General practice after COVID-19:

lessons learned

The COVID-19 pandemic has caused a detrimental impact on human populations across the world, with colossal changes to our personal, social, and professional lives. However, there have been some abrupt and unexpected positive shifts in human behaviour in response to the pandemic. Along with the rest of the population, clinicians have rapidly adapted to the new ways of working and climbed a steep learning curve. Working differently has certainly brought some challenges but also some unforeseen opportunities and scope for innovation, making it more positive than initially thought.

The pandemic has broadened the public awareness of the importance of health. People are now more aware that nothing really matters when health is lacking, and this raised awareness is the driving force towards healthier habits; children and families are taking handwashing, personal hygiene, and other prevention measures seriously. We need to embrace these affirmative behaviour changes and 'new ways of working', and reflect on how we can build on some of these methods to endure beyond the pandemic. Our prime aim is to improve our primary care system with a view to support and sustain the trusted relationship with our patients. In addition, staff need to be satisfied with these new methods, and we should work together with the aim of improving staff morale and general wellbeing. Sustainable staff wellbeing is also associated with improved performance.

PATIENT ACCESS

A key part of the NHS Long Term Plan is digital-first primary care; patients using digital and online tools for faster and improved access to advice, support, and treatment. The intention of total triage and remote consultations is to improve patient access while reducing workload pressures in general practice. According to the figures from NHS Digital, around 80% of GP consultations were delivered face-to-face before the pandemic, the rest mostly by telephone. During the pandemic, clinicians turned to 'total triage' and remote consultations were deemed

necessary to reduce footfall and to limit exposure to infection to protect both patients and staff. It also enabled clinicians who are well but have to self-isolate, or who fall into high-risk groups and require shielding, to continue providing medical care. Here is how I envisage general practice to be 'after COVID-19':

TRIAGING MODEL

A total triaging model should be continued in primary care. Online triaging models offer patients a secure workflow system. Patients contact their practice via a link from the practice website, without the need to queue. They request a consultation, stating a preference for consultation type; face-to-face, telephone, online message, or video. Non-digital users are taken through the same process by practice staff over the phone.

REMOTE CONSULTATIONS

Remote consultations reduce consultation length and improve accessibility, and patients appreciate being given this option. The experience of personal communication matters more to patients than the consultation modality. Having a blended approach to communication focuses on patient need giving patients their choice of the mode of consultation; perhaps, a 30–70 split with face-to-face and remote consultations. Being open and prepared to switch between different modes of consultation depending on technical, patient, or clinical factors would ensure the consultation safety in addition to patient and clinician satisfaction.

Digital communication is not ideal for every patient. Some patients and clinicians may prefer the traditional face-to-face consultations because of the loss of the personal touch, or potential risks to patients' privacy associated with digital communication. Those patients needing or preferring a face-to-face contact can be given an allocated time to come to the surgery avoiding full waiting rooms with ill, possibly contagious people. Managing workload becomes much easier, improving staff satisfaction, morale, and general wellbeing. The added advantage to the

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primary care health professional is that working remotely promotes flexibility and convenience, potentially leading to better staff retention and a more sustainable workforce. This would also ensure adequate emergency cover is available at all times, particularly during unavoidable staff sickness as we have the option of having a 'remote working locum bank' with known staff members.

Video consultations are an approximation of face-to-face interaction and are a 'visual upgrade' of widely used telephone consultations. The scope for video consultations for long-term conditions is wide and includes management of diabetes, hypertension, asthma, post-stroke, psychiatric illnesses, cancers, and chronic pain. It would also help people who are housebound, in nursing or care homes, or needing palliative care, potentially reducing home visits.

ONLINE CONSULTATIONS

Most people in the UK with internet access are interested in using it to communicate with their healthcare provider. Online consultations offer a quick, convenient, and secure alternative to visiting a practice, enabling patients to choose how they interact with clinicians. They have a vital role to play in preventive health care, health education, and managing non-urgent medical problems and increasing access, especially for patients with physical disabilities or who live remotely. They

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enable clinicians to manage their workloads in a more efficient and controlled way. For example, when patients submit photographs of rashes, pigmentation, or moles digitally, diagnosis and management of skin conditions becomes efficient and saves time.

Patient queries can be prioritised and directed appropriately to the clinical or administrative team according to patient preference and needs, improving efficiency. For example, queries related to prescriptions can be directed to clinical pharmacists. Queries related to contraception or repeat prescriptions of the pill, patches, Depo-Provera injection, HRT, or pessary can be directed to the nursing team. Any referral queries can be passed on to the referral team. Any administrative tasks related to issuing copies of test results or medical notes can be directed to the reception team.

