COVID-19 Workload Prioritisation Unified Guidance

11 January 2021

Note

This guidance has been developed by the RCGP and the BMA GP's Committee for clinicians working in general practice in the UK. It replaces prior guidance on workload prioritisation during COVID-19, including "response levels" and "RAG ratings".

This document should be read alongside local and national guidance from NHS and government bodies and is not a substitute for clinical judgement. **The situation with COVID-19 is rapidly changing. This guidance is correct at the time of publishing.**

Background

In response to the COVID-19 pandemic, the RCGP and the BMA's GP committee has prepared joint guidance to help practices across the UK to prioritise the clinical and non-clinical workload in general practice.

The current guidance on COVID-19 Response Levels can be found below. As of 11 January 2021, the RCGP and BMA believes it appropriate that most practices across the UK are operating at response level 4 or 5.

The initial pandemic peak in the spring of 2020 saw a reduction in the breadth of GP services offered as general practitioners and their teams focused on infection prevention and control in order to keep staff and patients safe and prioritised workload to focus on the clinical priority of responding to COVID-19 whilst keeping essential core services running. This was followed by a period of reduced COVID-19 spread, during which most practices were able to restore some or all routine services.

A shifting national context

As we move into 2021, the prevalence of COVID-19 is high and rising rapidly, with renewed lockdowns in place across the four nations of the UK. This is leading to significant pressures on health and social care services, which GPs and their teams are responding to, while also taking a central role in the COVID-19 vaccination programme.

We must recognise, however, there these pressures are not uniformly felt across the regions and nations of the UK. We also know that decisions not to seek care for long-term conditions or newly developed potentially serious symptoms can place patients at a level of risk which, for some, is as significant or higher than the risk from COVID-19.

A flexible response

Taken together, these factors mean there is no single 'one size fits all' blueprint for how practices should operate, or what measures should be taken to manage workload that can be suggested. GPs and their teams must be given 'permission' to provide care that best serves the needs of their patient population, in a way that adds most clinical value and keeps patients, clinicians and staff safe from the risk of contracting COVID-19.

We must also recognise that the general practice workforce has been physically and psychologically drained during the last year.

General practice is open

Most importantly, whatever steps we take to manage workload, we must not undermine the message that general practice remains open and that patients will be seen face to face where it is clinically appropriate. We must continue to encourage patients with potentially serious symptoms to contact their surgery to enable an assessment.

Local decision making

CCGs or health boards across the four nations will need to work in partnership with local GPs, other health and social care partners, and patients. We must ensure any re-prioritisation of clinical and non-clinical workload is based on clinical judgement and informed by experience gained during the earlier stages of this pandemic. Different local workforce factors will also guide which aspect of workload to de-prioritise. A shared understanding of the response level faced in a particular geographical area is an important first stage. For more information see the COVID-19 Response Levels (below). As of 11 January 2021, the RCGP and BMA believes it appropriate that most practices across the UK are operating at response level 4 or 5.

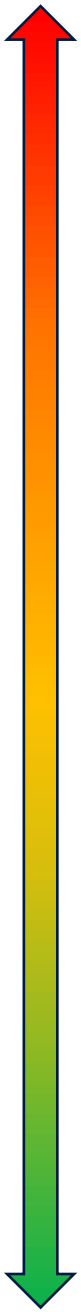
The RAG ratings guide (below), could be reasonably used to inform these discussions and then once agreed would be valuable as a guide for clinicians and patients as to what level of service can reasonably be expected.

COVID-19 Response Levels

These response levels outline types of work that should be undertaken in primary care, depending on COVID-19 prevalence and other workload and workforce factors.

As COVID-19 becomes more prevalent, and as GPs and their teams focus on delivery of the COVID-19 vaccination programme, it may be appropriate to move to higher response level, re-prioritising some clinical and non-clinical work to focus on continued delivery of a reduced range of general practice services. Decisions to move between levels should be taken at a local level, with due consideration of national conditions and guidance.

Maintaining public confidence that 'general practice is open' and that where clinically appropriate, face to face access to general practice is possible, must be a clear communication priority at all levels of response.



