NHS

To: NHS Trust Medical Directors
NHS Trust Chief Nursing Officers
GPs
CCG AOs
ICS/ STP CEOs

Dear Colleagues,

NHS SUPPORT FOR PATIENTS WHO ARE SHIELDING

Since the start of the pandemic, you and your teams have devoted a great deal of time and effort identifying and advising patients who are clinically extremely vulnerable to COVID19, ensuring they are put on the Shielded Patient List (SPL), and most importantly of all, changing how the NHS provides care for this group of over 2 million people who were strongly advised to stay at home. We are hugely appreciative of your invaluable work in continuing to support these patients and helping to keep them safe and well.

The Government's updated advice

On Sunday evening 31 May, the Government published updated guidance on shielding on its website. This letter confirms the actions for the NHS.

The Government states that it has revised its advice by a small degree to reflect that COVID-19 disease levels are substantially lower now than when shielding was first introduced, with the most recently estimated prevalence in the community being, on average, 1 in 420 people.

The Government's advice is that people who are shielding should continue to take precautions but can now leave their home if they wish, as long as they are able to maintain strict social distancing. If they choose to spend time outdoors, this can be with members of their own household. If they live alone, they can spend time outdoors with one person from another household. Ideally, this should be the same person each time. If they do go out, they should take extra care to minimise contact with others by keeping 2 metres apart.

The Government's shielding guidance remains advisory. Some patients may well choose to remain in their own home at all times if they do not feel comfortable with any form of contact with others. The Government's advice is that for many people who are in the clinically extremely vulnerable group, the opportunity to go outdoors while maintaining social distancing may enhance their physical and mental health, without exposing them to significant risk of catching covid-19.

The Government has also confirmed that everyone who has been advised to shield and added to the SPL is able to access government support, including food and medicines deliveries.

The Government is currently advising everyone who is considered clinically extremely vulnerable to continue to 'shield' at home, in this modified way, until the end of June 2020 to protect themselves from COVID-19.

The Government has committed to reviewing the shielding guidance alongside each review of the wider social distancing measures to ensure that the latest epidemiology is directly considered with advice to clinically vulnerable groups. They have confirmed the next review will take place the week commencing 15 June 2020. The government plans to write to all individuals on the SPL with information about next steps on shielding advice and the support that will be available to them after this review point.

Maintaining the Shielded Patient List

In the meantime, the Government has asked the NHS to continue to maintain the Shielded Patient List, using the existing criteria and processes. Individual clinical conversations with patients, helping them to make informed choices through shared decision making is central to this.

The NHS has been asked to continue to identify those who are clinically extremely vulnerable. It is important patients who are newly diagnosed as clinically extremely vulnerable are advised to take extra precautions and receive a letter, as this allows them access the government support offer, including access to food and medicines deliveries, and the letter also acts as necessary evidence for their employer as to why they cannot leave their home to go to work. The letter to patients being newly added has been updated to reflect the latest Government advice and is attached.

Many of the people meeting the shielding criteria have been identified by the national algorithm run by NHS Digital (see NHS Digital website). These people are sent the letter via a national distribution system. GPs or specialists are able to add individual patients to the SPL where they consider them to be clinically extremely vulnerable. They may also remove people from the list where they believe someone has been identified in error through the national process, or if they no longer think someone is clinically extremely vulnerable. This should only ever be done in consultation with the patient and other clinicians where appropriate. The process for additions and removals is in annex A.

If you have added or removed someone from the list and not yet been in contact with them, please do that now, before the next government review on 15 June.

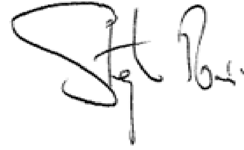
Any national additions and additions or removals by specialists are updated in GP records and the Summary Care Record Application weekly.

Meeting the ongoing health and care needs of those who are shielding

People who are shielding may be less likely to seek and access the NHS care. The NHS has already significantly changed how it operates to meet the needs of those who are advised to stay at home, for example using digital technology. Based on learning from this, and input from an expert advisory group, we attach at annex B guidance to support the NHS in providing ongoing care to the shielding group. **The guidance lists 9 actions that the NHS**

should continue to take or implement now, if not already in place. Systems (STPs/ICSs) have the overall lead responsibility for ensuring that these actions are fully in place in their geography. These actions apply to all providers of NHS care.

