Specialty Paragraphs for vulnerable HCWs

RESPIRATORY

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| Condition | Guidance |  |
| Asthma | It is important to recognise that this remains a personal decision and some front-line staff may still wish to work in their patient facing roles irrespective of their asthma and the asthma service will support these individuals where needed. In line with existing PHE guidelines it is recommended where possible members of staff work from home but this is not an option for many front-line members of staff. • For members of staff with severe asthma+ (hospital diagnosed) including those requiring biologic treatments, maintenance oral corticosteroids or other immunosuppressants it is recommended that they self-isolate at home as per the current PHE guidance.• For members of staff taking high-dose inhaled steroids alongside additional controller treatments\* for their asthma who have suffered 2 or more asthma exacerbations requiring oral steroids over the past year and continue to experience frequent asthma symptoms requiring use of their reliever medication line managers should strongly consider reallocation away from front-line duties. * For members of staff with mild asthma that is well controlled an individual is not at high risk.

 During the COVID-19 pandemic members of staff with asthma should not routinely be advised to escalate their asthma treatments but should follow their asthma self-management plan if their asthma symptoms worsen. There is no basis for starting steroid tablets earlier or routinely prescribing antibiotics for those with asthma attacks during the COVID-19 pandemic. It is essential that members of staff with asthma who are prescribed regular (preventer) asthma treatments take these everyday and have their reliever medication with them at all times (including a spacer device where needed). They should ensure they have a sufficient supply of their asthma medications available and that they have an asthma self-management plan to follow if their asthma symptoms worsen.  +Diagnosis in accordance with the ATS/ERS Severe Asthma guidelines; Contact appropriate Severe Asthma Service to provide clarification of the diagnosis of severe asthma where necessary.\*High-dose ICS considered to be >1000mcg/day BDP equivalent maintenance ICS dose, additional controller medications include long-acting β2-agonists, long-acting muscarinic antagonists, leukotriene receptor antagonists and oral theophyllines (see BTS/SIGN Asthma Guideline: <https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/>). |  |
| COPD | Recommendations should be in line with PHE guidelines – which may be updated further. Currently, they recommend where possible members of staff work from home but this is not an option for many front-line members of staff.We anticipate that Trust Occupational Health (OH) reviews have considered the fitness for current frontline workers with COPD, with an acceptable risk of meeting patients who have infection. However, during the pandemic, some frontline roles may require more frequent / prolonged wearing of a mask for PPE.  This should be factored in and assessed given it may impact on their breathing. New OH risk assessments would be needed for staff moving into new roles where they are now seeing patients and at risk of infection. Staff with COPD, are likely to be older and therefore many will already fulfil a more vulnerable group and may have known or subclinical cardiovascular disease or other co-morbidities. Those with additional risks such as older age or co-morbidities, those on oral maintenance corticosteroids, oxygen or those with a history of frequent exacerbations requiring oral steroids or antibiotics would be encouraged in particular to discuss with their line manager about re-allocation away from front-line duties.  It is important that all staff with COPD ensure they have a sufficient supply of their COPD medications available and that they have a self-management plan. During the COVID-19 pandemic, members of staff with COPD should continue on their standard COPD management. They should follow optimal inhaler technique and if using an MDI, use a spacer device. If they exacerbate, they should follow their self-management plan and if oral steroids or antibiotics are recommended for the exacerbation, that they follow this, in line with National guidelines. A proportion will be current smokers which brings an additional risk and smoking cessation is advised. |  |
| Bronchiectasis | TBC |  |
|  |  |  |
| Issues to note | Frontline workers with respiratory disease should already have agreed an acceptable risk of meeting patients who have infection such as pneumonia, TB, flu etc. New risk assessments would be needed for staff moved into new roles where they are now seeing patients and at risk of infection.Local liaison with OH is vital and advice above may be amended as further advice from PHE becomes available. |  |

*BTS 20 March 2020*

DIABETES

Early indications from the Corona virus pandemic suggests people with diabetes are at increased risk of developing a more severe illness.  At the present time risk stratification for individuals with diabetes based on factors such as age, diabetes control, the presence of complications or co-morbidities is not possible due to lack of evidence.  ABCD is in discussion with other organisations in this regard and will await availability of further evidence.  Until then ABCD recommends Occupational Physicians should continue to follow the current PHE guidance.  Healthcare workers with diabetes should discuss their fitness to work with their local diabetes team and occupational health department.

