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TRANSCRIPT

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Steven:

Good afternoon. You are joining me live in the APM studio for another of our daily CPD sessions and I'm joined remotely by Jonathan Hearsey who is the director of Camden MSK. Jonathan, welcome. Camden MSK, that's your business isn't it? An osteopathic business. You been an osteopath since 1994, but you're in partnership with university college London hospital. Is that right?

Jonathan:

No, it's not actually. So Camden, MSK is a clinical partnership, so it's a community musculoskeletal service set up in partnership between five different organizations. University college London hospital, The Royal Free, CNWL which Central Northwest London foundation trust also Connect Health, who provide our physiotherapy and In Health who provide our imaging.

So I'm an employee of University College London hospital, so it's, it's nothing to do with me as an osteopath. I've got the role through my background working for the NHS since 1996, so I've gone from initially running my own business, running a contractual arrangement with the fund holding practice and then with a primary care group and then a primary care trust and then gradually helped develop my interest outside of osteopathy please is developing integration between MSK services.

So now as clinical director of quite a big MSK community service in Camden, .We're able to do that integration.

So in principle, if you were Camden patient and you have a GP in Camden and you have any musculoskeletal need, be that hip replacement or back pain or TMJ pain, you know, anything like that. You go through and you get referred to Camden MSK and we triage and facilitate that referral into surgery to physical therapy, to chronic pain management. And then we facilitate and integrate those services. Everything that's MSK in Camden comes through us.

Steven:

Is that something that's replicated elsewhere in the country? Because that's the first I've heard of that sort of system.

Jonathan:

Yeah. So there's this national initiative which started back in 2006 with the MSK framework in NHS England. I've only been Camden MSK 2 years. My background, I helped devise one of the biggest in the land, which is Sussex MSK Partnership. And they're considerably bigger, we serve 250,000 patients in Camden. Sussex has 650,000. There are lots of differences like this, that work in that way. And, and these, these communities services seem to bridge the gap between primary care, GP, secondary care or acute care, which would be the hospitals.

Steven:

It's a quick jump with you, wasn't it, you qualified as an osteopath in 94 ,in 96 you were already working within the NHS?

Jonathan:

Yes. Yeah. I when I, when I left and graduated and started working as a, as an associate initially there was a, there was talk of NHS services employing osteopaths. And I remember going to what is now an IO conference, but it was the OAGB conference I think at the time. And some of the old seniors of the profession standing up thinking it was abhorrent that junior osteopaths might be the enticed into the NHS because it would completely belittle profession and that that really wet my appetite. And I thought stuff that, I'm not be told how I'm going to work. And of course NHS working is, I've done lots of different things within the NHS, within the service. It has been phenomenal. So I'm in a management role now, but for 10 years I was in the extended scope practitioner, what we'd now call a spinal advanced practitioner, right?

I've worked with consultants. I've worked with surgeons and, and in the services, all the diagnostics, processing the diagnostics and really treating, managing MSK services within the community, which is, which saves money and saves time and improves patient flow. And these are the things that we're trying to achieve.

Steven:

Yeah. So, I mean, you were doing this before perhaps, but it sounds very comparable to what James Booth is doing up in Nottingham.

Jonathan:

Yes. But I don't think initially he was at Queens medical centre, I think he was working actually as an acute in the service.

Steven:

I suppose what people are really interested in at the moment though is, I mean, you were heavily involved in MSK stuff and this, to set the stage not a discussion about whether people should or shouldn't open their own practices, but I think we're all very interested to know how the NHS is handling MSK cases when, you know, we have such severe constraints over coronavirus.

Jonathan:

Yeah. So, I mean, about four weeks ago, four, maybe five weeks ago, we realized that things were going to develop and of course we're party to perhaps more information than most people would be. And we started doing our business continuity plans. And, and I mean I can speak for our service and UCLH say from, from quite a big trust point of view.