PROMOTING SELF-CARE AND SELF-MANAGEMENT

Self-management is about coping with long-term health conditions, and managing the emotional and practical issues they present. Self-care applies to acute illness or injuries, and focuses more on treatment.

Due to the pandemic, patients are better placed to engage with clinicians in regards to accepting advice on the importance of lifestyle medicine; regular physical activity, healthy, sustainable eating, adequate sleep, stress management, avoidance of risky substances, forming and maintaining relationships, and reducing loneliness. We should take this opportunity to continue to engage and empower patients, promoting self-help measures and self-care as a part of daily living. This will enable us to spend more time treating patients with complex health problems and long-term chronic illnesses. Examples include: encouraging patients to manage self-limiting minor ailments and common conditions with over-the-counter medications; simple wound care; self-injection of contraception (for example, Sayana Press); and self-management interventions for long-term physical health conditions and mental health problems. This reduces needless visits to the surgery and helps change the culture of doctor dependency.

GENERAL PRACTICE GOING GREENER

The NHS is responsible for about 5.4% of the UK's carbon footprint, equivalent to all the planes taking off from Heathrow in an average year. Also, 65%–90% of carbon footprint in general practice is associated with pharmaceutical prescribing, yet only 16% of patients take their medicines as intended by their health professional. Medicine taken

incorrectly, or not taken at all, is a potential risk to patients and leads to wastage, placing a huge financial and carbon burden on the NHS. Coronavirus is the wake-up call that we need as a society to make a change to battle against the climate crisis. GPs are at the forefront of patient management so are ideally placed to influence health-led environmental change. We need to raise awareness that the climate crisis is a health emergency and each and every individual has the responsibility towards helping to reduce their carbon footprint. Examples include: looking at alternatives to drugs (in situations where there is good evidence for lifestyle intervention); considering prescribing low-carbon alternatives (for example, DPI versus MDI inhalers); reducing wastage and appropriate disposal of medications; encouraging active travel and engagement with nature (beneficial effects on emotional and physical health); and recycling. With a green approach we could collectively help to improve care and wellbeing, support our patients and staff, ease workload, and help tackle climate change. In addition, there is an overall financial benefit.

ADDITIONAL ROLES REIMBURSEMENT SCHEME (ARRS)

The traditional 'solo GP' no longer exists. GPs continue to face enormous strain, low morale, and a recruitment and retention crisis due to additional demands and legislation, the expectation of meeting targets, staffing issues, and business management. Hence the significance of GPs working in a multidisciplinary team with a range of skill-mix, sharing workloads and ensuring the best appropriate care and support given to the patient population. The ARRS presents us with the opportunity to do things differently across primary care. In choosing what additional roles (such as social prescriber, clinical pharmacist, paramedic, mental health link worker, and occupational therapist) to add to the team, it is essential that practices have a deep understanding of the needs of the population they serve, and that they employ the right professionals with the right skills to provide that care. This would help towards sustainability, flexibility, morale, and maintenance of work-life balance in general practice.

BURNOUT AND COVID RECOVERY PHASE

During the early stages of the pandemic we had some time to rest and recuperate, particularly away from the mundane non-clinical work (for example, writing medical reports). We could reflect on our roles and what it meant to have a work-life balance.

Our energy was spent on different challenges — learning about new ways of working or the new virus so that we could educate ourselves and our patients. In reality, it didn't take away the weariness and burn out completely.

The majority of routine consultations in general practice deal with supporting patients who experience social and psychological problems. Post-pandemic, there will be a huge impact on the wellbeing, both physically and mentally, of people not being able to grieve the loss of loved ones in the normal way. This is in addition to the trauma resulting from varying levels of isolation.

We also need to be aware of the impact of non-COVID morbidities. The pausing of breast and cervical cancer screening programmes, the implications from occupational therapists not assessing older people in their homes, and the patients who have ignored symptoms because of fear of attending the hospital.

No one knows how long the 'COVID recovery phase' will last. We may face unidentified health issues resulting from the pandemic. We should be aware of the potential increased workload ahead and be prepared to take on this challenge, and explore and work with other health professionals who could offer appropriate support to patients. If we are to deal with the potential of a more complex workload we need to look at development of new models of care that might address these challenges. This would certainly involve being open-minded, flexible, building robust relationships between professionals within primary care and beyond, and between primary care and the wider community.

GOING FORWARD

There isn't a 'one size fits all' model. Lessons learnt from the pandemic should be used to plan how we should shape general practice in the future. No one model will be ideal for any practice as it would depend on the demographics and demands of the practice population, in addition to the available resources and workforce.

While we embrace these changes and adapt to the 'near normal working life', we need to be open-minded and constantly review, reflect, discuss, and modify suggestions to suit the needs of our patients and workforce in order to have an effective and efficient primary healthcare system.

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