*Dr Dinesh Nagi Chair ABCD, Dr Rob Gregory Past-chair ABCD*

CARDIOVASCULAR DISEASE

Cardiovascular disease seems to predispose towards worse outcomes with COVID-19. It is important to recognise that may patients with severe coronavirus infection are older and have other medical conditions in addition to heart and circulatory problems. In the absence of clear evidence, we believe that it is likely that individuals less than 70 who are otherwise fit with well controlled symptoms and on appropriate medication are unlikely to be at significantly increased risk from developing more severe infections.

However, some features that may be associated with higher risk are:

* Heart failure with breathlessness walking on the flat (NYHA Class II or above) requiring medication
* Severe heart valve disease with breathlessness or chest pain walking on the flat
* Angina (chest pain) on the flat or at rest (CCS Class III or IV) despite medication
* Recent (within 3 months) open heart surgery
* Poorly controlled blood pressure despite medication (grade 2 hypertension, BP 160-179/100-109 or higher)
* Uncontrolled atrial fibrillation (HR > 100) especially if associated with reduced left ventricular function
* Patients with complex congenital heart disease
* Patients with a previous heart or heart lung transplant

For all these categories the risk is higher if the individual also has diabetes, kidney impairment or lung disease

*Prof Simon Ray President BCS / Prof Nick Linker NCD Heart Disease*

**HIV**

**COVID-19 can manifest as a severe illness in people with weakened immune systems including, for example, those with cancer. We currently do not know if people with HIV have an increased risk of getting  COVID-19 or developing serious illness due to COVID-19; our advice will be updated as new evidence emerges. Based on expert opinion we suggest that the following groups may be vulnerable and should take extra precautions to reduce exposure:**

**1)  People whose HIV is not well controlled as indicated by a lack of viral load suppression (viral load greater than 200 copies) or a low CD4 count (less than 200 cells/mm3)**

**2)  People with well controlled HIV who have other risk factors, including:**
**a.     Age over 60 years**
**b.     Chronic conditions such as kidney, heart, liver or lung disease, hypertension or diabetes**

**c.     Cancer**

**3) Women with HIV who are pregnant**

***Elizabeth Carlin Chair GUM JSC / David Asboe Chair HIV CRG***

**KIDNEY DISEASE**

Early evidence suggests that significant kidney disease and immunosuppressive drugs to treat this are associated with an increased risk of complications and mortality from COVID-19 infection.

**This risk stratification below was created following the CMO initiative to identify the 1.5 million most vulnerable adults in the UK some of whom will be healthcare workers.  It was led by the RCP and coordinated with all other specialist societies who also care for patients with autoimmune disease.  The guidance for kidney disease was drawn up by a small working group of 4 adult and 4 paediatric nephrologists with expertise in this field.  It acknowledges that there is no good evidence base in this area and these represent pragmatic guidance to try to offer consistency about who the most vulnerable renal patients are in this group**

Cases should be individualised and take into account patient age and overall co-morbidity, current and past immunosuppression and previous clinical manifestations of susceptibility to infection.

**Group 1 (highest risk with one of the following should all be advised to self-isolate for at least 12 weeks). Healthcare workers in this group should contact their Occupational Health Departments by phone. In line with national guidance, these patients should not work with direct patient contact and should self-isolate. They can continue to work providing virtual clinic support from home if IT governance allows, providing organisational support and administrative and policy planning**

* Renal or other organ transplant recipients with CKD
* Those with End stage kidney disease (ESKD) receiving dialysis.
* Those currently receiving intravenous induction immunosuppressive medication for  autoimmune  disease eg receiving CYCLOPS/Euro lupus regimens or have received cytotoxics/rituximab/other biologic within the last 6 months
* Those who are currently receiving cyclophosphamide orally
* Those who have received a corticosteroid dose of > or = to prednisolone 20mg/day or 35mg/m2/day for more than 4 weeks within the last 6 months.
* Those who have received > 5 mg/day, or >0.25mg/kg/day, prednisolone (or equivalent ) for > 4 weeks plus at least one other immunosuppressive medication within the last 6 months
* Those who have current nephrotic range proteinuria or who have a history of frequently relapsing nephrotic syndrome.
* Those whose overall cumulative burden of immunosuppression (IS) is high over a number of years even if their current IS is in stable maintenance phase e.g. patients who have received repeated courses of cyclophosphamide/biologics /or repeated high dose corticosteroids.

