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?

- We are now back in lockdown, but this does not mean a move to emergency appointments only. The government website[33] 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'
- Any patient wanting an appointment should be remotely triaged first[1]; 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?
    - 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.

Think about how you are going to manage respiratory symptoms over the winter and be aware of the issues with COVID-19 in children and what to do if resuscitation is needed

During the peak of the first wave of the pandemic, many areas provided 'hot hubs' where patients who needed a face-to-face assessment and had potential symptoms of COVID-19 could be seen. Some of these have been stood down as the prevalence dropped and this will need to be reviewed as we head into the winter with a greatly increased prevalence of respiratory symptoms. Talk to your CCG, PCN, Health Board and federation and know what the arrangements are locally – 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.

Guidelines have been published regarding resuscitation in primary care[2]. 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[3] 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 paused and is unlikely to return in the same form as at the start of the pandemic

Shielding has now restarted, but with a different focus. The 'stay at home all the time' message of the first lockdown has been withdrawn. Those in the clinically extremely vulnerable (CEV) group, also known as the shielding group should stay at home as much as possible, and in particular should not attend work. This is different from the general population and moderate risk groups who should attend work if not possible to work from home. Those in the shielding group can attend medical appointments and are encouraged to leave the house for exercise. Adults with Down's syndrome have been added to the shielding list and GPs have been asked to identify them. Patients with stage 5 chronic kidney disease have also been added and will be identified by renal units. The RCGP is involved in discussions on shielding at a high level and will pass on updates as soon as there is more certainty in this 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.

You should still keep the shielding register active. More information about this is in our eLearning resource, which is being regularly updated. Some patients are asking GPs for a letter for their employer if they are in the moderate risk group or the group that was previously asked to shield. 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[4], 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. We have been asked to review our list of shielding children and remove anyone who is obviously on there in error.

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

Practices should read the full document[1], 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 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[5] or by calling 119. Testing is also offered via this route for professionals who regularly visit a care home and are taking part in a scheme that involves regular testing. There have been well documented problems with timely access to tests – many areas have their own arrangements whereby healthcare professionals can get priority tests if they or their families have symptoms, to avoid disruption to services from prolonged self-isolation. Find out what is available in your area before you need to use it.
- Staff who are clinically vulnerable should consider not seeing patients face to face. Consider carrying out a formal risk assessment[6,7] for your staff.
- 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[8] if they have no family or friends to collect for them. Make full use of EPS.
- Don't forget mental health – this document[9] 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.

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

- 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[10]. Appraisal, which was suspended as part of the COVID-19 response has now restarted, with a new format involving significantly less need for documentation; preparation should take only 30-40 minutes[11]. Changes to appraisal are summarised in this useful video[12]. 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 patient survey then talk to your appraiser or appraisal office – in this situation revalidation will usually be deferred. Similarly, if 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 – the BMA have expressed concern about the timing of this and called for a complete overhaul of the inspection process[13].
- 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[14].
- 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[15].
- 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[16] – 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[17]. 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.

Continue to wear PPE when seeing patients face to face, and continue 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 unless damaged, damp or dirty[18]. 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 is 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. Feedback we have received is 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. Gloves are not required for flu vaccination

clinics, instead hand sanitiser should be used between patients[18]. For patients requiring vaccination in their own home, PPE including gloves and apron should be worn as would be the case for any home visit. 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[19] and an eLearning resource on flu. At the time of writing there is much discussion about how a proposed COVID-19 vaccine will be administered – updates will be pro

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[20].

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'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. 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[21],and the NHS wellbeing support line[22], NHS Employers also has a wellbeing and support page[23].

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

Children have now returned to school, but there may still be issues such as partial school closures due to COVID-19 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. Whilst existing informal childcare arrangements can continue, this must be part of an 'existing childcare arrangement[32]' and so some staff may be affected by the loss of more ad hoc arrangements, especially during school holidays. 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 14 days but this ends if they get a negative test. Contacts of a proven case must self-isolate for 14 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[24] 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[25] 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 has now been retired and normal monitoring should be resumed[26]. 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[27] 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[28].

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[29] 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 what was going on. NICE have brought out a guideline about the management of COVID-19, including end of life symptoms[30]. 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[31].

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