General practice in the post Covid world
Challenges and opportunities for general practice
Executive Summary

The Covid-19 pandemic has the potential to change general practice radically and permanently. Across the UK, practice teams have had to reconfigure their operating model overnight. The pace of change has demonstrated the remarkable adaptability of general practice. Now, as we start to transition towards a ‘new normal’, we have an historic opportunity to embed or accelerate those changes which have been for the better, while discarding those which are detrimental to the profession, to the NHS and to the communities we serve.

In 2019, the College published *Fit for the Future*, our vision for what we wanted general practice to look like in 2030. The vision has not changed as a result of the pandemic. Delivery of care that is holistic, person-centred and relationship-based, remains at the heart of our vision for general practice.

However, we are now re-thinking how we realise that vision, as we adapt to the new post-Covid-19 health landscape. This report focuses on the following three key features of the Covid-19 response which, we believe, have the most potential for transforming general practice so that it is equipped to meet the health challenges of the 21st century:

1. **New ways of working enabled by digital technology:** Before the crisis, a minority of practices used doctor-led remote triage as the access point for services; within weeks nearly all were doing so. Over 70% of GP consultations in England were carried out face-to-face prior to the Covid outbreak; within weeks the figure was 23%. Digital technology has also enabled new ways of working across organisational boundaries in the health and care sector and has the potential to contribute to remote diagnosis and monitoring of disease.

2. **Reducing workload by eliminating unnecessary contractual and regulatory compliance activities:** There has been a welcome relaxation of the bureaucratic and administrative burdens imposed on general practice, and flexible approaches applied to enabling doctors to return to the workforce. These changes have enabled GPs to devote more time to clinical care for patients.

3. **Developing the public/community health function of general practice:** General practice has played a key public health role in the pandemic response, including targeting support for our more vulnerable patients, addressing health inequalities, helping patients to self-care, utilising the assets which exist within our communities and providing data to aid the pandemic response. GPs and their teams will also play a key role in managing the long term physical and psychological consequences of Covid-19.

This report builds on thinking in a recent BJGP article, *Covid-19: a danger and an opportunity for the future of general practice*. It is also informed by a rapid RCGP engagement exercise with members, patients and external stakeholders. This included virtual engagement events during the Covid-19 lockdown; a written consultation exercise with our member groups and Committees; a virtual workshop with external stakeholders including think thanks, academics, clinical leaders, and policy makers; and written submissions from responders to a consultation document. We have included a summary of key themes which emerged through this engagement exercise in Appendix 1.
New ways of working and digital technology

A remarkable aspect of the pandemic response has been the pace at which general practice transformed its operating model and became a predominantly remote service. Although a proportion of remote care has been delivered by telephone, the adoption of digital triage and consultation by GPs was significantly accelerated during the pandemic response. Digital technology also enabled new ways for practice staff to work as teams and to collaborate across organisational boundaries in the health and care sector.

Total triage and remote consultations

During the pandemic, practices remotely triaged all patients requesting an appointment, known as ‘total triage’, either by phone or online. A key benefit was that GPs could respond to patient’s needs and decide the most appropriate mode of follow-up consultation, whether that was a face-to-face, video call or telephone, and vary its length, allowing longer consultations for those with more complex problems. As we look to the post-Covid landscape, there is a compelling case for general practice retaining total triage in order to better flex how consultations are delivered according to the needs and preferences of patients. However, the evidence suggests that telephone triage does not reduce GP workload, so we need to continue to evaluate how total triage impacts on workload and patient-centred care.

After Covid-19, we would expect the proportion of face-to-face appointments to increase, albeit not to their pre-pandemic level. We should look to deliver more consultations remotely to those patients who want or need them, e.g. people with mobility problems or who cannot take time off work. However, we should not lose sight of the centrality of the relationship between the GP and patient which lies at the heart of general practice. Remote consultations have clear benefits – such as convenience and ease of access – for some patients and certain types of consultations, e.g. minor health problems, but they cannot be a substitute for face-to-face consultations, which are better suited to fostering trust and empathy between doctors and patients. Digital consultation channels should, therefore, complement but certainly not replace face-to-face appointments. Moreover, an entirely digital service does not work for all patients, not least for those who have no internet access. In our engagement, both GPs and patients warned about the digital divide and the consequent risk of widening health inequalities. Fully evaluating the impact of remote consultations during the Covid-19 response is needed to understand how these impact on patient experience, health inequalities and relationship-based care.

