Southwark COVID pathways

Southwark proactive care pathway for patients most at risk from COVID-19

Latest version: 26/6/2020
Guidance will be updated regularly
Available on
http://gp.selondonccg.nhs.uk/#proactivecare

Recent pathway updates

26th June: SHIELDING ADVICE IS CHANGING OVER JULY AND AUGUST MOVING FROM SHIELDING TO STRICT SOCIAL DISTANCING. SEE GOVERNMENT ADVICE

from 6th July patients may meet up to 6 people outdoors, maintaining social distance, no longer need to socially distance from household members, form a social bubble with another household if single. From 1st August shielding will be paused moving to from shielding to strict social distancing, allowing return to work and school as long as COVID-safe. The letter practices send to patients has been updated accordingly.

Southwark proactive care pathway for patients most at risk from COVID-19

High risk

Essentially those >70 or eligible for flu jab for medical condition (link or list p.2)

SNOMED/EMIS code = **Moderate risk category** of developing complications from COVID-19 infection

Stringent social distancing

Shielding/Extremely vulnerable group

Extreme susceptibility to infection (link or list p.2)

SNOMED/EMIS code = **High risk category** of developing complications from COVID-19 infection

Stay at home, no face to face contact for 12 weeks from date received letter

Consider co-existing autism, learning disability and dementia

Pro-active care for patients most at risk from COVID-19:

- Remote (telephone and/or video) patient contacts to optimize the management of underlying conditions
- Coding of COVID-19 risk category
- Tailored information giving

Pro-active care may also include advance care planning if appropriate.

This pathway is supported by the Southwark pro-active care for patients most at risk from COVID-19 template on your EMIS system.

- Team members will have varying clinical skill mix and clinicians should work within their knowledge and competencies.
- Patients with no risk factors may also develop COVID complications, clinical assessment, remote or face to face, is key.

SHIELDING ADVICE IS CHANGING OVER JULY AND AUGUST MOVING FROM SHIELDING TO STRICT SOCIAL DISTANCING. SEE GOVERNMENT ADVICE

Identifying patients and coding

SHIELDING PATIENTS: are identified using regularly reviewed criteria (p.2) by central searches from hospital and GP data and patients contacted directly, patients may also self identify – self identifying patient need clinical confirmation by the practice to be include on the shielding list . GP teams should identify patients who meet shielding criteria but have not been included using SNOMED/EMIS code**: High risk category** and send the NHSE shielding letter to the patient. Remove patients wrongly identified as shielding from the register by coding **moderate or low risk category**. Contact these patients to discuss/explain. There is additional disease specific guidance on http://gp.selondonccg.nhs.uk/. Concerns re specialist coding decisions should be raised with the consultant involved.

PLEASE NOTE: SNOMED/READ codes use **different** terms from the government risk terminology

Shielding group described above – SNOMED/EMIS code = **High risk** of developing complication from COVID-19 infection

High risk group described above -SNOMED/EMIS code = **Moderate risk** of developing complication from COVID-19 infection

All others: - SNOMED/EMIS code = **Low risk** of developing complication from COVID-19 infection

Consider carefully the impact of shielding on a patient's mental health and offer wellbeing support (p.2). Patients can self register as in the shielding group here..

High risk group described above **:** identify patients from practice searches, QOF registers and Southwark CCG Enterprise searches and reports.

Further guidance to follow. EMIS COVID coding guidance link

1 Optimise management

Clinician

Review of underlying health condition(s) to optimise care.
This should include healthy lifestyle advice including smoking cessation advice.
Plan further contact if clinically indicated.
Review and adjust personalised care plans.
Support self management

Resources:
Southwark LTC Pathway during Covid and beyond and COVID-19 clinical support SEL website for disease specific guidance during pandemic.

Medication review: Ensure

- Adequate supply
- Electronic prescribing set up
- Consider repeat dispensing if appropriate

Do not extend usual prescription duration or support stock piling as will impact on supply chain.

