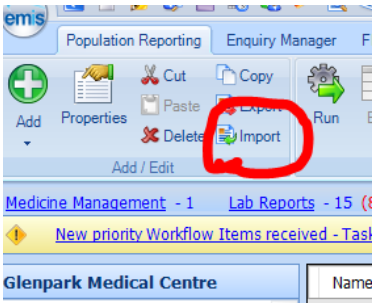
Shielding Against Coronavirus – A Guide For Primary Care

Updated 22 May 2020

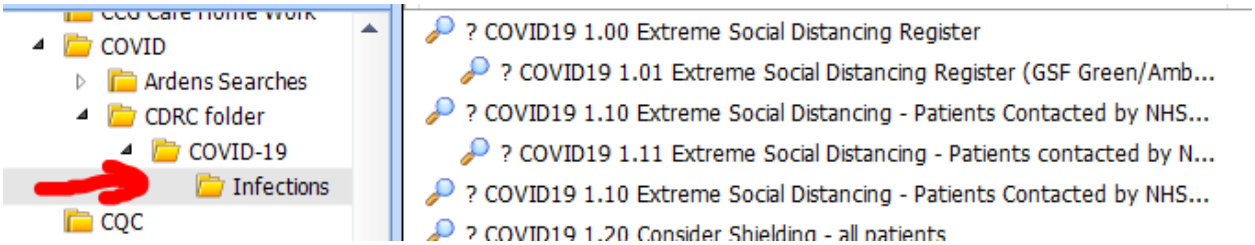
CDRC Resources to help practices

A set of searches to help manage patients who are on the shielding register can be downloaded from https://cdrc.nhs.uk/resources/covid-19/

To use, download the file to a convenient folder. Open the download and Click on Extract all. Import these searches into EMIS via the Population Reporting Module.



The import will take time but will create a folder called “COVID-19”. The relevant searches in a subfolder called “Infections”



What is shielding?

A very restrictive regime comprising not leaving home at all and having no face to face contact with anyone, even members of their own household unless they also shield.

What do patients gain from shielding status?

Aside from the reduced risk of infection, patients may also gain priority access to support such as home deliveries and may also derive financial and employment benefits.

Where is the shielding register?

The register is in the primary care record. Patients are included on the register if they have a ‘high risk of coronavirus complication’ code without a subsequent moderate or low risk code. NHS England extracts the register from the primary care record at regular intervals to share with other partner delivering care.

Who should be included in the register?

Shielding is not for all patients over 70 or eligible for an influenza vaccine, although, confusingly, these patients are term high risk and vulnerable.

Shielding is for patients at **very** high risk, also described as **extremely** vulnerable.

The criteria for inclusion are defined by a combination of guidance from the Chief Medical Officer, NICE (defining severe asthma) and various medical colleges and societies (see appendix 1). NHSE have indicated that only patients who meet these criteria should be shielded.

1. Solid organ transplant recipients who remain on long term immune suppression therapy
2. Cancer, including people receiving chemo or radiotherapy; certain specific cancer treatments affecting the immune system; cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment; bone marrow or stem cell transplants in the last 6 months (or who are still taking immunosuppression drugs).
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell)
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. People who are pregnant with significant congenital heart disease

The NICE and college/society guidelines mainly serve to clarify groups 3 and 5 from the list above. They also add a few, important, additional groups of patients, the most notable being:

- Anyone with motor neuron disease
- Anyone with neurological conditions significantly affecting respiratory or bulbar function

The British Lung Foundation also included all patients with significant lung disease AND diabetes or heart disease for several weeks but this recommendation now appears to have been removed.
23rd April NHSE confirmed they wished to add absence of spleen to the list of conditions.

How are patients added to register?

By adding the high risk code to the primary care record, either:

- Centrally - this was done in two batches (20/24th March and 9th April) by EMIS/TPP using a list of patients given to them by NHSE
- Or added manually by the GP practice

How are patients identified?

- Central database searches (primary and secondary care data) by NHSE (ongoing)
- Local GP knowledge
- Secondary care specialist identification (e.g. active cancer treatment, severe respiratory disease, immunosuppressant treatment)
- Patient self-identificaton – either directly to GP or via NHSE website

Why do I need to get involved? I thought the patients were being identified by NHSE and specialists?

