Classification: Official

Publications approval reference: C1288
20 May 2021, Version 4.3

Guidance and standard operating procedures

General practice in the context of coronavirus (COVID-19)

Version 4.3

This guidance is correct at the time of publishing, but may be updated to reflect changes in advice in the context of COVID-19. Any changes since v4.2 (12 April 2021) are highlighted in yellow.

Please use the hyperlinks to confirm the information you are disseminating to the public is accurate. The document is intended to be used as a PDF and not printed: weblinks are hyperlinked and full addresses not given.

The latest version of this guidance is available here.

To provide feedback about this SOP please complete this email template.

Operational queries should be directed to your commissioner.

Contents

1. Scope

This guidance applies to general practices operating under contract to the NHS in England, including those providers that operate outside core GP contract hours.

We trust healthcare professionals to use their clinical judgement when applying this guidance.

2. Communications

For urgent patient safety communications, we will contact you through the Central Alerting System (CAS). For less urgent communications, we will email you through your local commissioner. You can also sign up to the primary care bulletin.

3. Case definition of COVID-19

Public Health England (PHE) has the current case definition for COVID-19.

4. Infection prevention and control

Infection control precautions are to be maintained by all staff, in all care settings, at all times, for all patients; please refer to the latest national guidance. This includes videos and posters demonstrating correct procedures for donning and doffing personal protective equipment (PPE), and guidance on the care of the deceased with suspected or confirmed COVID-19.

Clinical waste must be disposed as per the COVID-19 waste management SOP.

Advice on PPE supply is available here. Practices should register with the PPE portal; government has published its strategy for supplying PPE over the next phase of the pandemic and guidance on accessing the PPE portal. If practices have any queries or have not received an email invitation for the PPE portal, please contact the Department of Health and Social Care (DHSC) portal customer services at: 0800 876 6802.

5. Guidance for staff

All NHS staff have access to free wellbeing support, including Looking After You Too and Looking After Your Team. NHS Employers has resources to support staff wellbeing. Frontline health and care staff can access NHS volunteer responders' support for themselves, including delivery of groceries, dispensed medication and essential items, by calling **0808 196 3646**.

Staff should report COVID-19 related absences through this absence tracker.

5.1 Staff with symptoms of or exposure to COVID-19

Staff with symptoms of COVID-19 should stay at home as per advice for the public. Staff who are well enough to continue working from home should be supported to do so. If staff become unwell with symptoms of COVID-19 while at work, they should put on a surgical face mask immediately, inform their line manager and return home. Please refer to government guidance for healthcare staff, which includes information on staff exposure to COVID-19, testing and return to work criteria. Advice is available on how and when staff should pause use of the NHS COVID-19 contact tracing app.

5.2 Staff testing

Lateral flow antigen testing has been rolled out in primary care for asymptomatic staff delivering NHS services in England. Standard operating procedures (SOPs) on lateral flow antigen testing in primary care can be found here. Patient-facing primary care staff should test themselves twice weekly and report their results to Public Health England (PHE), via the NHS Digital online platform. Please be aware that it is a statutory requirement to report all results, including negative, positive or void. FAQs for primary care are also available, as well as a brief guide for staff on how to self-administer the tests.

NHS staff displaying symptoms of COVID-19, or those in their households, can access testing via the GOV.UK website. Symptomatic practice staff and members of their household may also access PCR swab testing available on site (provided to practices by NHS Test and Trace); see section 8.3 of this document for more information.

Information about the COVID-19 antibody testing programme can be found on the GOV.UK website.The indemnity arrangements for staff antibody testing in general practice are clarified in an FAQ on the NHS Resolution website.

5.3 Staff at increased risk from COVID-19

All staff should be risk assessed and mitigations should be put in place as required; consider whether staff should work from practice premises or from home, whether they should see patients face to face, and any additional measures that the practice or primary care network (PCN) can put in place to support staff safety. Risk assessments should be updated in light of changes to individual staff circumstances or local risk of COVID-19. Prerana Issar and Nikita Kanani's letter dated 23 March 2021 provides information on supporting staff who are clinically extremely vulnerable (CEV), including that risk assessments for CEV staff should be refreshed from 1 April 2021, reflecting the current workplace context.

NHS Employers has published guidance on risk assessments for staff. The Faculty of Occupational Medicine has published the Risk Reduction Framework for NHS staff (including Black, Asian and minority ethnic (BAME) staff) at risk of COVID-19 infection. The government has published guidance for pregnant employees. Staff may be referred to an occupational health professional for further advice and support (contact your commissioner for details of your local occupational health service if not known).

Remote working should be prioritised as appropriate for all staff to increase social distancing and reduce community transmission of COVID-19. GP practices should support staff to follow stringent social distancing requirements if they are not able to work from home. Where shielding is in place, CEV staff should be supported to work from home.

