Urgent Care Clinical Bulletin 3 April 2020

A big thank you
Thank you to everyone who is working in our urgent care services or who has offered to help out. A great example has been the GPs, nurses and administrators who stepped-up to fill the expanded Ipswich ED streaming rota at very short notice. In addition, 75 clinicians new to our urgent care services, have responded to our plea for help and will start working over the next few days. Our support teams, particularly the Rota Team, drivers, administrators and operations have been exceptional. Thank you.

COVID triage protocol and medication algorithm
Please use the protocol on Page 2 of this newsletter and the medication algorithm from Page 3 to 11. They are now being used across Suffolk daytime and out of hours primary care. Any questions please email Simon Rudland (s.rudland@nhs.net).

PPE – our approach
- We are open and honest.
- Minimising exposure of high-risk staff by them working from home.
- Ensuring that face to face consultations are only undertaken when there is absolutely no alternative.
- Giving the option of not undertaking face to face consults.
- Whenever possible the clinician undertaking a visit/face to face triages/assesses the patient and therefore individually understands the potential risks.
- Supporting you to make you own judgement about the amount of risk you are willing to accept.
- Emphasising that we support all our clinicians in their individual judgement – we know that this will be based on personal health and family considerations which we respect are private.

PPE guidance
- All face to face in a base - plastic apron, gloves and fluid resistant mask.
- Home visits – the COVID triage protocol will identify which PPE equipped car is needed:
    - Less risk of aerosol transmission - long sleeved gown, gloves, fluid resistant surgical mask, over shoes and eye protection. All cars have this PPE.
    - CPAP, HFNO or very ill patient in a confined space that is likely to need sub cutaneous bolus injection – long sleeved gown, gloves, fit tested FFP3 mask, over shoes and eye protection. We will soon have some cars available 24/7 equipped with clinicians who have fit tested FFP3 masks.
- If a clinician enters a house with non-FFP3 PPE and realises the environment is different to that envisaged at triage, they withdraw.

Plan for the COVID surge
We are expecting this to start just before or during Easter. We have a joined-up plan with Suffolk GP practices and the wider health system:
- Suffolk practices will be open all four days of Easter along with an enhanced Out of Hours rota. We will have a mutual aid system in case either a practice or Out of Hours is overwhelmed. The Fed will do all visiting.
- If whole system under too much pressure Fed calls in ‘surge’ assessment capacity i.e. clinicians who can work from home at short notice
- We will have a pandemic home visiting service running 24/7. This will be staffed by practices during the in-ours daytime.

- Ipswich Hospital ED Streaming is now running 8am to midnight and may go to 24/7 if demand dictates.
- There will be a Clinical Shift Lead in Riverside 24/7. They will be in communication with our hospitals regarding bed capacity and admission thresholds. There will be enhanced visit request triage capacity.
- Out of Hours will continue to stream cases from the Clinical Assessment Service but will also manage 'low acuity' cases from the Ambulance Service and provide advice to ambulance crews.
- Riverside and Drovers House will have separate respiratory zones.

Remote consulting
Last weekend we managed 768 patients of whom only 39 were F2F or visits (5%). This compares with the last weekend in February when we managed 786 with 73% F2F. Our F2F are significantly lower than in other out of hours services. Thank you to everyone involved you are doing a great job.

We will have video consults available using GP&Me within the next two days. We will send out instructions when it is ready. For technical reasons we cannot use AccuRx.

Covid-19 - a remote assessment in primary care – BMJ article
BMJ 2020; 36 (Published 25 March 2020) - https://www.bmj.com/content/368/bmj.m1182

GP Registrars' Supervision in OOHs
- No new induction for registrars until further notice
- All observational, direct supervision and near supervision shifts suspended
- Registrars that require 'remote supervision' can continue working on telephone triage shifts, base shifts or home visit with appropriate protection
- Consulting room and cars limited to 2 people e.g. clinician/patient or clinician/driver

SystmOne 'Consent override'
If a record is not shared and you require access you are able to over-ride consent to support direct care. Please note the reason.

Covid testing
Despite it being announced there are no details of how this will work other than they want to prioritise self-isolating.

