GPs at the Deep End

DEEP END REPORT 36

General Practice in the time of Covid-19

12 general practitioners in Deep End practices in Glasgow and Edinburgh report and reflect on their experience of how the Covid-19 pandemic has affected patients and practices. As the pandemic continues and the economic consequences unfold, the report also considers the future implications.

June 2020

Executive Summary : General Practice in the Time of Covid-19

12 general practitioners in Deep End practices in Glasgow and Edinburgh report and reflect on their experience of how the Covid-19 pandemic has affected patients and practices during May 2020, and on the implications for what happens next.

General practice during the pandemic

- General practice adapted rapidly and universally in response to the Covid-19 pandemic, using remote consultations for initial triage and keeping in touch with shielded patients.
- Practice teams proved agile, resilient, enterprising and committed.
- Usual general practice activities have been reduced (routine consultations), some significantly (home visits), while others have stopped (practice nurse triage).
- Remote consulting, by phone or video, works for some types of patients, problems and purposes. The best uses of these technologies need to be established.
- Community link workers have been "invaluable" in contacting vulnerable patients, meeting their needs and making connections with community resources for health.
- PPE supplies were inadequate at the outset. Many practices bought their own. Eventually these problems were resolved.
- Symptomatic staff were frustrated at the delay in getting a Covid-19 test and obtaining the result at the beginning of the outbreak.

Concerns

- The NHS has protected itself by putting much of its work on hold. There are many challenges to come.
- GPs are worried about "missing patients" and the backlog which has built up in chronic disease management, screening, immunisation and cancer referrals.
- Face to face consultations are still essential for many patients with complex problems and for those unable to access or use remote consultations effectively.
- There is concern about vulnerable children and families who have had their support networks withdrawn, including the watchful waiting function of general practice.
- Mental health problems are increasing and impacting directly on general practice capacity, particularly in areas of socio-economic deprivation.
- The economic consequences of the pandemic will impact most on disadvantaged groups, who live in precarious financial circumstances, and will widen the health inequality gap.
- Will the generous support for people experiencing homelessness and those with no recourse to public funds survive the pandemic?
- There are significant concerns for women's mental health and child wellbeing as more women stay at home to look after children, losing their financial security and independence.

What comes next?

- General practice is going to have to be centre stage in addressing the health consequences of the pandemic.
- New challenges will include the clinical backlog, the complications of neglected conditions, new types of health inequity due to remote consulting and an epidemic of financial and psychological distress.

- Continuing and increasing challenges include multimorbidity, health service fragmentation, inequity in health care provision and the workforce crisis in general practice.
- If the generalist clinical function is not strengthened, disease complications and crises will occur earlier, putting pressure on emergency services.
- The balance between specialist and generalist services in the NHS, which for 15 years has been heavily weighted towards the former, needs to be re-set.
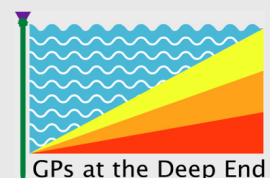
Promoting generalist clinical care

- Generalist care provides unconditional personalised continuity of care, whatever problem or combination of problems a patient has.
- The package of necessary measures includes extended consultations for selected patients, enhanced multidisciplinary teams, embedded co-workers (link workers, social care workers, alcohol nurses, financial advisors etc) and collegiate learning.

Addressing inequity in health and health care

- Unresolved aspects of health care inequity include the toxic combination in very deprived areas of a time-poor service with lower levels of health literacy; for different reasons patients, practitioners and the system settle for sub-optimal care.
- New partnership is needed within Health and Social Care Partnerships (HSCPs) between general practices dealing with the consequences of longevity and practices serving groups with premature mortality and lower healthy life expectancy.
- Provision of Community Link Workers should be increased from 50% to 100% of Deep End general practices.
- The proven benefits of embedding Financial Advisors in general practice should be recognised and funded as part of the new Scottish Social Security system.
- Most of the new mental health morbidity will present in general practice, below thresholds for referral to mental health services. There is an urgent need to expand the model of embedding mental health workers in general practice.
- New metrics are needed to inform, monitor and evaluate policies to improve health equity.

The Covid-19 pandemic has displayed many positive features of general practice: the unconditional approach, adaptability, teamwork, collegiality, passion, caring, commitment. Can the tragedy of Covid-19 be converted into opportunity, collectively addressing inequalities in health and the fragmentation of care?

CONTENTS   **Page**

1. INTRODUCTION

General practitioners working in very deprived areas of Glasgow and Edinburgh were asked to report and reflect on their experience of the Covid-19 pandemic during May 2020 - two months into the period of lockdown and before the lockdown restrictions were relaxed.

The 12 who replied were mostly members of the Deep End steering group. Although a small number and not a representative sample, previous experience of roundtable discussions and reports has shown that discussions involving 7-8 Deep End GPs are sufficient to describe experiences and views which resonate with most Deep End GPs. The report is neither comprehensive nor definitive but may be of interest.

Although the report is based on the experience of GPs working in practices with large numbers of patients living in areas of severe socio-economic deprivation, many of the observations and conclusions are likely to be relevant to general practices serving more socially-mixed populations.

> Nayanika Basu, locum GP, Glasgow
> Jean Beckley, Niddrie Medical Practice, Craigmillar Medical Centre, Edinburgh
> David Blane, Pollokshaws Medical Centre and the University of Glasgow
> Peter Cawston, Drumchapel Health Centre
> Gillian Dames, Parkhead Health Centre
> Maria Duffy, Pollok Health Centre
> John Montgomery, Govan Health Centre
> Anne Mullin, Govan Health Centre
> Helen Richardson, salaried GP, Parkhead Health Centre
> Petra Sambale, Possilpark Health Centre
> Emma Sheppard, Easterhouse Health Centre
> Andrea Williamson, Homeless Health Services Glasgow and the University of Glasgow

Contributions were received from :-

Their contributions have been merged in a single, mostly unattributed report, in seven sections and two appendices. Text in italics is based on individual comments and does not necessarily represent the experience and views of the group. The report was compiled and edited by Professor Graham Watt with input from David Blane and Anne Mullin.

2. GENERAL PRACTICE EXPERIENCE OF THE COVID-19 PANDEMIC

> *Our practice was transformed from being an open practice in an urban inner city health centre, with a large daily footfall in GP surgeries and associated clinics, to an empty health centre with closed doors and multiple Covid-19 notices informing patients that, while general practice is still functioning, they would need to phone us first to discuss their request.*

Two parallel but connected patient pathways were established for patients with non-Covid-19 and Covid-19 symptoms in the community. Non-Covid patients are managed in general practice. The first point of contact is their practice or Out-of-Hours (OOH) centre. GPs will see patients at the surgery or OOH centre after triaging the patient by phone, but try to manage most problems remotely. Patients are referred as normal to outpatient clinics with the caveat that wait times are longer, while some services have stopped accepting referrals altogether during the pandemic. Same day and urgent referrals are made for cases requiring early specialist attention. Elderly and housebound patients may still be visited at home, provided they do not have Covid-19 symptoms, but house visits are at a minimum level. Babies are seen for 6 week checks.

> *It's the first time that I have worn PPE and been challenged to make a baby smile whilst wearing a face mask.*

Patients with Covid symptoms are managed via a dedicated pathway and may be advised to self-manage, directed to a community Covid Hub for clinical assessment, visited at home or directed to hospital if they have severe symptoms. The system allows patients who require medical examination and treatment, but not necessarily hospital admission, to remain in the community and to recover in their own homes.

In the 2009 Swine Flu pandemic, general practices did not restrict access but, working closely with public health colleagues, constantly tested patients attending surgeries. Practices had access to adequate PPE early on and spent a lot of time rescheduling surgery appointments and triaging patient requests. Potentially infected patients attended the practice at a certain time and were isolated in a separate room.

The potentially greater mortality and morbidity from Covid-19 meant that protecting patients and staff has been vital – thus the need for two parallel systems.