6. Operating model

Collaboration between GP practices within PCNs and federations, community pharmacy, community health services and the wider healthcare system is crucial to manage the current demands on general practice, including clinical prioritisation of the backlog of care. Local health systems should ensure clear leadership, robust workforce planning and appropriate data sharing and patient record sharing are maintained.

The 2021/22 priorities and operational planning guidance sets the priorities for the year ahead, against a backdrop of the challenge to restore services and meet new care demands that are a direct consequence of the pandemic, whilst supporting staff

recovery and taking further steps to address inequalities in access, experience and outcomes, and should be reviewed in conjunction with this SOP.

6.1 Prioritisation of services

As the pandemic continues to pose unprecedented demands on general practice, care should be clinically prioritised for those most in need of support, including those with urgent healthcare needs.

Our letters of 7 January, 21 January and 3 February describe additional support and contractual flexibilities to ensure general practice remains open and safe for patients, and to support the roll out of the COVID-19 vaccination; GP practices/PCNs can consider this further with their commissioner.

As capacity allows, general practice teams and PCNs should continue to:

- deliver accessible services, including face to face appointments as well as the option of online consultatons, connecting patients to the right service for their needs, following IPC and social distancing guidance
- reach out to patients whose health needs may have increased, developed or gone unmet during the pandemic, working with closely with local communities to addresshealth inequalities
- support patients with self-care and self-management, where appropriate
- support staff wellbeing and recuperation.

6.2 Outbreak management

The Government has issued guidance on the local restriction tier system determining the regulations/guidance that will apply in an area (which applies when national measures are not in place e.g. lockdowns).

General practices will have business continuity plans to ensure arrangements are in place to minimise the impact of a local incident on services. Practices should ensure plans are updated to capture the risks of COVID-19. This should include local outbreak scenarios that could temporarily disrupt delivery of services from practice premises or disrupt staff availability. Plans should consider high levels of staff sickness and self-isolation, call handling, staff and patient communication and, ultimately, denial of access to premises for staff and patients.

Business continuity arrangements should recognise the opportunities to maintain patient services through remote working and support from local PCNs; consider the use of buddying systems with other providers and aligning plans with local community pharmacies. Using clinical judgement and experience of recent months, general practice teams may need to consider how to prioritise their workload to deliver the best possible care to their population.

In the event of an outbreak impacting the delivery of services, practices should:

- inform their local commissioner in line with local reporting/escalation processes
- follow PHE guidance on communicable disease outbreak management
- be aware of any local containment plans published by the local authority
- communicate service changes to patients and update the NHS 111 Directory of Services (DoS).

In response to an outbreak, additional measures including shielding may be reinstated for people who are Clinically Extremely Vulnerable (CEV); see Section 9.2 of this document for more guidance.

It may also be helpful to refer to our 9 June letter on minimising nosocomial infections in the NHS and 9 July letter which includes information about flexibilities to respond to local outbreaks.

6.3 Access to general practice

All GP practices must ensure they are offering a blended approach of both face to face and remote appointments, so both are always available to patients according to what is clinically appropriate.

Patients and clinicians have a choice of consultation mode. Patients' input into this choice should be sought and practices should respect preferences for face to face or remote care unless there are good clinical reasons to the contrary, for example the presence of COVID symptoms. Practices should continue to ensure that public health measures can be safely implementedThe RCGP has published guidance on 'Remote versus face-to-face: which to use and when?'.

Patients should be treated consistently regardless of mode of access. This includes consistency of processes. For example, patients can be supported to complete a triage quesionnaire by reception staff on the phone or face to face, using the same process as patients that contact the practice via an online access route.

Practices should continue to prioritise patient care based on need, and to enable care to be delivered by the most appropriate team member or service. To avoid queues and crowded waiting rooms, remote triage and patient navigation should be used wherever possible, with patient preference of triage and consultation mode taken into account. Patients must be able to either go online or walk in to practice reception areas for triage, as well as care.

All practices must offer patients online routes to make requests and ask for support (known as 'online consultation systems'), as there are benefits for patients in terms of more flexible access and for practices in understanding patient needs in advance of a consultation to support triage and navigation. Patients should be able to make requests via an online system at any time[1]. Any time patient access to online tools does not mean that practices are expected to respond to these requests outside of core hours, and switching off online consultation systems out of hours is likely to be less convenient for patients and reduce patient satisfaction. For this reason practices should inform their CCG before proceeding and explore whether additional support may be available. Our advice on how to establish a remote triage model in general practice using online consultation systems may be helpful. Support for implementation of digital tools is available via commissioners.

