommendations for restoration phase in primary care, synthesised from interviewee accounts.

Table template adapted from Understanding Crisis Response Measures, developed by the RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce) as previously used in our rapid reporting

2. Introduction

COVID-19 has bought about profound changes to the health and care system. As rates of infection began to increase, there was anticipation of unparalleled demand on primary and secondary care. Healthcare systems responded, in line with national guidance and local contexts, by implementing a range of innovations to achieve transformational system change.

It was understood that many of these changes would accelerate longer-term national and regional ambition yet bring potential risks to existing and planned/forming structures; and with potentially negative consequences for some groups of patients.

The Strategy Unit agreed a programme of work with Herefordshire and Worcestershire STP to support an evaluation of the system's response. The aim of the qualitative strand of the evaluation was to capture the dynamic experience of healthcare staff, as they responded to the crisis. Beginning with GPs (the focus of this report), and extending to other staff including mental health practitioners, cancer specialists, care home managers, system leaders and members of the public, this strand of work seeks to capture evidence of what has changed and how, as well as what lessons have been learnt. An objective assessment of the different stakeholder perspectives is expected to lead to more informed planning for exiting from the COVID-19 response and sustaining effective change in a new business as usual. In conducting the evaluation in a timely way, the Strategy Unit has trained commissioning and service leads to gather qualitative data, providing guidance and support and supplementing this with independent analysis. The involvement of commissioning staff in the evaluation also results in rapid actions to support effective change, once identified through the interviewing process and supported through rapid-cycle learning (see section 3), rather than waiting for the full analytical and reporting phases (including this report).

This report synthesises the evidence collected to date in primary care, mapped to the following key lines of enquiry:

- What has happened – what has worked well and less well?
- What is going to happen – what are the implications with respect to the backlog of patients, to ways of working?
- What needs to be in place to sustain effective change?

3. Method

Interviewees in a leadership position in Herefordshire and Worcestershire Primary Care were identified by the CCG and invited to participate in the research. In total, 14 primary care interviews were conducted; 13 were GPs (most of whom were also Clinical Directors of Primary Care Networks (PCNs)) and one interviewee was a non-clinical lead of a Federation. Interviews were conducted by phone or video by three senior commissioners at Herefordshire and Worcestershire CCGs, following interview training by the Strategy Unit. Interviews were semi-structured; the topic guide was co-designed by the Strategy Unit and the CCG (see Appendix A) and was structured to explore participants' perspectives of changes in service delivery in primary care in response to COVID-19; and, key lessons to inform recovery and future planning.

Interviews spanned a six-week period in April-June 2020 (Table 1). Interviewees were asked for consent for recording and audio files were transcribed. Interviewers also took notes which were shared with the Strategy Unit for rapid reporting processes in regular reflective workshops during the data collection process. These workshops provided space for reflection on the practice of the interviews – for instance, the function of the topic guide and process of note taking – and emergent findings. Three rapid-cycle reports were produced from these notes and workshops[3]. Through the rapid reporting we developed a coding framework for qualitative analysis of the transcribed data, which was conducted using specialist NVivo 12 software and is reported here (see Appendix A for more detail of on the analytical process). In the discussion of findings (section 4), we provide a narrative account of the thematic analysis; direct quotes are italicised.

Table 1: Interviewee number and date of interview.

Interviewee	Date of Interview
PC1	27/04/2020
PC2	27/04/2020
PC3	28/04/2020
PC4	05/05/2020
PC5	07/05/2020
PC6	06/05/2020
PC7	04/05/2020
PC8	07/05/2020
PC9	01/05/2020
PC10	27/05/2020
PC11	21/05/2020
PC12	05/06/2020
PC13	05/06/2020
PC14	05/06/2020

[3] Rapid reports were previously shared in May (dated 02/05/2020, 10/05/2020 and 28/05/20).

4. Findings

4.1 Need, Demand and Behaviour

The analytical process identified an overarching theme relating to the delivery of patient-centred care. Within this, three further sub-themes were identified. These are expanded in the sub-sections below but can be summarised as follows:

- An initial drop in demand was observed as patients worried about going to their surgery, and making contact with healthcare professionals more generally.
- After a few weeks of lockdown, communications from practices highlighting remote appointments took effect and the number of consultations increased (although they remained below normal).
- GPs were observing an increased acuity of need and a backlog building for healthcare, they were using the capacity available to make plans for longer-term management of demand.

4.1.1 Reduced primary care demand was a result of public anxiety

Demand for general practice services fell dramatically in the first few weeks of lockdown, as one GP described: "*the first few weeks it was as if people had just dropped off the face of the earth*". Even after a few weeks of lockdown, the demand for appointments was said to be less than half of usual. This decrease was perceived to be due to people minimising all healthcare need, whether it was for symptoms of COVID-19, general wellbeing, chronic conditions, or other acute illness. The fall in demand was especially noticeable at smaller practices where patients were well known to practice.

"So I think there's an unmet need – and it's not demand because people aren't demanding an assessment, but I think there's a lot going on that people aren't flagging up their problems." (PC1)

There was some confidence that patients with long term illnesses were able to self-care and manage their usual symptoms. However, there were also instances of clinical fears being realised as exacerbation of symptoms were confirmed. GPs described patients having to be admitted to hospital because they had waited too long for their symptoms to resolve.

"Just two that have come into my mind from the last fortnight that have ended up being admitted as emergencies, and they admitted to the fact that they didn't want to make contact with anybody because they didn't want to go to hospital. Well actually, they've ended up going to hospital in an emergency because they didn't seek help early enough to get the right treatment to avoid hospital." (PC2)

GPs interviewed at the beginning of the process (i.e. late April), reported that the fear of being in contact with health services was so immense that necessary home visits and cancer treatment in hospital were being refused by patients.

"*Some patients got a definite cancer on their scan and they need to be seen and they need to have treatment, but they're terrified of going near the hospital saying 'no, I really don't want to go. I've read the news and the news says it's everywhere and I might die, so I'm not going to go.*" (PC1)

4.1.2 Demand for primary care support slowly increased over time

GPs interviewed in early May reported that their practices had become more active on social media (e.g. Facebook) after noticing the decline in appointments, to encourage patients to get in touch. In their communication they described the alternative types of consultations and services available during lockdown. This, and more wider system communication did take effect, as there was an observed increase in the numbers of patients making contact with their practice.

Of the patients making contact, most patients were apologetic in tone when doctors felt they had no need to be. However, there were other patients who were more demanding of their right to be seen face-to-face when clinical need did not necessitate it. GPs reflected whether this type of patient behaviour meant that primary care demand would return to pre-COVID-19 levels as soon as lockdown eased.

"*Especially when lockdown ends and people are out and about, they're going to be expecting our services to be back to being able to deal with whatever they want*." (PC7)

Even where clinical risk of delayed referrals and appointments was low, GPs noted that they were providing an increased reassurance function to patients to manage anxieties in the absence of a specialist consultation.

"*I've done a two week wait urology for a man with a raised PSA and he's rung us back to say his appointment is in July. So, now I know that between May and July there's not going to be a significantly increased risk but for a patient who you say 'I think you should have your prostate investigated', that will feel like a long wait to them.*" (PC6)

There were also other COVID-19 reasons for people getting in touch with their practice. Much of the national guidance around social-distancing needed interpreting for individual patient circumstances and there were also requests for shielding letters and certification for being off work.

