# May 2020 NEWSLETTER

LOCAL MEDICAL COMMITTEE
LMC
GLOUCESTERSHIRE

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## COVID 19

General practice has changed almost beyond recognition. You should now be operating to a Covid-19 prioritised workload. Your entire efforts at a practice level should be in line with the joint RCGP BMA NHSE guidance on workload prioritisation. The CCG continue to send daily briefings. People are suffering from information overload and may not have time to read all items. We need to challenge our traditional thinking of how we best assess patients. We need to remember that 90% of the diagnosis comes from the history and be creative in the way that we use video consultations or pictures to maximise the examinations that we can perform remotely.

The BMJ has published a guide on assessment of suspected Covid-19 cases to enable this to be done remotely, and as safely as possible, without face to face review. You should be able to manage the overwhelmingly majority of your patient needs using www.AccuRx.com video consulting embedded into your system, and into their, or their carer's/next of kin's smartphone. Failing that, the telephone. A tiny number will need to be seen at the surgery premises. These patients should be triaged remotely first, and you should speak with a colleague if you aren't sure if they really need to come in.

**Remember: Remote consultations are essential - they fulfil government requirements to stay at home where possible, and they minimise transmission between an essential workforce and our most frail patients. They will save lives.**

You must assume that all patients, and all workforce, are asymptomatic incubators, and everyone needs to wear PPE when examining any patient at any time for any purpose - both the clinician and the patient. How you don and doff your PPE is critical to minimise the risk of vector transmission. We should assume all patients are 'hot' and manage remotely where clinically safe to do so.

So, who is going to be seen face to face? First ask:

- What examination is needed?
- Could that examination be performed by any other method?
- Will examining ultimately change your management plan, based on the history?
- Will bringing in the patient for examination have an impact on the morbidity/mortality of the patient? Very few clinical scenarios fulfil these criteria.
- Nursing F2F could include immunisations, complex dressings, depot antipsychotics, Zoladex injections, removal of sutures.
- GP F2F could include acute abdomen, potential ectopic, potential DVT, testicular swelling, new breast lump (i.e. non-covid emergencies).

Many other life-threatening emergencies such as cardiac chest pain still need triaging and remote assessment, but you will save time and lives by arranging an acute admission through the usual channels, as judiciously as you presently do.

## REMOTE REVIEW OF LONG-TERM CONDITIONS

These can be carried out using telephone or video consultation and now most commonly used video technologies are acceptable to use.
The duration of the current pandemic is hard to predict, and therefore it is very likely that patients with long term conditions will need to be followed up and assessed remotely to ensure these patients receive relevant and appropriate clinical support. Practices should do what they can, alongside managing other more acute priorities related to COVID-19, to help patients manage their long-term condition to reduce avoidable deterioration. Whilst doing remote reviews in the next few months will be easier with more patients staying at home it may also establish new ways of working that could be used for future reviews and patient contacts, as is appropriate for individual patients. Most conditions lend themselves well to remote assessments and could be enhanced through this method, not least in the easier opportunity to share care plans, information and guidance through links to websites and shared documents. These could also include agenda setting for long term conditions so that, in advance of future reviews, a patient can share what their goals of treatment would be.

**Hypertension:** This can be monitored by patients using their own home monitors and results fed into the patient's record electronically or by telephone. This may lead to a reduction in white coat hypertension and enable better control.

**COPD:** The review could be carried out remotely but would benefit from a video consultation to be able to see the patient and observe their respiratory rate and function. Spirometry will not be able to be completed and should not be attempted during the COVID-19 pandemic. Indicators in QOF 20/21 have changed to include the following- Patients could have a review including smoking status, a record made of the number of exacerbations in the last year, as well as MRC dyspnoea scale completion. Patients could have medication reviews and altered if control has altered significantly over the year.

**Asthma:** A remote review is possible for this group of patients. The practice could consider online assessments including inhaler technique using video assessment. Patients who do not already have a peak flow meter a home could be prescribed one. In line with QOF 20/21 the patient should have an assessment of control using a validated asthma control questionnaire, recording of number of exacerbations and a personalised written plan. The plan could be sent electronically, and the control and exacerbation could be collated using an online self-assessment

**Heart failure:** Practices could consider remote review of shielded patients first including a functional review and medication review to ensure dose optimisation. Home blood pressure monitoring could be done when medication is titrated upwards.

