Message

From: HEALD, Scott (NHS NATIONAL SERVICES SCOTLAND) [scott.heald@nhs.net]
Sent: 18/03/2020 16:33:07
To: Caroline.Lamb [caroline.lamb@gov.scot]; NR @scotland.gsi.gov.uk; Jonathan.Cameron@scotland.gsi.gov.uk; Name Redacted @gov.scot]; NR (NHS NATIONAL SERVICES SCOTLAND); NR @nhs.net; Name Redacted (NHS NATIONAL SERVICES SCOTLAND); Name Redacted @nhs.net]
Subject: RE: Vulnerable people

Thanks NR – that's a really good summary of our discussion.
Happy to engage with further discussions as required,
Scott

From: Caroline.Lamb@scotland.gsi.gov.uk <Caroline.Lamb@scotland.gsi.gov.uk>
Sent: 18 March 2020 16:23
To: NR @scotland.gsi.gov.uk; Jonathan.Cameron@scotland.gsi.gov.uk; NR @scotland.gsi.gov.uk; HEALD, Scott (NHS NATIONAL SERVICES SCOTLAND) <scott.heald@nhs.net>; NR (NHS NATIONAL SERVICES SCOTLAND; NR @nhs.net>; Name Redacted (NHS NATIONAL SERVICES SCOTLAND) Name Redacted @nhs.net>
Subject: RE: Vulnerable people

Many thanks for this. I'll try and pick this up with 4 Nations Colleagues, particularly to see where they are with GP Systems.

Caroline

Caroline Lamb
Director of Digital Reform and Service Engagement
St Andrew's House, Regent Road, Edinburgh EH1 3DG
I&S

From: Name Redacted @gov.scot>
Sent: 18 March 2020 16:06
To: Lamb C (Caroline) <Caroline.Lamb@gov.scot>; Cameron J (Jonathan) <Jonathan.Cameron@gov.scot>; NR Name Redacted @gov.scot>; scott.heald@nhs.net; NR (NHS NATIONAL SERVICES SCOTLAND) NR @nhs.net>; Name Redacted @nhs.net
Subject: RE: Vulnerable people

Dear Caroline, colleagues

Had a good chat about this with Scott Heald, Name Redacted and Name Redacted from ISD earlier this afternoon. Although keen to support this requirement, the letter from England rings some alarm bells for them. To summarise:

1. The letter identifies 9 groups with corresponding SNOMED codes. SNOMED is not yet used in primary care in Scotland. Although all READ codes used in Scotland have a corresponding single SNOMED-CT code, the reverse is not true – i.e. some SNOMED codes will not translate directly to READ and be coded under one of multiple READ codes.

2. The quality of READ coding within the GP practice is variable. For example, rare diseases are often recorded under catch-all codes, with additional information provided as text. ICD-10 codes would not go to the level of granularity required to identify rare diseases.

3. ISD holds central data returns that might be used in some way. For example, SMR data would identify those with solid organ transplants over the last 10 years, but NOT within the last 6 months since data is not submitted in real-time. ISD would not know if a patient had died the last 2 months. This approach could help to identify some broad numbers, but would not be sufficiently reliable for letter generation.

4. People vulnerable because of immunosuppression may not have been in hospital in the last 5 years or be known to GPs, so it may not be possible to identify them.

5. GP practices will not necessarily know if patients are receiving radiotherapy or chemotherapy once they are in the acute system.

6. Due to the issues outlined above, there is risk that people may be missed (not registered with a GP, not coded, wrongly coded…) or lettered inappropriately (not vulnerable, dead..).

7. Scott and colleagues reported that ISD is being contacted directly by GP practices looking to see if SPARRA can be used to identify lists of people they are most concerned about. SPARRA currently uses algorithms to identify those people most at risk of hospital admission. It would be possible to configure SPARRA to identify some if not all of the cohorts on the target list. SPARRA is well-used and trusted by GPs in Scotland and there is no equivalent in England, so this might be an option for us. This approach could be used if letters were to be sent out by the GP, who would also know if any patients had recently died or should not be contacted for some reason (the Adults with Incapacity Act guards against sending letters 'cold' to people with severe mental health problems since it may result in unintended consequences).

8. The GP system suppliers themselves might be asked to assist. Emis and Vision could be asked to write a procedure that identified vulnerable people from their systems if we were able to specify the exact criteria. They may already be working with England on developments that could be used in Scotland. It would be useful to find out if/how they are involved.

9. The PARD (Persons at Risk Database) was originally thought to be a potential data source, but this does not hold the data necessary for this purpose (focuses on frail and elderly/mobility and would not identify all those targeted below).

10. ISD colleagues were asking whether other communication methods have been considered, such as online messaging, radio etc. I guess this will depend on how condition-specific the content of the letter is likely to be.

I should stress that, in spite of the concerns outlined above, ISD colleagues are very keen to engage in further discussion and provide support in any way they can.

