COVID-19 RESPONSE, RECOVERY & RESTORATION

Welbeck Road Health Centre
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To Note:

- No two practices are the same…
- This is what worked for us…
- New to us all- no one had/has all the answers…
- We've tried our best along the way, but we've learnt and improved…
- We're happy to share that learning…
- And to carry on learning from our own experiences and from others.

Scope

- Practice Overview/Context
- Key Challenges
- Impact
- External Engagement
- Opportunities
- New Ways vs. Old Ways
- Looking to the Future
- Summary

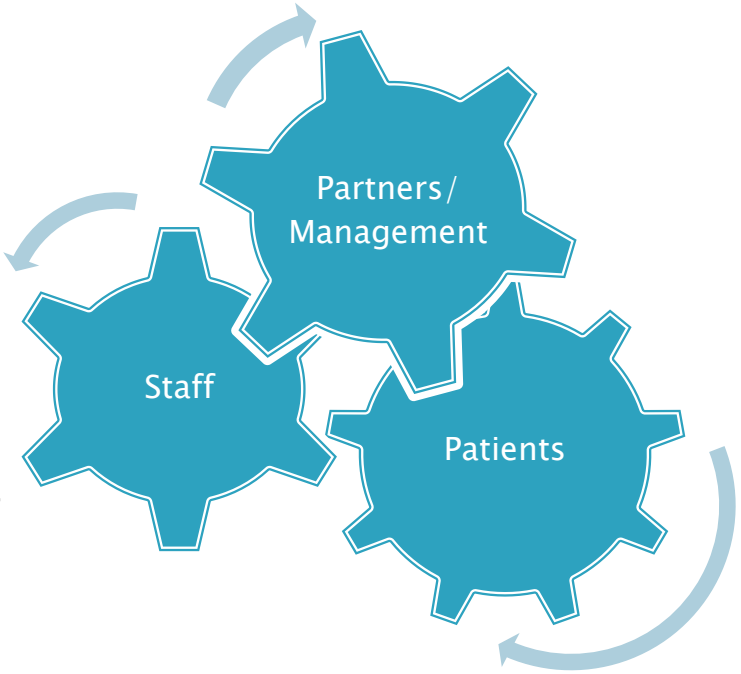
Practice Overview/Context

- Patient list size (11265)
- 43 staff
- 2 sites:
  - Main site at Bolsover (leased building, shared with DCHS)
  - Branch site at Glapwell (owned building)
- Dispensing practice (4114 dispensing patients)
- Training practice

Challenges

We've broken the "challenges" in to three main stakeholder groups:

1. Partners/Management
2. Staff
3. Patients



1. Partners/Management Key Challenges

- How do we protect staff? HR side- risk assessments, reduced staffing, staff shielding and high-risk.
- How do the Partners keep up with all the info/guidance and reduce the risk of burnout?
  - Appointed leads, COVID-19 Clinical Lead and Non-Clinical Lead, Shielding/Safe and Well Lead.
  - Whatsapp groups.
  - Weekly "breakfast club" meetings.
  - Clear areas of responsibility.
- How do we ensure all staff receive timely and pertinent info (without overloading)?
- Whatsapp groups, staff group updates via SystmOne and face-to-face.
- Making information and new guidance seem manageable and drip-feeding in bitesize chunks (can be overwhelming).