So bizarrely, we were initially for this next couple of years looking at innovative ways of transforming our service of keeping people out of physiotherapy and, out of consultations and basically having big high value estates within London. And so part of our business plan as have most of the trust on this is to look towards innovative ways of keeping service going. In principle we've stopped everything. So all the elective referrals for orthopaedics and rheumatology, has stopped. if you still have a fracture, then there's virtual fracture clinics you can go to with guys from orthopaedics, if you've got an early onset arthritis, then the rheumatology teams would see you. I think they would probably try and see you virtually first of all, as opposed to our service. So all of our clinical assessment and triage appointments have been now remotes. So they already via phone or via video conferencing for our physiotherapists. And that is pretty much across the board. So we're trying to keep people in London out of public transport as well.

Steven:

So even in, in your group of practices down there cases which are urgent or essential is still being done by remote link rather than being brought into physio osteo chiropractic clinics.

Jonathan:

Exactly. So, so we, we benefit from the referral process. We get a minimum data set of information that is necessary. So, so that's an agreed minimum data set. So the information, we get outlines the patient's medical records and outlines the presenting condition, and then we can pick through the patient's medical records remotely as well to, to work out what they need. So, so at the point of triage, we've got an understanding of really what that patient might need for the routine cases for the normal functional low back pain the diagnostics aren't necessary . we'll manage them remotely by giving them exercise, by having physiotherapy on the phone. We've obviously stopped all our classes and group clinics, all our patient management clinics have stopped as well. So generally it's we work remotely. Obviously we can highlight patients or flag patients that might need diagnostic imaging or bloods. And we can do that remotely as well. So we're running a, the truly skeleton serviceand diagnostics, but if a patient comes with presents and needs a diagnostic imaging MRI scan or a CT, we kind of refer them for that remotely. And we will set up and then they will have to travel obviously to have the imaging.

Steven:

You talked earlier on about a virtual fracture clinic. I'll have in my mind an image of somebody who's sent a packet of plaster of Paris and the a video link on how to apply it. What happens in those, I mean, are you talking about fractures that need no further treatment or

Jonathan:

Yes. Virtual fracture clinic is being trialed in most areas. Fracture clinics and dermatology actually can be done remotely. Obviously you need an X Ray, so the patient presents to the ED has an X Ray and then gets discharged. Usually with an air boot now or whatever it might be, but if they do need it, they still use plaster. But that would then be sent away. But then the, the sort of post fracture care will be done remotely. So the consult, if it needs to go to consultant or to advanced practitioner/physiotherapist, they will look at that, that image, we can get the imaging remotely. Well most of the time we can get it remotely and then we can discuss that with the patient and oversee exercises that way rather than in a similar way to how perhaps osteopaths and chiropractors and private physios should be working now or could be working now. And that's something that I knew we're all feeling. I only went three days a week.

For Camden MSK I'm mindful of the fact that you know, it's Friday and I should be seeing lots of patients and I'm not so, so I feel that as well. Both financially and this…

Steven:

What are you doing with your patients, your own private patients? Are you contacting them to check they're okay or taking other health measures

Jonathan:

Because of how I've always worked since graduation. I've either taught or worked for the regulator or worked for the NHS. I've, I've got a very acute practice anyway, so I don't tend to have patients I've seen routinely. I don't have patients with arthritides that need regular treatments for example. So, so most it tends to be patients phoning up and seeing me and then I'm triaging them as I would or as we would in Camden. We're asking whether they have issues with their activities associated with daily living. If they do and, and pain is causing a problem, I will see them. We would be carrying out all the usual public health England checks beforehand, made sure they've not been traveling, no cough, no temperature. We're giving them anti-bac back as they come in. We're wearing gloves, they're not allowed to use facilities and things like that. So, but it's very scaled down. We've gone down by about 90, 95% of our patient numbers.

Steven:

So again, this isn't about how anyone else should run their clinic and we want to make absolutely clear. What measures are you taking in your own clinic. Then you mentioned anti bac, which I presume you mean 60% alcohol rather than of anti-bacterial, but other than that, what are you doing to protect them from contaminating each other by your treatment tables or

Jonathan:

Again, we use anti bac wipes too, so we'd wipe down between each patients. I make sure that I'm clean. We've a kind of seal, so people can't… So I actually see private patients from home, and one day a week in another surgery. And the surgery would take temperatures. They're triaged at the door. We have a nurse taking temperatures.