> *Looking back to the beginning of the Covid-19 pandemic, and remembering the daily mortality rates in Italy, it seems strange that alarm bells were not ringing at the highest levels of government. Public Health pandemic flu experts did not seem to have the prominent role that they had in the 2009 pandemic.*

A practice provided information from an audit they had carried out, comparing their work in the 4 weeks from lockdown on 23rd March with the same period a year earlier. The audit showed :-

- A significant switch to GPs consulting remotely by phone or video
- Patients were still requesting access to a GP. The number of GP consultations (excluding telephone calls to shielded patients) was only 20% less.
- House calls had reduced significantly but had not stopped.
- Acute prescription requests had increased – perhaps due to patients stockpiling, or doctors being more liberal with antibiotics
- Triage by practice nurses had stopped.
- The number of referrals had more than halved, although the numbers of cancer referrals and urgent referrals were similar
- There was a significant reduction in practice nurse appointments, generating a backlog in chronic disease management

Much clinical management has been focused on prescribing requests and reviews of vulnerable patient groups- for example, contacting patients who are shielding and liaising with Nursing and Care homes. A key task is to ensure that vulnerable patients have a KIS (key information summary) completed, so that colleagues in acute services and OOH have as much patient information as possible in order to manage care appropriately.

Rules requiring face to face patient contact for the review of long term conditions have been relaxed and a significant proportion of time is now spent phoning patients at home to review their progress and monitor medications.

Some NHS services have become virtual, or provide advice from a web link, but there is still a need and demand for a tangible and physical connection to patients at the front line of community-orientated health care. While there have been many changes and uncertainties during the Covid-19 pandemic, general practitioners working with primary care colleagues, including district nurses, community midwives, health visitors and others, are still the front line of NHS care.

Continuity of care, based on knowing patients well and being able to access extensive detailed health information, continues not only as a safety net, but also as the basis of effective patient care.

3. NEW ARRANGEMENTS

3.1 Speed and agility

General Practice changed overnight in Glasgow on Sunday 15th March 2020, when practices shut their doors to unsolicited patient access and moved to a triage system, minimising the risk of transmission of Coronavirus from patients to staff and from staff to patients. There were similar changes in out-of-hours provision.

The uniform general practice response happened without a Government directive. It highlighted not only the seriousness of the threat and the importance of Government advice but also *"how general practice is an astonishingly adaptive system when freed from unnecessary bureaucracy."*

> *Working a shift at the Covid Assessment Centre in the first week, I was astonished – and impressed – at how quickly things could change. One of the managers chatted to me about how suddenly those in charge were saying "yes" to everything where previously changes would take months of meetings.*

> *Previous system intransigence has been brought into sharp relief. For example, the community phlebotomy service, which had been developing at snail's pace, was suddenly galvanised into a functioning service.*

The new situation had some novel and positive features.

> *It is great to work without red tape: no appraisal, focus on the job, be there for our patients instead of ticking boxes.*

> *On the public holiday, support services (e.g. phlebotomy) only worked until lunchtime, but I had some positive experiences as well: Got patient in, took bloods at 2.30, uplifted at 3, results phoned at 5pm and patient received treatment before the weekend, avoiding hospital admission and potential vertical infection in a high risk group. Very satisfying medicine, possibly because the labs weren't too busy.*

> *The 'quieter' couple of weeks let me see what it was like to not be working long days and to work at a slower pace. We can forget the demands on GPs working with an ill population such as a Deep End one. This made me reflect on the value of contact with Deep End colleagues and the sense of support and common goals that such contact brings. I think this is particularly important for GPs in the early years of their careers.*

> *I found in the first week that everything changed quite overwhelming – hundreds of phone calls, trying to advise people calmly over the phone, frequently through a telephone interpreter, about something of which I knew little. Each day email boxes were full of new guidance – meaning that the advice I'd given the day before was potentially wrong. There were a lot of anxiety-provoking conversations and decisions to be made. I have never liked telephone consulting; I feel I need to sit across from someone and take in their facial expressions and body language to really understand what is going on, even video can't provide that.*

> *And I have been very grateful for the Deep End Pioneers alumni WhatsApp group. which has been an incredible source of information and stimulating discussion. Peer support is always so important – but especially now.*

I think as a doctor it is a strange time with so much 'care at a distance', including issuing death certificates- I always had a face to face chat with families. The change is strange.

In the pared back life that is lockdown, I have been lifted by the power of simple acts of kindness. These have been important to me as an individual, to my working life and my response to patients.

- *The thank you card through my letterbox from my neighbour offering practical support when I was working extra and changed shifts.*
- *The new team Zoom meetings to include remote workers in daily discussions – including the kind words and smiles and the seeking of opinions that this involves.*
- *When I had to work from home when a family member had Covid – the Practice team's careful involvement of remote workers, and willingness to work through problems.*
- *Turning up for my first Covid Assessment Centre shift to be pleasantly surprised how many colleagues form the Deep End Group had stepped up and who worked together effectively to make the new system work.*
- *Turning up for my first OOH shift in years to meet the Deep End Chair also doing a shift.*
- *Seeing a retired colleague who had returned to take on a lead role at the Covid Assessment Centre.*
- *Young GP Trainees negotiating remote working, phone and video consultations, managing risk in a highly uncertain time.*

> *The swift development of GP Whats App groups and Microsoft Teams has been key to coordinating care, ensuring a consistent approach and providing a support network for practices who were being bombarded with information. Personal examples include the South Glasgow GPC, our local cluster of 7 practices, my current partners, and a wider one including current partners and former retired partners, with whom we still keep in touch, and the health centre coffee morning group.*

3.2 Safety

Practices were provided with Personal Protective Equipment (PPE) by the Health Board, starting with basic surgical face masks (which were out of date, with stickers with new expiry dates covering old dates) and plastic aprons. Goggles had to be sent back as inadequate and were replaced with visors. Many practices bought their own scrubs, gowns and visors. In general, the supply of PPE was slow and variable in starting but then got up to speed with no current problems. Eventually practices were reimbursed by the Health Board for additional Covid expenses.

> *We couldn't get hold of scrubs through any official ordering route – all sold out – but we found someone on Face Book who made them for us and we donated to her Go-Fund page.*

Testing for the presence of the virus was confined initially to hospital admissions with suspected Covid-19 infection. Then, if NHS staff were unable to go to work because of self-isolating, due to a symptomatic household member, testing could be requested, subject to permission from a line manager. Next, NHS and other frontline staff could access testing on-line, followed by anyone aged over 65, and then anyone aged over 5. Such requests were centrally managed, with most testing done at Glasgow airport. There were limited supplies for home testing of people who could not get to the airport. In mid-May, Covid hubs still did not have access to testing, except for 4 tests per day for surveillance purposes.

> *Testing is via the website, so we have nothing to do with it and did not get results. We now get results from staff being tested in Care Homes and we can ask for suspected Care Home patients to be tested. We do not really know how many Covid-19 cases are in the community. I would like to know that but we do not get drilled down information or, at least, I am not aware of it.*

Once the Covid Assessment Centres were established and all symptomatic patients were channelled via that route, safety issues within practices were reduced. There no guidelines, however, on social distancing within practices or the use of barriers, such as the Perspex screens used in supermarkets.

> *I tried to get tested in Glasgow when a family member tested positive (in NHS Lanarkshire) and I felt unwell (but well enough to work) so that I wouldn't need to work from home for a full two weeks. Occupational health didn't get back to me for three day and then only when I chased them and then they said they didn't know how to get a test for me but they thought through my practice manager. By that time I'd contacted the clinical director who told me that I was too late for testing. There had been an email about who to contact for testing some two weeks previously, apparently. So, that is illustrative of the testing shambles.*

For GPs involved in the swine flu pandemic in 2009, when a system was set up very quickly to test all patients attending general practices, it was clear that Public Health infrastructure was deficient at the beginning.

