LOTHIAN | LMC

LOTHIAN LMC & GPs COVID UPDATE 9/4/2020

LMC Chair, Dr Drummond Begg, welcomed guests:

- Claire Gordon, Acute Receiving Physician, WGH
- Caroline Whitworth, Acute Medical Director
- Carey Lunan, Chair RCGP Scotland
- Sian Tucker, LUCS lead and many other roles
- Kim Rollinson, Salaried GP representative.

He also acknowledged those working with him in the GP Sub-Committee COVID Group (Annie Lomas, Ramon McDermott, Iain Morrison, Catriona Morton, Amy Small).

Current Hospital Situation (Drs Whitworth and Gordon reported):

- RIE: 2nd floor now all COVID wards, which is 50% of the bed base. COVID patients now outnumber those without infection
- WGH: increasing number of COVID wards – split into sections (eg respiratory, ID, cancer, medicine for elderly and so on)
- ICU 40 patients, around half in the RIE; other half split between WGH and SJH
- increase not as rapid as predicted, steady influx
- Still additional capacity, max 113
- On admission patients are separated into red (COVID) & green/amber (non-COVID) hospital pathways
- An emerging issue is the *long recovery period*; patients not getting home quickly so a long length of stay. This is gradually using bed capacity.

Thresholds for admission

- The criteria are equivalent to those for COVID Hubs
- Oxygen sats crucial including desaturating on exertion
- Respiratory rate can be deceptive – sometimes not greatly raised with low sats
- Community hubs and GP assessments are excellent – patients being referred appropriately. Small numbers admitted just overnight for assessment (often asthma / anxiety) but a high % are admitted.

Discharge

- Due to prolonged admissions, patients are deconditioned and are generally frailer
- COVID can present as acute confusion and falls in the elderly, prolonged admissions thereafter
- Development of ‘safe haven beds’ in nursing home as places of safe intermediate care
- ‘Home First’ teams are being strengthened
- Much of this lies with HSCPs – deciding where best to site care; and making optimal use of packages of care

PPE in Secondary Care (Dr Gordon)

- PPE as in General Practice (including eye protection) but ‘sessional’ use; just changing gloves and apron each time
- Need to always consider “what to wear and when”

Ceilings of care and ICU (Dr Gordon)

- Much more discussion than previously – aim for that to happen within 4 hours of admission where possible, not least as need to know about CPR if the patient arrests (very poor outcome, high risk for staff). Occasionally delayed eg if delirium.
- ACP form, TRAK version
- Do need to be honest with the very ill at high risk of dying
- It's a "grim illness if you end up in ICU" with prolonged rehabilitation and reduced Quality of Life
- Many post-ICU have significant debility including polyneuropathy, nutritional deficits and so on
- Survival estimated at 30-50% of admissions to ICU (even with conservative criteria for ICU admission)

Outpatients (Caroline Whitworth)

Dr Begg reported that some referrals are being returned, essentially creating a Primary Care waiting list, which isn't possible to safely operate and duplicates work.
Dr Whitworth outlined that it is difficult as no current access eg to investigations unless urgent.
This will be discussed Lothian Interface Group to seek resolution.
Dr Begg will also meet with Modern Out-patient team next week.

Generally urgent cases are seen.
Some departments are undertaking phone assessments of all new referrals – a form of active triage – allowing some to be discharged, others booked for follow up. *But essentially many routine referrals requiring non urgent Ix /F2F assessment will not be dealt with till the pandemic has settled*

Anticipatory Care Planning / SHIELDING – Carey Lunan

Dr Lunan outlined that it was important to get this right – both to support clinicians and patients and for public messaging. There had been some very negative accounts (including in the press) mostly round approaches to DNACPR forms, particularly where it was perceived that these were forced on people, or not individualised.
She outlined the approach to stratification with the high-risk group needing KISs activated without individual consent, thereby showing high level information (priority 1 Read codes). This has to be done individually – although Ian Evans has developed a macro which can be installed (suggest Peter Cairns for further detail).
Shielded patients need to be contacted proactively, and she outlined the guidance re discussion: what are patient wishes, what approaches do they want, what support is needed.
These are nuanced discussions, and the Scottish Government documents are guidance not protocols. Secondary care is to do a share of the work, for those patients actively being treated by / well known to their specialists.
There has been undue focus by some on DNACPR discussions, leading to negative feedback including by patients and the press. CPR is generally futile in COVID, (respiratory failure vs VF arrest) so limited value on focusing on that. Much better to consider what can be done to support.
There is NO specific requirement to discuss DNACPR in the Scottish guidance – seems most appropriate when the patient raises the issue, or where it feels important to do so
The evidence is that of those contacted:

- 1/3 do not want that discussion at all
- 1/3 engage to some extent and may need a further contact (where capacity exists for that)
- 1/3 welcome the opportunity to talk things through.

She anticipates that the COVID ACP work will demonstrate how useful and effective the process is and better embed the work, IT support and so on after the pandemic.

Dr Begg emphasised that shielding work is not contractual, obligatory or prescriptive. However, some of the additional £15m to support GP COVID work is for this type of activity. Secondary care indicate that such preparatory conversations can be tremendously useful.
Some patients asked for documentation to support self-isolation: they should be directed to the NHS Inform website, but sometimes the GP may provide automated letters (patient summaries) and it is then up to others (employers OCC health provider) to apply to individual employment context.

