Health Services Public Health

Primary Care

22 April 2020

SHIELDING UPDATE FOR NHSGGC PRACTICES

This letter provides updated nationally agreed guidance on the wider group of patients with respiratory disease who may require to shield.

Scottish Government have also issued a consolidated guidance note on shielding which incorporates their previous communications. Minor change identified: **where practices are notifying a removal from the shielding list, could they also provide a reason for removal.**

Dear colleagues,

Further to my letter of the 17th April I'm writing to provide further advice in relation to nationally agreed guidance for the broader group of respiratory conditions which were included in the shielding categories in response to advice from Asthma UK and BTS.

This advice was been received after the EScro Shielding Report was developed and my previous letter sent. Having considered the advice it is in broad agreement with the advice already given on the use of clinical discretion to decide if a patient has to shield or not. It is intended to support colleagues but I appreciate that the timing will be problematic as many practices will already have reviewed their **Additional Searches for Review** tab in the ESCRO tool and will have already made decisions on whether or not the patient should shield. If having read the guidance you feel that you wish to change your decisions around shielding advice, you should feel free to do so, citing this more recent guidance. I am acutely aware that in some cases this may well cause further distress to your patients and so this must be a decision for practices who know their patients best. I am truly sorry for the additional burden that this places upon staff at this time.

MCN guidance for severe asthma

The searches in the EScro Shielding Report uses a slightly different definition for severe asthma in comparison with the National Respiratory cell definition. It incorporated Asthma UK advice relating to LABA and high ICS doses, or high ICS and montelukast. The MCN suggests a higher dose of daily prednisolone of 10mg whereas the original national searches by ISD used 5mg. The EScro model does not identify asthmatic patients taking a steroid sparing agent such as methotrexate, azathioprine or MMF (mycophenolate mofetil). **We would recommend that if practices are aware of asthmatic patients who receive these agents and have not already been shielded, they should be issued with a letter, coded, contacted, and their CHI returned as per previous guidance.** We would expect that these patients will already be well known to practices in terms of severity.

Severe COPD

The EScro tool has not been designed to pick up COPD **and** bronchiectasis together. I suspect most of these patients will have been identified as bronchiectasis in the additional searches tab and you may well have considered them on the basis of severity. The GOLD classification and active transplant list are not well coded and have not been included in the ESCRO searches. Finally, we have searched for prescribing of azithromycin and COPD, but not for doxycycline, cotrimoxazole or penicillin. **Practices may wish to search for patients who have both COPD and are on regular prescriptions of these further three medications**. Due to severity, they are very likely to be well known to the practice and are likely to be already shielding based on the original searches done by iSD which identified those prescribed 'triple' therapy (ICS+LABA+LAMA).

Interstitial Lung Disease

The MCN guidance is extremely helpful in this section, and sets out the need to shield patients with Idiopathic Pulmonary Fibrosis. Other ILD groups should have severity measured by issues such as palliative status, long term oxygen, antifibrotics such as pirfenidone and nintedanib (not within the EScro Shielding Report), on more than 5mg of prednisolone daily, or on other immunosuppressants in the last 6 months.

Patients with a historical diagnosis of interstitial lung disease not receiving treatment or secondary care **need not shield**.

Sarcoidosis

Many patients will already have been contacted directly from secondary care. Patients who should shield include: ongoing parenchymal lung disease (stages 2 to 4), AND on oxygen, AND/OR on steroids (any dose), AND/OR immunosuppression (includes methotrexate). For those with stage 0 or 1 disease, only those receiving 20mg or more prednisolone per day for 4 weeks or more, or 5mg or more for 4 weeks plus and immunosuppressants should also shield.

Patients with a historical diagnosis with no ongoing treatment or secondary care follow up, and those with stages 0 or 1 parenchymal lung disease, not on steroids or immunosuppressants **need not shield.**

Bronchiectasis, ventilator support and pulmonary hypertension

The majority of these patients who should shield will already have been contacted by secondary care. If in doubt, please contact your local respiratory team. Bronchiectasis includes uncommon conditions such as ciliary dyskinesias.

Rescue packs

The guidance also provides some further advice on the use of rescue packs.

Summary

- The new ESRCO search utility can be downloaded from Monday 20 April www.escro.co.uk/EScro_Shielding/Escro_Shielding.htm (link to website here)
- Practices should review the ***Additional searches to review*** tab.

- For asthma we would suggest that practices should consider the use of steroid sparing agents such as methotrexate, azathioprine and mycophenolate. It is very likely that these patients will already have been shielded due to severity.

- For COPD, where patients also have a diagnosis of bronchiectasis (in the additional searches tab), they should now shield.

- For COPD, long term antibiotics including doxycycline, cotrimoxazole or penicillin should be considered when assessing shielding. It is very likely that these patients will be well known to practices and will already have been shielded due to severity.

- Patients known to have idiopathic fibrosing alveolitis should shield.

- Patients with other instersititial lung disease should be assessed for severity considering factors such as long term oxygen, antifibrotics, regular steroids or other immunosuppresants. Those without active treatment or specialst follow up **need not shield.**

- Patients with stage 2 to 4 sarcoidosis who are also receiving oxygen, and or steroids, and or immunosuppression should shield. Patients with stage 0 or 1 sarcoidosis should shield only if they are receiving 4 weeks or more of high dose steroids (20mg or more) or lower dose steroids (5mg or more) for four weeks plus another immunosuppressant. Patients with a historical diagnosis with no ongoing treatment or secondary care follow up, and those with stages 0 or 1 parenchymal lung disease, not on steroids or immunosuppressants **need not shield.**

- The majority of those with bronchiectasis, requiring ventilator support or with a diagnosis of pulmonary hypertension who need to shield will already have been contacted. If in doubt, please liaise with your local respiratory team.

- As previously, for the group of patients in this list who you consider would benefit from shielding, record their CHI and return the list to COVIDSHielding@ggc.scot.nhs.uk

Once again I apologise for the further work and timing of the update. Thank you for all that you are doing at this time. I'm very grateful to Dave Anderson, local respiratory MCN colleagues, Tom Fardon and the National Respiratory Cell for their helpful advice.

Please stay safe.

Kindest wishes,

John

Dr John O'Dowd

Consultant in Public Health Medicine & GP

Encs 2

MCN guidance: definitions of patients etc

SG consolidated guidance on screening