V9 31 March 2020 Rudland

Triage of Covid-19 patient at PCN or in OOH modified from Barnet CCC
Use with medication algorithm

Category 1
Mild symptoms

Disposal– provide selfcare advice. Escalate via 111

No home visit

Category 2
Moderate to severe symptoms – only requires face to face consultation if this will change clinical pathway

Category 3
Severely unwell – dyspnoea, confusion and co-morbidity risk factors. Disposal – **Admit** via ambulance if resources permit or prioritise home visit via clinical shift lead for palliation (see palliation pathway)

Home visit only if effective PPE available

Category 2a
Cough, Fever may be a little SOB

Full sentences, able to selfcare and ambulant to usual standard.
Roth score: counting number 10 or more, or counting time of 7 seconds or more -
Sats likely to greater or equal to 95%

Disposal – selfcare, consider antibiotics escalate via 111

Category 2b
Cough, Fever may be a little SOB

May not manage full sentences at rest, still able to selfcare, SOB on exertion.
Roth score: counting numbers 10 -7, or counting time between 7 - 5 seconds

Disposal – **active care**, **consider admission** if no advanced directive and bed availability

Home visit only if effective PPE available

Category 2 c
Cough, Fever and SOB
Breathless, not be completing long sentences, progressive SOB, struggling with selfcare, fatigue and lethargy
Roth score: counting number 7 or less , counting time of 5 seconds or less suggestive of Sats less than 90%

Disposal – **active care**, **consider admission** if no advanced directive and bed availability

Consider direct admission in view of hypoxia
Home visit only if effective PPE available

For all patient with SOB prevent secondary bacterial infection:
Amoxicillin 500mg tds 7 days or
Clarithromycin 500mg bd for 7 days
(there is little pneumococcal penicillin resistance in Suffolk)

St Elizabeth Hospice
Onecall patient support 0800 5670111
Professional advice 0800 5670111 – you will be directed to duty consultant 24/7

Roth Score:
Roth score index is measured by having the patient count from 1 to 30 in their native language, in a single breath, as rapidly as possible. The primary result of the Roth score is the duration of time and the highest number reached. Maximal counting number <10 or counting time <7 seconds identified patients with a room-air pulse oximetry <95% with sensitivity of 91% and 83%, respectively. Maximal counting number <7 or counting time <5 seconds identified patients with a room-air pulse oximetry <90% with sensitivity of 87% and 82%, respectively.

Guiding principals:
Most infectious at the beginning of illness
Illness is biphasic – Replication stage and adaptive immunity stage second peak at 8-10 days
Droplet spread and direct contact (2 m), don't self inoculate from hard surfaces – survival up to 3 days.
If asthmatic up SABA – don't add oral steroids, don't use nebuliser. Treat fever with paracetamol not NSAID
14% will be hypoxic and benefit from supplementary 0xygen (Martin Kiernan), Sats of 93% or less threshold
There does not appear to be a validated tool to assess breathlessness over the telephone or by video – Roth Score is the best we have however not fully validated
Clinical judgement, through careful history taking and questioning, may currently be the best available method
Auscultation is not predictive of chest pathology – leave your stethoscope in a clean area.
Co-Morbidities: Current cancer, Immunosuppression, LTC, Smoking, BMI > 40

PPE principals
Coughing and sneezing are known to release aerosols, however, it is thought that aerosols generated by medical procedures pose a more significant risk to infection transmission, rooms with few air changes an hour may add to risk (usually 6 per hour in hospital)
Suffolk GP Fed should be able to provide FFP3 fit tested mask with associated PPE including eye protection in community setting judged as high risk of Covid-19 infection.
The use of long sleeved gown gloves fluid resistant surgical mask and eye protection provides a high level of protection for clinicians visiting Covid-19 suspected patients where there is less risk of aerosol transmission.

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Suffolk GP FEDERATION

Community symptom management and palliation of patients with COVID-19

Introduction

- It is envisaged that there will be large numbers of patients in primary care suffering from Covid -19, as their primary complaint who cannot be admitted to hospital because of resource limitations, or have an end of life plan in place, and wish to be managed on their own homes.
- There will be patients discharged for end of life care to the community from the hospital.
- There will be resource issues, a shortage of syringe drivers and clinicians who would normally support community palliative care.