"*Many have struggled to understand the government's message around, not necessarily shielding, but also just socialisation in general, and around furloughing of staff, and that, coupled with a sort of a mixed information that's come out nationally around how that's to be managed did, certainly initially and still at the moment means that we get a number of enquiries about shielding letters and certification for being off because of being at risk etcetera, etcetera.*"(PC3)

4.1.3 Primary care demand would be affected by system backlog

GPs were very concerned about their patients whose outpatient appointments had been cancelled or who had chosen not to attend appointments for diagnostic tests, both in terms of what it meant for individual patient's health but also in terms of the future burden on healthcare services. There was concern about specific patient cohorts, such as those with serious known/new pathologies (e.g. cancer), those with mental health issues and the elderly in care homes.

There was also additional COVID-19 related increase in demand expected for minor mental health illnesses, some of which was already being observed by mid-May.

"*The big surge is anxieties, a lot of low-level mental health that's been made worse. There's a lot of new low-level mental health that wasn't there before.*" (PC11)

Another concern that GPs had was of the increased acuity of need when managing patients in primary care. For example, GPs were managing abdominal/gall bladder pain by providing antibiotics when referral to hospital for surgical consideration would usually be more appropriate.

"*We're seeing quite a few patients where antibiotics and first line treatments haven't worked. So with that I mean stuff like abdominal pains, UTIs, gall stones. So heart failure's another one that we've started to see a bit more of an increase in because we've tried some first line stuff, it's not really worked and then you think oh, which direction do we go next?*" (PC9)

Interviewees suggested that planning for increased future demand should happen soon whilst there was flexibility, capacity and energy for change, considering both a graded return to business as usual and dependency with secondary care activity (interviews in early June confirmed that a planned process to manage demand had been put into place).

"*Because the demand will increase because all those people who aren't calling will start calling. What we have got to do is find a way of managing that demand, within the flex that we currently have……we are doing that and starting to do that more and more and more and talking about doing that more and more and more. And this has been a huge revolution, absolutely amazing.*" (PC3)

4.2 Primary Care Delivery in Response to COVID-19

The rapid reporting had previously identified that primary care had rapidly reorganised itself to deliver care. In the more in-depth analysis reported in this section, we describe how this reorganisation occurred, summarised as follows:

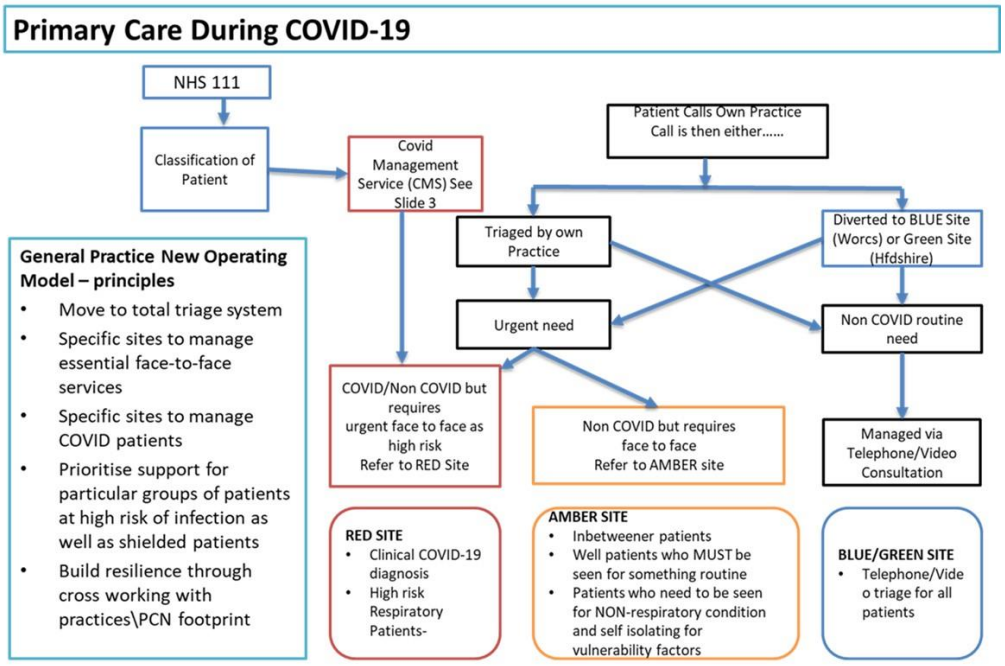
- General Practices had to rapidly plan and deliver a reorganised primary care, changing the types of appointment offered, how they worked and where they worked.

- Staff morale remained high through the crisis due to team spirit and public support, and despite personal health and wellbeing concerns.
- Practices were proactive in different ways in quickly managing their patients and their stuff as clinical risks of COVID.
- With increased pressure on care homes and reduced ability to refer to secondary care primary care carried much of the burden of healthcare need at the time of the crisis.
- The adoption of technology in facilitating primary care delivery was seen as a revolution; GPs cautioned against wholesale use of remote consultations due to the loss of aspects of person-centred care and widening inequalities through digital exclusion.

4.2.1 Primary care reorganised into hubs

Primary care had reorganised themselves, with CCG support, into site working as hubs (see Figure 2). These were classified as: RED for those with clinical COVID-19 diagnosis, or those with high risk; AMBER for non-COVID patients who needed to be seen face to face; and BLUE/GREEN for those who could be managed by a remote consultation.

Figure 2: Primary Care Standard Operating Procedure for COVID-19 March to June 2020



Some practices had already merged or were working in a networked way in anticipation of PCNs. As a result, there was a range of perspectives on how hubs for COVID-19 were working and how hub-working may or may not be accepted in the future.

"I don't think the patients would have accepted it, I mean, thankfully the patients have been on that two year journey with us to realise that they could be seen at other sites and patients had already adapted to that, to have suddenly done that to patients through COVID would have been a tricky journey." (PC10)

It was perceived by GPs that for some patients, especially those living in rural areas and accustomed to having primary care needs met locally, hubs would be less acceptable in the future both with regards to inconvenience of travelling (up to 40 minutes for some) and the impersonal nature of them.

"*We don't have any community transport to get the patients there because there is no bus route, so lots of patients don't want to go. Then when they do get there, they're just very unhappy about it because it's big and impersonal and it's just not what they're used to.*" (PC9)

4.2.2 Practices had to rapidly adapt to change

Practices with large buildings were able to accommodate most of their GPs working on site, in some cases dividing their building up to accommodate different types of patients and PPE type to improve patient flow. Many practices took the approach of rotating staff who worked in the premises with working from home, taking account of preferences where possible; for example, inability to work from home due to young children or having dedicated space to work out of. In contrast, staff who needed to shield or were at risk were encouraged to work from home.

"*I've got three doctors that are BAME and so I've said, because if you ask them 'do you want to start having face to face with patients?', that's not in the ethic of a clinician, nurse or doctor, really, So I made the decision that in [surgery] I see the amber and they do the green*." (PC6)

In the first instance, practices reviewed how to continue delivering the services which had agreement for continuation (such as immunisations, high risk drug monitoring, baby checks) safely. For example, at one practice, GPs worked with pharmacists and dispensaries to implement a process that did not require the physical touching of prescriptions. A few practices found their dispensary teams to be a *'pressure point'* as patients stocked up on their repeat prescriptions in advance and were then supported by the admin team to organise the logistics of dispensing and delivery. They also changed their modes of ordering repeat prescription and collecting medicines.

