Londonwide LMCs Guide

Covid-19 - Supporting Safe Care In General Practice - A Londonwide LMCs Living Guide

CORRECT AT TIME OF PRODUCTION. ALL INFORMATION MAY CHANGE.

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Preface

This living document is produced by the GP Medical Directors of Londonwide LMCs in collaboration with clinical colleagues withing the NHS system in London to guide London's GP practices to best help our patients. We have produced this guide in the early stages of an unprecedented coronavirus (Covid-19) pandemic during which the imperative is to flatten the curve to enable NHS services – emergency, hospital, community and primary care – to work together to beat the consequences of a novel infectious disease which has no vaccine, in the context of substantial risk that services might become overwhelmed.

Such times demand rapid learning and change in practice. The balance of power between our ability to prevent disease versus end of life care has, for now at least, shifted. Given time this will change. But during this period where drastic social distancing appears to be the main defence, we must park our accustomed practices and give permission to ourselves to concentrate on the task at hand. That task is defined by safely caring for our patients' most pressing needs - be they Covid-19, or related to other key disease - maintaining immunity against diseases preventable by immunisation, preventing practice staff from being vectors of disease and caring for ourselves so that we remain fit to care for our patients.

We draw on available evidence and information from multiple sources, including real-time examples from China, Italy and elsewhere, and we recognise that, as in all times of trouble, there will be innovations and advances in both clinical practices and in the systems to support them. These may well challenge decades of traditional practice but our hope, as we work through this coming period, is for us all to get through and come out the other side safely, armed with those new solutions and ways of providing the care that will enable us to meet our patients' whole person needs for the rest of the decade and beyond.

Finally, I wish to pay special tribute to Londonwide LMCs' GPs Dr Lisa Harrod-Rothwell, Deputy CEO and Dr Elliott Singer, Medical Director for their unheralded insight and tireless work in creating this living guide.

Dr Michelle Drage MBBS FRCGP
CEO Londonwide LMCs

Section 1

1.1 General principles

1. It is vital that general practice is able to continue to deliver care safely to patients, in the context of the Covid-19 pandemic.
2. Patients need to be able to access general practice but the model of delivery of care must change.
3. In-hours general practice supported by primary care services should remain the primary method by which patients access healthcare.
4. GPs/practice HCPs should undertake an initial remote assessment of all patients via online / telephone, depending on practice facilities.
5. GPs should use video if available to undertake an initial examination.
6. In order to protect patients and staff, GPs should only see patients face to face (in the surgery or

through home visits) if initial assessment deems it essential and adequate precautions are taken.

7. To be aware of our continuing safeguarding responsibilities and to adapt our practice to best fulfil these and to be aware of how best to protect our most vulnerable patients with our changed practice.
8. Special consideration needs to be given for particular groups including patients who have difficulty communicating in English, people with disabilities like deafness and blindness, homeless patients and other such groups.
9. We recommend that the decision to move to face to face assessment should require discussion between at least two clinicians, if possible, prior to the decision being made: the following issues should be considered:
   a) What specific examination is needed?
   b) Can the required information be obtained via another method?
   c) How likely are the examination findings to change the diagnosis and management?
   d) Is making the diagnosis essential at this point?
   e) Will a delay in making the diagnosis or managing the condition have a significant impact on the morbidity/mortality of the patient?
10. The time of the interaction and the number of individuals involved with the patient is minimised.

1.2 Community Assessment Room/Centre

- Although nearly all consultations should be carried out through video or phone, a minority of patients are likely to need to be seen face to face in a primary care facility.
- GPs should consider the most appropriate population size across which to deliver this function be that at practice, primary care network (PCN) or federation population levels.
- The purpose of the assessment room/centre is to provide a safe environment to perform a physical examination or procedure when required.
- It is essential that practice follow the essential principles of universal precautions for any patient assessment or treatment, these include:
  - Wearing personal protective equipment (PPE) when assessing all patients and donning and doffing the PPE appropriately before and after every patient contact;
  - Cleaning the consultation room after every patient;
  - Advising at the initial telephone/video assessment that the patient should not bring in relatives/ friends into the appointment unless there is an essential need to do so (children, disabilities);
  - Ensuring all patients are asked screening questions (have you or a household member had a fever, new continuous cough or experiencing shortness of breath) and consider a temperature check on arrival;
  - Ensuring that the patient spends as little time in the practice or centre as possible;
  - No waiting room- once screened, escorting the patient straight into the examination room;
  - Minimising the number of people with whom the patient comes into contact - ideally the examining/treating clinician meets them, screens them as described above, treats them and escorts them straight out of the centre;
  - Ensuring that history taking and any part of the examination that can be done remotely is completed prior to arrival and physical assessment;
  - Explaining to the patient in advance of attending what specific

examination/treatment they are attending for, how this will be performed and reason for this;

