Joined Up Care
Derbyshire

Letter to GP Practices regarding COVID-19 and patients with long-term conditions

Update 7: 25 May 2020

This letter pack is for GPs across Derby and Derbyshire in regards to managing their patients with long-term conditions and COVID-19. We are aware that the rapid developments in the recent days have led to a significant change in routine practice in addition to managing and treating patients face-to-face.

This pack covers guidance around updates to:

- General
- Respiratory
- Diabetes
- Cardiovascular Disease

General

Prioritisation for long term condition reviews in Derbyshire (including asthma, COPD, diabetes, CVD and mental health)

The following is a pragmatic guide to prioritisation of workload in primary care where there is a backlog of reviews which could not be done during the Covid pandemic.

We would advise that it is better for us to proactively invite the higher risk patients rather than waiting for the more engaged and generally lower risk to contact us. In some practices, it will not be possible to review every patient with a long-term condition (LTC) by the end of March 21, and we need to make difficult choices based on the principle of distributive justice.

NHS England advise making sure LTC reviews are being done, with as much care delivered virtually and as little face to face contact as possible. This guidance will need to be adapted as further advice from NHS England is received in line with the changing nature of the pandemic.

Patients with serious mental illness (SMI) and a LTC have 10 x higher risk of unplanned admission via ED, and 2-3x mortality rate compared with those patients with purely a LTC, hence this group of patients being in the high priority “red” group.

Tarun Narula has run searches on this draft proposal in his large urban practice in Chesterfield to give an idea of numbers, and % of list size.

List size 20000.

Diabetes (types 1 and 2)- 1364 (6.8% of list size)

Hypertension- 3310 (16.5%)

High priority “red” patients- those who need review now as a priority, even during the pandemic

- Type 2 DM with Hba1c above 75mmol/mol or 9% =169 (0.8%)

- Type 1 DM with Hba1c above 75mmol/mol or 9% (if your practice usually sees these patients)
- Type 2 diabetes on insulin or sulphonylurea with HbA1c<48 (high risk of hypos)
- Hypertension with Qrisk above 20 %- =719 (3.5%)
- Heart failure patients = 1% of list size
- Asthma: High dose inhaled steroids; MART +LTRA + Theophylline; > 2 exacerbations in last 12 months; suspected or confirmed Covid 19 with or without any exacerbations, any ITU admission in the past
- COPD – MRC dyspnoea scale 4/5; on Triple therapy; >2 exacerbation in last 12 months requiring steroids and/or antibiotics ; COPD hospital admission in last 12 months ; FEV1 (predicted) < 50% ; suspected or confirmed COVID19 with or without exacerbations
- Adult patients on serious mental illness (SMI) or learning disability (LD)/autism registers with comorbidities (CVD/diabetes/asthma/ COPD/poorly controlled hypertension)

Medium priority "amber" patients - medium priority patients who definitely need a review by 31/3/21.

- All people with type 1 diabetes.
- All people with type 2 DM not picked up by the "red" or "green" searches.
- Hypertension with CKD 3-5 = 784 (3.9%)
- Hypertension with CHD/TIA/CVA/PVD/HF (all of whom need BP reviews) = 744 (3.7%)
- Asthma: Low or moderate maintenance dose inhaled steroids; 1-2 exacerbations in last 12 months requiring antibiotics and/or steroids
- COPD: MRC dyspnoea scale 3; FEV1 predicted 50-79%, 1-2 exacerbations in last 12 months requiring steroids and/or antibiotics
- Adult patients on the SMI or LD/autism registers with Qrisk>20.

Low priority "green" patients - lower priority, only see before 31/3/21 if staffing permits.

Medication could be reviewed and renewed by GP/nurse and text sent to let them know, offering to see them if any new problem or concerns.

- People with type 2 diabetes who in the last 15 months were meeting all 3 treatment targets (3TT) ie BP<140/80, total cholesterol<5, HbA1c <58, had code for low risk feet, GFR>45 and were not on a medication causing hypos eg insulin or sulphonylureas (central search would be done)
- People with pure hypertension and no CKD/CHD/TIA/CVA/PVD/HF
- COPD: MRC dyspnoea scale 1/2; FEV1 >/= 80% and no exacerbations in the last 12 months
- Asthma: on SABA inhalers only, No exacerbations in the last 12 months
- Adult patients on the SMI or LD/autism registers with no documented increased Q risk.

Consideration was given to choosing a BP cut-off, but there is no set level for monitoring other than stage 1 and 2 on diagnosis, the last BP may have been a clinic reading or HBMP/ABPM which have different targets, and the searches would be complicated to set up.

