LMC & Lothian GPs COVID meeting 2nd April 2020.

Drummond Begg chaired the meeting and gave a welcome to Lothian GPs. Several speakers gave presentations, and questions were addressed that had been submitted in advance.

Shielding patients.
Lothian LMC view is that:

- Better in clean environment ie in practice than on housecalls as advised in the letter to patient
- That asking patients to phone 111 if ANY symptoms is inappropriate.

Both views are being discussed nationally.

PPE - Andrew Cowie, Co- Vice Chair SGPC.

- New guidance issued by Public Health England today - tweeted from Lothian LMC tonight
- Risk assessment of each patient is crucial
- Wear PPE with ALL F2F patients – and not just those seen for covid assessment
- The PPE supplied to Primary Care is exactly the same as that used for equivalent risk in hospital settings.
- There will always be some disagreement about what level of risk is acceptable and therefore what level of PPE appropriate.

LMC action plan was published last week – practices using it have found it very helpful. It will now be updated to reflect this new guidance **ie all rooms where patients are seen are considered 'red'.**

COVID hub information. Gareth Evans, Covid Hub Lothian lead.
Activity and referral levels:

- 53% of NHS 24 calls passed to COVID triage
- 1400 calls last week
- F2F 11%
- Admitted 26, 2 died.

Numbers are going up a little this week but not by much. Response from professionals to help has been good, after an initial shortfall.

Covid Assessment and Admission:

- Most admitted were obese, breathless and hypoxic
- Often those admitted had no / low grade fever – Listlessness and breathlessness seem key Sx
- NOTABLY - if young fit patients (non-smokers) were breathless - they were often severely hypoxic
- The ROTH TEST has now been discounted (NB: PROFESSOR TRICIA GREENHALGH has today said that it is NOT reliable and should not be used)
- The STAR[1] assessment is useful and helps define the level of admission
- There is variation in admission rates – relating to GP tolerance of risk – and some will explain to patients that they are not ready for admission 'yet' – that may come as illness progresses.

An issue is other clinical scenarios referred to the Hub where Covid not the main concern.

COVID Hub sites:

- Triage at Astley Ainsley, next to Flow Centre

[1] SaO2, Temperature, Appearance, Respiratory Rate

- Adults only F2F @ WGH (Royal Victoria), Musselburgh Primary Care Centre and Midlothian Community Hospital; looking at West Lothian hub
- Mountcastle (Edinburgh) due to open by end of this week/Monday
- Children all through RHSC Emergency Department.

PRACTICE INVOLVEMENT.

Some practices have capacity and keen to offer their help. Dr Evans is reviewing pathway for direct GP practice triage to flow centre for F2F assessment by Monday. For practices willing to do this – but not an expectation. Already introducing Adastra into willing practices (licenses limit that).
An issue has been NHS24 delays – patients were waiting 73 mins earlier this week; now settled to 7 mins today. There are Flow Centre delays too – can be significant – but call numbers now going down. Covid hubs send only 10% of those triaged to Flow.

House calls:

- 2 groups: those with no transport and those genuinely housebound
- Scottish Government investigating national contract with taxis just now
- Genuinely housebound – no house visiting system now. May develop in liaison with hospital at home for assessment and continuing care, Caroline Armstrong (Edinburgh Medicine for Elderly) is leading with this, and liaising with the other Lothian teams.
- GPs have varying views on how to best manage frail elderly.

E-health – Peter Cairns.

SGD – huge rollout with upscaled firewall. Unable to do more in short timescale because of legacy IT.
Issues for locums:

- Locums can have access but need to remote into a specific desktop (which is then unavailable)
- They can negotiate that with PMs where part of a practice team – more difficult for those doing ad hoc session.

NB: Kim Rollinson represents locum issues (at national level).