- Escorting the patient directly from the centre after examination/treatment, unless severely unwell and needing immediate management and ongoing support;
- Conducting a further telephone consultation with the patient to conclude the clinical encounter, explaining findings and management plan;
- Requiring nursing/care homes and similar facilities to obtain and know how to utilise all necessary equipment for patient assessment this should include thermometers and blood pressure monitor but may possibly include pulse oximeter and PEFR meters.

- Although we understand that a revised national Standard Operating Procedure document will be available soon, NHS England currently recommends categorising patients into two cohorts: those who have Covid-19 symptoms and those without Covid-19 symptoms. However, potentially, general practice face to face interactions will be required to meet the needs of three different cohorts, although universal precautions apply to all groups:
  - **Cohort 1**

    Patients who are not suspected to have Covid-19 who require essential interventions such as administration of immunisations and injections, and for urgent/essential phlebotomy. Some of these patients may be at particularly high risk of severe Covid-19 if infected;
  - **Cohort 2**

    Patients who are not suspected to have Covid-19 who require face to face assessment for a presumed non-Covid-19 condition. It must be borne in mind that Covid-19 typically presents with cough and fever, but there are many other presenting symptoms, and some may be atypical;
  - **Cohort 3**

    Patients who are suspected to have Covid-19 who require face to face assessment for a presumed non-Covid-19 condition.
- If possible, we recommend separating these three cohorts either through:
  - Having 3 separate rooms at each site, for each of the three cohorts above (zoning), or;
  - Separating these cohorts across two different sites within a PCN/federation footprint (practice designation). It may be possible to designate a site for seeing asymptomatic patients (cohort 1), and a site for seeing symptomatic patients (cohort 2) which includes a designated room for those with symptoms suggestive of Covid-19 (cohort 3).
- Patients will at times require a home visit. The decision to visit a patient at home will take into consideration the same factors that apply in the non-pandemic environment, (for example extremely vulnerable and requiring shielding, frailty, or palliative care). These could be in patients with or without Covid-19 infection. The principles to be considered in deciding if a patient needs a home visit are the same as those for any face to face assessment, including wearing appropriate PPE, with correct donning and doffing techniques, before and after every patient contact. It is worth considering if a home visiting service could be organised at network or federation level.

1.3 Caring for ourselves and colleagues

It is important to acknowledge that a lot of us are feeling fearful and anxious. We have had to move to a new way of working within a rapid timescale, caring for our patients whilst trying to keep on top of guidance, which is changing daily, sometimes hourly. Please look at our website www.lmc.org.uk for resources to help support yourselves and colleagues during this time, as well

as signposting to organisations which may be helpful if you are feeling overwhelmed. Many of us are also caregivers and an important point of contact for family and friends who are worried. This can be hard to balance but try and have some allotted time to 'switch off' from doctor mode.

Below are some important principles to keep in mind:

- Beware of exhaustion and how this affects decision making. This includes recognising where we have reached our capacity for one day; there are only so many hours to do everything in and a lot of things can wait until tomorrow.
- Maintain physical health as much as possible. This might mean starting the day with some exercise or setting aside some scheduled time in the week for an exercise you enjoy. There are lots of online options available to explore.
- Maintain mental health. Check in with each other, acknowledge when you are struggling and recognise your personal triggers. As either a practice or PCN consider planning regular times not just on an ad-hoc basis.
- Share the workload or concerns between colleagues. Your PCN networks or neighbouring practices may have valuable experience to share or be happy to discuss complicated cases which may have had secondary care input. This is particularly important if you are a single-handed practice.
- Use your PCN or other informal networks as emotional support for colleagues. Find out if there is a group such as a WhatsApp group or list server which you can join.

Further advice about emotional and psychological wellbeing is contained in the document from Red Whale GP Update.

1.4 Safe Practice Policy

A safe practice policy is to protect patients, staff and colleagues and minimise the risk of Covid-19 transmission in practices. In the absence of widespread Covid-19 testing, and with data from Italy and China that 'cold' patients are significant vectors for spreading disease you **MUST** adopt universal protection as of now.

