NETWORK RECORDING DECLARATION

During this ECHO session discussions will be recorded so that people who cannot attend will be able to benefit at another time. Filming is regarded as ‘personal data’ under the General Data Protection Regulations (GDPR) under that law we need you to be aware that this Data will be stored with password protection on the internet.

This Data will be available for as long as your network continues to meet and will then be taken down from the internet and either stored securely at the Superhub or deleted.

Your ongoing participation in this ECHO session is assumed to imply your agreement to the use of your data in this way.

If you are NOT willing for your data to be used in this way, please LEAVE the session at this point.

www.hospiceuk.org
WELCOME TO CLINICAL ECHO April 2022
Evidence Update Max Watson

Palliative Care Research

Equitable care for all Ethnicities Audit. Sabrina Bajwah

APM Update from Palliative Care Congress Matt Dore

Discussion and Feedback Max, Kate and Matt

Chat Box
- Your Questions
- Resources
- Information /innovations
- Email clinical@hospiceuk.org

Please share resources, powerpoint, links etc. with those who would benefit.

April 13, 2022
Chat Box

• What are your major workforce issues in your service?

• How are you planning to meet your workforce challenges?

• What would be most helpful to support your workforce?
Update
11th April, 2022

52 million infected in last month
(52 million in Previous Month)
The UK Health Security Agency (UKHSA) has published updated guidance to support the next stage of the COVID-19 pandemic, with the focus on protecting those who are most at risk from the virus.

The guidance offers advice for those with symptoms of respiratory infections such as COVID-19, people with a positive COVID-19 test and their contacts, and advice on safer behaviours for everyone.

Dame Jenny Harries, chief executive of the UKHSA said: "The pandemic is not over and how the virus will develop over time remains uncertain. COVID still poses a real risk to many of us, particularly with high case rates and hospitalisations."

In February this year the Scientific Advisory Group for Emergencies (SAGE) said that there are a range of possible futures for the course of the pandemic, and considered four scenarios, which they concluded that "there are no certain predictions."
The Future....

- Reasonable best case: Relatively small resurgence in autumn/winter 2022/23 with low levels of severe disease
- Central optimistic: Seasonal wave of infections in autumn/winter with comparable size and realised severity to the current Omicron wave
- Central pessimistic: Emergence of a new variant of concern results in a large wave of infections, potentially at short notice and out of autumn/winter, with severe disease and mortality concentrated in certain groups e.g. unvaccinated, vulnerable and elderly
- Reasonable worst case: A very large wave of infections with increased levels of severe disease seen across a broad range of the population, although the most severe health outcomes continue to be felt primarily among those with no prior immunity
Testing

Contact tracing
Contact tracing helps prevent the spread of coronavirus (COVID-19)
The app will send you an alert if you have been in close contact with someone who has tested positive for the virus.
To enable Contact Tracing for this app you need to allow ‘Exposure Notifications’

Continue
Covid restrictions and free mass testing to end in England

Announcement by Boris Johnson shows Rishi Sunak has won out over Sajid Javid in cabinet battle over funding

See all our coronavirus coverage

Data in the absence of general testing

Covid laws and free mass testing are to be swept away across England after Rishi Sunak won a cabinet battle on cutting the cost of the pandemic, prompting fears that the poor and vulnerable will pay the price.

Boris Johnson announced plans to end free testing for the general public from 1 April, saying it was time for people to “get our confidence back”.
USEFUL RESOURCES

We have produced a downloadable spreadsheet that indexes reports since July 2020. Please visit this page to find out more and download the spreadsheet.

**Resources for local information about the Covid-19 situation.**

Professor Karl Friston has prepared a short guide for parents and schools about measures that schools can take depending on the local level of infections their area.

We have also collated some useful websites for information about COVID-19, particularly local level information.