**Those who are currently on stable (possibly modest) maintenance IS but whose additional factors make them vulnerable to a severe course in COVID-19 – e.g.:** **Healthcare workers in this group should contact their Occupational Health Departments by phone.**

* + those over 70 years of age
	+ those whose AI disease  has affected their CVS/Respiratory systems such as lung fibrosis
	+ Those with any non-autoimmune underlying co-morbidity of `respiratory/cardiovascular system, hypertension  or diabetes mellitus
	+ Those with CKD stage 3 or above
	+ Those who have previously manifested adverse infectious complications of immunosuppression – e.g. those with recurrent CMV or chest infections
	+ CKD 4 and 5

**Group 2 (intermediate risk :if one of the following risk factors exist:  these patients are  not currently advised to self-isolate but may be moved in to Group 1 at a later stage, as understanding develops) Healthcare workers in this group should contact their Occupational Health Departments by phone. Advise as for group 1.**

* Those with well controlled disease activity and no co-morbidity who are on a single oral immunosuppressive drugs.
* Those known to have  low IgG levels even if not currently on immunosuppression.
* Those who despite completing biologic induction treatment more than 6 months previously remain B cell depleted.
* Patients who despite achieving disease remission remain on maintenance low dose prednisolone

**Group 3 (may not require self-isolation in the first instance but should follow all hygiene measures and social distancing as per standard government guidelines). These patients should inform their Occupational Health Department for discussion but are unlikely to be at substantial increased risk in the setting of**

* Patients less than 60 years who are generally well and whose  disease has been stable for > 6 months who are on Hydroxychloroquine alone
* CKD 1, 2 and 3 A/B Unless falls into previous Group 1 or2 above.

**Notes:**

1. Immunosuppressive medications include: Azathioprine, Leflunomide, methotrexate, MMF, ciclosporin, tacrolimus and sirolimus
2. Biologic/monocolonal  includes – Rituximab; all antiTNF drugs – etanercept, adalimumab, infliximab, golimumab, certolizumab and biosimilar variants of all of these; Tociluzimab; Abatacept; Belimumab; Anakinra; Seukinumab; Ixekizumab; Ustekinumab, Eculizumab.

*Dr Graham Lipkin, President Renal Association*

**Association of British Neurologists guidance for healthcare workers living with neurological health conditions on their fitness to work.**

Public Health England has published guidance on social distancing in vulnerable groups which does not specifically take into account the requirements of healthcare workers or the huge variability in severity of their conditions.

General guidance on social distancing and neurological disease and their treatment has been issued by the ABN. This guidance focuses on the general needs of neurology patients and inevitably focuses on the more severe end of the spectrum of disease.

The ABN has contributed to a Royal College of Physicians document on social isolation and COVID-19, which is still in preparation.

**Multiple Sclerosis and immune disorders**

Patients with multiple sclerosis are not significantly at risk from coronavirus, unless they either have advanced disability with bulbar or respiratory compromise, or they are on selected immunotherapies.

We do not recommend that patients stop injectable or oral therapies or natalizumab as the risk of a relapse of multiple sclerosis exceeds the risk of the medication itself. The risks of coronavirus infection and its complications are moderately increased with ocrelizumab, so we recommend caution in starting this treatment, and delaying re-treatments, during the coronavirus epidemic. We advise against autologous haematopoietic stem cell transplantation , as well as alemtuzumab or cladribine treatments and re-treatments, as these represent the highest risk to patients.

Patients with serious coronavirus infection complications and multiple sclerosis may safely stop their immunotherapy for up to four weeks, in consultation with their MS team.

**Immunosuppressive therapies**

The risks for a patient are often more defined by their immunotherapy than the underlying individual disease.

Many patients are on more than one drugs, thus increasing their overall risk.

