Tameside and Glossop CCG/LMC General Practice Guidance
V3 15/06/2020

Hints and tips on providing a safe service during the second phase of Covid 19 pandemic (Living with Covid)

The following guidance has been produced to support practices as activity increases through the restart of or increase of volume of activity currently reduced.

Use of Practice Buildings

Consider your surgery's layout and facilities:

- How do patients enter the building? Could there be a separate entrance for certain groups eg shielded, mother and baby, patients with respiratory symptoms
- Could an automatic door release be installed so that patients can be "buzzed" in to help manage footfall?
- What hygiene facilities are there for patients? Is there a hand gel dispenser where they come in?
- Are there clear floor markings showing patients where to wait 2m apart?
- Do you allow patients to wait in the waiting room at all? If so, are the chairs wipe able? Are the chairs spaced 2m apart?
- Ensure all staff have had a risk assessment (GM Guidance previously circulated is available at: http://nww.tamesideandglossop.nhs.uk/GPGuides.htm)
- Consider how you can further promote self-care. Could you use targeted MJOG campaigns to promote:
    - Online access to records
    - Self-monitoring eg BP
- Consider care navigation for every patient contact

Styles of Delivery

Always consider what can be done remotely:

- Does this patient need a face-to-face (F2F) consultation?
    - Consider double triage with a colleague
    - If does need F2F, who needs to do it? What else can be done at the same time? Can multiple tasks usually requiring different members of staff be done by just one person instead?
    - And if F2F contact is required the aim should be to minimise the time within any patient consultation to protect the patient and health care professionals
- Does the patient need to come into the building? Could care be delivered outside eg injections? INRs? Blood tests?
- Continue to manage possible or confirmed Covid 19 positive patients remotely where clinically appropriate to do so
- Continue to use remote saturation monitoring if available
- Home visit requests: consider if care can be provided by telephone or video consultation.
    - Can a family member or neighbour help with this if the patient doesn't themselves have a smartphone or tablet?
    - Could another HCP visit the patient and do observations and provide the video link back to a GP working in the practice or remotely?
- All patients to wear face covering/masks whilst in the practice
- Can you stagger patient appointment times?
- Consider having one list on your appointment book for all face-face appointments so everyone knows when patients will be entering the building and from which entrance.
- Consider trying to ensure that clinicians are ready and waiting for patients when they arrive.

Restarting Paused Activity

Some routine work could now be restarted if it had been paused during the pandemic. See the attached list for further ideas on how individual aspects might be delivered.

Consider how services could be offered by other practices or across a PCN or through the pre-bookable element of PCAS if an individual practice is unable to do so

Continue to refer as normal – if it's not going to change your management don't see the patient F2F and don't do bloods.

Use Advice & Guidance to discuss non-urgent referrals where necessary

All work should be reviewed with consideration given to:

- Staff risk assessments
- Ability to socially distance patients from each other
- Capacity
- PPE availability

Protective Equipment

See attached guidance regarding protective equipment

Video Consultation Guidance

New guidance aimed at NHS general practice staff who are consulting via video with patients at home has been published. Supported by the Royal College of General Practitioners and other key stakeholders as part of the guideline development group, it includes the key principles for safely assessing patients using a video consultation. The guidance is split into two sections; the first section covers general information for staff such as information governance, medico-legal and consent. Section two outlines guidance for remote examinations including intimate examination and a practical step-by-step guide to starting a remote video consultation.