Practicalities:

Different GP practices are working within the guiding principles above and using them within their own model of care**,** and three examples are given below**:**

1. TN practice covering 20000 patients: the plan is to do annual reviews of high risk "red" pts who are due for review this month.

   This will involve seeing 14 people with diabetes and 60 with hypertension with Qrisk above 20% (some of whom will have diabetes)- approx. 74 pts every month.

   They plan each month for the nurse to contact each patient to agree the best place to do checks, according to whether they are shielding or not.

   - For BP to provide patient with HBPM sheet with instruction to check BP at home, or how to buy if able to do so. For pts unable to buy one then practice to loan them where possible. NHS volunteers may be able to support delivery and collection for shielded patients.

   - For bloods- come to car park or designated room in the surgery or home visit as per practice policy.

   - urine ACR drop at surgery where indicated.

   - weight over phone if they have scales.

   - diabetes foot checks currently only advised if any concern (community podiatry also available if new concern)

2. KO practice covering 15000 patients: plan is to review each month's patients who are due reviews and see "red" patients plus amber patients with diabetes where the HbA1c has been rising or dropping significantly. "Green" patients and amber patients who are meeting their personalised targets (which may well be higher than the national 3TT) are sent a text to inform that their medications have been reviewed and which month they are renewed until. From next week, HCA doing the blood test will also be checking BP if no home readings, and checking weight and feet, but all discussion is taking place over the phone.

3. Other practices have decided to undertake a search for "red" patients and prioritise them now, even if they would not be usually be reviewed this month.

Potential future plans

- Discuss with the PCN clinical directors and act on their feedback.
- Liaise with diabetes and CVD specialist teams for their feedback.
- Request medicines management support for setting up searches.
- Consider if we would like a “one stop shop” for all diabetes face to face checks in each PCN. Each person with diabetes could potentially have their annual retinopathy screening, bloods, ACR, foot check, weight and BP done in the same place at the same time. All other reviews would be done virtually. KO has liaised with retinopathy screening manager who is looking to see if there are free rooms for potential co-location if practices could provide HCA cover to see their own or their shared PCN patients- very early stage discussion.
- Consider ‘LTC hub’ in each PCN which could initially support practices for LTC reviews during the pandemic and eventually evolve into a community centre for managing complex or poorly controlled LTC management for uncontrolled HTN, HF, poorly controlled diabetes/insulin initiation. These could also serve as diagnostic centres for ECG (performing and interpreting), ECHO, spirometry, FeNO testing.
- Virtual app LTC support for patients to self-manage at home- CCG exploring options.
- Home BP meters for shielded patients- need to explore options.

Respiratory

ImpACT+ Respiratory Service: Vitual MDTs re-instated (Southern Derbyshire and Erewash area):

From June 2020 vMDT meetings for GP Practices will be re-instated via Microsoft teams from June. If you want to attend these please let us know via email (dhft.impact-plus@nhs.net) so we can send you the meeting invitation and link.

You can forward the invitation and link to any other members of your team who may want to attend, or attend different meetings if you cannot make the one specific to your area – just let us know and we will send you the appropriate invitation.

Here’s how to join and refer instructions.

How to refer patients for discussion: When booking a patient for discussion at a virtual MDT clinic, please complete the virtual MDT referral form (available on the website or email us), complete section 1-3 and request a share for patient’s records. Please do this at least one week before the clinic. In the new spirit of COVID we have made the referral form shorter!

Access the MDT referral form here.

Send completed forms to **dhft.impact-plus@nhs.net**

Home Oxygen Update: 19.05.2020

FOR INFORMATION - Update from air Liquide regarding Virtual Risk Assessments (Field Risk Assessments) for all HOSAR clinicians and Part B Prescribers

Please click on this link to view an update from Air Liquide (agreed by Regional Leads), in relation to the ongoing suspension of Field Risk Assessments (FRA). Due to COVID19 there is a growing concern that patients may not be receiving the support required in relation to their oxygen usage and reinforcement of safety messages. Air Liquide Healthcare has started to complete partial risk assessments over the telephone. These are designed to take the patient through a risk assessment allowing us to reinforce messages, check understanding and also check the well-being of the patient.