Practices should implement direct online booking of appointments by patients where appropriate, eg planned care such as flu clinics. Practice receptions should be open to patients to ensure that those without easy access to phones or online services are not disadvantaged when accessing care. Physical access to practices should be consistent with infection prevention and control guidance; patients self-isolating due to COVID-19 should in no circumstances present to practices in person.

Practices should consistently engage with their patient population regarding access models, adapting their processes as needed in response to patient feedback.

The change in access to general practice may disproportionately affect certain patient groups and this should be mitigated as far as possible; some examples of the impact on health inequalities and inclusion groups can be found in Section 10.8 of this document. If you are aware a patient has specific access needs, this information should be passed on in referrals. If patients need extra support to access remote

[1] Data on demand through the online system can be obtained directly from the relevant supplier or via this dashboard.

consultations (eg access to phone/IT), raise this with the local commissioner and/or local authority.

Practices should take advantage of opportunities to collaborate with local community pharmacies receiving referrals for minor illness thorugh the new Community Pharmacist Consultation Service https://www.england.nhs.uk/publication/nhs-community-pharmacist-consultation-service-toolkit-for-GP-PCN-staff/

Communications to patients

Practices and PCNs should ensure patients have clear information about how to access GP services; this information should be made available in accessible formats to all patients, including mobile phone, email and for those who do not have digital access and those for whom English is a second language. It is important to ensure patients understand that although physical access to their general practice may be managed appropriately under this SOP, they can access help and advice remotely, and will be seen face to face where clinically appropriate. This communications toolkit may be helpful.

Information on how to access GP services should be kept up to date on practice websites, and should include advice about:

- how to contact the practice to book an appointment and ask for help;
- how the practice's triage model works including the option of walking into practice reception areas,
- how face to face or walk-in services can be accessed.

Practices should gather patient's mobile phone numbers and email addresses wherever possible, as the ability to communicate with patients by text, phone and email is an important part of a modern patient relationship.

People requiring translation and interpretation

The use of remote consultation and use of face masks and face coverings in face-to-face consultations requires additional considerations, including the impact of PPE on lipreading.

Consider how online messaging and/or video consultation solutions can support interpreter-led, type-based and lip-read communications.

Practices should work with commissioners to ensure their patients can access translation and interpretation services as required.

Patient registration

Practices should continue to register new patients where capacity allows. Practices should continue to register new patients where capacity allows, including those with no fixed address, asylum seekers, refugees and people leaving custody. Practices may only refuse registration if they have reasonable grounds to refuse services to patients. Delivery of applications for patient registration may be by any means, including post and digital (eg an email or scanned copy). Where a practice has online registration options, a supporting signed letter or email from the patient, is acceptable to complete the registration. Information required for online patient registrations can be found on the GMS1 guidance on the GOV.UK website.

6.4 Mode of consultation (face-to-face and home visits)

Face-to-face assessments

When assessing patients face to face, ensure careful consideration is given to protecting staff and patients from risk of infection. Practices should co-ordinate care so that as much as possible is done in a single consultation, and use careful appointment planning to minimise waiting times and maintain social distancing in waiting areas.

Configuration of sites

When face-to-face assessment is clinically appropriate, consider the following options for cohorting patients, premises and workforce to separate those with symptoms of COVID-19 from all other patients:

- **Separate patient cohorts across a PCN footprint**, using designated GP practices or other sites as ‘hubs’ for managing different patient groups.
- **Separate patient cohorts within practices**, using designated areas and workforce.

Avoid using GP practices that are co-located with pharmacies to deliver services to patients with symptoms of COVID-19. If this is not possible, cohorting with strict infection control and cross-contamination protocols must be in place between the GP practice and the pharmacy. If physical separation between the community pharmacy and GP practice in a co-located site cannot be maintained, this should be reported to the NHS England and NHS Improvement regional team, who will assess the impact.

Patients, communities and local systems (including NHS 111, DoS leads, pharmacies, community, mental health and secondary care services) should be kept up to date with changes to the configuration of general practice. We have published guidance on using DoS to report general practice capacity.

The Care Quality Commission (CQC) may need to be informed of changes to services: for example, if hubs are set up to review patients with symptoms of COVID-19. Guidance on registration and general practice focused advice is available on CQC's website.

Preparing sites for patient visits

Please refer to the Health and Safety Executive guidance on making your workplace COVID-secure, and government guidance on working safely during coronavirus (COVID-19). The following advice may also be helpful:

- Use clear signage to direct patients to the appropriate site/space.
- Ensure alcohol gel/handwashing facilities are readily available for patients and staff, including at site entrances.
- De-clutter communal spaces and clinical rooms to assist decontamination.
- Communal areas should allow for physical distancing between patients; consider the use of floor markings, seating arrangements and signage to support this.
- Ensure clinical rooms have the necessary equipment for patient examination readily available, and adequate and accessible provisions of PPE and clinical waste bins.
- If possible, identify toilet facilities for the sole use of patients with symptoms of COVID-19.
- Consider measures such as asking patients to wait in private vehicles, where possible, to reduce numbers in communal spaces.

