GP Fact Sheet

Last update: 01.05.20

In this update, you will find :

Guidance for Remote Verification of Expected Death (VoED) Out of Hospital

During the COVID-19 pandemic the processes in relation to death registration and management have been changing. If a patient has died in the community and there is no trained person in attendance to verify the death, it should be reported to the GP practice or Out of Hours. If an agreed local pathway is in place, it should be followed. If not, a GP can establish that the person in attendance feels entirely comfortable to assist the VoED process via video consultation.

Following a check of the body to determine if rigor mortis is present an assessment must be carried out:

A) If body is not stiff check:

- [ ] Pupils for dilation
- [ ] No chest wall movements in the last 3 minutes
- [ ] Absence of breath sounds
- [ ] Carotid pulse to ensure no pulse for at least 1 minute
- [ ] Absence of heartbeat
- [ ] Repeat all checks after 10 minutes

B) If body is stiff, document:

- [ ] Time of verification of death name of patient
- [ ] Date of birth of patient
- [ ] Anyone in attendance
- [ ] Circumstances of death
- [ ] Name of guiding clinician – will complete death certificate or report to the coroner and offer family bereavement support
- [ ] If known:
  - Address
  - NHS number
  - Next of kin

- If the guiding clinician is not from the patient's registered practice the registered practice must be informed immediately containing the above information and they may arrange for the completion of death certificate (sent electronically to the registrar) and/or report the death to the coroner.
- If relatives or friends of the deceased wish to support the process before the undertaker arrives, care must be taken to ensure it is appropriate and handled with sensitivity
- If it is not possible to support the process remotely, then alternative verification methods will be necessary. The clinician carrying out the procedure must inform the undertaker of any notifiable disease or any equipment e.g. pacemaker, syringe driver or catheter in place
- The RCGP has produced a useful flowchart - please go to page 7

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NHS Primary Care Webinar Summary – 30 April 2020

- NHS Employers are currently developing a Primary Care risk assessment for Black, Asian and minority ethnic groups (BAME) due to the high proportion of deaths seen within this group
- NHS England expects a greater number of patients to contact their surgery on the next bank holiday on 8 May compared to Easter, but recognises that Practices may implement a different model in agreement with their local CCG
- Practices should encourage patients to contact their GP for non-COVID related medical concerns as part of the 'Help us to Help You' campaign
- **Testing**

  A. Government Testing (5 Pillar) Strategy was published on 4 April, first 2 Pillars are in progress:

  - Pillar 1: Scaling up NHS swab testing for those with a medical need and, where possible, the most critical key workers
  - Pillar 2: Mass-swab testing for critical key workers in the NHS, social care and other sectors

  B. Patient Testing

  - Hospitals are expected to test all admissions and all discharges to a care home
  - Getting results back depends on the route the patient was tested, if the test was done at a hospital then local lab results 'should' come to the GP, if the patient carried out self-testing there is no guarantee that their GP will be informed so encourage patients to let Practices know their test results

  C. Staff Testing

  - This was expanded on 12 April increasing groups this is being offered to
  - Absence rate dropped 20% since COVID began
  - Route for testing for locums will vary, either by a usual Practice or through an agency

- **Shielded patient list**
  - Shielding to continue until 30 June but this is being kept under review
  - RCGP e-learning module has been updated to reflect the latest information
  - Expert patient group – details coming soon

- Self-declared list (before 29 March) was a one-off task, Practices will not be getting another list to check
- Further information will be issued next week

- **IT**
  - Remote consultations have helped with workload but Practices who still have not chosen a product to use for this are urged to do so soon
  - Any IT queries (if limited support from local CCG IT Team) can be sent to digitalprimarycareengland@nhsx.nhs.uk

- **The National covid-19 clinical assessment service (CCAS)**
  - All EMIS & TPP Practices have this system activated
  - Patients should be booked into the surgery priority list, with no specific appointment time but the Practice must contact the patient within 30 minutes either to see them via video/ telephone consultation in a 30-minute slot (maximum)
  - NHSE England is continually reviewing the need for 1:500 patients for 111 direct booking of Covid patients
  - More than 700 retired GPs and locums on boarded now

