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

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Keep up to date with who should do what

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 whilst travelling on public transport are now recommended in all 4 UK nations. Social distancing measures should still be followed in the workplace[1]. Patients who phone their GP with anxieties 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 at particularly high risk have been sent a letter advising them to 'shield', discussed more in point 3.
- Those who have symptoms must still self-isolate for 7 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.

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.

Patients will ring to ask if they should shield

There has been widespread discussion about the list of patients who are deemed to be at particularly high risk and should therefore shield, i.e. stay at home for 12 weeks. Those at most risk have been sent letters or texts from NHS digital advising them to shield; this search will be updated weekly as some patients may move in and out of the group, for example if they start chemotherapy they will move into the group. A pregnant woman with heart disease who gives birth will move out of the group. NHS digital will insert the code 'High risk category for developing complication from COVID-19 infection' (EMIS and TPP) or 'Risk of exposure to communicable disease' (Vision) in the GP notes and we will be able to see this. GPs should not make any attempt to systematically identify patients who should shield. The list of those who should shield is expanding all the time and consultants will also be adding patients who they feel should shield. The shielding advice was slightly relaxed on June 1st , with shielding patients advised that they could leave home and spend time with one person from another household, as long as they stay outdoors and maintain social distancing. From July 6th, shielded patients in England can meet with up to 6 people from different households outside (8 in Scotland) and from July 31st they can stop shielding and can return to work if their workplace is COVID safe. No changes have been announced in Wales or Northern Ireland.

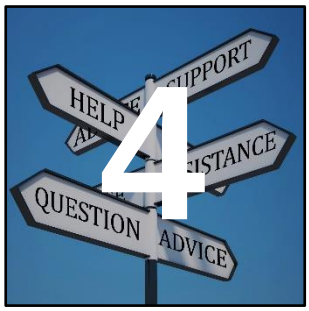
New RCPCH guidance on shielding for children points out that it is extremely unlikely for a child to need to shield if they are not under the care of a consultant. The number of children who are shielding is likely to reduce due to this guidance; we in primary care should never make a shielding decision 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.

There are two scenarios likely to arise in primary care. The first is a patient who has had a shielding letter or text but does not believe that they should shield. If a patient like this phones you, review their notes and if there is no reason for them to shield then you can reassure them that the communication was sent due to a coding problem and they should just socially distance, more stringently if they are aged over 70 or medically in the group who usually get an NHS flu vaccination. If in doubt as to whether a patient has been correctly added, you can email NHS Digital (or equivalent in devolved nations) for advice on Splquery@nhs.net. Alternatively the patient might want to contact their consultant or nurse specialist, or you might do that if the particular team is easy to get hold of. If in doubt it is probably safest to leave the patient on the shielding list.

The second scenario is when a patient phones to ask for a shielding letter. If your clinical judgment is that you feel they are particularly at risk then you can add codes above to their notes and send them a shielding letter, if not then advise them about social distancing. If

they do not meet the criteria for shielding but have phoned to ask for a letter for their employer, advise them that this is not a medical issue and they could consider talking to occupational health or their union.

More information on shielding can be found in our eLearning resource. It 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. All practices should identify a shielding lead and make sure that all shielding patients have had at least one phone contact from the practice[7].



There is a new standard operating procedure (SOP) for primary care

Practices should read the full document[7], but some highlights are given below:

- Remote consultation, with video if needed, should still be done first line.
- Follow your local pathways for patients with symptoms that could be covid – this may involve a 'hot hub' or practices being segregated into 'hot' and 'cold' areas. Practices with pharmacies in them should not be used to see patients 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[8] 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 but at the time of writing many NHS hospital labs are not able to offer this.
- Staff who are clinically vulnerable (those who are not shielding but are over 70 or normally in the flu vaccination group) should not see patients face to face. Consider carrying out a formal risk assessment[9] for your staff.
- Symptomatic patients should not collect medicines from the pharmacy – use the NHS volunteers system[10] if they have no family or friends to collect for them. Make full use of EPS.
- Don't forget mental health – this document[11] 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

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[12]. Appraisal has been suspended in some areas. 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.[13]
- If your 19/20 QOF figures are worse than the year before, you will be paid according to the 18/19 figures[14].
- LCS schemes will be suspended and the money paid to practices automatically[14].
- 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. 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]. Those who receive a shielding letter should show that to their employer. Those not considered high risk but who wish to stay at home for 12 weeks 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[16].
- 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.[7]
- Complaints handling has been paused for 3 months from March 31st 2020[18].

PPE is not just a degree in politics, philosophy and economics

Check how much PPE (personal protective equipment) you have and consider developing a protocol for how PPE is used and for how long it is worn. Primary care PPE consists of gloves, an apron, eye protection and a fluid resistant surgical mask, all of which should be disposed in the clinical waste after being taken off[19]. 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 start wearing 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.

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[20] – 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[21],and the NHS wellbeing support line[22], NHS Employers also has a wellbeing and support page[23].

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

We are currently at the end of the beginning, not the beginning of the end. Some children are going back to school on June 1st, as well as the existing provision for the children of keyworkers, but there may still be issues such as 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 and some will need to shield for 12 weeks. Keep on top of what should and shouldn't be done – in some areas smear tests are now restarting, 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 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[25]. Don't stop doing childhood imms. Guidance has been issued[26]

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[27].

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 an analytical approach using probability. Learn to tolerate uncertainty and share this with the patient. 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[28]. 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[29].

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