Face coverings

Government has published advice on the use of face masks and face coverings by staff and the public in primary care. The safety of both our staff and our patients is of paramount importance and face coverings or face masks should be worn by patients in a practice setting, in line with government guidance. We expect that all patients who are able to do so will follow these recommendations.

For the small number of patients who may not follow this guidance, we fully support practices in ensuring that they can take all reasonable steps to identify practical working solutions with the least risk to all involved. Practices should undertake a risk assessment which should consider, for example:

- offering the patient a mask, if the patient is willing to wear one
- booking the patient into a quieter appointment slot, or one in a separated area
- providing care via a remote appointment.

Symptomatic patients may be given a surgical face mask to minimise the dispersal of respiratory secretions and reduce environmental contamination. In all cases, please follow the infection prevention and control guidance.

Home visits

For home visits, the number of healthcare professionals visiting the patient's home should be limited as far as possible. Where possible, liaise with the wider community care team looking after the patient to ensure that the visit is carried out by the most appropriate professional.

Any healthcare professional who visits the patient should consider whether they can perform duties of other team members to avoid multiple visits. Follow infection prevention and control guidance and be aware of any additional precautions required (eg if the patient is on home non-invasive ventilation); ensure visit bags contain necessary PPE. PPE waste can be left behind in a bag and stored for 72 hours before being put into the patient's domestic waste stream, as set out in the COVID-19 waste management SOP.

6.5 Specialty referral pathways

Practices should continue to refer patients to secondary care using the usual pathways and to base judgements around urgency of need on usual clinical thresholds. Practices should take account of national guidance on high quality referrals, taking into consideration need for non-face-to-face consultations, likely delays in restarting routine elective activity, and communicating likely delays to patients at point of referral. NHS Digital has produced guidance on the NHS e-Referral Service (e-RS) in this context. Clinicians should continue to use specialist advice and guidance where available to inform the management of patients in primary care, stream patients to correct services, avoid un-necessary outpatient

activity and refer to the latest guidance on evidence based interventions to support high quality care for patients with the best possible evidence available.

7. Information and support for patients and the public

7.1 COVID-19 guidance

Please refer to the government guidance on COVID-19 for general public information; this is translated into multiple languages. Doctors of the World has translated relevant NHS guidance into 60 languages. Please also refer to NHS advice on COVID-19. Government has also published guidance on domestic abuse and how people can get help during the COVID-19 outbreak.

7.2 Support for patients and the public

NHS volunteer responders

NHS volunteer responders can be asked to help people who need additional support. Patients can self-refer by calling 0808 196 3646 between 8am and 8pm. The practice team can make referrals via the NHS volunteer responders referrers' portal or by calling 0808 196 3382. Guidance for primary care professionals on how to make best use of NHS volunteer responders can be found on the FutureNHS website.

Social prescribing link workers

Social prescribing link workers are working closely with practices, PCNs, local authorities, community services and voluntary sector partners to co-ordinate support for people identified by health and care professionals as especially vulnerable and experiencing health inequalities. They are well placed to support people whose health and wellbeing has been affected by the social and economic implications of the pandemic, such as with loneliness, debt, housing or unemployment, and connect them to the appropriate health coaching and community offers in line with social distancing protocols. More information can be found on our website.

Practices and PCNs should consider how they can enable link workers to be compliant with data protection laws when working remotely, and provide adequate clinical supervision.

8. Managing patients with symptoms of or exposure to COVID-19

8.1 COVID-19 case reporting and coding

COVID-19 is a notifiable disease; please refer to PHE guidance on reporting notifiable diseases. Suspected COVID-19 cases should be notified by general practice. Test-confirmed cases will be notified by the laboratory. PHE provides guidance on which cases should also be reported to local health protection teams.

It is important to ensure suspected and confirmed cases of COVID-19 are correctly recorded in patients' records. Details of COVID019 information standards, including guidance from the Professional Records Standards Body (PRSB) can be found here. Details of the Post-COVID assessment service coding minimum dataset and the Long-COVID primary care coding minimum dataset can be found here.

Following the roll out of lateral flow antigen testing to asymptomatic patient-facing staff in primary care (see section 5.2), staff will be required to report the result of their twice-weekly tests to Public Health England (PHE), via the NHS Digital online platform. Please be aware that it is a statutory requirement to report all results, including negative, positive or void.