At another practice, clinicians conducted a medicine review to transfer patients to alternative medications for some conditions so that they didn't need as frequent blood monitoring (for

example, changed medication from Warfarin). At this practice, high risk patients were also identified, and nurses regularly checked in with them by phone.

"Before the shielding, the vulnerable list came out we sat and made a list, based on our QoF registers and patients that we know, patients that live alone, that we thought were particularly vulnerable, social isolation, that sort of thing. And what we did was, we got our nurses phoning them every week or fortnight, because they had capacity. So, they're still doing that now" (PC2)

GPs acknowledged that most primary care nursing tasks could only be delivered face-to-face and as a result, nurses were viewed as the staff group whose daily activities had to change most significantly. One practice described lengthening the duration of face-to-face nursing appointments to allow for the additional time required for PPE/social distancing processes.

"I think the nurses are the interesting group in all of this for primary care work because they're the people that have had to carry on doing the face-to-face work, because you can't do leg dressings, you can't do immunisations and you can't give Zoladex and things over the phone." (PC9)

When conducting the home visits according to Hub designation, the scale of the rural areas to cover could be problematic for GPs, with some travel time taking up to an hour. Where home visits were necessary, both cars and patients' gardens were used as alternatives to the patients' house where possible.

There were also other services which had to be stopped. These fell mainly in the screening and health-checks categories such as smears, aortic aneurysm screening and long-term condition checks. The latter were slowly being re-introduced.

"*The long-term condition care, almost all of it's been postponed at the moment, although we're already starting to reintroduce nurse appointments, nurse telephone and video and GP appointments, so that's filtering back up now naturally*." (PC1)

GPs at RED sites were also conducting tests (such as Troponin and ECG) in primary care that would normally be done in a hospital setting, to judge the severity of COVID-19 and support clinical decision making for hospital admission. There were also practices that had made contact with diabetic patients whose blood sugar levels were in the higher range, to do a remote consultation when the additional risk for COVID-19 with diabetes was identified.

Some practices were also providing support to care homes (sometimes sharing this with other practices), delivering virtual ward rounds and emailing them, performing swabs for COVID-19 testing and responding to concerns raised by care homes about their residents. There were some difficulties acknowledged in delivering this care, these related to the volume of support required for both the calls and writing-up patient notes. As other healthcare professionals who would usually support care homes were unavailable, the bulk of the support had fallen to GPs.

"*The surgery is expected to do a ward round at the hospital, which usually would be at least three hours, and then either back in the building having showered first, or more routinely to go home, shower and then do the rest of their work on the laptop and telephone triage for the rest of the day. And that seems to have worked, although it's quite complicated…I'm not sure it's been as easy for the network to cope with us having that additional responsibility.*" (PC5)

At the same time, some GPs felt that the wider system was insufficiently consulting GPs as the COVID-19 care homes crisis unfolded nationally. There were also the usual GP tasks that had to be conducted even more sensitively, such as bereavement and which required additional time.

"*Well, today's been really busy, so we've had a couple of people who died yesterday, so we're just chasing up the family for bereavement and one of them died in hospital, we don't know if they're COVID so they don't know what they're doing with the body. It's all quite complicated. And there's quite a lot of end of life stuff going on and just in case boxes and respect forms.*" (PC1)

Practices had been able to meet demand by working differently, mainly abetted by the fact that those doctors socially isolating, or shielding were still able to offer remote consultations. In addition, with the drop-in activity there was a reduced reliance of locum GPs.

4.2.3 Morale in General Practices was high despite personal health risks

Many GPs commented on how understanding their staff had been in adapting to the new ways of working, being responsive and flexible in their work, working as teams, and working extra hours when necessary.

"*We've got now a picture of the whole of general practice in terms of what could be offered and the internal sigh of relief I made once I saw the scale of the offer from general practices, amazingly generous offers that people made of what they would be prepared to give, if the worst came to the worst, made me feel much more assured that we would be able to meet whatever challenge came to us.*" (PC10)

Not all practice staff, including GPs had understood prior to lockdown just how much primary care would need to adapt but as the crisis unfolded quickly acclimatised to new ways of working.

"*It was a Saturday and they were cross because they'd been called in – and one of the doctors said 'look, it's just a virus. We've had viruses before' and another doctor said 'I don't read my emails on a Friday because I don't work because I have a life, and so that's why I didn't know'. Now those two doctors are so on board.*" (PC6)

Contributing to the high staff morale was the value the public placed on the NHS, whether it was the weekly clapping or the individual comments from patients.

"*But I think the NHS has become much more valued than it was, and I think people realise actually how lucky they are to have a health service like we have here. And I don't think I speak to a single person, patient, at the moment, who doesn't thank me*." (PC2)

Whilst morale was generally high, GPs and practice staff were anxious about their own risk of exposure to COVID-19 and of infecting their families and children, and took whatever steps they felt they needed to minimise risk, including: sourcing PPE for their own practice (see section 4.5.2 for more details on PPE); keeping face to face contacts low; and reducing availability of services. They still viewed themselves, even as GPs working in RED Hubs, to be safer compared to other healthcare staff.

"*But then I feel more sorry for the social care staff who are dealing with patients on 12 hour shifts. So I may have needed to take blood off someone for 90 seconds, but 90 seconds isn't very much exposure, not compared to the people working in the hospital*." (PC1)

There were mixed views to the alterations to the physical space, especially with regard to decluttering (including posters and magazines in waiting rooms). For some it was something they wanted to keep, to minimise future infections risk, whilst for others it made their working area less personal.

"*All the rooms have been stripped bare. That's, in some respects, a good thing, but being stuck in a room for eight hours, it becomes a much more sterile room because there's nothing that gives it any character, because it's all been taken out*." (PC3)

As the initial response to the crisis passed, interviewees in late May became more concerned about burn-out and the emotional toll on individuals and teams. There was also some apprehension around the immediate future as lockdown eased and what that meant in terms of increased risks, especially because of the lack of adequate PPE.

"I think we're all petrified that everybody's assuming that just because this curve has flattened, when the brakes come off everybody's going to go bonkers and we'll be back in lockdown in very short order." (PC11)

4.2.4 There were different preferences for technology adoption in general practices

GPs were in agreement that COVID-19 was acting as a catalyst for broader change in primary care, especially in the adoption of technology and providing virtual/remote appointments. Primary care clinicians and support staff now had their own laptops and webcams, access to the appropriate software (EMIS and AccuRx) that allowed them to work remotely.

"*So whereas to get laptops rolled out to the whole of [the STP] would have taken…three or four years. Again, it's all come out immediately, along with all the webcams and the various other bits and*

pieces that we have to deploy. It's been nothing short of a revolution and the consequences of which will be felt and continue to be felt for a very long time, because I don't see us going back." (PC3)

The wholesale move to a remote appointment system across general practices, alongside the reduced demand, meant practices were now able to offer same day appointments and often within a few hours. Patients were described to be pleasantly surprised by this quick access to a GP.

"If patients phone on the day they can be dealt with. I have not known in years a time when if a patient phones up they can be, always, whatever the problem, dealt with on the day." (PC3)

Many of the GPs interviewed were of the opinion that a remote consultation was sufficient for the majority of GP appointments, and that most patients including the elderly, had '*embraced*' them. Interviewees described how many patients saw the benefits of remote consultation and were appreciative of the efficiency of the process. A few GPs went as far as to say that for some groups of people a remote consultation would be their preference in the future.