Covid -19 symptoms we wish to manage

- Dyspnoea, fear and agitation
- Delirium, viral pneumonitis, pneumococcal pneumonia
- Hypoxia and associated confusion, oxygen is unlikely to be available in the home

An alternative therapeutic strategy

- The clinician needs to deliver a therapeutic solution for their patient either remotely or on visiting, without syringe drivers.
- The pathway will potentially represent a one touch intervention
- The pathway can be self managed with remote support by carers or family

Therapeutic pathway 1 (remote patient contact)

1. Clearly share your decision-making plan with the patient and their relatives or carers.

2. Prescribe using ETP, provide no more than a 7 day supply.

3. Share advice document and medication record chart with patient or carer by email or SMS.

4. Apply transdermal opiate (**Buprenorphine** 5 microgram/ hour preferred, or Fentanyl 12 microgram/ hour matrix patch cut in ½ diagonally if concern about opiate dose) - *to manage dysponea, cough and agitation* **(prescribe one)**

5. Give **Lorazepam** 1mg tablets for oral or sublingual dose, 500 micrograms to 1mg, every two hours as needed – *to manage anxiety and panic associated with breathlessness* **(prescribe twenty eight)**

6. **Hyoscine hydrobromide** 1.5mg patch (Scopoderm) 1 patches every 72 hours placed behind the ear– *to manage nausea and secretion* Remove if agitation or confusion seems to get worse occurs. **(prescribe two)**

7. **Morphine Sulphate – oramorph -** 10 mg/5mls (2mg per ml) 1- 2 mls 2-4 hourly as needed - *to manage dysponea, cough and agitation* **(prescribe 100mls – one bottle)**

8. **Micropore tape** (2.5cm x 9.1m) – patch adherence may be problematic in a pyrexial patients **(prescribe one)**

9. Consider **Amoxicilline** 500mg tds (21) or **Clarithromycin** 500mg bd (14).

Therapeutic pathway 2 (direct patient contact)

1. Clearly share your decision-making plan with the patient and their relatives or carers.

2. Prescribe using ETP, provide no more than a 7 day supply.

3. **Morphine** 10mg/ml ampoule, 2.5 – 5 mg (0.25-0.5ml) with **Levomepromazine**1ml ampule, 25 mg in 1ml, 25-50mg mg (1-2mls) with **Midazolam** 5mg/ml ampoule 2.5mg, (0.5 ml) , together as sub cutaneous bolus administration – *to manage dysponea, cough, nausea related to opiate, agitation (Note injection volume will be 1.75 – 3.0 ml)* **It is intended as a single bolus SC injection when there is direct contact with a clinician to initiate pathway which will then continue via transdermal or orally administered route, not as a repeated intervention.**

4. Apply transdermal opiate (Buprenorphine 5 microgram/ hour preferred, or Fentanyl 12 microgram/ hour matrix patch cut in ½ diagonally if concern about opiate dose) - *to manage dysponea, cough and agitation*

5. Consider **Amoxicillin** 500mg tds (21) **or Clarithromycin** 500mg bd (14)

6. Arrange (ETP) prescription for:

    - (**Buprenorphine** 5 microgram/ hour preferred, or **Fentanyl** 12 microgram/ hour matrix patch cut in ½ diagonally if concern about opiate dose) **(prescribe one)**
    - **Lorazepam** 1mg tablets for oral or sublingual dose, 500 micrograms to 1mg, every two hours as needed **(prescribe twenty eight) -** *to manage anxiety and panic associated with breathlessness*
    - **Hyoscine hydrobromide** 1.5mg patch (Scopoderm) 1 patches every 72 hours placed behind the ear Remove if agitation or confusion seems to get worse occurs. **(prescribe two)**
    - **Morphine Sulphate – oramorph -** 10 mg/5mls (2mg per ml) 1- 2 mls 2-4 hourly as needed **(prescribe 100mls – one bottle)**
    - **Micropore tape** (2.5cm x 9.1m) – patch adherence may be problematic in apyrexial patients **(prescribe one)**

These medications, including CD can be collected by a family member or friend with supporting evidence from the patient, partner or carer.

7. Leave copy of patient guidance in use of these end of life medication, which will include a modified drug chart for them to record when medication are given. This document will have advice regarding non pharmaceutical measures to take to support the patient, and death certification. This document will include Hospice Onecall details.

8. Leave standard CD collection permissions letter

9. Indicate that a follow up call will be made to monitor response, evolve plan and support carers.

10. Leave sharps in the home in small sharps box – to in due course to be returned to host GP practice.

St Elizabeth Onecall support line 0800 5670111 – you can be directed to a palliative care consultant 24/7 (from 6.4.20)

Additional Dose Guidance:

Morphine 2.5 – 5 mg with **Levomepromazine** 25-50mg mg with **Midazolam 2.5mg** can me mixed together in water– total volume 3 mls, sub cutaneous bolus administration.