8.2 NHS 111, Clinical Assessment Service (CAS) and GP interface

Patients with symptoms of COVID-19 may make direct contact with practices or be referred to practices by NHS 111. If patients present directly to general practice, they should be assessed by the practice rather than redirected to NHS 111, as this poses significant risks to unwell patients.

Patients who contact NHS 111 will be assessed and triaged to determine whether they require urgent hospital admission, advice on self-help/isolation at home or referral into a clinical assessment service (CAS) or other service. A CAS may refer patients into general practice for further management. NHS 111 / CAS will provide practices with a post-event message.

GP practices should make nominal appointment sessions available for NHS 111 / CAS and ensure that patients are picked up and assessed. This will act like a prioritisation list, which may result in a number of different outcomes, including remote management, future follow-up or a face-to-face assessment, which may be at the practice or an alternative local service. Practices are asked to review patients referred by NHS 111 and arrange for any ongoing management that might be required.

Integrated urgent care (IUC) providers operating outside core practice hours should allow direct bookings from NHS 111 to be made using their existing processes. Practices and IUC providers should review the NHS 111 / CAS assessment information, and prioritise patients accordingly.

To facilitate direct booking into GP practices, GP Connect needs to be enabled. Guidance to support set-up of GP Connect is available on NHS Digital's website. Practices need to make sufficient slots available each day for NHS 111 to book into - up to one per 500 registered patients per day; they should assess the use of the slots each day and adjust the number to meet demand. We would not expect the demand on a practice to exceed one slot per 500 patients per day. Where there are locally commissioned services for management of patients with COVID-19 symptoms, and the technical functionality exists to directly book into these services, this can continue subject to local agreements.

8.3 Guidance on assessment and management of patients with symptoms of COVID-19

Ensure that an adequate assessment is undertaken to exclude alternative diagnoses in patients with symptoms of COVID-19.

COVID-19 testing

People with symptoms of COVID-19 can access testing via the gov.uk website. If they have problems using the online service, they should call 119.

Patients who present to general practice settings with COVID-19 symptoms may be offered a PCR swab test (provided to practices by NHS Test and Trace) which can be self-administered by the patient at the practice. This service is designed to streamline patient care and increase access to testing for patients who would otherwise be unlikely to get a test via the primary testing routes, for example due to barriers around language, disability or digital inclusion; practices can use their

discretion to offer the swabs where they deem it to be clinically appropriate. Most patients should be able to self-administer the swab test. Where this is not possible, for example due to disability, we would encourage staff to support patients with this test. Practices may also offer this service to their staff (and their households) who may be displaying symptoms of COVID-19. Practices may opt in to offer this service, which is a supplementary option and does not replace any of the existing routes for patients to access testing; more information is available on the GOV.uk website.

Follow up and remote monitoring of patients with COVID-19

When considering follow-up for patients with symptoms of COVID-19, be mindful that patients may deteriorate later in the course of their illness. Thorough safety netting is therefore vital.

As treatment of COVID-19 improves, it seems likely that earlier detection of hypoxia at home in high-risk groups could help reduce mortality and hospital length of stay. Many practices, PCNs and community teams use oximetry to support remote monitoring of patients with COVID-19 at home and in care homes. It is recommended that all CCGs should put in place a "COVID-19 Oximetry @home" model as rapidly as possible, further to our guidance on the use of pulse oximetry. The default assumption is that the model is primarily implemented in general practice, eg practice sites designated as 'hubs' for managing patients with COVID-19, working with community teams.

The COVID Oximetry @home pathway should be available to people who are:

I. Diagnosed with COVID-19: either clinically or positive test result **AND**
II. Symptomatic **AND EITHER**
III. Aged 65 years or older **OR**
IV. Under 65 years and clinically extremely vulnerable to COVID or where clinical judgement applies, taking into account multiple additional COVID risk factors. National criteria for inclusion on the CEV list are set and updated by government.)

Please refer to our SOP on COVID Oximetry @home, which includes information on staffing, clinical pathways and supply of pulse oximeters.

Long-term effects of COVID-19

A growing number of people are reporting associated long-term symptoms following COVID-19 infection: the Office for National Statistics estimates that around 1 in 5

people who test positive for COVID-19 experience symptoms for 5 weeks or longer, and 1 in 10 for 12 weeks or longer. Please refer to the NICE guideline for guidance on identifying, assessing and managing people with long-term effects of COVID-19. Please also refer to the SNOMED CT codes for COVID-19. Please note that this guidance applies to people who present to any healthcare setting, irrespective of whether they were hospitalised or had a positive or negative COVID-19 test result.

Systems are establishing Long COVID assessment services with 69 sites being announced, as providing services in line with the recently published commissioning guidance, with more services planned to be operational in January, further information can be found here. Details of the clinical pathways are being disseminated locally by systems. The commissioning guidance is now also being refreshed in light of the new NICE guidance.