**Diabetes Mellitus:** Practices could consider remote review and complete most aspects of the annual review this way. Consideration needs to be given to those patients that would

most benefit from checking their HBA1c, reducing this physical contact to the minimum. A partial foot assessment could be done via video, looking for signs of ulceration and reviewing their risk status. This could be carried out using video techniques.

**Serious mental illness:** Patients with serious mental illness should be reviewed remotely were possible and with the support of mental health services when relevant. Many of these patients may need additional psychological support during the current pandemic.

## HOT HUBS AND CQC

A concern was raised that areas where hot hubs are being set up were being contacted by CQC staff saying that all practices were going to have to inform CQC of changes to their operating model. After Gloucestershire LMC raised it the BMA has discussed with CQC and agreed a solution to the problem. They are statutorily required to maintain up to date information on service delivery and so did not feel they were able to waive the requirement completely. However, where a group of practices in a locality have worked together to set up a "hot hub" (i.e. a facility where patients of all practices can be seen F2F if they may be at higher risk of having coronavirus) then only the provider running the hot hub site need contact CQC. They would need to submit a change to their Statement of Purpose (Part 3). Here is a proforma you can adapt for your use. This applies to other PCN led changes in future as well, for example alterations in IA and Extended hours

## CHILDREN AND COVID

The Royal College of Paediatrics and Child Health wish to raise awareness in Primary Care about delayed presentation of unwell children to Secondary Care. A free Arden's template for EMIS ad TPP users - to help and support you. Arden's have now published some 'Paediatric Remote Assessment' clinical templates for System One and EMIS Web that offer guidance on how to risk assess children remotely, including guidance on recommended management. The templates are based on the NHS Healthier Together pathways to assist clinicians in performing remote consultations where there is a risk that important symptoms/signs may be missed. Arden's have made these templates available for all practices for free.

For more information on how to access these resources, please visit Ardens. You may wish to consider sending a text message to parents: **COVID-19 is unlikely to cause a serious illness in children, but please remember children can still become seriously unwell from other causes that are always around. Please do not let concerns over COVID-19 stop you from contacting medical services. If you are not sure if your child needs to be seen please go to https://www.what0-18.nhs.uk/national *for* advice or contact 111 or your GP. For information about crying babies go to https://www.what0-18.nhs.uk/national If your child is severely unwell call 999 or go to ED.**

## HOME DELIVERIES

LMC has confirmed with GHFT that there is no requirement for GPs to prescribe diamorphine or pethidine for use by midwives attending home deliveries.

## OVERSEAS PATIENTS STAYING WITH RELATIVES FOR THE DURATION OF THE PANDEMIC

Some of you have asked what to do about people from overseas staying with UK residents, and unable to travel home due to the pandemic, hence requesting prescriptions or other medical services. All patients, wherever they are resident, are eligible for GP NHS services on an urgent /immediately necessary basis for free. Supplying prescriptions does fall into that category. Visitors staying for less than 3 months are temporary residents. If staying for more than 3 months, they should register for NHS services. Confusingly, guidance has varied over the years, but the current settled version can be found here and here.

## PCN DES

The PCN DES documents have been published. Read them here. A lot has changed since the original contract was agreed and the focus of the PCN DES is now to mainly support practices to increase their workforce and deal with the national emergency of Coronavirus (COVID-19). Needless to say, the ongoing crisis will mean that general practice will need more support both in the short term and in the medium/long term and that will remain our focus as we navigate the coming weeks/months. PCN DES is like any other DES. You can choose to take part in it or not, that is for the practice to decide. Like with other DESs, you can retain your core contract without signing up to PCNs. The latest BMA guidance on it here should answer most of your questions. General Practice will look very different once this is all over and the BMA has commenced work on what that could be like.

## BMA PRACTICE TOOLKIT

BMA has published a toolkit for GPs and practices which should hopefully answer many of the questions we've been getting on a large range of topics.
It covers: Service provision, Home visits and care homes, redeploying staff, working in hubs and furlough, Indemnity, Annual leave, Dispensing and medications, Locum doctors, Primary care networks and has links to our updated guidance on returning doctors, IT, homeworking and remote consultations. Access it here.
Any updated guidance or FAQs will be added to, or linked from, this toolkit so please do check it regularly for any new additions.

