So, how is COVID progressing?

The evidence tentatively suggests we are flattening the curve and looking at a lower peak with a longer tail. This is down to the rapid flexibility of Health Services to alter models of provision, and the compliance of the general public in maintaining the social distancing guidance. If this is maintained, it appears the overall impact of COVID 19 will not be as severe as anticipated. However, we have another 3 weeks of lockdown to anticipate, and beyond that we need to gradually restore services to a norm.

Everyone in Primary Care should be proud of the agile response when needed, to protect patients and ensure safe delivery of care on an ongoing basis. We are already at the point of considering next steps and what will be needed to return to “normal” provision – some of this process will involve considering if practices want to retain different ways of working and the ability to flex the offer to patients on a more permanent basis, should it suit them.

This is the latest update and covers issues and challenges ? alongside some concerns that have not yet been resolved:-

**Testing**:-

Every CCG now has a system in place to test in primary care, currently apart from HRW/South Tees locality (who will also test symptomatic key workers), this is restricted to family members who are symptomatic, leading to key staff having isolate with the family. This is via:-

[Nyccg.covid@nhs.net](mailto:Nyccg.covid@nhs.net) for NYCCG

[VOYCCG.patientrelations@nhs.net](mailto:VOYCCG.patientrelations@nhs.net) for VOYCCG

(Kate – can we check with Danielle and Steve re the Bradford contact, thanks)

Testing will be carried out at various sites across the Region – there is also a drive through site at Temple Green in Leeds, and separate provision is made for children, which may also involve a trip to Leeds. The intention is to free the key worker to return to work. It is possible in 6-8 weeks that a more widespread antibody testing will become available which will help with understanding how far COVID has spread in the community, currently PCR is all that is available.

**PPE**:-

There remain issues with access and supply of PPE, there is a new NHSE [supply page](https://www.england.nhs.uk/coronavirus/primary-care/infection-control/ppe/?utm_source=The%20British%20Medical%20Association&utm_medium=email&utm_campaign=11479157_GP%20ENEWSLETTER%20160420%20-%20COVID19%20-%20ENGLAND&dm_i=JVX,6U1DH,36HV4G,RDY7K,1), it remains an area of high priority for the BMA, GPC and LMC, a guide for PPE in various environments has been agreed in NYY area (flow chart to be disseminated by CCG) – it concurs with our previous guidance, currently unless there is an aerosol generating procedure as [defined by PHE](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe) the guidance suggests there is no need for a gown in primary care (this also fits with A/E procedures).

**Shielding**:-

The process has been frankly diabolical, following discussion with GPC this week, it is hoped most practices will have completed the majority of this work (though it is recognised this is an ongoing process). The latest [guidance](https://www.england.nhs.uk/coronavirus/publication/guidance-and-updates-for-gps-at-risk-patients/) should be followed, dated 9/4 and issued on the 10th.

[The NHSEI letter on Caring for people at highest risk of COVID-19](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/2020-03-21-COVID-19-at-risk-Trust-letter_FINAL.pdf) also advises that, with regards to shielding, it is open to the practice to determine how to treat this group of patients.  The letter states that practices should “immediately review any ongoing care arrangements that you have with these highest risk patients. *Wherever possible, patient contact, triage and treatment should be delivered via phone, email or online.* However, if you decide that the patient needs to be seen in person, please arrange for your practice to contact them to organise a visit to the surgery, a hub or their home as appropriate.“

The Government has also published an [update on their shielding policy and implications for general practice](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0178-letter-to-gps-on-clinically-highest-risk-patients-3-april-2020.pdf). The letter provides further information regarding the management and shielding of patients who are at the highest risk of severe morbidity and mortality from COVID-19.

The BMA/GPC have also developed the most recent [advice](https://www.bma.org.uk/news-and-opinion/identifying-patients-at-highest-risk-from-covid-19-advice-for-gps?utm_source=The%20British%20Medical%20Association&utm_medium=email&utm_campaign=11479157_GP%20ENEWSLETTER%20160420%20-%20COVID19%20-%20ENGLAND&dm_i=JVX,6U1DH,36HV4G,RDY7D,1) based on the current situation.

If you have any questions, please contact the NHS Digital Shielded Patients List Hub: [splquery@nhs.net](mailto:splquery@nhs.net). This mailbox will be monitored and responses provided asap.

**Advance Care Planning**:-

This sensitive subject remains pertinent during COVID 19, and practices should consider how they will progress this work.

The BMA has issued a [joint statement](https://www.rcgp.org.uk/about-us/news/2020/april/joint-statement-on-advance-care-planning.aspx) with the RCGP, CQC and the Care Provider Association, about the importance of continuing with advance care planning during the COVID-19 emergency.

When developing advanced care plans with patients, practices should adhere to some key principles:

* Careful consideration needs to be given to which patients may specifically benefit from having these discussions at this time, based on relevant clinical factors.
* All discussions must be tailored to the individual circumstances of the patient.
* It is unacceptable for blanket decisions about advance care plans, and decisions about do not attempt cardiopulmonary resuscitation (DNACPR), to be applied to particular groups of people.
* Care needs to be taken when considering how patients are first contacted with a view to initiating these discussions.
* Discussions need to be managed sensitively and compassionately, ensuring that patients understand why they have been contacted and what they are being invited to do.
* When discussing the possible treatment options in the event of them becoming ill with COVID-19, it is important that patients are not given the impression that decisions about access to intensive treatment will be made on the basis of their age or disability. It should be made clear that every patient will be considered individually based on clinically relevant factors, such as their physical ability to benefit from the complex and demanding treatment provided in intensive care.
* Whilst patients should be encouraged to think about their wishes for future care and treatment, they must not be put under pressure to do so, or to reach a particular decision.  
    