Remote monitoring

Remote consultations are only one aspect of telecare or e-health. While patients with smart phones and internet access can talk to their GP remotely, they will need the tools and skills to be able to realise the wider benefits of telecare: for example, remote monitoring of long-term health conditions. Digital technology to aid remote monitoring and self-care is a fast-moving landscape, with a proliferation of apps and bio-sensing wearables which can track a range of health metrics; for example, blood pressure, heart rate or blood sugar, as well as mobility and falls. In order to facilitate and expand remote monitoring of health conditions, we will need significant investment in digital telecare tools and training for both staff and patients to use these tools.
Flexible working and team cohesion

While some GPs with whom we engaged expressed concerns about ‘call-centre medicine’, others said they valued the benefits that remote working offered. The ability to deliver consultations from home or to schedule ‘call back’ appointments around their other commitments has enabled GPs to work more flexibly. Remote working could, therefore, make partnership or salaried roles more attractive to GPs, particularly those with caring responsibilities. However, if we want to enable more homeworking in the future, it is necessary to remove some of the technical obstacles to home-working that GPs have encountered. An RCGP survey in the first few weeks after lockdown, found that lack of laptops or secure VPN connection hindered many GPs from being able to work remotely – 63% of those who could not work remotely said access to technology was the problem.3

One of the challenges faced by GPs and practice staff during lockdown is the potential impact of remote working on team cohesion. This challenge has forced practices to adopt new ways for teams to talk and bond and to ensure staff do not feel isolated, for example through morning ‘virtual huddles’. In some practices, this has actually helped to improve team working. Video conferencing has also been used to facilitate handovers between different members of the practice team which, in turn, aids continuity of care.

Working across organisational boundaries

Digital technology has not just enabled remote care for patients during the pandemic, it has facilitated collaboration between practices and across organisational boundaries. Members have told us that video conferencing has helped GPs to build relationships and communicate with hospital consultants - for example, a hospital running video meetings between consultants and GPs, which has reduced referrals and improved communication, or the use of apps, such as Consultant Connect, Near Me and Pando, which allow GPs to communicate directly and confidentially with consultants. The College has long strived to improve the interface between primary and secondary care, so it is vital that these new channels of communication across organisational boundaries are sustained after Covid-19 and developed further, for example, three-way video meetings between the GP, consultant and patient.

Digital communication has also facilitated collaboration between GPs and social care providers. While GPs have still been providing face-to-face visits to care homes, when it is clinically appropriate to do so, they have also been delivering care remotely, using video conferencing platforms to undertake virtual ‘rounds’ and remote consultations with residents. The main barrier to digital communication between practices and care homes has been the lack of IT infrastructure in residential and nursing homes. In Bradford, there has been an investment in telemedicine across 150 care homes to facilitate remote clinical reviews.

The Covid-19 response has accelerated the take up of paperless electronic prescribing. The NHS in England has been rolling out its Electronic Prescription Service (EPS) to practices and pharmacies since November 2018. The number of repeat prescriptions ordered through the NHS App increased by 97% in March 2020, while new EPS nominations – where a patient nominates a pharmacy to which their prescription will be sent electronically – rose from 304,000 in February 2020 to 1.25 million in March.6 The use of electronic prescriptions is less advanced in the Devolved Nations. Electronic prescriptions are not available in Scotland and Northern Ireland. In Wales, the Government has indicated support in principle, but no timetable has been set out for the roll-out of the scheme.
Data sharing