Steven:

Yeah. It's funny how hard it is to get hold of the moments as at the moment.

Jonathan:

Thankfully, primary care have plenty of those. But, but in terms of here, you know, we're not booking patients in together so it's a very small concern. So we will space those patients out a good 15, 20 minutes between them. But the numbers are, you know, I think, I think I might see two this week.

Steven:

Have you, I mean, about a week ago I saw some research which said that the coronavirus hangs around in the air for an hour before it ceases to be a transmissible concern. Is that sort of understanding that you have

Jonathan:

That's the first I've heard of that actually. So again, I'm not a virologist, so I'm not entirely sure that would be the case. But again, over my field

Steven:

And I haven't had aquestion about this, but I can predict that somebody will ask it. There are lots of people who feel that we shouldn't treat patients without full PPE. You know, I'm guessing you're going to tell us that that's only if they've actually got COVID 19.

Jonathan:

But that's the process within the NHS. Obviously there is, there is massive debates about what full PPE is. You know, because there's, there's PPE for primary care, which was changed yesterday. So that's a bit upscaled a little bit, but then there's PPE for example, in NHS Nightingale where they're, they're full blown, you know, protected from, from droplet infection. So, so my understanding is that is well, I mean with regards to practice, you know, I think we have a duty of care to our patients. If we're triaging our patients, if we can't do it remotely, and this will upset lots of people, but if they need evidence-light manual therapy and an ability to have exercise prescribed for them so they can continue and care for themselves and care for others and the look after themselves, or go back to work, if they can't do that, I think we do have the duty to do that.

But I think it's a very, very difficult situation. If it was like the classic Mrs Miggins with bilateral arthritic hip, coming in every Monday for a bit of articulation, you know, I'd be putting her off.

We're e quite strict about seeing those patients, but equally, I don't mind saying this, but that there is a commercial need. You know, I fear for my own business, you know, I'm not entirely sure that that is going to come out of this very well. And for those people that run, limited companies aren't getting the, furloughing staff or you know, just taking dividends as salary. You know, it does seem a bit difficult. And so, so it is very hard. This is not a very nice landscape.

Steven:

I was talking to someone yesterday about the plight that some practitioners find themselves in in particular one lady who had had several months of maternity leave, who had no real income to show and therefore who's going to get nothing, wasn't entitled to much in the way of universal credits or whatever else. And you know, and the picture was looking very, very bleak indeed. And while we can, those of us who have got a little bit of security in our businesses can say, well phew, we'll probably pull through this, there are some who are, who are worried sick.

A couple of questions that have come in. It's about PPE and it's, it's curiosity questions really. You mentioned full PPE in one practice and you also mentioned the revised guidelines for primary care. Let's start with the latter. What's are the revised guidelines for primary care?

Jonathan:

So again, I'm not a PPE specialists, and have not going through that this morning. So, I'm probably not the best person to ask, but I know the primary care teams were being given a paper mask and very thin aprons and not sterile gloves. And I think they've upgraded that now to full sleeves. And full body PPE. Yes. The people that work with COVID patients have full visors. Obviously it's droplet infection, coughing and sneezing, et cetera. So, so that's when they got the full face and eye glasses as well.

Steven:

Interesting though, because you said full visors, but actually that's quite different from some of the masks we've seen, which are almost like anti-gas respirators, you know, things with little filters on the side and yes. And in your own clinic, I mean, what are you wearing, for example, are you changing your clinic top between patients or would you had you seen,

Jonathan:

Yeah, so I'm making sure that if I, if I was to see consecutive patients I would be changing my clothes. There's only one way in and out of the clinic. So I'll be making sure that I would be properly as best I could.

But I still think it's that prevention. If you've got a patient that's been isolated efficiently and socially distanced for the last two weeks, which we are coming to now, then, then chances are if they're not showing any symptoms then, you know, we're probably in a safer space, but I still think we need to be, be questioning this.

Steven:

You might, you might have a better idea than most about the period during which people could be asymptomatic nonetheless contagious.