  NHSEI has also published a letter from Professor Stephen Powis and Ruth May about [Maintaining standards and quality of care in pressurised circumstances](https://www.england.nhs.uk/coronavirus/publication/maintaining-standards-pressurised-circumstances/).

We have attached a word version of the NHS template. (ATTACHMENT 04)

**NHS111 CCAS Appointments**:-

The GPC has agreed to an increase in allocated worklist slots for patients from the 111 CCAS service of 1/500 patients, these are NOT fixed time appointments and patients will be informed they will receive a call back from the practice with no promise of acuity/timing. Practices should view this as a triage list and manage the patients as they see fit. It has been agreed some practices may need to increase provision to accommodate this and need additional resource to provide this service.

NHS111 CCAS are also looking for volunteers to assist with remote triage calls, GPC has serious concerns re low pay rates, but interested parties can sign up [here](https://covid19-cas.nhs.uk/gp-practice-crs).

**DVLA** have persisted with confused guidance stating they have made no medical requests since 24.3.20 but also stating that renewals still require a medical, we await a further statement.

**The BMA** has updated it’s [GP Preparedness Guide](https://i.emlfiles4.com/cmpdoc/3/7/7/5/2/files/661402_general-practice-preparedness-guide-v1-03.04.20.pdf?utm_source=The%20British%20Medical%20Association&utm_medium=email&utm_campaign=11451481_GP%20ENEWSLETTER%20020420%20-%20COVID19%20-%20ENGLAND&dm_t=0,0,0,0,0), which is a useful tool to sense check where the Practice stands at present. Compare and contrast with the [NHSE preparedness letter](https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-general-practice/) – both have valuable information about changes needed to face the current service requirements, the NHSE letter also has links to the recently released PCN DES requirements for the first 6 months of the year.

**Section 61** in the Regulations refers to dispensing practices, this allows Commissioners to authorise dispensing practices to dispense medication to non-dispensing patients IF LOCAL PHARMACIES ARE NOT AVAILABLE eg BH mornings or late evenings in rural areas. The numbers are expected to be small and we are gaining agreement from LPC and CCG colleagues that this is pragmatic in the current crisis.

**Verification of Death**:-

There has been a lot of interest nationally with regards to this, on discussion with our local Coroners, no changes have been anticipated and it is considered “business as usual” we are aware of guidance issued to Southern Coroners but it has not been adopted locally, there are 2 recent pieces of guidance we would advise (ATTACHMENT 02) – from the BMA, a strong response and clear guidance, and London Clinical Advisory Group guidance (ATTACHMENT 01) with reference to remote Verification – there is further guidance due VERY soon in an agreed format between BMA/RCGP and CQC, which may well supersede all of the above.

**Finance issues**:-

GPC has continued to negotiate with regard to PCN tax and VAT issues, HMT has declined a temporary solution and a more definitive permanent solution is awaiting a reply from Ian Dodge, National Director of Strategy, NHSI

IR35 changes have been deferred for a year, this will impact on several self-employed sessional GPs.

**EDUCATION AND TRAINING**:-

There are a variety of helpful links to COVID related topics and updates, there is evidence of late presentation of paediatric emergencies emerging – please be aware of other potential causes of paediatric disease, and the sudden increase in non-COVID related death has yet to be fully explained and many colleagues will be aware of the risk of missing other acute presentations.

Training for North East and Yorkshire region – summary table (ATTACHMENT 03)

**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 SystmOne 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 [www.ardens.live/covid19.](http://www.ardens.live/covid19)

**NICE** have developed a suite of [CVOID related guidance](https://www.nice.org.uk/guidance/published?type=cov,coa) with a wide variety of disease specific assessments and also a clear steer on the use of NDAIDs in COVID related disease.

**Locums**:-

As an LMC we Represent all GPs in our area – many sessional colleagues have seen their work diminish as practices try to restrict footfall and cope internally, especially with many holidays being cancelled. NHSE and the LMC are aware for Primary care once COVID is released there is likely to be a further spike in demand of delayed diagnoses, admin and rebooting of the whole system, this will place an additional demand on practices and we would encourage the judicious use of sessional GPs to ensure clinicians in the practice maintain their wellbeing and rest where possible. We are also discussing with the CCGs how they encourage and facilitate best use of the available workforce.

Our wellbeing resources are available to sessional GPs, an integral part of the workforce. Sessional GPs may need a practice to “sponsor” COVID 19 testing and we would ask that practices do so with those they use regularly to try and facilitate early returns to work and maintain the workforce.

**Wellbeing**:-

YORLMC has reviewed and rejuvenated it’s [Wellbeing pages](https://www.yorlmcltd.co.uk/wellbeing) – there is a more comprehensive offering that is easier to navigate, please take the time to review and consider the support that is available.

YORLMC continue to offer a mentoring service to GPs that are struggling. We are also aware of the massive strain on the rest of the Practice Team. Take care of your colleagues, be aware of pressures and those needing support. We have heard of sickness and even resignations amongst staff due to the stress and pressure amongst support staff. The [wobble line](https://www.basics.org.uk/) is an offer from basics for anyone involved in pre-hospital care for support with anxieties and fear, we are also looking to develop other avenues in the near future.

Expected this week –

Guidance on restarting referrals and how Trusts should deal with these.

Guidance on May Bank Holidays, 2 weeks notice expected, likely to be “core” hours 8th May, and if numbers go as expected back to normal for late May.

Guidance on Verifying life extinct (joint).

Possible online delivery portal for PPE.

Further news on the shielding saga and self-identifying patients

More Laptops for primary care (Nationally 9500 delivered – 13000 on order)

Definitive notes on funding of COVID and locum contract via CCGs.