Response Level	Workload Prioritisation Guidance
Level 5 **Emergency response** **Prevalence very high**	All non-essential work stopped to allow general practice to cope with very significant, potentially overwhelming, demand relating to COVID-19, acute deterioration in long-term conditions, new symptoms indicating potentially serious disease and the COVID-19 vaccination roll out. Public messaging that general practice remains open but that a very restricted service is available.
Level 4 **Prevalence high or rising rapidly**	Significant volume of non-essential work stopped. Local prevalence of COVID-19 and staffing factors will determine the amount of non-essential work that can continue. This de-prioritisation of services should be decided in conjunction with local commissioners and system partners. Strong public messaging that general practice is open, but most non-clinical services and significant volume of routine non-urgent clinical services are not available.
Level 3 **Prevalence raised but plateauing**	Some non-essential work stopped or delayed. Local prevalence of COVID-19 and staffing factors will determine the amount of non-essential work that can continue. Practices maintain all relevant services that are appropriate for the local population and restore clinical services that may have been stopped at higher level of pandemic response. Public messaging that general practice is open but that many non-essential services won't be available or will be delayed.
Level 2 **Prevalence low or reducing rapidly**	Most clinical services are operating. Non-clinical services previously stopped are reviewed and restored if capacity and staffing factors allow. Public messaging focuses on message that general practice is open and most clinical services are available but that some non-clinical services may still be restricted to allow a focus on providing clinical services.
Level 1 **COVID-19 endemic with limited risk**	All services in place. New ways of working established. Social distancing and PPE requirements in line with national guidance. Public advised all services available although delivered in a way determined by practice to minimise residual risk of COVID-19 transmission.
Level 0 **Pandemic over** **Very limited residual COVID-19 risk**	All services in place. Successful vaccine programme fully established. New ways of working maintained. Social distancing and PPE requirements may no longer be needed. Routine pre-pandemic infection prevention and control measures in place. Public correctly assume all services are routinely available and personal patient preference may determine how they receive these services.

RAG Ratings

These RAG ratings provide a suggested prioritisation for specific elements of general practice workload. During the development of this guidance consideration was given to work that is essential to maintain public health and that which is unlikely to cause harm if delayed for a short period. It is not an exhaustive list of GP workload and is not intended to replace clinical judgement, nor clinical experience from earlier in the pandemic, for individual patient cases.

Past experience has shown that there is a risk that more patients will die from non-COVID-19 related illnesses than COVID-19.[1, 2, 3] General Practice has an important role in maintaining the underlying health of our population. It is important to note that the COVID-19 pandemic is not affecting all areas of the country in a uniform way. There is an important balance to be achieved locally between addressing the needs of patients with COVID-19, patients with non-COVID-19 health issues, managing workload pushed onto general practice from elsewhere in the system, as well as rolling out the COVID-19 vaccination programme. Ensuring the ongoing care and treatment needs of patients are met and managed will depend upon the individual practice circumstances, the time and the workforce capacity available.

Practices should also be aware of and follow current guidance and standard operating procedures outlined by NHS England and Improvement (https://www.england.nhs.uk/coronavirus/publication/managing-coronavirus-covid-19-in-general-practice-sop/) and its equivalents in the devolved nations (which can be accessed via the RCGP's "Latest COVID-19 advice in your area" webpage, https://www.rcgp.org.uk/covid-19/latest-covid-19-guidance-in-your-area.aspx). Additional guidance on general practice preparedness, including protection of practice income, has been provided by NHS England (https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-general-practice/).

Where patients do need to be seen, this should be remotely where possible (via telephone or video), but if a face to face appointment is required, then appropriate personal protective equipment must be worn in line with current PHE guidance (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control).

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[1] R. E. Falcone & A. Detty, "The Next Pandemic: Hospital Response", *Emergency Medical Reports 36* (26): 1–16, (2015).
[2] World Health Organization, *Ebola Situation Report. Weekly data report, April 15* (2016).
[3] L. Rubinson, R. Mutter, C. Viboud, N. Hupert, T. Uyeki, et als., "Impact of the Fall 2009 Influenza A(H1N1) pdm09 Pandemic on US Hospitals", *Medical Care 51* (3): 259–65 (2013).