Overall government data on new tests, cases, hospital admissions and deaths in the UK and also additional data on England: [https://coronavirus.data.gov.uk/](https://coronavirus.data.gov.uk/)


Wales publishes its COVID-19 data [here](https://covid-19.wales):

Northern Ireland publishes its COVID-19 data [here](https://www.gov.uk/coronavirus):

**Incidence of new infections by local authorities and NHS Trusts in:**

**England:** [https://www.fil.ion.ucl.ac.uk/spm/covid-19/dashboard/local/](https://www.fil.ion.ucl.ac.uk/spm/covid-19/dashboard/local/) (incidence of infections as estimated from reported cases and deaths in local authorities served by NHS Trusts. This can be used in conjunction with the infographic in our schools report)

**Official numbers of reported cases by local area in**

**England:** [https://coronavirus.data.gov.uk/cases](https://coronavirus.data.gov.uk/cases) (incidence of reported cases). The weekly Public Health England report is also a useful summary of local information. It is published every friday [here](https://coronavirus.data.gov.uk/cases).

This [volunteer-run website](https://covidmessenger.org) (Covid Messenger) is very good for quickly assessing rates in your local authority and whether they are going up or down. It is updated daily using Government figures.

**Scotland local data**

**Wales local data** (Note – you can choose time period at the top right – e.g. last day, last week, last month…)

**Northern Ireland local data**
Dynamic Causal Modelling of COVID-19

Dashboards

National and local dashboards demonstrating the modelling of COVID-19 using DCM are available on this website.

See also the long-term forecasting of the COVID-19 epidemic using Dynamic Causal Modelling.

Disclaimer: the modelling and accompanying estimates are reported in these pages for purely academic (open science) purposes. This modelling has not been commissioned. In particular, dynamic causal modelling is not commissioned by the Independent SAGE (on which Prof Friston serves as a panellist). The independent SAGE does not commit to – or engage in – any particular modelling initiative.

link to local data

https://www.fil.ion.ucl.ac.uk/spm/covid-19/dashboard/local/
South Lanarkshire

Population: 0.32 million
Reproduction ratio: 1.03
Undetected community cases: 1929
Estimated new cases per week: 7748 per 100,000
Proportion seropositive: 77.2%
Prevalence of infection: 4.72%
Proportion previously infected: 192.9%
Infectious period: 4.2 days
(based on ONS census figures for lower tier local authorities)
These measures are taken from the Independent SAGE consultation document on return to school – and are based upon recommendations to schools in Germany, adjusted for the prevalence of infection in the United Kingdom.
Free tests for people who have COVID-19 symptoms will continue to be provided to the following groups, largely via the existing channels:

- NHS patients in hospital, who will be tested via the established NHS testing programme
- Those eligible for COVID-19 antiviral and other treatments, who will be sent a pack of tests and can request replacements if they need them
- NHS staff and staff working in NHS-funded independent healthcare provision – the current lateral flow test ordering portal will remain available for this group to order their own tests
- Adult social care staff in care homes, homecare organisations, extra care and supported living settings and adult day care centres, as well as residents in care homes and extra care and supported living settings via the established organisation ordering portal
- Adult social care social workers, personal assistants, Shared Lives carers and CQC inspectors will be able to order tests from the current online lateral flow ordering system
- Staff and patients in hospices will be supplied tests by the hospice
- Staff and detainees in prisons and other places of detention will be supplied tests by the detention premises as currently happens
- Staff and detainees in immigration removal centres will be supplied tests, as currently happens, by the organisation concerned
- Staff and users of high-risk domestic abuse refuges and homelessness settings
Asymptomatic testing

During periods of high prevalence, asymptomatic testing will continue to mitigate risk. Testing will continue to be provided for:

- adult social care staff and a small number of visitors providing personal care
- hospice staff
- patient-facing staff in the NHS and NHS-funded independent healthcare provision
- some staff in prisons and other places of detention, and some refuges and shelters

Care home outbreak testing for all staff and residents will also continue all year.

Full guidance will be published shortly setting out how the current testing regimes will change to reflect the Living with COVID-19 strategy, which will include specific guidance for high-risk settings.
Visitors to high-risk settings

Most visitors to adult social care settings, the NHS, hospices, prisons or places of detention will no longer require a test.

Tests will continue to be provided to a small number of visitors to care homes and hospices who will be providing personal care.