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Challenges

1. Partners/Management Key Challenges

- Establishing new ways of working with clear protocols to support the changes (ensuring clarity and safety at all times)- incident response, decontamination, green patient protocols, red patient protocols (purple patient protocols, i.e. car park patients).
- Contingency planning for staff needing to self-isolate i.e. remote working. Laptop pooling and set-up for all clinicians.
- How do we maximise resources such as limited phone lines (overnight went to 100% telephone triage)?
- Re-configuring the building, inc. flooring, car parks and utilising rooms differently. Working collaboratively with DCHS , enabling us to temporarily utilise some of their space.
- Building set-up to ensure “red area” completely separate from “green area” and away from dispensary.
- How we manage normal workload vs. COVID- how we maintain access for patients and ensure we protect them?
- How do we increase/improve patient access- Footfall, Accurx, photographs, text use, video consultations.
- Being aware of postponing “routine” things for staff… the need to deal with the backlog (e.g. mandatory training for staff)
- Financial impact of COVID-19 and cash flow for the practice (being VAT registered resulted in a delay in CCG reimbursements).
- External sourcing of PPE
- Keeping our morale up (partners, management and staff). Open door policy, listening to staff, implementing changes and fuelling everyone with cake!
- Communicate, communicate, communicate.

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Challenges

2. Staff

- Wellbeing and morale.
- Balance of quantity/format/frequency of communication from the partners and management.
- Additional stress/pressure for staff affected by COVID-19 in their personal lives e.g. family health, family job security, general concern over pandemic.
- Increased pastoral role of management, open door policy and increased access outside of working hours.
- Staff Whatsapp groups and regular update notifications on SystmOne.
- Adapting to new roles and rotas (e.g. staff on door taking temperatures, green PPE doctor, red PPE doctor).
- Recognising that all staff are different in their approach to change and have differing levels of comfort with risk. The challenge in recognising those differences, responding to them individually yet still operating as a team.
- Overall increased levels of uncertainty and anxiety.
- Risk-assessing all staff (health conditions, BAME etc.)
- Responding to staff with varying levels of skill/ability/comfort with technology.
- Having plenty of opportunity to ask questions and be listened to- additional forums for communication (e.g. weekly clinical meetings).
- Managing staffing shortages (shielding staff, staff in reduced roles etc.)
- Management of staff expectations- annual leave, bank holiday working.
- As a training practice managing our trainees- additional change and uncertainty, exam delivery, tutorial delivery , extended rotations etc.

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Challenges

3. Patients

- Managing their concerns, queries. Answering questions without any additional guidance than what they've already received from the government/media.
- Timely communication- continuous updates of phone message, signs, texts and the website.
- Clear, consistent messages to all patients (scripts/guides given to all reception staff to ensure consistency and minimal ambiguity).
- Helping patients through education and understanding.
- Worry/demand from patients for prescriptions – initial surge in activity.
- Management of dispensary stock shortages due to suppliers limitations.
- Management of how people could access their scripts/medications – including those not eligible for support as not shielded.
- Managing the need to see red and green patients (and separate shielding patients) and the realisation that our population would struggle to utilise a hub-model due to worsening of local public transport provision (due to COVID-19 and deprived area).
- Ensuring patient support is in place, e.g. vulnerable pts, delivery of meds for dispensing patients (shielding).
- Encouraging "appropriate" patient contact.
- Suspending of some services… managing patient expectations as a result of these changes.

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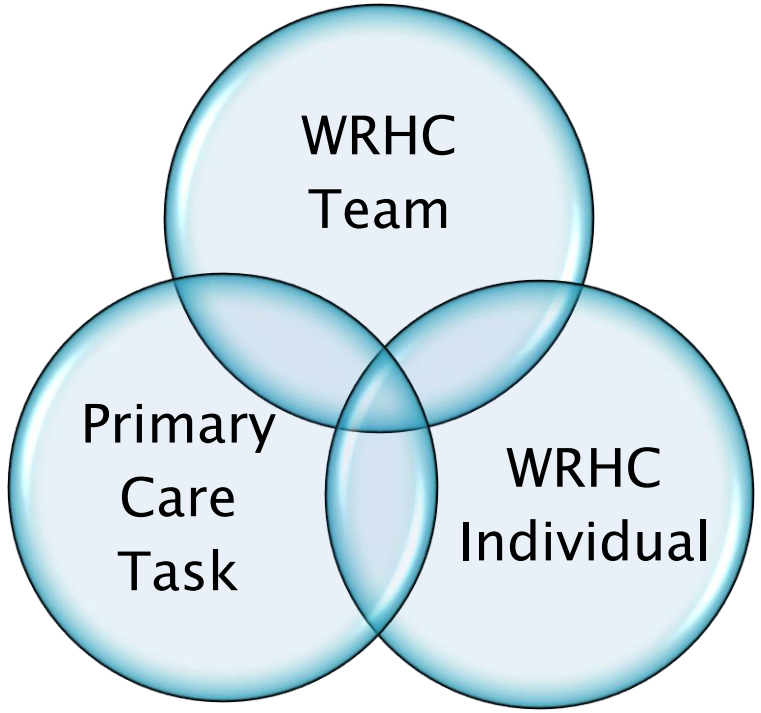
Impact (a few surprises)

