

Long COVID: playing the long game

As per NICE/SIGN/RCGP guidance, long COVID is a commonly used term to describe:

- ongoing symptomatic COVID-19: signs and symptoms of COVID-19 from 4–12 weeks; and
- post-COVID syndrome: signs and symptoms that develop during or after COVID-19, continue for more than 1 week, and are not explained by an alternative diagnosis.

A study of over half a million adults in England (<https://doi.org/10.1101/2021.06.28.21259452>) found that one in 20 had persistent COVID-19 symptoms. The research looked at survey data from the Imperial College London-led REACT-2 study, collected from random samples of the population between September and February. Nearly 29 000 (around 6%) reported experiencing at least one of 29 symptoms linked with COVID-19 for 12 weeks or more.

STILL LEARNING

COVID-19 is a relatively new and complex disease and we are all still on a very steep learning curve. The longer-term consequences of COVID-19 are likely to significantly impact our lives. Although we know relatively little about the longer-term health consequences of COVID-19, studies such as REACT-2 and rapidly emerging real-world data from the NHS frontline are helping us develop a deeper understanding.

The government have pledged a total of £100 million into long COVID care; £50 million to support research, and £20 million of this is via the National Institute for Health Research for research into long COVID. As a stand-alone sum, £50 million is unlikely to do more than scratch the surface of understanding the long-term effects of COVID-19 but it is definitely a step in the right direction. It is hard to know at this time if the government's pledge is a party-political, vote-winning strapline or part of a well-thought-out coordinated strategy. Irrespective of whether this pledge of funding may be a trite platitude or a genuine attempt to trigger meaningful change; what *is* known

is that the NHS is in dire need of additional funding to cope with the added pressures of COVID-19 as we approach winter. The COVID-19 vaccination programme has been the biggest coordinated global vaccination programme in history. General practice needs to be commended for delivering the lion's share of the programme at the same time as honouring its core contractual obligations.

Despite delivering over 90% of NHS contacts for less than 8% of the funding, general practice has been resourceful and innovative, and gone the extra mile in supporting patients with COVID-19-related problems during the pandemic. Despite this, the profession's efforts seem to have been largely unfunded, unrecognised, and undermined by the court of public opinion, regulators, and politicians.

RECOGNISING LONG COVID

A tranche of £30 million has been earmarked for a long COVID enhanced service (ES) for general practice. Although the sentiment may be well-intentioned, it seems to fall short by being overly bureaucratic and needlessly complicated. There is a relentless anti-GP narrative in the media that *'GPs in England may be failing to recognise thousands of cases of long Covid'*. This was *The Guardian's* interpretation and contextualisation of the research from Oxford University that the clinical coding in primary care of long COVID seems to reflect a significantly lower prevalence to that predicted in the REACT-2 research. However, this discrepancy is most probably explained by GPs being unaware of which clinical Read codes to use to document and record the patients they diagnose/treat with long COVID. From personal experience, on the shop-floor, there has been a paucity of clear communication about the consensus relating to the formal diagnostic Read codes. So, technical recording issues may be the root cause of this reported discrepancy as opposed to a true low prevalence of long COVID in the population at large.

NO STICKING PLASTERS

If it transpires that patients with long COVID are presenting to their GP with symptoms,

and that these are being unrecognised and therefore not immediately diagnosed as long COVID, then this reinforces the need for increased investment to fund education and training. If the discrepancy is due to patients with long COVID being reportedly unable to access their GPs, then further investment is required to improve workforce and infrastructure. It can be overly simplistic to think that all problems can be solved by 'throwing money at them' but it is clear that general practice has been chronically underfunded, and the system and the workforce is beyond capacity.

What is needed is additional resource and funding to free-up our teams to be able to have the flexibility and agility to care for our patients. System-wide additional funding into the core-contractual global sum to frontline GPs. GPs must be given the trust and autonomy to utilise the funding as they see fit to cater for the specific needs of their patient cohorts. What general practice *doesn't* need are reels of red tape, endless box-ticking, and administrative hoop-jumping to secure small sums of funding in the form of ESs. Rather than providing sticking plasters for the grazes, general practice requires life support to address its pre-terminal state caused by the workforce/workload crisis and chronic underfunding. General practice has repeatedly demonstrated through its ingenuity, goodwill, and resourcefulness that it can deliver more value for money for every penny of the taxpayer's pound than any other specialty within the NHS. We do this because of our belief in the system and our commitment to the NHS and our patients. We do this because the buck generally stops with us and because it's ethically and morally, the right thing to do. Unfortunately, however, we often do it at the expense of our family lives, work/life balance, and mental health and wellbeing. The pandemic has exhausted the profession and made it clear that goodwill and civic-mindedness are not infinite or sustainable without the adequate recognition, trust, and resources.

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