Our Joint Pathway for Long COVID

GSTT with Partners

KCH and SLAM

Southwark Health Overview

and Scrutiny Commission

March 22nd

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Who Are Long Covid Patients?

NICE describes Long COVID as *"signs and symptoms that continue or develop after acute COVID-19"*

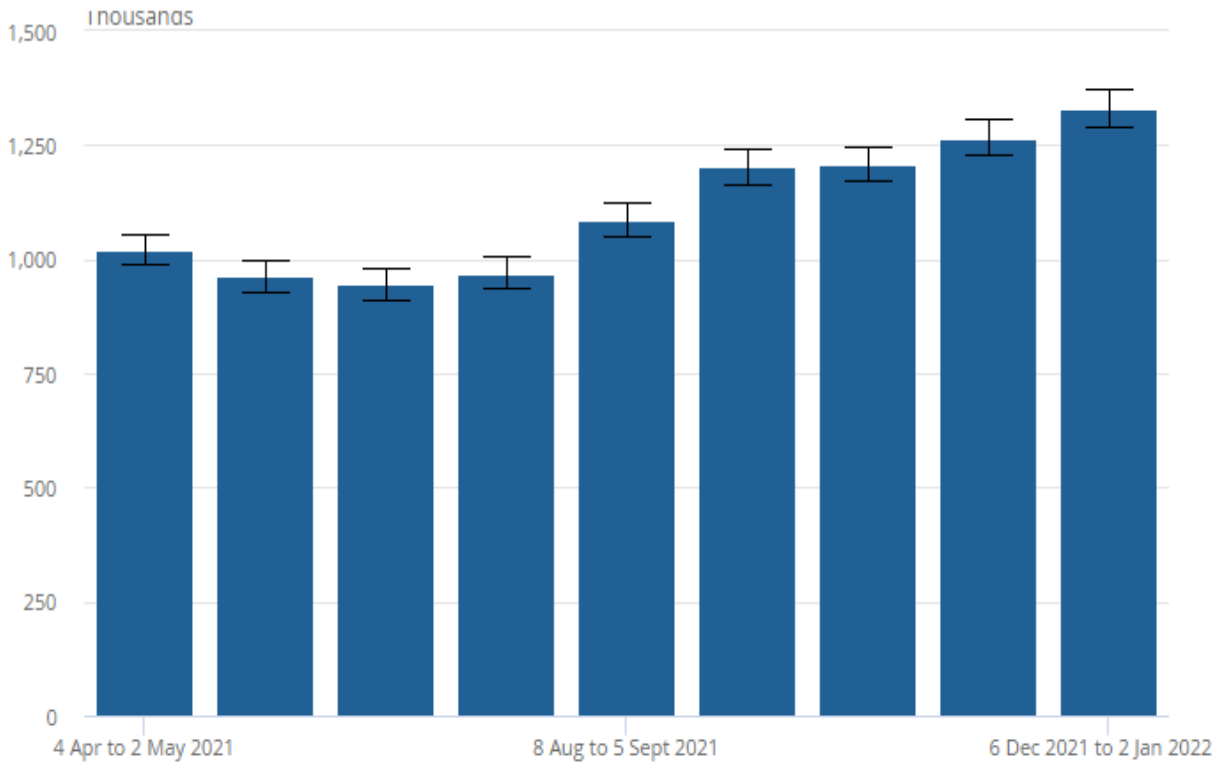
This definition includes both

- **symptomatic COVID-19** signs and symptoms of COVID-19 from 4 to 12 weeks
- **post-COVID-19 syndrome** signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis (NHS Plan 2021)

Vaccination
Observational studies suggest that vaccination decreases the prevalence of Long COVID. Equally, where there is self reported Long COVID, initial observations suggest the symptoms are less severe.

Omicron
There is uncertainly on the impact of Omicron, though the high rate of infection suggests a potential increase in the rate of Long COVID.

Estimated number of people living in private households with self-reported long COVID of any duration, UK: four-week periods ending 2 May 2021 to 2 January 2022



An estimated 2.4% of the population who had acute COVID were experiencing self-reported long COVID as of 31 January 2022. Highest prevalence ages are between 17-69.

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Office of National Statistics March 2022

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What Does The Evidence Suggest People Receive?

Long COVID is a new and emerging condition, which can have a significant effect on people's quality of life. It also presents many challenges when trying to determine the best-practice standards of care based on the current evidence.

