LOTHIAN | LMC

LMC COVID UPDATE – Zoom 23 April 2020

Dr Drummond Begg and Dr Susan Arnold (Co-Chair SE Scotland Faculty, RCGP) welcomed guests to the meeting: Mark Hunter (Primary Care Finance Lead), Prof Brian McKinstry (Professor Primary Care eHealth), David Small (Director of Primary Care Transformation), Sian Tucker (Clinical Director of LUCS, Co-Chair SE Scotland Faculty, RCGP and various other roles).

Mark Hunter outlined COVID finances:

It is thought that 'reconciliation' of the national £15m for COVID expenses will happen – there has been a steer but NO definitive guidance. 1/3 is for Easter Friday/Monday cover; the other £9.9m for "COVID-related costs". Included will be the funding for extending previous sick leave cover to include the first 2 weeks.

Team overtime is an obvious expense, higher phone or post bills , costs relating to video setups. Internal locum costs (eg for additional telephone triage work) are justified if the team has had to do more.

Dr Begg outlined that a complete re-design of the appointment system was required by many: last time his practice did that it cost an estimated £10k: there has been extensive organisational time required of GPs. As yet no certainty regarding further resource being available.

Practices need to keep a record of their expenses for the first quarter – March to June.

Mark Hunter: the average amount per practice is around £20K: this does not need to be paid back unless costs were not incurred.

David Small emphasised a common sense approach (the 'Daily Record' test – what would seem reasonable as headline news!). Weekend work by partners re-organising systems is reasonable (and partner time is expensive), COVID sickness leave by admin staff; but not 'treats'. Mr Hunter outlined that detailed scrutiny of accounts was not anticipated; rather receipts, or declarations by staff or partners relating to time and activities (including systems development).

Enhanced Service Returns.

Dr Begg outlined the tremendous pressures on Practice Managers. Mr Hunter responded that last year's returns can be used. However practices can submit this year's figures – probably only an advantage where there have been increases in list sizes or activity. There have been no major changes in enhanced service arrangements, so this was considered a pragmatic, proportionate approach.

The 'New Normal' – David Small.

The 'COVID Tactical Group' met with the four Independent Contractor groups - a good session looking at the immediate and long term post-COVID. The assumption is that COVID will go on for 12-18 months, either plateauing or as a series of waves. "Zoom"ing GPs were asked if they wanted have a follow-up meeting on this and there was a general consensus that this would be useful (likely to be **Wednesday 13th May, 7.30pm – 8.30pm,** further details to follow).

There has always been a focus on bed numbers, but now there is to be a primary care focus: an 'early warning' system looking at NHS24, COVID hub and ambulance activity. What we don't want to do is "unchange" developments resulting from the pandemic which have been good for the NHS, populations,

practices and Boards. There are national discussions around this too and some speculation that even the Phase 2 GMS contract may be reconsidered too.

RCGP SE Scotland Faculty – Susan Arnold (Co-Chair).

Dr Arnold reported that Faculty activities had been curtailed – they had one staff member, currently furloughed. However, the College had been working hard with SGPC and Scottish Government, under the leadership of Carey Lunan. This includes work on infection control issues, care homes, end of life and a joint statement with the Scottish Academy on how to support in the final days of life, including access by families, with a focus on the moral and ethical dimensions.

Out-of-Hours – Sian Tucker, Clinical Director LUCS.

Dr Tucker praised and thanked the Lothian GPs who had worked tirelessly to support COVID patient care. She had been hugely impressed by:

- a "phenomenal" response around rotas
- the move from WGH to the Royal Infirmary site, involving brilliant work by administrative and other teams
- work done rapidly and effectively, despite everyone maintaining social distancing
- many new and ex-GPs had signed up to work
- use of Near Me and telephone triage - hugely helpful – with the hope to develop and retain these
- Pharmacy – rapidly progressing new work. Whilst it is not possible to keep CD stocks in care homes (other than for named patients), non-CD scripts could now be emailed to pharmacies OOH, and in the longer term OOH e-prescribing has been given the go ahead nationally (future development).