Your sincerely,



Ruth May
Chief Nursing Officer, England

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

ANNEX A – ADDITIONS OR REMOVALS FROM THE LIST

When adding or removing someone from the list, the following steps must be taken:

a. **Additions:**
People identified as clinically extremely vulnerable should be contacted and made aware that they may be at high risk from COVID-19 and are being advised to shield in line with revised guidance. Any clinician adding a patient to the list should also speak to the patient and send them the updated letter. This explains how to access government support and can be used as evidence for their employer if needed.

All patients who are clinically extremely vulnerable should have their ongoing care needs considered and adjusted in line with the actions set out in Annex 1.

To process an addition:

- **GPs** should add the 'High risk category for developing complication from coronavirus disease' flag to the individual's GP record. Guidance on how to do this can be found on the NHS Digital website.

- **Specialists** should submit the individual's details to NHS Digital via their Trust's SEFT system. Guidance on how to do this can be found on the NHS Digital website. They should also inform the patient's GP.

b. **Removals:**
Patients can only be removed from the list by either their GP or specialist. No one is removed by the national algorithm.

Where a clinician thinks a patient should not have been added to the list or is no longer considered to be clinically extremely vulnerable, they should contact the patient to let them know that they are not considered to be high risk and are no longer advised to shield. As part of this discussion, the patient should be made aware that as they can return to more routine patterns of daily life access to the government support for food, basic supplies and medicines will be stepped down and end. A template patient letter to support this communication is available on NHS Digital's website.

Where the individual is receiving treatment from a specialist hospital team, or teams, there must also be a clear communication between the specialist and the individual's GP. This is critical whether it is the GP or the specialist proposing to remove someone from the list.

A removal should only be processed once there has been a discussion with the patient and, where necessary, agreement reached between their GP and specialist.

If you have removed someone from the list and not yet contacted them, please do so now.

To process a removal:

- **GPs** should adjust the flag in the patient record, marking the person as 'moderate' or 'low' category for developing complication from coronavirus disease. Guidance on the definitions of the risk categories can be found on the NHS Digital website.

- **Hospital clinicians** should mark the individual for removal in their Trust's SEFT system. Guidance on how to do this can be found on the NHS Digital website.

Once removed from the list, the individual may be contacted to confirm they are no longer on the list and will not get access to government support. It is therefore critical they have heard from their GP or specialist before they are removed.

People who still need help with the delivery of shopping and medicines during the pandemic can access support via the NHS Volunteer Responders Service. They can be referred by their GP practice or via local schemes run by councils or can contact the service directly using the phone line (0808 196 3646). These services are free to access, but payment for food may be required.

Please contact splquery@nhs.net if you have any questions about the process to add or remove patients from the list.

GPs and specialists in acute hospitals are able to add or remove patients from the list through the routes set out above. Mental health and community trusts are not expected to add patients to or remove patients from the Shielded Patient List. Any suggested changes to an individual's position should be discussed with the individual and their GP or specialist.

ANNEX B – ACTIONS FOR PROVISION OF NHS CARE TO PEOPLE SHIELDING AT HOME

Whilst people are continuing to shield at home, they may be less likely to seek and access the NHS care they need, because of the advice to stay at home.

The NHS has already significantly changed how it operates to address that risk. In the light of that initial experience, an advisory group has informed this guidance. It provides a list of 9 actions that the NHS should continue to take or implement now, if not already in place.

Systems (STPs/ICSs) have the overall lead responsibility for ensuring that these actions are fully in place in their geography. These actions apply to all providers of NHS care.

Although focused on people shielding at home, most of the actions have a wider relevance for the proactive provision of coordinated and convenient NHS care for patients with significant ongoing needs.

The NHS should:

1. **Put in place a lead, named care coordinator/team.** Every patient shielding at home should have a lead, named care coordinator or single point of contact to help support patient-led follow up or provide regular check ins, where these are required. For most patients this will be someone from their GP practice. In some cases where the main ongoing care is with a specialist, it may be a secondary care or community health team. For children and young people, it may be paediatricians at secondary or tertiary hospitals or Advanced Nurse Specialists in all environments. In some cases, it may be appropriate to identify a (clinical or non-clinical, e.g. social prescribing link worker) care coordinator who can coordinate activities between different healthcare teams, for example pharmacies, mental or community health services.

2. **Proactively contact** those in the 'shielding' cohort to ensure they know how to access care if they need it and have an appropriate personalised care plan for when this needs to happen. Mental health, learning disability and autism teams should ensure that patients under their care who are known to be shielding are proactively contacted and supported through this time; for example, with helplines / websites staffed by trust teams.

