

General practice preparedness guide

GPC England has produced this guidance to support practices and LMCs on emerging themes for COVID-19 pandemic preparedness in general practice in England. Further versions will be released over time as more information is made available and agreements made.

Safety and preservation of a finite workforce to help support delivery of health care within an extremely challenging and pressurised time is an immediate priority. This requires a rapid shift in thinking and culture as never before to enable a sustainable and safe way of operating for the benefit of all. This will be hard and must not be underestimated but is crucial to achieve the end goal of minimising lives lost within the resource limits that GPs and their teams will be operating under. As a profession and as individuals health care workers have a duty to their communities and patients.

Key principles

- Health Care Worker safety is paramount
- Protecting Health Care Workers protects patients
- Everything possible should be done to reduce infection transmission
- Procedures and pathways should be evidenced based

The principle goal of social distancing is to minimise infection spread; this applies for patients and health care workers. All those working in primary care must be able to continue to perform their duties throughout this challenging period. This means that avoiding infection is vital to ensure they remain in the system working safely for the benefit of patients.

Whilst we are working rapidly to make changes, we need to ensure that every action taken, and decision made, is as well thought out and planned as possible. This will be hard at times but it's crucial for the long-term benefit of all. All members of the team will need to be supported in this process continually, both now and in the recovery phase after the pandemic has ended.

System enablers

There should be a focus on community care as well as individual health care, the overall goal is to limit spread, to identify cases, to isolate and support those with symptoms as well as those with urgent needs requiring intervention. The pandemic is a public health emergency and as such the focus needs to be on managing and supporting the health of the population with a focus on measures that will achieve this goal.

Adopting a population approach will require an urgent review of infrastructure and using timely intelligence to inform interventions needed.

Honest and transparent conversations with ICS/CCG leaders and LMCs should take place urgently about expected morbidity and mortality figures locally in the coming weeks. This will help in planning for what's coming. Emergency planning will need input from CCG/ICS to identify estates and the necessary support with infrastructure and additional funding, alongside input from infection control teams /infection disease specialists to advise on rigorous PPE arrangements. GPs should consider the role of local authorities and third sector/voluntary bodies who could

have suitable estates or could offer support. Where new estates (not previously used for health) need to be established, CQC has committed to an accelerated registration process, taking hours.

First steps

Identify key stakeholders to support the response, segment and stratify population, allocate resources and work collaboratively reconfiguring in real time to dynamic needs.

- Define the overall goal and then subsequently the goal for each population segment
- Define the stakeholders who will be needed for the overall system and then for each segment, for example NHS bodies, local government, VCSE, local business, media
- Define the needed infrastructure: data, data sharing agreements, MOU for collaborative working, estates, IT, Specialist teams, especially at the segment level (for example child immunisation, safeguarding, maternity services, frailty, long term conditions such as respiratory, cardiology, elderly care, palliative care)
- Pool resources in the community, challenges will be common, draw up clear pathways of care that can be iterated and followed uniformly by all

Intervention

Different parts of the country are at different stages of the pandemic. Practices should have already [stopped doing non-essential work and moved to total triage arrangements](#). In the coming days the initial gradual increase in cases will be followed by a sudden rise in activity which at different points will require different dispositions and responses. The situation will develop swiftly and the decisions that have to be taken will get harder. At this early stage steps should be taken to optimise care. GPs should take a proactive approach to managing conditions or adopt processes that can begin now, in order to support capacity in the future when COVID-19 related activities will rise exponentially.

Proactive care

- Utilise all staff groups available to complete this work, social prescribers or retired GPs returning can help too
- Identify all high risk groups, high needs groups and vulnerable patient groups (see [NHSE/I guidance](#))
- Remote review should be done by the practice before any potential face to face contact, which should now only happen in exceptional circumstances
- Put care plans in place for those that don't have them where this is appropriate; the practice should determine the best way to review the care plans/needs of the most high risk shielding group, as capacity allows, and based on clinical need and local knowledge, contacting patients directly when necessary to, for instance, check there are no medication supply issues
- Review care plans and optimise them for those that do have them
- Discuss individual DNAR directives when clinically appropriate and ensure forms are in place and patients' views documented
- Discuss with local partners, such as community teams, how end of life medications might be stored, released or made available as required