The pandemic response has necessitated the temporary relaxation of some data sharing restrictions to enable GP data to be shared more easily for the direct care of patients, infection monitoring and research. The use of data from the RCGP Research and Surveillance Centre (RSC) has played an important role in Covid-19 surveillance and research, with the number of participating practices in England doubling from about 550 to over 1,100 in a few weeks. Public Health England (PHE), building on its existing disease surveillance programme based at the RSC, established the Covid-19 Observatory, which started collecting virology and serology samples from patients as early as February, identifying the first patient infected in the UK. Continued surveillance work will be important for the identification and monitoring of future Covid-19 outbreaks, identifying mutations and supporting vaccine development. Research and analyses using patient health data in databases such as the RSC is and will continue to play a role in understanding socio-economic factors of Covid-19, identifying factors in mortality in Covid-19 and understanding treatment pathways. While data sharing safeguards should be restored after the pandemic, as agreed, we need to strike a balance to enable data to be shared and used to improve treatment and care.

Our calls

- Governments in each nation should ensure that GPs and their teams have the IT tools, skills and broadband connectivity tools to deliver remote digital consultations – both from surgeries and from home – and to work collaboratively across health and care boundaries.

- Paperless electronic prescribing systems should be rolled out in each nation of the UK:
  - The Scottish Government and Northern Ireland Executive should commit to the national roll-out of fully paperless electronic prescriptions with a clear timeframe.
  - The Welsh Government should commit to national roll-out of paperless electronic prescriptions by June 2021.

- Governments should invest in and scale up the use of digital telecare tools which enable the remote monitoring of health conditions.

- Data security safeguards, which were temporarily relaxed during the Covid-19 response, should be restored when the pandemic is over, albeit in a way which enables data sharing for the purpose of improving treatment and care, directly or via research and audit.
Reducing workload by eliminating unnecessary contractual and regulatory compliance activities

During the Covid-19 outbreak, we have seen a temporary suspension or relaxation of many of the routine regulatory processes and contractual requirements that are usually placed on general practice. This includes the suspension of inspections of practices, relaxation of appraisal and revalidation requirements and a number of contractual obligations across the UK, for example the suspension of the Quality Outcomes Framework (QOF) in Northern Ireland and England, and the Quality Assurance and Improvement Framework (QAIF) in Wales; reduced local audit, assurance and data requirements (England); self-certification measures to replace fit notes (Scotland); and rapid roll out of flexed routes for GPs to return to the workforce in each nation.

Administrative workload

Workload in general practice saw a reduction during the initial weeks of the pandemic across the UK. RCGP’s Tracking Survey found that 59% of GPs in England worked over their contracted hours every day before the Covid-19 outbreak, which fell to 39% during the outbreak. This is likely to be largely a result of fewer patients seeking appointments, due to the suspension of routine GP services, fear of infection and patients not wanting to trouble their GP. However, members told us that reduced bureaucracy also helped to reduce workload, as one said, “from 140% to 100%”. The number of respondents to our Tracking Survey who said they had enough time to treat patients adequately, went up from 24% to 38% during the pandemic. Table 1 below illustrates the drop in clinical administrative workload in England during the Covid-19 outbreak (although this has started to increase in recent weeks), and we have heard about similar trends across the UK through our engagement. We now have an opportunity to look at which routine activities, which were switched off during the pandemic response, can be stopped altogether. This report focuses mainly on administrative tasks, but we should also look at reducing clinical workload by only resuming clinical activities which are evidence-based and beneficial for patients.

Table 1: GP activity in England

Weekly GP clinical appointments and clinical administration activity per 10,000 patients for weeks 5-20 in 2020 and 2019.
Appraisal and revalidation

During the Covid-19 crisis, appraisal and revalidation requirements were suspended to allow doctors to focus their time and efforts on patient care. This has been welcomed by the GP profession and many others. While there were some positive views expressed about the appraisal process and its emphasis on wellbeing in Wales, this was not the case across other areas of the UK, and members consistently tell us that the requirements are too burdensome. It is a timely moment to review the appraisal process to ensure it is supportive while minimising the paperwork.

Work is already under way to design and implement a post-Covid appraisal process that recognises the pressures of the last few months, dramatically reduces the pre-appraisal meeting documentation and administrative burden, and has a much stronger focus on maintaining the health and wellbeing of doctors.

