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RCGP Guidance on workload prioritisation during COVID-19

This guidance has been developed for clinicians working in general practice in the UK. It should be read alongside guidance from the BMA on workload prioritisation dated 19 March 20. 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 approximately a short number of months. It is not an exhaustive list of GP workload and is not intended to replace clinical judgement for individual patient cases.

Past experience has shown that patients will die from non-COVID-19 related illnesses in addition to COVID-19 itself as we divert all of our health care resources towards it (1). General Practice has a huge role to play in maintaining the underlying health of our population in an attempt to prevent this. It is vital that we continue to provide care to all patients if we have the capacity, with workloads stratified to ensure that those at greatest need are prioritised.

Practices should also be aware and follow the guidance and standard operating procedures outlined by NHSE&I (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Managing-coronavirus-COVID-19-in-general-practice-SOP_19-March.pdf).

Note: The situation with COVID-19 is rapidly changing and it is recommended that clinicians should also refer to local guidance. This guidance is correct at the time of publishing.

RAG Colour coding explained:

Green category: Aim to continue regardless of the scale of the virus outbreak

Amber category: Continue if capacity allows and if appropriate for your patient population

Red category: Postpone, aiming to revisit once the outbreak ends, ensuring recall dates are updated where possible.

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GREEN - CONTINUE	AMBER – IF POSSIBLE	RED - STOP
Patients believing themselves to be unwell if requiring medical attention following initial remote consultation, including immediately necessary patients Patients with possible COVID-19 should be separated from patients who do not fit case criteria.	**Med3** Med3 for first 7 days not required. No Med3 should be provided by General Practice for self-isolation past 7 days. Advise patients that a self-isolation note is available here: https://111.nhs.uk/isolation-note	**Mild self-limiting illness and worried well** (advise to use NHS choices or seek local pharmacy advice first)
Medication/problems that cannot be dealt by community pharmacy. **Remote review should be the norm unless there are overriding reasons that a face to face assessment is necessary. If possible recommend utilising PCN pharmacist if available.** Consider 6-12 months repeat prescribing of 28 day supplies to prevent supply issues. Avoid lengthening supplies of repeat medication unless clinically indicated.		**Coil checks/change** (consider starting POP as an interim measure (also for those with contraceptive implant changes or needing depo injections)) Specific advice is given by Faculty of Sexual and Reproductive Health https://www.fsrh.org/documents/fsrh-position-essential-srh-services-during-covid-19-march-2020/
Investigations for immediately necessary conditions such as serious anaemia. For patients on warfarin, if appropriate consider switching to DOAC.	**Contraceptive services** Be aware of the possible risk of increased pregnancies following isolation periods. Consider extending pill prescriptions for low risk patients without review. Specific advice is given by Faculty of Sexual and Reproductive Health https://www.fsrh.org/documents/fsrh-position-essential-srh-services-during-covid-19-march-2020/	**Ring pessaries**
Symptoms consistent with cancer that may require referral. Can this be performed remotely e.g. skin lesions by photo and postmenopausal bleeding for immediate referral	**Complaints** Consider a standard response to delay formal response during COVID-19 outbreak	**Minor surgery**
Palliative care including anticipatory care and EoL conversations Proactively complete Respect/ DNAR forms and prescribe anticipatory medications in advance of a worsening spread of disease	**F2F reviews of routine care for most at risk groups and those LTCs who do not meet the green criteria.** Remote review is strongly recommended, wherever possible.	**Advice re self-isolation or information for employers and schools etc. Guide patients to national websites.**

Wound management/dressings. Encourage patients to self-care, providing dressing where possible		**Travel vaccinations, insurance reports, medicals, non-urgent paperwork, DVLA medical examinations**
Acute home visits to housebound/residential or nursing home patients BUT 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 if possible		**Ear syringing** (can advise to continue use of olive oil or arrange privately at a high street provider)

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Childhood immunisations. The aim is to avoid an increase in preventable diseases	**Blood monitoring for lower risk medications and conditions eg ACEi, antipsychotics, thyroid disease.** Consider increasing the interval of testing if clinically safe to do so	**Spirometry and routine annual ECGs unless clinically indicated**
LTC reviews for those at higher risk, Review remotely where possible. • T2DM with HbA1c>75, recent DKA, disengaged* • 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 12months (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)	**Vitamin B12 injections –** consider teaching appropriate patients to self-administer and ensure frequency is not more than 12 weekly	**New patient registration medical examinations, unless clinically indicated.**
If a commissioned service from general practice, blood monitoring for high risk medications eg INR, DMARDS, immunosuppressants etc	**Routine smears that are considered to be low risk**	**Stop smoking clinics**
Dispensing , if a dispensing practice.		**New patient checks, NHS health checks, medication reviews, frailty and over 75's annual reviews**
If commissioned, essential injections – e.g. Prostap, aranesp, clopixol, testosterone** Consider teaching patients to self-administer if appropriate		**For those socially isolated or more vulnerable, e.g. elderly, carers, learning disabilities, refer to social prescribing teams for help**
Smears with previous high risk changes/treatment to cervix or on more frequent recalls		**Friends and family test and engagement with PPGs**
Postnatal checks – where possible combine with childhood immunisations, may need designated clinics		**Data collection requests unless related to COVID-19, DESs/LISs/LESs, audit and assurance activities, routine CQC inspections and reviews, appraisal and revalidation work**

Blood results review and filing		
Routine vaccinations, such as seasonal flu, 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		

*usual sick day rules advice should be given
**may need designated clinics for those at risk of immunosuppression
***additional information on contraception is available at
https://pcwhf.co.uk/resources/how-to-manage-contraceptive-provision-without-face-to-face-consultat

References

(1) Elston JW, Cartwright C, Ndumbi P, Wright J. *The health impact of the 2014-15 Ebola outbreak*. Public Health 2017;143:60-70. doi: 10.1016/j.puhe.2016.10.020.