2 Advance care planning IF APPROPRIATE

Senior Clinician

Undertake only if you have experience and confidence in this area and this is appropriate for the patient

Assess **Clinical Frailty Score (CFS)**– see page 2.
Patients with high CFS may consider or be offered supportive care at home if they become unwell.
Code via template or:
CSHA (Canadian Study of Health and Aging) Clinical Frailty Scale Score

Advance care planning:
Support your patients to have an advance care plan.
Update Coordinate My Care (CMC) record.
CMC now linked on EMIS see left hand bar/external

Advance care planning and CMC guidance and resources

3 Information giving

Clinician/Non-clinician/Social Prescribing Link Worker

Shielding patients:
Receive a letter from government, hospital and/or GP . Southwark council is proactively contacting all shielding patients

Reinforce hygiene and isolation advice

YOUR GP IS OPEN

COVID-19 symptoms
Contact 111 online or by telephone

Non-COVID symptoms
Requiring medical attention: contact GP, ideally on-line or by telephone for usual care.
SEEK ADVICE ON-LINE OR ON THE TELEPHONE

Signpost or refer to support see page 2.
Agree a named care coordinator or single point of contact for concerns – most likely GP team member or GP practice

Clinical Frailty Scale (CFS) may be helpful when considering future care

Also known as Rockwood Scale or Canadian Study of Health and Ageing CFS

'The CFS should not be used in younger people, people with stable long-term disabilities (for example cerebral palsy), learning disability or autism. An individual assessment is recommended in all cases where the CFS is not appropriate'

Link for further guidance

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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Risk groups

Not exhaustive- use clinical discretion

At high risk: (essentially those >70 or eligible for flu jab for medical condition)

- Over 70
- Heart disease e.g. heart failure
- Lung conditions e.g. asthma, COPD,
- Chronic kidney disease
- Liver disease e.g. hepatitis
- Neurological disease e.g. Parkinson's, Multiple Sclerosis
- Diabetes
- Weakened immune system e.g. on steroid tablets or chemotherapy
- BMI >40
- Pregnant

Shielding/extremely vulnerable group:

- Solid organ transplant recipients
- Cancer patients: undergoing chemo or radical radiotherapy, blood cancers, immunotherapy or other immunosuppressant treatments
- Bone marrow or stem cell transplant in last 6 months
- Severe respiratory conditions including cystic fibrosis and severe asthma and COPD
- Rare diseases and inborn errors of metabolism that increase risk of infections. For example; homozygous sickle cell disease, and genetic conditions that particularly affect the immune or respiratory system (local wording)
- On immunosuppressant therapy sufficient to increase risk of infection
- Pregnant with significant heart disease
- Recently added: Splenectomy, interstitial lung disease, pulmonary hypertension, renal dialysis
- Consider also MND

EMIS COVID-19 coding guidance for codes to add patients to this shielding group who meet the criteria

Clinical support:

Seek advice for complex cases and refer to A&E in emergencies

Consultant Connect (CC):
Download to your smart phone.
Routine referrals – discuss with CC/ERS advice and guidance before referring.

GST Palliative care team: 020 7188 4754

Asthma team mobile 07554 338018 **M-F only** (Patients and clinicians)
Interstitial Lung Disease nurse specialist 07554 338016 **M-F only** (Patients and clinicians)

Integrated respiratory team: COPD only 7 days a week 0900-1630
Clinicians: 07796 178719 **Patients**: 07717 701120

Outpatients pathways for up to date guidance

Patient support

SOCIAL PRESCRIBING LINK WORKERS
Offer remote assessment, signposting and tailored support

Welfare
Bereavement
Benefits and housing
Healthy lifestyle advice

Access to befriending, volunteers and community groups

Refer via Elemental on your EMIS system (click icon below for video guide) or via email – links below
North Southwark (QHS)
South Southwark (IHL)

Emis Demo on how to use Elemental.mp4

SOUTHWARK WELLBEING HUB
Wellbeing directory of local support and Hub Support Coordinator contact details 0203 751 9684 or 07849084368

SOUTHWARK HEALTHY LIFESTYLE OFFERS
Including health remote health coaching

SOUTHWARK APPROVED LIFESTYLE APPS

NHS Volunteers Responders referral portal

Government support for shielded patients 0800 0288327