Jonathan:

Again no, you know, I've read lots of different things between two and five days or world health organization talking about 14 days, you know, about 14 days actually. So that would say to me that the possibly it's family spread, you may be looking at five days.

Matt Hancock came out yesterday after six days, so that doesn't, doesn't match any anyone's guidance.

Steven:

six days asymptomatic?

Jonathan:

So I don't know. But some occupational health teams within a NHS trust were saying that you could return to work after seven days, but they've said I should change that to 14 now.

Steven:

Yeah. I guess I guess the issue was how over what period before people show symptoms might they still be contagious and therefore, you know, you would do your triage in your NHS practice or whatever and you wouldn't know that they were contagious. It's always a risk.

Jonathan:

Absolutely. And I genuinely think that's, that is a big risk and nobody knows. So, so in truth, we're trying to see those patients and keep them going and that feels like the right thing, that I'm asking all the right questions. But actually I could be wrong. You know, I'm going to see a patient this afternoon. I'm going to see one patient. He has been in self isolation for the last 14, 15 days. On the phone, he said he's got no symptoms. However he might well have bumped into somebody in Tescos yesterday. Yeah. That is an issue.

Steven:

You talked about anti bac wipes and so on. Somebody asked me to get a bit more clarity on that because soapy water is supposed to kill Corona virus and 60% alcohol supposed to kill coronavirus but antibacterial sounds by definition that it have no effect at all on the virus.

Jonathan:

I think they're just Alco wipes. They're pretty toxic.

Steven:

Hanna Mccloud has asked about osteopaths that have registered an interest in working for the NHS. Do you have any understanding of what roles osteopaths who aren't already in the, in the system might be playing? And that would go for chiropractors as well

Jonathan:

Yeah, of course. So I'm assuming, I mean in terms of, in coping in the COVID crisis, just offering to help while their practices are closed. Which is, which so honourable and fantastic news and with 25% of the medical workforce being off at the moment either ill, or self isolating or just under that it's going to be necessary. But I think probably at the moment you're going to be doing low level HCA roles. And, and I use myself - the only thing that I am actually qualified to do within the NHS is to triage patients. I could go into to the emergency department for example, and triage musculoskeletal screening patients. I've got the competencies to do that. But everything else and there's a high chance I'll be redeployed, you know, I'll be doing, I'll be turning in bed, I'll be doing mobilizations, I'll be toileting. And I think it's the HCA type, the healthcare assistant roles that we'll be doing. If we're going to go in there to try and do osteopathy, that will not happen

Steven:

I think they genuinely want to know how they can help and, and of course all the things you've just said, it strikes me that from, in most cases the NHS would want to train people to do those roles. They wouldn't just take an osteopath/chiropractor and say, right, you go in turn people and do all these other things you've talked about. There will be a period of training for that, which of course they probably didn't have the manpower to do that.

Jonathan:

No, I mean the training for HCA role, you can, you can do that quite quickly. So there's stuff we do, you know, I do yearly sort of manual handling course which takes about an hour and you can do that and then you can do a lot of the stuff online. So, so that could be done. And again, I can't speak for Nightingale, but I know that my own position at UCLH. If I do get ready called up, I'm more likely to be on the normal wards freeing up the nurses to go to COVID wards. So I think that’s the place we could use anybody with a healthcare background

But more important, I think the thing is that all osteopaths/chiropractors do have, forget osteopathy, forget chiropractic. I just think I would be more interested in having osteopaths in the NHS. The fact that they're osteopaths rather than they do osteopathy. And I think the same as with chiropractic as well. It's more about that the care-givers and the healthcare professionals we need. So the more people that volunteer, the better really, but expect to be doing, And again, I may be, we don't know, but I would say it's rapidly changing, so, so I can assume that this is going to be the usual health care system

type roles, you know, get gettingup, moving patients, as I said, toileting, mobilization might be something that we could do in terms of getting people up out of bed better.

Steven:

And have you got any information on how people can get involved in that? And I knew that there's a volunteering section in the NHS website, but there were lots of people standing around very frustrated at the moment wanting to be out there doing something useful.

Jonathan:

Yeah, I think there was something and I call, I can't quote the, the sites, but I think the GOsC the IO issued something today. Or it might've been in yesterday just about volunteering. And I think people are playing catch up.