Unfortunately this isn't correct. GPs have been given the following responsibilities:

- Maintaining the shielding register (including adding and removing patients as their clinical situation changes)
- Vetting all patients identified by NHSE central searches to confirm those patients do fit the criteria specified above
- Responding to requests from patients to be added to the register (either directly or via the NSHE website)
- Identifying eligible patients who were missed by the NHSE and secondary care searches

Why does it matter?

If you do not correctly identify patients who need to shield, they are at risk of infection and poor outcomes. You may be held accountable for this.

If you incorrectly inform patients they need to shield, you are exposing them to unecessary psychological trauma, an extremely unpleasant regime and you may risk their livelihoods. You may be held accountable for this.

Why is this whole thing so complicated?

There are large numbers of reasons why this process has been so complex. These include:

- A complex and flawed NHSE strategy, that changed over time
- Confusing terminology – high/highest risk, vulnerable/extremely vulnerable
- Patient and clinician confusion between high risk (stringent social distancing) and very high risk (shielding)
- Medical colleges/societies producing conflicting and changing guidelines.
- Extremely mixed (often inaccurate) messages widespread on social media e.g. 'all patients with asthma, should have received a shielding letter'.

What is severe respiratory disease?

The following is a guide to what constitutes severe respiratory disease:
All patients with pulmonary fibrosis, cystic fibrosis, significant pulmonary sarcoidosis, pulmonary hypertension.
Patients needing home oxygen or home ventilation.
Patients with asthma on high dose ICS AND another preventor (e.g. LABA/LAMA/montelukast/biologic)
Non-asthma lung disease with:

- FEV1 <50% predicted
- MRC score 3, 4 or 5
- Bronchiectasis and prophylactic antibiotics
- Hospital admission
- Frequent exacerbations

What level of immunosuppression is relevant?

This is difficult. Each of the medical colleges/societies has designed a slightly different algorithm to determine which patients need to be shielded. All seem to agree on the following points:

- Many patients on immunosuppressants will not need to be shielded
- Sulfasalazine and hydroxychloroquine are not relevant at all
- Recent cyclophosphamide or steroids at a dose of >=20mg prednisolone or equivalent requires shielding
- For most other medication, they use scoring systems based on the number of immunosuppressants taken, dose of prednisolone (if relevant), age and comorbidities.

The links to the individual societies will provide more detailed information. Alternatively ask the opinion of the specialist supervising the medication.

How do I vet the patients identified by NHSE?

The central searches have relatively low specificity, with a significant proportion of patients inappropriately identified as needing to shield (probably somewhere around a fifth). GPs are required to review all the patients identified by NHSE to confirm eligibility for shielding. Use the resources in appendix 2 to help make this process easier.

How do I identify patients missed by NHSE and secondary care?

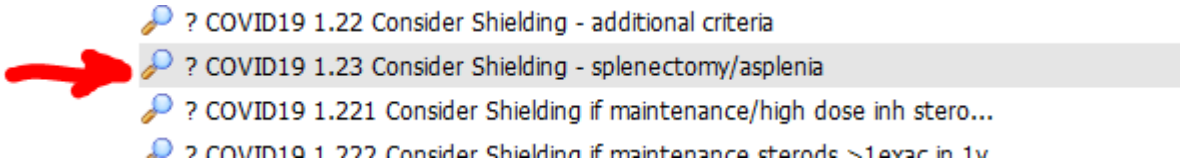
The central searches have relatively low sensitivity, missing a significant proportion of patients who do need to shield (probably about a third). GPs are required to identify these additional patients. Use the resources in appendix 3 to help make this process easier.

Do patients with HIV need to shield?
In general, well controlled HIV is not a condition that requires shielding.

Do patients on hormone treatment for cancer need to shield?
In general, hormone treatments alone such as tamoxifen/aromatase inhibitors for breast cancer or GnRH analogues for prostate cancer are not indications for shielding.

What about splenectomy?
The position for patients without a spleen has been confusing. Many were contacted in the initial NHSE process. NHSE then gave advice that such patients did not need to be shielded. On 23rd April, NHSE stated these patients did need to be shielded.

The following search will identify any patients without a spleen who are not currently on the shielding register.