- Getting more comfortable with being re-active as opposed to pro-active. Reacting and responding to new guidance, changes in direction.
- Deferring as appropriate… but not for too long… or too much…the need to catch up will arise!
- Patient & clinician satisfaction, clinicians missing face-to-face appointments.
- PPE- shortages, management of stock, multiple new processes of ordering… Even making our own visors.
- Shields for reception desk, vinyl flooring in our "red corridor", investment in equipment etc.
- Realising how much can be done remotely.
- How quickly most patients adjust to change (when needed).
- New ways of communicating within the practice- weekly clinical zoom meetings, Whatsapp groups.
- Implementing "how-to" videos (using Accurx, donning PPE etc. shared at a practice level and PCN level).
- Templates for computer, auto-consultations, COVID-19 updates for palliative care template (e.g. link to PDF crem form, palliative prescribing in COVID-19)
- Surprising impact of how the practice has embraced and embedded technology.
- Impact on how we work with secondary care (i.e. would normally refer, but letters bouncing patients back with suggestions, occasionally feeling like a half-way house between primary and secondary care. If pathways change, more work is needed to ensure primary care have the resources to support.
- Overall impact – emotional, risk, learning/training. How we continue to absorb it and recognise it whilst realising there is no "end-date" for the situation. Ensuring what we're doing is sustainable.
- Overall impact- we're coming through it as a stronger team, but it is impacting on everyone in different ways.



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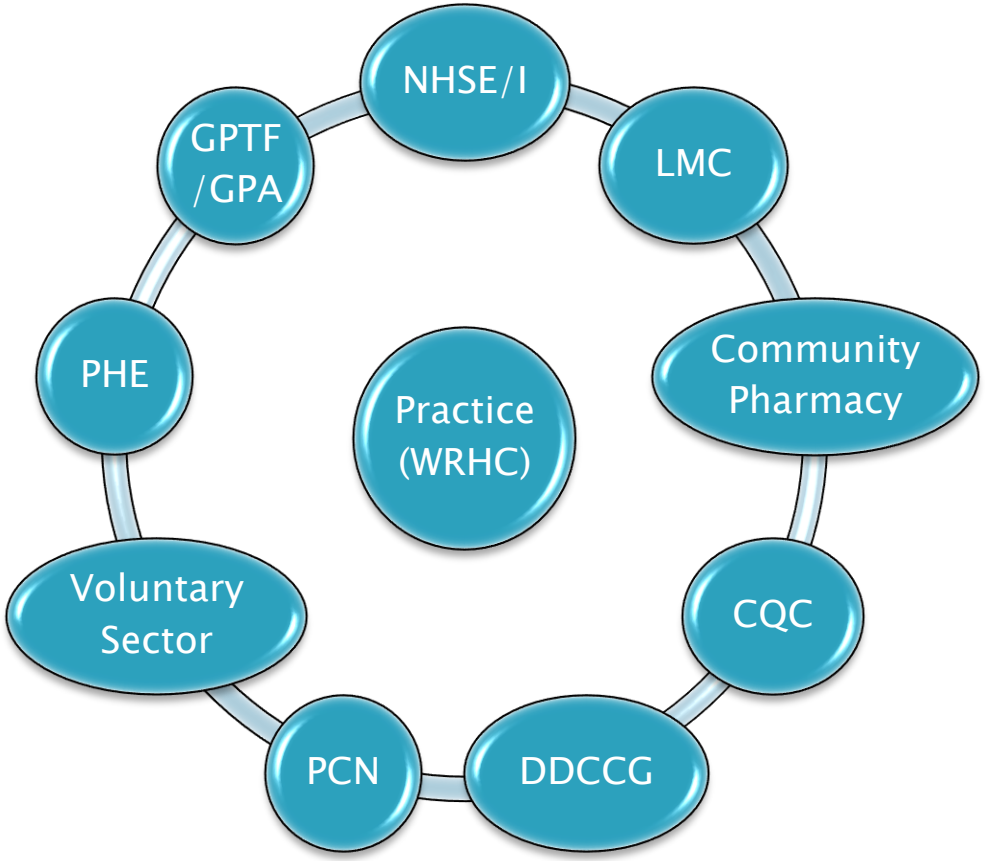
External Engagement