Practising safely involves:

- Operating a remote screening system;
- Carrying out consultations remotely through video or phone wherever possible;
- Only seeing patients face to face (in the surgery or through home visits) if initial assessment deems it essential;
- Screening people prior to entry;
- Minimising the time a person spends in practice;
- Minimising the number of people the patient encounters;
- Wearing appropriate PPE for all face to face consultations and making sure all staff adopt correct donning and doffing techniques.

Operating a Safe Practice Policy does NOT mean that the practice is closed. It means it is continuing to provide appropriate essential services under a different, but safe, operating model predominantly based on telephone and video remote consulting.

1.5 Prepare a contingency plan if a practice has to temporarily close due to mass staff illness during a pandemic

Full policy can be found here

Key points to consider:

- This should only be implemented if the practice has no other option;
- Closure would be due to having insufficient staff to maintain a safe patient service;
- Practice should discuss with their PCN and/or federation in the first instance how they can continue to support their patients;
- You need to inform your CCG and NHS England primary care commissioning team of the closure and, if possible, the expected period of closure;
- Patients will need to be made aware and given advice on how they will continue to be able to access general practice care.

Operating a Safe Practice Policy does NOT mean that the practice is closed. It means it is continuing to provide appropriate essential services under a different, but safe, operating model based on telephone and video remote consulting. We will be providing links to guidance on the safe donning and doffing of PPE.

Section 2

Caring for Patients with Suspected Covid-19

2.1 Key resources:

- BMJ pathway
- NHS London: Primary and Community care resource pack during Covid-19

2.2 The clinical course of covid-19 – what do we know?

Epidemiology and aetiology

Covid-19 is an RNA virus which is mostly transmitted through large droplets either through coughing or sneezing. These can be transferred through fomites (objects) where the virus is reported to last up to hours or days, depending on the type of material, with potential transfer to a new host if they are in contact with these objects and then touch the mucosal surfaces on their face. There is also the potential for airborne transmission in some studies.

The period of infectivity from studies seems to be up to eight days from the point of transmission. The World Health Organisation advises 14 days of isolation for positive cases whilst current UK advice is self-isolation for seven days if symptomatic. This is mostly due to differences in testing. The mean incubation period is five days according to studies.

Presenting symptoms (from cases series)

Below are some of the most common presenting symptoms. However, increasing evidence points to potentially large pools of asymptomatic transmission. Approximately 90% of patients present with more than one symptom, and 15% of patients present with fever, cough, and dyspnoea.

For more information see this BMJ article on Covid-19 history and exam.

- Fever 83-98% of cases (less common in children and the elderly)
- Cough 57-82% of cases (less common in children)
- Dyspnoea 18-55% of cases (onset usually 5-8 days after other symptoms)
- Fatigue 29-69% of cases
- Myalgia 11-14% of cases
- Anorexia 40%
- Sputum production 26-33%
- Sore throat 5-17% of cases
- GI symptoms 1-11% (likely underestimation)
- Anosmia/dysgeusia (anecdotal evidence, no case reviews)

The most prevalent comorbidities in patients with Covid-19 are hypertension, diabetes, cardiovascular disease, and respiratory disease. In Italy, the most common comorbidity was obesity.

Complications of Covid-19

The main complications of Covid-19 which lead to mortality are pneumonia or acute respiratory distress syndrome (ARDS) which can come on suddenly after seemingly mild symptoms. Reports of 'cytokine' storms in some patients has also led to mortality. The median time from onset of symptoms to hospital admission for severe illness is seven days with 14% of patients with severe illness requiring oxygen therapy and 5% requiring admission to ITU for intensive support (usually respiratory or cardiovascular). In the UK the current survival rate for those who are admitted to ITU is 50%. NICE currently recommends basing decisions on ITU admission on clinical frailty scores.

Terminal symptoms

The most common terminal symptoms are fever, rigors, dyspnoea, cough, delirium and agitation. Importantly the terminal phase can be rapid, often just a few hours so, where possible, advance planning is helpful.

2.3 Monitoring of patients with suspected Covid-19

- We would advise that practices develop a system for remote follow up of patients with suspected Covid-19 in the community, including those discharged into the community with ongoing symptoms.
- We are currently exploring technical solutions for self-reporting and stratifying patients so that practices are supported to clinically prioritise the patients who require clinician review.
- We need to effectively manage the workload of monitoring community cases, and practices should develop an operating model that is appropriate in the context of immense demand and reduced workforce.