I noticed just from talking to other osteopaths last week actually on the APM webinars, just the chat rooms that people had been volunteering and then they'd been interviewed by phone and I think that gets your name out there.

There was something around Nightingale last week, which I, looked at and it was just basically a case of your name, your national insurance number and what sort of skills you've got. Osteopathy wasn't on there, but there was another section that you could just fill in. You could approach individual trusts. So obviously go to your local trust. They're inundated, I mean even your bank staff and bank partners who tend to run NHS bank staff for trusts, they're inundated anyway because at any one time there's quite a lot of people off work.

Steven:

I'm pretty sure this is going to be outside your area of remit, but you may have an opinion. Elspeth has asked about testing and what the holdup has been in testing. Have you been tested?

Jonathan:

I have not been tested no, my cushy director's job's turned into anything but, we've been relentlessly trying to organize our staff and organize our services. So I don't think I would be tested at the moment anyway. It should be going to the front line.

Steven:

Absolutely. Yeah. There's priorities when you're doing the small number that they are at the moment.

Jonathan:

Yeah. The messages that we're getting from central government around a lack of the, I forget, the agitator or something, and the chemical industry are saying that there's no lack. You know, I don't quite know. I think there's differences in the antibody test and the test for COVID. I don't know what the issue is actually sorry. Elspeth

Steven:

Fiona says, is there a viral load issue for frontline staff working with a lots of virus patients?

Jonathan:

I think that's a real risk. Again, I'm not a virologist in any way, but it's something that we, that we've discussed with all staff. You know, we, we've got physiotherapy, we've got very, very experienced advanced practitioner physiotherapists that have been sort of 10, 15 years in you know, in, in that role. And we're now asking them to go to patients that might have COVID and, and quite legitimately they're asking about viral load. But again, people just don't know. Frontline doctors and frontline medics seem to be talking about this, the, the viral load risk. But again, I don't think people know.

Steven:

And what about paperwork? Somebody asked whether you find that a bit overwhelming working in the NHS. Is it different to normal now?

Jonathan:

Generally it's quite interesting. I think if you don't work in the NHS, you just think it's a big pot of money and you, you'll go to work and you do your, you do your stuff and then you come home. It doesn't work like that. Every trust is a business and then has to account like a business. So every patient you see if you're on a tariff based contract and you paid for that patient, so you have to then fill in a form to say what you've done and whether stopping clocks cause there are different fines for waiting times and things like that. That is quite arduous. UCLH are now a year anniversary into a new electronic patient recording system, which we're only using a small percentage of in the moment. But, but most of that is now automated.

Centrally, the NHS had been putting trusts on block contracts. So you get X amount of million pounds to do X amounts of work and if you go over that tough and if you go under that, good for you. So, so contracts are changing, but this is, this is blowing it all out of the water, so the debts that have been released from the NHS yesterday is significant. And that changes the financial landscape as well. So post COVID you know, I don't know what people are going to be doing. But yes, the paperwork used to be hideous. It's better now.

Steven:

I guess my own question here is, do you think that the, the trusts are having to cut corners with their paperwork because it's far more important that they get on with dealing with people with COVID

Jonathan:

No, I think the trust are mindful. You forget actually that, you know, behind, I don't have any, Ooh, the NHS is the fifth largest employer in the world. So there are an awful lot of staff. So behind every frontline clinician, there's a team of administrators and accountants and lawyers and everything else. So that work is still going on and that work can be done really easily. But I haven't actually been into work for three weeks and nothing has been affected. In fact, I've been, we've been, been far busier because of what's happening, but we've not been hampered by me not being there. But some people need to go into work. But, but no one's cutting corners. I think it's, it's all hands to the pump really, and everybody's working. When we clap at 8 o'clock on a Thursday, you know, you're clapping for everybody actually. So the frontline staff particularly, but behind there are whole teams of people that are keeping this.