Dr Morton outlined guidance on Lothian shielding she sent to practices this week:

- Jointly formulated with Lothian secondary care and aimed to help define who did what
- In general, specialist discussions for the following:
    - Transplant / cancer-chemotherapy / cystic fibrosis / unusual metabolic / genetic conditions
    - Immunosuppression where actively managing patients or treatment.

As the patient may have already had a specialist discussion always important to check when phoning if someone else has already been in touch.
Mr. Jim Powell (Consultant Transplant Surgeon) is NHS Lothian Shielding Clinical lead, and he and Dr Whitworth had supported this interface work. Dr Lunan suggested that across Scotland Lothian probably led on this.

Dr Small highlighted a useful resource – the COVID19 information sharing portal – to which GPs can add documents. She has added a cover letter which can be posted to patients with DNACPR forms once those have been discussed and agreed with them. The site is by invitation only – and she suggests GPs email her if they want to access that.

The new shielding category (7)

- GPs or specialists can add patients not covered by categories 1-6 to the shielding list
- Must be significantly at risk of COVID19 complications from COVID19 infection
- GPs can decide and potentially may also include social vulnerability
- Patient then eligible for the associated benefits
- MND and interstitial lung disease added to the cohort today *(NB: MND not subsequently confirmed by acting CMO's letter but would seem a priority for GP contact).*
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Drs Morrison and Ian Thomson (Scottish Govt Digital Health) outlined the process:

- Vision practices: if clinical audit 9d44 code is added, this will register the patient for the shielding group. This creates a separate Category 7 sub group.
- The EMIS process is essentially the same
- Then e-mail the CHI to the shielding team who will then arrange a central letter to ensure the additional support when needed (social care, food parcels and so on)

Contact covid.highrisk@nhslothian.scot.nhs.uk for people who need removed or added to the shielding list

Verification of death (Dr Lomas)

- can be done by a variety of health professionals, but NOT others: the legislation (2017) has not been changed from pre-COVID.
- The Health Professional Council determines that eg paramedics, OTs and physiotherapists can do this, but they must be trained
- This is now available online - attempts are being made to fast track people through the course
- PLE advice - *don't* get close for listening for breath sounds - just auscultate, check pupils & pulse. *Use PPE for this*.

Death Certification

Step by step guide being prepared by Dr Annie Lomas for Lothian GPs with input from local Registrar.

Locum issues - Kim Rollinson

Death in service

- different for locums as won't get paid as much if die on a day not in work – SGPC taking this up on behalf of LMC nationally

Occupational Health Service

COVID Swabs

Suggest access these through a Practice Manager – a practice where there has been a relationship; or where a locum placement is booked. Important to get all GPs back to work during the pandemic - we must support locum colleagues - and all work together as a team.

Cancellation of locum work

- Practices are sometimes cancelling very last minute
- Recommend that locums agree their *own* terms and conditions in advance,
- Practices – please be kind to your locums, all GPs are needed - and locums will be kind in return!
- Practices can claim back for additional locums needed for COVID – so consider using locums more for flexible working, or to provide time for shielding conversations or COVID-related organisational change

Communication

- Crucial for locums to be able to keep up to date with information – no single solution, multiple approaches attempted
- Please include locums in communications if your practice is their regular place of work – and again be kind and inclusive where you can. Ideal is to add to the practice mailing list.
- GMS updates now going to LASGP and its webpage which is helpful. Suggest also keep up with Facebook, the LMC, and her!
- The ideal is a national solution eg a performer's list with a mailing list.

Dr Begg addressed a few issues raised by GPs:

Expenses

- LMC is developing an easy user's guide for accessing money from £9m uncapped fund
- GPs can consider locums (including internal ones) for additional workload – they should not lose out because of COVID and the emphasis should be on GPs claiming appropriately and professionally
- Up-front payments to cover Easter should be paid by 16th April.

Six week Baby Checks

Practices should still do these – the ideal is to use the same appointment as the 8-week vaccination to reduce additional F2F contact.

Out of Hours (LUCS)

Dr Sian Tucker has emphasised the importance of practices organising ACP meds in households which might need them, as well as the District Nurse medication administration sheet. Clearly out-of-hours pressures challenging at this time. Please consider urgently.

A further update will be sent imminently:

- **Dentist** - People can phone their regular dentist, who will offer emergency advice / assessment / analgesia / antibiotics if needed. There is a central care centre where that is needed.
- **Optometry -** contact local optician, telephone contact, will see emergencies only. Some smaller contractors are not managing to remain open.

Practice Action Plan by Lothian LMC

This is NOT prescriptive, but an advisory guidance document, requested by GPs. Has been benchmarked against practices and other health care settings. There will inevitably be variation across practices as circumstances differ, and GPs remain responsible for their own arrangements.

Concluding Remarks.

Dr Begg reflected on what a difficult and unique time this was, and that it was not always easy to strike the balance when principles collide (e.g. treating patients vs protecting self /team).
He noted that “good people can disagree” and suggested finding the middle way, Aristotle style!
He observed that GPs were making pragmatic and proportionate responses to provide comfort and confidence for our patients and teams.
The GP community had responded to the COVID outbreak with great professionalism.

He wished everyone a restful Easter and to take good care of themselves and each other.