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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 2020 and your own local guidance. During the development of this document consideration was given to work that is essential to maintain public health and that which is unlikely to cause harm if delayed for a short period. It is not an exhaustive list of GP workload and is not intended to replace clinical judgement for individual patient cases.

Past experience has shown that there is a risk that more patients will die from non-COVID-19 related illnesses than COVID-19 (1-3). General Practice has an important role in maintaining the underlying health of our population. It is important to note that the COVID-19 pandemic is not affecting all areas of the country in a uniform way. There is therefore an important balance to be achieved between preparing the facilities and capacity to manage patients affected by COVID-19 and addressing the ongoing needs of individual patients. General Practice is operating in extraordinary times and circumstances with a system of telephone or online triage approach for all patients across the country. It is important that, working within the constraints of this model, the ongoing care and treatment needs of patients are met and managed dependent upon the individual practice circumstances, and the time and capacity available.

Practices should also be aware and follow the most up to date guidance and standard operating procedures outlined by NHSE&I (https://www.england.nhs.uk/coronavirus/publication/managing-coronavirus-covid-19-in-general-practice-sop/) and its equivalents in the devolved nations via the RCGP's latest COVID-19 advice in your area webpage (https://www.rcgp.org.uk/covid-19/latest-covid-19-guidance-in-your-area.aspx).

Note: The situation with COVID-19 is rapidly changing. This guidance is correct at the time of publishing.

RAG Colour coding explained

We would expect you to move between each category at different stages of the pandemic dependent upon staff, resources and prevalence of disease in your locality

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

Where patients do need to be seen, this should be remotely where possible (via telephone or video), but if a face to face appointment is required, then full personal protective equipment must be worn in line with current policy found here (https://www.gov.uk/government/news/new-personal-protective-equipment-ppe-guidance-for-nhs-teams)

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GREEN – High priority	AMBER – Medium priority	RED – Lower priority
Urgent care **Acutely unwell adults and children:** • **COVID-19 related already screened by 111 and referred back to primary care** • **Non COVID-19 related self-referring to primary care** • **Other patients contacting general practice directly** It is essential to remember general practice plays a vital role in identifying and treating acute illness and worsening of chronic disease during the pandemic. This is to prevent increased morbidity and mortality from non COVID-19 causes.	**Contraceptive services** Be aware of the possible risk of increased pregnancies following isolation periods. • Consider extending pill prescriptions for low risk patients without review. • Consider changing depot injections and LARC that requires changing to the progesterone only pill or patient administered Sayana Press (https://www.pfizerpro.co.uk/product/sayana-press/long-term-female-contraception/sayanar-press-self-administration) Specific advice can be found here https://www.fsrh.org/documents/fsrh-position-essential-srh-services-during-covid-19-march-2020/	**Coil checks/change** Consider starting POP as an interim measure 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/
Chronic care **Remote LTC and ongoing reviews for those at higher risk** • 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 12 months (needing oral steroids), on biologics/maintenance oral steroids Significant mental health with concerns regarding suicide or deliberate self-harm risk or currently unstable mental health. (Consider using social prescribing teams for help.)	**Routine care review for most at risk groups and those LTCs who do not meet the green criteria.** Remote review is strongly recommended, wherever possible.	**Routine non urgent screening for example** • New patient checks, NHS health checks, medication reviews, frailty and over 75s' annual reviews
Cancer care: assessment of new potential cancers and ongoing care of diagnosed cancers **Symptoms consistent with new or ongoing cancer that may require treatment/ referral.** • Consider if it could be performed remotely e.g. skin lesions by photo or postmenopausal bleeding for immediate referral		**Routine smears that are considered to be low risk**

