**COVID-19 Frequently asked questions**

**Clinical questions**

**1. What do we know about the virus?**

At present there are still a lot of unknowns. What we can glean from research papers

* Incubation period 7-9 days
* Some patients infectious 2-3 days before symptoms
* Viral pneumonia peaks at around days 5-9 of illness
* Infectivity probably greatest when most symptomatic
* Elderly and those with usual comorbid risk factors at greatest risk
* Children mild symptoms only, but can get infected, do shed virus but not sure how infective, usually they are recipient of infection from adults rather than transmitters to others AFAIK
* Unclear if can get re-infected (conflicting evidence, some say no, some say yes, but possibly just viral shedding weeks later)
* Main mode of transmission DROPLET spread > Contact > Airborne >> (faecal?). Hence why surgical mask affords sufficient protection cf FFP3/N95 masks. Also why hand hygiene/cleaning important as droplet -> contaminated hands -> face.
* Social distancing/home isolation key so must strongly insist on this for high risk patients (and staff) who may be infected

**2. Are there any facilities for community swabbing?**

NO. Following change of national approach, as of 14/3/20 there is no community swabbing available of suspected cases. The Easingwold COVID19 test facility has been stood down. Swabbing will only occur if patients meet the case definition (i.e. admitted to hospital overnight, with clinical or epidemiological criteria). See CAS 12/3/20. Swabbing criteria is likely to be updated w/c 16/3/20.

**3. Where should patients with symptoms be assessed?**

As a general rule, potential callers with COVID19 should be kept out of hospital or any face-to-face healthcare setting, and at home whenever possible to minimise the risk of disease spread.

Practically, this means that patients who meet the criteria for self-isolation should not attend primary care settings unless they need face to face assessment and can travel. Further national guidance is awaited. Separating patients into suspected COVID19 vs non-COVID19 pathways is a pragmatic way forward and should be seen in a suspected COVID19 room/building (with separate access/staff etc.) that is separate from non-suspected COVID19 patients. Bear in mind that these patients are currently relatively low risk for COVID19 as numbers locally are still small. See primary care advice for PPE, decontamination, travel etc.

**4. What PPE is advised?**

See primary care advice and look at PPE guidance.

**5. Is the use of a nebuliser an aerosol generating procedure (i.e. does it need additional PPE)?**

NO. Nebulisation is not considered an AGP. See PPE guidance on primary care advice for acceptable PPE.

**6. What if 111 identify that a patient who meets the self isolation criteria** meets their criteria for primary care disposition.

Patients will be advised to call their practice for assessment (i.e. not to expect an appointment/visit).

**7. Should all patients be directed to 111 if they meet the self isolation criteria but need assessment?**

This is a clinical decision. 111 has unprecedented demand. There is a lack of national guidance at present. Pragmatically, practices will need to triage requests and offer assessments using pragmatic isolation and PPE. Patients who are reasonably well should be directed to the 111 online tool.

**8. Do all COVID19 positive presentations meet the criteria for self-isolation (fever and persistent cough)?**

NO. Some will have atypical presentations. Clinicians should be alert to the possibility of atypical presentations in immunocompromised callers

**9. Does having the symptoms mean that patients have COVID19?**

NO. Currently, most will not have COVID19. Case definition is sensitive but tend to be non-specific. As case numbers rise, more patients with the symptoms will be positive. Patients who meet the criteria for self-isolation are classified as possible cases.

**10. What’s happening with the COVID19 Home Management Service?**

This was set up to manage patients who are positive COVID19 and are self-isolating at home. This is NOT for patients who are self-isolating without a positive COVID19 test result. How the COVID19 Home Management service interacts with primary care is being worked through. For VOYCCG, the Home Management Service is run by Vocare 24/7.

**Business continuity questions**

**11. Is there an approved video consultation module?**

NOT YET. There are various options available. At the moment use whichever you have used in the past. There is expected to be a national recommendation shortly. Positive reports about using AccuRx have been received.

**12. What routine primary care services can be stopped?**

National guidance is awaited on QoF etc. However, routine services may need to be suspended or deprioritised. Further advice will be given.

**13. Are there any HR and Occupational Health advice/policies.**

NOT YET. Local guidance is being produced to help practices

**14. What’s happening about additional IT requirements?**

The CCG is working closely with NECs to understand IT functionality across VOY and additional equipment as appropriate. This will include consideration of video consultations where they are not currently available in practices.