RC GP LEARNING

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

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

Last updated on September 9th

Keep up to date with who should do what and think about how you will offer face to face care to those who need it

Things are changing all the time - nominate one person in your practice to keep an eye on the guidance and cascade any changes.

- The 'stay at home' message has now been relaxed and those who cannot work from home should return to work if their workplace is open. Travel on public transport is discouraged unless unavoidable and face coverings are now compulsory on public transport throughout the UK and in shops and some other public venues in England and Scotland. Social distancing measures should still be followed in the workplace[1]. Patients who phone their GP because they are concerned about returning to work, but are not unwell, should not be given a sick note but should be advised to discuss this with their manager, occupational health or their union.
- Those who have symptoms must still self-isolate for 10 days and their household contacts must self-isolate for 14 days[2].
- A track and trace system will contact patients who have been in contact with a known case; these contacts will be asked to self-isolate for 14 days.
- Any patient wanting an appointment should be triaged first; some will need to be seen face-to-face and all practices must be able to offer face to face appointments when needed. Shared decision making principles should ideally be used when deciding whether a face to face appointment is needed, although 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).
    - 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 option? 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?
    - Does the patient have a condition for which a face-to-face appointment is preferable, even if not essential? For example managing mental health 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 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?
-

Triage, triage, triage – be on the alert for ill children and know what to do if resuscitation is needed

No patient should attend their GP without being phone or video triaged first. Patients with mild symptoms (of a cough or fever, defined as feeling hot on the chest or back) can be told on the phone to self-isolate and those who are clearly severely ill should have an ambulance called. For the middle group who need a face to face assessment, you need to know what your local service is. Some areas have a hot hub, others have a visiting service or an oxygen saturation monitor delivery service (where you would be comfortable to manage the patient on the phone/video if you knew their sats). Remember that new anosmia or lack of taste is a symptom of possible COVID-19 which should prompt self-isolation[3] and do not examine the throat as this carries a particularly high risk of spread[4].

Guidelines have been published regarding resuscitation in primary care[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. 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.

Concerns have been raised[6] that some children with COVID-19 will develop a multi-system inflammatory reaction which can require intensive care. 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 pausing in England, except in areas of local lockdown.

Those at most risk from coronavirus were advised to shield i.e. stay home all the time for a period of 12 weeks. Shielding has now been paused in all four countries of the UK[7,8,9,10]. The exception is for areas of local lockdown[11], in which shielding may continue or resume..

You should still keep the shielding register active as it will be needed if shielding is restarted in your area or nationally. More information about this is in our eLearning resource, which includes links to relevant public health and NHSE websites, as well as information to help identify which patients on immunosuppressants should shield and further details on shielding in Scotland and Wales, where the procedures are slightly different to those in England. Some patients are asking for a letter for their employer. There is no obligation for a GP to provide such a document, however some practices are finding that empowering reception to give a standard letter takes pressure off the clinical staff. If this is the case in your practice, you can find a standard downloadable letter in our eLearning resource.

New RCPCH guidance on shielding for children, 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. The number of children who are shielding is likely to reduce due to this guidance; we in primary care should never make a shielding decision on a child. If asked to do this by a parent, signpost them back to their 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.

Looking ahead, work is taking place on a more detailed online risk calculator similar to those which we already use (such as FRAX or QRisk). It is hoped that this will be ready in the months to come and that it will be patient facing, to empower conversations with employers, as well as available for GPs to use if they wish to do so.

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

Practices should read the full document[12], 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.
- Follow your local pathways for patients with symptoms that could be COVID-19 – this may involve a 'hot hub' or practices being segregated into 'hot' and 'cold' areas. Practices with pharmacies in them should not be used as hot hubs. The same applies if a patient who is self-isolating needs to be seen face to face – they should be treated the same way as those with symptoms of COVID-19.

- Practices have all been asked to make some appointment slots bookable by 111 and the covid clinical assessment service (CCAS). These can be telephone appointments.
- Patients or staff with symptoms of COVID-19 can apply for a test online[13] or by calling 119. Testing is also offered via this route for healthcare workers who are household contacts of someone with symptoms of COVID-19. The SOP also includes a link to the antibody scheme which is available to patients and NHS staff in some areas.
- Staff who are clinically vulnerable (those who are not shielding but are over 70 or normally in the flu vaccination group) should consider not seeing patients face to face. Consider carrying out a formal risk assessment[14,39] for your staff.
- Patients should be asked to wear a face mask. For those who do not have one, practices may offer the patient a mask. If they refuse to wear one then consideration could be given to other options such as seeing the patient in a separate area from other patients or managing them remotely.
- Symptomatic patients should not collect medicines from the pharmacy – use the NHS volunteers system[15] if they have no family or friends to collect for them. Make full use of EPS.
- Don't forget mental health – this document[16] on learning difficulties and autism is 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.