For example:

- A Covid-19 appointment list is created and, after initial assessment, those that require active follow up are booked onto this list for follow up in either 24-48 hours or 72 hours depending on the clinical situation, the patients co-existing disease and whether the patient lives alone.
- A member of the admin team, or if available an HCA, checks this list daily and makes the initial contact with all patients on the list.
- Practices may wish to consider utilising any staff member who is self-isolating to do this initial follow up contact with these patients. We are exploring if it would be permissible to utilise NHS volunteers for this role.
- Any patient who reports worsening of their symptoms/concerning features is escalated to a clinician for further review.

- Patients should be assessed and monitored remotely. However, there may be some circumstances in which the history and remote examination alone do not enable the clinician to stratify severity, and therefore manage appropriately, or may cause the diagnosis to be in question.
- PCNs should discuss how best to manage this circumstance.

  For example:
  - Discuss case with at least one other clinician;
  - If an oxygen saturation is deemed necessary to determine further management, practices should consider the best way to obtain this. There must be limited exposure of the patient to others, and ideally the patient should maintain their self- isolation. This could be through:
    - Pulse oximeters delivered to patients, if pulse oximeters available.
    - 'Drive-through' oximetry testing stations using Bluetooth devices.
  - Infection control measures must be considered in all environments, and for all staff and devices;
  - We are developing guidance on the appropriate use of pulse oximeter and models of how patients can access testing;
  - The Roth's Score has been suggested as a remote method of getting an indicative oxygen saturation but the value of this scoring system is still being considered;
  - Please note, technology is evolving quickly and soon we may be able to reliably and accurately measure 02 saturation remotely, without the need for an oximeter. We will update practices of any developments in this area.
  - There is now a requirement from NHS England regarding patients who have been assessed by 111. For full details click here.

In summary it states that GPs should:

- Enable GP Connect for both appointment booking and record access , click here for guidance;
- Ensure nominal appointment slots are always available into which the National Covid-19 Response Service can 'book' patients into a work list. Patients will be told that they will be contacted by their practice with further information about the follow-up, not given a specific appointment time. No additional clinical triage will be required, but practices will decide how to deliver the appropriate care to each patient according to the record of the assessment already made and the local delivery model.

2.4 Management of patients with suspected Covid-19

Please see NHS London: Primary and Community care resource pack during Covid-19 for referral criteria. This document was published by NHS London Clinical Networks on Saturday 28 March; it is an iterative document with plans for weekly updates covering:

- Supporting patients to manage at home.
- Emergency referral of patients.
- Palliative care of patients with suspected Covid-19.

Section 3

Delivery of Care to Patients with Non-Covid-19 Health Needs

3.1 Principles

- The principles of providing safe care during the Covid-19 described above all apply. Although we will all be experienced in providing non-Covid-19 care, we will need to rapidly adapt how we diagnose and assess these conditions in order to minimise risk to our patients.
- We recommend signposting patients to patient information site to support self-management and safety netting https://www.nhs.uk/Conditions or https://www.patient.co.uk.

3.2 Remote examination guidance

This is initial thinking on remote examination techniques. We are currently working with GP colleagues to develop this further and will be sharing work on safe remote examination for each system in due course. Below are initial suggestion of what could be done but all clinicians should feel competent in the examination technique and mode of assessment. If anyone has any expertise in remote examination and would like to assist with this work please contact Londonwide LMCs.

It should be recorded contemporaneously in the medical record that this was a video consultation/ examination, that the examination had been explained to the patient in advance and that they had verbally consented to being examined in this manner.