> *…just another example of a hollowed out Public Health system that has really been playing catch up since the first Covid-19 deaths and well before that*

> *We do not see too many patients and any Covid-19 suspect goes to the Covid Assessment Centre. I think it is well organised.*

> *When 'suspected' Covid-19 patients were redirected to 111 and the Covid Assessment Centre, I was concerned that patients were expected to arrive in their cars, and those who didn't have them were struggling. But this issue did seem to be rapidly resolved, as volunteers came forward or staff were re-deployed and patient transport became quite readily available.*

> *In hours access to transport to Covid hubs has helped reduce inequalities of access to care. Could this be rolled out to primary care as well?*

3.3 Shielding

> *Shielding discussions have been very useful and have led to changes in behaviour and show me the true value of being a GP for the patients I know. I have had some challenging but good discussions regarding end of life care and wishes of where to stay in case of infections. I hope we will have enough end of life medication.*

> *Shielding discussions have developed into significant discussions about other health issues. Knowing the patient enables this and has resulted in one admission and one chasing of a CT scan that was cancelled for a patient with suspected cancer*

> *Having conversations about shielding over the phone has been difficult and highlighted the variety of challenging circumstances people are facing. One patient was deaf and would usually be seen with a BSL interpreter. I was able to speak to his aunt, who confirmed he had everything he needed, but it wasn't ideal.*

> *Another patient, with severe COPD, lived alone and had no family or friends to go to the shops for her. She had contacted the government support service and had a box of groceries delivered: mostly tinned goods and nothing that she actually needed. Was I really telling her that as well confining herself to the house for 3 months she had to eat the same food for the entire time? At that point the voluntary sector options were not so well coordinated, but thankfully we had a links practitioner working from home who could help find alternative options.*

> *Another man, who lived in sheltered housing, told me that his carers had stopped coming in because of coronavirus. This resulted in him breaking shielding restrictions and asking a friend of his to visit to help him get dressed and prepare food. I contacted social care who confirmed that care had been stopped due to coronavirus and staffing levels. They said they would review it in light of my concerns, but later I read that this had happened to many people.*

> *I'm not at all sure that shielding has been a good idea. The decisions around this have been informed by specialist clinicians considering 'to whom would I not give a live vaccine'. This fits really poorly with the epidemiology and emerging pathogenesis of Covid-19, which is about vasculopathy, with high risks for those with hypertension, obesity, diabetes and cognitive impairment, vascular and so on. It will be interesting to compare the impact and harms of this approach with what happened in other comparable societies who have just used social distancing, but not had a shielding cohort per se.*

3.4 Remote consultations

> *Staff and patients adapted rapidly to telephone and video consultations. However, there were difficulties: although the video software was easy for us to use, we found many of our patients' smartphones were not up to date; others had no credit on their phones; and some just don't have phones.*

New audiovisual technology, such as 'Attend Anywhere' software, is another aspect of a rapidly scaled-up system to enable video consultations. While useful in some situations video-consulting is not a substitute for direct GP-patient interaction. Photographs and videos can be helpful but eventually patients who are not improving need to be seen, while patients with atypical symptoms need a GP review. A pandemic is not the best time to be trialling new technologies.

> *Only 30 percent of my attempted video consultations worked, often due to older smart phones that did not have new technology and thus couldn't be accessed. They had to be seen face to face or by phone. I gave up on trying to do video consulting for patients who require translators.*

> *Our team is very experienced in phone consultations, but the new normal can be challenging as our patients are struggling to describe, give concise information and change topics. Knowing my patients well helps, but I prefer face to face in complex presentations.*

> *Barriers to access have always been on the agenda, but the challenge of needing a telephone to access your GP is a new and important barrier for us to consider. We need to think about how we change our services and relationships, and access to care in a safe manner. Are telephones and new plastic screens, which are multiplying in some health centres, taking us in the wrong direction?*

4. COLLECTIVE WORKING

Teamwork is the antidote to fragmented care and the key component of well organised care, not only within practices but also between practices working together and between practices working with other services and community resources. All aspects have been on display.

4.1 Collective working within general practices

> *Our team is great. Everybody supportive, trying to find solutions; holidays (and one retirement) were put on hold when we needed sickness cover and partners offered to help; 3 of 4 GP partners attended the Covid hub to give something back, although at present Covid hub well staffed; so far 2 partners had suspected Covid-19 .*

> *It is different, the never-ending flood of emails, trying to filter what is important and what not, trying to implement can be exhausting, the team helps to make sure we do not forget changes and make use of all available services.*

4.2 Collective working between general practices

Although clusters of general practices had already been formed prior to Covid-19, as part of the new Health and Social Care Partnership (HSCP) reforms, the pandemic has given a strong stimulus to cluster working. Local leadership and an engaged GP body can make changes can happen very quickly.

GP leaders in HSCP clusters have had a key role in highlighting local issues and coordinating responses. The communication route operates both ways. GP leaders can alter the provision care from the ground up while national guidance provides a direction of travel that all can adhere to, adapting advice to a local context.

> *Local issues like arranging buddy practices could have been done pro-actively but it was done via the lead reactively (we had arranged it ourselves a long time ago). I think it is important to stress that it all depends on local leadership and the right person in the right job.*

> *The pandemic is a great chance for collaborative working, although it can also highlight the dysfunctional system of funding, e.g. I would be happy to work very collaboratively with our buddy, but I would struggle to support some practices in the cluster who seem to have high patient numbers, low overheads, taking more profit out of the practice and expecting that the cluster might need to help them out.*

4.3 Working as a whole system

OOH services and in-hours GP services are now seen as part of a whole NHS system with one workforce as a vital resource for response planning. GPs have been needed to work across in-hours and OOH services to enable the Covid and non-Covid pathways to function as intended. The whole team and whole system approaches blur the boundaries of conventional working and the limits of contracts.

> *I have enjoyed aspects of working with secondary care that have resulted from the Pandemic e.g. e-mailing patient photos and discussing cases and management plans with hospital specialists. This has been a good learning experience. Not just the clinical side but also the IT side. I think we have to watch, however, that if there is further shift of work from hospital to the community as a result of the Pandemic it needs to be resourced properly and not unfairly increase our workload.*

> *Increased access to the clinical portal (e.g. out of hours) has been transformational in making safe assessments. Better shared access with mental health and health visiting services would likewise help improve communication and safety.*

4.4 Community Link Workers

> *Link Workers have been absolutely invaluable.*

GPs have been working with Community Link Workers to increase contact with vulnerable patients by directly phoning them and arranging support as required. IT systems did not, initially, allow Link Workers to work remotely from the practice, by accessing EMIS (which GPs can do) but by the end of May, this issue had been sorted.

> *How do practices in areas of deprivation manage without a Link Worker when so many patients are struggling with mental health and isolation issues? Link Workers are better placed to connect with community organisations that have quickly adapted to offer support with food and prescription delivery, and activities to counter isolation and mental health problems during lockdown.*

> *I have had weekly phone contact with our Link Worker who is working remotely and has been dealing with a huge range of patient problems and referring on as appropriate e.g. to our Financial Support Worker. His work is invaluable and so important in a Deep End population. I really worry about the financial impact of the pandemic and feel there will be an increasing need for Deep End populations across Glasgow and Scotland to have a practice-based Financial Support Worker.*

4.5 Pharmacists

GPs are working closely with Community Pharmacy colleagues who have been invaluable in supporting General Practice, reorganising the collection of prescriptions and coordinating the delivery of prescriptions to housebound patients. This might involve a pharmacist attending an OOH centre to collect a prescription for end-of-life care for a patient in a Nursing Home that doesn't have access to prescribing support. The pharmacist steps in to liaise with the Nursing Home and prescribing GP and minimise the impact on stretched services.

There was concern, however, about prescribing support workers being withdrawn from practices to work remotely.

> *Our support Pharmacists are working remotely and I fear this might continue and we will lose the benefits of having them on site. I feel their working remotely in the long term could potentially increase GP workload. I do wonder if there may be a more 'top down' rather than 'bottom up' feel to this service. Maybe not, time will tell.*

> *I do not understand why prescribing support pharmacists have to work remotely. We need them in the surgery to be able to discuss issues and avoid duplication of work. Funding was taken away from GP to get the prescribing teams to help us but I regard them as key workers and if we were employing them we would have them on the premises (I do not want to blame the individual workers who do their best, but the management decision...)*

4.6 Advanced Nurse Practitioners

> *The Advanced Nurse Practitioner (ANP) Service at our big nearby care home has been involved in the day to day care of our patients there and is a great support in our work at the practice. This valuable support predates the pandemic. She has also been really useful for advice when we are creating/updating the EKIS's and for advice on individual patients when we were filling out the Covid-19 Palliative Care medicines proforma sheets. She has also been able to discuss with us the availability of oxygen should it be needed in the home. We have been getting a lot of updates/e-mails sent to us throughout the pandemic and it makes a huge difference when you have a point of contact to discuss how these are fitting in with practice within the home. We Fortunately, we haven't so far had a Covid-19 death in our patients but I know the home tragically has. She also helps with infection control as before she was there we had many house visit requests. She also deals with many queries from the Care Staff which helps with GP workload.*

4.7 Public health

Although most discussion about Covid-19 and its impact on health has focused on hospital admissions and the very high mortality once admitted to ICU, it is increasingly apparent that community epidemiology is the key to understanding and controlling infectious disease outbreaks.