- Consider care for cancer patients, and where appropriate agree end of life plans and palliation in advance, anticipate potential for deterioration and have a plan in place
- Discuss ceilings of care and ensure it is well documented
- Look at patients with long term conditions, optimise treatment, do relevant checks, issue ePS scripts for anticipatory and rescue packs where appropriate being mindful of pharmacy supply issues, provide a clear plan for how these scripts will be utilised
- Put data sharing arrangements in place
- Ensure SCR additional information has relevant information
- Share dashboards of patients across PCNs that need reviews/input and ensure immediate and necessary needs have been considered and tasks completed; share these lists across teams, so care can be seamless irrespective of staff sickness/practice closure
- Identify patients requiring immunisations and vaccinate as soon as possible; consider a plan for how you can organise immunisations as a community.
- Switch suitable patients from warfarin to DOAC
- Consideration for patients with serious mental illness on depot, patients receiving vitamin B, hormone or other injections and how these patients can receive their medication and/or be properly monitored
- Signpost patients to sources of support such as local council services, volunteer groups, third sector and online resources, that may be able to support them

Repeat medication

- Enable patients to order their medication from home; online ordering should be actively encouraged and while it is not normally recommended, practices that have stopped telephone ordering will need to reinstate this service for the duration of the COVID-19 situation for those patients with no online access
- Use the Electronic Prescription Service (ePS) as much as possible
- Practices should be mindful of the impact of any changes they make on local pharmacy and should co-operate closely with community pharmacies; they should not be required to be the sole provider of repeat prescription ordering
- Medication durations should not be altered from the practice's usual routine, nor should additional quantities of medication be prescribed when it is not clinically necessary
- Consider patient reviews on a case by case basis; it may be possible to delay these for individuals on well-established treatment regimens, however the decision to do so should not be automatic
- Phlebotomy or near patient testing for drugs such as warfarin or DMARDS may be delayed if patients are stable and would be at risk of attending surgery, or if a practice has acute staffing problems, but these decisions should be made on an individual patient basis or on a group basis in consultation with the local consultant service sharing the responsibility for management
- Consider patients who are unable to get medication in their normal manner (such as those in self-isolation); liaise with social services/voluntary agencies to ensure these individuals are provided for
- Post-date scripts where necessary, keeping to usual (likely 28 days) time frames to avoid surges of demand that may compromise supply chains
- Practices should work with and support local pharmacies to agree the best way to ensure these most vulnerable patients have secure arrangements in place to order and receive medication

Workforce planning

Collaborate with LMC, LPC, local council, volunteer workforce, PPG (if they have capacity), CCG medicine optimisation teams, palliative care teams, ambulance services, community nursing teams, hospice and all other relevant system partners. Early dialogue about pathways of care, ceilings of care, community rehab and palliative care agreeing how the pathways will flow will be helpful.

- Pool resources in the community (decide level of scale based on delivery model: buddy practices/PCN/Federations/CCG)
- Model workforce at 20-50% loss at any given time
- Outline regular review points to assess level of workforce engaged and losses due to illness/self isolation/morbidity/mortality
- Liaise with local trusts and community services to try and map out picture of what is happening, for example, demographics of those admitted for hospital care etc
- Optimise remote working so that staff in isolation at home can continue to contribute
- Consider creating and allocating teams to specific delivery models, such as shared back-office staff, in anticipation and preparation
- Be prepared to change plans flexibly so that the delivery is optimised, potentially with a dwindling workforce
- The modelling will need to be flexed depending on bed availability and other aspects as it's not just the number of cases, but also the availability of HCWs, so the same service cannot be delivered at all times
- Think about how to repurpose roles and people's skills; in the short, medium and long term, up-skill members of the team now
- Anticipate and plan for significant numbers of patients with COVID-19 infection in the community who are not being admitted to hospital; consider the increase in end of life care arrangements which may be time limited for each individual
- Pathways could be social prescriber or volunteer driven, contacting patients who are self-isolating with COVID-19, social distancing or shielding, and only when necessary passing on these patients for clinical assessment
- Set up similar pathways of care for other presentations, depending on what local challenges are being faced
- Think of how volunteers can support the delivery model
- Many carers continue working, they could be a resource that could be drawn on to deliver care; include them in your care pathway
- Large numbers of high risk patients will be treated and supported in the community and there will be more deaths; consider the advice to family members, can this be standardised and how can they be included in a pathway of care?
- Create resources for family members/other staff groups to enable delivery of palliative care in the community
- Have a dedicated well-being process; this will be a traumatic and stressful time for staff, well-being is important from a mental and physical viewpoint (guidance available [here](#))

Personal Protective Equipment

All patients in primary care should be treated as if they have COVID-19 infection and PPE must be worn at all times. Without widespread testing, and for the protection of frontline healthcare workers and patients alike, all must be properly protected.