Appendix 1 – Links To Royal College and Medical Society Guidance and Relevant Codes

Links

Association of British Neurologists https://www.theabn.org/page/covid-19_patients

British Society of Gastroenterology https://www.bsg.org.uk/covid-19-advice/bsg-rcp-advice-for-ibd-liver-clinicians-on-identifying-immunosuppressed-patients-for-shielding/

The Renal Association https://renal.org/stratified-risk-prolonged-self-isolation-adults-children-receiving-immunosuppression-disease-native-kidneys/

British Society for Rheumatology https://www.rheumatology.org.uk/News-Policy/Details/Action-needed-coronavirus-identifying-high-risk-patients

British Association of Dermatologists http://www.bad.org.uk/healthcare-professionals/covid-19/covid-19-immunosuppressed-patients

British Thoracic Society https://www.brit-thoracic.org.uk/about-us/covid-19-identifying-patients-for-shielding/

The Royal College of Ophthalmologists: https://rcophth.ac.uk/2020/04/covid-19-update-and-resources-for-ophthalmologists/

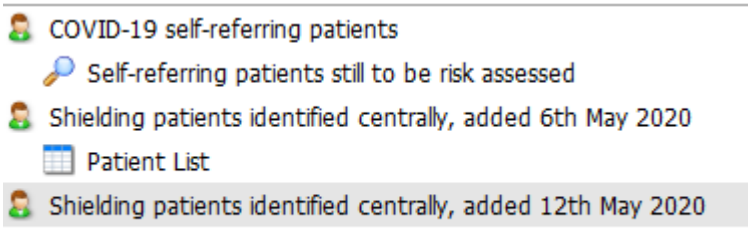
Relevant Codes

Low risk category for developing complication from coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 infection (finding)
Moderate risk category for developing complication from coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 infection (finding)
High risk category for developing complication from coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 infection (finding)

Appendix 2 How do I vet the patients identified by NHSE?

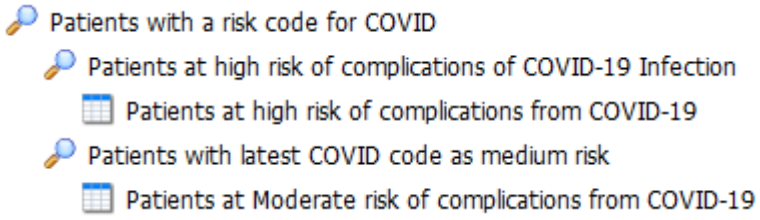
EMIS

The EMIS provided searches should help. These can be found within your practices own population folder, in a separate folder called "EMIS Health:COVID-19 Searches.