There is an evolving evidence base but no internationally agreed clinical definition or clear treatment pathway. NICE have recently published a guideline but we expect there to be an evolving evidence base, which KHP is contributing to.

SEL Long COVID Plans Aligned To NHSE Guidance 2021/23

The following outlines the approach to new services planned in South East London against NHSE guidance 2021 and funding to support patients with Long COVID. In addition South East London partners ae being funded by our local charities to explore what the best care to Long COVID patients should look like.

NHSE Guidance	SEL Setting	Southwark
Post COVID assessment clinics	KCH GSTT PRUH	KCH GSTT
Diagnostics, treatment and rehabilitation	Community ,secondary, mental health and tertiary settings	GSTT and SLAM Therapy services
Support patients to be managed in primary care, where appropriate and enable consistent referrals	Primary care services	Primary care

South-East London Long-COVID programme

Purpose	Funding Partners	Delivery Partners
To create a blueprint for the 'gold-standard' of multidisciplinary care of people with long COVID with the aim of speeding up recovery to share nationally	Guy's & St Thomas' Charity, NHS Charities Together	KCH, GSTT, SLAM, Bromley Health care, One Health Lewisham, Oxleas NHS Trust, Joint Programme for Patient, Carer and Public Involvement in COVID Recovery: Long COVID

Principles of Care

Long COVID: the NHS plan for 2021/22 (June 2021)

• **Personalised care**: By listening to people and asking, ‘what matters to you?’ a personalised care and support planning process based on what matters most to individuals is a crucial initial step in providing personalised care.

• **Multidisciplinary and rehabilitation**: A multidisciplinary team should tailor support and rehabilitation for the person to enable the development of individual care plans for physical, mental and social needs.

• **Supporting and enabling self-care**: Some people with milder symptoms may be able to help themselves through self-management.

Core service criteria:

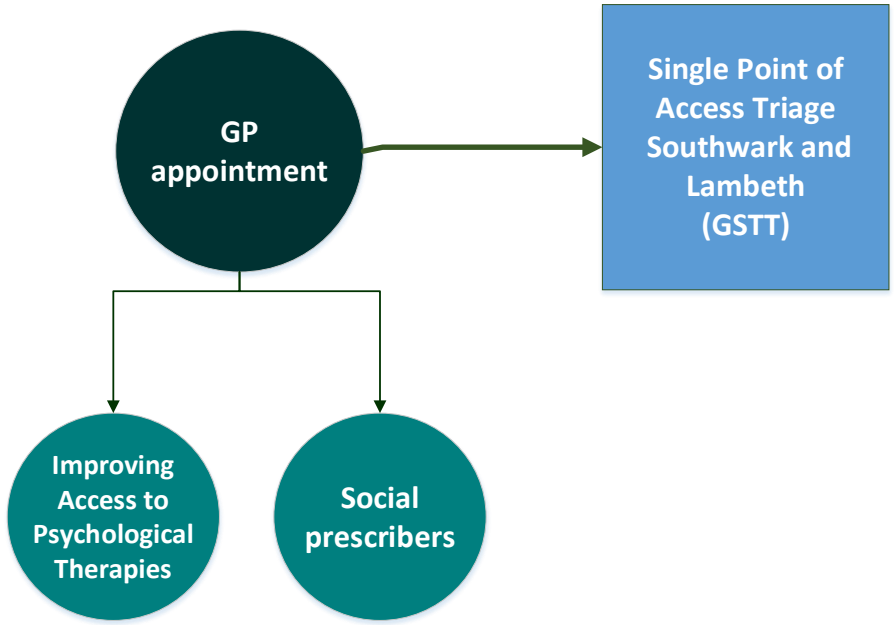
• multidisciplinary, physical, cognitive, psychological and psychiatric assessment with the aim of providing consistent services and face-to-face appointments available where appropriate.

• make provision for all those affected including those who were never admitted to hospital or tested for COVID-19.

• Services must ensure equity of access. Consideration must be given to groups most likely to be impacted by health inequalities and how they access and utilise healthcare services to ensure that no one is discouraged or unable to benefit.