Steven:

It's actually quite nice to think, isn't it that quite apart from the, the amazing work that the NHS frontline staff are doing at the moment because of the COVID crisis, it's kind of showing up the NHS for being the world-leading organization that it is. It's probably a better healthcare system than almost any other in

the world. Struggling to cope with the volume that we've got at the moment. But it's a good system. Jonathan's asked a question. What's the best way for an osteopath to start work within the NHS? Apart from the coronavirus thing. Cause he says he's, he's emailed or contacted his Sussex CCG on a number of occasions and they just say they don't use osteopathy within their services.

Jonathan:

Well I can, I can tell you for a fact that they do because, depending which part of Sussex, but I've had contracts in West Sussex and in East Sussex and there are osteopaths working in East Sussex. I was the first and then helped other people work. So I know there are three or four now. So, so you have to go to, you have to actually go to the people that are commissioning services are provided rather than just go to the CCG. In the CCG there are policy makers and strategists and accountants that kind of just filter the money. But actually that will, they will be commissioning other providers to do the search. So that may be the trust or not. But all people need to do , and this is where osteopaths and chiropractors are particularly bad, they don't like to ask, just Google me, you'll get an email address or telephone but I'll put you in touch with the right person is particular if it's in Sussex.

Steven:

Thank you. That's really helpful. And I think you highlights a point there. I mean it's a huge organization and lots of bits of it don't know what the other bits of it do. For many people they will just say this is too difficult. We don't deal with chiropractors and osteopaths, so go away.

Find the right person. They'd probably actually quite keen to get someone to take the load off other people.

Jonathan:

Yeah, I mean the things you mentioned. So there are, there is a national shortage, forget COVID, but there's a national shortage of band six, physiotherapists. So that's someone that's been out of university for a year, so when they graduated they're band five, and then most jump to band seven if they stay in the NHS, or go into private practice. But to recruit into a band six physiotherapist's role is nigh on impossible. The adverts just roll and roll and roll.

So if you look on NHS jobs or trap jobs, there will be roles with band 6 physiotherapists and just contact them and then contact the person. There always be a contact. Why not employee an osteopath, you know, I've worked as a lone osteopathic with surgeons and with physios all my work life and I stand by this. That's there is a role in the NHS for osteopaths, not necessarily for osteopathy, funnily enough, because we are moving away from that and that's okay. I feel okay saying that, but the team is better when an osteopath is in that team because we well trained as are chiropractors. We're well trained and we understand and we're good caregivers and that's what you need and you work as a team.

Steven:

I'm really pleased to hear you say that. I'm fond of saying slightly provocatively that osteopathy doesn't fix anything. It's what you do and how you think. And, and that crosses all those professional boundaries. We all have different skillsets.

Elspeth is back: what do you mean by bank staff?

Jonathan:

The temporary staff. Any trust has a bank of temporary staff. And, and you, you know, you get paid holiday, but you register with banks, you have to cover a minimum set of training, which is hand washing, it's manual handling and that sort of stuff. And then they just send you roles that may be suitable to you, right.

Steven:

Just as one gets bank nurses that do the same thing.

Jonathan:

Yeah. And you get, you get the clerics and bank admin staff too.

Steven:

Okay. You say that you do a lot of triage within NHS. Is that something you can do because of your skillset as an osteopath or a chiropractor? Did you have to be specifically trained in new skills within the NHS to do that triage?

Jonathan:

It's difficult to answer. So they are now, and we've set those up in Sussex, we were one of the earlier adopters for this sort of community service. But there are sets of competencies which you have to meet. And that's, that gives you the triage skills. But, but some of those, some of the things I learned, which is they were just the way I processed that information that I'd already had. So it was, I wasn't learning a new skill. It's a bit like ordering MRI scans or requesting diagnostics for bloods and things like that. There are some things that you have to go to courses on. So we have, I had to do a blood course and that was really simple. And I had to on the job as part of my competency look at MRI scans and that's a really good example because privately you can order MRI scans but mostly they're ordered incorrectly.

So when you're working in the NHS, a standard story that we see, is an osteopath for example, says they've been treating a patient five or six times, the patient hasn't got better. So they then send the patients to the NHS because they wanted an MRI scan and they wants an MRI scan to help the osteopath continue treatments. And that is a completely lame use for MRI scan because you're not asking a question, you're not asking for a diagnostic image you don't know doing beforehand. So how's the scan going to help you? It's things like that that you learn quite quickly on the job. And that's why it's brilliant because you work in a team and everyone's, everyone's learning together.