Buprenorphine Patch 5 microgram/ hour applied to dry hairless skin left on for 7 days, (Equivalent to 20 mg sub cut morphine over 24 hours).
10 and 20, 35, 52.5, 70 and 100 microgram/hours patches are available, tape may be needed to ensure adhere. **Preferred as up to 7 day action.**

Or

Fentanyl matrix patch 12 micrograms/hr applied to dry hairless skin left on for 3 days. (Equivalent to 20 mg sub cut morphine over 24 hours). Can be cut diagonally , don't cut reservoir patches. 25, 50 75 1nd 100 microgram/hours patches are available, tape may be needed to ensure adhere.

And

Lorazepam 1mg tablets, 500micrograms - 2mg, for oral or sublingual dose.

Or

Midazolam 2.5 or 5 mg oromucosal solution (Buccolam) Each pre-filled oral syringe contains 5 mg midazolam (as hydrochloride) in 1 ml solution

Alternative Medications:

Hyoscine hydrobromide 1.5mg patch (Scopoderm) 1-4 patches every 72 hours placed behind the ear– *to manage nausea and secretion* Remove if agitation or confusion seems to get worse occurs.

Levomepromazine 6mg tablets (Levinan) – sublingal or buccal 3mg 4-6 hourly as needed - *anti-emetic, antihistamine and anti-adrenaline activity and exhibits a strong sedative effect. May be special manufacture awaiting advice.*

Prochlorperazine 3mg buccal tablets (buccastem) – buccal, 4mg 6-8 hourly max 16mg per day - *to manage nausea*

Strength of this approach:

- Potentially provides a one touch plan to deliver a palliative pathway
- Using medications that are familiar to most clinicians and that are available from community pharmacy.

- Based on Scottish Palliative Care Guidelines published in response to the Corona 19 pandemic.
- Designed by a primary and local Hospice Palliative Care specialist for use in primary care
- We will develop a Plan B to accommodate drug availability

Weakness of this approach:

- The pharmacokinetics of opiate patches leads to a steady blood level being achieved between 17 and 24 hours after the patch has been applied, this is faster in a pyrexial patient.
- Levomepromazine hydrochloride had a long half life of 30 hours and it is hoped that the use of this drug in conjunction with oral morphine will bridge this therapeutic gap, this remains an unknown.
- Covid 19 is an unknown with few reports off palliative care within the community setting. All reports reviewed, written and oral, have come from secondary care with access to clinical support and supplementary oxygen.
- We will not know anything of our patients renal function, a pragmatic decision has been made to base this protocol on morphine. Additionally patients will only be receiving a single SC morphine bolus.

Annex A

Supporting literature and documents reviewed.

Levomepromazine hydrochloride 25mg per ml (Nozinan 25mg/ml Solution for Injection/Infusion)

4.1 Therapeutic indications
Management of the terminally ill patient. Levomepromazine resembles chlorpromazine and promethazine in the pattern of its pharmacology. It possesses anti-emetic, antihistamine and anti-adrenaline activity and exhibits a strong sedative effect.

Nozinan potentiates the action of other central nervous system depressants but may be given in conjunction with appropriately modified doses of narcotic analgesics in the management of severe pain. Nozinan does not significantly depress respiration and is particularly useful where pulmonary reserve is low.

Nozinan is indicated in the management of pain and accompanying restlessness or distress in the terminally ill patient.

5.2 Pharmacokinetic properties
Maximum serum concentrations are achieved in 2 to 3 hours depending on the route of administration. **Excretion is slow, with a half-life of about 30 hours. It is eliminated via urine and faeces.**

https://www.medicines.org.uk/emc/product/1428/smpc

Buprenorphine (BuTrans)
Each transdermal patch contains 5 mg of buprenorphine in a 6.25 cm^2 area releasing a nominal 5 micrograms of buprenorphine per hour over a period of 7 days.

Each transdermal patch contains 10 mg of buprenorphine in a 12.5 cm^2 area releasing a nominal 10 micrograms of buprenorphine per hour over a period of 7 days.