Reducing the administrative burden of regulation

While some of the administrative requirements and processes in general practice will need to resume, we have an important opportunity to rethink regulation and make it more proportionate for GPs, so they are not distracted from providing care, whilst still benefiting patients. A government review into reducing the bureaucratic burden on practices was announced as part of the 2020 GP contract deal for England, a commitment which is both welcome and timely.

A better balance needs to be struck between giving GPs sufficient time for clinical consultations while also assuring the safety and quality of patient care. At present, we have low trust, high regulation regimes. We need to shift the dial towards greater trust in professionals. If we look, for example, following inspections, 95% practices in England were rated ‘good’ or ‘outstanding’ by the Care Quality Commission in 2019, and in Wales, 93% of respondents to the National Survey for Wales stated that they were satisfied with the care received from the GP.

We need inspection systems which are intelligence-led and based on proportionality, and that focus on the minority of practices which may need regular monitoring and support to improve.

Streamlining the process of returning to the GP workforce

We have seen a streamlined approach implemented during the Covid-19 crisis, which has enabled doctors to return to the workforce as quickly and as easily as possible. Overall, 8,856 GPs received temporary registration from the GMC across the UK, though not all of these have gone on to apply to return to Medical Performers Lists (MPL), a requirement for any GP working in primary care services within the NHS. Of these GPs, at least 1538 returners have been reinstated to the National Performers List in England. While not all doctors who are eligible for temporary GMC registration will go on to complete the process of returning to a national Performers List, and some may not wish to remain in the workforce longer-term, for example due to retirement plans, some GPs may be persuaded to stay in practice, given a favourable working environment and conditions.

Return to practice during the pandemic has been facilitated by more flexible routes and requirements, enabled through flexibility of the Medical Performers List (MPL) regulations. However, RCGP still received some feedback that aspects of the emergency process were challenging. And while there have been ongoing improvements to routes back into practice across the UK over the past few years, GPs consistently tell us that the typical process is too burdensome. It will be important to learn from the streamlined approach taken with emergency returners during Covid-19, and to evaluate which elements of this could be maintained and built upon without compromising patient safety. We also need to consider what a supportive and less bureaucratic appraisal and revalidation process for returners might look like.
One option could be the creation of a form of a ‘Reserve List’ to enable doctors to remain on the Medical Performers Lists for a longer period of time, such as four years, with radically reduced requirements in terms of clinical practice and appraisals. This could allow GPs to return to the workforce during peak times (e.g. in winter or a pandemic). This should also look at a range of roles for these GPs, such as roles focussed on education and coaching other members of the workforce. Flexibility within Medical Performers List regulations should also be introduced to enable GPs to move between nations of the UK more easily, without significant additional administrative burdens.

Our calls

- Governments in each nation should develop an action plan to reduce the workload burden of regulation and administration on general practice to free up time for direct patient care.

- 2021, new approaches to intelligence-led monitoring of the quality and safety of care, which minimise the administrative requirements on practices, should be introduced, in particular in countries which have low-trust systems of assurance (England, Wales, Northern Ireland).
  - For example, in England, CQC inspections should only be applied where light-touch monitoring indicates that a practice may not be performing adequately or where significant concerns have been raised.

- Contractual requirements, such as QOF (England and Northern Ireland) and QAIF (Wales) should focus on high-trust approaches to assuring or improving quality with low administrative requirements.

- A new yearly appraisal system should be implemented by December 2020 across the UK, which minimises pre-appraisal documentation and the administrative burden on GPs and includes a focus on wellbeing, reflective practice and development. The new system should be reviewed in June 2021, with the aim of sustaining and building on improvements.

- Requirements for returning GPs should be rapidly reviewed by the end of 2020 to reduce the administrative requirements for GPs to get back into the workforce, including keeping them on Medical Performers Lists for longer and with greater flexibility, underpinned by further investment to support and incentivise their return.
Developing the public & community health function of general practice

The Covid-19 outbreak is the most significant public health emergency in our lifetimes. It has also raised the question of what the public health function of general practice should be. Although responsibility for public health has been transferred from the NHS to local authorities, general practice has, nonetheless, demonstrated the role it can play in emergency preparedness through its agility in adopting a new operating model; working collaboratively across local health and care systems; targeting those with greatest need; leveraging community assets to support vulnerable patients; and helping patients to self-care. General practice also has an essential future role in dealing with the long-term health impact of the pandemic.