Smears with previous high risk changes/treatment to cervix or on more frequent recalls		
Palliative care including anticipatory care and EoL conversations 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		**Ring pessaries**
Medication that cannot be dealt by community pharmacy. • Remote review unless there are overriding reasons that a face to face assessment is necessary. • Consider batch prescribing e.g. 6-12 months repeat prescribing of 28 day supplies to prevent supply issues. • Avoid lengthening supplies of repeat medication unless clinically indicated. • Dispensing if a dispensing practice	**Med3** Med3 for first 7 days not required. No Med3 should be provided by General Practice for self-isolation past 7 days. Advise patients that COVID-19 related sick notes are available here: https://111.nhs.uk/isolation-note	**Minor surgery (unless you participate in skin cancer excision which should continue)**
Investigations for immediately necessary conditions or where the test will make a difference to treatment • Blood tests • INR for patients on warfarin, if appropriate consider switching to DOAC • DMARD/ shared care bloods (review national guidance regarding safety of increased intervals in blood testing e.g. British society of rheumatology here (https://www.rheumatology.org.uk/news-policy/details/covid19-coronavirus-update-members)	**Blood monitoring for lower risk medications and conditions such as** • ACEi, if appropriate consider alternative medication that does not require blood monitoring • antipsychotics • thyroid disease. Consider increasing the interval of testing if clinically safe to do so referring to national guidance where available	**Advice on mild self limiting illness or COVID-19 social isolation for individuals, employers and schools etc.** • Guide patients to national websites • For those socially isolated or more vulnerable, e.g. elderly, carers, learning disabilities, make use of social prescribing options, link workers etc where these are available
Routine vaccinations, such as seasonal flu, pneumococcal etc for all patients where they are recommended. Prioritise vulnerable patients in high risk groups, such as • patients with a solid organ transplant • undergoing active chemotherapy or radical radiotherapy for lung cancer • with leukaemia, lymphoma or myeloma at any stage of treatment • 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		**Non urgent investigations that will not impact on treatment for example** Routine/ annual ECGs **Spirometry: Consider home peak flow monitoring where indicated**

• 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		
Childhood vaccinations, postnatal checks and new baby checks, also: • New baby vaccinations • Pre school boosters • HPV etc should continue **Consider undertaking post natal check at 8 weeks to coincide with first childhood immunisation.**		
Essential injections – e.g. Prostap, aranesp, clopixol etc** • Consider teaching patients to self-administer if appropriate	**Vitamin B12 injections for post bariatric surgery patients** - consider teaching appropriate patients to self-administer and ensure frequency is not more than 12 weekly. Review whether oral supplementation would be appropriate.	**Vitamin B12 injections –** consider teaching appropriate patients to self-administer and ensure frequency is not more than 12 weekly. Review whether oral supplementation would be appropriate if asymptomatic with a dietary deficiency BMJ 2019 https://www.bmj.com/content/365/bmj.l1865
Safeguarding The role of primary care in safeguarding at this time is to continue to recognise when children/adults/families are struggling or potentially suffering abuse or neglect, signpost to resources which can help, refer to other agencies as available and appropriate, and support vulnerable patients were possible. https://elearning.rcgp.org.uk/pluginfile.php/149180/mod_resource/content/2/COVID-19%20and%20Safeguarding%20%286%29.pdf		
Wound management/dressings. Consider increasing the interval between dressings if clinically appropriate or encourage patients to self-care, providing dressing where possible		**Ear syringing** (can advise to continue use of olive oil or arrange privately at a high street provider)
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 where possible		**Data collection requests unless related to COVID-19, DESs/LISs/LESs, audit and assurance activities**

Essential paperwork	Complaints	Non essential paperwork
• Blood and test results review and filing • Discharge letter review and medication reconciliation • DVLA medical examinations for essential workers e.g. HGV supermarket drivers • New patient registrations especially for new residents for care homes and the homeless.	Consider a standard response to pause a formal response during COVID-19 outbreak**.** See https://www.england.nhs.uk/contact-us/complaint/complaining-to-nhse/information-for-public-frequently-asked-questions/	• DVLA medicals for non-essential workers • Private to NHS prescription changes. These can go straight to a pharmacy • Hospital outpatient prescriptions. These should be filled at the hospital or secondary care can provide patients with FP10s to use in community pharmacies • Insurance reports • Data collection requests unless related to COVID-19, DESs/LISs/LESs, audit and assurance activities, • Friends and family test etc

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