Each transdermal patch contains 20 mg of buprenorphine in a 25 cm^2 area releasing a nominal 20 micrograms of buprenorphine per hour over a period of 7 days

Absorption:

Following ***BuTrans*** application, buprenorphine diffuses from the patch through the skin. In clinical pharmacology studies, the median time for ***BuTrans*** 10 microgram/hour to deliver **detectable buprenorphine concentrations (25 picograms/ml) was approximately 17 hours**. Analysis of residual buprenorphine in patches after 7-day use shows 15% of the original load delivered. A study of bioavailability, relative to intravenous administration, confirms that this amount is systemically absorbed. Buprenorphine concentrations remain relatively constant during the 7-day patch application.

In a study of healthy subjects, application of a heating pad directly on the transdermal patch caused a transient 26 - 55% increase in blood concentrations of buprenorphine. Concentrations returned to normal within 5 hours after the heat was removed

https://www.medicines.org.uk/emc/product/124/smpc

Fentanyl (Durogenic DTrans, Marifen)
After the first Durogesic DTrans application, serum fentanyl concentrations increase gradually, **generally leveling off between 12 and 24 hours and remaining relatively constant** for the remainder of the 72-hour application period. By the end of the second 72-hour application, a steady-state serum concentration is reached and is maintained during subsequent applications of a patch of the same size. Due to accumulation, the AUC and C_{max} values over a dosing interval at steady state are approximately 40% higher than after a single application. Patients reach and maintain a steady-state serum concentration that is determined by individual variation in skin permeability and body clearance of fentanyl. High inter-subject variability in plasma concentrations has been observed.

Skin temperature elevation may enhance the absorption of transdermally-applied fentanyl (see section 4.4). An increase in skin temperature through the application of a heating pad on low setting over the Durogesic DTrans system during the first 10 hours of a single application increased the mean fentanyl AUC value by 2.2-fold and the mean concentration at the end of heat application by 61%.

https://www.medicines.org.uk/emc/product/157/smpc

SC Morphine
Peak plasma levels at 2 hrs with an elimination ½ life of 2 hrs - in healthy subjecct

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2014910/pdf/bcp0049-0207.pdf

Oral Midazolam (Buccolam)
After oromucosal administration midazolam is absorbed rapidly. Maximum plasma concentration is reached within 30 minutes in children. The absolute bioavailability of oromucosal midazolam is about 75% in adults

Plasma clearance of midazolam in children following oromucosal administration is 30 ml/kg/min. The initial and terminal elimination half-lives are 27 and 204 minutes, respectively.

https://www.medicines.org.uk/emc/product/2768/smpc

Lorazepam
Lorazepam is almost completely absorbed from the gastrointestinal tract and peak serum levels are reached in 2 hours. It is metabolised by a simple one-step process to a pharmacologically inert glucuronide. There are no major active metabolites. The elimination half-life is about 12 hours and there is minimal risk of excessive accumulation.

No information available relating to subligual use

https://www.medicines.org.uk/emc/product/6137/smpc

Opiate conversion doses

https://www.wales.nhs.uk/sites3/Documents/814/OpiateConversionDoses%5BFinal%5DNov2010.pdf

Converting prior opioid regimens to a syringe pump: Opioid Equivalence Table

Mercadante, S and Caraceni, A. (2011) Conversion ratios for opioid switching in the treatment of cancer pain: a systematic review. *Palliative Medicine,* 25:504-515

COVID-19 and Palliative, End of Life and Bereavement Care

25th March 2020Adapted from: Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland by: Dr Iain Lawrie FRCP, MRCGP and Fiona Murphy MBE

Annex B

1.Standard Letter for CD collection permission

GP Fed Header

I give:

Relation to patient:

Permission to collected controlled drugs prescribed for:

Patients name and address:

2. Patient advice regarding supporting patients with Covid -19

- positioning (sit upright, sometimes leaning forward can also help)
- relaxation techniques (eg music/ slow breathing)
- reduce room temperature
- cooling face by using a cool flannel or cloth
- do not use portable fans have been linked to cross infection therefore avoid these in COVID-19.
- humidify room air
- oral sips of fluids / honey & lemon in warm water/ suck cough drops / hard sweets

- try and maintain hydration
- minimise cross-transmission risk: cover nose & mouth with disposable tissue when coughing. Dispose of used tissues promptly into waste bin
- clean hands regularly: soap/ alcohol hand rub

3. Record of medication administration

Drugs:	Buprenorphine patch	Hyoscine patch	Morphine Liquid	Lorazepam tablet	Other:
Date/Time/Dose					

4. Medication plan for patient and their carer

We have prescribed some medication for your loved one to help with their symptoms caused by Covid-19. This guide is designed to help you have confidence in administer these medications, in order that they can alleviate your loved one symptoms as effectively as possible.