Your COVID Recovery now has two phases. Phase 1 is open access and provides patient-facing information to support people recovering from COVID-19. Phase 2, the virtual rehabilitation aspect of the platform, was launched in November 2020: this is available to people who have been assessed and referred by a health care professional. Details of the clinical pathway for Long COVID assessment services including Your COVID Recovery have been developed locally and are being disseminated by systems.

The RCGP has produced an e-learning module on Long COVID and an e-learning module on recovery from COVID-19, which summarises current knowledge on the clinical sequelae of COVID-19.

Additional guidance and advice

- NICE has published rapid guidance for relevant conditions in the context of COVID-19, including Managing suspected or confirmed pneumonia in adults in the community and Managing symptoms (including at the end of life) in the community.
- The *BMJ* has a collection of resources on COVID-19, including guidance on the remote assessment of patients with symptoms of COVID-19 and on interpreting a COVID-19 test result. *BMJ Best Practice* has an evidence-based overview of COVID-19.
- The RCGP has a collection of resources in its COVID-19 resource hub.

8.4 Children with symptoms of COVID-19

COVID-19 tends to be a mild, self-limiting illness in children. Prolonged illness and/or severe symptoms should not be attributed to COVID-19 and should be evaluated as usual. The threshold for face-to-face assessment in general practice and for referral to secondary care should not change during the COVID-19 pandemic. Where available, GPs should use secondary care consultant advice via 'consultant hotlines' for support as needed.

The Royal College of Paediatrics and Child Health produced a summary of key current evidence regarding COVID-19 in children and young people and guidance on paediatric multisystem inflammatory syndrome temporally associated with COVID-19.

8.5 Access to medication for patients with symptoms of or exposure to COVID-19

Patients who have COVID-19 symptoms or who are self-isolating due to COVID-19 exposure should be advised not to go to community pharmacies. If they require a prescribed medication, this should be collected by someone who is not required to self-isolate – eg a neighbour or relative not in the same household – or collected and delivered to the patient's home through NHS Volunteer Responders , or using an NHS 'online' service offering postal delivery.

8.6 Hospital admission and discharge of patients with symptoms of or exposure to COVID-19

If an ambulance is required, the call handler should be informed of the risk of COVID-19. If an ambulance is not required, the admission should be discussed with the relevant hospital team, to inform them of the risk of COVID-19 and agree the method of **transport** to hospital.

Patients can travel by private transport, accompanied by a family member or friend **if** the family member/friend has already had significant exposure to the patient **and** is aware of the risk of COVID-19. Otherwise, hospital transport should be arranged. Patients should not use public transport or taxis to get to hospital.

We have published advice and guidance on the healthcare needs of COVID-19 patients following discharge from hospital.

9. Patients at increased risk of severe illness from COVID-19

The Government has produced guidance for people considered clinically extremely vulnerable (CEV) from COVID-19. The RCGP has produced guidance on CEV patients.

The Shielded Patient List (SPL) will continue to be updated and will remain important to help identify patients who may require additional support. Identification and notification of people who are CEV from COVID-19 should continue and patients made aware of this. More information on this process is available on NHS Digital's website including template letters to inform people they are being added / removed from the SPL.

The COVID-19 Population Risk Assessment has been developed to help identify people who may be at high risk from COVID-19. It has been used at a national level to help identify an additional group of patients with specific multiple risk factors which, combined, may put them at similar risk to those who are clinically extremely vulnerable to severe outcomes. Patients identified in this way will be added to the SPL. As part of the current SPL process, you can add or remove a patient at any time.

9.1 Care homes

Care homes have been particularly susceptible to outbreaks of COVID-19, and residents are often at increased risk of severe illness from COVID-19. Primary care and community health services should continue to support care homes in tackling COVID-19 and ensure that care home residents receive the best possible NHS care in this challenging time. This should include:

- a consistent weekly 'check-in', to review patients identified as a clinical priority for assessment and care
- developing and delivering personalised care and support plans for residents
- providing clinical pharmacy and medication support to care homes.

We have published information on the transition and best practice guidance for the Enhanced Health in Care Homes (EHCH) clinical services requirement, part of the PCN contract Directed Enhanced Service.

Reference to government guidance for care homes on the admission and care of residents during the COVID-19 pandemic may also be helpful.

