One can't pour from an empty glass

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Covid19 has transformed general practice in a way that was unimaginable only less than a year ago. Primary care responded to the challenge of continuing to be accessible in a way that reduced risk for patients as well as the staff.

General practice has also adapted its response based on experience resulting in an increase in the number of face-to-face appointments after an initial drop at the start of the pandemic.

This data suggests that general practice offered 1.5million more consultations in September 2020 compared to September 2019[(1)]. In the backdrop of a dwindling number of general practitioners [(2)] and reduced availability of some secondary care and community services, this is an extraordinary feat.

The mode of consultation has undergone a seismic change with a much higher uptake of digital consultations than ever before. Clinicians have amazingly adapted to the use of e-consultations, using video technology as well as the use of messages and pictures where appropriate. In September 2020, there were 56% face to face appointments, 25% less than the corresponding period in the year before.

The use of technology has helped practices manage access in a way that reduces the risk for all. It has also been convenient for many who did not have to take time off to attend their appointment and were able to seek medical opinion sitting in the comfort of their home. The digital switch also has benefits in helping NHS reach its aspiration of becoming carbon neutral with reduced reliance on transport and saving the cost of travel for many. On the other hand, this has been a rather sudden change in the way they have traditionally consulted their GP. Besides, digital modes of consulting may not be suitable for some vulnerable groups, some from BAME communities, elderly patients and those with learning difficulties etc.

The promise of the government for providing six thousand GPs needed in the NHS remains a distant dream. The NHS is drawing in pharmacists, physiotherapists, social prescribers, physician associates and others with additional role via primary care networks (PCNs) [(3)]. The extended multidisciplinary team is going to be the key in future primary care models and it will help to bring more efficiency. For instance, many GP consultations tend to be related to social issues, some of which our social prescriber colleagues may well be able to help with, freeing up precious clinical time. This also means that the consultations with GPs are becoming more complex and hence more demanding and exhausting.

We are seeing an increasing number of people whose mental health has been adversely impacted by Covid and the lockdown. Similar factors and changes in work pattern have also resulted in a detrimental impact on the psychological well-being of the medical workforce.

Besides, among mixed messages from our leaders, the misperception that practices have not been open during the pandemic has resulted in GPs vilified in the media with many GP surgeries facing abuse [(4)]. It has further eroded the morale of the general practice staff.

Understandably, many patients feel fed up due to not being able to access some community services with many secondary care services deprioritised, elective procedures cancelled, and, in many areas, referrals being suspended or triaged. It has resulted in a very toxic atmosphere which can be highly draining. There is also the likelihood of higher complaints from patients. Some regulatory bodies have already flagged up concerns. [(5)]

Latest BMA Covid 19 tracker survey [(6,7)] is a sombre read and reflects the impact of many of the above factors. Nearly 60% of GPs were suffering from anxiety, depression, burnout or other mental health disorder related to or made worse by work. The situation is unsustainable.

What does the future hold?

The technology will have a far bigger focus in the delivery of clinical care across the NHS. It was already a priority in the pre-pandemic era in the NHS long term plan [8]. It will require ongoing IT support from the commissioners as well as additional training for many. The interface with secondary care needs improving with technology and mutual recognition of workload. We also need to find the right balance between virtual and face to face consultations as well as involving and empowering patients in such decisions. Also, the practices need to find what works for their patients rather than a one size fit all approach.

As the primary care multidisciplinary team becomes a more extended group of professionals, the role of a GP is changing to a 'consultant' in primary care who supports the extended team and focuses on complex patients with multi-morbidities. GPs have always been specialists in generalism, and this evolving role demands a different approach. The ten-minute consultation mode will need to change for the sake of our patients and the well-being of the clinicians.

Continuity of care risks becoming the sacrificial lamb in the new world. We know that the relationship with is clinician is not only related to higher patient satisfaction but is also cost-effective [9]. It is instrumental in helping general practice manages to provide 90% of the patient contact across the NHS with less than 10% of NHS funding. It is also associated with higher job satisfaction for clinicians. We need to have conversations around how we can use technology to enhance continuity, building relationships with patients and still manage to provide 'cradle to grave' care.

The dramatic changes that have happened need a period of stability and support. Hence, the well-being of the workforce needs to become an absolute priority. Health practitioner programme, locally commissioned occupational health services, support from Local Medical Committees (LMCs) along with formal or informal peer support will be the need of the hour.

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