## QOF AND COVID

The changes for QOF are highlighted on the BMA website: here. The current position in relation to QOF, in view of COVID is highlighted here. In short, prioritise COVID, do what you can for QOF (when you can), and NHSE/I have stated that income will be protected.

## SHIELDED PATIENTS

The Govt commissioned and ran a search to identify relevant patients who should be shielded. You briefly scan and check that list, add to it the ones you think are missing, this is the relevant and proactive piece. Please don't spend hours and hours on it.

**What is the validated list?** The list by definition is dynamic- new people can be added and removed by GPs, hospitals and changes in diseases (i.e. new diagnosis) and time elapsed – e.g. therapy finishing. The method by which the list was validated has been published here.

**Why is the list "inaccurate"?** The list is based on hospital (administrative data) over 14 years and GP data (Flu extract) ever coded. Hospital data is valid for payment purposes – and uses clinical classifications – this are by their nature broad, and the route of coding can be (More historically) separate from the patient.
It is by its nature old – i.e. HES/ & BAS is 3 months old and thus misses everyone in that range. It also does not capture people who do not go to hospital or had significant procedures abroad or privately. GP data uses terminologies which are more specific and is near to the patient but highly variable between practitioners. Hospital procedures / interventions are coded in a variable manner.
The 10th of April release used GP flu data form the 16 of March – which did not have many cancer codes nor drug codes. Codes and classifications have historically been used for purposes other than intended – the practice of using "local codes" has reduced but is still widely recognised across the system. The CMO categories and the data production has been done at speed and in best endeavours approach. These are all known risks and have been accepted by the CMO and government. The perception of inaccuracy is dependent on your view of what is true – e.g. a person does not have a cancer until you know they have a cancer. This is why the system has shared the reason for being on the list in the free text
**Specific issues**

- Identifying sickle cell trait as high risk: This has been identified as a significant number of people with trait have been coded as disease. The code in itself is correct but not correctly applied.
- Identifying people with nothing other than PVD: Peripheral vascular disease is not on any of the inclusion criteria. This cannot be explained without further specific investigation. It may be a different reason entirely or a miscoding practice at a particular centre.

Identifying young people with no co-morbidities at all: This cannot be explained without further specific investigation. It may be a different reason entirely or a miscoding practice at a particular centre.
**False positives:** The risk to false positives is being exposed to a significant intervention of no contact for a minimum of 3 months. This is significant but has perceptually been slightly lessened in the context that the country is all socially distancing.
**False negatives:** These are a real concern and can only be found using local knowledge; specifically, anything that has happened in the last 3 months. Hence the approach to have additions and subtractions from the service (GPs AND Hospitals).
The example of transplant patients is interesting - it should only be patients who have transplants on immunosuppression. No search can link the two causally.

The variety of searches is challenging
The examples given are:
Transplant patients – this was done via HES data for transplants and BSA data for Immunosuppression drugs (note age of data)
Cancer register to see who is receiving active chemo – this is significantly challenging and was done by a number of routes depending on the cancer type solid, lung, or haem, and treatment) as each category in the CMOs definition is different.
Severity of asthma – was defined as step 5 of BTS/Sign i.e. on regular prednisolone + base therapy. All of these approaches have been written up and published publically https://digital.nhs.uk/coronavirus/shielded-patient-list/methodology
**Communication:** We agree this has not been what it should – the fear of saying something wrong has led to delays and the coordination has not been great. The number of voices now are many and it is difficult to tell what is right and wrong on the ground.

**Timelines /Workload on the profession:** We agree 4 days to work through this over a bank holiday in this context was very challenging. There was no central request for re-engineering of searches. It was to take people off and add people on.
**BAME:** This is an emerging theme, looking at the conditions there is a racial bias, and looking at the ICU admission and mortality data that indeed seems to be follow through. The underlying causes and reasons for this are not apparent. But we agree it is deeply concerning.
**Exit from lockdown:** This will have many and multiple repercussions well beyond the issue of shielding for the profession and planning the needs of the profession and support for patients is something the BMA are carefully considering.
**Primary care staff who received a shielded message:** Check that it is appropriate, and not a 'false positive'. If the individual must be shielded, aim to let them work from home if at all possible. If their work cannot be done from home and they are shielded for 3/12, then the BMA advice is that they be paid as it is not their fault, and the cost added to your business costs. If you have to employ someone else to do their work, discuss this additional expense with the CCG.