Supporting vulnerable patients and leveraging community assets

One of the responsibilities of GPs during the Covid-19 response has been to identify and support extremely clinically vulnerable or ‘shielded’ patients. There has been considerable confusion about the definition of ‘vulnerable’, over who should and should not be included on the shielded list and who requires social and practical support. There has also been, inevitably, a large degree of variation in how vulnerable patients have been supported, but there are many examples of innovative practice that we should spread and sustain through the recovery phase and beyond. For example, care coordinators, in a Deep End practice serving a deprived community in Edinburgh, carried out proactive outreach telephone calls to the most socially vulnerable patients on the practice list. These five-minute check-in calls covered food security, housing security and personal security, with 80% of calls resulting in an onward referral to foodbanks, welfare rights advisers or clinicians.

A new cohort of NHS and local authority volunteers has been recruited to provide support for patients on shielded lists as well as other vulnerable groups, e.g. elderly and housebound people. Volunteers have helped vulnerable patients who have had to self-isolate at home with shopping, collecting and delivering prescribed medicines and by providing emotional support and much needed social contact over the phone or online. In this way, primary care has played a vital role in and mitigating the potentially damaging risk of increased social isolation during lockdown. We now need to plan for how we retain, support and find new opportunities for local health and care volunteers to contribute to their communities.

The social prescribing link worker role has really come into its own in the pandemic response. Social prescribers have often been at the heart of local support for vulnerable patients, connecting up shielded patients with NHS volunteers and signposting to other sources of social, practical and financial support. This is a practical demonstration of the role that primary care can play in building community resilience and tackling health inequalities. In Fit for the Future, we said general practice should evolve from mostly providing clinical care to becoming ‘well-being hubs’. By sustaining and building on the new forms of community support, general practice can take a very concrete step towards realising this aspect of our vision.
Supporting patients to look after their health effectively

A key challenge facing general practice in recent years has been meeting increasing patient demand for professional help. Expanding workforce capacity is the primary solution to this problem. However, a key mitigation is encouraging and supporting patients to self-care and become less reliant on health professionals. We were told by GPs in our engagement exercise that more patients have had to self-care during the pandemic. GPs and their teams have a role to play in supporting patients to appropriately self-manage and monitor their own symptoms. Looking to a post-Covid future, it is vital that we consider how we can develop the capabilities in the general practice workforce to encourage and support patients to self-care.

The fear of Covid-19 has also motivated people to make lifestyle adjustments. There is some evidence of increased rates of exercise, though this is more pronounced amongst younger age groups and higher social economic groups. There is also evidence that more people have cut down or given up smoking altogether. For many people, the pandemic has made them more aware of and receptive to public health advice.

The long-term health impact of Covid-19

While much of the political focus during the pandemic response has been on acute hospitals and intensive care units, it is clear that general practice will have to deal with the health consequences of Covid-19. There is emerging evidence which suggests that patients who have recovered from the virus have been experiencing chronic fatigue, respiratory difficulties and mental health problems – such as anxiety, depression, adjustment disorder, Post Traumatic Stress Disorder, both in terms of new and worsening of existing conditions. Patients who have required mechanical ventilation in intensive care, in particular, will require significant rehabilitation in primary care to manage the physical and mental health consequences of treatment. The social and economic impact of lockdown, for example social isolation and unemployment, will also have adverse health consequences. We know from the Marmot Review 10 Years On that health inequalities have increased over the last decade, and we expect that the economic and societal impacts of Covid-19 will further exacerbate financial and personal hardship. It is vital, therefore, that we take action now to ensure that general practice is well-prepared to meet the post-Covid wave of secondary health problems. This means developing systematic approaches for GPs to proactively identify those patients who are most likely to require support in primary care. It will also be important to expand the multi-disciplinary workforce working in primary care, including mental health therapists. It also means taking decisive action to address the ‘inverse care law’ whereby the most deprived areas are also those where it is hardest to recruit and retain GPs, for example by increasing the number of training practices in deprived areas. One of the unexpected benefits of delivering a remote service is that practices have been able to employ doctors from other parts of the country to deliver consultations by video or telephone. For example, the Haxby Group, a large group of practices which covers York and Hull, was able to use staff in York, where recruitment is less problematic, to undertake remote triage for patients in Hull.
Our calls