"Younger generation I think are all quite liking getting phoned back and being seen on camera and probably wouldn't want to go back to face-to-face when we do, because they'd rather have us ring them at their convenience." (PC11)

Many GPs inferred the unintended consequence of the crisis in mainstreaming remote/video consultations. There was a majority view that where it was clinically safe to do so, a remote appointment improved patient experience by providing quicker access to a GP.

"It's always been a challenge to think 'how do we get the right expertise to the right patient?', you know, in a way that's convenient to them but ensures good quality of care. And I think these sorts of video consultations will allow that, as long as we can get all the physical stuff done in one go." (PC10)

Other GPs were less enthusiastic about primary care consultations conducted remotely on a routine basis. There was a concern for them about the '*mechanistic*' nature of telephone and video consultations; these GPs missed the personal interactions especially when it came to the poorly patients.

"Seeing patients face to face is quite nice, you know, greeting them, having a quick chat, you know, 'what do you think about the weather?'. When you're doing a video and a telephone consultation, you're probably not going to do that, so you lose a bit of the humanity of it and that's one of the things that actually gives you a bit of relief in the day." (PC6)

Most GPs acknowledged that increased reliance on video consultations would result in inequities in access, for specific patient cohorts, such as the elderly and vulnerable over the longer-term.

"Quite a few patients don't have access to camera phone or internet particularly the elderly patients who are vulnerable and others are digitally illiterate, and we need to make sure we don't forget them". (PC3)

It was clear from GPs interviewed at the beginning of the process that they were on their own rapid learning curves: adjusting to the new forms of consultation and working with the new technologies. Consultations could incorporate relevant follow-up clinical tasks, such as writing prescriptions and reviewing lab reports once the patient facing aspect was over, technology and time permitting. However, there were additional administrative tasks because the technologies being used, and their interface, required improvement.

"*I've done a few this morning and it's been a bit painful really. The videos aren't very good quality and then you need them to send in a picture, so then you send an AccuRx invite and then they send you a picture on that. That doesn't quite save to EMIS, you've got to download that onto your desktop, name it, reattach it to the records and then carry on with your video on your phone. So, it's all a bit clunky but it's not quicker than seeing them face to face.*" (PC1)

Towards the end of the interview process (late May), there was a view emerging that remote consultations could in fact take longer than face-to-face because the consultations were becoming more complex. There were more questions to ask of both the patient and other professionals as the issues were more clinically challenging; and there were safety risks associated with this that could be more problematic for less experienced clinicians including nurse practitioners.

"*The minuses, it's a little bit frightening initially doing telephone triage. You do slightly worry you're going to miss something significant. You need to remind yourself that you very seldom come across something significant in General Practice, and when you do it's normally pretty easy to spot*." (PC11)

The more enthusiastic adopters of technology speculated how different clinics such as baby clinics, family planning, asthma or other long-term conditions could be run differently to encourage patients to self-manage/care.

"*So even for asthma and things you could post out a peak flow meter to people and get them to tell you what their peak flow is to do their asthma review and things…you could watch their inhaler technique over a video and things. So I want to encourage people to think about doing work but in this way that we're doing it now that's safe and more remote.*" (PC9)

Importantly, technology was also facilitating team working within practices. Regular meetings were now held via a video conferencing app (mainly Zoom) and additional video meetings were also arranged so that staff could keep in touch in the absence of the normal day-to-day, face-to-face, interactions.

"It has been very challenging as a team but also very uplifting too. The morale or support from the team just has been amazing, the WhatsApp chats, the videos that everyone's sending, the connections and communication between the whole team has been brilliant I think, but communication's harder because we're not seeing each other…thank goodness for Zoom, but we're just missing out on those day to day conversations." (PC4)

4.3 Working as a Primary Care Network

Our rapid reports previously identified that primary care was making use of PCN infrastructure to respond to the pandemic. In the more in-depth analysis reported in this section, we describe how collaborative ways of working were helpful, summarised as follows:

- Collaborative working across primary care was readily accepted as a way of working during the crisis as staff viewed prior experience of merged practices and Networks positively
- Easily accessible virtual meetings had enhanced both peer support for clinical decision-making and relationship building for future delivery.

4.3.1 Network working accelerated resilience of primary care

GPs as Clinical Directors of PCNs had directed the changes as relevant to their Networks, in some cases liaising closely with practice and Network staff to co-design and implement responses. Some GPs reported that changing the way of working within their own practice as a response to COVID wasn't difficult as their practices were accustomed to working as a team to deliver change. GPs described how previous mergers of practices in their STP and the establishment of their PCN the previous year had provided a foundation for network working in the current crisis. For example, one GP described how their practice had also paid attention to staff experience when unifying five practices: it had put into place a project which allowed all staff to go to the other practices that they were going to merge with to understand how they worked.

"*So no one could have predicted it, but actually pulling networks together the previous year was really good timing. So you can imagine, in certain parts of the country, if practices weren't working together, you'd be trying to work together in the middle of a crisis, with no support*." (PC8)

There were a number of daily meetings set up in primary care in the initial stages of the pandemic to allow Networks to be agile and dynamic in meeting need, involving Clinical Directors, PCN leads and managers, as relevant. GPs found the forum to be easily accessible because they did not need to travel and could join and leave as necessary. They also found then useful because in the presence of their peers they could have their say, listen and clarify any information gaps, make decisions for change and enact them. This included covering clinical duties for one another due to sickness or shielding (and was offered as an explanation as to why the use of locum doctors had fallen).

"*Because you can work, you can bounce ideas off each other and understand things better, it's quite nice hearing other people's perspectives on things and it's allowed better communication…it enables the grass root doctors to understand the policy or where the policy's coming from, whereas before*

you'd have got the email and everybody would have ranted and raved about it and then that doesn't get fed back and it's just everyone remains cross with each other!" (PC4)

There was a consensus that the regular virtual meetings within PCNs, set-up due to COVID-19, had meaningfully enhanced communication within the PCNs and as a consequence there was '*fast-forwarding'* and '*catapulting*' of the relationship building required for PCN working.

Relationships that were fraught before are fine, you know, there's a bit of banter in the chat boxes, you know… I'd been to a couple of meetings before the PCNs took off and it was very, you know, they were tense, they weren't nice" (PC6)

GPs were extremely positive about their experience of working as a PCN especially during the time of COVID-19, describing themselves to be '*lucky*' to work within '*great*' PCN with colleagues that were '*amazing*' and '*cohesive*'. The peer and moral support as well as leadership provided by colleagues was specifically highlighted as having enabled individuals to carry out their roles effectively during the crisis.

"*So people have really stepped up, and I think the more mature your network, probably the more people have been able to step up… but they'd done what I would expect them to do, they've looked after their patients well, they looked after their staff, they responded really, really wel*l." (PC8)

As the need for frequent meetings subsided in early June, later interviewees reported that there were discussions around the meetings, the suggestion being that they could be shortened rather than held less regularly, as practice teams saw the value in the frequent contact with other practices in their PCN.

"We're now having conversations about should we reduce the frequency as work increases in general practice and they are quite reluctant, so they're shortening them, but they like the dynamic nature that's developed around being able to touch base quickly with other practices in their PCN." (PC14)

PCN team working was not limited to GPs; there were examples provided of individuals within practices with expertise in EMIS, staffing, and pharmacy being loaned out or supporting wider PCN working in new ways. The ability to work together as a PCN was described as having improved the resilience of primary care.