## CCAS APPOINTMENT SLOTS

**Utilising NHS111 online as the first port of call for people feeling unwell with possible COVID-19 symptoms, rather than approaching their GP Practice:** NHS 111 has been commissioned nationally to provide a dedicated COVID-19 response service to free practices to focus on managing those most at risk of complications from COVID-19.
A consistent **algorithm** will be used to stream patients into the following cohorts:

**Cohort 1**–patient demonstrating severe symptoms, requires treatment in hospital and will likely require an ambulance response.
**Cohort 2a**–symptomatic patients requiring further clinical assessment before final disposition is decided (these are referred to the COVID Clinical Assessment Service or CCAS).
**Cohort 2b**–patient exhibiting mild symptoms but has self-declared high at-risk status, having received a letter from the NHS – a post-event message recording this contact will be sent to registered GP for information.
**Cohort 3**–patient is showing mild symptoms and advised to self-isolate at home and to reassess via NHS 111 (online whenever possible) if symptoms deteriorate (GP informed via a post event message).
To deliver this service additional workforce is being mobilised, including from the experienced retired doctors' community. They will be immediately employed to remotely support CCAS ensure high quality clinical triage on which practices will be able to rely. The reliance on NHS 111 online will minimise the number of patients contacting their practice for advice unless they have been triaged as requiring it.

**Where CCAS assessment is required, this will result in one of the following outcomes:**
**Reclassification as Cohort 1** – patient demonstrating severe symptoms, requires treatment in hospital and will likely require an ambulance response.
**Reclassified as Cohort 3** – patient is showing mild symptoms and advised to self-isolate at home and to reassess via NHS 111 (online whenever possible) if symptoms deteriorate (GP informed via a post-event message and call closed)
**Requires proactive action from practice** – e.g. telephone monitoring
**Requires face-to-face assessment in primary care**; message sent to appropriate service to arrange.
In a small number of cases, the patient cannot be managed remotely and requires face-to-face assessment by local primary care services. To implement this, the National COVID-19 Response Service will transfer the last two categories of patient to general practice for follow-up.

**Practices must therefore:** Enable **GP Connect** for both appointment booking and record access. Guidance on doing so can be found here.

**EMIS information - GP Connect and COVID Clinical Assessment Service (CCAS) information**: EMIS have produced a guide on how to configure your clinical system to support the CCAS. More information can be found here.

## DEATH VERIFICATION

The LMC has received the following advice from the BMA: "Essentially the Ministry of Justice has now formally acknowledged the second and third of the two assertions below:

- Anyone can verify death
- No need to have ever attended or seen after death to issue an MCCD.
- No need to have attended or been in presence of body to complete Form 4

The MOJ Policy unit confirms "I note the points regarding attendance of the patient in a given period of time prior to their death and viewing the body not being statutory requirements, and it is correct that a crematorium medical referee can accept a form Cremation 4 where none of these two conditions has been fulfilled." They have also revised guidance: See the various documents here. Note in particular paragraphs 22 and 26 and the answers to Q7 an Q8 found in this specific guidance for Medical practitioners found here.
It is clear GPs are entitled to complete these forms as above having had no "attendance."
Coroners are likely to face a considerable number of potential referrals and Medical Referees dozens of form 100A applications. That is if there was no MOJ defined "attendance".
However, if the Registrars and Coroners, who we know can make their own local rules, were to decide that telephone consultations did represent an attendance after all, then processes would be smoother, and GPs would not be put at risk."
English law does not contain a definition of death in the ordinary sense, nor does it state who can verify life extinct. In the Army, at times of conflict, the Chaplain/Padre takes the ROLE function.
We can make no assumption that most deaths will be in hospitals, and we haven't reached the peak of deaths in the community yet. The LMC has respectfully asked the Coroner, and all concerned in the death processes, to weigh this information carefully when making decisions that might place GPs at unnecessary risk. Please find the latest BMA resource on verification of death, death certification and cremations here.

