Briefing to CMO on potential requirement for a Phase II shielding process in Wales.

Purpose

The purpose of this briefing note is to update the CMO in relation to the impact of phase II shielding work being undertaken in the other home nations and the effect this has on the volume of potential additional patients (who could in maintaining a consistent approach to NHS England) be added to the Shielded Patients List (SPL) in Wales.

Context

All four home nations developed Shielded Patient Lists (SPLs), however, in each of the nations a slightly different approach was taken. This was influenced by, the iterative nature of the development of the methodology, central decisions on the burden of work to be placed on local primary and secondary care services, and differential access to available data sources. One of the area of differences where differences exist relates to identification of patients on immuno-suppressants, where due to the need to rapidly identify vulnerable patients requiring shielding a wider definition was adopted than was ultimately used in NHS England.

In each of the nations it was acknowledged that the centrally derived SPL would be incomplete, as the process relied heavily on clinical coding and because specific guidance on which patients were a priority to shield was in the process of being developed by specific clinical societies and unavailable at the time of the production of the initial SPL list.

It was recognised that a second phase to the shielded patient list process may be required, however until the need for this was determined, NHS Wales agreed a process where GPs would be able to add patients to the SPL in order to provide a safety net for the system. The first census of additions made by GPs, has identified that circa 4300 patients have been identified by GPs for addition to the SPL since the shielding letters were first issued. In England, secondary care was also asked to identify patients who should be shielded by following guidance issued by The Academy of Medical Royal Colleges (AoMRC) and specific British clinical societies (appendix 1). The wider group of specialists were asked to only identify those that they would consider to be at the very highest risk, bearing in mind the severity and unpleasant nature of the intervention that will be proposed for this group.

The safety net of GPs adding to the SPL however, is under pressure as following the issue of the AoMRC/ British Society and Association guidance's, secondary care clinicians in Wales are advising and issuing letters to patients to shield although they have not been advised to do so. Evidence suggests that in some areas secondary care clinicians are advising patients to go to their GP to be added to the list however, this is not consistent, moreover, the guidance's of the British Societies have not currently been included as part of the Welsh SPL methodology.

Anecdotal feedback from a number of practices suggests that GPs are unsure if patients referred from secondary care meet the criteria of the CMOs guidelines and should be added to the SPL list.

An alternative process would be required and currently teams are investigating the possibilities of using the Audit+ system to search for criteria based on read codes, this will take approximately 10-14 days to complete.

Considerations

- The initial wave of Phase 1 letters were issued with a guide to undertake 12 weeks of shielding, in part this was influenced by our understanding of the likely presentations of COVID to secondary care services, given current understanding would this guidance change? It should be noted that provision of an alternative date in shielding for Phase II patients may be problematic from a communications perspective.

- Irrespective of the ability centrally to identify patients that meet the AoMRC and British Society Guidelines for shielding, secondary care clinicians will continually identify patients for adding to the shielding list. As such there would be a benefit for an agreed process within Wales to facilitate this a proposed process is included as appendix 2 if Wales wants to adopt these criteria

- Agreement of a process to enable the incorporation of the respective AoMRC and British Society Guidance's into the agreed Welsh SPL methodology as this occurs across the 4 nations, will support and clarify both primary and secondary care additions to the SPL.

- In addition to establishing a simple process to support secondary care additions to the SPL, re iteration of the process for GPs to add patients to the list is also likely to be desirable to ensure all eligible shielded patients are appropriately identified.

- As with Phase I a second Phase of the process would need to be undertaken over a short period of time 7-14 days to enable data from all the respective data sources to be captured and validated.

Conclusions

Initial review of the NHS England phase II shielding methodology suggests that approximately 13000 patients, would immediately be added to the Welsh Shielded Patient List centrally if the revised English APC methodology were applied and hospital Immuno–suppressant patients included. This number will grow as data from all aspects of the reconciliation to the approach followed in NHS England becomes available.

The CMO is asked to consider the paper and advise:

- If further shielded letters are to be issued to the patients identified via phase II searches and if so, how long will shielding be recommended for.

- If and when specific AoMRC / British Society guidance's should be added to the Welsh SPL methodology