- Governments in each nation should develop plans, in conjunction with health, care and third sector organisations, for sustaining and refocusing the new volunteer networks to support communities after the pandemic.

- Governments should review general practice funding arrangements to ensure primary care budgets are weighted to support practices serving the most deprived populations and develop strategies to recruit and retain staff in under-doctored areas.

- Governments in each nation should develop comprehensive plans to manage the long-term health consequences of Covid-19 in the community, with additional primary care funding attached.

- NHS workforce bodies should develop the coaching and motivational interviewing capabilities of general practice workforce so that patients are supported to self-care and increase physical activity.
Appendix 1

This section briefly outlines the other key themes which emerged from the engagement exercise, excluding the priority areas in the main paper.

Patient experiences

Patients raised concerns about the impact of new service model on relationship-based care. In particular, there were strong concerns about remote consultations being the ‘new normal’ and a blanket approach for all patients. We were told that patients will have different needs at different times, and while they accepted the need for remote consultations during the pandemic, this channel may not work for those with complex or longer-term needs.

Variable patient access to digital technologies and the ability to use them was also highlighted as a concern. Evaluation and impact assessments were recommended to ensure that any new modes of care do not worsen health inequalities.

Concern was expressed about the ability to build a rapport and trust between patients and clinicians via remote technologies, and the need for strategies to overcome these barriers, as well as to maintain face to face consultations for some patients. Patients were receptive to approaches to allocate one or two GPs to care for patients with complex needs.

Patients recommended maintaining and building on the flexibilities and proactive approaches seen during Covid-19 to support access to care for homeless people and other vulnerable groups.

There were concerns about the capacity within general practice to manage the health consequences of Covid-19, including those stemming from social and economic factors, and that a comprehensive plan would be needed. We were told that it was important to communicate the message to patients that the NHS is open for business.

At scale working

GPs described considerable variation in how networks or clusters of practices managed the pandemic response – this was particularly acute in England. In some areas, Primary Care Networks (PCNs) played a leading role; in others, it was federations or local systems with larger footprints, such as Clinical Commissioning Groups (CCGs), which led the pandemic response.

We heard the more mature networks, where trusting relationships existed, had found it easier to respond effectively and rapidly reconfigure models of care, e.g. establishing hot hubs. The Covid-19 response did, however, enable some newer networks to galvanise around a clear shared vision, a process which might have taken much longer in normal circumstances.

In Scotland, we heard that GP clusters (introduced in 2017) had proven effective in managing the pandemic response because trusting relationships between practices enabled collaboration.

In Northern Ireland, we heard about increased cooperation between practices and with larger structures such as federations during the Covid-19 crisis, and that cross-practice working through the Covid-19 centres had been a positive experience.

We also heard positive feedback about clusters in Wales being able to provide supportive virtual staff networks.
Workforce wellbeing

The Covid-19 pandemic placed a significant amount of pressure on staff in general practice, both professionally and personally, due to a range of factors including the demands of implementing new ways of working, cancellation of planned closures, and staff not taking leave. Many staff were also working in more high-risk settings such as ‘hot sites’, caring for patients with Covid-19 symptoms, and remote working appears to have increased feelings of isolation among some clinicians.

However, other clinicians talked about positive impacts to their well-being, including the ability to contribute to the Covid-19 response. Initially reduced workload pressures and fewer administrative burdens, coupled with more flexibility in appointment length, enabled many to devote more time for patients without having to work unsustainable hours. Similarly, many GPs, particularly earlier career GPs and students, said that being able to work from home and in more flexible ways were a significant improvement.