- **COVID Reimbursement Fund** – these funds are making their way to general practice. It is currently with the Treasury for approval and there will be a further update next week

- **Network Contract Directed Enhanced Service (DES) – Care Homes**
  - Whilst many Practices already provide proactive support to local care homes, there are variations around the country in delivering this support
  - Although GPs are expected to provide Enhanced Health in Care Homes under this DES from 1 October 2020 NHS England wants to introduce some elements of this sooner due to the current COVID situation – the specification will remain unchanged
  - Letter will be issued on 1 May setting out what this requirement looks like and funding will follow

- Next Primary Care webinar on 7 May will cover topics on PPE, contracts and funding, pharmacy, and IT/remote working

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Maintaining immunisation services during the COVID19 pandemic to reduce the serious risk of vaccine-preventable disease

Practices will be busy responding to the COVID-19 pandemic and the routine immunisation programme will continue to play an important role in preventing ill-health through causes other than coronavirus infection.

The national immunisation programme is highly successful in reducing the incidence of serious and sometimes life-threatening diseases such as pneumococcal and meningococcal infections, whooping cough, diphtheria and measles. It remains important to maintain the best possible vaccine uptake to prevent a resurgence of these infections.

The routine immunisation programme should be maintained including the following important vaccinations:

- routine childhood immunisations, from 8 weeks up to and including vaccines due at one year of age, and selective neonatal hepatitis B vaccination for babies born to hepatitis B infected mothers
- pertussis vaccination in pregnancy
- pneumococcal vaccination for those in risk groups from 2 to 64 years of age and those aged 65 years and over (subject to supplies of PPV23 and clinical prioritisation)

Other non-scheduled vaccinations should still be given opportunistically for example missing doses of MMR. Coronavirus responses may have disrupted immunisation clinics in the past few weeks, so anyone who has missed their scheduled immunisations recently should be invited for vaccination.

Non-dietary vitamin B12 deficiency

(e.g. pernicious anaemia, prior gastrectomy, bariatric surgery, achlorhydria, pancreatic insufficiency, short bowel syndrome, bacterial overgrowth, inflammatory bowel disease)

NICE 2019 recommendation: administer hydroxocobalamin 1 mg intramuscularly every 2– 3 months for life British Society for Haematology advice during the COVID-19 pandemic for patients established on intramuscular hydroxocobalamin:

The need for intramuscular (IM) hydroxocobalamin should be discussed with each patient individually.

We recommend that screening questions for COVID-19 infection are asked before patients attend their GP surgeries. Alternatives to attending the GP surgery such as local pharmacies or home administration by district nurses should be explored.

As an alternative, oral cyanocobalamin can be offered at a dose of 1 mg per day until regular IM hydroxocobalamin can be resumed, i.e. once GP surgeries are able to do so safely, aiming to have a shortest possible break from regular injections.

Patients should be advised to monitor their symptoms and should contact their GP if they begin to experience neurological or neuropsychiatric symptoms such as pins and needles, numbness, problem with memory or concentration or irritability. Patients who are already self-administering IM hydroxocobalamin should continue to do so but we do not recommend a patient switching to self-administration during the COVID-19 pandemic since instruction is likely to be difficult.

Dietary Vitamin B12 deficiency

NICE 2019 recommendation: advise people either to take oral cyanocobalamin tablets 50– 150 micrograms daily between meals or have a twice-yearly hydroxocobalamin 1 mg injection. In vegans, treatment may need to be life-long, whereas in other people with dietary deficiency replacement treatment can be stopped once the vitamin B12 levels have been corrected and the diet has improved.