There is scope for greater links between the new institution of Public Health in Scotland and front line working in general practice to understand and learn lessons from the community impact of Covid-19. GPs have also been alerted to the value of public health colleagues in coordinating local arrangements, not only in response to the pandemic but also, and potentially, in addressing inequalities in health.

5. CONCERNS

5.1 Missing patients

> *Everyone remarked on how quiet it had become, compared to the usual very busy days dealing with patients with lots of complex problems. Suddenly no one wanted to see us, and this was worrying – their problems had surely not gone away.*

> *It was very 'quiet' at the Practice initially though it is getting busier. This was worrying as I know the Practice has a population with complex health problems and need. I was concerned they were not or maybe could not access medical care or their medicines.*

Many patients were socially isolated before the pandemic and have effectively been living away from society for months, perhaps due to mental health issues and anxiety in combination with their long term physical conditions. Conversations with patients show that some understand the directives to shield or socially isolate more than others. Some patients are terrified to go out even if they are not at high risk.

> *Where are our patients, the sick children, the multimorbid patients? I worry, the really sick that I have seen were reluctant to be admitted. The rare presenters need to have face to face contact as I had some pretty impressive and surprising morbidity not expected when I did the phone triaging*

The current changes to General Practice deal with the challenge presented by the Covid-19 pandemic but are neither sustainable nor desirable in the long term. Patients have adapted for now to the initial triage procedures and the reduction in face to face consultations but, in the longer term, risk management and safety netting will have to be resumed using conventional methods.

In addition to the backlog of chronic disease management, screening programmes and outpatient referrals, GPs expect to see an increased number of delayed presentations, on account of patients not consulting earlier with their symptoms.

Some level of remote consulting will be here to stay, especially for encounters which can safely and effectively managed this way, but it is important that the new technologies do not introduce new types of exclusion e.g. those who struggle with health literacy or who do not possess a mobile phone. A counselling contact phone number or mindfulness App is not adequate for many patients with mental health problems.

> *I worry about my patients accessing of health care. I know that a lot of them have difficulty working the 'Attend Anywhere' video consultation ("awe we'll just stick to the phone". So much communication in General Practice is non-verbal, especially, for example, during a mental health consultation. I do wonder if a 'Deep End' population such as ours might suffer more than a more affluent population in this regard.*

> *I worry about a move away from face to face consultations in the long term, though this may well be the new reality, in the short term at least. How many times in our particular patient population do we uncover problems during consultations that the patient has but that wasn't the reason for which they had made the appointment? Will we lose the ability to do this with our culture of stricter phone triaging? Will our ability of opportunistic 'discovering and dealing' with previously unrecognised, unmet problems be reduced or even lost?*

5.2 Mental health

> *I get regular calls from worried patients who are not in the highest risk groups but have significant comorbidities (respiratory, diabetes, hypertension, IHD) and who are expected to have face to face contact (e.g. in shops, care homes or wards in the NHS). I signpost to the ACAS website, ask if unionised and was truly shocked to hear of NHS managers who expect patients with comorbidities and in high risk age groups to work in Covid wards. (I had patients in their 70s still going to work ....) In many cases I give a sickline for acute stress/anxiety.*

> *Many anxious key workers have underlying health problems but do not fit into the shielding category and cannot be furloughed. One worker in a bus station in a public-facing role had asthma and worsening anxiety. Another worked in a care home and had a young son with a chronic respiratory condition (not severe enough to be considered highly vulnerable). She was constantly fearful of carrying the virus between work and home. In several cases the anxiety levels themselves made these people unfit to work – in which case I could give a certificate – but this didn't fix the underlying issue.*

> *So many patients are struggling, phoning us on a daily basis as other support mechanisms seem not enough for them. We are the constant place for them. I have relapsing opioid dependency patients who needed urgent input. I worry about domestic violence and more deaths due to overdoses. Looking ahead there are the longer term impacts of the pandemic on the economic and mental health wellbeing of patients, families and communities.*

> *Home-based working has meant that colleagues in addictions, social work and mental health services have been easier to phone to discuss cases which has been helpful. We have attempted to encourage addictions and mental health teams to join us in undertaking more opportunistic management or data gathering (e.g. BP, weight, bloods) for the many Deep End patients with co-morbidities to help reduce face to face contacts in the pandemic. This has had limited success but we need to move it forward. Shared record keeping, such as on the diabetes model, would help.*

> *I was delighted to hear that mental health services were given access to video consulting. This could have been transformational for our patients who have so many barriers to face to face consulting. But it is disappointing that local service pressures resulted in reduced availability of mental health services and no use of video consulting that I was aware of. In any second wave, there absolutely should be redeployment **to, not from** mental health services.*

> *General Practice can only be a small part of it, but I deal daily with increasing mental health issues, bereavement and tragedy. I see the impact in our population and the role we can play if we have competent and compassionate GP.*

5.3 Vulnerable children and families

I am writing on behalf of the practice to convey our dismay at the increased and growing risk that vulnerable children are facing on a daily basis and with the hope that this can be conveyed to those with the power to alter the current level of childcare provision.

The Early Years Centre in our area, which many children from vulnerable families, including children on the Child Protection Register (CPR), were attending, is closed, in line with other centres across the city. The staff of the centres have been following up children with a weekly phone call and have been involved in emergency food distribution. This in no way provides adequate oversight of an extremely vulnerable group of families under increased stress.

Schools remain closed and although parents of children at risk can apply for a space very few have. When I asked our attached health visiting team whether they could think of a single family with school age children on the child protection register, who had accessed school provision, no family or child could be named.

My understanding is that children with an allocated social worker can be helped by social work to apply for a school place. However, I am not aware of any child who is on the CPR and registered with our practice who is attending school

It seems to me unlikely that these families will be aware they may be entitled to a school place or that they are likely to manage to negotiate the administrative hurdles to obtain one, especially if children with social workers are not even accessing the service.

The GP role in monitoring and supporting vulnerable children and families has been minimised. This is normally a routine part of daily GP working and there is concern that, despite the availability of virtual support networks, stressed families will not access them. Watchful waiting and opportunistic assessment in General Practice have stopped. Education is the lead agency for coordinating the response for most children but there remains a large disconnect between frontline education and frontline General Practice in communication and collaborative working. The lockdown has not improved but has exacerbated this and there is a sense of urgency in addressing the status of vulnerable families.

> *We now know that childcare and school closures are likely to remain in place until at least late August.*
>
> *In effect this means that these children will not have the additional early years support that they and their families have been assessed as needing. Families that were just about managing, with the support of these centres and schools, are more likely to fail now this support has been removed, especially given the financial pressures and instability caused by the pandemic. My sense is that this is happening already but is largely hidden from view.*
>
> *In the last 3 weeks almost every substance misuse consultation that I have had has revealed increased drugs use. I have given out more emergency opiate reversal kits than I care to count. Some of these patients have young children. In a patient with unstable drug use, my normal practice is to put patients on supervised or daily dispensing and to liaise with the Early Years Centre and school or refer to the Substance Misuse Service for more intensive support. It is more difficult to take such protective action now.*
>
> *Our local chemists have long queues and these patients (often single parents) have to take their children to obtain their script, so it's not just them but their children I expose to Covid-19 and all the others standing in the queue. We have been told that drug misuse services are currently not able to take on new patients and have been reducing face to face contact. This results in a very difficult situation.*
>
> *If the children of key workers can be accommodated within schools and nurseries, can we not also seek protection and care for the most vulnerable children in our society? Not to do so exposes them to unacceptable risks. I fear we are currently failing in our duty to protect them. When restrictions are lifted what will we find?*

Women are more likely to be in low paid jobs, be the main caregivers for children and are often lone parents working in precarious employment conditions. The majority are earning poverty wages and this will result in a gender imbalance as more women stay at home to look after children and lose whatever financial security and independence they have. This has implications for women's mental health, financial security and child wellbeing, which are interdependent factors.