Service	Advice	Links
Acute care:		
Unwell patients	Access via tel/video/online consultations per practice arrangements	
Acute home visits	Encourage care homes to use pulse oximeters, thermometers and electronic sphygs; use telephone/video and obs where possible to assess. Try to exhaust all other avenues before visiting - consider who is best placed in your team to visit the patient, eg could a HCA visit do obs and bloods and enable video consultation with the patient?	
Cancer care: assessment of new potential cancers and ongoing care of diagnosed cancers	Telephone/video consult; consider if it could be performed remotely e.g. skin lesions by photo or postmenopausal bleeding for immediate referral. F2F only if it will change your management.	
Routine care:		
Ear syringe	Reasonable to postpone. Consider encouraging patients to buy OTC bulb syringe.	
Minor surgery and joint injections	Some practices are starting to offer these	
Ring pessary	Changes can be deferred up to a total of 6 months from when the change was due. Use tel consults to review patients due for change and identify those that need to be seen sooner.	https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-09-bsug-guidance-on-management-of-urogynaecological-conditions-and-vaginal-pessary-use-during-the-covid-19-pandemic.pdf
Contraception:		
Coils and Implants	Some practices have started to offer routine LARC initiation/changes. Coil and implant removals should be done where clinically necessary. Consider changing to POP for the interim if no service available. Follow FSRH guidance on extending use beyond license	https://www.fsrh.org/fsrh-and-covid-19-resources-and-information-for-srh/
Depot Injections	As far as possible switch to POP; if giving Depot wait 14 weeks per FRSH guidance, do r/v over telephone and minimise f2f contact time to just administering injection; or patient administered Sayana Press	https://www.pfizerpro.co.uk/produc t/sayana-press/long-term-femalecontraception/sayanar-press-selfadministration
Pill check	Consider asking patients to complete online questionnaire - there's one in eConsult. Or tel/video consult. Follow FSRH guidance on whether it's reasonable to renew a prescription without a recent BP reading	https://www.fsrh.org/fsrh-and-covid-19-resources-and-information-for-srh/
Injections:		
B12	Only for pernicious anaemia or neurological symptoms; consider changing all others to oral	http://gmmmg.nhs.uk/docs/covid-19/06-RDTC-Covid-19-QAA-Alternatives-to-hydroxycobalamin-injection-Version-2-GMMMG.pdf
Prostap	Consider teaching patients to self-administer if appropriate	
Aranesp	Consider teaching patients to self-administer if appropriate	
Clopixol	Consider teaching patients to self-administer if appropriate	
Testosterone	Consider changing to topical testogel	http://gmmmg.nhs.uk/docs/ip/Testosterone-info-sheet-for-GPs-Final-version-approved-by-FMESG.pdf
Preventative care:		
Palliative care including anticipatory care and EoL discussions	These conversations should ideally be done via video link where possible and all end of life and ceiling of care conversations must be made on an individual basis; proactively complete DNAR / SOI forms and prescribe anticipatory meds.	
Frailty	All residential home patients to have Advanced Care Planning including discussion re: DNACPR, Preferred place of care	

Chronic disease reviews:	Consider using a risk stratification tool to prioritise workload	https://s31836.pcdn.co/wp-content/uploads/UCLPartners-Primary-Care-Support-Package-April-2020-FINAL.pdf
COPD	Tel / video consultation; spirometry is NOT yet advised to be done as is AGP	
Asthma	Tel / video consultation; spirometry is NOT yet advised; consider home PEF monitoring. Questionnaire could be done via MJOG/Accurx	
Mental Health	Telephone or video consultation. Clinician to decide if/when further F2F examination/investigations required	
Dementia	Telephone or video consultation. Clinician to decide if/when further F2F examination/investigations required	
Learning disability	Telephone or video consultation. Clinician to decide if/when further F2F examination/investigations required	
Rheumatoid arthritis	Telephone or video consultation	
Diabetes	Bloods and BP in practice; nurse to f/u with telephone / video consult.	
Hypertension	Encourage patient to buy monitor if possible and email in 1 week of home readings for review	
Smears	As per NHSE guidance	
Monitoring:		
Bloods:		
DMARD bloods	Continue with monitoring as per GMMMG shared care guidelines	
Other monitoring bloods e.g.ACEi, lithium, thyroid	Triage prior to appointment	
INR	Consider self monitoring - convert to NOAC where clinically appropriate; if doing F2F INR bloods - follow up with telephone appointment to minimise F2F contact - use PCN pharmacist to deliver this	
Home BP monitoring	If lending out machines to patients, ensure adequate cleaning between patients and consider 'quarantining' the equipment for at least 72hrs. Encourage patient to buy their own monitor if possible	
Routine annual ECGs	Clinician decision	
Vaccinations:		
Routine vaccinations, e.g. flu, pneumococcal	Should be done; prioritise vulnerable patients in high risk groups	
Child imms, postnatal & baby checks	Should be performed. Initial telephone consultation, including consenting for imms; F2F kept to minimum contact time; red books could be completed afterwards and collected at a later time or printed information could be posted to patients	
Travel vaccinations	Discussion with the patient to confirm what would be needed based on their travel; risk assess vaccination on an individual basis depending on circumstances	
DVLA medical examinations for essential workers e.g. HGV supermarket drivers	Continue	
New patient registrations especially for new residents for care homes and the homeless	Continue	