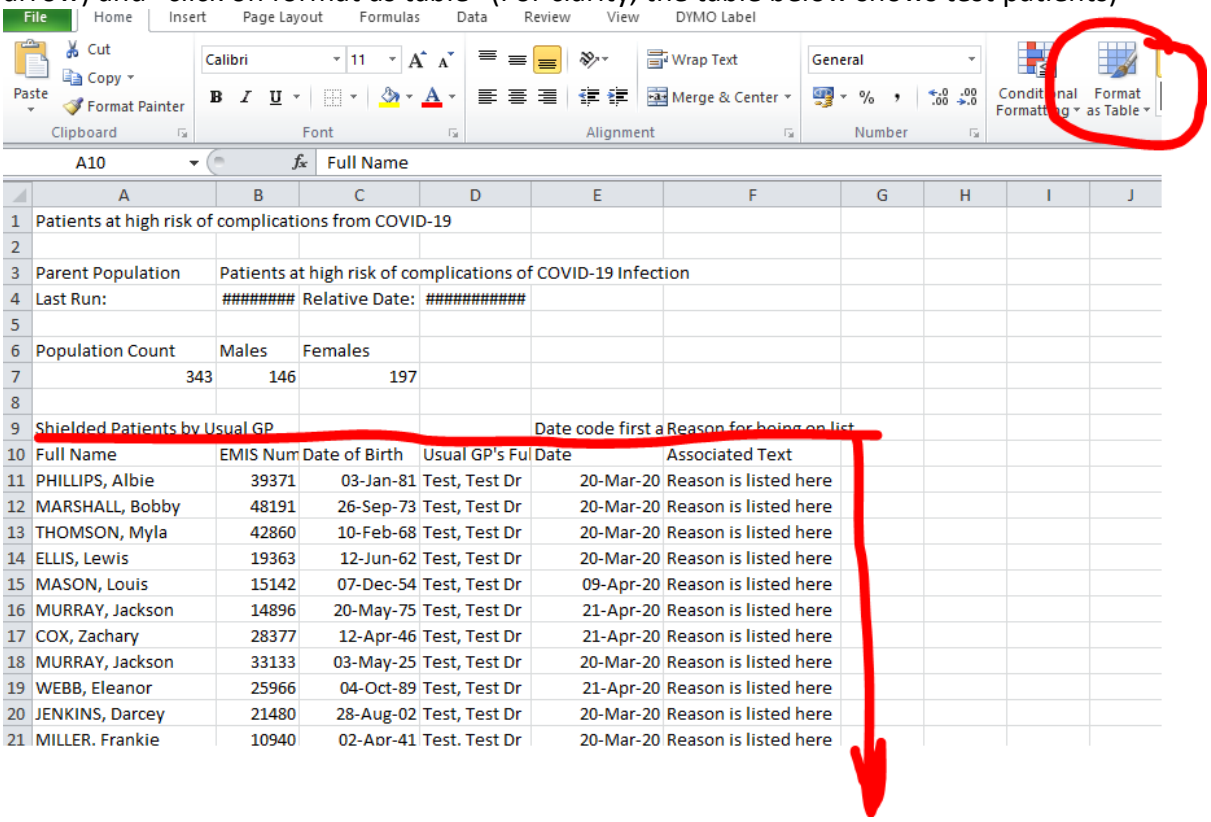


The CDRC has produced a separate set of searches which could also be used. This can be downloaded here **INSERT LINK**

Importing these 2 searches into EMIS gives a more detailed view of all patients on your high and moderate risk registers. However, it can be a little more difficult to sort through the various cohorts.

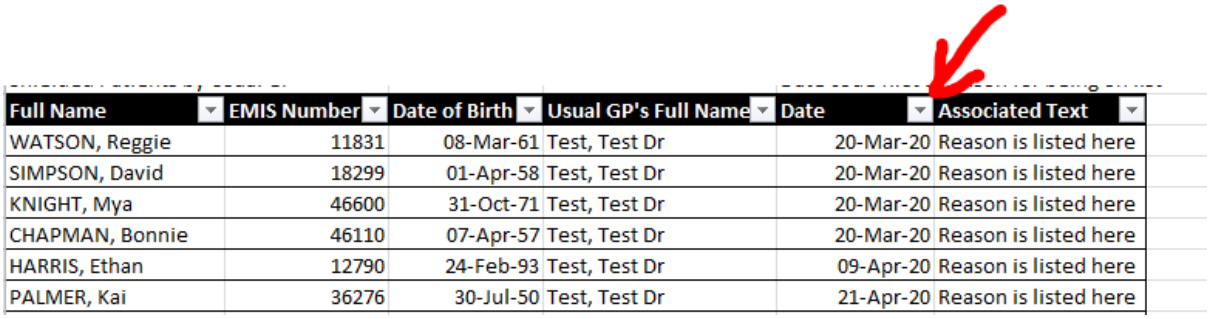


To get around this, export the result of the searches to Excel, highlight the data (shown by the red line and arrow) and "click on format as table" (For clarity, the table below shows test patients)