Review for Referral Primary Care	Paper Triage Joint Therapies	Assessment Joint Therapies	Treatment Options	Follow up Joint Therapies

Our Southwark And Lambeth Treatment Pathway (From April 2022)- Developed With Primary Care, KCH, SLAM And Patient Discussion



Multi-Disciplinary Assessment face to face (KCH)

Multi-Disciplinary Assessment Face to face (GSTT)

Telephone assessment (GSTT)

Specialist Clinics -KCH and GSTT

Persistent Physical Symptoms service (SLAM)

Vocational Rehabilitation (KCH)

Long COVID group rehabilitation (GSTT)

1:1 therapy support (GSTT)

Supported self management (GSTT)

3 month follow up

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Joint Therapies includes Occupational Therapy, Physiotherapy, Dietetics, Speech and Language and Psychology

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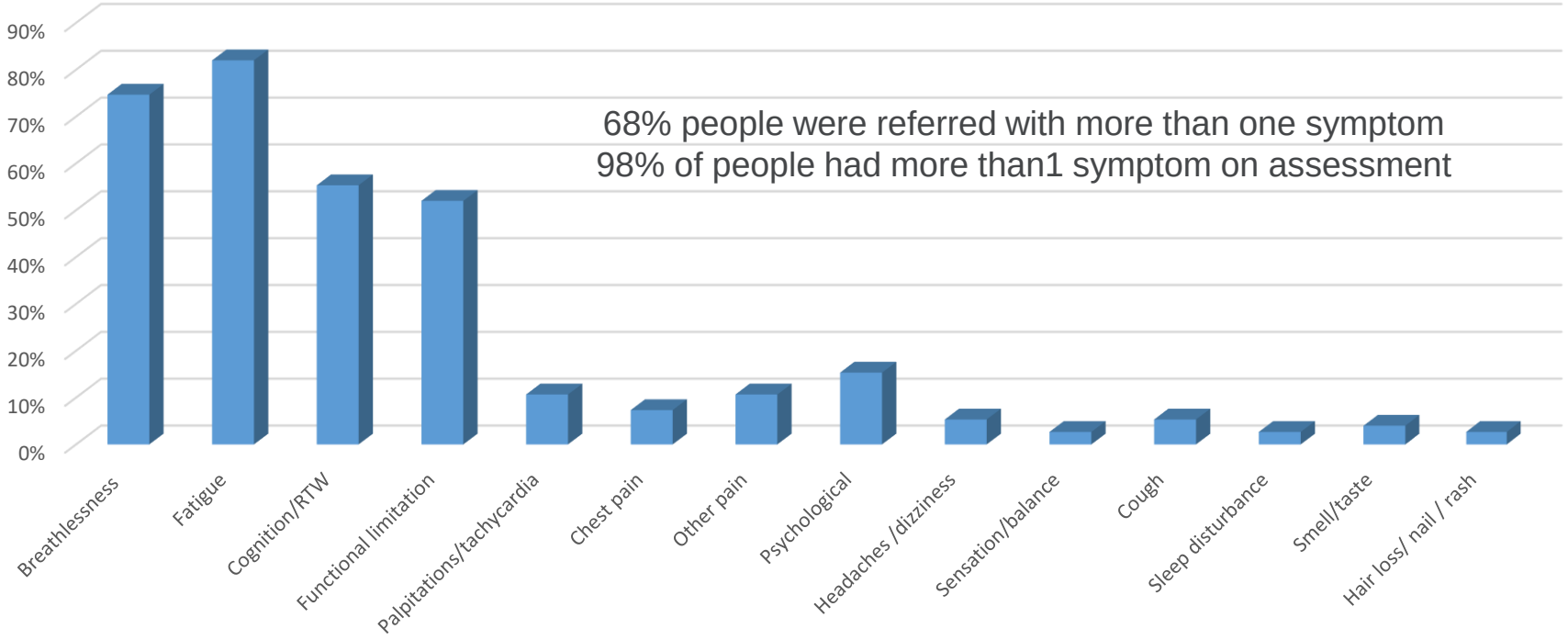
Our Initial Clinic Activity and Patient Profiles

- Assessment clinics were initiated in GSTT and KCH in April 2021
  - GSTT- therapy led and medically supported via Multi Disciplinary Team meetings
  - KCH - medically led and now moving to therapy led

GSTT and KCH Activity (April 21 – Jan 22)			
	GSTT	KCH	Total
New	378	517	895
Follow up	175	140	315

Patient Symptoms Seen in GSTT Assessment Clinics



Patient Profile from GSTT Assessment Clinics (n=385)