Steven:

Yeah. It's something we've heard from other people on here is that first of all, you can't get an MRI very often if you don't specify the question, but it doesn't help radiologist does it because if he doesn't know what he's looking for, he's going to miss something. And you'll look for some standard stuff and miss completely things that you think might be the problem.

Someone else where we would see these adverts for physiotherapists.

Jonathan:

Yeah. So on NHS jobs, so if you look at this, they have two websites, www.jobs.nhs.uk and www.trac.jobs. That's where things are recruited, where the NHS recruit their jobs. I believe they're interlinked, I think the, the, the websites share platform or something.

Steven:

Here's a good one for you. Probably outside your remit. Several people have asked if a patient you see is asymptomatic but capable of transmitting the bug, whether it's private or NHS, what's your standpoint legally? Are you covered by insurance?

Jonathan:

I can't comment on that, but I think that the work that I've done with the GOsC on fitness to practice, if I was doing everything I can and covering my standards and everything that a reasonable osteopath would be doing... So you stop infection then I think would be fine.

Steven:

I think possibly, I can answer that question because the insurance that you have to have to be registered as a chiropractor or an osteopath is medical malpractice. It's professional liability. It's insurance specifically against you doing something wrong. So therefore it's there to cover you if you get something wrong or something bad has happened, it goes wrong because you've done something correct.

So first of all, it would cover you on that, on those grounds. But also I had a long conversation with Joe Balen a couple of days ago because someone had asked me whether they were covered to treat patients over telehealth appointments because there's been misinformation about that.

And rather like the NHS, part of Baslen's insurance company were telling people that you couldn't see new patients on their insurance over telephone or video links. And actually there's nothing wrong with it. Your insurance covers you for telephone, video conversation, consultations, and for face to face.

And regardless of whether your patients have got COVID- 19 or simply contaminated with coronavirus, you know, that's irrelevant. You're simply required to carry out good practice in order to survive the professional conduct committee if you ever complained about. But as our legal guy the other day, Jonathan Goldring said, nobody's ever going to be able to prove that it was you who transmitted the bug. They could say subsequently we didn't think your practice was paying attention, doing your due diligence in terms of decontamination measures.

But you know, the insurance is a, is a big worry for people, but I think it's overblown. You are covered for this.

Someone else has asked. If you're working within the NHS as a practitioner, are you allowed to do the sort of things that chiropractors and osteopaths love to do? Are you allowed to HVT? Can you do the stuff that is within our scope of practice?

Jonathan:

Yes. So, you know, back in the late nineties I was seeing patients as an osteopath and I was getting referrals from consultant surgeons and pain clinicians and physiotherapists that were asking me to manipulate. In Sussex we set up we, we actually advertised a couple of years ago now, as part of my leadership program that I did with the GOSC, we put osteopaths in the physiotherapy department and they were getting different treatments and, and so were getting osteopathy. It was blind actually. They weren't even asking patients. It was a case that the patients would be triaged in and they might see, an osteopath, they might see physiotherapists. But again, there's no protectionism there. You're not having the osteopaths say, well, I'm going to keep this patient, she's got to get that patient better. And there'll be some cross-learning there. And that's perfect.

Steven:

So did the same practitioner see the same patient on their repeat?

Jonathan:

And that's again, that's a sort of misconception. If the physiotherapist wants to see a patient again, they see them again and it'll be the same person. You do sometimes go in there and they've lost your notes and all those underfunded pressures and that's does happen.

Steven:

It happens in my clinic as well once in a while!

Jonathan:

I must say once that happens, once in a blue moon, but that's an underfunded service. But mostly you can see that patient again.

Steven:

Jonathan, the guy who asked the question about working for Sussex CCG, said what you said was really helpful. He was asking in Brighton where he got a blanket no, and he says he'll make sure to contact the right people next time. I suggest I suggest the right person to contact is you and you tell him who the right people are.

Jonathan:

I'm sitting in Brighton.