Please see ABN Guidance on COVID-19 for details. All of the drugs listed would put an individual at an increased risk. The presence of additional risk factors would put them at a high risk or very high risk.

**Parkinson’s disease**

The overall risk of any patient with a movement disorder should not be solely based on the neurological diagnosis, but also take other aspects of their health into account. These include age, other medical conditions and resulting medication, and the stage of the Parkinson’s disease.

There is probably no significantly increased risk to treatment responsive patients with mild Parkinson’s disease. Standard treatment for Parkinson’s disease does not put patients at an increased risk of COVID-19.

High risk groups, which are unlikely to include active health care workers, include patients in care homes, those with significantly impaired bulbar or respiratory function, and those with additional cognitive impairment which limits their ability to understand and follow health advice.

**Learning disabilities**

The overall risk of any patient with a learning disability should not be solely based on the neurological diagnosis, but also take other aspects of their health into account.

Healthcare workers with mild learning disabilities are unlikely to be directly at increased risk of COVID-19. Risk would be associated with inability to follow guidance on infection avoidance such as hand cleaning.

For guidance on the risks arising from associated physical disabilities, such as bulbar or respiratory disease, see ABN Guidance on COVID-19 and Neurological Conditions.

**Epilepsy**

Non-complex epilepsy is not associated with increased risk from COVID-19.

The number of healthcare works with complex epilepsy is likely to be very small. Risk may be associated with the underlying diagnosis which could result in significant bulbar or respiratory muscle weakness. Increased risk would be found in those with respiratory compromise associated with kyphoscoliosis or impaired mobility, with fever-sensitive epilepsies (e.g. Dravet Syndrome) and those with Rasmussen's encephalitis on immunosuppressive medication.

**Cerebral palsy**

The overall risk of any patient with cerebral palsy should not be solely based on the neurological diagnosis, but also take other crucial aspects of their health into account. Mild cerebral palsy would not increase the risk from COVID-19. Risk might arise from respiratory or bulbar weakness.

David Burn, President ABN

British Society of Gastroenterology (BSG), British Association for Study of the Liver (BASL) and Royal College of Physicians (RCP) Guidance for Healthcare Workers with Moderate Risk Inflammatory Bowel Disease and Liver Disease, 26/3/20

The contribution of all healthcare workers in the COVID 19 outbreak is very much valued. However there is a requirement to protect those who may be at risk of an adverse outcome if they caught the virus. This is a guide for how the health service could reduce the risk of infection for those with moderate risk inflammatory bowel disease and liver disease. There are available equally valuable roles that can be performed without direct contact with suspected or confirmed COVID 19 patients.

This advice is for patients with moderate risk inflammatory bowel disease and liver disease.

Definition of Moderate Risk (stringent social distancing) inflammatory bowel disease:

Patients on the following medications:

* Ustekinumab
* Vedolizumab
* Methotrexate
* Anti-TNF alpha monotherapy (infliximab, adalimumab, golimumab)
* Thiopurines (azathioprine, mercaptopurine, tioguanine)
* Calcineurin inhibitors (tacrolimus or ciclosporin)
* Janus kinase (JAK) inhibition (tofacitinib)
* Combination therapy in stable patients\*\*
* Immunosuppressive/biologic trial medication

Definition of Moderate Risk (stringent social distancing) liver disease

* Patients with decompensated liver cirrhosis

Advice

The following considerations should be taken into account

* They should not have direct contact with patients with suspected or confirmed COVID19.
* They are able continue to work in a virtual or administrative capacity. For example, they would be able to do telephone triage, telephone clinics, help line calls, and similar duties.
* They should be supported in working from home if at all possible.
* If working within a hospital environment it is essential to have adequate office space in an appropriate “clean” environment that does not have multiple unselected members of staff moving through.

It would be possible for them to do some low risk patient facing duties if the patients were screened prior to the contact. However given the current situation this is not feasible although could be considered if the available testing changes.

*Ian Arnott, Chair of the Inflammatory Bowel Disease Section
Philip Newsome, Vice President Hepatology
Tony Tham, Chair of the Clinical Services and Standards Committee
Cathryn Edwards, President- British Society of Gastroenterology*