Normal admin is being reduced, but you may still have to quarantine if you go on holiday

Many of the administrative burdens on primary care are melting away:

- Doctors who were due to revalidate between 17 March 2020 and 16 March 2021 have had their revalidation submission dates moved back by one year[17]. Appraisal, which was suspended as part of the COVID-19 response, will restart in October with a new format involving significantly less need for documentation[18]. Those who miss an appraisal will not need to catch it up and will revalidate with one less appraisal in this revalidation cycle.
- There will be no routine CQC inspections in England.[19]
- If your 19/20 QOF figures are worse than the year before, you will be paid according to the 18/19 figures[20].
- LCS schemes will be suspended and the money paid to practices automatically[20].
- VTS half-day release and the CSA exam have been suspended, allowing trainees to spend more time in practice.
- You do not need to do a med3 for anyone staying at home due to coronavirus, 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]. Those who receive a shielding letter and wish to discuss their safe return to work should show that to their employer. Those not considered high risk but who wish to stay at home need to discuss this with their employer and are not eligible for a medical certificate unless unable to work for any other reason. It may be useful to direct them to the ACAS page about work and coronavirus[22].

- 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 scanned and e-mailed to patients – patients do not need to have the original with a 'wet' signature, but this can be posted if requested.[12]
- Healthcare professionals returning from a country with which the UK does not have an 'air bridge' must quarantine for two weeks before returning to work[24].

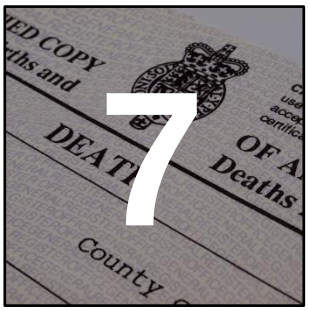
Continue to wear PPE when seeing patients face to face, and start planning for a much bigger flu vaccination season than usual

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[24]. 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.

The flu vaccination cohort will be much bigger than usual this year, including all those aged over 50 as well as all household contacts of patients who were in the shielding group. It is also possible that many of those in the usual at-risk group who have declined vaccines in the past will be more health conscious and accept them this year. It is estimated that twice the number of people as usual will be vaccinated.

PHE have announced that single use PPE is not necessary for 'clinical outpatient settings, such as vaccination/injection clinics, where contact with individuals is minimal' unless there is exposure to blood or other bodily fluids or broken skin[25]. The RCGP have published a

document considering some of the issues that may arise when running a mass vaccination programme in the time of COVID-19[26].



Death certification is changing

You can put COVID-19 on a death certificate if the patient was diagnosed clinically but did not have a swab[27] – many who die in the community won't get tested.

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 screencast 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'll be of no use to anyone. As well as using PPE if you see patients with possible coronavirus, look after your mental health if this is stressing you out. If you are on the list of high-risk people who should shield, think strongly about staying home for 12 weeks, even if you feel like you are letting people down. Doctors affected by this may be able to do telephone triage or other non patient-facing tasks such as remote prescription signing or document management. An occupational health opinion could be sensible for some GPs with chronic conditions. If your mental health is affected, consider using some of the services available for GPs, such as practitioner health[28],and the NHS wellbeing support line[29], NHS Employers also has a wellbeing and support page[30].

Plan ahead; this will be a marathon, not a sprint

We are probably at the end of the beginning, not the beginning of the end, although this will depend on where in the UK you work. If you have access to the data, keep an eye on local trends in diagnoses so that you have some warning if a local lockdown is likely. It seems probable that numbers will rise more steeply as the weather gets colder and people spend more time indoors.

Children have now returned to school, but there may still be issues such as partial school closures due to covid cases and after school clubs and wrap around care being unavailable, 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? You are likely to have significant numbers self-isolating for two weeks at short notice as household contacts develop symptoms. Keep on top of what should and shouldn't be done – smear tests have now restarted in many areas, 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[31] and consider prioritising them when you restart. Make sure that what you are doing is sustainable for you and your practice. Consider what 'routine' work can be put off and what should still be done, using this joint RCGP/BMA guidance[32]. Don't stop doing childhood imms. 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 and there is also guidance on which patients with DMARDs can have their blood tests safely spaced out at longer intervals than normal[34]. Consider restarting the fitting of long-active contraceptive methods if this is something that you do and have not yet restarted. 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.