See further contacts below for Air Liquide regarding equipment queries, prescriptions, orders or patient queries:

GPs/Healthcare professionals: 0808 202 2229 (where they can contact Air Liquide to provide alternative contact details for patients, and also discuss equipment and prescription queries)

Patient Helpline: 0808 143 9999

Out of Hours (For new patients requiring oxygen): The referrer should complete a Part A HOOF (referral) on www.airliquidehomehealth.co.uk/hcp/

Respiratory Support for GPs Available:

Chesterfield Royal Hospital (North Derbyshire GPs): North Derbyshire GPs can access the CRH respiratory line for general respiratory advice and guidance by calling their unique Consultant Connect Dial-In Number shown on their practice poster or use the free Consultant Connect App to call (the app can be downloaded from either the App Store or Google Play). The app is the quickest and easiest way to speak to a consultant. Also embedded below is the GP start up guide. If GPs have any queries regarding using Consultant Connect, contact Grace Housden at Consultant Connect on the following email:
grace.housden@consultantconnect.org.uk
Consultant connect GP start-up guide

Impact+ (Community Respiratory Service (South Derbyshire GPs): GPs in South Derbyshire and Erewash areas can also contact the Lung Line at Impact+ for general advice and support with respiratory patients – Tel 01332 788225 (select Option 1 or Option 4 if Option 1 is busy).

For any queries regarding the above please contact
ddccg.conditionsspecific@nhs.net

Diabetes

Derbyshire guide to blood ketone testing

Our agreed meters for people with type 1 diabetes for blood ketone and glucose testing are:

- Glucomen Areo on 0800 243667
- Caresens Dual on 0800 881 5423.

Both companies are happy for clinicians or patients to contact them and they will send the meter and leaflets on how to use a ketone meter directly to the patient. Both meters test blood glucose and ketones and strips for both would need to be added to repeat. The companies make a loss if they issue meters purely for ketone tests. Patients can continue to use their current lancet device with any meter.

We would suggest every practice has a working ketone meter with blood ketone strips available for use in the following circumstances:

Uses of these meters:

1. To give to every person with type 1 diabetes so they can test blood ketones when unwell. Please issue a copy of the Trend sick day rules from http://trend-uk.org/wp-content/uploads/2018/03/A5_T1Illness_TREND_FINAL.pdf or search “Trend sick day rules type 1 diabetes”.
2. Unwell person with type 1 diabetes seen in the GP practice.
3. New patient with diabetes who has osmotic symptoms (thirst, urinary frequency etc) as raised ketones would indicate type 1 diabetes and need for admission.
4. Person with type 2 diabetes on an SGLT2i eg empagliflozin needs a blood ketone check if they present unwell in any way to exclude DKA even if their blood glucose is normal.
5. Person coded as having type 2 who has a rising blood glucose or surprisingly quickly rising HbA1c, especially if in the first year after diagnosis or losing weight or relatively low BMI or a strong family history of diabetes. They could have a more “slow burn” type 1 or an unusual type of diabetes. Raised ketones would alert you to the need for urgent advice.

How to use the meter:

The meters are used in exactly the same way as testing a finger prick blood glucose with a drop of blood. The only difference is a blood ketone strip needs to be inserted into the machine.

Interpretation of blood ketone results

- Less than 0.6 mmol/L is normal
- 0.6 to 1.5 mmol/L – person is at risk of developing DKA so test again after 2 hours if at home or arrange review with safety netting in primary care. Ensure a person with type 1 diabetes has access to and understands sick day rules.

- 1.6 to 2.9 mmol/L- person is at at risk of DKA and should contact their diabetes team as soon as possible, or health care professional can seek advice on their behalf. They will need to follow the sick day rules.
- 3 mmol/L or higher- person is at high risk of DKA:
  - If Ketones > 3.0, but well, and able to eat and drink, follow sick day rules - contact the advice line immediately, aim to manage at home
  - If ketones > 3.0 and ill, especially abdominal pain / vomiting- needs urgent 999 admission
  - If ketones > 3.0 and if in doubt /unsure of sick day rules / can't access advice- needs admission

Urgent advice if ketones raised:

North Derbyshire:

Urgent advice on 07880 147785 8am-5pm during the Covid 19 outbreak.

You can also phone 01246 277271 and ask switchboard to bleep the diabetes nurses on 781 or 013. For less urgent queries please phone the diabetes centre on 01246 512113.

South Derbyshire and Erewash:

Urgent advice line 01332 787671 from 8am-6pm.

A COVID-19 response action – Diabetes management in care homes

NHS Diabetes Prevention Programme (NHS DPP) and Blood Tests Update:

Due to the impact of COVID-19, many individuals who have previously been categorised with Non-Diabetic Hyperglycaemia following a blood test and are therefore eligible for the NHS Diabetes Prevention Programme, may not have access to a repeat blood test maintaining their eligibility (i.e. their last recorded blood test may now be 12 months + ago); for example because they are shielding, or because primary care are currently focusing on COVID-19 response.