## HGV MEDICALS

BMA has spoken to DVLA. They stopped requesting medicals as of 24 March. If colleagues have outstanding requests they can just refuse to do them and ask the patient to go back to the DVLA.
Further announcements will be coming out shortly once they have been approved by the Minister and will be widely communicated as was the MOT suspension.
Taxi medicals are the responsibility of the Local Authority but applying the DVLA or near DVLA standards. Read about it here.

## PERSONAL PROTECTIVE EQUIPMENT (PPE)

Thank you to those who completed the BMA surveys. The results provide evidence to keep the subject visible in the national news so that the needs of Primary Care are not forgotten. Public Health England (PHE) has updated its guidance on PPE to now recommend eye protection. Also, NHSE said in their webinar that PPE should be used for all face to face contacts, and all patients should be assumed to be infected. The use of PPE in all face to face contacts is also recommended by the BMA. The LMC continues to campaign for appropriate and sufficiently plentiful PPE for constituents and we continue to maintain that despite these improvements by PHE, the standard of PPE still falls short of the recommendations of the WHO, particularly with regard to fluid repellent gowns, and is therefore not acceptable. The BMA has also made it clear to the LMC that they do not

endorse the new PHE policy on PPE. Also, the BMA and other unions have called on the Government to repurpose industry to mass produce appropriate PPE for NHS staff.

## URGENT WORKFORCE RESPONSE UPDATE

The CCG and the Gloucestershire Primary Care Training Hub are working to develop workforce solutions to ensure that practices are supported over the coming weeks.

Solutions include:

- Working with over 20 retired GPs to discuss return to general practice or other support roles
- Engaging with locums who have additional capacity to match with practices and services over the next 8 weeks
- Supporting primary care training and development needs during this time
-

Practice Managers and GPs are advised to complete their SITREPs each day to include any workforce challenges that they may currently be experiencing, from which requests will be passed to the Primary Care Workforce Team at the CCG. Correspondence and information relating to this Urgent Workforce Response can be found on the Gloucestershire Primary Care Workforce Website at this link.

The Hub is interested in understanding the support primary care needs with either workforce or training during this time. Queries can be made through the existing channels, or direct contact via email at glccg.pcwc@nhs.net or 0300 421 1433.
During this very challenging time for the NHS, new applications to the GP Retainer Scheme in Severn will not be processed. Doctors approaching HEE regarding the scheme will be signposted to other workstreams within primary care that they might wish to consider. Their interest in the scheme will be recorded, and they will be invited to apply once this crisis passes. This does not affect colleagues currently on the Scheme. As you will be aware, HEE has negotiated with NHS England that these doctors can undertake additional sessions, separate to the scheme (and so without the reimbursement payments to the practice), to support the workforce at this time.

## SAFE HOUSE

GP Safe House (GPSH) is a virtual safe house providing a refuge and support for practitioners experiencing professional challenges. It guarantees anonymity, security and confidentiality and understands that these are essential. GPSH has five virtual rooms which offer support, information and resources. Each room corresponds to a different potential problem area. It has recently received a makeover/update from Somerset LMC who devised it.

Services available are:
**Consulting Room** - Personal Health Information for the Gloucestershire Area
**Burnout Recovery Suite** - Burnout and Stress
**Professional Relationships Bureau** - Working Relationship Problems
**Library of Solutions** - Non-clinical Aspects of Patient Care
**Career Development Office** - Professional Development
**Contacts for Support and Advice** - This is a link to the Gloucestershire LMC Advocate Area which offers the possibility of a personal, completely anonymous, one-to-one, online consultation with a professional advisor as well as more everyday modes of communication!

The administration staff from the LMC have emailed all GPs who have not previously been issued a password. If you did not receive an email from us but feel you would like to use this service please contact the office via telephone, email or the Contact Us form on our website. The LMC pastoral care support continues. An advocate can be chosen via the Safe House or contact the office.

Also, please find below a link to the 'Supporting GPs Mental Health and Well-Being' page on the Training Hub Primary Care Workforce Centre website which has been set up to provide GPs with information and links to the resources currently available to provide support. Read it here.

Dr Ansell Consultant Psychiatrist recommends the covid resilience hub.

## SESSIONAL GP ISSUES

NHS mail has been rolled out for all sessional GPs, recognising the important contribution of locum GPs to the workforce. GP locums can apply here. Sessional GPs are represented on the LMC by Dr Jethro Hubbard, who can be contacted at jethro.hubbard@nhs.net. GPCE is working hard to try and get assurance from NHSE regarding pension provision and death in service benefits for locums at this difficult time.