There have been widespread concerns that PPE has not been reaching general practice quickly enough, in sufficient quantities or to the right specification. Primary and community care healthcare workers should be provided with fully protective PPE, which should include fluid repellent face masks, eye protection such as visors and goggles, disposable gowns or single use aprons and gloves. Scrubs/medical uniforms/shirts should be bare below the elbows, with scrupulous attention to hand and arm washing after each patient contact. Eyewear should be used at all times during patient contact. Aerosol generating procedures (AGP) will require additional PPE. A [blog from Dr David Farren](#) (a consultant medical microbiologist and infection control specialist) provides more guidance on this. BMA guidance is also available [here](#).

If sufficient deliveries have not been received seek support in the community, including the CCG and local Trusts. The workforce should be properly protected and infection limited so they are able to continue to deliver healthcare to the community and population. Consider following a clearly established pathway when seeing patients.

- Never see a patient without PPE
- GPs can refuse to treat patients if their PPE is inadequate, they are at high risk of infection and there is no other way of delivering the care
- Minimise physical contact with patients to only essential clinical need and maximise telephone and [video consultations](#)
- Consider fully protected home visiting team and use of home observations by the patient/relative/carer rather than patients attending the premises
- Provide home visiting bags with oxygen probe, thermometer, and automatic sphygmomanometer that can be left on a patient's doorstep for them to use once and then return to decontaminate afterwards
- Use daily changed and cleaned scrubs/carry a change of clothes, and once at work change into work clothes, don adequate PPE
- Training on doffing and donning of PPE is important to address
- Set process for putting on/taking off when assessing patients
- Scrupulous hand hygiene, tuck all hair away; remind everyone to wash their face too if in close contact/coughed on
- Ensure ventilation and air circulation within premises where patients are being seen is thought through, ideally with support of ID team
- Consider an arrangement where the patient walks in, washes hands, puts a face mask on, is instructed not to touch anything (have clear instructions laminated and visible)
- Minimise time spent with a patient face to face (limit only to essential examination/intervention, the rest can be completed via remote assessment) and maintain safe distance where possible
- Wash hands frequently
- Can patients be asked to wait outside the practice, being called on mobile to walk in when you are ready to see next patient?
- Can patients wait in their car (you see them whilst they are in their own car - don't get in)?

- Plan how staff and patients will move through the premises; where possible have specific entrances for patients attending for examination
- Maintain social distancing between staff at all times

Deploying the workforce

Be clinically led and adaptable. Previous guidelines may no longer be appropriate. Work with local partners, commissioners, community and hospital teams to clarify admission criteria directly linked to bed status and capacity in hospital. This is likely to require daily status reports and coordination at locality/system level. It will also depend on what transport options there are available. Consider creating comms groups (WhatsApp/Slack) to share time relevant status updates among local colleagues.

With a significant proportion of the workforce self-isolating because of COVID-19 related symptoms they or those they live with have, widespread and easily accessible testing must be made available for all those in primary and community care.

Consider where possible to train families, carers, patients to deliver care for the patient/themselves.

Dedicated home visiting teams with equipment for self-assessment observations may increasingly be required, particularly for palliative care. Consideration needs to be given to risk of exposure, viral load, PPE and cleaning post visit. Work with ID team to consider risks of such a model.

Be clear what level of PPE you will need for each area of the practice/facility in which you are working in or when home visiting, this will be determined by what procedures you think you will be carrying out in each area.

Health care workers in the community should not be engaging in CPR or using nebulisers or suction that can generate aerosol spread without the necessary PPE used for aerosol generating procedures.

Death Verification, Certification and Cremation Forms

The Coronavirus Act 2020 has changed the systems in place for certification of death and cremations. The most up to date guidance is available [here](#).

Key things to remember

Healthcare workers are force multipliers. Their training and experience is invaluable moving into this crisis, if they become unwell, this will impact on the service and it will cost lives. Their priority should be to protect themselves first.

- Things will get worse before they get better
- GPs are going to be faced with some very difficult decisions
- They should put their needs first

- They should be led by their moral and ethical values, others may not share their views and values
- All healthcare workers should respect and support each other
- All healthcare workers have a responsibility to protect and look after each other