RCGP LEARNING

Coronavirus – Top 10 tips on what to do in primary care

Written by Dr. Toni Hazell, Dr. Steve Walter and Dr. Barbara Noble

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Consider your balance between remote and face to face care – have you got it right and how might it need to change in the months to come?

- There is now a roadmap for gradual easing of restrictions, with the intention to lift all restrictions on July 19th. The government website[1] says that 'we are supporting the NHS to carry out urgent and non-urgent services safely, and it is vital anyone who thinks they need any kind of medical care comes forward and seeks help'.
- The NHSE standard operating procedure (SOP)[2] gives more detail, saying that practices should 'deliver accessible services, including face to face appointments [and]…reach out to patients whose health needs may have…gone unmet during the pandemic'
- Where possible, any patient wanting an appointment should be remotely triaged first[2]; some will need to be seen face-to-face and all practices must be able to offer face-to-face appointments when needed. The decision as to whether a face-to-face appointment is needed is a clinical one which should ideally be made using the principles of shared decision making. The GP will also have to take into account the resources available to them and how important it is to reduce footfall (this may vary depending on local COVID-19 prevalence).
- When deciding on remote versus face-to-face, consider the following:
    - Does the patient need an examination that cannot be done by phone or video?
    - Has the patient had several phone or video appointments for the same problem, which has not resolved? If so then they probably need to be seen in person.
    - Is there something you are missing? Could they be in a situation of domestic abuse or coercion and not able to speak freely on the phone? Listen to your instincts and if you have any inkling that they may not be speaking freely, or if there is a past history of domestic abuse, then consider a face-to-face review alone.

    - Does the patient have a condition for which a face-to-face appointment is preferable, even if not essential? For example managing patients with mental health difficulties remotely may miss non-verbal cues. Consider whether these patients should be seen in

person for some appointments, with others being done remotely. Broadly speaking, remote consultations work best for more straightforward conditions, those which are more complex or sensitive are more likely to benefit from a face-to-face assessment. Remember though that for some patients with underlying complex problems but with a simple question, such as a repeat prescription or issuing a fit note, it may be appropriate to deal with their problem remotely.

  - Remember that medico-legally clinical staff need to be able demonstrate that satisfactory assessment and decision making has taken place. If you aren't sure, it would be better to see the patient face-to-face.
  - As always, communication is important. Listen to what your receptionists are saying – are they explaining how remote assessment can work and benefit both patient and GP? Practices who implemented phone triage before COVID-19 often spent many weeks training reception staff, but the pandemic has meant that many haven't had the luxury of such training. Is now the time to think about reception training to ensure that staff are conveying the possible options to patients correctly? If you are a commissioner, consider whether your CCG should provide staff training resources at scale.

- Public Health England's infection prevention and control (IPC) guidance will remain in place across health care settings including GP surgeries after the 19th July[40]. This means that staff, patients and visitors will still be expected to wear a mask, face covering or personal protective equipment (PPE) to ensure protection of both staff and patients.

Think about ongoing management of respiratory symptoms and be aware of the issues with COVID-19 in children and what to do if resuscitation is needed.

Know what the 'hot hub' arrangements are locally for patients with symptoms that could be COVID-19 – they may include a physical hot hub, a visiting service, a saturations monitoring service or 'hot rooms' within individual practices. The initial contact should always be with the patient's own GP who should assess by phone and video, referring on to a 'hot hub' or similar only if a face-to-face appointment is necessary.

Remote management using home pulse oximetry has been shown to be safe, as long as there is clinical support available using a 'virtual ward' model[3]; in some areas, saturation monitors have been bought in bulk and distributed to patients for whom this will help the decision making process. Concern was initially raised that these devices may be less accurate in those with black or brown skin, however this issue is mainly for those with saturations of below 90%, who should hopefully be in hospital rather than being managed in primary care. As

always, patient assessment should be holistic, rather than relying solely on a number from a saturation monitor, and the patient's usual baseline should be taken into account.

Guidelines have been published regarding resuscitation in primary care[4,5]. An arrest should be checked for by the absence of signs of life and normal breathing or the lack of a carotid pulse; do not put your face close to the patient's mouth to establish this. In the first few minutes after a non-asphyxial arrest, compression only CPR may be as effective as combined ventilation and compression. Ventilation is considered to be an aerosol generating procedure (AGP) by some authorities and should only be carried out if appropriate protective equipment is available. This includes a filtering face piece (FFP3) mask, often not available in primary care. If all you have is non AGP protective equipment (e.g. an apron, surgical mask, gloves and eye protection) then you should attach a defibrillator as soon as possible and shock if appropriate. If chest compressions are carried out then the patient's nose and mouth should be covered with a cloth. If a situation arises where mouth to mouth ventilation is carried out then a face shield should be used when available. No self-isolation is needed afterwards unless the patient has been confirmed positive for COVID-19.

