RC GP LEARNING

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

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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 significant pressure in the press for GPs to return to seeing all patients face to face, with little understanding of the pressures that GPs are under. The RCGP is vigorously defending GPs against the allegations that we are hiding[1]. Consider what is right for your practice – many practices operated a triage model even before COVID-19 and others may consider that phone or online triage is a useful future model to deal with the pressures on general practice and to make best use of the widening of the primary care workforce to include staff including clinical pharmacists, first contact physiotherapists, mental health workers, care coordinators and social prescribers.

Whilst face masks have become optional in many public areas and on public transport, they should still be worn by patients and staff in all healthcare settings[2].

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.
- NHSE have advised that practices should respect preferences for face-to-face care unless there are good clinical reasons to the contrary (e.g. COVID-19 symptoms) and that a clinician proceeding with remote care should be confident

that it will not have a negative impact on their ability to carry out the consultation effectively[41].

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.

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.

Hot hubs have gone in most areas, but some practices may be using a separate 'hot room' for patients with respiratory symptoms. If a symptomatic patient needs to be seen in your own surgery, consider bringing them down at a quieter time of the day, at the end of a session, or using a different entrance or consulting room.

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 or hood, 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.

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 has ended but QCovid is available for GPs who find it useful

The shielding programme has now been closed down in all four countries of the UK. More information about this is in our eLearning resource, which will be updated again if there are any changes.

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. 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.

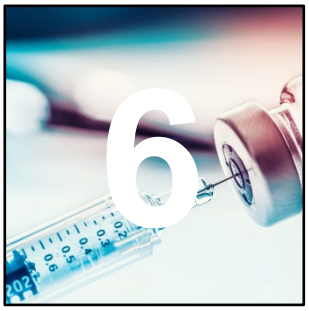
Think about which groups of patients may find it hard to access primary care with our current ways of working

With the move to full triage, we must be careful not to exacerbate health inequalities for some groups of patients, particularly those who are digitally excluded. More information about this can be found in the recently published RCGP module on health inequalities. Don't forget those with mental health issues – there are NHSE resources to do with dementia[9], learning disabilities[10] autism[10], and hearing loss[42] which may be useful. Consider how deaf patients will access your surgery if the main access point is on the phone[11,12].

Appraisal has restarted in a very light-touch way and the CQC have restarted inspections

- The 2022/23 appraisal year has now started and so far the 'light touch' format from last year is continuing, involving significantly less need for documentation; preparation should only take around 30 minutes[13]
- Changes to appraisal are summarised in this useful video[14].
- 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 soon 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. Surveys can be carried out after face to face or remote consultations.

- CQC inspections have restarted[15] – the BMA have expressed concern about the timing of this and called for a complete overhaul of the inspection process[16].
- You do not need to do a fit note 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 for longer than that they can get a certificate online from 111[17].
- 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[18] – 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[19]. It is also a GMC requirement[20] 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 and community treatments

As of. 1.6.22, over 143 million COVID-19 vaccination doses have now been administered to UK citizens[21].

Eligibility is as follows:

- Age 5-11 – those who are particularly vulnerable were offered the vaccination from January 2022[22]. A universal offer of two doses started in April 2022, using a lower dose than that given to adults[23]. Appointments can be booked via the national booking website.
- Age 12 – 15 without immunosuppression – this group are being offered a course of two vaccines (but no booster) with a 12-week gap between the doses. Those at serious risk of severe illness can have their two doses with an eight-week gap
- Age 16 and over – this group are being offered two vaccines plus a booster three months after the second dose of the primary course.
- Those with a severely weakened immune system who are aged 12 and over have been offered a three-dose primary course, after which they can have their booster – they will therefore receive four doses in total[24]. Further information on this is available on these links for England, Scotland, Wales, and Northern Ireland.
- A further booster, called the 'Spring booster' is now being offered to all those aged 75 or over, those who live in a care home and those aged 12 and over who are immunosuppressed. Unlike previous boosters/vaccination rounds, health and social care workers are not being offered this booster. It should be given no earlier than

three months after the last booster dose. The green book chapter on the COVID-19 vaccine[25] contains a table advising on which conditions count as being immunosuppressed for the purposes of this booster. Broadly speaking this corresponds more to the shielding group than the group who usually get an NHS flu vaccination, for example those with asthma are only eligible if they are on systemic steroids or have needed admission in the past.

The JCVI has given interim advice about an Autumn booster to be given later this year. It will be for frontline health and social care workers, all those aged 65 years or over, all residents and staff of care homes and adults aged 16 – 64 who are in a clinical risk group[46].

There is now less publicity about thrombosis with thrombocytopaenia after COVID-19 vaccination; this was a rare side-effect of the OAZ vaccine and should therefore be less of an issue as we use more Pfizer/BioNTech and Moderna for boosters.

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 or those with multiple unknown anaphylactic reactions[25]. The need for patients to remain at the vaccination centre for 15 minutes after being vaccinated has now been suspended, although driving should be avoided for the first 15 minutes[26].

Pregnancy, breastfeeding and being on an anticoagulant are not a contraindication to either vaccine and women who are pregnant are recommended to have vaccination with either Pfizer/BioNTech or Moderna.

At the start of the vaccination programme there were significant restrictions on how the Pfizer/BioNTech vaccination could be moved once it had been defrosted; these have now been relaxed somewhat, which makes it easier to give in community clinics. It can now be stored in a fridge after defrosting for 31 days (increased from five)[27] and can be moved for up to two journeys of six hours each, or one journey of twelve hours (including initial delivery to the main site).