## A PENNY FOR YOUR THOUGHTS

A pandemic, terrible though it is, highlights our mutual interdependence in a way that only tragedy can. The beauty of *The Plague* is that it asks the reader to map the lessons of a pandemic onto everyday life. The principles that drive the hero, Dr Rieux, are the same principles that make every society worthwhile — empathy, love, and solidarity. If we learn these lessons now, in a moment of crisis, we'll all be better off on the other side of it.
'And, indeed, as he listened to the cries of joy rising from the town, Rieux remembered that such joy is always imperilled. He knew what those jubilant crowds did not know but could have learned from books: that the plague bacillus never dies or disappears for good; that it can lie dormant for years and years in furniture and linen-chests; that it bides its time in bedrooms, cellars, trunks, and bookshelves; and that perhaps the day would come when, for the bane and enlightening of men, it would rouse up its rats again and send them forth to die in a happy city.'

Who is the author of 'The Plague?' Answers, by 20/05/20, to penelopewest@gloslmc.com

Congratulations to Dr Jim Holmes, winner of the April competition. A donation has been made to Cancer Research UK. The answer was 'Hitchhiker's Guide to the Galaxy' by Douglas Adams. There were 3 correct entries, though I was hoping for 42. Our fun competition will continue. Prizes henceforth will be a £10 donation to a charity chosen by the winner, who will retain the bragging rights. **The LMC will continue to run with a mixture of office and home working. Some of our meetings will be by skype, Zoom or telephone. My personal mobile number is 07415290140 if that is useful.**

*This newsletter was prepared by Dr Penelope West and colleagues, at the LMC Office.*

*Acknowledgements to resources kindly shared by partner LMCs, especially Wessex, Somerset, Cambridgeshire and BBO. When in doubt, seek legal or financial advice as necessary.*

## JOB OPPORTUNITIES

A full list of current job adverts is at http://www.gloslmc.com/blog-job-vacancies.asp and available below.

| **GLOUCESTERSHIRE** | | | **Date posted** | **Closing Date** |
|---|---|---|---|---|
| Kingsway Health Centre | Gloucester | GPs | 25 Sept 19 | Open |
| Chipping Campden Surgery | Gloucestershire | GP | 20 Nov 19 | Open |
| The Lydney Practice | Lydney | Partnership | 28 Nov 19 | Open |
| The Culverhay Surgery | Wotton–Under-Edge | Salaried GPs | 28 Nov 19 | Open |
| Royal Crescent Surgery | Cheltenham | Salaried GP | 4 Dec 19 | Open |
| Gloucester Health Access Centre | Gloucester | Salaried GP | 11 Dec 19 | Open |
| Brunston and Lydbrook Practice | Coleford | Salaried or Partner GP | 13 Dec 19 | Open |
| Aspen Medical Centre | Gloucester | Salaried GP | 20 Dec 19 | Open |
| Gloucester City Health Centre | Gloucester | Salaried GP | 15 Jan 20 | Open |
| Stoke Road Surgery | Cheltenham | Salaried GP – 1 Year | 16 Jan 20 | Open |
| Stroud Valley Family Practice | Stroud | Retainer or Salaried GP | 24 Jan 20 | Open |
| Aspen Medical Centre | Gloucester | Saturday Morning Locum | 29 Jan 20 | Open |
| Yorkleigh Surgery | Cheltenham | GP Opportunities | 05 Feb 20 | Open |
| Yorkleigh Surgery | Cheltenham | Long Term Locum GP | 28 Feb 20 | Open |
| Community Hospitals | Gloucestershire | Sessional GPs | 25 Mar 20 | Open |
| Various Surgeries | Gloucestershire | OOH GPs | 18 Apr 20 | Open |
| Phoenix Health Care | Gloucestershire | Salaried GP | 27 Apr 20 | 17 May 20 |
| The Chipping Surgery | Gloucestershire | Salaried GP | 28 April 20 | 31 May 20 |
| **ELSEWHERE** | | | | |
| Avon Local Medical Committee | Avon LMC | Director of Nursing | 22 April 20 | Open |

***REMINDER:*** *If you are advertising with us and fill the vacancy please let us know so we can take the advert down.*