Steven:

That's quite bizarre, isn't it? Really?

This is an interesting philosophical one, you need to justify what you said earlier on, it seems, because several people have asked whether you said it's okay to move away from osteopathy and doesn't that mean the profession will die?.

Jonathan:

If we all did, if we all moved away from it, it would die. Equally we all shut our practices, the profession'll die. I think this is a big risk, a big risk to osteopathy at the moment, I think COVID is a big risk to us because noone's getting it at the moment, but it comes down to what is osteopathy? If you we didn't have a regulator and there's a body of 6,000 osteopaths, we went together to the government and said, please could you regulate us? The first question is what is osteopathy? And we probably would not get a consensus of opinion, right? And I think that's the issue. But what I was saying before is that we, what those 6,000 people in a room would be 6,000, well educated, well committed and, and thoughtful, caring people.

That's who I want to work with. Genuinely. I don't care whether it's cranial, visceral manipulation, articulation, that doesn't bother me actually, but there is still a place for that. And I still use that, I would say two days a week. I still use that because there's a small number of patients that choose, if you look at low back pain and the nice guidance, manual therapy is in that. And if we use that with a combination of either psychological support and or exercise supports those patients do better than if you don't, so there is still a place to do this. So hope that qualifies.

Steven:

Someone's asked whether, you know of any chiropractors working in the NHS and I want to apologize to our chiropractor viewers. The fact is that we get a lot of osteopaths on the show, but we are also getting quite a few chiropractors this year as well.

Jonathan:

Yeah I know of one but not by name, who's contacted me recently about, I think he's working as a first contact practitioner role. But, but I don't know of many actually. I might, my advice would be to, to the chiropractors, dare I say it, is that they seem to be a little bit more impassioned about chiropractic per se. And I think that tends not to fit so well in an NHS mould because we're all learning that there is no protectionism there. If you drop your guard and I've seen it with osteopaths as well, saying that needs osteopathic manipulation, it might do, but it might not. Let's try both. And that's, that's how you learn. So I think that's my only thing. For everybody going into an environment like that, you don't have to shout very loud. You just have to give an opinion and then do the best for that patient. Yeah.

Steven:

How have the physios responded to osteopaths or others within the system if they're having to share patients? Are they resentful?

Jonathan:

No? Why would they be? And that's it. It's another person to, to bounce ideas off. We integrated my previous job at UCLH, I was in charge of the MSK team and we had lots of osteopaths coming through and no issues at all because you know, you make sure it's the right person. We have different ideas. The first question that I was ever asked by an orthopedic surgeon, I sat down in the room and he says to me, hi Jonathan, what do you do? I said, I'm an osteopath. He looked me square in the eyes and said, what do you do for facet joint pain? And I told him and I said, that's why I think we would do, what do you do? He said I'm orthopaedic surgeon, I specialize in treating spines. And he was asking me a question. So the first thing he wanted, was asking me for advice. He wasn't testing, what do you do about facet joint pain? That's what, and I think that's, that's it. There's no resentment. I can't ever see what it would be.

Steven:

I got the impression from James who we mentioned earlier on that actually the orthopaedic consultants were very pro what he was doing, I didn't sense that it might've been the same from the physio world at the Queens medical centre. And I mean, you said, why should there be resentment? Sadly, we are all humans and a lot of us feel very precious about our disciplines, don't we? It must occur from time to time, which is a huge shame because to me it doesn't matter what you call yourself. It's whether you get a good outcome with the patient which is a critical thing.

Jonathan:

Yes. And that's true. I mean, the physios fight all the time, but amongst themselves, they always have. And again, it's surrounding yourself with the right people, isn't it? To get the best. It's sharing a purpose. If you share the same purpose, then that patient gets better.

Steven:

Bob Allen says, where can he find a job description for a band six physio?

Jonathan:

I got some on my computer. If he emails me, I'll send one. Jonathan.Hearsey@nhs.net

Steven:

My only final thing is that we've had a number of people writing in to say this has been a really good insight into what goes on in the NHS, particularly, you know, when we're in this sort of crisis situation. So Jonathan, thank you so much for giving up your time.