Concerns have been raised that some children with COVID-19 will develop a multi-system inflammatory reaction which can require intensive care. This syndrome has been named paediatric inflammatory multisystem syndrome (PIMS)[6]; clinical features are similar to Kawasaki's syndrome. Most children with COVID-19 will only have minor illness but we should be on the alert for a small number of children who may become critically ill.

Shielding is paused

Shielding is paused throughout the UK, however the shielded patient list of those who are clinically extremely vulnerable (CEV) should still be kept up to date in case shielding needs to restart nationally or locally.

The QCovid calculator[7] has been developed by Oxford University and uses data from the first wave of the pandemic to calculate the absolute and relative risk of catching COVID-19 and being admitted, or catching COVID-19 and dying from it. This has now been centrally applied to primary and secondary care notes. Patients with a risk of catching COVID-19 and dying that is in the top 2% of the population were added to the CEV group and prioritised for vaccination. GPs have access to QCovid if they wish to use it. It can sometimes be useful in a consultation, for example to reassure a patient who is nervous about attending hospital for an essential appointment.

More information about this is in our eLearning resource, which is being regularly updated.

RCPCH guidance on shielding for children[8], referenced in our eLearning resource, points out that it is extremely unlikely for a child to need to shield if they are not under the care of a consultant. Questions on this should be directed to the child's consultant. If they are recently discharged and have concerns then contact their previous consultant or refer again, via advice and guidance if appropriate and available in your area.

Know about the standard operating procedure (SOP) for primary care

Practices should read the full document[2], but some highlights are given below:

- Maintain social distancing in waiting rooms; this may require appointment planning or asking some patients to wait in their cars until they can be seen.
- Practices have all been asked to make some appointment slots bookable by 111.These can be telephone appointments.
- Patients or staff with symptoms of COVID-19 can apply for a test online[9] or by calling 119. The same link also outlines how to access lateral flow tests, which give an almost instant result but are less sensitive than PCR tests and so are not appropriate for those with symptoms.
- Formal risk assessments should already have been carried out for staff[10,11].
- Patients aged 11 or over should be asked to wear a face mask. For those who do not have one, practices may offer the patient a mask. There are no set criteria for mask exemption but genuine reasons may include learning difficulties, autism, trigeminal neuralgia or facial deformities. Those with asthma or COPD are generally able to wear a mask. If the patient refuses to wear a mask then consideration could be given to other options such managing them remotely or delaying an appointment for a non-urgent problem.
- Symptomatic patients should not collect medicines from the pharmacy – use the NHS volunteers system[12] or local equivalents if they have no family or friends to collect for them. Make full use of EPS.
- Don't forget mental health – there are NHSE resources to do with dementia[13], learning difficulties[14] and autism[14] which may be useful.
- Think about how your deaf patients and those who don't speak English can access the surgery – the SOP has links which can help.
- You should have at least a weekly 'check-in' with care homes; more about care homes is in the PCN DES.
- Primary care PPE consists of gloves, an apron, eye protection and a fluid resistant surgical mask, all of which should be disposed of in the clinical waste after being taken off. The latter two items can be worn for a session and do not need to be changed between patients unless damaged, damp or dirty[15]. More substantial PPE (e.g. gown or fitted mask) is only necessary for aerosol generating procedures such as intubation which are not done in primary care. Use of a nebuliser or oxygen alone is not defined as an aerosol generating procedure.
- Consider whether staff should wear scrubs, which can be easily washed at a hotter temperature than normal clothes. Consider how you will manage visits to your care homes and to patients in their own homes.

Appraisal is restarting in a very light-touch way and there are other changes to administration