Throughout COVID-19 we found engagement with external bodies/authorities to be imperative in enabling us to remain up-to-date and implement change in a timely manner. Collaboration with other local practices was also essential in helping us during the pandemic.

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External Engagement

PCN

- Whatsapp group (for work matters and morale boosting).
- Weekly PCN teleconferences and regular updates from the Clinical Director (CCG meetings etc.) Standing items on the agenda such as PPE levels, staffing, numbers of red/green patients.
- "SOS" agreement-if a practice in the PCN was struggling (i.e. PPE, staffing) a SOS message would be sent and as a PCN we'd all support.
- Developing red hub models with geographic and demographic challenges.
- Deciding when/if to implement the red hub model… As a PCN, all practices felt that numbers of red patients were manageable at a practice level. As of yet, not moved to a hub model of operating.
- PCN approach allowed local ownership of operating model and collaborative working.
- Social Prescriber/Link Worker- invaluable in conducting "self and well checks" for patients and supporting our vulnerable groups.

CCG

- New scale models of care (i.e. red visiting service).
- Weekly/bi-weekly teleconferences chaired by Dr Chris Clayton.
- MMT support- technicians and pharmacist, helping relieve some pressure off clinicians (e.g. remote medication reviews and ranitidine work.
- NECS IT- support in setting up clinicians remotely (Away From My Desk, BMS tokens etc.)
- Incident Centre- extended hours/weekend support.

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External Engagement Continued…

LMC

- Invaluable support.
- Digestible bulletins with access to updates. Streamlined information and clarity for practices.
- Weekly PM teleconferences.
- Helped cover NHSE, PHE and CCG comms (good sense-check to ensure nothing had been missed).

Community

- Voluntary sector- processes and information that needed clarifying initially. GP practice was often on the receiving end of lots of patient questions. Once we had this clarity- all staff informed of processes and how/what patients could access. Social prescriber was key in this work.
- Bolsover Council/Derbyshire County Council- Community Response Centre (support with dispensing patients if required).
- Local pharmacies- issues for patients with some pharmacies who were using EPS sub-optimally. Knock-on impact led to patients returning to the practice confused/ill-informed. Should pharmacies have received additional support given they were right on the front line?

Opportunities

- Challenging our current ways of working and perceptions (and those of our patients too).
- Opportunity to re-design the service, review current working, moving patients to telephone consultations & on-the-day appointments as much as possible.
- Technology- advancing change at a far faster rate than expected. Truly appreciating the value of technology advancements from experiencing the benefits first hand.
- Accelerated plans to making systems more electronic with a lot more ease.
- Upskilling staff's IT skills.
- Encouraging staff and patients to be flexible and helping them to embrace change. Hopefully this will remain as systems have become more established as time has gone on.
- Care homes -learning to manage more things themselves, contacting remotely or waiting until the weekly virtual ward round. An opportunity to encourage and support this change safely.
- Seeing staff demonstrate their flexibility and commitment to the practice, embracing new ways of working and engaging and contributing towards changes.
- An opportunity to see our "tried and tested" leadership and management of a true crisis.