5.4 Care homes and care workers

From visits to care homes, discussions with care home staff and liaison with Advanced Nurse Practitioners (ANPs), GPs learned of the lack of PPE in some homes, the feeling of care home staff that they are unsupported, and the widely reported issue of patients with Covid-19 being returned to care homes.

> *This crisis has highlighted to me how undervalued care workers and other key workers are in this country. I recently found out that more than a third of key workers in Scotland are paid less than £10 an hour and I felt very aware, during my phone calls with care home and hospital staff from the safety of my office, how much more they were putting themselves at risk than I was.*

> *We all know about how much social care services and their staff have been neglected - and the numbers of Covid-19 deaths in care homes has been highly publicised - but reading about the state of the care sector in Allyson Pollock and Louisa Harding-Edgar's policy note (https://www.scer.scot/database/ident-12745) made the problems crystal clear. Hopefully change is coming and GPs can have a voice in that.*

5.5 Homelessness

> *Probably like most GPs at the moment I am delighted at the end of the working day to get a break from the phone or a computer screen. A working day that used to be about serial face to face consultations has moved to a series of phone calls.*
>
> *In the setting of homelessness health service, we have struggled to find ways to use video consulting with "Attend Anywhere" and worry about the patients we are not hearing from because they do not have a phone or credit on their phone, although support workers and accommodation providers have been finding all sorts of ways to ensure patients can make access if they need to. In some projects staff offices are vacated so that patients can have confidential phone consultations with us. Mobile phone provision is available for some patients felt to be at particular high risk, such as gender-based violence.*
>
> *Joint working with our addiction services colleagues has been strengthened - whether that involves dropping off prescriptions to pharmacies across the city or sorting out wider health needs when patients drop in for addictions care. It is times like this that the dedication and vocation of colleagues working in our sector is re-remembered. When routines drop away, the can-do, can-help spirit comes to the fore.*
>
> *That 'no recourse to public funds' for people with failed asylum status has been waived for now in Scotland is a really positive move and similarly the accommodation in hotels of people previously sleeping rough. The speed and success with which this has been organised is one of the shining positives that the Covid-19 pandemic has brought to Glasgow.*

> *However, homelessness is not simply about lack of shelter. Everyone to a greater or lesser extent is finding the enforced reduced social contact difficult; but for many homeless people their only social contact may have been dropping into support services for a meal or other activity, visiting family which they now cannot do, while being out and about on the streets may have involved money generating activity. Those activities are now no longer possible or have become more visible and more likely to attract attention from the police. Activities that might have previously helped people find social connections and manage their poor mental health are sparse, and although substance use recovery communities have made amazing efforts to stay connected through online forums, this is not easy to access for people experiencing homelessness.*

5.6 Comparison with other countries

> *The UK is dealing with the consequences of ten years of austerity and policies to reduce hospital bed numbers. The updated Kings Fund report in March 2020 warned that the pre-Covid-19 level of NHS hospital bed occupancy was too high and that the numbers of ventilators and ICU beds were too low compared to similar countries, and that this will affect our patients by the need to triage early with many patients never getting a chance to get treatment. This is DIFFERENT IN OTHER COUNTRIES and makes me angry. I find it hard to have this at the back of my mind when I have patient contact as I worry about my patients and their families if they get the virus.*

5.7 Health and social impacts of the pandemic

Social impacts

There is emerging evidence of a social gradient in Covid-19, with poorer outcomes for those from more socio-economically deprived areas. Recent statistics show that people from more deprived areas are more likely to die from Covid-19 and more likely to become critically ill, requiring intensive care and ventilatory support [1].

This is likely to be multifactorial, including: increased susceptibility due to poorer pre-existing health; increased exposure due to adverse living and working conditions (poorer housing, air quality, low paid jobs); and increased stress during lockdown due to these conditions. There are also well-established associations between socio-economic status (SES) and other risk factors for Covid-19, such as obesity and ethnicity.

Direct health impacts

Direct effects on health include the impact not just on individuals with Covid-19 disease, but also on their families. The psychological effects of not being able to spend time with loved ones in hospital, or of not being able to have a normal funeral are likely to be considerable. If people in deprived areas are dying at relatively younger ages compared to Covid-19 deaths in more affluent areas, the impact of those premature deaths may be felt more acutely. The

considerable increase in fear and anxiety related to Covid-19 can also be considered a direct health effect [2].

Indirect health impacts

Economic effects e.g. patients who were 'high risk', but not on the official shielding list, who felt under pressure to return to work for economic reasons. Also, more families at risk of food insecurity, as per recent Food Foundation surveys. This is a combination of reduced access to food and reduced incomes.

Social isolation e.g. patients who are shielding and have not seen family members for weeks. Many patients do not own tablet computers or smartphones, so miss out on video calls with family.

Family relationships e.g. a single parent with a background of complex trauma struggling to such an extent that she started drinking heavily and her children moved out to stay with other family. More frequent letters from A&E about domestic abuse incidents.

Unhealthy coping behaviours e.g. patients in recovery from alcohol or drug dependence who have relapsed during lockdown.

Changes in help-seeking e.g. patients describe reluctance to contact the NHS, or reluctance to attend hospital (if admission is advised), resulting in health harms, such as a woman in her early 50s with symptoms of possible TIA/stroke who delayed contacting her practice.

Many of the groups identified by Douglas et al [2] as being at particular risk from the policy responses to Covid-19 are more prevalent in more socio-economically deprived areas – e.g. people with mental health problems, people who use substances or are in recovery, people with a disability, people with reduced communication abilities (e.g. learning disabilities, limited literacy or English language ability), people experiencing homelessness, people in the criminal justice system, undocumented migrants, workers on precarious contracts or self-employed, people on low income.

1.   https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports
2.   Douglas M, Katikireddi SV, Taulbut M, et al. (2020) Mitigating the wider health effects of covid-19 pandemic response. BMJ https://www.bmj.com/content/bmj/369/bmj.m1557.full.pdf

6. **CONSEQUENCES**

This report collates the experience and views of 12 general practitioners working during the Covid-19 pandemic in some of Scotland's most deprived communities. Much of the report may be relevant to general practices serving more socially-mixed and healthier populations elsewhere in the country.

6.1 Information needs

Experience and views are important sources of evidence, especially when there are no other types of evidence, but need to be complemented by analyses of information and research studies on many aspects of the pandemic including :-

- The epidemiology of the Covid-19 pandemic including incidence, complication and case-fatality rates in different kinds of population

- The epidemiology of "excess deaths"

- A focus on general practice denominators, in addition to conventional geographical and deprivation-based denominators, grouping similar types of practice to capture the experience of practices with different population profiles

- Investigation of the apparently low mortality rates from Covid-19 in some general practices and care homes

- The epidemiology of "vulnerable" groups selected for shielding, including their prevalence in different types of practice

- Analyses of the nature and extent of remote consulting, with a focus on the types of issues and patients best suited and least suited to this approach

6.2 Post-mortem on the Pandemic

I think everyone is allowed to make mistakes in a pandemic.

The strong impression made by many contributions to this report is of a public health service and system which were poorly prepared for the pandemic and which took time to get into gear. Issues such as the availability and distribution of PPE, the targeting of testing and the timing and effectiveness of policies including social distancing, lockdown, shielding and contact tracing will no doubt be reviewed and clarified in due course. This report includes experiences and views on many of these issues but is not competent to pass judgment.

6.3 Looking ahead

Notwithstanding the possibility of further waves of Covid-19 infection, and the need for policies and services to be ready for such eventualities, the focus now switches to what happens next.

The NHS "has been protected" by putting a large amount of work on hold and storing this work for the future. The economic and mental health effects of the pandemic have hardly begun and are likely to fall especially on previously disadvantaged groups.

As with an impending tsunami, the tide has gone out, and there is a period of calm while the flood wave is expected. How this is handled will have huge consequences for patients,

practitioners and practices.

General practice was one part of the front line of the NHS in dealing with Covid-19 cases, and will certainly be at the front line for dealing with the health consequences of the pandemic. There is a combination of new and continuing challenges.

New challenges

- The backlog of work resulting from services having been put on hold during the Covid-19 pandemic, including chronic disease management, screening and outpatient referrals. This must be managed in tandem with all practices adhering to a common plan.