3. **Review and adjust personalised care plans.** Given the diverse health, care and wellbeing needs of shielding patients, personalised care plans should be adjusted on the basis of individual circumstance, preference and an assessment of clinical risk. A particular focus should be placed on tackling health inequalities. Care plans should focus on meeting the mental, physical and wider social needs of patients. In balancing risks, priority should be given to care which supports quality of life, autonomy, dignity and daily functioning. The plan, or as a minimum a discussion on key decisions for care and treatment, should:

    a. be developed through shared decision-making with the individual, and with parents, carers and community teams if appropriate (e.g. learning disability liaison nurses)

b. take account of an individual's clinical condition(s), preferences and circumstances, including access to, and confidence in, using digital tools / technology
c. include the named care co-ordinator or single point of contact where needed
d. balance wellbeing, treatment needs and social vulnerabilities with risks of exposure
e. cover all aspects of the individual's needs (physical, mental health and wellbeing)
f. include arrangements for medicines delivery at home, as required of community pharmacy
g. ensure that patients have direct access to the appropriate clinical team via e-mail, telephone or in any other way that facilitates communication between the patient and their contact point
h. incorporate any reasonable adjustments they need[1]
i. be owned by the individual who should where possible, have a (digital) copy of their plan / record of decisions taken

4. **Support self-management** to help patients to have the knowledge, skills, confidence and support they need to manage their own health and wellbeing effectively in the context of their everyday life during this pandemic. This includes information to parent / carers and age specific information. More information on self-management support is available here.

5. **Provide NHS care at home, wherever possible**; virtually or online by preference. This includes GP and hospital outpatient appointments, e.g. using tools such as AttendAnywhere. Particular focus should be paid to supporting those who may have the greatest challenges in accessing care remotely, to reduce health inequalities. Where remote service delivery is not possible, it should be via safe (i.e. infection controlled) general practice or community health service home visiting where clinically necessary. Systems should expand and resource all relevant home-based services, such as a home-visiting phlebotomy service.

6. Wherever care at home is not possible, **provide safe NHS care in infection-controlled clinical settings**, in line with latest infection prevention and control guidance. For, example for invasive treatments, diagnostic tests or procedures. In such cases, identify a safe location and ensure the patient has safe 'door-to-door' transport (see requirements for patient transport). All NHS providers can access the Summary Care Record Application (SCRa) which has a specific flag for every patient currently recorded as being shielded. Advance warning should be given when a clinically extremely vulnerable patient is to attend an NHS site and can make additional adjustments, wherever possible, to further reduce exposure. This can be confirmed via pre-appointment checks or the Summary Care Record application[2]. Ambulances should also let emergency departments know where they are conveying a patient who is clinically extremely vulnerable. Any paperwork or information about their care plans should accompany the individual and be given to the hospital team. Clinically extremely vulnerable patients have been asked to prepare a single hospital bag for these situations.

[1] In line with current policies and procedures, care should be adjusted to reflect and adequately respond to an individual's disability, ability to comprehend and converse; ensuring everyone can access the same safe care
[2] Patients identified as being clinically extremely vulnerable are recorded as such in their summary care record, and this is also visible in the "additional information" section of the SCR which is shared across the system unless the patient has dissented from this

7. **Provide regular checks and treatment.** Ensure patients continue to access regular checks, screening and treatment[3] where needed, both for both physical health and mental wellbeing. In specialties such as audiology, dentistry and eye care careful consideration should be given to the benefits of intervention against the potential risks, if remote checks are not possible. These regular checks and treatments should form part of an individual's care plan or health 'passport'. Everyone in the clinically extremely vulnerable group should be given access to the seasonal flu vaccine.

8. **Ensure rapid access urgent and emergency care**. In the event of a rapid deterioration, and in alignment with the patient's wishes, patients needing urgent or emergency treatment should be conveyed to hospital as quickly as possible. Before attending hospital, they should call 111 or 999, so that the ambulance service and hospital can make necessary arrangements to deliver safe care.

9. **Make every contact count**, to deliver more than one check or treatment when visiting someone's home and coordinating activity across primary, community, mental health and hospital care, i.e. taking a multi-disciplinary approach to care. This is particularly important to ensure regular mental health and safeguarding checks, which may involve upskilling some staff, or clinicians working in innovative ways across disciplines. It is as true for urban as rural areas.