Visits by people with symptoms may still be allowed in exceptional circumstances, such as end of life visits. Please contact someone responsible at the setting prior to visiting in these circumstances.

If you wish to test yourself, lateral flow tests will continue to be available to buy from pharmacies and supermarkets, including online.

It is vital that everyone continues to follow the simple steps to keep themselves and others safe.
Changes in Scotland, Wales and Northern Ireland
The devolved governments have set out their own plans:

Scotland
Wales
Northern Ireland

If you do not fall into the categories listed but you wish to test yourself for COVID-19, lateral flow tests will continue to be available to buy from pharmacies and supermarkets, including online.
Virus
# SARS-CoV-2 variants of concern as of 7 April

<table>
<thead>
<tr>
<th>WHO label</th>
<th>additional mutations</th>
<th>detected (community)</th>
<th>mutations of interest</th>
<th>first detected</th>
<th>Impact on transmissibility</th>
<th>on immunity</th>
<th>on severity</th>
<th>Transmission in EU/EEA</th>
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</thead>
<tbody>
<tr>
<td>Delta</td>
<td>B.1.617.2</td>
<td>India</td>
<td>L452R, T478K, D614G, P681R</td>
<td>December 2020</td>
<td>Increased (v) (1)</td>
<td>Increased (v) (2-4)</td>
<td>Increased (v) (3-5)</td>
<td>Community</td>
</tr>
<tr>
<td>Omicron</td>
<td>BA.1</td>
<td>South Africa and Botswana</td>
<td>(x)</td>
<td>November 2021</td>
<td>Increased (v) (6, 7)</td>
<td>Increased (v) (8-10)</td>
<td>Reduced (v) (11-13)</td>
<td>Community</td>
</tr>
<tr>
<td>Omicron</td>
<td>BA.2</td>
<td>South Africa</td>
<td>(y)</td>
<td>November 2021</td>
<td>Increased (v) (6, 14)</td>
<td>Increased (v) (8)</td>
<td>Reduced (v) (15, 16)</td>
<td>Dominant</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>WHO label</th>
<th>Lineage + additional mutations</th>
<th>Country first detected (community)</th>
<th>Spike mutations of interest</th>
<th>Year and month first detected</th>
<th>Impact on transmissibility</th>
<th>Impact on immunity</th>
<th>Impact on severity</th>
<th>Transmission in EU/EEA</th>
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<td>BA.4</td>
<td>South Africa</td>
<td>L452R, F486V</td>
<td>January 2022</td>
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<td>Omicron</td>
<td>BA.5</td>
<td>South Africa</td>
<td>L452R, F486V</td>
<td>February 2022</td>
<td>No evidence</td>
<td>No evidence</td>
<td>No evidence</td>
<td>Sporadic/travel</td>
</tr>
</tbody>
</table>

VOC

VOI
Vaccine
Vaccination and IBD
INTRODUCTION: There are concerns regarding the effectiveness and safety of SARS-CoV-2 vaccine in inflammatory Bowel Disease (IBD) patients. This systematic review and meta-analysis comprehensively summarises the available literature regarding the safety and effectiveness of SARS-CoV-2 vaccine in IBD.

METHODS: Three independent reviewers performed a comprehensive review of all original articles describing the response of SARS-CoV-2 vaccines in patients with IBD. Primary outcomes were (1) pooled seroconversion rate SARS-CoV-2 vaccination in IBD patients (2) comparison of breakthrough COVID-19 infection rate SARS-CoV-2 vaccination in IBD patients with control cohort and (3) pooled adverse event rate of SARS-CoV-2 vaccine. All outcomes were evaluated for one and two doses of SARS-CoV-2 vaccine. Meta-regression was performed. Probability of publication bias was assessed using funnel plots and with Egger’s test.

RESULTS: Twenty-one studies yielded a pooled seroconversion rate of 73.7% and 96.8% in IBD patients after one and two doses of SARS-CoV-2 vaccine respectively. Sub-group analysis revealed non-statistically significant differences between different immunosuppressive regimens for seroconversion. Meta-regression revealed that the vaccine type and study location independently influenced seroconversion rates. There was no statistically significant difference in breakthrough infection in IBD patients as compared to control after vaccination.