In addition, many individuals with an eligible blood-reading have had their referral into the programme delayed due to COVID-19, and now have a blood test result more than 12 months old. This makes them technically ineligible for the service.

To ensure that individuals in these circumstances are not disadvantaged due to the impact of COVID-19, the requirement for a confirmatory blood test indicating NDH to be within 12 months will be temporarily increased to 24 months. This change will apply until 1st April 2021, at which point we plan to revert to 12 month eligibility.

For any queries regarding the above please contact
ddccg.conditionsspecific@nhs.net

New Diabetes & COVID-19 Data (NHS England & Improvement):

NHSE/I has released new data in relation to diabetes and COVID-19. This new data has been shared with CMO and Government have confirmed that NERVTAG will review the evidence for shielding, including what evidence is emerging about who is at highest clinical risk of severe illness if they catch COVID-19. This will inform the future of the shielding programme.

Please click on this link to read further information

People with diabetes, their carers and those that treat them may be concerned, however we would like to reassure them and you that the risk for people aged under 40 with diabetes is still low. The NHS has put extra measures in place so that people living with diabetes can continue to receive care and is currently commissioning services to help people with diabetes of all ages self-manage their condition with online support.

There is an extended diabetes helpline for anyone with insulin-dependent diabetes to help with any concerns during this difficult time. The helpline is available via **Diabetes UK's Support Helpline** on **0345 123 2399.**

NHSE are currently working up some materials to help local teams promote these new services including template letters to people with diabetes, promotional tweets and newsletter/bulletin copy which will be circulated soon.

NHS Diabetes Advice helpline

NHS England and NHS Improvement have launched a new helpline in response to disruption to normal diabetes services due to the COVID-19 pandemic and response.

The service is for adults living with diabetes who use insulin to manage their condition and require immediate clinical advice.

Whether you or a member of your household have caught the virus, or routine care has been disrupted, the helpline is available for immediate clinical advice to help you understand how to effectively manage their diabetes.

You can access NHS Diabetes Advice via Diabetes UK's support line on 0345 123 2399 Monday-Friday from 9am-6pm in addition to this FAQ guide.

Cardiovascular Disease

Heart Failure

The Heart Failure team are still converting face to face clinics and home visits to telephone support unless patients are decompensating and then a home visit is made.

The Ambulatory Heart Failure unit at Royal Derby Hospital remains open for high risk patients only.

In South Derbyshire the Heart Failure team are still reviewing Heart Failure patients in Royal Derby Hospital in order to divert / avoid admissions.

The team are looking at how they move forward in the coming months.

CVD

Patients urged to “act quickly” and call 999 if they’re experiencing heart problems.

A UHDB Consultant Cardiologist has urged patients to “act quickly” and not hesitate to call 999 if they think they’re experiencing problems with their heart. Follow this link for more details:

https://www.uhdb.nhs.uk/latest-news/patients-urged-to-act-quickly-and-call-999-if-theyre-experiencing-heart-problems-8817

Stroke

GIRFT (Getting it right first time) have worked in collaboration with the Oxford Academic Health Science Network to produce a guide which outlines how stroke services can adapt during and after COVID-19. See link below, and includes guidance reports on:

- Implementing telemedicine to support specialist decision making in stroke care during the COVID-19 pandemic
- Delivering safe stroke care at hospitals without acute stroke units during the COVID-19 pandemic: guidance for clinical networks and acute trusts in England
- Developing virtual clinics for managing TIA and minor stroke during the COVID-19 pandemic

https://gettingitrightfirsttime.co.uk/guide-outlines-how-stroke-services-can-adapt-during-and-after-covid-19/

Enhance Stroke Services at UHDBFT

Enhanced Stroke Services are starting this week across UHDB. From Wednesday 20 May 2020 at 8am, UHDB is enhancing its Stroke Services at both Queen’s

Hospital Burton and Royal Derby Hospital. This will see patients benefit from improved access to specialist consultant delivered care.

The Trust is expanding the Hyper Acute Stroke Unit (HASU) at Royal Derby Hospital to be able to treat patients from East Staffordshire in the first critical 72 hours after a patient has suffered stroke. More details on this new article can be found here: https://www.uhdb.nhs.uk/latest-news/enhanced-stroke-services-are-starting-this-week-across-uhdb-8807