The RCGP has a short eLearning module on the COVID-19 vaccination as well as a reference on anaphylaxis and the COVID-19 vaccination. Any other queries are likely to be answered with reference to the relevant chapter of the Green Book.

Antivirals can now be used in the community to treat patients with COVID-19 who do not need to be admitted to hospital. Patients who are very high risk (this group is more similar to the shielding group than to the group who are regularly offered an NHS flu vaccination) should have a PCR test to keep at home. A positive PCR (or lateral flow test uploaded to the NHS website) should prompt their local COVID-19 medicine delivery unit (CMDU) to phone them directly and offer either an oral antiviral or an intravenous monoclonal antibody. In theory the GP does not need to be involved in this process, but inevitably there are limits on coding accuracy and some patients may not have been picked up centrally but could still qualify for such treatment. If unsure, the GP can refer to their local CMDU via the eRS system; the clinics are found under infectious diseases. Patients who are aged over 50 or have any co-morbidity (broadly corresponding to the usual flu vaccination group) can enter the PANORAMIC study where they have a 50% chance of being allocated to a treatment arm and being given antiviral drugs. Information on these new treatments is summarised here[28].

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[29].

The Coronavirus Act has now expired and some of the changes in it have reverted back to normal. Others will remain.

Ministry of Justice guidance[44] is that the death certificate or cremation form (Form 4) can now be signed if the person has been seen in their final illness **either** in the 28 days before death, **or** after death, but it must be signed by the doctor who has seen the patient – the option for any doctor to sign the form is now gone.

If the death was expected and someone other than the GP has verified death, but the GP has not seen in the 28 days before death or after death, then it may be possible for the coroner to sanction the signing of the death certificate, and the crematorium referee to allow the cremation form to be signed. There will be no return of the Form 5 (colloquially known as the 'part 2') for cremation purposes.

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[30], and the NHS wellbeing support line[31].

There has been a significant change, with the end of the mask mandate in primary care[54]. Patients with respiratory symptoms who need emergency treatment should wear a face mask if tolerated, but other patients are not required to wear a face mask unless it is their personal preference. Healthcare professionals need only continue to wear a face mask when working in COVID-19 or respiratory pathways and when clinically caring for those with suspected or confirmed COVID-19. They do not need to wear masks in non-clinical areas such as offices.

Continue to plan ahead; this is a marathon, not a sprint
Free testing has been significantly scaled back in England although lateral flow tests are still available for those who may be eligible for COVID-19 antivirals[51].

There is no longer a legal requirement for the general public to self-isolate if diagnosed with COVID-19, however many schools are still asking children who test positive to stay home and so colleagues may be affected by childcare issues. Can you support such staff, for example by allowing them to do just core clinical work in the surgery and admin from home after the kids are in bed?

The advice in Scotland changed on May 1st and most people no longer need to test if symptomatic. Free tests are available for health and social care workers, those who would be eligible for antivirals or for the self-isolation support grant, unpaid carers and anyone who is visiting a care home or going into hospital for a procedure or operation. Anyone who tests positive should isolate for three days (if aged 18 or under) or five days (if aged over 18), with the day of the test being day zero. Close contacts no longer need to test daily.[45, 46].

In Wales, lateral flow testing is available free of charge only for those who have symptoms – those with a positive test should self-isolate for five full days and test again on day five (the first day of symptoms being day zero). If the day five and six tests are negative then self-isolation can end on day six, if not then continue daily tests and self-isolate until there are two negative tests in a row, or until day 10 is reached[47, 48].

In Northern Ireland, free lateral flow testing is available for those with symptoms and the self-isolation advice is the same as for Wales. Lateral flow tests for those without symptoms also remain free and are advised before meeting friends or family, attending social gatherings, spending time in a crowd or visiting someone who is elderly or vulnerable[49,50].

NHS staff can continue to access free lateral flow tests and should continue to test twice weekly[52]. Those with symptoms should also do a lateral flow test but are no longer required to do a PCR test[53].

Those who have a positive test should do the following[53]:

- Stay away from work for at least five days.
- Carry out a lateral flow test on day five (day zero being the day that symptoms developed or the day of the test if there were no symptoms).
- If the day five test, and a repeat at least 24 hours later are both negative, they may return to work, if they feel well enough to work and do not still have a fever. If not, then they should continue to test daily and may return to work when two consecutive tests taken 24 hours apart are negative.
- If the person still tests positive on day 10, they should discuss this with their line manager, who may undertake a risk assessment
- A risk assessment should be carried out for those who work with patients who are especially vulnerable to COVID-19 – this may result in them being redeployed for 10 days after the positive test, regardless of lateral flow test results.

Healthcare staff who are contacts of COVID-19 should continue with twice weekly lateral flow testing, but no longer need to do a PCR test. They should discuss ways to minimise risk of onward transmission with their line manager. This may include redeployment to lower risk

areas, working from home or limiting close contact with others. Organisations working with individuals who are particularly vulnerable to COVID-19 may carry out their own risk assessment and put more stringent conditions in place.

Routine care has 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[32] and consider prioritising them. Make sure that what you are doing is sustainable for you and your practice. Childhood immunisations must continue. Guidance has been issued[33] 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[34] has now been retired and normal monitoring should be in place 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[35] 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[36].

Your core clinical skills are still important

Not every ill patient will have COVID-19; 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 been validated in a study[37] 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[38]. If your patient needs referring to secondary care, then you should still make the referral rather than holding onto them in primary care. You will be likely 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[39] and RCGP eLearning resources[40] 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.