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**To all practices Surrey and Sussex LMCs**

13th April 2020

Dear Colleagues

**General Practice Covid19 response: Update**

1. **Shielded Patients**
2. **Certification Issues**

**1 Shielded Patients**

I am writing to summarise the expectations of the ‘Shielded Patients’ programme for General Practice.

**Shielded Patients:** The Government has established a Shielded Patient process which identifies patients who are most at risk of Covid19 infection, because of concurrent clinical conditions, and who are being asked to stay at home and avoid face-to-face contact for at least 12 weeks. This is a substantial sacrifice for anyone, and so only patients for whom it is clinically appropriate should be placed on the shielded programme. The Government is coordinating a support offer to ensure access to medicines and basic supplies during this time. It is estimated approximately 2% of patients nationally will be identified as appropriate for shielding.

**Phasing** There are four phases to this programme.

**Phase 1:** Involved identifying patients on the basis of nationally held data.

**Phase 2:** Involved adding additional identified patients based on centrally extracted primary care data.

**Phase 3:** involves both Consultants and General Practitioners adding or subtracting individual patients from this list; this is divided into:

**Phase 3a** Individuals identified by Hospital Specialists

**Phase 3b**  Individuals identified by General Practitioners

**Phase 4:** A number of individuals have self-identified as very vulnerable via a national website: GP practices will be sent a list of these on or after 17th April, if they have not been identified via the central process [Phase 1 and 2]. There are likely to be comparatively few such patients per practice, and many of these will have been identified via Phase 3.

**Phase 1 and 2 [Centrally identified patients]**

**What do GPs need to do?**

All GP IT systems should have flagged these centrally identified vulnerable patients by Easter weekend, each IT system supplier will send a search process to practices. Details of this are in NHS England’s weekend letter accessible at:

[CEM\_COM\_2020\_016.pdf](https://www.cas.mhra.gov.uk/ViewAndAcknowledgment/viewAttachment.aspx?Attachment_id=103521)

GPS are asked to check these flagged high-risk patients to see if any have been inappropriately identified. If so, and the LMC recommends after discussion with the patient, they can be moved to a medium or low risk flag **once these flags are available in the system,** **which will be on or after 14th April.**

**Phase 3a**: Hospital Consultants have been asked to identify those who also fall within the high-risk category; in many cases these will be patients currently undergoing cancer treatment.

Such patients should receive letters directly from their Hospital Consultant.

In addition, NHS Digital is being informed, to update the GP record with high risk flag.

Consultants have also been asked to inform the GP if they have identified a patient as of the highest risk.

This process is on-going, and GPs can expect to receive such information over time.

**Phase 3b:** General Practitioners should try and identify what is likely to be a comparatively small number of remaining very high-risk individuals who in their professional judgement should be considered at the highest risk. These patients can be flagged, and on a weekly basis NHS Digital will extract these flags from GP practice data. GPS should send these patients a ‘high risk’ shielding letter, available at:

[**https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/at-risk-patient-letter-march-2020.pdf**](https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/at-risk-patient-letter-march-2020.pdf)

A copy of this letter is included as an attachment

**Phase 4** When this list is received, GPs should review it and make a clinical judgement; those who are considered to be at high risk should be flagged and those patients need to be sent the template shielding letter, Those who are not can be flagged as medium or low risk. The LMC recommends this process is undertaken in discussion with the patient.

**IT searches**

All IT information is available as an Annex to the letter at:

[CEM\_COM\_2020\_016.pdf](https://www.cas.mhra.gov.uk/ViewAndAcknowledgment/viewAttachment.aspx?Attachment_id=103521)

**Clinical Algorithm:**

Clinical Conditions included in the central clinical algorithm, together with additional specialist guidance, are:

**NHSE Central list**

1. Solid organ transplant recipients who remain on long term immune suppression therapy
2. People with specific cancers:

a. people with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer

b. people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment

c. people having immunotherapy or other continuing antibody treatments for cancer

d. people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors.

e. People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs

1. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
2. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell)
3. People on immunosuppression therapies sufficient to significantly increase risk of infection.
4. People who are pregnant with significant congenital heart disease

**Neurology**

<https://cdn.ymaws.com/www.theabn.org/resource/collection/C5F38B64-DC8F-4C67-B6FC-F22B2CDB0EE5/ABN_Neurology_COVID-19_Guidance_v6_9.4.20_FP.pdf>)

* Active myositis/polymyositis
* Muscular dystrophies
* Motor Neurone Disease
* Any neurological condition impacting on respiratory/bulbar function

**Gastroenterology**

<https://www.bsg.org.uk/covid-19-advice/bsg-advice-for-management-of-inflammatory-bowel-diseases-during-the-covid-19-pandemic/>

* IBD over age 70 on anti-TNF (infliximab, adalimumab)
* IBD and co-morbidity on anti-TNF
* IBD on ≥ 20mg prednisolone equivalent per day
* Recent combination biological/immunomodulatory/steroids last 6/52
* Short gut syndrome requiring nutritional support
* TPN requirement

**Renal**

<https://renal.org/stratified-risk-prolonged-self-isolation-adults-children-receiving-immunosuppression-disease-native-kidneys/>