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New Ways vs. Old Ways

Understanding Crisis-Response Measures Collective Sense-Making			
During Crisis: Started	END	AMPLIFY	⇨ NEW PRACTICE
During Crisis: Stopped	LET GO	RESTART	⇨ OLD PRACTICE
	Stopped	Started	
	POST-CRISIS		

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End

- Closed front door.
- Some change in roles and practices e.g. manned front door so we can gain capacity again

Amplify

- Telephone consulting, use of texts (patients may get info more quickly, fewer letters generated, more immediate). Requirement to balance this with job satisfaction and risk of limited face-to-face contact.
- Use of photographs.
- Challenging/questioning things we've always done to identify and implement improvements for patients and the practice.
- Practice meetings via Zoom/Teams (e.g. clinical meetings and partner meetings) – more accessible and convenient. Easier access for staff. People wanting to access from home.
- Remote communication with patients e.g. through online consultation platform or by text.
- Video appointments.
- Triaged appts.
- Relationship with care home.
- Reduced home visits.

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Let Go

- Amount of home visits – the number of visits truly needed seems much lower. Questionable whether some patients are truly housebound or struggle with public transport/taxi costs. This became apparent naturally as patients didn't want to see us as much because of fear of COVID-19.
- Face to face consultation as the default.
- Old systems e.g. paper post.
- Majority of appts being face-to-face that the patients could book into with little triage.
- Some services that may not be necessary and can be offered in other ways.

Restart

- More of the long-term condition reviews, chronic disease management and more screening.
- Increased patient services.
- Some degree of follow-up appts to allow more continuity.
- Branch surgery- hours to be restored.
- BP machines and scales to be used by patients themselves again.
- Quality improvement projects to be restarted.
- PCN development (additional roles recruitment, Enhanced Health in Care Homes, Structured Medication Reviews, Early Cancer Diagnosis etc.)
- Practice strategy and business development.
- Business as usual returns- IG toolkit, Dispensing Services Quality Scheme etc.

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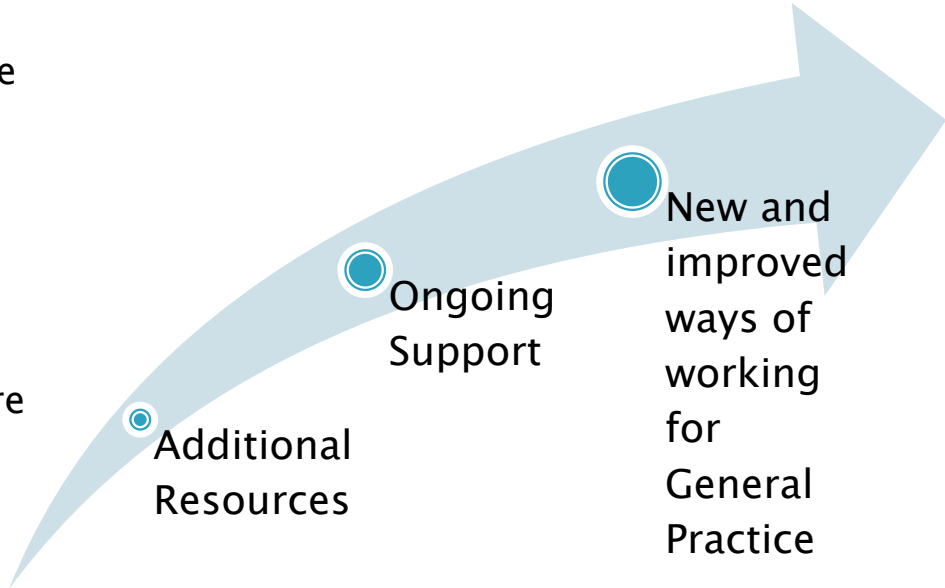
Looking to the Future

