Taking stock:

delivering care home primary care

REFLECTING ON THE RECENT CHANGES TO THE WAY WE DELIVER CARE HOME PRIMARY CARE TO INFORM FUTURE PRACTICE

NHS England-led changes to the way we deliver primary care to our care home residents were due to start in October 2020; however, because of the unexpected COVID-19 pandemic, these changes were accelerated.[1] Changes involved not only structural changes by allocating care homes to particular Primary Care Networks but also an emphasis on virtual home rounds with the use of information technology (IT) and a focus on personalised care.[2]

Haxby Group in York provides primary care to residents in nine care homes. The primary care and care home staff have worked tirelessly to bring the changes, as stipulated in the service specification, to fruition.[3] As more than a year has now passed since the inception of these changes, and as we begin to emerge from the pandemic, we wished to reflect on these changes and draw upon these reflections to inform future care planning.

To capture these reflections, we conducted two anonymous questionnaires. The first was sent to care home managers in our network. We asked them not only to provide reflections on their staff's experience of the changes but also how they felt their residents coped, as an advocate for this patient group. The second questionnaire was sent to our primary care staff, which included the GPs and primary care practitioners (PCPs) who lead on care home care to the nine care homes. The responses were collated to capture the key themes.

CARE HOME STAFF REFLECTIONS

Overall, care home staff reported a positive experience of the changes. Most had embraced learning new skills such as taking physical observations to assist

the clinicians during remote consultations. The reduced footfall in the care homes was felt to be safer from an infection control perspective. Both the staff and their residents appreciated the weekly nature of the virtual rounds, and felt that this not only nurtured continuity and personalised care but also enabled a higher volume of residents to be seen regularly.

The main challenges reported were their frustrations with the internet and IT equipment, which frequently did not work effectively and therefore hindered remote consultations. They also felt that, although most residents embraced the new technology, some struggled because of cognitive impairment and/or sensory difficulties.

There were concerns about the limitations of virtual consultations, in particular the risk of important things being missed because of the lack of face-to-face assessment.

PRIMARY CARE STAFF REFLECTIONS

Our staff reported several positives with the virtual weekly rounds including improved continuity of care as staff had allocated care homes that they looked after, and this therefore enabled good relationships to be established. The virtual rounds were felt to be more time efficient than face-to-face as less time was wasted on travelling and trying to find the patients and their notes. They commented on the lower infection risk by reducing footfall in the homes and also felt that it was safer clinical practice by having the medical records to hand when consulting remotely.

However, some concerns were raised about virtual rounds. The main concern and frustration was the lack of reliable internet and IT infrastructure. There was also some anxiety raised regarding what might be missed by not attending face-to-face, particularly missing subtle signs signalling a safeguarding concern. Some residents were noted to struggle with the new technology and hearing clinicians over video, which made it difficult to conduct conversations, particularly around advanced care planning. It was felt suboptimal in those instances compared with face-to-face interactions.

In terms of future practice, there was a clear appetite among staff for a hybrid

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clinical approach to the way we deliver primary care to our care homes, with a mix of remote and face-to-face interactions. Remote interactions were deemed helpful for meetings with specialists, for example, mental health teams and district nurses, and for sending photos of skin lesions and reviewing patients on non-ward round days where possible. Remote consulting was also felt suitable for simple tasks such as medication changes, liaising with relatives, and reviewing care plans.

It was felt that the GPs working in tandem with the PCPs as a 'yin & yang' relationship in the larger care homes was particularly effective. The GP could deal with the management of long-term conditions, advanced care planning discussions, and medication reviews while the PCP attended to the acute face-to-face assessments as required.

Staff were keen for a multidisciplinary meeting at regular intervals as this was felt to be quite fragmented at present. Ideally, this would be with the inclusion of a pharmacist, nursing team, mental health practitioner, and frailty workers. It was felt that this may reduce specialist referrals and promote personalised care. However, it was highlighted that more time would need to be made available to do this effectively as current demands would not allow this.

This reflective process highlighted the willingness of staff and patients to embrace change at a rapid pace. However, it also highlighted several areas of learning that must be considered when planning future care. In particular, there was the need for robust IT infrastructure to optimise remote consulting if this method of consulting is to stay post-pandemic.

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