- The caseload of delayed disease presentations as a result of patients not contacting general practices during the pandemic

- The increase in mental health illness due to financial and other effects of the pandemic

- New issues of health service access and equity as a result of the expansion of remote consulting, involving the use of phone and video technology

Continuing challenges

- Multimorbidity is the "new norm", including both the multimorbidity of old age and the multimorbidity of socio-economic disadvantage.

- For over a decade there has been preferential investment in specialised NHS services (with referral criteria, waiting lists and the ability to exclude patients), resulting in increased fragmentation of care and increased treatment burden for patients with complex multimorbidity.

- Parallel relative under-investment in general practice, compounded by issues of GP recruitment and retention, has resulted in weakened health care in the community and increased reliance on A&E as the front line of care (providing care at the foot of a cliff rather than a fence at the top of the cliff).

- There are gross longstanding inequalities in health and health care with large differences in healthy life expectancy and life expectancy between the most affluent and most deprived sections of Scottish society (accounting for many more "Years of Life Lost" than the pandemic).

6.4 Essential features of primary health care

In considering how best to address these challenges, this report illustrates four important attributes of general practice and primary health care :

> *General practice adopted a whole system change almost overnight (which is unprecedented) to provide a uniform and consistent approach to the pandemic flu response across Scotland and across practices in DE communities. Many of the lessons cannot be forgotten or the positive changes undone as we come out at the other end of this pandemic.*

1. The potential for flexibility and whole system change

> *I also have been reflecting on how quickly General Practice has adapted to the changes that have resulted from this pandemic. Maybe it's in a small part due to GPs often not knowing what is going to come 'through the door' in their day to day work and them often just 'having to get on with things' and adapt and try and sort things as they arise.*

2. The value of an unconditional, personalised approach, especially for patients with complex multimorbidity and often beginning with a face to face consultation.

> *See Patient Snapshots in Appendix B on pages 36-37*

3. The role of close connections between practices and community resources for health

> *See Section 4, pages 13-16*

4. The importance of leadership, communication and coordination

> *GP leadership, collegiate working and horizontal accountability, acknowledging that in-hours and out-of-hours GP is part of the same system, with the same workforce, and that practices can work across their HSCP to share best practice and work together to help each other and cooperate with other statutory and 3rd sector agencies to provide good health and social care - these are the building blocks of how services will evolve in the future.*

Learning from Deep End Projects

(This is covered in greater depth in previous Deep End Reports and in the Deep End Manifesto 2017, all accessible at www.gla.ac.uk/deepend)

The Govan SHIP Project and Care Plus Study show that extended consultations with selected patients (based on practice knowledge of patients), linked to structured monthly multidisciplinary team meetings (with protected time for GPs to arrange and organise), is an effective way of re-assessing and prioritising patients' problems, agreeing a way forward and developing integrated care via existing inter-professional arrangements.

The Govan SHIP (social care worker), Link Worker, Alcohol Nurse and Financial Advisor Projects all show the value of attached co-workers who are *embedded* within practice teams and not simply, and less effectively, *co-located*. Embedded co-workers result in: trusted professional relationships; quick, local, familiar and reliable referral pathways; and increased numbers of new referrals.

Packaging the active ingredients of effective community health care

The essential element of efficient and equitable primary health care is unconditional, personalised continuity of care for all patients, whatever conditions or combination of conditions they may have.

Without such care, complications occur sooner and patients present earlier to out of hours, A&E and other emergency services. High quality and equitable health care in the community protects emergency services from overload. The solution to A&E overload lies in the community, and not in extra resources for A&E.

Generalist clinical care linked to local services and community resources also reduces health care fragmentation (i.e. care lacking continuity and coordination) and thus, the patients' treatment burden, including the number of health professionals and clinics they have to attend.

In the aftermath of Covid 19 the package of active ingredients of general practice should include :-

- Remote consultations for patients whose needs can be managed safely this way
- Face to face consultations for patients whose needs are unlikely to be met by remote consultations
- Extended consultations for selected patients with complex multimorbidity
- Regular and well-supported multidisciplinary teams for the review, planning and coordination of care for vulnerable adults, children and families
- Continuity of contact, and of information, building patients' knowledge, confidence and agency in understanding, managing and living with their conditions
- High morale teamwork within general practices
- Embedded co-workers, providing short, quick and reliable links to the most important support services
- Reliable referral links to other services in primary and secondary care
- GP leadership, engaging with practices and communicating on their behalf
- Support systems enabling the sharing of information, activities and learning between practices

6.5 Inequalities in health and health care

As a social determinant of ill-health, inequitable health care is less fundamental and less far-reaching than many factors operating outside health care, especially in early life. Measures to address inequity in health care can have short-term effects, however, unlike measures to address other social determinants, many of which will take decades to influence adult health statistics.

Inequalities in health, the social determinants of health and the inverse care law are abstract concepts and seldom mentioned in the daily discourse of general practice. A more practical issue is the gap observed daily between what practices can do for patients and what they could do with more time and better connections.

The concept of "vertical equity", whereby care is provided, not only in terms of equal access (horizontal equity) but also on the basis of need, is generally applied within hospitals and within individual general practices, where patients are given attention, investigation and treatment according to the severity of their needs. Vertical equity is less obvious between general practices as a result of a funding formula based on how busy practices are, rather than on how more active and effective they could be. What is missing from the data which inform resource distribution is information on the resulting "unmet need" or, more accurately, the nature and extent of "suboptimal and poorly coordinated care."

The recent Scottish Government report *"Re-mobilise, Recover, Re-design: The Framework for NHS Scotland",* (published in May 2020), outlines NHS priorities for the next 100 days getting back to normal, keeping the ability to deal with Covid-19 and preparing the NHS for the winter season. It also includes a commitment to address inequity in health and health care.

One of eight guiding principles

- Understand the needs of people and places; who are the most impacted by inequalities
- Produce models of care based on what matters to them
- Including: strengthen relationship-based approaches, and provision of support to those who might be missing (e.g. not using virtual methods; or who DNA from routine appointments)

Objectives "to ensure equity"

- This pandemic has exposed and exacerbated deep-rooted health and social inequalities.
- We will act to mitigate these and ensure that services are provided in a way that is proportionate to need.
- The framework that we take forward will focus on how best to support those that are most vulnerable (socially and clinically)

For these familiar aims and objectives to be realised, NHS Scotland will need to be more effective in its actions to address health care equity than it has been in recent decades.

It is axiomatic that addressing inequity in health care is a direction of travel and not a quick fix. It requires structural solutions to structural issues, not small temporary projects on the margins of mainstream health care. The generally successful and Government-funded Govan SHIP Project and GP Pioneer Scheme both involved only small numbers of practices and stopped when funding ran out.

The simplest prescription to improve health in deprived areas, and narrow inequalities in health, is to increase the quality, consistency, range and volume of care provided, but general practitioners and practice teams cannot do this on their own.

6.6 Stumbling blocks and immediate actions

Three major stumbling blocks are :-

1. The time poor nature of consultations in general practice in deprived areas, which research has characterised as involving higher levels of complex multimorbidity, lower levels of patient enablement (especially in patients with mental health problems, which is the commonest co-morbidity in deprived areas) and greater GP stress. The Care Plus Study showed that longer consultations for selected patients is a cost-effective use of NHS resources. When will this research evidence be applied?

2. Lower levels of patient knowledge, confidence and agency, resulting in lower levels of demand for given levels of need. The system depends on patients being satisfied, or resigned, with less. Recognition that new technologies for remote consultations may introduce new types of horizontal inequity is simply a new variant of this issue. Patients who are sometimes described as "hard to reach" are also "easy to ignore" and are often ignored. To what extent does the NHS wish to be proactive in addressing this issue?

3. Striking a balance between the needs of patients and practices dealing with the consequences of longevity and the needs of practices with patients lacking longevity and with lower levels of healthy life expectancy. How to find a way of addressing the latter without disadvantaging the former?

In the short term, while these issues are being considered, we propose four initial measures for the Government's new assault on health care inequity.

1. **Community Link Workers**

    The Community Link Worker Programme currently involves only 50% of general practices serving very deprived communities in Glasgow. How this happened, despite a manifesto commitment to provide all such practices with link workers, is a case study of how the inverse care law continues to operate. As this report illustrates, general practices with Community Link Workers prior to the Covid-19 pandemic found them an invaluable resource in meeting the needs of vulnerable patients. In anticipation of the economic and social problems lying ahead, and their likely concentration in practices serving very deprived areas, all such practices should be provided with an attached Link

Worker as a matter of urgency. The necessary infrastructure for procuring, training and coordinating Link Workers is already in place.