British Society for Haematology advice during the COVID-19 pandemic for patients established on intramuscular hydroxocobalamin:

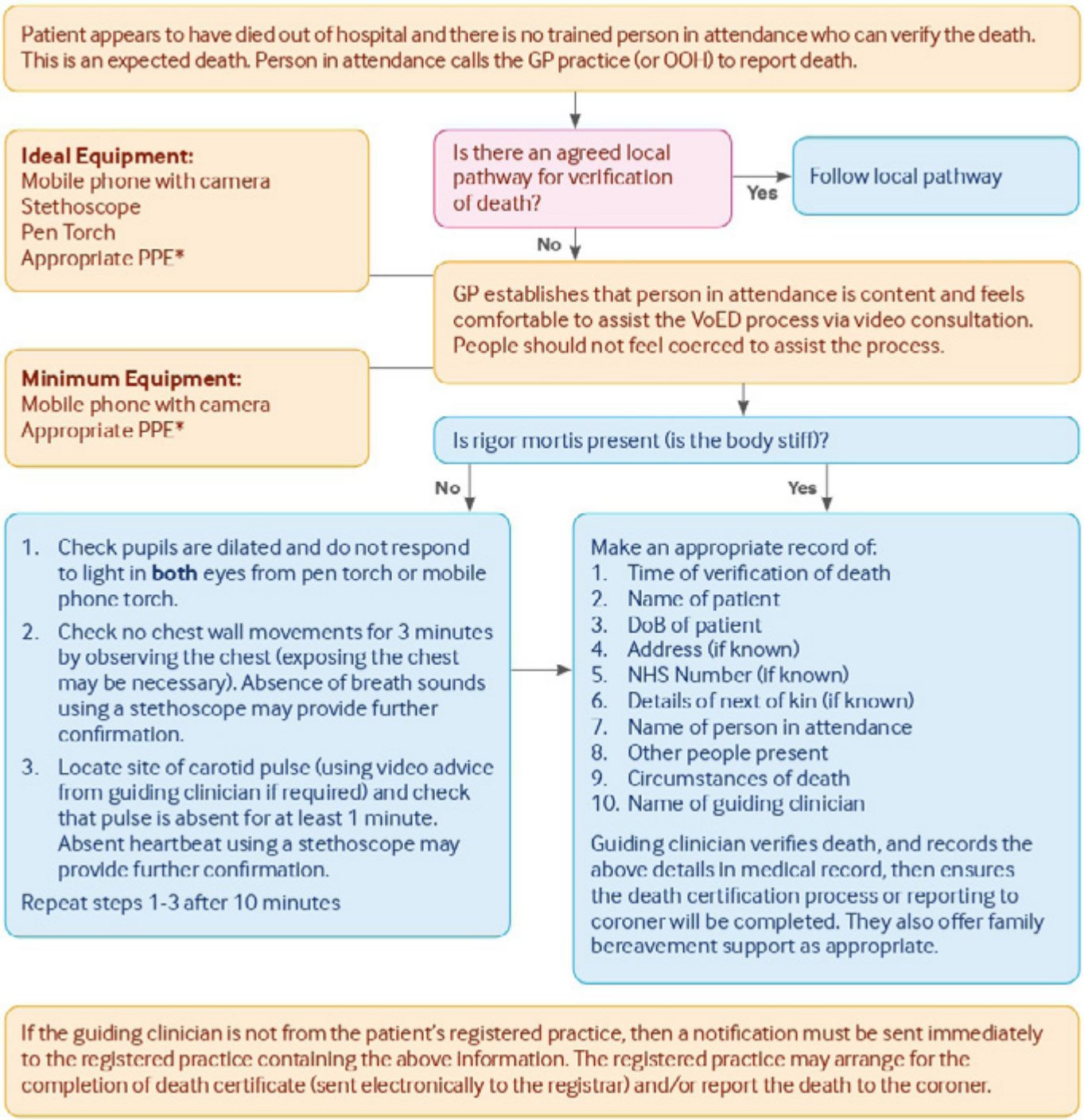
An alternative is to offer oral cyanocobalamin tablets, 50–150 micrograms, daily between meals. We recommend reassessing serum B12 prior to recommencing IM hydroxocobalamin. However, many of these patients may be vitamin B12 replete with adequate levels within the liver, and therefore may be able to safely stop taking vitamin B12 supplements possibly for up to a year (Hoffbrand 2016).

Dietary advice should be given to all patients. Patients on vegetarian and especially vegan diets should continue taking oral supplements.

Cancer safety netting patients during the COVID-19 pandemic

Please see this safety netting guide from Cancer Research UK.

Additional resources



**Please find the full original document here, by BMA*