Long Covid Assessment Service

Following publication of National Guidance for post-COVID syndrome assessment clinics and newly published NICE Guidance, <https://www.nice.org.uk/guidance/ng188> Doncaster CCG have been developing a service with RDaSH.

 

This service is for patients who meet the clinical case definition of post-COVID syndrome as defined by NICE and the RCGP who, following a period of support by Primary Care and supported self-management symptoms do not improve. The **patient can be referred into the Long Covid Assessment Clinic at or after 12 weeks.**

**Patient Management**

The Newcastle post-COVID syndrome Follow-Up Screening Questionnaire should be undertaken by Primary Care as part of the initial consultation, and following this all necessary diagnostics must be undertaken to rule out any underlying/pre-existing conditions.

* Full blood count
* Urea and electrolytes
* Liver function test
* CRP/ESR
* Thyroid function testing
* Random blood glucose
* IgA and serum electrophoresis
* Serum calcium and serum CK
* NT-proBNP
* Chest X-Ray
* Electrocardiogram

Patients should be supported to self-manage using “Your covid recovery” and utilisation of social prescribers as necessary. If symptoms to do improve then this cohort of patients will be referred to the Long Covid Assessment service delivered by RDaSH via their SPA. Email referrals must include the completed Newcastle Screening Tool and all diagnostic results.

Inclusion criteria

* Age 16 or older
* Ambulatory with or without walking aids (no assistance)
* Independent with sit to stand

COVID related criteria

* Symptom history suggestive of COVID-19 infection (fever, cough, fatigue or loss of smell/taste)
* Or
* Patients with persisting symptoms most likely due to COVID-19 but who didn’t require hospital admission.
* Patients presenting with respiratory symptoms with an in-patient stay +/- evidence of pneumonia
* Patients who had a prolonged hospital stay who received high flow of oxygen therapy or non-invasive ventilation

NB. For all COVID related symptoms other medical causes should be excluded.

Exclusion criteria

* Those with suspected active COVID-19 infection, particularly if COVID-19 was not confirmed during an initial influenza like illness
* Any new +ve COVID screen, applies to patients and those living in same household or in their ‘Bubble’. Review 14 days post initial onset of symptoms
* < 1/12 post COVID diagnosis (potential for transmission if virus remains active, as per present research findings)
* Patients admitted with COVID-19 but presenting predominantly with problems related to neurological, cardiac, renal, or polytrauma or other body systems. They may be better suited to alternative specific predefined rehabilitation pathways for rehabilitation e.g. complex neurological or stroke rehabilitation
* Patients presenting with COVID-19 with co-existent active cancer requiring treatment decisions and plans, would be best initially managed on the cancer pathway
* Patients with persisting rehabilitation need requiring in-patient multidisciplinary rehabilitation following a prolonged or severe hospital admission. The proposed rehabilitation detailed here does not replace this but may take place at a later date
* New onset of symptomatic palpitations
* History of falls / unexpected or more than 1 year requiring medical attention. Patients presenting with fall-related injuries should be referred to appropriate local falls prevention services
* Difficulty with walking and balance
* History of syncope
* Active neurological or psychiatric illnesses which prevent engagement with rehabilitation. (these may need to be addressed first)
* Known history of poorly controlled diabetes or hypertension.
* Any contra-indications absolute or relative to exercise training as listed below
* Had a cardiac event within the last 6 weeks
* Severe musculoskeletal or neurological disorders that limit mobility
* Severe psychiatric disorders
* Patients presenting a) from nursing homes, b) with severe frailty, c) in the end of life period and d) with overwhelming palliative care needs may not benefit from this rehabilitation intensity, nature and style and be better managed using alternative pathways

The Service will then undertake a comprehensive assessment which has been developed across SYB based on the Nationally Accepted Tool and develop a plan and referral on/signposting to relevant services as required.

Initially the service has the resource to review 8 cases per week, as this is truly an unknown need; however we will be having weekly meetings to monitor referrals and activity to other services to allow this to develop and grow as the ongoing Long Covid needs of our population are known.

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