Video consulting

- Hugely helpful, encourage use. Useful for marginal covid cases; may prove more so when people start consulting again with non-covid symptoms still requiring 'red room' use
- 'Near Me' facilitators coming out to practice next week to see how it is working, and facilitate use of single / multiple monitors.
- Works on smart phone while having clinical record up on desktop
- SGD buddy practice and remote access – use this if needed
- Sign up for Microsoft Teams - guidance has been sent to practice manager.

Shielding and IT

- Coding guidance being sent week beginning 6th April
- EMIS practices should receive shielding list tomorrow, Vision on Monday. Will be in BATCHES according to condition (1,3,5 first; 2 & 6 to follow; some rarities later)
- We will be given searches to catch missed people - GMS facilitators to help with this; sense-checking work to be done first
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The at risk patients (not shielded - the flu vaccine cohort)

- Turn KIS on – this has to be done individually; many practices are doing this now.
- No other solution for mass KIS switch on – some practices using Medical student volunteers

Terms and conditions issues - Andrew Cowie

Shielding work

'Shielding group work is additional and non-contractual'

- Dr Cowie agreed – this should not take a higher priority than those that are ill / believe themselves to be ill, BUT if spare capacity then extremely valuable work to do. No doubt that it helps both specialists and other GPs seeing the patients.
- Practices can claim REASONABLE EXPENSES eg additional staff to help with this work.

Suggested script for practice receptionists for patients who phone – we have not received the list but will respond when we can.

Death in service if opted out of scheme:

- boards offering locums zero hours contracts
- Very complex due to tax and employment law, but there is at least a solution for locums
- GPs opted out of pension scheme - "assurance" given of protection but Dr Cowie would like more.

Easter holidays:

- payment through global sum – equivalent to 2 days of work
- submit expenses claim if extra expenses incurred

'Reasonable' expenses

- keep account of all additional costs for reimbursement (need the evidence!)
- Main costs likely to be staffing
- Internal/external locums covered

CPR – Ramon McDermott

- Guidance keeps changing (Resuscitation Council and Health Protection)
- Guidance from local A/E consultant – Chest compressions and defib
- Chest compressions not a significant aerosol generating procedure
- Do not listen or feel for breathing – instead check for carotid pulse only
- If absent, use defibrillator to assess rhythm.
- Can use ambubag.

CHILDREN – more difficult as commonest cause of arrest is respiratory not cardiac. BUT severe covid rare in this group so consider usual measures.

Drummond Begg reported on other services:

Opticians

- Some closed others not – small business pressures
- Total telephone triage
- Eye emergencies can potentially be seen
- Eye clinic have a list of open opticians

Community Pharmacies

- PCCO will send out details of Phramacy opening over Easter weekend
- Under pressure too; initial panic ordering settling.

Dentist

- phone triage emergency only
- Centralised service in Lothian for essential treatment

Oxygen (Andrew Cowie)

- claim under expenses if extra required
- Lots of flexibility round this

Palliative care guidance – Annie Lomas

- Scottish guidance about to be released (currently with CMO)
- Palliative care teams keen to work with and support GPs;
- HSCPs and Hospital at Home working hard to support palliative care
- Practices can stock controlled drugs provided in locked cupboard or bag and they have a controlled drug register
- Death in hospital has normally been within 5 days (19 hours on average from decision for palliative treatment), so rapid quick deterioration and need for escalation of palliative care meds more quickly than we may be used to
- There are national plans for providing rapid access to palliative drug supplies for individual patients
- Approaches will need to be realistic and pragmatic; ACPs always help
- Syringe drivers are an issue: being discussed at Primary Care Tactical Group.

The RCGP offers an excellent resource on palliative care for covid patients.

Drummond ended by thanking all those for attending, and those who contributed to the evening. He acknowledged the outstanding response of the Lothian GP community working tremendously hard and fast to contribute to care during the pandemic.
He advocated two P&Cs, that we be Proportionate and Pragmatic; and offer Comfort and Confidence to the teams we lead and the patients we serve.