Some educational providers have produced webinars that are free to access, going through all of the principles of how to structure remote consultations, ensuring access to primary care for all patient groups without discrimination whilst best using the technology that is available to us. For example:

- RedWhale
- NBMedical

- We recommend that clinicians explore with the patient what information they are able to provide with the equipment that they have available (temp, pulse, O2 sats, BP, PEFR).
- Examination by system:

  o ENT examination:

  Inspection of the neck can be viewed by video with good light or patients can upload/send pictures to the practice if any lumps or abnormality are visible. Although tonsils can also be examined in this manner we are awaiting further guidance on the risk this poses to the person performing the

examination if it is not the patient doing this directly. The feverpain score should be utilised for assessment of tonsillitis, RCPCH guidance recommends that the need for antibiotics can be based on this assessment alone without examination.

o MSK examination:

This can be performed via video. It is possible to inspect and observe functionality including passive and active movements, and strength. Some specific tests can be carried out with clear patient guidance including demonstration by clinician.

o Dermatological examination:

Dermatology diagnoses are best made by taking a full history and the patient electronically sending pictures of the affected area because still pictures give better resolution than video. Patients can also measure and carry our tests during a video consult, eg to determine whether blanching.

o Cardiovascular examination:

Most CV diagnoses are based on the history and subsequent investigations. Remote examination can include pulse both rate and rhythm, a patient can be asked to tap out their pulse to determine the rhythm. If the patient has a monitor, blood pressure can be provided and the patient can be instructed on how to check for peripheral oedema. Auscultation can be done remotely but the equipment required is not readily available.

o Respiratory examination:

Remote examination is by general observation, respiratory rate and if available pulse oximetry. This provides a very limited respiratory examination but this has to be balanced against the risk of a face to face examination of an acute respiratory problem, as all such patients should be assumed to have Covid-19 infection until proven otherwise and all possible precautions and safeguards implemented.

o Gastrointestinal examination:

An acute abdomen would need face to face assessment as signs of peritonitis may not be possible to observe remotely. It is possible to carry out a remote assessment of hydration status, general appearance and some obs. As a screening tool, a family member or carer can be instructed on abdominal palpation solely to elicit any signs of tenderness.

o CNS examination:

A simple, basic CNS examination can be done via video, including some cerebellar signs. This could give enough information to understand whether patient can continue to be safely managed remotely, or if a more detailed assessment is required urgently in primary care (or secondary care in an emergency situation).

o PNS examination:

Neuropathy/weakness can be determined based on the history. Muscle wasting and fasciculations may be identified through video consultations, and it should be possible to observe active movements and global limb strength (tip-toes, squats, raising from chair, pushing up from chair with arms etc).

- Genito-urinary examination:
  - For acute urinary symptoms the diagnosis is normally based on the history supported by general examination observations and urinalysis.
  - Common examples include UTI, for which NICE guidance is available. A pyelonephritis diagnosis is based on the history including renal angle tenderness, temperature, urinalysis/ msu. A renal calculi diagnosis is based on the history and presence of haematuria followed by further investigations.
  - If a patient has a genital rash, lump or externally visible lesion it may be possible to examine this via video-link. In such a situation, you should be mindful of the following:
    - The limitations and sensitivity of assessment via video-link;
    - The possibility that a further assessment and/or investigations may be indicated (for example if genital herpes is identified, screening for other STIs may be indicated);
    - The sensitive nature of the examination and the examination setting (for example, traditionally it is unusual for a GP to undertake an examination in this way, the patient may want to relocate to another room if there are other family members in the vicinity). It is therefore important to seek the consent of the patient, tailored to the specific circumstances of the remote examination;
    - With the consent of the patient, a chaperone could be present with the GP and could witness the nature and extent of the video examination that was undertaken;
    - The nature and extent of the examination (together with all the other aspects of the consultation) should be contemporaneously documented in the records. You should also document whether or not a chaperone was offered and either declined or present (if a chaperone was present, you should record their identity, including their designation and the extent of the assessment witnessed [for example “present for the complete video-linked assessment”]).
- Paediatric examination:
  - Paediatric remote assessment guidance can be found on the Healthier Together website and been developed in partnership between parents and healthcare professionals from across Dorset, Hampshire and the Isle of Wight.

Section 4

Maintaining Essential Services

The RCGP and BMA have produced guidance on workload prioritisation during Covid-19. The following areas are recommended essential services at the time of producing this document. The RCGP/BMA document is iterative so practices will need to frequently review this guidance regarding the essential services that need to be maintained as the pandemic progresses.

It is also important for practices to ensure wherever practicable that new patient registrations continue. This should be facilitated through online registration where possible.