"*I want to be quite clear – so there's been sharing for resilience, there's been, you know, people have now within the formal information governance sphere, people have been sharing the ability to work remotely on another surgery's patients if somebody was off sick…We've got access to EMIS across the network, which I think is excellent*" (PC5)

4.3.2 Collaborative working had allowed primary care to be collectively more responsive

For some, working to deliver Hubs with PCN rather than practice-based organisation and infrastructure, had been the bigger change, predicated on the '*biblical effort'* to establish collaborative working in primary care over the previous few years. PCNs had enabled primary care to be '*nimble*' in moving to Hub working, providing an accepted culture for change as a response to the crisis.

"*So the way that we were able to share learning between what was good practice within one PCN and share it in others, how we were able to agree that one site would be the service for the whole county and how we would work collectively in terms of our Urgent Care sites – none of that would have happened without having a structure to unit the PCNs*." (PC10)

Similar to increased communication within individual PCNs, more communication channels across PCNs were established allowing for wider discussions and collaboration, including to share knowledge or expertise. They also provided a forum for less experienced GPs to gain some reassurance in how they were conducting their clinical duties, whilst also providing them with exposure to more experienced GPs and hospital consultants.

Well, certainly in [region] there has been a lot of collaboration and cooperation. Right from the outset I was added to a WhatsApp group which effectively has all the GPs in [region] on it, who are all talking together etcetera, and then suddenly appearing on that group were consultants. So, there was a huge amount of discourse and discussion, and cooperation. (PC3)

A weekly clinical discussion for all of general practice across the STP had also been established, the focus was on a specific clinical area; but it was also used as a 'temperature check' of views and morale.

"*We've had up to 80 odd people coming on the call. And we've sometimes used it for panel discussion for things like care home work. We've used it – we did dermatology yesterday, we've got mental health next week – and part of the discussions have also been about having a 'slido' at the end where we ask them, we temperature check what their views are*". (PC13)

GP leads saw the primary care singular response as PCNs to be a driver for cultural change, allowing the wider system to perceive the true value of primary care. There was acknowledgement that a '*collective voice'* of primary care had emerged, as practices had come together with speed and flexibility, adapting to a '*fantastic*' new delivery model that had future utility and would result in a '*stronger*' primary care.

"So I think for the first time really the rest of the system have been able to view general practice as one system rather than separate practices, you know, we've been able to demonstrate that we can work collectively and, you know, it's not perfect and – no actually – but it's been pretty close to it and

I think people have done a really good job at working in a united way, holding ranks together, learning from each other." (PC10)

4.4 System Working to Support Primary Care

Our rapid reports previously identified the dependency and overlap of primary care delivery with that of the wider system when responding to the pandemic. In the more in-depth analysis reported in this section, we describe the main features of system working, summarised as follows:

- Support from other primary care providers such as Neighbourhood Teams was deemed to be very helpful especially in managing those discharged from hospital due to COVID-19 pressures.
- The CCG support had been most useful in providing IT hardware, training in software use, being an additional pair of admin hands, and for trusting GPs to lead.
- GPs were beginning to think about the redesign of wider healthcare services such as outpatients based on the lessons they had learned.
- The critical role of social prescribers in leading and coordinating community efforts to support demand for non-medical needs was identified.
- System efforts to respond and restore requires representation of primary care leaders at all levels of leadership structures.

4.4.1 The local system supported primary care to deliver an effective response

The barriers to working with system partners described were mainly those of communication and transparency, and to some extent they were being addressed via the emergence of a genuine system-wide response, with providers reported to be working collaboratively together. For example, practices had continued to work with their Neighbourhood Teams to provide support to patients in the community with complex care needs or who had reduced care and support and those that had been discharged from hospital in the early stages of the crisis. The Teams were described to have coped well with the additional capacity they had taken on.

"*We've got a lot of patients who live at home on their own who have had reduced care or support, but the neighbourhood teams have stepped in and fortunately they've had capacity and they've been brilliant and family have stepped in where able.*" (PC4).

The role of the CCG in providing practical support in the initial phases was mentioned by many interviews: through the supply of laptops and other hardware; staff to support administrative duties especially in the smaller practices where staff sickness/isolation was an issue; and also in providing trust, reassurance or moral support in a 'hands-off' way. A few GPs felt that the initial response of

the CCG could have been faster, both with respect to supplying technical hardware or anticipating changes in processes.

"*The most powerful thing [CCG] did was to trust us and instead of, you know, this top down worried approach they could have taken…they took a trusting approach to say 'we need your help, what can you do, we can support you with this, that and the other' – and let us get on with it – and that's been probably one of the most powerful things that anyone could have done. Real stars in being so trusting.*" (PC10)

There was a regional variation in the visibility of the GP Provider Board, for some they were a key player in the post COVID-19 system response, but other GPs described not being sighted on their activities.

"*I think the GP Provider Board, in my opinion, has definitely got a role and I think for me it's the strategy element that sits across the STP for those areas where we need to collectively work on something that's common. I think where the GP Provider Board has fallen down in [Area] is in the operationalisation of what we need it to do.*" (PC9)

Many GPs had started to think ahead to the future to embed what had been learnt so far in primary care across the system, such as the breakdown of services into for example, elective care, urgent care and voluntary care was helpful as they were so interlinked. A number of GPs queried the future of outpatient appointments, as they saw outpatients as a community service rather than an acute one.

"*We've seen some changes in the collaboration between primary community and acute care and mental health and those changes for patients need to stick for the future, i.e., it's not just us using videos but two week waits are being done now by video consultation, so I don't want to miss any of the changes across the system. It's not just about what GPs do, it's about how we work with other bits of the system.*" (PC5)

4.4.2 The community engagement was unprecedented

A social prescribing system was already established in the region, however in the initial phases of COVID-19 there had been limited resource available to meet demand. This had resulted in some discussion with integrated care partners with respect to tasks prioritisation based on their employer (PCN) needs.

Social prescribers had called all shielded and non-shielded vulnerable patients to understand their social distancing/isolation needs, for example in getting groceries. Social prescribers were recognised to have gone '*above and beyond*' in the service they had provided.

"When we've had a bit of a particular pickle with people, when we had a patient who needed chemotherapy, to be collected from [place], and our Social Prescriber went and did it. And this woman ended up being able to have her chemotherapy." (PC2)

When capacity issues emerged, they looked to NHS Volunteers for support. The local response to volunteering was described to be *'amazing'*, with individuals, local authority and businesses providing either their time or their expertise.

"*The support that's been offered by the council in terms of the [council led COVID-19 volunteer scheme] in particular and, you know, support with shielded patients again has just been phenomenal and, again, was mobilised really quickly."* (PC14)

For some, the crisis had highlighted the critical role of social prescribers in meeting the less medical aspects of primary care need in the future. They were perceived as being drivers of integration in their ability to work across local authorities' services and local support networks.

"The role of the social prescriber will I think become even more important…. that will be I think an amazing prize that comes out of all that we've all lived through for the last few months." (PC5)

4.4.3 Primary care leadership was stronger as a result of the crisis

Changes in primary care in response to the crisis required senior GP oversight and leadership, especially as the national guidance was late or changing rapidly in the initial stages. GPs interviewed were using their own networks and alternative sources of information to change how they provided services.