The introduction of virtual ‘tea breaks’, or WhatsApp groups, have provided space for staff discussions. Some GPs felt that the widespread wearing of scrubs, which was necessary for infection control, helped to create a sense of being part of a team. The NHS Practitioner Health Service was also valued, though it is currently only available to GPs (and dentists) and not the rest of the practice team.

Workforce expansion and Multidisciplinary Team (MDT) working

We heard that the initial reduction in workload in some areas had had an adverse impact on locums, many of whom felt they had been side-lined. As workload returns to ‘normal’ and potentially grows due to extra post-Covid pressures, it was expected that the demand for locums would resume. There was some discussion of the creation locum banks as a way of meeting fluctuating demand.

A number of returning GPs reported delays in the process, particularly between submitting an application and being contacted about next steps. This was felt to have led to a loss of good will among some returners. Some also expressed disappointment at the limited range of roles open to them and a lack of guidance on how to take up varied roles in practices.

A significant number of returners were nonetheless enthusiastic for returning and were in favour of measures to encourage returners to remain in the workforce post-Covid.

Many GPs were positive about the role played by staff from the wider MDT during the crisis. Many took on specific Covid-19 work, for example, Healthcare Assistants (HCAs) in supporting infection prevention and control. There was also widespread support for the principles of MDT working through the Covid-19 response, particularly the role played by social prescribing link workers and community partners, such as health visitors and district nurses, who have provided significant support for shielding patients. We also heard about Mental Health Practitioners in practices in Northern Ireland supporting patients during the pandemic whose mental health difficulties had been exacerbated and signposting them to other community services.

After the pandemic, many felt the whole MDT would need additional training in certain skills (e.g. digital consulting, remote disease management, use of PPE, infection prevention and control), to enable an effective response to rising demand for services and possible future public health emergencies.
Research and data in primary care

Some GPs highlighted the increase in practices engaged in research, including through the RCGP Research and Surveillance Centre (RSC). This was recognised as valuable in effectively managing the pandemic response, as well as planning services on an ongoing basis. Others mentioned the impact of work conducted by high-profile primary care researchers, such as Professor Tish Greenhalgh, during the crisis.

There was a widespread view that changes adopted during the pandemic, such as total triage, remote consulting and a greater emphasis on patient self-management, will need to be rigorously evaluated to ensure that they are not harmful to patients.

There was also appreciation for the role of the College in disseminating new research through the Covid-19 hub.

Education and training

There was some feedback that general practice education and training would need to change in response to the pandemic. In particular, students and earlier career GPs felt that there should be a greater emphasis on population health management within the GP training curriculum, as well as more training on key skills such as remote consulting and triage.

There was also an appetite among earlier career GPs for more post-CCT support and training, including in business skills, which have proven important in response to rapid changes to the business models of general practice during the pandemic.

There were positive views about the increased provision of online learning seen during the crisis, particularly within GP Specialty Training, but also online talks, webinars and conferences. It was suggested online learning could be expanded to reduce variability of training offers across the country. However, there were also concerns that an over-emphasis on online learning might have drawbacks, particularly in limiting opportunities for unstructured and informal peer-learning, and that a balance would need to be struck moving forwards.

Sustainability and the green agenda

A number of respondents felt that changes to ways of working, discussed throughout this paper had the potential to benefit the sustainability of general practice.

Travel was noted as one of the most significant environmental impacts of general practice, and some felt a shift towards more remote consultations and remote working over the longer term could bring significant environmental benefits.

Some GPs felt that support for patient self-management during the crisis (as discussed in section 3) could be a positive strategy for reducing travel and the environmental costs of overprescribing and costly medical interventions. The wider benefits to population health and cleaner air were also recognised.
References

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9. This data is based on RCGP/Oxford University’s Research and Surveillance Centre extracts from the clinical computer systems of approximately 500 practices in England, with a patient cohort broadly representative of the England population. Comparable data is not currently available for the rest of the UK. The data covers the week 5 to week 20 period of 2020 (week ending 2nd Feb 2020 to week ending 17th May 2020), which covers the period since the first Covid-19 case in the UK and makes comparisons to the same period in 2019.
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