4.1 Essential to Maintain Good Health

4.1i) Supporting patients to manage long term conditions

- Management of LTCs should be carried out remotely;
- Practice should consider prioritising reviews for those at higher risk (from RCGP doc):
    - o T2DM with HbA1c>75, recent DKA, disengaged*.
    - o 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.
    - o Asthma with a hospitalisation in last 12 months, ever been admitted to ICU, 2 or more severe exacerbations in last 12months (needing oral steroids), on biologics/maintenance oral steroids.
    - o Significant mental health with concerns regarding suicide or deliberate self-harm risk or currently unstable mental health (consider using social prescribing teams for help);
- Management should take into account the need to appropriately prioritise elements of routine preventative care due to reduced staff capacity, the limitations due to the need to avoid face to face assessment, and the lack of access to routine investigations;
- Chronic respiratory conditions, see BTS guidelines via link below:
    - o Practices to consider issuing COPD rescue packs with advice to defined cohorts of pts. However, need to consider changing usual practice regarding issuing/advising use of PO steroids. See BTS guidelines.
    - o Practices to consider issuing peak flow meters to their patients with asthma who contact the practice as they are unwell or concerned, who have a history of hospital admission for asthma or who have required multiple course of oral steroids.
    - o British Thoracic Society has produced specific guidance relating to Covid-19;
- Essential drug monitoring must continue. We are currently seeking guidance on acceptable frequency of monitoring for essential drugs from expert bodies;
- If possible, blood monitoring for lower risk medications and conditions eg ACEi, antipsychotics, thyroid disease can continue. Consider increasing the interval of testing if clinically safe to do so;
- Practices can consider signposting patients to on-line patient facing resources. Please see our website for some links.

4.1ii) Supporting people with panic, increased anxiety and depression due to Covid-19

Many of our patients will understandably be experiencing increased anxiety, depression or loneliness during this pandemic, regardless of previous mental health history. Many mental health services are being restricted with limited access or telephone assessment only and use of online tools may be helpful for some patients.

- Good Thinking is an excellent platform of online mental health resources which patients resident in London are able to access, mostly free of charge. These include validated tools for managing anxiety, depression and insomnia .
- Mind have also put together helpful resources for patients including practical tips for general wellbeing and crisis information
- Young Minds is a mental health charity for young people and they have useful guides for young people including managing OCD and eating disorders during the coronavirus pandemic.
- The Mental Health Foundation also has information for people who are worried about their mental health at this time and links to organisations who can advise regarding concerns about housing and

finances.

- This is an excellent app https://www.nhs.uk/oneyou/.
- The Alzheimers Society has information for people who are living with or caring for people with dementia during the pandemic including details of their crisis line.
- Cambridge University Hospital has produced a patient information leaflets to help patients self-manage their breathlessness.

4.1iii) Routine vaccinations

1) Pneumococcal, shingles 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.
  - having immunotherapy or other antibody treatments for cancer.
  - having other targeted cancer treatments which can affect the immune system.
  - had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs.
  - 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.
  - pregnant with significant congenital heart disease.

2) Childhood imms

- Practices/PCNs to consider the safest way of delivering these, ensuring that risk of Covid-19 exposure is minimised. See our principles.

4.1iv) Essential injections – e.g. Prostap, aranesp, clopixol, testosterone**

- RCGP suggest considering teaching patients to self-administer if appropriate.
- Practices/PCNs to consider the safest way of delivering these, ensuring that risk of Covid-19 exposure is minimised.

4.1v) Vitamin B12 injections

- If possible, maintenance administration of B12 injections can continue. However, ensure that frequency is not more than 12 weekly. RCGP suggests considering teaching appropriate patients to self-administer.

4.1vi) Postnatal checks – where possible combine with childhood immunisations, may need designated clinics.

- Baby checks:

- Remote consultation for verbal assessment of maternal and baby health and well-being and concerns prior to immunization appointment.
- Baby check to be carried out at appt for imms at 8/52. As short time as poss for physical encounter.
- To minimise risk of Covid-19 exposure, must mitigate risks of environment, staff, equipment etc, and ensure thorough infection control measures.

4.1vii) Contraception

- See FSRH guidance.

4.1viii) Smears

- The current RCGP guidance states that practices should continue to offer smears to those with previous high risk changes/treatment to cervix or on more frequent recalls.

4.1x) Wound dressings/management

- Consider whether self care with remote monitoring is possible.
- Need to ensure that physical care site has minimized risk of exposure.

4.2 Essential Care to Those with Potential Non-Covid-19 Life- Threatening Conditions

4.2i) Immediately life threatening

- Practices need to continue to diagnose non-Covid-19 life threatening conditions. This should be carried out remotely wherever possible.
- There are clinical indications when calling 999 is warranted. With increased demand on ambulance services the threshold for calling 999, rather than using own transport, may change. We are liaising with LAS to provide further guidance for practices on safe advice regarding this.