[3] Examples of regular checks and treatments include: immunisations and vaccinations, developmental checks, safeguarding checks, flu jabs, dental care, eye care, audiology, chiropody, phlebotomy, medicine reviews, physical health checks for people with severe mental illnesses, learning disabilities and autism, mental health assessment and treatment (by IAPT or secondary mental health care services)

ANNEX C: Patients identified as being Clinically Extremely Vulnerable

Clinicians in England identified specific medical conditions that, based on what we knew about the virus so far, place someone at greatest risk of severe illness from COVID-19. These were signed off by the UK Senior Clinicians Group (including four United Kingdom Chief Medical Officers and clinical leadership at NHSE, NHSD, and PHE).

Patients were identified in four groups:

Group 1: Identification of a core group of patients who have been contacted centrally by the NHS. Most patients with the conditions below have been identified by NHS Digital and letters have been sent to them advising that they should follow shielding measures for the next 12 weeks.

- Category 1 – Solid organ transplant recipients
- Category 2 – People with specific cancers
  - People with cancer and are having chemotherapy
  - People with lung cancer and are having radical radiotherapy
  - People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
  - People having immunotherapy or other continuing antibody treatments for cancer • People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
  - People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- Category 3 – People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
- Category 4 – People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell disease)
- Category 5 – People on immunosuppression therapies sufficient to significantly increase risk of infection
- Category 6 – People who are pregnant with significant heart disease, congenital or acquired

The methodology for the extraction can be found here:
https://digital.nhs.uk/coronavirus/high-risk-vulnerable-patients-list/vulnerable-patient-list-methodology

Group 2: Identification of people in medical subspecialties in secondary care not identifiable centrally. Patients in Group 1 category 5 should be contacted by specialists in secondary care across six subspecialties (rheumatology, dermatology, gastroenterology, renal, respiratory and neurology). Some specialty organisations have developed decision-support tools to help identify these patients.

Group 3: Academy of Medical Royal Colleges (AoMRC) cascade of general guidance to allow other hospital specialties to identify further at highest clinical risk patients from their caseload. We are working closely with the AoMRC who have picked up a further group of

immunocompromised patients in ophthalmology via this route. A decision-support tool for this group is available here: https://rcophth.ac.uk/2020/03/covid-19-update-and-resources-for-ophthalmologists/ .

Group 4: Identification of a small number of patients in primary care considered to be at highest clinical risk. We envisage that the majority of these patients will have been included in the shielding cohort through identification routes in Groups 1-3 (above). We have given GPs the discretion to add further people to this group, bearing in mind the highly restrictive nature of the intervention and practical limitations on the number of patients able to shield effectively.

ANNEX D: Other useful resources

Useful examples of how care and treatment has been modified for patients during this pandemic and that can be adapted or used for shielded patients:

- University Hospitals Birmingham is using its Solihull Hospital for mainstream elective inpatient activity in a COVID-free setting
- Video consultations can reduce the need for physical attendance; existing services such as Consultant Connect could be combined with home visits for this, where appropriate
- Community pharmacies and dispensing doctors can deliver medicines to shielded patients
- The Project Surgery in London is minimising contact time for children's immunisations with a drive-through service
- Leicestershire Partnership NHS Trust are using a remote monitoring platform for patients who were discharged from hospital earlier than usual due to the pandemic
- Guidance on providing IAPT services remotely is available here
- Cystic Fibrosis Trust has provided patients with medical information cards to alert care teams of their treatment needs should they need to attend hospital

Service planning and Standard Operating Procedures (SOPs):

- The Primary Care SOP has a section on shielded patients and further information on conducting home visits, managing face to face appointments and social prescribing
- The Community Services SOP also has information on home visits and seeing shielded patients in healthcare settings
- DHSC has published FAQs on the provision of home care during COVID, including for shielded individuals, see also PPE guidance for domiciliary care
- Patient Transport Requirements includes information on transport for shielded patients
- Guidance on providing IAPT services remotely is available here
- RCGP has guidance on caring for shielded patients in secure environments
- Shielded patients are included in guidance on supporting those with mental health needs, a learning disability, autism or dementia in inpatient settings

Information on the existing support offer for shielded patients

- Guidance on the local and national government support offer (food deliveries, access to supermarket deliveries, details of social contact and basic care provision)
- Information on NHS Volunteer Responders, the patient referral form is available here

Shared decision-making and personalised care and support planning

- Shared decision-making: summary guide
- Social Prescribing Academy: Personalised wellbeing plan template

Further information on shielding

- Public Health England Shielding Guidance
- NHS Digital website describing the process for creating the Shielded Patient List