"*That morning on the gov.uk site it still said that you couldn't spread it if you were asymptomatic and we had all just read a meta-analysis from King's College saying 'yes you could and you would probably infect three people before you developed symptoms' and so I had already then done a second stage of COVID preparation.*" (PC6)

GPs described the importance of clear communication with staff members, establishing who to turn to for advice and support, in order to manage anxieties of working in a crisis situation. One GP acknowledged that GP leads were probably *'a bit alarmist'* at the beginning, but that this was necessary considering the expectation of how COVID-19 could spread through their population and the ability of local hospitals to cope.

"There are clear lines of communication. And I think at times people have found it quite difficult, but I think with the open-door policy, knowing who to go to, we've managed to sort of get through." (PC8)

The leadership that had emerged in primary care was described to be non-hierarchical and *'compassionate'*. GPs described colleagues having '*stepped up'* and actively involved themselves in

the response, be it within the GP Provider Board, PCN activities or being flexible in delivering clinical care. The Clinical Directors in particular were described to have '*gelled*' together and PCN managers were referred to as being '*impressive*' in what they had been able to achieve.

"*I think everyone who's been involved in it has had to step up and it's been quite incredible to see that response and I've loved to see that people grow and the ownership that they've all had with taking forward some of these things*". (PC13)

There was acknowledgement that leading in a crisis situation was difficult, scary and exhausting. However, there was a sense that as a result, high performing teams had emerged, albeit with internal but challenges, where individuals were able to be autonomous leaders.

"*I feel I've really developed over the last eight weeks. It's been exhausting and I don't think we should be afraid of saying that, you know, the hours we've all worked, the intensity of what we've been doing, the importance of what we've been doing, you know, takes its toll, doesn't it, on individuals and I think sustainability is an issue for us as leaders and we need to reflect on that.*" (PC14)

There was a view emerging that the clinical leadership '*unleashed*' within Primary Care, and from Clinical Directors especially, would challenge existing healthcare leadership structures, including the Local Medical Committee and that they would want to be Executive members of the ICS Board to represent primary care interests and shape the future system.

"*I think the CDs are beginning to feel they want to be part of that conversation. The only question I guess is how big that table needs to be and how many people need to sit around it.*" (PC11)

4.5 National Support for the Primary Care Response

The analytical process identified an overarching theme relating to the national role. Within this, further sub-themes were identified. These are expanded in the sub-sections below but can be summarised as follows:

- Primary care felt let down by national agencies on all aspects of the crisis response, including safety, guidance, shielding and testing
- Practices had to resort to personal networks to resource PPE; GPs were innovative and considerate of other professionals to improve collective safety.
- National shielding lists were deemed to not be fit for purpose; local measures to identify and support those at risk were used instead.

4.5.1 National handling of the crisis was deemed to be poor

GPs were highly critical of the Government's handling of the pandemic in general but especially where it related to the availability of PPE, the '*shielding debacle'*, the *'confusing'* and '*conflicting*' national guidance and the '*testing saga'*.

So all the things that have had to have a national sort of involvement, I think have all been really poor." (PC8)

There was some concern that regulation and performance measures would be reinstated too quickly in primary care and detract from what GPs felt to be really valuable; away from delivering safe patient care to meeting targets.

"*I can see exactly why we have QoF, but I hadn't realised how it had felt like I was working to please a master and not working for the health of the patient*." (PC6)

4.5.2 Practices had resorted to personal networks to resource PPE

Most GPs were in agreement that availability of PPE through national mechanisms had been at best *'disappointing'* and at worst a *'nightmare',* with some GPs expressing anger over the *'indefensible'* official line.

"I don't think it's been particularly helpful that the national official line on protection has been peddled by everybody, because as we all know, that's based on A, availability and cost and B, trying to defend decisions that were taken several years ago when it was deemed unnecessary and trying not to sort of pour a smoke screen over that really, which as we know was a flawed judgment." (PC3)

Those GPs that reported no problems with PPE had understood local need quickly and sourced externally. Specific individuals were described to have sourced and then coordinated activities to share PPE across the practice or PCN. One practice was able to access PPE through the National Helpline once the order system had been renewed nationally. However, in all other instances GPs reported practices making use of personal networks to source PPE, often privately and sometimes innovatively.

"*My [relative's] company do lamination, so because they're not doing that sort of thing at the moment they'd made visors and they sent some out to me to trial and sort of feed back. So we had quite a good supply of visors. That was through mates rather than anything else."* (PC2)

Where GPs sourced their own PPE or other safety/supportive equipment (for example, mop heads to clean potentially contaminated areas, portable oxygen concentrators, pulse oximeters) they did out of concern for themselves, their staff and other healthcare professionals they worked with.

"*I took a whole load of goggles from a primary school to [hospice] a few weeks ago, so that their staff could have eye protection*." (PC3)

"*When everyone realised that I'd bought the scrubs, they suddenly realised that it mattered, their safety mattered to me personally*." (PC6)

4.5.3 National shielding lists were not fit for purpose

GPs were vocal that the national approach to producing shielding lists which identified people as high, moderate and low risk for COVID-19 was poor and inaccurate; some went further and called it a *'disaster'*.

"Yeah I think the big disappointments is almost anything that's been organised nationally, so you know, the shielding is useless, the initial shielding was poor at best, inaccurate in lots of ways. And they still seem to be sending out inaccurate information on that." (PC8)

The speed with which practices were requested to return the shielding list for their practices had been especially burdensome and they were concerned where the liability for inaccuracies in the shielding lists fell.

"*We were talking yesterday about where the liability sits, so if you haven't identified somebody as a practice because we've been told not to run searches, but then the national stuff has not picked them up and then they obviously get COVID or die from it, where does that liability and responsibility sit? Does it sit nationally or does it sit with you as a practice*?" (PC9)

The GP view was that primary care clinicians, supported by the wider local system and using primary care data, rather than secondary care would have more accurately assessed individual patient risk. There had been locally-led innovation in this regard with the setting-up of a 'super green' service for shielding patients.

"*I'm not sure that's been done in many parts of the country, but I would suggest that it's probably, you know, the quality of that is, you know, I'm very proud to highlight that, because I think it is spot on in terms of the approach for shielded patients*." (PC13)

4.5.4 National guidance was confusing

The majority of national guidance targeted at primary care had come too late for GPs, who all viewed their own PCN as being '*ahead of the curve*' in having addressed some challenges weeks prior to the guidance being issued.

"We've had to locally sort it out, haven't we, basically amongst ourselves…we've done it despite what's happened nationally and sometimes if it was a good idea they catch us up later on!"(PC12)

GPs acknowledged that the ability to access relevant information at the right time from national sources was helpful where it was possible, but most described being overwhelmed with multiple sources of national guidance, pertaining to both clinical and operational information. This was compounded when local leaders shared other information on social media that was derived from international experience.

"*We've had information overload a lot of the time, you know, something from the RCGP, something from the BMA, something from NHS England and then a load of other groups*." (PC12)

4.6 Future Ways of Working

This section discusses GP views on future primary care delivery, beyond the restoration phase. Figure 1 (and Figure 3) also synthesises the lessons learnt by primary care as recommendations for the future. The sub-sections below describe:

- The role of GP leadership and wider system support in sustaining change for patient benefit
- The positivity around the depth of both service and cultural change achieved could catalyse further transformational change

4.6.1 Primary Care needed wider system support to sustain energy for change

GPs were unanimous in their view that future primary care must be clinically and locally designed, paying attention to local geography and need. They warned against (the re-establishment of) a centrally dictated command and control model with national contractual elements that disempowered the local leadership that had emerged.