Acute COVID management	
Critical care	4%
Hospital	13%
Community	82%

- Average age = 47
- Female (66%)
- **Ethnicity:** 68% white,16% Back, 7% mixed 6.5% Asian, 3% Other ethnic group
- **Employment**: 70% employed, 9% on sick leave (12% NHS)

Onward Referral and Outcomes of our GSTT Clinics at 3 Months

GSTT Clinic Onward Referral	
Therapies	46%
Improving Access to Psychological Therapies	36%
Persistent physical symptoms service	29%
Pulmonary Rehabilitation and respiratory specialist	18%

GSTT Assessment clinic outcome (n= 374)

59% - completed 3 month Follow up

8% - discharged from service

Reported change in symptoms at 3 month follow up

48% - people felt there symptoms were the same

39% - improved

14% - new symptoms or reported their symptoms were worse

Patients who at 3 months have not improved are reviewed and a new personalised care plan discussed; with the option of being able to refer people on to our new suite of therapy led Long COVID services, as outlined in the new pathway.

Additional Support for our Staff post COVID 19

An Occupational Health Post COVID-19 Clinic offers advice and information regarding pacing of activities, exercise (if appropriate) and return to work for staff members with confirmed or suspected diagnosis of COVID-19 who have ongoing symptoms of fatigue, muscle aches, or joint pain for more than 4 weeks.

Joint Programme for Patient, Carer and Public Involvement in Covid Recovery

- Established September 2020, **to ensure the involvement of patients, carers and the public in ongoing changes and the development of services necessitated by the COVID pandemic**.
- Partnership between Guy's and St Thomas' including Evelina London Children's Hospital and Royal Brompton and Harefield hospitals and King's College Hospital.
- Funded, over two years, by GSTT Charity and supported by KCH Charity.
- In Year 1, telephone survey to understand patients' and carers' (n=1,500) behaviours and attitudes to accessing care and services during the pandemic. To inform how services continue to be designed, improved and delivered during COVID-19, recovery and beyond.
- By May 2021, extensive scoping, identification and prioritisation exercise completed to refine focus of the programme. Resulted in focus on three topics and project briefs:
    - Virtual access to care
    - Waiting for treatment and self-management
    - **Long COVID**
- By September 2021, Procurement process selected London South Bank University Health Systems Innovation Lab and People's Academy to deliver the three projects.

Also involving:

Patient-public stakeholders incl. governors

healthwatch

NHS South East London Clinical Commissioning Group

ROYAL BROMPTON & HAREFIELD HOSPITALS CHARITY

Ipsos

London South Bank University

Joint Programme for Patient, Carer and Public Involvement in Covid Recovery

Aims:

- Understanding the experiences and support needs of people with long COVID
- Exploring barriers to accessing services and support and how to overcome barriers
- Shaping the design of existing and future services
- Developing a network of people with experience of long COVID

Working with:

- Development of Lambeth and Southwark borough based services
- South East London long COVID programme funded by NHS Charities Together

Sharing progress and learning with:

- ICS, Proactive Case Finding Task and Finish group, Post COVID London - and others

Phase 1: Understand & find Oct–Dec '21

- **Desk research**
- Establish & involve **design teams** for projects
- **Participants** mapping & selection

Phase 2: Co-design Mar–Jun '22

- Series of **workshops** bring together staff with people who are and are not accessing long COVID services

Phase 3: Delivery Jul–Sep '22

- Peer **network**
- **Service model** co-designed by patients, carers and staff
- Report + **next steps**

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What Our Patients Have Told Us	How We Are Designing Our Service
Need the route to accessing services to be clear and well explained – availability of information about the service	We have developed a patient leaflet for primary care to explain our pathway
The service having a Multi-discipline working at its core, being a one stop shop rather than spilt across different specialisms	Each intervention option is multi-disciplinary including therapies with psychology embedded in each option
Patients need information about what to expect – who can access the service, how and what the service is offering.	Clear criteria for referral are explained within the patient leaflet and agreed with Primary care
Referral process needs to be straightforward. GPs need to know what the service offer is, in order to explain the service to patients and make appropriate referrals	From one referral a service triage enables patients to be quickly directed to an appropriate assessment to coordinate a bespoke treatment plan.
Need time to talk things through in detail and be listened to. Not possible with GPs.	Patients are given time to talk through out their pathway, enabling shared decision making and personalised care
Patients need hope. What treatments are available over and above self-management?	Options include remote and face to face appointments, 1:1 /group therapy, vocational rehabilitation and Persistent Physical symptoms and specialist services