Hope this is helpful.
NR

From: Lamb C (Caroline) <Caroline.Lamb@gov.scot>
Sent: 18 March 2020 10:12
To: Name Redacted @gov.scot>; Cameron J (Jonathan) <Jonathan.Cameron@gov.scot> NR
Name Redacted @gov.scot>; scott.heald@nhs.net
Subject: RE: Vulnerable people - quick update

With thanks to Scott for his input on this. Below is the list of individuals at high risk of complications from DH&SC which our CMO is content with. These are the patients that we need to communicate with, potentially with condition specific information……

Dear all

I am writing to follow up on the conversation at yesterday's meeting regarding the identification of individuals at high risk of complications.

Many thanks to everybody who has fed into the process by which we arrive at a final list at such pace.

In attempting to draft an explanatory letter from UK CMOs letter to GPs, it became clear that we need to offer a more structured pathway to help them identify their other high risk patients than just asking them to use their clinical judgement, as there was no clear clinical rationale for why some conditions were not included. Therefore we further considered the list and have settled on a slightly expanded version, which has wider coverage of high risk conditions, to ensure that we equitably cover all groups.

Chris is content with the following list which is drawn from the broad categories that the Clinical Reference Group list covers. We hope this can be cross referenced with SNOMED codes to ensure we also obtain coverage across primary care conditions and would like to pick this up asap please.

1. Solid organ transplant recipients
2. People with cancer undergoing active chemo / radiotherapy
3. People with specific cancers (eg haematological)
4. Severe respiratory conditions (inc CF) requiring repeated hospitalisation
5. Severe single organ disease (liver, cardio, renal, neurological, GI)
6. Specific Rare diseases
7. Severe Autoimmune diseases on immunosuppression
8. Other significant immunosuppressed
9. Severe frailty

For info in case people are not aware - Clinical Reference Groups support NHSE in direct commissioning of services. They were asked to consider the conditions they felt would put patients at high or very high risk of complications (attached), but they were not specifically aware that this group would be asked to go into extended self isolation. The individual list of conditions identified by the CRGs are not easily extractable from existing datasets, but as all of the included conditions are eligible for flu vaccination, we are confident that broader categories of them (as summarised above) can be identified using Jonathan Benger's very pragmatic approach.

Chris remains keen that we keep the numbers low – within 1.5million – due to the highly restrictive nature of the measures we are asking the group to take. We hope to achieve this by skewing the included groups towards the more severe end of the scale (eg for severe single organ disease). We need to work out the best way to achieve this.

We need to sign off the list urgently today as the PM wishes to announce this on Thursday, and we need to ask colleagues in NHSD / E to help us identify the revised group of patients. I would be grateful for comments by 6pm today. If we do not hear back by this point we will assume that you are happy with the revised list.

Best wishes

Nisha

Department of Health & Social Care

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From: Name Redacted @gov.scot>
Sent: 17 March 2020 18:31
To: Lamb C (Caroline) <Caroline.Lamb@gov.scot>; Cameron J (Jonathan) <Jonathan.Cameron@gov.scot>; NR Name Redacted @gov.scot>
Subject: Fw: Vulnerable people - quick update

Here's Scott coming back with another couple of options we might explore further (2 emails below)- Julie

Sent from my BlackBerry 10 smartphone.

From: HEALD, Scott (NHS NATIONAL SERVICES SCOTLAND) <scott.heald@nhs.net>
Sent: Tuesday, 17 March 2020 18:24
To: Name Redacted
Cc: NR (NHS NATIONAL SERVICES SCOTLAND)
Subject: RE: Vulnerable people - quick update

Another option to consider is our SPARRA (Scottish Patients and Risk of Readmission and Admission to hospital) – essentially gives a patient listing based on an algorithm which predicts their likelihood of going into hospital. Not sure we'd have patient addresses, as the listing is sent to GP practices, but might be something to work with which would keep the "vulnerable" definition manageable?
Scott

From: HEALD, Scott (NHS NATIONAL SERVICES SCOTLAND)
Sent: 17 March 2020 18:17
To: NR @scotland.gsi.gov.uk
Cc: NR (NHS NATIONAL SERVICES SCOTLAND) NR @nhs.net>
Subject: Vulnerable people - quick update

Hi NR

Just spoken with NR and he's going to explore another option for you tomorrow. There's a database maintained by NSS called PARDs (Patients at risk database) – it's meant to be something which exists to be used in an emergency to notify authorities about vulnerable people in their area (e.g. if there was a flood, PARDs could be used to identify vulnerable people, e.g. the elderly, living in those areas so that they can be contacted). Might be possible to use this for the purpose you were describing. We'd have to think through things like false positives and false negatives (i.e. people

in the system who might not be vulnerable and, potentially worse, people who are vulnerable but aren't on the database). Not sure how the database is populated but we could find that out.

The original list of vulnerable diagnoses that we used for the analysis earlier this week identified around 2 million people (quickly adds up when you count the elderly) so some thought to the definition you want to use really needs to be given. Could get very complicated and, as I say, runs the risk of missing people or including people who aren't vulnerable. Our analysis was based on a variety of data sources so it's not as straightforward as it may first sound.

I'll check with the CHI team in ISD tomorrow re what might be possible from CHI.

Thanks – in the office tomorrow if it would help to have a follow-up call. Have copied NR into this email as he's our COVID-19 lead for ISD and good to have him involved in discussions so that he can join up other conversations across SG.

Speak tomorrow if that would be helpful,

Scott

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