- The new appraisal year has just restarted, with a new format involving significantly less need for documentation; preparation should only take around 30 minutes[16].
- Changes to appraisal are summarised in this useful video[17].
- Those who have missed an appraisal will not need to catch it up and will revalidate with one less appraisal in this revalidation cycle
- If you are due to revalidate after April 2021 and before your next appraisal, but have not yet been able to carry out your surveys then talk to your appraiser or appraisal office – in this situation revalidation will usually be deferred. Similarly, if appraisals are still happening in your area but you feel unable to take part in the appraisal process due to personal circumstances please talk to your appraiser or local appraisal office – there is understanding of the recent difficulties and you are likely to receive a helpful and empathetic response.
- CQC inspections are restarting[18] – the BMA have expressed concern about the timing of this and called for a complete overhaul of the inspection process[19].
- Local enhanced service schemes are re-starting, with commissioners being asked to do what they can to reduce administrative burdens with regard to data collection[20].
- You do not need to do a med3 for anyone who is self-isolating, unless they need to be off work for more than two weeks. Those self-isolating for 7 days can use a self-certificate and if it extends to 14 days they can get a certificate online from 111[21].
- Patients who ask their GP about problems at work, such as concerns that their place of employment is not COVID-19 secure, should be encouraged to talk to their union or ACAS[22] – there is no obligation on GPs to write letters to employers in this situation.
- If you are working somewhere different from usual, or working in a different way due to COVID-19, the government's indemnity scheme will still cover you. It will also cover new activity due to COVID-19 for which there is no existing indemnity in place. It is still good practice to act only within your level of competence[23]. It is always sensible to have your own indemnity cover and all of the major defence organisations have information about COVID-19 on their websites.
- Fit notes can be e-mailed or texted to patients – patients do not need to have the original with a 'wet' signature, but this can be posted if requested.

Keep up to date with COVID-19 vaccination changes

All adults aged 18 or over have now been offered a vaccine. The timing of second doses varies from area to area, with surge vaccination, including early second doses, taking place in some areas of high COVID-19 prevalence. The second dose is routinely being given at eight weeks, earlier for those who are due to start immunosuppressive therapy.

The following groups aged below 18 should also be vaccinated[41]:

- All those aged 16 and 17.
- Those aged 12 - 15 with the following:
    - Severe neuro-disabilities.
    - Down's syndrome.
    - Underlying conditions resulting in immunosuppression.
    - Profound and multiple learning difficulties.

The national and medical press has been covering concerns about thrombosis with the Oxford AstraZeneca (OAZ) vaccine, specifically the risk of cerebral sinus vein thrombosis (CSVT) accompanied by thrombocytopenia.

From reports up to May 26th, there have been 13.6 cases of CSVT per million first doses of the OAZ vaccine and 1.3 cases per million second doses, with a total of 61 fatalities. To put this into context, it is estimated that the vaccine programme has prevented 13,000 deaths In adults aged 60 or over and it should also be remembered that over 20% of those admitted with COVID-19 have a thrombotic event[39].

This adverse effect appears to disproportionately affect younger adults; this changes the risk/benefit calculation for these patients and all those aged under 40 should be offered a vaccine other than OAZ. The OAZ vaccine should only be given if there is a genuine clinical reason (e.g. allergy to a constituent of the other vaccines available) and this should be authorised by the senior clinical lead on duty at the vaccine centre before the person is vaccinated. In some cases this may mean that the person cannot be vaccinated when they first attend and must return on another day.

If someone aged under 40 has already had their first OAZ vaccine and has not had a thrombotic event, they should continue and have a second dose of OAZ. There is no current evidence on the safety or effectiveness of mixing brands between the first and second doses.

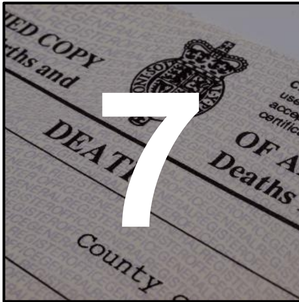
The OAZ vaccine should not be given to any patient with a history of heparin-induced thrombocytopaenia and thrombosis, but a history of other thrombosis, or of thrombophilia, is not a contraindication. This factsheet is useful when answering questions from patients.

Anyone who has a headache that persists for more than four days after receiving the OAZ vaccine is advised to seek medical advice. The headache of CSVT may have features of raised intracranial pressure (worse on lying or bending) or may be accompanied by other signs such as blurred vision, vomiting, altered speech, weakness, drowsiness or seizures. A new onset severe headache which has any of these features, new pinprick bruising or bleeding or other features of thrombosis such as shortness of breath or calf swelling, should prompt urgent

referral to hospital[24]. The RCGP resource on the COVID-19 vaccination has been updated to feature more information on this issue.

Adolescents aged 16-18 who are CEV should all be vaccinated. Those aged under 16 who are in the CEV group are not largely being vaccinated at the moment. The exception to this is the small group of children who have neuro-disabilities and recurrent respiratory tract infections who require residential care.