CONCLUSION: In summary, the systematic review and meta-analysis suggest that SARS-CoV-2 vaccine is safe and effective in IBD patients.
Vaccination and Haematological Malignancies
The objectives of this study were to assess the immunogenicity and safety of COVID-19 vaccines in patients with hematologic malignancies. A systematic review and meta-analysis of clinical studies of immune responses to COVID-19 vaccination stratified by underlying malignancy and published from January 1, 2021, to August 31, 2021, was conducted using MEDLINE, EMBASE, and Cochrane CENTRAL. Primary outcome was the rate of seropositivity after 2 doses of COVID-19 vaccine with rates of seropositivity after 1 dose, rates of positive neutralizing antibodies, cellular responses, and adverse events as secondary outcomes. Rates were pooled from single-arm studies while rates of seropositivity were compared against the rate in healthy controls for comparator studies using a random effects model and expressed as a pooled odds ratios with 95% confidence intervals. Forty-four studies (16 mixed group, 28 disease specific) with 7064 patients were included in the analysis (2331 after first dose, 4733 after second dose). Overall seropositivity rates were 62% to 66% after 2 doses of COVID-19 vaccine and 37% to 51% after 1 dose. The lowest seropositivity rate was 51% in patients with chronic lymphocytic leukemia and was highest in patients with acute leukemia (93%). After 2 doses, neutralizing antibody response rates were 57% to 60%, and cellular response rates were 40% to 75%. Active treatment, ongoing or recent treatment with targeted and CD-20 monoclonal antibody therapies within 12 months were associated with poor immune responses to COVID-19 vaccine. New approaches to prevention are urgently required to reduce COVID-19 infection morbidity and mortality in high-risk patient groups that respond poorly to COVID-19 vaccination.
Covid: Nine new symptoms added to official list

By James Gallagher
Health and science correspondent

© 4 April | Comments

Coronavirus pandemic

“Main symptoms of coronavirus have finally changed after two years of lobbying... hurrah.” Prof Tim Spectre

1. fever
2. new continuous cough
3. loss of sense of smell or taste

1. shortness of breath
2. feeling tired or exhausted
3. aching body
4. headache
5. sore throat
6. blocked or runny nose
7. loss of appetite
8. diarrhoea
9. feeling sick or being sick

"Main symptoms of coronavirus have finally changed after two years of lobbying... hurrah.” Prof Tim Spectre
Participants 1057174 people who tested positive for SARS-CoV-2 between 1 February 2020 and 25 May 2021 in Sweden, matched on age, sex, and county of residence to 4 076 342 control participants.

Compared with the control period, incidence rate ratios were significantly increased 70 days after covid-19 for deep vein thrombosis, 110 days for pulmonary embolism, and 60 days for bleeding.

Conclusions The findings of this study suggest that covid-19 is a risk factor for deep vein thrombosis, pulmonary embolism, and bleeding. These results could impact recommendations on diagnostic and prophylactic strategies against venous thromboembolism after covid-19.
So What?

Although many infections with the omicron variant are mild, the new study confirms an increased risk of venous thromboembolism even among those with milder infections who do not require admission to hospital. The association was much weaker (relative incidence 5.87, 95% confidence interval 4.88 to 7.05 for pulmonary embolism) than that among patients admitted to hospital (64.49, 53.91 to 77.15) and those admitted to intensive care (196.98, 128.71 to 301.46), but mild disease accounts for a much larger proportion of infections (94.5% in this study). This patient group may therefore contribute a substantial number of thromboembolic events.

A study from England* reported a doubling in the incidence of, and mortality from, thromboembolism since the start of the pandemic in 2020 compared with the same periods in 2018 and 2019. The same study reported comparable increases among individuals without positive SARS-CoV-2 test results. Some of those without a positive test result will have been infected before widespread testing was available, but others will have had mild or asymptomatic infections.