4.2ii) Life threatening in longer term without urgent treatment

- GPs will continue to need to identify people who meet criteria for 2WW and refer.
  - This should be through remote consultation. We are currently liaising with London and national cancer bodies to determine whether referral criteria will be changed to reflect need to limit face to face encounters.
  - Cancer Alliance information on managing cancer referrals
- GPs will also need to continue to be distinguish between serious and benign illness
- This should be through remote consultation and assessment wherever possible. A face to face assessment, in an assessment site or through a home visit, should only be carried out if examination is required to make diagnosis or for the management, of potential non Covid-19 serious illness. We recommend that two clinicians agree that a face to face consultation is required.
- Patients should limit their journeys and encounters. If face to face appointments and urgent bloods are required, practices should consider offering this during single visit, limiting any wait times, wherever possible.
- GPs should continue to make urgent referrals, and should seek timely advice and guidance if doubt

whether a referral is warranted at this time, or for discussion regarding whether the patient can be managed remotely and appropriately in primary care with specialist support whilst routine secondary care is suspended.

4.3 Referral to hospital

- For any acute referrals, we would advise discussion with the specialty admitting team (if possible) to consider if the benefit of hospital assessment/admission outweighs the risk to the patient.
  - o If the risk out-weighs the benefit, the speciality team may give advice and support so that the patient can be managed safely in the community.
  - o If the benefits outweigh the harm, the clinician will discuss with the patient the quickest, safest, most appropriate method of transfer from the practice or their home to the hospital.
- 2WW referrals should continue according to the normal local pathways.
- For all non-acute referrals where a delay may not be clinically acceptable, we would advise that timely 'advice and guidance' is the primary method of referral. This will enable secondary care colleagues to advise on how to manage in the community, or advise on the best way of access secondary care services during the pandemic.
- For conditions where a delay is clinically acceptable, patients should be asked to represent once the current emergency situation has passed, if the condition has not resolved and they still require further assistance.
- We will continue to liaise with NHSE to ensure that we have shared understanding with our secondary care colleagues regarding the primary:secondary care interface, so that we can all work effectively in the best interests of our patients during these unprecedented and challenging times. We will update our advice accordingly.

4.4 Certification

4.4i Death certification

- The Chief Coroner has produced guidance on the update death certification regulations. The key points are below:
  - There is no need for the doctor to see the patient after death as long as any doctor saw them in the 28 days before death (including for verification of death).
  - The doctor should write 'N/A' on the Cremation Form 4 where it asks about what examination was made of the body. Ideally they should say who did see the patient when alive.
  - Any doctor can now complete the MCCD as long as a doctor saw them in the 28 days before death. The do not have to have seen the patient alive and they can also complete Cremation Form 4, With the following caveats:
    - o Section 8 of the form should be completed as NA;
    - o The doctor completing the form should indicate (if possible) which doctor saw the patient in the 28 days prior to death;
    - o If no doctor saw the deceased within the 28 days before death, the body should be seen after death to avoid referral to the Coroner - **this is the only circumstance in which the body needs to be seen after death.**
- Video/telemedicine counts for 'attending' a patient during life but **not** after death – please refer to the

information at the following link. Advice from the General Register Office.

4.4ii Medical certification

- Isolation notes:
  - Digital isolation notes for patients are now available online.
  - The isolation note can be accessed through the NHS website and NHS 111 online. After answering a few questions, an isolation note will be emailed to the user. We would recommend that the link to this is added to the practice website.
  - The patient does not need to contact the practice to obtain this.
  - Isolation notes provide patients with evidence for their employers that they have been advised to self-isolate due to coronavirus, either because they have symptoms or they live with someone who has symptoms, and so cannot work.
  - If a patient does not have an email address, they can have the note sent to a trusted family member or friend, or directly to their employer.
  - The service can also be used to generate an isolation note on behalf of someone else.

- Med 3
  - When required Med3s should be sent electronically. There are a number of ways of doing this electronically.
  - Print, sign, scan and send as an email or text attachment.
  - Complete and don't print, then print a duplicate to a pdf file and attach to an email or text.
  - Complete electronically, including digital signature and attach to an email or text (full guidance available for Emis and System1).

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