RAG colour coding explained

Individual practices or practice groupings should expect to move between each category at different stages of the pandemic dependent upon staff, resources and local disease prevalence.

Green category High priority	Aim to continue regardless of the prevalence of COVID-19 for the duration of the pandemic.
Amber category Medium priority	Continue if time/ resources allow and appropriate for your patient population regardless of the prevalence of COVID-19 for the duration of pandemic
Red category Lower priority	Lower priority routine work which could be postponed in the event of a high prevalence of COVID-19 in your patient population, aiming to revisit once the pandemic ends, ensuring recall dates are updated where possible.

Green – High priority	Amber – Medium Priority	Red – Lower Priority
Urgent care **Acutely unwell adults and children:** • **COVID-19 related already screened by 111 and referred back to primary care;** • **Non-COVID-19 related self-referring to primary care;** • **Other patients contacting general practice directly.** It is essential to remember general practice plays a vital role in identifying and treating acute illness and worsening of chronic disease during the pandemic. This is to prevent increased morbidity and mortality from non COVID-19 causes.	**Contraceptive services**[4] Be aware of the possible risk of increased pregnancies following isolation periods. Consider extending pill prescriptions for low risk patients without review. Consider changing depot injections and LARC that requires changing to the progesterone only pill or patient administered Sayana Press (https://www.pfizerpro.co.uk/product/sayana-press/long-term-female-contraception/sayana-press-self-administration) Specific advice can be found here https://www.fsrh.org/documents/fsrh-guidance-srh-services-second-wave-covid-october-2020/	**Coil checks/change**[4] Consider starting POP as an interim measure. Specific advice is given by Faculty of Sexual and Reproductive Health https://www.fsrh.org/documents/fsrh-guidance-srh-services-second-wave-covid-october-2020/

[4] Additional information on contraception is available at https://pcwhf.co.uk/resources/how-to-manage-contraceptive-provision-without-face-to-face-consultations/.

Chronic care **Remote LTC and ongoing reviews for those at higher risk** • T2DM with HbA1c>75, recent DKA, disengaged;[5] • COPD with a hospitalisation in last 12 months and/or 2 or more exacerbations in last 12/12 requiring oral steroids/oral antibiotics, patients on LTOT Asthma with a hospitalisation in last 12 months, ever been admitted to ICU, 2 or more severe exacerbations in last 12 months (needing oral steroids), on biologics/maintenance oral steroids; • Significant mental health with concerns regarding suicide or deliberate self-harm risk or currently unstable mental health. (Consider using social prescribing teams for help.)	**Routine care review for most at risk groups and those LTCs who do not meet the green criteria.** Remote review is strongly recommended, wherever possible.	**Routine non-urgent screening** For example: • New patient checks; • NHS health checks; • Medication reviews; • Frailty and over 75s' annual reviews.
Cancer care: assessment of new potential cancers and ongoing care of diagnosed cancers **Symptoms consistent with new or ongoing cancer that may require treatment/ referral.** Consider if it could be performed remotely e.g. skin lesions by photo or postmenopausal bleeding for immediate referral.		
Smear tests Both cases with previous high-risk changes / treatment to cervix or on more frequent recalls and routine, low-risk smears (note change from previous guidance).		**Minor surgery** With the exception of skin cancer excision which should continue.
Palliative care including anticipatory care and end of life conversations These conversations should ideally be done via video link if possible and all end of life and ceiling of care conversations **must** be made on an individual basis.		**Ring pessaries**

[5] Usual sick day rules advice should be given.