The extensive new ACP-KISs done by GPs were superb, and hugely welcome: always useful to imagine what would help most at 2am! Next of kin details (and also NOK views / approaches were relevant) help. Always good to know about challenging animals in the household!

Dr Tucker is also working on systems at a national level with Michelle Watts (Scottish Government Primary Care Advisor). Governance is proving even more important in these challenging times – clinicians having to work in new ways, with new risks and clinical management. Important to have secure footing both in and OOH. Been working closely with Dr Begg and secondary care.
There is adequate PPE across LUCS and recruitment processes have been streamlined, so signing up is quick.

Telephone triage works *very* well however there is a need to continue with more triage doctors, we may need more in cars, and we have to work with our DNs to support them.

Work coming out soon from SG;

- Palliative care toolkit
- Community oxygen guidance

Death certification:

- The acting CMO issued more guidance on 20/4/20
- LUCS is NOT issuing death certificates over the weekend unless there is a specific religious reason
- Note Registrars are now open 7 days / week

There is on-line training for nurses to verify (both expected / unexpected).

Dr Tucker referred to several national issues:

- Testing is considered the only way out of lock down
- Post-COVID rehabilitation is going to be necessary
- Highlight that General Practice is still open for business
- Care Homes and Prisons are recognised as areas where there are specific challenges and national work is ongoing with the care home sector about guidance.

The Homeless (Access) Practice has been extraordinary, open 8am-10pm, 7 days a week, helping clients into homes and hostels and allowing people to isolate where necessary. Those plans would also allow access to alcohol and drugs where necessary, protecting both them and others.

E-Health developments – Brian McKinstry.

Video Consulting.

Prof McKinstry reported on research done last year (Near Me):

- Safe, welcomed by both GPs and patients
- Worked best for younger; people used to Skype / Facetime; helps those working / mobile or with mental health problems
- Less good for older (our biggest workload) and those who are digitally compromised: that may improve over time
- Less good for those with cognitive or learning difficulties
- Not suitable for those needing a physical examination, but the clinician can see if the patient looks ill

Very valuable for those with mental health problems:

- Give similar information to f2f consultations – cues crucial for checking understanding and rapport
- Patients possibly more relaxed as not facing the stress of attending the surgery
- Rapport was good – with patients feeling that the GP paid them more attention than phonecall

There were some technical problems, but NHS Lothian bandwidth has improved since then. The mean phonecall length was 5.5 minutes; video 9.6m (similar to f2f).

Dr Begg commented that in his experience 60% of video calls were successful, in around 40% the link did not work for the patient – a phone issue? The browser must be Google Chrome or Safari. Phonecalls much faster! And always useful to get medical students to do the IT setup.

Remote Monitoring - Prof McKinstry

Cancer Research UK recently published that deaths due to postponed Dr encounters will outweigh COVID. Remote monitoring is available for BP, COPD and heart failure:

- Previously demonstrated that telemonitoring clearly improves BP control
- Resulted in large scale implementation in Lothian (4,000 patients, 70 practices)
- If telemonitoring was generalised across the population, there would be a 15% reduction in strokes, 10% in MIs
- Benefit also shown in diabetes, heart failure (post-discharge) but NOT COPD (all outcomes measured)
- Telemetry not generally measured against no care

Dr Begg commented that BP would be the obvious focus for further rollout, and is a high volume workload.

Prof McKinstry is to do more work round monitoring BP in pregnant women – hopefully can help those shielding.

Dr Begg encouraged the scaling up of this approach, saving the limited monitors for those who could ill-afford them and encouraging others to buy their own. Prof McKinstry – there are plenty!; cost £12 each.

COVID MONITORING / RESEARCH - Prof McKinstry

Some COVID patients are assessed but not admitted – however a subset will:

- Deteriorate very rapidly (minority)
- Or become hypoxic without subjective breathlessness
- Aim is to remote monitor, in conjunction with symptom questionnaire, pulse oximetery and temperature
- And patient contacts usual routes if answers or measures suggest deterioration.

This is about to be implemented in pilot sites in Scotland but will be evaluated in terms of impact on safety, workload, acceptability and utility of different measures.