	A	B	C	D	E	F	G	H	I	J
1	Patients at high risk of complications from COVID-19									
2										
3	Parent Population	Patients at high risk of complications of COVID-19 Infection								
4	Last Run:	########	Relative Date:	##########						
5										
6	Population Count	Males	Females							
7	343	146	197							
8										
9	Shielded Patients by Usual GP				Date code first a	Reason for being on list				
10	Full Name	EMIS Num	Date of Birth	Usual GP's Ful	Date	Associated Text				
11	PHILLIPS, Albie	39371	03-Jan-81	Test, Test Dr	20-Mar-20	Reason is listed here				
12	MARSHALL, Bobby	48191	26-Sep-73	Test, Test Dr	20-Mar-20	Reason is listed here				
13	THOMSON, Myla	42860	10-Feb-68	Test, Test Dr	20-Mar-20	Reason is listed here				
14	ELLIS, Lewis	19363	12-Jun-62	Test, Test Dr	20-Mar-20	Reason is listed here				
15	MASON, Louis	15142	07-Dec-54	Test, Test Dr	09-Apr-20	Reason is listed here				
16	MURRAY, Jackson	14896	20-May-75	Test, Test Dr	21-Apr-20	Reason is listed here				
17	COX, Zachary	28377	12-Apr-46	Test, Test Dr	21-Apr-20	Reason is listed here				
18	MURRAY, Jackson	33133	03-May-25	Test, Test Dr	20-Mar-20	Reason is listed here				
19	WEBB, Eleanor	25966	04-Oct-89	Test, Test Dr	21-Apr-20	Reason is listed here				
20	JENKINS, Darcey	21480	28-Aug-02	Test, Test Dr	20-Mar-20	Reason is listed here				
21	MILLER, Frankie	10940	02-Apr-41	Test, Test Dr	20-Mar-20	Reason is listed here				

Then use the date filter to select the relevant cohort



Full Name	EMIS Number	Date of Birth	Usual GP's Full Name	Date	Associated Text
WATSON, Reggie	11831	08-Mar-61	Test, Test Dr	20-Mar-20	Reason is listed here
SIMPSON, David	18299	01-Apr-58	Test, Test Dr	20-Mar-20	Reason is listed here
KNIGHT, Mya	46600	31-Oct-71	Test, Test Dr	20-Mar-20	Reason is listed here
CHAPMAN, Bonnie	46110	07-Apr-57	Test, Test Dr	20-Mar-20	Reason is listed here
HARRIS, Ethan	12790	24-Feb-93	Test, Test Dr	09-Apr-20	Reason is listed here
PALMER, Kai	36276	30-Jul-50	Test, Test Dr	21-Apr-20	Reason is listed here

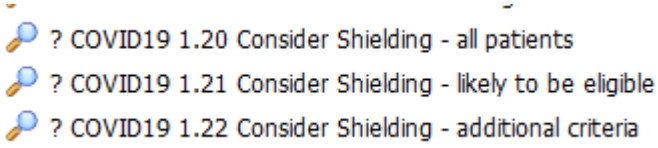
The commonest reasons for misidentification by NHSE are:

- No apparent reason or clearly incorrect information – the free text added to the high risk code by TPP/EMIS may help – see example below from a patient with no history of PPH
  High risk category for developing complication from coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 infection (finding) (Y228a) - Central analysis of NHS Data has indicated the patient may have these risks: Primary pulmonary hypertension|2014-08-19
- Immunosuppressant medication. The NHSE search looked for any issue of some immunosuppressants without applying the additional tests recommended by the medical societies e.g. looking at comorbidities, age, steroid use and multiple immunosuppressant use. The majority of patients taking immunosuppressants (for non transplant indications) will not require shielding.
- HIV, transient or minor past immunosuppression codes e.g. a temporary agranulocytosis

If the patient is not high risk, add a moderate risk code (if the patient is over 70 or eligible for an influenza vaccine) otherwise add the low risk code. There are model letters in the system to send to these patients called, *Covid 19 Low/Moderate Risk letter to patient.* Although not strictly necessary, it wold be helpful to add the high risk code to those you confirm to be high risk to help with future audits.

Appendix 3 How do I identify patients missed by NHSE and secondary care?
SystmOne

The following searches may be of help.



1.20 Patients with information in the primary care record that indicates addition to the shielding register might be necessary.
1.21 The subgroup of 1.20 who are highly likely to be eligible for shielding.
1.22 The subgroup of 1.21 who may be eligible depending on factors such as inhaled or oral steroid dose or frequency

Clinical review of the record is mandatory before addition to shielding register.

The commonest reasons for patients to appear in the searches above are:

- Severe respiratory disease
- Patients taking methotrexate (along with additional factors indicating the need to shield) – methotrexate was not detected by the NHSE search
- Older or comorbid patients taking steroids e.g. patients with polymyalgia

If the patient is at high risk, add the high risk code and send the model letter called, *Covid 19 High Risk letter to patient*