9.2 Other considerations for clinically extremely vulnerable people

In the event of a coronavirus outbreak, people who are considered CEV from COVID-19 may be advised the government to take additional precautions. They may also be advised to shield, in which case the Government will write to people in this group to confirm this. You can check the latest government advice for these patients here. Practices should ensure additional support is in place for these individuals, including:

- Ensure a named lead co-ordinator is in place, either in primary or secondary care.
- Review and update personalised care and support plans and undertake any essential follow-up. We have published guidance on personalised care and support planning and the National Academy for Social Prescribing has developed a personalised wellbeing plan for people shielding.
- Support patient self-management.
- Support patients with urgent medical needs (note that patients may also need to contact their specialist consultant directly).
- Provide care at home wherever possible; if this is not possible, provide safe care in infection-controlled clinical settings in line with infection prevention and control guidance.
- People advised to take additional precautions (including shielding) may be particularly affected by mental health issues. GPs should work with local mental health, learning disability or autism services to review patients receiving care from these services.
- Specialists have been asked to review ongoing care arrangements and will contact patients directly to make adjustments to hospital care and treatment as needed.
- People who work in an area where shielding advice is in place, but live outside this area, can apply for a shielding note via this online portal.

10. Other considerations for general practice

10.1 Medicines and prescribing

Practices should not increase repeat prescription durations and should not routinely authorise repeat prescriptions before they are due as this could put pressure on the medicines supply chain; consider the use of electronic repeat dispensing instead.

Some practices do not accept orders for repeat prescriptions from third parties and expect to receive them directly from patients. Any practice following such a policy should review this urgently, as it may not support people to meet guidance on social distancing and isolation, and may delay patients from receiving their medicines.

DHSC and NHS England and NHS Improvement have published guidance on reuse of medicines in care homes or hospice settings.

10.2 Medicines supply

Electronic repeat dispensing should be used where suitable to help patients secure their regular medicines supply. An NHS home delivery service may be commissioned from both community pharmacies and dispensing doctors to ensure delivery of medicines to different cohorts of people nationally or in specific areas for specified times, for example CEV patients advised to take additional precautions (including shielding) or self-isolating patients following a positive COVID-19 test. Patients will be notified of these arrangements directly. Commissioners will inform your practice of these arrangements locally.

10.3 Employment guidance, self-certification and fit notes (MED3)

The Department for Business, Energy and Industrial Strategy has published guidance for employees on COVID-19. Digital isolation notes provide patients with evidence for their employers that they have been advised to self-isolate due to COVID-19 and so cannot work. The notes can be accessed through the NHS website and NHS 111 online.

Employers may require fit notes for non COVID-19 health conditions. Employers have been asked to exercise discretion in asking for medical evidence to support

periods of sickness absence at this time, which again should reduce fit note requests (including a signature). These notes should be scanned and emailed or posted to a patient. Employers should accept e-mailed notes which are classed as 'other medical evidence'. GPs should give due consideration to GDPR, with necessary consent. GPs can issue fit notes for a clinically appropriate period of up to 13 weeks in the first six months of a condition, in line with existing guidance.

10.4 Verification of death and death certification

DHSC has published guidance on verifying deaths during this period, including how to access remote clinical support (for non-clinicians verifying a death outside hospital). Updated guidance on death certification, registration of death and cremation forms for medical practitioners has been published on our website. CQC has produced guidance on when it should be notified of deaths related to COVID-19 and updated the Regulation 16 (death notification) form. PHE has published guidance for care of the deceased with suspected or confirmed COVID-19.

10.5 Expanded seasonal influenza programme

Government has published details of the national seasonal influenza programme, expanding the eligibility criteria to more people, including:

- household contacts of those on the NHS Shielded Patient List
- health and social care workers employed through Direct Payment (personal budgets) and/or Personal Health Budgets, such as personal assistants, to deliver domiciliary care to patients and service users
- household contacts of immunocompromised individuals.

Reference to the Directed Enhanced Service specification, the enhanced service specification (childhood), guidance on Accessing government-secured flu vaccines, MRHA's guidelines for the movement of flu vaccines, and RCGP's eLearning module on Influenza prevention and treatment may be helpful.

10.6 COVID-19 Vaccination programme

We have published information about the COVID-19 vaccination programme including SOPs for designated sites leading the delivery of local vaccination services on our website. All practices should work with designated sites within their PCN grouping to call and recall relevant patient cohorts as set out by the Joint Committee of Vaccinations and Immunisations (JCVI); EHCH clinical leads should support

designated sites who are roving into care homes with important information about residents health care and mental capacity to consent.

10.7 Mental health, dementia, learning disability and autism

Patients may feel distressed, anxious or low in response to the COVID-19 outbreak. Every Mind Matters has resources on mental wellbeing; NHS.UK has information on stress, anxiety, depression and wellbeing, and where to get urgent or emergency help for mental health needs.

Patients should be referred as usual to mental health services. All areas are putting in place 24/7 all-age open-access NHS mental health crisis support lines. We have published specialty guidance on learning disability and autism in the context of COVID-19.