2. Embedded Financial Advisors

The embedding of Financial Advisors in general practice has been shown to generate large numbers of new welfare benefit claimants, whom conventional advice services have not reached. The average annual financial benefit per claimant is over £7000. Patients have benefitted from this arrangement in only 19 of Glasgow's 75 most deprived general practices. The number was recently reduced as a cost-cutting measure. In anticipation of the financial hardship lying ahead, this scheme should be extended to include a much larger number of general practices, pro rata based on need and funded as part of the new Scottish Social Security system, not primary care development funds.

3. Attached Mental Health Support

As the consequences of the pandemic take hold, putting pressure on household incomes, especially in groups already disadvantaged, a large increase in mental distress is expected. Only a small part of this is likely to meet conventional criteria for referral to mental health services and much of it will be combined with other health and social problems. More than ever, there is a need to shorten the distance between general practice and mental health support by providing support close to practices, following the embedded worker model.

4. Metrics to drive change

Metrics on inequities in health care are needed so that policies are informed, monitored and evaluated regularly in terms of the process and outcome measures they are trying to address e.g. use of emergency services, with practice populations grouped not only by cluster but also like for like characteristics.

7. FINALLY

The Covid-19 pandemic has shown NHS Scotland to have been poorly prepared in the stockpiling and distribution of key materials and the capacity of its public health system to cope, but it has also shown the intrinsic resourcefulness, adaptability and commitment of NHS staff, in hospitals and in primary care, working as a whole system.

As attention turns to the economic and health consequences of the pandemic, community-oriented health care will be centre stage. This report provides many individual examples of the importance of relationships, between patients and practitioners, between practitioners and community link workers, and between general practices and community resources for health.

Consistent approaches across general practice and primary care require good communication and coordination between GP cluster leads, GP clusters and public health colleagues,

supported by information and resource. The challenge is to build on the relationships and on the momentum that have been achieved.

This pandemic has made me reflect on how 'big' the whole healthcare system is and how many different specialties etc are involved in it. It has brought home to me how much the work of Public Health isn't just about "Prevention' but how it is involved in planning and setting up of services e.g. the Covid Assessment Services, temporary hospitals etc. I also thought about how quickly resources can be found and services developed when there is a will and a clearly identified need. If we as a country want to address health inequalities can we as a country throw ourselves and our resources at that problem as we have for this one? Will there be a will to do this when cash is tight? Do we really need, as a country, to wait for a pandemic and depend on fear to get things done? Can we use what we have learned from the pandemic to address health inequalities?

I have seen lots of green shoots in Glasgow prior to Covid-19, and even during Covid-19, but we need to address equity in Scotland and should not lose our focus on areas of concentrated deprivation. We do not have an equal system for GPs serving their populations and if we do more of the same it won't work. We need leadership now to turn tragedy into opportunity, collectively addressing inequalities in health and the fragmentation of care.

GPs at the Deep End
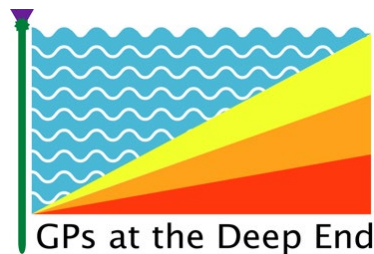
June 2020

8. APPENDIX A: PERSONAL REFLECTIONS

8.1 REFLECTIONS - NAYANIKA BASU

During the Covid-19 response, I have worked as a sessional locum GP in practices, community hubs and out of hours.

I'm not sure any of us really knew what was about to hit us, even as late as February 2020. We went about our usual routines with routine conversations about sick lines, viral illnesses and post viral fatigue, unwittingly participating in the delay to identify the impending pandemic. The arrogance that the UK government displayed behind the scenes when credible concerns (and solutions) were presented - and the subsequent panic over key messages, track and trace and lockdown decisions, PPE and ventilators – could be the syllabus of a master class on the need for humility in a globalised world.

It is striking that the interest in Covid-19 grew only as it hit destinations popular with UK holidaymakers. By which point, we had missed the opportunity to emulate countries who responded well. As I have grieved for colleagues, friends and family and read heartfelt tributes on school gates, I have felt the cold embrace of reality. So, like many of us, I have found focus and recovery in my family, work and self-care.

The flurry of daily statistics and homogenised Covid-19 updates have left me jaded. I've trawled through indistinguishable subject headings and turned to colleagues on social media to make sense of the contents. Concise and meaningful communications have been absent and I have found myself worrying about the accuracy of my knowledge in the face of daily and changing cascades of information flooding in. I have felt admiration as I observe the diverse skills and personalities that coordinate services and society together but also, a familiar sense of anger on behalf of the many low paid or zero hour contract workers for whom recognition is fleeting, with no 'death in service' clauses on the horizon. Careless status quos undermining the fragile threads that bind us.

For example, the lack of testing and basic PPE provision for workers on the ground led to panic. Hospitals were constructed in record time, correctly so – but then were empty while out of hours services struggled on. Appreciation of the real challenges faced by essential workers across food and energy supply chains, council and emergency services is still superficial, with similarly little understanding of the fine balance between patients, staff and NHS services. This, along with effusive praise and hero worship, has left an aftertaste of skewed efforts and confused priorities.

There have been occasional sparks of catharsis, such as Emily Maitlis speaking fiercely on Newsnight about the unequal impact of Covid-19, but mostly, the vulnerable push forward alone. The Covid-19 instalment of the inverse care law. They still take the bus to low paid, precarious jobs while their ethnicity and social circumstances are mirrored in Covid mortality heat maps. Where are all the patients who have upped their harmful drinking and those with

broken pasts? I've worked through lists from the safety of my seat and shared despair with the single parent crying on the phone, the father with an 18 hour history of cardiac chest pain who didn't want to bother us and the residents and staff of a nursing home, weathering the consequences of inaction. Phone calls are adjusted to compensate for additional extreme stress and mental health storms of hopelessness and loss. Most show little interest for my safety netting and risk management and want validation and reassurance. I hardly go into deeper education on breathlessness, 'active cycle breathing exercises' or postural clearance for the chest. A far cry from consultations with ultra-marathon runners or colleagues. I can only imagine how these unequal conversations perpetuate unequal outcomes. Getting help relies also on excellent communication and a forensic knowledge of the system and its barriers. But that's nothing new for those facing inequalities all their life.

I recall advising self-isolation to a benefits advisor who left, mildly shocked. As I wiped down the door handles and checked in with public health, I wondered to myself how people on his caseload would cope. An answer came soon enough in the media reports of record numbers of Universal Credit applicants and an overwhelmed system. Universal Basic Income never felt more relevant.

Safe spaces and silver linings

On a positive note, individuals and local efforts have been nothing short of outstanding. Community spirit and caring and neighbourly connections have released an outburst of creativity and kindness and reached thousands who would otherwise be invisible or isolated. In this bizarre dystopia, one of the biggest contributions in deprived postcodes is from schools, social services and local charities. By keeping channels open, they create and maintain safe spaces for: provision of school meals; online learning for those in need of inspiration and structure; hope for people in abusive, violent situations and the vulnerable and homeless.

On a lighter note, I had a positive experience when I needed to admit a patient directly from home over a telephone triage call. The patient and family were deaf with almost no literacy skills, so communication could have been extremely challenging but the ingenuity of the BSL interpretation and video relay service made it a memorable and easy experience with the added advantage of a visual assessment from the interpreter. A valuable reminder of a good idea working and providing more than it was set up for, in extraordinary times.

Kali Yuga

During the pandemic, my vocabulary has grappled with now common themes and acronyms - flattening the curve, furlough, CAC (Community Assessment Centres), SATA (Specialist Assessment and Treatment Area), FRSM (fluid resistant surgical mask) – and so on.

My experiences are coloured by relative privilege, safety and a slightly melodramatic Indian family so it's no surprise that a mythological word has crept into our family parlance.