Medication that cannot be dealt with by community pharmacy • Remote review unless there are overriding reasons that a face to face assessment is necessary. • Consider batch prescribing e.g. 6-12 months repeat prescribing of 28-day supplies to prevent supply issues. • Avoid lengthening supplies of repeat medication unless clinically indicated. • Dispensing if a dispensing practice	**Med3 after 7 days**	**Med3 for first 7 days and COVID-19 self-isolation** Advise patients that COVID-19 related sick notes are available here: https://111.nhs.uk/isolation-note.
Investigations for immediately necessary conditions or where the test will make a difference to treatment • Blood tests; • INR for patients on warfarin, if appropriate consider switching to DOAC; • DMARD/ shared care bloods. Review national guidance regarding safety of increased intervals in blood testing e.g. British society of rheumatology: https://www.rheumatology.org.uk/practice-quality/covid-19-guidance	**Blood monitoring for lower risk medications and conditions** For example: • ACEi, if appropriate consider alternative medication that does not require blood monitoring; • Antipsychotics; • Thyroid disease. Consider increasing the interval of testing if clinically safe to do so referring to national guidance where available.	**Advice on mild self-limiting illness or COVID-19 social isolation for individuals, employers, schools etc.** Guide patients to national websites; For those socially isolated or more vulnerable, e.g. elderly, carers, learning disabilities, make use of social prescribing options, link workers etc where available.
Wound management/dressings Consider increasing the interval between dressings if clinically appropriate or encourage patients to self-care, providing dressing if possible.		**Ear syringing** Can advise to continue use of olive oil or arrange privately at a high street provider.
COVID vaccinations and Routine vaccinations For example, seasonal flu, pneumococcal etc for all patients where they are recommended. Prioritise vulnerable patients in high risk groups, such as patients: • With a solid organ transplant; • Undergoing active chemotherapy or radical radiotherapy for lung cancer; • With leukaemia, lymphoma or myeloma at any stage of treatment;		**Non urgent investigations that will not impact on treatment** For example: • Routine/ annual ECGs; • Spirometry: Consider home peak flow monitoring where indicated.

• Having immunotherapy or other antibody treatments for cancer; • Having other targeted cancer treatments which can affect the immune system; • Having had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs; • With severe respiratory conditions ; • With rare diseases and inborn errors of metabolism that significantly increase the risk of infections; • On immunosuppression therapies sufficient to significantly increase risk of infection; • Who are pregnant with significant congenital heart disease.		
Childhood vaccinations, postnatal checks and new baby checks • New baby vaccinations • Pre-school boosters • HPV etc should continue Consider undertaking postnatal check at 8 weeks to coincide with first childhood immunisation.		
Essential injections For example, Prostap, aranesp, clopixol etc.[6] Consider teaching patients to self-administer if appropriate	**Vitamin B12 injections for post bariatric surgery patients** Consider teaching appropriate patients to self-administer and ensure frequency is not more than 12-weekly. Review whether oral supplementation would be appropriate.	**Vitamin B12 injections** Consider teaching appropriate patients to self-administer and ensure frequency is not more than 12-weekly. Review whether oral supplementation would be appropriate if asymptomatic with a dietary deficiency. See BMJ 2019: www.bmj.com/content/365/bmj.l1865

[6] May need designated clinics for those at risk of immunosuppression.

Safeguarding The role of primary care in safeguarding at this time is to continue to recognise when children/adults/families are struggling or potentially suffering abuse or neglect, signpost to resources which can help, refer to other agencies as available and appropriate, and support vulnerable patients were possible. https://elearning.rcgp.org.uk/mod/page/view.php?id=10392		
Acute home visits to housebound/residential or nursing home patients Only following remote triage and when clinically necessary. Encourage homes to purchase pulse oximetry probes, thermometers and electronic sphygmomanometers and use video calls to assess where possible.		**Data collection requests unless related to COVID-19, DESs/LISs/LESs, audit and assurance activities.**
Essential paperwork • Blood and test results review and filing; • Discharge letter review and medication reconciliation; • DVLA medical examinations for essential workers e.g. HGV supermarket drivers; • New patient registrations especially for new residents for care homes and the homeless.	**Complaints** Consider a standard response to pause a formal response during COVID-19 outbreak.	**Non-essential paperwork** • DVLA medicals for non-essential workers; • Private to NHS prescription changes. These can go straight to a pharmacy; • Hospital outpatient prescriptions. These should be filled at the hospital or secondary care can provide patients with FP10s to use in community pharmacies; • Insurance reports; • Data collection requests unless related to COVID-19, DESs/LISs/LESs, audit and assurance activities; • Friends and family test etc.