Information on the care of people with dementia in the context of COVID-19 is available on the British Geriatric Society website. We have published a specific framework for personalised care planning in the Dementia: good personalised care and support planning guide.

Practice staff should work proactively with secondary mental health care services to identify which individuals on the severe mental illness (SMI) register are due a physical health check. Services should engage with eligible individuals to explain the purpose of the check and agree a suitable and safe way for it to be completed. Where face-to-face checks are not possible, practices should complete elements remotely, where practicable. Reasonable adjustments should be made to accommodate the needs of people with SMI in the completion of checks.

Practices are asked to support Learning from Deaths reviews for people with a learning disability and release case notes to reviewers as quickly as possible (ideally within a week of a request being made using the secure Learning Disability Premature Mortality Review (LeDeR) web-based portal). If preferred, a GP can have a direct discussion with a LeDeR reviewer. More information is available on our website.

10.8 Suspected or diagnosed cancers, including ongoing cancer treatment

Practices should continue to refer patients who fulfil NG12 criteria. Secondary care will triage and prioritise if capacity is constrained. Practices may be asked to support prioritisation with additional tests alongside referrals, if they have capacity and appropriate access. Post-referral, secondary care will use patient tracking lists where investigations take place at a later date.

Identifying, diagnosing and treating cancer is a priority in 2021/22. GPs and primary care colleagues will continue to play a critical role in the identification and rapid referral of this group of patients.

As a result of the pandemic, we saw an overall reduction last year in the number of people being referred urgently with suspected cancer. Thanks to the efforts of colleagues in primary care, overall referral numbers are recovering to expected levels. However referral numbers for some cancers remain lower, including for lung, urological, upper gastro-intestinal, prostate, and skin cancers including melanoma. GPs should be particularly alert to the risk of cancer in patients with symptoms suggestive of these tumour types. Practices are encouraged to contact their local cancer alliance for further advice and guidance, including on cancer diagnostic services.

Secondary care continues to require consent from the referring clinician in primary care if considering circumstances for the downgrade of any urgent cancer referrals as a clinical decision.

It is expected that patients due to begin or continue cancer treatment will proceed as planned. Some patients may still wish to defer referral/treatment, and it is essential that they are appropriately safety-netted using the appropriate SNOMED code and monitored if this is the case.

10.9 Health inequalities and inclusion health

COVID-19 has had a disproportionate effect on certain sections of the population – including older people, men, people living in deprived areas, BAME groups, those who are obese and those who have other long-term health conditions, mirroring and reinforcing existing health inequalities, as highlighted in the PHE review of disparities in risks and outcomes and the PHE report on the impact of COVID-19 on BAME groups. Furthermore, the long-term economic impact of the pandemic is likely to

further exacerbate health inequalities. Our 31 July letter highlights the need for collaborative work with local communities and partners to reduce health inequalities, and recommends urgent actions that health systems should take in this area.

General practices can play an important role through working with voluntary and community organisations to make sure those who are most excluded have access to primary care services, and through working within PCNs to shape interventions around community needs, using co-design and co-production.

People experiencing homelessness: During the pandemic some of your registered patients may have been displaced out of area and/or a group of homeless people relocated into your catchment area due to measures applied by local authorities. Practical resources are available from the Faculty of Inclusion Health and the FutureNHS Collaboration space (contact FutureNHS for access).

The Home Office may have set up initial accommodation for **asylum seekers** in your area who may need access to (and have a right to register for) GP services. Commissioners may arrange dedicated or enhanced services to support asylum seekers in your area. PHE has published advice on **healthcare for refugees and migrants**. Doctors of the World can provide specialist advice on working with asylum seekers and refugees.

Gypsy, Roma and Traveller communities face some of the most severe health inequalities and poor health outcomes in the UK. Friends, Families and Travellers has a service directory on its website, and relevant information on COVID-19.

10.10 Advance care planning

Patients who have capacity should be centrally involved in planning their care. The key principle is that each person is an individual whose needs, circumstances and preferences **must be taken account of individually**, as outlined in our letter to healthcare providers and the BMA, CPA, CQC, and RCGP joint statement on advance care planning.

- Guidance on advance care planning can be found on the NHS.UK website; note people living with dementia can require a specific approach; further guidance is available on our website.
- We have developed a template advance care plan and patient-facing guidance in the context of COVID-19.

- The Resuscitation Council has information on the ReSPECT process of treatment escalation planning and resources and guidance in the context of COVID19.

10.11 Symptom management and end-of-life care

NICE has published guidance on managing COVID-19 symptoms (including at the end of life) in the community. The British Geriatric Society has produced a resource collating guidance on end-of-life care in older people in the context of COVID-19, including specific advice for end-of-life care for patients with COVID-19 who have dementia.