"I think if we could allow it to be clinically-led by practice and by PCNs, because everybody's got a slightly different geography and a slightly different make-up, we'd really allow that change to come from the grass roots and build up I think. If we dictate it in a contract, if we don't dictate it down from the system and say 'look, everybody's got to go to this', you just get 'well we can't do that because of this, and we can't do that because of this' and it is those subtle differences in delivery at practice level." PC9

This empowerment of local clinical leadership was recommended as learning for system leaders and commissioners too; interviewees argued that past primary care transformations had failed because sufficient GPs had not been adequately involved in change or hampered by what GPs viewed as bureaucracy.

"*Don't try and hamstring it with process and protocol because that's when things get bogged down and don't get delivered. Yes of course, that famous word "assurance" you know, we need to have a robust assurance mechanism to ensure that what new things that are being delivered are…..this has demonstrated that you can deliver an effective service quickly if you let the right people get on with it, whereas if you bog it down in process and protocol, you fail. And that's part of the reason why a lot of things haven't been delivered well in the past.*" (PC3)

4.6.2 Primary care could assume responsibility for planning future services

Early interviewees (end of April) expected that as a vaccine for COVID-19 would not be available for some time, demand for face-to-face appointments would remain low as some cohorts of patients would remain shielded. They perceived that this period lower of demand would be an ideal time to embed new ways of working in primary care working.

"*So everyone over 70 is still going to be self-isolating in a year's time I would assume and they won't be wanting to go to appointments as much, so I think it's an ideal time to bed it all in*." (PC1)

As the lockdown progressed and GP appointments increased, later interviewees cautioned against resuming services fully too quickly both in case anticipation of a second wave but also to take time to review newly established processes such as booking appointments, triage, types of consultation and referral. They argued it is important to create the space to learn from the current crisis and building in relevant safety assurances.

*"I think we need to have designated time frames and some principles really about what we're going to do…..almost like a traffic light system for what activity needs to restart when and what you can do remotely and what needs to be sort of partially remote and what is urgent work that needs to come back in…I'd like to see us get to the point where we can carry on with QoF and the chronic disease management and things that we need to do, but in a safe and modernised way." (*PC9)

Many GPs also suggested using the momentum for change that had been built to address longstanding general practice issues, such as staffing and support of care homes.

"*And I think if we could now use the impetus of what the … are doing, to make that a reality and actually do some proper transformation, we stand a better chance of bringing everybody out of the hole that we've been in for the last three years both financially and clinically. To me, this is our Vanguard moment*" (PC11)

GPs also reflected that their new experiential knowledge could be built into continuous learning cycles to inform the design of future cost-effective services in primary care. The pandemic had demonstrated to most practices that there were different ways of doing things which were safe, efficient and provided a good experience for staff and patients alike.

"*It's really do you go back to lots of the old things, or do you come up with probably something like a hybrid thing, which is more remote working, more working from home where that's appropriate, but keep the best bits of the old system, which is that continuity of care, that named clinician and that relationship which we've built up*". (PC8)

In assessing future ways of working for primary care, GPs remarked on the significant change that had been achieved, how some aspects would not revert (e.g. Networks) and how they were hopeful of retaining the aspects that had worked well (e.g. virtual meetings).

"*I don't really want to go back to the bean counting and the big governance and having the sort of committees of approval and things. That's been just so refreshing, just to be able to do something because we are in that category for emergency, just to say 'look, we're moving to hubs, we're going to hubs'*" (PC9)

5. Conclusions

This analysis of qualitative data derived from interviews with primary care leads in Herefordshire and Worcestershire (see Section 4) provides an understanding of the changed primary care activity observed nationally[4]. We find the decreased attendance to be a result of public anxiety; which, despite system efforts to encourage, remain significantly lower than usual, even in early June from interviewee accounts. This reduction in activity, as a consequence of altered patient behaviour is not limited to primary care; Strategy Unit analysis of A&E activity during the pandemic[5] demonstrates that the reduction in footfall predates lockdown, suggesting that patient behaviours have also played a role here.

Primary care leads in H&W quickly, proactively and collaboratively reorganised into Hubs to deliver services based on urgency of need and COVID-19 status. Individual practices followed, willingly and rapidly adapting to the changed way of working, with strong team spirit. This collaborative team working was made possible by the developing Primary Care Networks infrastructure; PCNs allowed primary care to bed in joined up ways of working and as a result be more responsive and resilient.

Support from national agencies was a source of disappointment and even anger for the GPs we interviewed. They felt let down on all aspects, including safety and guidance. Practices had to resort to personal networks to resource PPE, shielding lists were not fit for purpose and national guidance was late and/or confusing. In contrast, there was a collective sense of pride in the singular primary care voice that has emerged from the crisis; primary care leaders were emboldened and empowered, ready to assume responsibility of future primary care services in their system.

Local CCG support was reported to be, in the main, proactive to expected need, responsive to emergent need, and effective. GPs requested further support, from both the centre and their local system, to sustain energy for change, especially in dealing with the healthcare backlog and acuity of need. This request and the wider lessons learnt are captured in Figure 3, they echo the principles developed by the BMA for both GP-led change[6] and restoration of wider NHS services[7].

[4] Appointments in General Practice May 2020: Experimental statistics June 2020 NHS Digital
[5] Exploring the fall in A&E visits during the pandemic July 2020 Health Foundation and Strategy Unit
[6] Trust GPs to lead: learning from the response to COVID-19 within general practice in England June 2020 BMA
[7] In the balance: Ten principles for how the NHS should approach restarting 'non-Covid care' June 2020 BMA https://www.bma.org.uk/media/2487/ten-principles.pdf

Figure 3: Recommendations for restoration phase in primary care, synthesised from interviewee accounts mapped to BMA principles of GP-led change[1] and restoration of wider NHS services[2].

Table template adapted from Understanding Crisis Response Measures, developed by the RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce) as previously used in our rapid reporting

6. Appendix A: Analysis

Analysis of qualitative data

An inductive coding approach was used to analyse the interview notes for rapid reporting purposes. This was further developed into a coding framework for in-depth thematic analysis of the transcribed data.

1. Codes 1-8 which relate to the individual organisations involved in the system and the context of the evaluation.

2. Codes A-D which relating to overarching themes of national support, analysis needed, lessons learnt and performance.

In the first phase, two qualitative analysts coded all of the interview transcripts against the deductive coding framework. Summaries of each code were produced, this was followed by the development of a narrative based on the main themes emerging across the summaries. The narrative was reviewed by all members of the Strategy Unit project team.

The analytical process was further supported by regular reflection meetings between the Strategy Unit and the interviewers for the rapid reporting as well as between the analysts for the in-depth reporting.

Ethics and Governance

The evaluation is being conducted to accepted ethical and governance standards, in accordance with the code of conduct outlined in the *UK Framework for Health and Social Care Research* and the highest practical standards of handling patient identifiable information according to the *7 Caldicott principles* and *7 GDPR principles.*

The Strategy Unit works to the following core principles:

- Protect and promote the dignity, rights, safety and wellbeing of participants, patients and staff involved through:
- Attaining informed consent – by fully informing participants with participant information sheets and allowing sufficient time to consider the information and raise any queries about involvement. All participants were free from coercion and given the right to refuse or withdraw participation at any time without explanation.
- Consideration of any disturbance to all participants, patients and staff that may result, by accommodating availability, considering mobility and adopting a sensitive and considerate approach to interviewing.
- Careful consideration of circumstances that may necessitate ethical approval such as involving vulnerable groups or those lacking consent capacity.