PROTECTIVE EQUIPMENT – T&G GUIDANCE

- Practice responsibility to assess individual risk to the workforce and to protect them from risk.
- Practice responsibility to reduce risk to patients in the boundaries of the practice.
- Risk cannot be abolished, only mitigated.
- Risk of infection reduces as prevalence of C19 decreases.
- Risk of infection increases as footfall through health spaces increases.
- Protective Equipment is more encompassing than PPE.
- PE is only as good as procedures in practices.
- Benefit of PE is undone by poor policies and training on:
  - Personal hygiene
  - Cleaning
  - PPE donning doffing
- Use of physical controls and protections will decrease PPE burn.

Protective Equipment - Environmental modifications to consider:

- All pts advised to wear face coverings/face masks
- Queues
- Outdoor queue spacing can be marked on tarmac with line marking spray
- Queues should not intersect where possible. If they do, leave a 4m gap at intersection
- Provide instructions at gates/near queues.
- Doors
- External doors should remain locked to control patient flow through practices.
- Remote electronic unlock-opening, controlled from inside is preferred
- Consider removing handles where possible.
- Clean pushplates/handle after each use if manually unlocked ungloved.
- Internal non firedoors - wedge open where possible.
- Drop-off boxes
- For pre-bagged biosamples, equipment.
- Fixed to wall etc or secured to surface with velcro.
- Drainable, washable, resilient, linable with plastic bags
- Pick Up Boxes
- For lab samples, external mail, patient sample kits (nb confidentiality)
- Reduces foot traffic to door
- Screens
  - e.g. Reception areas - screens are advised at high traffic areas where staff work - height to 180cm
- Despite screen being present, avoid patient-HCW interaction at the screen to reduce cleaning frequency
  - e.g. Offices - where 2m worker separation is impossible - such as face to face desks, fix between desks - height to 140cm

Personal Protective Equipment

- Provision of PPE is legally the employer's responsibility.
- NHSE will only supply General Practice with PHE advised PPE (Apron, Gloves, FRSM) from national stockpiles via Local Resilience Forums.
- Recommendations are drawn from WHO guidance 6 April 2020 *outpatient consultation room, home care* . Symbol + next to PPE indicates the recommendation goes beyond WHO guidance.
- Situation - CPR or Ventilated-at-home patient (AGPs)
  - +Washable cotton bandana
  - Visor
  - Respirator mask FFP2 or FFP3
  - Nitrile Gloves
  - Washable cotton gown
  - Disposable apron over gown
- Situation - Usual GP surgery or home visit direct patient care
  - Visor
  - Fluid Resistant Surgical mask
  - Disposable plastic apron
  - Gloves
- If patient symptomatic for Covid-19, add;
  - Washable cotton gown
  - +Washable bandana
  - Situation - Pharyngeal/nasal swab testing - sessional activity
  - +Washable bandana
  - Visor
  - Respirator mask
  - Nitrile gloves
  - Washable cotton gown
  - Disposable apron over gown
  - Apron and gloves doffed and changed after each patient contact

Technology

- Use of 2 way AV (eg ring doorbell) at entry advised. Allows communication and instructions to be given (eg sample drop off)
- High level UV lighting - under consideration but unlikely to be advised (high cost vs uncertain benefit)
- Hand held UV lighting - avoid

Considerations

Provide uniform scrubs to your clinical workforce. OK to wear clean scrubs to work, used scrubs not to be worn outside the workplace.

Covid Claims

PPE in line with PHE guidance is being supplied and is the level of PPE reimbursable under the covid claims process.
For resus scenarios – 4 gowns and 4 respirators masks will be provided for each practice site.