# Southwark COVID pathways

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

**Replaces pathway circulated on 15.4.20**

Published 23/4/2020
Guidance will be updated: 1/5/2020
Available on
http://gp.selondonccg.nhs.uk/#proactivecare

# 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 (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 (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 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.

**Identifying patients and coding**

SHIELDING PATIENTS: have been identified using criteria (p.2) by central searches from hospital and GP data and patients have been contacted directly, patients have also self identified. 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. Shielding patients are eligible for additional support.

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

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.

**Resources:**

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

**Patients in shielding group will have been contacted by government (see above)**

Reinforce hygiene and isolation advice

**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.

Consent to share details with community organisations.

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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## 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**

## 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

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

## Patient support

Follow links

Southwark Council COVID support
Includes food access and financial advice
020 7525 5000
NHS Volunteers Responders referral portal
Citizens Advice 0344 499 4134
Support for shielded patients
0800 0288327
Social prescribing link workers (QHS)
qhs.socialprescribing@nhs.net

**Wellbeing support:**
Southwark Wellbeing Hub signposting organisations to help in crisis

Manage Your Health
Good Thinking

**Wellbeing for young people**:
Kooth
The Calm Zone