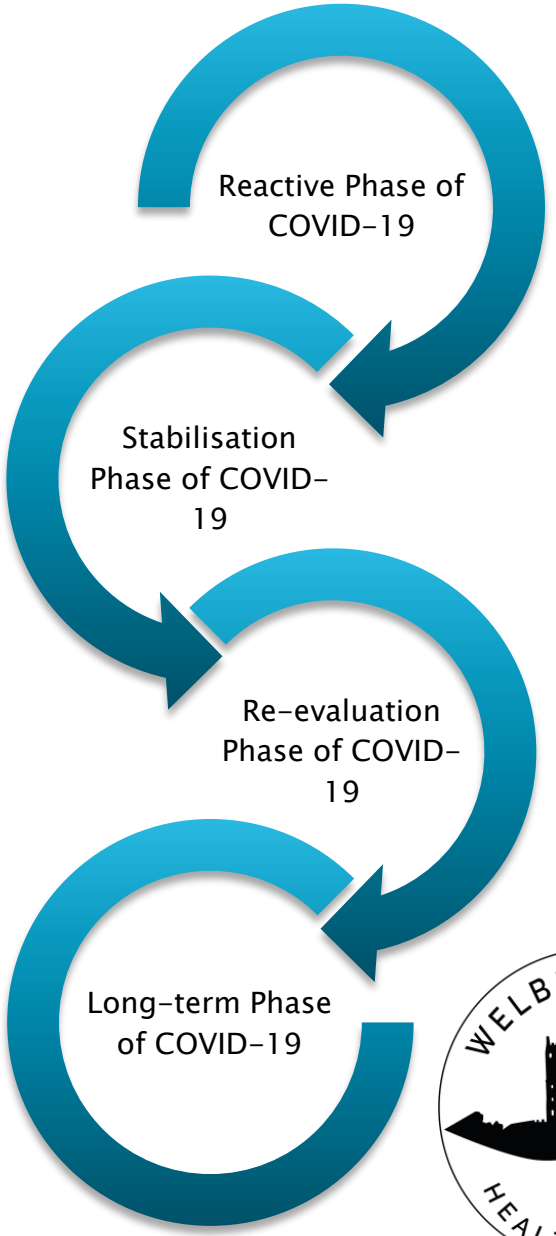
What would help us as a practice when looking towards the future:

- Additional resources to help with the ongoing situation. For us this looks like possible infrastructure changes, IT investments (such as more laptops), online consultation developments etc.
- Support with continuing to develop a remote service and implement new ways of working.
- Working out how to best balance patient demand, the "primary care task" and also job satisfaction for staff (e.g. less full interaction with patients, more time on a phone/PC- missed by some clinicians).
  - Specifics including increasing demand for home visits.
  - Care home requirements.
- Ongoing support (no mistaking that this is far from over). The type of support we need will vary at different stages of recovery/restoration.
- Timely communication and guidance (and agreement/consensus/clarity of guidance).



Summary

- At a practice level COVID-19 has been a real test of teamwork, leadership and effective management of transformational change, whilst continuously trying to keep our patients at the centre of what we do.
- We reacted the best we could to COVID-19. Continuously balancing the patients, the task, the staff, everyone's safety and re-assessing the risk and requirements.
- We're now stabilising (to an extent) and resetting. Focussing on how we continue to meet the needs of COVID-19 whilst delivering "business as usual" in terms of conditions and patient requirements. (Whilst not losing sight of the risk of a second peak!).
- We're anticipating entering the re-evaluation phase, a period where the balance between the management of COVID-19 vs. non-COVID-19 related services begins to top to the latter. (Whilst not losing sight of the risk of a second peak!).
- We're very much looking forward to the "long term phase"- a period when the direct COVID-19 impacts have resolved and services return to "normal" (if there is such a thing!).
- We're sure the challenges are far from over, but we've learnt an incredible amount and it feels as though as a team we're stronger than before.



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Thank You

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