Your core clinical skills are still important as is any spare time that you have

Not every ill patient will have coronavirus. Even under pressure still 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[36] 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 (possibly via a template) so that if your decisions are called into question in years to come you remember what was going on. NICE have brought out a guideline about the management of COVID-19, including end of life symptoms[37]. If your patient needs referring to secondary care then you should still make the referral rather than holding onto them in primary care – providers have been told to make referrals possible on eRS as normal[38].

References (accessed 3.8.20)

1. https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing/staying-alert-and-safe-social-distancing
2. https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-advice/
3. https://www.entuk.org/sites/default/files/files/Loss%20of%20sense%20of%20smell%20as%20marker%20of%20COVID.pdf
4. https://www.rcpch.ac.uk/sites/default/files/generated-pdf/document/COVID-19---guidance-for-paediatric-services.pdf
5. https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/primary-healthcare/
6. http://www.pulsetoday.co.uk/clinical/clinical-specialties/respiratory-/gps-alerted-to-coronavirus-related-condition-emerging-in-children/20040689.article

7. https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
8. https://www.gov.scot/publications/covid-shielding/
9. https://www.nidirect.gov.uk/articles/coronavirus-covid-19-pausing-shielding-extremely-vulnerable-people
10. https://gov.wales/guidance-on-shielding-and-protecting-people-defined-on-medical-grounds-as-extremely-vulnerable-from-coronavirus-covid-19-html
11. https://www.gov.uk/government/collections/local-restrictions-areas-with-an-outbreak-of-coronavirus-covid-19
12. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/CO485_guidance-and-standard-operating-procedures-general-practice-covid-19.pdf
13. https://www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/ask-for-a-test-to-check-if-you-have-coronavirus/
14. https://www.fom.ac.uk/covid-19/update-risk-reduction-framework-for-nhs-staff-at-risk-of-covid-19-infection
15. https://www.goodsamapp.org/NHSreferral
16. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0031_Specialty-guide_LD-and-coronavirus-v1_-24-March.pdf
17. https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/changes-made-to-revalidation-in-response-to-the-coronavirus-covid-19-pandemic
18. https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/?fbclid=IwAR1ZWg3i8byRa2U-FYvfiLvfop2D75Q8aZ6cQJnjN5IBFeKQYixfVOE3SVU
19. https://www.cqc.org.uk/news/stories/routine-inspections-suspended-response-coronavirus-outbreak
20. http://www.pulsetoday.co.uk/clinical/clinical-specialties/respiratory-/gp-qof-and-enhanced-service-income-to-be-protected-during-covid-19-outbreak/20040368.article
21. https://111.nhs.uk/isolation-note
22. https://www.acas.org.uk/coronavirus
23. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-coronavirus/
24. http://www.pulsetoday.co.uk/news/gps-no-longer-exempt-from-self-isolating-after-travelling/20041251.article
25. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf
26. https://elearning.rcgp.org.uk/pluginfile.php/149506/mod_page/content/75/Mass%20Vaccination%20at%20a%20time%20of%20COVID%20V2.0.pdf
27. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877302/guidance-for-doctors-completing-medical-certificates-of-cause-of-death-covid-19.pdf
28. https://www.practitionerhealth.nhs.uk/
29. https://people.nhs.uk/help/
30. https://www.nhsemployers.org/covid19/health-safety-and-wellbeing
31. https://www.bhiva.org/file/DqZbRxfzlYtLg/Monitoring-Guidelines.pdf

32. https://elearning.rcgp.org.uk/pluginfile.php/149509/mod_page/content/29/12062020COVID19WorkloadPrioritisationFlowchart.pdf
33. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Coronavirus/FINAL%20Guidance%20on%20safe%20switching%20of%20warfarin%20to%20DOAC%20COVID-19%20Mar%202020.pdf?ver=2020-03-26-180945-627
34. https://midessexccg.nhs.uk/medicines-optimisation/covid-19-resources/shared-care-drugs-1/3705-shared-care-drugs-monitoring-during-covid-19-pandemic/file
35. https://pcwhf.co.uk/?s=Covid-19
36. https://bjgp.org/content/70/698/e612
37. https://www.nice.org.uk/guidance/ng163/resources/covid19-rapid-guideline-managing-symptoms-including-at-the-end-of-life-in-the-community-pdf-66141899069893
38. https://digital.nhs.uk/services/e-referral-service/e-rs-features-that-may-help-with-managing-patients-referrals
39. https://www.bma.org.uk/advice-and-support/covid-19/your-health/covid-19-risk-assessment

DOI – Dr Hazell is on the executive committee of the PCWHF, a role which involves both paid and unpaid work