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NHS

Right Test Right Time

NCL guidance on direct access pathology during the COVID-19 pandemic

Policy environment

Demand for direct access pathology has reduced significantly with the cessation of QOF and other performance targets. As of early April, patients are happy to delay routine blood tests. GPs are currently making pragmatic extensions to testing intervals in light of patient-specific factors including the previous degree of stability of results.

Going forward, we must recognise that GP direct access pathology –the blood sciences and microbiology - and the complementary activity of community phlebotomy play a pivotal role in providing safe and effective management of chronic disease management. Failure to secure this activity in the weeks ahead risks increased rates of disease exacerbations and complications, or drug adverse events, in the months that follow, with an increased demand for acute services.

As people are discharged earlier from hospital, and admitted there with higher thresholds, GPs will be caring for patient with greater clinical acuity, with a corresponding need for different, and potentially greater, use of pathology. Moreover, with many of the most complex and vulnerable patients being shielded or otherwise practising strict self-isolation, the domiciliary phlebotomy offer must expand.

To accommodate this growth, we must focus the rest of direct access pathology on essential activity, while ensuring safe access to pathology for patients and the staff caring for them.

Access to pathology and phlebotomy

In three strands

- Cold, preferably out-of-hospital and sub-borough hubs where essential 'routine' work can continue. These maybe run by existing community providers including GP practices and federations. [1]
- Integrated to the home visiting model (with particular attention on ensuring results are available to the requesting team/risk holder). [2]
- Domiciliary services, to accommodate the growth in demand for people who are 'shielding' and thus newly housebound. Staff must be and feel safe. They must not become vectors for infection.

[1] We need to consider the potential role of near-patient testing to shorten and simplify care pathways, particularly for the boroughs more distant from the central laboratory.
[2] An expansion of near-patient diagnostics may be warranted, based on input from pre-hospital care experts

Principles: During the COVID-19 pandemic prioritise:

- Those at risk of a serious adverse drug event that can be identified through monitoring
- People taking a narrow therapeutic index drug during a phase when intensive monitoring is still required (e.g. upon initiation)
- Patients who have recently had an illness that may have impacted on how their drug works

Clearly essential testing

- Monitoring for high risk drugs, including INR for warfarin, and immunosuppressant drugs, particularly for transplant patients. Authoritative guidance has been published by the Specialist Pharmacy Service[3]
- See also COVID-19 rapid NICE guideline: *Managing safety of rheumatological autoimmune, inflammatory and metabolic bone disorders* [4]
- Measuring renal function in a patient at increased risk of AKI – for instance heart failure patients on both loop and thiazide diuretics; or ACEI/ARB and aldosterone antagonists.
- Essential serology – e.g. to check immunity in a pregnant woman exposed to a potentially teratogenic infection; new presentation of suspected BBV.
- Where use of pathology has the potential to avoid a hospital presentation – examples including D-Dimer to rule out VTE
- Microbiology to support safe use of antibiotics e.g. when treating more complicated UTIs to check for resistance, and in pregnancy; suspected STIs in symptomatic patients.

Non-essential testing

- Routine age-related or new patient health checks
- MSU for uncomplicated UTIs in women. Use the PHE guidance about using dipsticks (i.e. mostly don't use them).[5]
- Screening tests in asymptomatic patients – PSA, cervical smears, sexual health screens
- Stop h.pylori antigen testing and consider a treat-first, test-later instead
- Monitoring of type 2 diabetes (Hba1c) unless results will change management in the next few weeks
- Inflammatory markers, ESR and CRP, unless these are needed to make or rule out an important diagnosis (i.e., *not* for monitoring a known inflammatory condition)
- Autoimmune tests - e.g. ANA, RF and anti-CCP have weak predictive values in GP populations and can't be relied on to rule out disease. Avoid unless you are confident it will influence management in the next 3-6 months
- Vitamin D – advise OTC supplements for everyone during lockdown

[3] Specialist Pharmacy Service, Guidance on management of drugs requiring monitoring during COVID-19 https://www.sps.nhs.uk/articles/drug-monitoring-in-primary-care-for-stable-patients-during-covid-19/
[4] https://www.nice.org.uk/guidance/NG167
[5]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/829721/Diagnosis_of_urinary_tract_infections_UTI_diagnostic_flowchart.pdf

- Routine screening and monitoring of lipids, including LFTs for statins (not needed after 12 months even in routine practice)
- Monitoring of low-priority treatments (e.g. LFTs to monitor terbinafine for fungal nail infection) – stop the treatment instead.
- Swabs from a chronic leg ulcer (unless requested by tissue viability CNS).

Additional modification of practice/changes for standard-risk monitoring.

Blood monitoring of lower risk medications and conditions is 'amber' (if possible) in the RCGP workload prioritisation scheme.[6]

Most clinicians are doing this on an individual basis. It would be good practice to have a shared decision-making discussion with the patient and document this in the notes.

Examples to consider

- Anticoagulation - VTE. For patients on treatment doses, ensure the treatment stops at the end of the planned course.
- Anticoagulation – arterial/stroke prevention. For patients covered by the license, consider switching to a DOAC. Also consider extending testing intervals for stable patients e.g. from 12 to 14 weeks. Expert guidance on switching and INR monitoring is available from RPharmSoc, British Haematological Society and Specialist Pharmacy Service.[7][8][9]
- In patients on ACEI/ARBs for hypertension or CKD with stable GFR and no inter-current illness, measure U&Es only every 12 months.
- If stable, extend TFTs to 12 months.
- For patients taking lithium for more than a year, extend the lithium monitoring to six months if all the following conditions are met[10]:
    - Clinically stable
    - Not elderly
    - Most recent level in range and not greater than 0.8mmol/L
    - Normal renal function
    - Normal TFTs and calcium when last tested
- Also check U&Es, calcium (and BMI) every six months.

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[6] https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2020/covid19/RCGP-guidance/202003233RCGPGuidanceprioritisationroutineworkduringCovidFINAL.ashx

[7] RPharmSoc, Guidance for the safe switching of warfarin to direct oral anticoagulants (DOACs) for patients with non-valvular AF and venous thromboembolism (DVT / PE) during the coronavirus pandemic https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Coronavirus/FINAL%20Guidance%20on%20safe%20switching%20of%20warfarin%20to%20DOAC%20COVID-19%20Mar%202020.pdf?ver=2020-03-26-180945-627

[8] INR testing for out-patients on warfarin during COVID-19 restrictions https://b-s-h.org.uk/media/18170/inr-testing-for-out-patients-on-warfarin-during-covid-19-restrictions_26-03-2020.pdf

[9] Specialist Pharmacy Service. Management of patients currently on warfarin during Covid-19 https://www.sps.nhs.uk/articles/management-of-patients-currently-on-warfarin-during-covid-19/

[10] Specialist Pharmacy Service. Lithium drug monitoring during COVID-19 for stable adult patients https://www.sps.nhs.uk/articles/lithium-drug-monitoring-in-primary-care-during-covid-19-for-stable-patients/

- For new or add-on treatments for hypertension, consider favouring a drug that does not need laboratory monitoring (e.g. CCB, alpha-blocker) where these are not contraindicated

A comprehensive reference for primary care *Suggestions for Therapeutic Drug Monitoring in Adults in Primary Care* was produced by the Specialist Pharmacy Service in 2017, updated in 2018. GPs should ensure that testing intervals are not shorter that those suggested here.