We appreciate you may feel frightened and overwhelmed by the situation. You're not alone and there lots of people in very similar situation to you experiencing exactly the same emotions.

There is help and available for you and you may find this helpline supporting – **St Elizabeth Hospice** Onecall patient and carer support 0800 5670111.

Buprenorphine patch

This medication is a slow release morphine type of drug which is absorbed through the skin and has been prescribed to alleviate breathlessness cough and agitation that can accompany these symptoms**.**

The patch is usually applied once every seven days, extra patches can be applied during this period if necessary and you can call for advice about this by calling 111.

The patch doesn't stick so well too sweaty skin so you may need to use the micropore tape that you have to help keep the patching in place. If the patch falls off you can always reapply to a dry area of skin using the tape, along the edge of the patch, to keeping place.

Oral Morphine

The oral morphine medicine you have works in a similar way to the Buprenorphine patch. It starts working a bit more quickly, and doesn't last so long, so it's good as a top up medication. We suggest you give 1-2 mls of this mixture, every 2 to 4 hours if the Buprenorphine patch isn't helping with the breathlessness cough and agitation.

Don't be worried about giving too much of this medication it's better to use more than less.

Hyoscine hydrobromide (Scopoderm) patch

You may have come across these patches used for travel sickness. They are very good for sickness, which can sometimes be caused by morphine. They will also dry up respiratory secretions. They are best put onto the skin behind the ear, and last for three days at a time.

If one patch is not effective, you can always add a second patch during this period, so increasing the dose of this medication.

Just occasionally they can make someone's confusion worse, particularly very elderly patient, if this were the case, it's probably best to remove the patch.

Lorazepam tablets

These tablets help with the anxiety and panic that breathlessness causes. Normally a half to one tablet will help, they can be swallowed or if swallowing is the problem, dissolve underneath the tongue.

The dose can be repeated after two hours, and you mustn't worry about giving too much. The most important thing is to help with the symptoms.

We hope this simple guide gives you more confidence in your really important role.

Annex C

Important Message for GP's – death certification and registration
You will be aware that the Coronavirus (Emergency) Act 2020 has now been implemented. This Act includes provisions for changes to death certification and registration.
Effective immediately, Suffolk Registration Service are moving to a system of registering deaths by telephone. This will avoid the need for relatives to attend our offices in person to complete the registration, and avoid the need for relatives to attend your surgeries to collect the MCCD.

New procedures for issuing a Medical Certificate of Cause of Death, (MCCD)

- When complete, the MCCD needs to be scanned to: registrars.admin@suffolk.gov.uk. If scanning facilities are not available the MCCD can be photographed on a mobile device. Please scan or photograph the front and the back of the MCCD.
- Relatives should be informed that the MCCD has been scanned to us and then directed to our dedicated death registration page at:- https://www.suffolk.gov.uk/births-deaths-and-ceremonies/how-to-register-a-death/register-a-death-during-covid-19-pandemic If they do not have internet access they may call us on 0345 607 2050. Our preference is that they use our web page if possible as our phone lines are currently very busy.
- Please post the original MCCD to us at our head office, Suffolk Registration Service, St Peter House, Grimwade Street, Ipswich, Suffolk IP4 1LP

Changes to the 14 day and other death certification rules:

- Any medical practitioner can complete a MCCD if :-

- They, or another medical practitioner has seen the deceased either after death or 28 days prior to death.
- The definition of 'seen 28 days prior to death' includes a skype or video attendance.
- A skype or video attendance cannot be used to satisfy the requirement of attendance after death – that does need to be in person.
- They are satisfied the death is due to natural causes from the information available to them (eg; within patient notes)
- Please use the usual MCCD form and amend as necessary:-
  - Eg: 'last seen alive by ~~me~~ Dr xxx (via skype) dd/month/yyyy

Additional information

- Coronavirus / COVID-19 deaths do not need to be referred to the Coroner for this reason alone. Your duty is to notify Public Health.
- Please avoid referring deaths to the Coroner unless it is absolutely necessary.
- If you are using additional medical practitioners, for example retired doctors to assist you during this time, please make sure that their name is printed after their signature, include the GMC number and their name appears on the list of additional doctors appointed

Simon Rudland FRCGP
Suffolk GP Federation
29 March 2020