'Kali Yuga' is described in Sanskrit scriptures of Hinduism as the last of four ages or 'yugas' that the world cycles through. This 'era of darkness' reaches a fairly devastating peak and is

followed by hopeful rebirth and an era of truth. The rise in right wing politics, the urgency of climate change, and now Covid-19 all conjure up a post-apocalyptic image, not so very different from this!

The Future

We know only too well the lack of commonality in pandemic experiences across postcodes and households in Scotland, UK and the world. They vary from a gentler pace of wellbeing, green spaces and soothing birdsong to harsh home climates, a distillation of suffering and stressors and social exclusion. All of this could be glossed over in displays of solidarity but what is actually needed is continued, steady and necessary work to redistribute advantage and reduce risk. Scotland is ahead of many countries but is still a 'work in progress'. I hope we can build on learning from Covid-19 and plan for a better future. No doubt there is much more to come, but every step we take from now on will need to take in the long view, keeping our local and globalised communities at its very heart.

8.2   REFLECTIONS - PETER CAWSTON

The last few weeks have brought with them the whole rainbow of emotions but also a nagging feeling that what we are going through is really just a sharp reminder of how we have been living for many years. Not only have we unleashed a deadly virus, but during the course of my lifetime we have poisoned and destroyed every life-sustaining biosphere and flooded every human society on earth with toxic substances, from pesticides and carbon fuels, to sugar and cocaine. We have brought about the ecocide of countless species and the widescale loss of human life through poverty, violence, addiction and injustice. There is not a single one of us who is not burdened in some way with the physical and mental effects of this toxic, life-denying way of existence. Some however have paid an immensely greater cost than others. The spread of this bat virus is just a symptom of the real crisis that is unfolding all around us.

The new zoonosis has shone a spotlight also on our feeling of helplessness, or at best mild hand-wringing, at our plight. States have been exposed for failing to make effective provision to protect their populations from a threat that has been predicted as inevitable for at least the past three decades. Ideologies built on denial and failure to tell the truth have turned a crisis into a catastrophe. Our economies are, literally and metaphorically, bankrupt in the face of what should have been a minor challenge. Our media are filled with tales of heroes, tragedies and villains. Technology will save us with ventilators, vaccines or drugs. *Don't worry, life will return to normal. At any price. We must not wake up to the reality of our current condition.* A depressing barrage of bullshit.

At a human level our response to the crisis has involved neither heroes nor villains - we have all in our own ways been affirming, resilient, frightened, angry, kind, selfish, loving and self-sacrificial, in different measures. We mostly try to avoid contemplating the bigger picture, for no other reason than our brains do not cope well with existential threats. To a greater or lesser extent we take comfort in denial. However, it is at this human level that more authentic ways of living emerge.

The communities who have been most failed by the state have perhaps done the most to respond in a life affirming way. Kindness, mutual aid, civic responsibility and solidarity have been shown to be far more powerful forces for sustaining human survival than consumerism or rank individualism.

As a small example of this, my GP practice is partnered with two patient peer support groups. Both have provided lifelines of support during this lockdown, with practical help but more importantly, with emotional support and care during a period of intense loneliness and isolation. Many more such informal and voluntary networks have sprung up or stepped up at this time. They are no doubt flawed and frail, but have proved critical and highly effective, in many ways more so than statutory services and commercial supply chains.

One of our most difficult yet valuable roles as GPs during this period has been in supporting carers and nurses as they have looked after the people who have died in care homes and in their own homes. The vast majority have experienced compassionate care at the end of life and been treated with dignity, often at great personal cost to those caring for them. The way this has been discussed in the press and by politicians however has often made people's experience much more distressing. While fully recognising and respecting the suffering, loss and personal tragedy that many have experienced, we need as a society to learn to talk openly about the reality of death, to protect frail people from having suffering prolonged through unrealistic medical interventions, and to honour the dying and the bereaved. It has taken great courage at this time to support those who are coming to the end of their lives or who are grieving for their loved ones.

These small examples are just pointers among many others towards what is possible.
We can build economies and civilisations on communities and not corporations. We can create cultures in which birth, life and death are affirmed and respected. We can live with dignity within the intricate flourishing planetary networks on which all life, including our own, relies for sustenance. But this will require more than hand wringing and nice intentions. We are being given a chance, perhaps our last, to collectively say *"No More"*

APPENDIX B: PATIENT SNAPSHOTS

A patient attended the health centre because they were worried they may have a new DVT. When I had managed to reassure them this was not the case, it became clear they just really needed to spend some time with health care staff that they knew and trusted - even though I and the nurse were kitted up in full primary care PPE at the time. As we chatted, as we talked over the person's eviction from accommodation and their current precarious and possibly dangerous arrangement with their partner, our patient became visibly more relaxed. We sorted out the patient's current prescriptions, talked over when that spirometry test might finally get done, and issued a token for a local food bank. But the reason this sticks in my mind was the relief on our patient's face when I said 'Remember- we are here for you'.

One of the surprises has been the number of phone patient contacts that have been really positive and been very well received by patients. We hear a lot in 'normal times' from patients that needing to sit in the waiting room at Homeless Health services is risky for them - worrying about who they might bump into and the issues this might raise. Also, the significant effort needed to travel across the city whether that be in time or money. I am realising that quite a lot of the health issues we thought we had to meet the patient to sort out can be done over the phone which in some ways feels like a more empowering experience for the patient.

I had assessed a patient who is a migrant to the UK using phone interpreting support. I had to tell the patient that they really needed to attend the assessment centre for a physical examination. They were quite unwell - but despite that became very frightened when I told them they could not safely take a taxi, and that transport would be organised to attend. The patient was worried they would become a target if their neighbours saw an ambulance arriving and taking them away with PPE on. The patient was reassured and agreed to travel when I explained it would be a patient transport vehicle.

Next patient is on methadone, his life in tatters and decades of trauma behind him. I knew that shielding would be a tough shift, especially with these additional features. The isolation. The difficulties of coping. The broken relationships. The support staff keeping their distance and unsure of new systems. He calls the Community Links Practitioner and we both offer what support we can, the CLP with his knowledge of local services and me screening for suicide risk and mental illness but both keeping aware of the struggles and the person. The telephone consultation ends with the GP being addressed as a "wee gem". Probably short lived but no less uplifting.

The frail elderly man with multiple health problems whose family cared for him so lovingly. Always shaved and smartly dressed in the spotless flat. He did not want to go to hospital. His family worked with me and the district nurse in using video assessments, until we eventually visited wearing PPE. Despite their efforts he became so unwell that he was admitted to hospital a few days later. He died without his family present. Covid-19 victim. Had we brought it to him despite our PPE?

I'd to write a death certificate this week for a man who is the same age as me, mid-fifties. Sudden death. He'd had a bad chest, a 60-a-day smoker who'd been in hospital just 2 weeks previously and tested negative for Covid 19. Treated as a community acquired pneumonia and discharged. He'd not been seen for several days. The policeman had to break the door down. He wanted to know if I'd issue a death certificate. Was the death unexpected? I'd known him 22 years through alcohol and drug dependence, social problems, anxiety. He looked more like a man of 70; wizened, dental caries, unkempt. His life expectancy had been poor since I'd first met him. No suspicious circumstances the police officer said. Notify to the Procurator Fiscal? Notifiable disease? Covid? I learn that the only one who is currently authorised to do a Covid test on a deceased person is the PF. To the best of my ability I discern the time of death, and the cause of death. So much uncertainty. I spoke to the family. No paper certificates during a pandemic. I emailed the certificate to the death registrar, the local registrar and the son. I am left wondering. But I have another death certificate to write, staff who are working remotely who need to speak to me, trainees needing advice, and a surgery - mainly telephone appointments, some video, some face to face – to run. Mondays. Plus ca change, plus c'est la meme chose. Was his death unexpected?

I discovered that one patient with a history of mental health problems and addictions had called an ambulance three times within 72 hours. The paramedics were understandably annoyed. They thought she was drug-seeking. I thought she was isolated and overwhelmed. A couple of follow-up phone calls and liaising with her support worker and addictions team seemed to calm things down.

In out-of-hours I saw a woman with alcoholic liver disease who had stayed at home for 2 weeks as her abdomen swelled to the point that she had difficulty walking. I asked her whether she had spoken to her own GP. She had assumed they were closed. I think (hope) this was an unusual case, and certainly now people seem to realise they can contact their GPs – but the messages clearly confused some people.