7. Appendix B: Topic Guide

INTRODUCTION

Briefly explain purpose of interview

The COVID-19 pandemic has bought about profound changes to the health and care system, with rapid changes in implementing crisis responses in line with guidance.

The purpose of these interviews is to gather primary and community care perspectives on the changes that have been implemented and their future impact.

The interview will take approximately 45-60 minutes.

Confidentiality

- Advise participants that findings will inform both local and national learning
- Ask for consent to record for the purpose of aiding recall. Recordings will only be accessed by the research team and will be stored securely.
- Confirm that any quotes used will not be linked to any individual. No individuals will be identified in the reporting.
- Explain that the interviews are confidential to the research team, unless there is a concern about interviewee or patient safety.
- Explain findings will be shared to support the local and national response and decision making; and provide early learning for NHSEI.

CHANGES IN PRIMARY CARE

Can you briefly describe how the delivery of practice services has changed?

Prompts:

- How was the triage process introduced? How is it working?
- How have your appointment booking processes changed?
- How are practice activities coordinated across the practice team?
- How are consultations carried out (e.g. phone/video?) Will these be sustainable for your practice in the future?
- How have other practice activities been prioritised? Is this due to national or local direction?
- How have referrals changed why?
- Does your practice cover care homes? If so, how are you working with them now and why For Herefordshire and Worcestershire CCG, what technologies are you using? (Do you use video consultation systems {MS Teams or AccuRX})?
- How were these changed initiated and taken forward? (inc. over what time period)

What has been the impact on how you work as a practice team?

Prompts:

- How has your role changed?

- How are wider practice staff working differently? E.g. home working, changes in their roles? (How, if at all, has this differed for different staff groups, what travel time has been saved verses the additional clinical risk of not being able to touch the patient?)
- What has been the impact on general practice workload pressures?
- How, if at all, has/will the staff mix/skill mix in the practice change?
- What, if any, implications has there been on the need for locum cover?
- What training have GPs and staff undertaken to implement new ways of working?
- What, if any, further training needs have been identified?
- How has working differently affected staff morale?
- What changes have there been in how you work as part of the PCN?
- What has been the impact on how you work with other practices? And why?. What technology do you use for communicating with practices (Microsoft Teams, AccuRX etc…)

How has the practices use of resources changed?

Prompts:

- What additional resources for delivering primary care services have been made available to you (e.g. Online and Video Consultation systems, digital equipment, technical support, communication support)?
- Has PPE to carry out front-line care been made available to you? Is it used?
- How, if at all, has the practice shared resources across primary care and any other sectors?
- How are you recording or assessing any changes implemented?
- How are you investing in any long-term changes (e.g. time or costs)?
- What are the business implications of longer-term investment?
- Any additional technology the practice has reduced to manage workload or patient contact during the pandemic

Anything the practice feels that should have been available and/or supported in order to support different ways of working or supporting patients that would be of help moving forward.

WIDER IMPACT

What has been the impact on patients?

Prompts:

- How has demand for services changed?
    - What changes are you seeing in the types of patients being seen more or less? Why do you think this is?
    - Are you concerned about any particular segment of your population? Why?
    - Are you concerned about any particular condition? Is there a risk of a backlog for any conditions (e.g. cancer) accumulating? What would be the scale of this accumulation?
    - What has been the prevalence of COVID-19 in the practices' population?

- What has/will be the impact on outstanding/delayed elective procedures?
- What has/will be the impact on patient choice?
- What is your understanding of current patient experience/satisfaction with care?
- How is care for patients outside of hospital being supported? E.g. early discharge, redirected care needs
- What unmet needs have you identified? (health and other)
- What has been the impact on patients in care homes and the residents of other institutional settings?

What impact has/will the current situation have on how you work as a system?

Prompts:

- What has/will be the impact on wider practice/community provision of navigator roles, social prescribing, volunteer services etc?
- What has/will be the impact on multi-disciplinary team working: e.g. other GP practices, the PCN, secondary care, community care, pharmacy, and community and voluntary sector (may be different depending on interviewee)
- What have been the additional requirements for information / information sharing? How is information sharing working?
- **For GPs**: How are you working at scale, e.g. with H&W GP provider board, PCNs?

What have been the unintended consequences of the changes?

Prompts:

- What are the existing and foreseeable challenges and risks of the current changes?
- What issues have not been addressed?
- What are you most concerned about at the moment?

SUPPORT AND FUTURE

What support have you received nationally and from the CCG?

Prompts:

- Include: training, resources, technical support?
- What do you need further support with?
- Do you have any concerns about unmet support needs?
- How have local and national changes been communicated?

What lessons do you draw, for general practice/community nursing, from the current way of working?

Prompts:

- What has gone well that you would like to see taken forward?
- What have been the main barriers to change?
- What has enabled helpful changes? What needs to be in place to sustain this?
- What gaps are there in the current primary care response?
- What implications do you think this will have on the demand for particular clinical and non-clinical skillsets?

How do you think future demand for services will change?

Prompts:

- What types of services will be in demand and why?
- When do you think this might happen/under what circumstances?

WRAP-UP AND CLOSE

Any further comments *- Are there any topics to raise that we haven't mentioned?*

Prompts:

- Any other recommendations for improvements

Thank participant for their time and for the front-line work they are doing.

For further information - If you have any questions or comments about the interviews please contact:

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8. Appendix C: Further Activities

As described above, this interim report is an in-depth analysis of interviews conducted with participants in primary care. There is further work that makes up the evaluation activities; these will be completed and reported at the end of September 2020. A brief summary of those activities are provided below.

Interviews

Further interviews are planned or underway currently to gather the perspectives of the public and other staff groups in the health care system. The table below provides an indication of the participant grouping and the numbers of interviews expected.

Interview Group	Status of interviews	Number of interviews (expected)
Community Nursing Leads	Completed	6
Mental Health Services	Completed	10
Cancer Services	End of July	6
Care Home Managers	End of July	6
Secondary Care (Urgent Care)	End of July	4
Social Care	End of July	4
System Strategic Leads	End of July	18
Patient/Public Interviews	End of July	10

Logic model

We worked with STP/ICS staff to co-produce a logic model to capture the theory behind system changes. This outline model captured the changes put in place; and those that are planned. The identified workstreams required their own model and the session equipped the teams to produce these (together or in subgroups). The workstreams are:

- Primary care transformation
- Secondary care transformation
- System working.

The session built capacity for models to be produced independently, although further facilitated workshops for acute and primary care participants are now planned to refine these.

Analytical support

Analysts from the Strategy Unit team will support CCG and system analysts with quantitative modelling of activities, outputs and outcomes from COVID-19 and potential future service configurations.

Triangulation

Across the system there are other pieces of work that can usefully dovetail with this evaluation providing a more comprehensive picture of the COVID-19 response and restoration phases. For instance, Healthwatch and Age UK have both undertaken surveys and interviews with members of the public, the findings of which can further inform our approach to the patient/public interviews and their interpretation. We will consider all findings from all relevant evidence collected by others and shared with us in our final reporting.

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