Locum news - Kim Rollinson, Salaried GP representative (Lothian and national)

There is progress for death in service benefits for locums - positive news but needs strengthening. News in Scottish Government statement and BMA blog – **bmascotland.home.blog/2020/04/20/death-in-service-update**. Applies to ALL those delivering frontline treatment – lump sum and in-service benefits.
She would like to see better detail/clarification that "NHS locum staff" includes GPs (SGPC working on this); and the wording "frontline treatment for COVID19" – sets a new precedence: does it only apply to COVID? However Scotland is ahead of Westminster in this.

Coronavirus Test reliability – Ramon McDermott

Dr McDermott reported on a Royal College of Pathologists virtual meeting held the previous night. Dr Kate Templeton (Consultant Clinical Scientist, Head of Molecular Diagnostics, RIE) presented her review of all Lothian coronavirus tests (up to 10 days prior).

Of 5782 symptomatic patients with Covid illness tested in Lothian;

- 1258 patients were positive for RNA for covid 19
- 21% positive
- 79% negative

If admitted and re-tested, those who were initially negative only 8% positive on 2nd test. Therefore 2nd test not recommended in the community.

The gold standard in testing is endotracheal lavage (on ICU in patients with severe disease) – this yields 100% but only 60% of those will have had a prior positive swab. The suggestion is that early in the disease (URTI symptoms) the virus is largely located in the nose and throat; and later progresses to the lungs (so nose/throat swabs less likely to be positive later in the disease course).

A good nasal or throat swab will respectively bring tears to the eyes, or make the person gag. Nasal swab is 1/3 more likely to be positive than throat swab. Sputum and blood samples are virus negative on testing, 15% of urines positive but usually later in disease.

If negative, swab could be false negative as in Covid in lungs but not nasal or throat area but also differential illness - Strep Pneumoniae and Mycoplasma and other pathogens are still around.

In Scotland, of 43,000 tests, 9000 were positive ie in line with the Lothian figures - 21% positive and 79% negative. According to the recent Lothian website there have been 7,000 plus tests done in total however in last week, 27% were coronavirus positive.

Staff with a negative test may have missed the early window when more likely to be positive: so if symptomatic in keeping with COVID, this still needs to be considered if swab negative as virus may be in lungs but not throat or nasal area.

Shielding issues – Catriona Morton

There remains much uncertainty round shielding categories and how to interpret them. Mr James Powell (NHSL Shielding Clinical Issues Lead) is being very helpful and is very happy to hear directly from GPs with queries. Some had been sent to the LMC:

- The haematology / oncology descriptors seem vague. Lothian Oncologists have taken the pragmatic view that in general only those on active treatment (particularly chemotherapy) be included. Scottish Government had been asked for clarification too.
- Should patients with MS be shielded? Some will be immunosuppressed and should (noting that immunosuppression can persist long after treatment is stopped). For others it will depend on the clinical situation, and depend on a risk/benefit discussion with the clinician.

A large group are the frail / multimorbid. Margaret McCartney has undertaken a rapid review of the literature (which is incomplete and skewed) and the biggest risk for severe disease is age, men are more likely to become ill than women, cardiovascular co-morbidity (especially hypertension) and diabetes/metabolic syndromes follow. Few had asthma. Mr Powell's view is that the criteria for risk, and threshold for inclusion in the shielding list are not transparent.

Dr Morton outlined that the list was devised by a small specialist group – and that work had to be completed very quickly - but further discussion is now taking place. Her view is that for most patients a generalist discussion, considering risks and contexts, will need to take place. She emphasised that category 7 is not meant to include whole new categories but be based on individual patient decisions.

Finally, Drummond commented on several issues:

- The 6-week baby check is still required; some practices do this at the same time as the 8-week vaccinations
- PPE – the glasses provided are very poor; visors are better e.g. from Penicuik Printing Team (order via their Facebook page)
- Outpatient referrals are a hot topic – he is pursuing conversations and this will be considered at the Lothian Interface Group, and should be informed by the Modernising Outpatient work
- GPs are still open for business but need to balance with #3beforeGP messages.

He wished the GP community all the best.