Those with a history of anaphylaxis (to any allergen) had previously been told that they couldn't have the Pfizer/BioNTech vaccination but this has now been changed and the contraindication is only for those with allergies to a constituent of the vaccine[25]. Organisation of the vaccine has been made more difficult by the requirement for patients to wait for 15 minutes after vaccination due to the risk of anaphylaxis – this remains a requirement for the Pfizer/BioNTech vaccine but not for the OAZ one, though patients should not drive within 15 minutes of receiving the OAZ vaccine. Pregnancy, breastfeeding and being on an anticoagulant are not a contraindication to either vaccine. The RCGP has published a new reference on anaphylaxis and the COVID-19 vaccination.



Death certification requirements are relaxed for as long as the Coronavirus Act is in force

You can put COVID-19 on a death certificate if the patient was diagnosed clinically but did not have a swab[26].

Significant changes have been made to death certification and cremation paperwork. These include the fact that paperwork can be emailed, the doctor filling out the death certificate and cremation paperwork does not need to have seen the patient in life and there is no longer a need to see the body after death. For more detail on this, see our short module on death certification.

Look after yourself and your staff

Anyone who actually listens to the security briefings on a plane will know that you should put your own oxygen mask on before helping others. The same principle applies here; if you get ill, you won't be able to care for your patients or help your colleagues. As well as using PPE if you see patients with possible coronavirus, look after your mental health by taking the time to debrief and by taking breaks when needed. An occupational health opinion could be sensible for some GPs with chronic conditions for whom a practice based risk assessment is not enough. If your mental health is affected, consider using some of the services available for GPs, such as practitioner health[27],and the NHS wellbeing support line[28], NHS Employers also has a wellbeing and support page[29].

Continue to plan ahead; this will be a marathon, not a sprint

Schools are open, although colleagues may be affected by children being sent home to isolate after a case in their class. There may also be an absence of wrap around care, so check if any of your staff are affected by this and need to change their hours.
Could they switch to doing core clinical work in the surgery and admin from home after the kids are in bed?

Keep up to date with guidance on self-isolation for those with symptoms and those who are contacts of a positive case. Currently those with symptoms must self-isolate for 10 days but this ends if they get a negative test. Contacts of a proven case must self-isolate for 10 days whether or not they have a negative test. The test and trace service will make the judgement as to who is a close enough contact to have to self-isolate – this is generally contact within 1-2 metres for a prolonged period of time rather than contact which is briefer or more distant.

Much routine care has now restarted, including smears, with priority for those with a previous abnormal smear or those with severe mental health problems or who are otherwise vulnerable. Remember that all women with HIV should have annual smears[30] and consider prioritising them as you restart. Make sure that what you are doing is sustainable for you and your practice. Routine work may need to stop or reduce again if cases of COVID-19 continue to rise. Childhood immunisations must continue. Guidance has been issued[31] as to which patients on warfarin can be safely switched to a DOAC which will help to reduce attendances at anticoagulation clinics. Guidance on spacing out DMARD monitoring[32] has now been retired and normal monitoring was resumed in August, however this may need to be reconsidered depending on pressures on phlebotomy and other services. Consider restarting the fitting of long-active contraceptive methods if this is something that you or your practice normally provide. The Primary Care Women's Health forum[33] has produced a series of webinars on the practicalities of doing this as well as other information on women's health during lockdown and the Faculty of Sexual and Reproductive Health also has information on their website about restoration of services[34].

Your core clinical skills are still important

Not every ill patient will have coronavirus and remember that "normal" things still occur. Even under pressure allow space for patients to tell you what's wrong with them. Keep an open mind, think laterally, and suspend your judgement as it saves time in the end. Consider which are the relevant questions to ask; your core clinical skills are your most reliable tools. If 'pattern recognition' is not working, re-frame your ideas using first principles and using probability and an analytical approach. Learn to tolerate uncertainty and share this with the patient. Most of us have long been aware of the importance of recognising when a patient 'makes your antennae twitch' and this has now been validated in a study[35] showing the importance of GP gut feelings, so don't underestimate the importance of listening to your inner voice. Make sure that you document that your triage decisions are made due to COVID-19 so that if your decisions are called into question in years to come you remember the surrounding circumstances. NICE have brought out a guideline about the management of COVID-19, including end of life symptoms[36]. If your patient needs referring to secondary care then you should still make the referral rather than holding onto them in primary care.

You may be starting to see patients who are affected by long covid – find out if there is a multidisciplinary long covid clinic in your area and read the NICE guidelines[37] and RCGP eLearning resources[38] on long covid.

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DOI – Dr Hazell is on the executive committee of the PCWHF, a role which involves both paid and unpaid work. The quoted BMJ paper on remote oxygen saturations monitoring was co-authored by Dr. Jonathan Leach, RCGP Honorary Secretary.