* Intravenous immunosuppressant
* Oral cyclophosphamide
* ≥ 20mg prednisolone daily equivalent > 4/52
* > 5mg daily prednisolone equivalent plus one other immunosuppressant > 4/52
* Nephrotic range proteinuria
* History of repeated high dose immunosuppressant over a number of years
* Any immunosuppressant and:
  + Over 70
  + Autoimmune lung or heart disease
  + Co-morbidities – DM/respiratory/HTN/CVD/CKD3 or more

**Rheumatology**

<https://www.rheumatology.org.uk/Portals/0/Documents/Rheumatology_advice_coronavirus_immunosuppressed_patients_220320.pdf?ver=2020-03-22-155745-717>

* ≥ 20mg prednisolone daily equivalent > 4/52
* Oral cyclophosphamide
* Intravenous cyclophosphamide in last 6/12
* > 5mg daily prednisolone equivalent plus one other immunosuppressant > 4/52

(not hydroxychloroquine or sulphasalazine)

* Any 2 immunosuppressant therapies (not hydroxychloroquine or sulphasalazine)

**Dermatology**

<https://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6674>

* Any 2 immunosuppressant therapies (not hydroxychloroquine or sulphasalazine)
* ≥ 20mg prednisolone daily equivalent > 4/52
* > 5mg daily prednisolone equivalent plus one other immunosuppressant > 4/52

(not hydroxychloroquine or sulphasalazine)

* Oral cyclophosphamide
* Intravenous cyclophosphamide in last 6/12
* Rituximab or Infliximab for skin conditions
* Single agent immunosuppressant and other comorbidities or age > 70

**Respiratory**

<https://www.phauk.org/coronavirus-pulmonary-hypertension/an-open-letter-from-the-national-uk-pulmonary-hypertension-group/>

<https://www.sarcoidosisuk.org/information-hub/coronavirus-faq/>

* Pulmonary Hypertension
* Pulmonary Sarcoidosis
* Interstitial lung disease

**Updated list of Covid19 SNOMED codes**

These are all available in an attachment to this letter

**Contact with patients**

The NHS started to write to patients who have been identified as at the highest risk after 23rd March (using the results of the Phase 1 and 2 searches), so many will have received a shielding letter. This now represents approximately 1.3 million people nationally.

Not all patients identifed via these Phases may be at clinically so vulnerable, as some data relates to historic clinical information, and patients may contact practices expressing concerns about being identified in this way. If, clinically, you agree, patients can have their ‘flag’ changed to medium or low risk, **once these codes are available.**

There may also be genuinely high risk individuals who personally choose not to follow their shileding guidance, which is stringent and may have a significant impact on a persons wellbeing.

If people at lower risk wish to follow a more stringent shielding strategy than Is clinically recommended, they can do so but should not be flagged as high risk. This is because flagging a patient as requiring shielding provides access to the Governments nationally coordinated medicines and food delivery service.

Patients identified as at the highest risk have also received an SMS text message, if their mobile number was available centrally.

People in the shiedlded group should still seek help if available from friends, family, and neighbours, but all people who are extremely vulnerable should register at :

<https://www.gov.uk/coronavirus-extremely-vulnerable>

Contacting NHS111 is available as an alternative for people without access to the internet.

Patients can also receive support from the NHS Volunteer Responders at :

<https://www.goodsamapp.org/NHSreferral>

to which GPs can refer such patients.

**Information sent to patients**

I enclose as attachments the patient shileding letter and FAQs that have been sent to patients, for your informaiton.

**Accessing on-going care**

Whenever possible, shielded patients should receive care remotely. However, some patients will need on-going hospital care and have been advised in the shielding letter this will continue unless they are advised otherwise. They have also been advised it is for their GP practice to determine how best to deliver medical and nursing care to such patients. Colleagues should do this bearing in mind the principles of:

1. always remote consulting first,
2. minimising face-to-face contacts to those that are delivering care that cannot be delivered in any other way, and
3. ensuring a ‘first time response’ that means only the clinicain needed to deliver such care is in contact with the patient.

**2 Certification Issues**

1. **Shielded Patient letters:** any patient receiving a HMG letter that identifies them as at very high risk may use this letter as evidence to an employer that they have been advised to shield, and therefore must stay at home for at least 12 weeks. Such patients can continue to work from home, if they wish. GPs should not be asked to provide any further evidence or a letter confirming shielded status or on a patients clinical condition that confirms the need for shielding.
2. **NSS 111 isolation notes:** this on-line service issues isolation notes to individual with:
3. Symptoms of Covid 19, or
4. Those having to self isolate because they live with someone who has COvid 19 symptoms

Employers should accept this Isolation note as evidence that support absence from work and patients should not be asked to obtain a Med 3 from their GP,

1. **Non Covid 19 related certification:** This should be managed in the normal way excepting that practices can scan and send (with consent) a Med 3 via email. If an employer insists on a paper copy, the Med 3 should be posted to the patient.
2. **DVLA Medicals:**  the DVLA have confirmed they have ceased requesting any form of medical examination; patients who request these should be referred back to the DVLA
3. **MOT expiry dates** are being extended by six months, this will be done a few days before the actual expiry date and therefore tax applications may therefore need to be deferred until this is recorded in the DVLA system.

With best wishes



Dr Julius Parker

**Chief Executive**