WORKFORCE
“We have witnessed senior experienced staff crying with frustration and anger...[they are] mentally drained and despite their best efforts have seen patients suffer and have received negative comments from distraught relatives and carers.”

Almost all respondents who replied to a recent NHS Providers survey said that staff shortages are having a serious and detrimental impact on services and will hinder efforts to deal with those major care backlogs. Trusts need more staff to be able to reduce delays and to treat patients as quickly as possible.

NHS workforce shortages and staff burnout are taking a toll

Miriam Deakin director of policy and strategy

“We have witnessed senior experienced staff crying with frustration and anger...[they are] mentally drained and despite their best efforts have seen patients suffer and have received negative comments from distraught relatives and carers.”

These are the widely reported words of managers at Royal Preston Hospital in a letter describing how NHS employees are being reduced to tears. It’s an opening account of what’s happening in our health service.

All across the NHS, widespread workforce shortages and staff burnout are taking their toll on hard working, but overstretched professionals under sustained pressure.

Over the past few weeks, covid-19 infection rates have soared again in England. Hospital admissions and deaths have risen too, although not as high as before thanks to a successful mass covid-19 vaccination by the NHS. There has been a worrying increase in the number of NHS staff off work due to covid-19 which is having a knock-on effect on patient care, on efforts to deal with care backlogs, and on meeting ongoing demand for services. The last two years have undoubtedly been the most challenging period in NHS’s history. Staff continue to work flat out, doing their best for patients, but overstretched professionals are being reduced to tears.

It’s no surprise that all of this has dented morale and wellbeing, reflected in the results of the latest NHS staff survey. 

“Almost all respondents who replied to a recent NHS Providers survey said that staff shortages are having a serious and detrimental impact on services and will hinder efforts to deal with those major care backlogs. Trusts need more staff to be able to reduce delays and to treat patients as quickly as possible.”

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‘It’s tough too to see a sharp drop in public satisfaction with the NHS, although given the impact of the pandemic it isn’t completely surprising. We want the public and politicians to understand the pressures which the whole of our health service is under, with huge strain on exhausted staff. They need to see that the government will offer support to help boost morale and retention.’

NHS Providers, along with more than a hundred health and social care organisations, have supported the inclusion of measures in the Health and Care Bill going through parliament requiring ministers to publish regular independent assessments of the number of health and care workers needed to make workloads sustainable. This has so far been resisted by the government.

As workers and employers start paying for the welcome extra investment from the Health and Care Levy it’s vital too that the government comes up with a fully costed and funded long term plan to ensure that we have the workforce we need to meet increased demand for NHS and social care services today and in the future.

Competing interests: none declared.

Provenance and peer review: commissioned, not peer reviewed.

1 BBC News. Royal Preston Hospital: ‘Staff in tears as patients “wait days for beds.”’https://www.bbc.co.uk/news/uk-england-lancashire-60988208


4 NHS Providers survey said that staff shortages are having a serious and detrimental impact on services and will hinder efforts to deal with those major care backlogs. Trusts need more staff to be able to reduce delays and to treat patients as quickly as possible.

5 It’s tough too to see a sharp drop in public satisfaction with the NHS, although given the impact of the pandemic it isn’t completely surprising. We want the public and politicians to understand the pressures which the whole of our health service is under, with huge strain on exhausted staff. They need to see that the government will offer support to help boost morale and retention.”
Data from NHS Practitioner Health, the service offering NHS staff treatment for mental health issues and addiction, show that more doctors presented for care during the pandemic year (April 2020 to March 2021) than in the first 10 years of the service put together. A recent UNISON poll reported that of 10,000 NHS workers, 54% were looking to leave their jobs, of which 67% said they were doing so to protect their mental health.
Britons more worried about the cost of living crisis than Covid

Survey shows rising prices are a bigger concern for middle-aged than other groups

Household finances became the primary concern for Britons ahead of the energy price cap rising by 54% in April © Dan Kitwood/Getty Images
End-of-life care will become a legal right

Government backs law to ensure NHS coverage across England

Dying people will be given an explicit legal right to healthcare for the first time in NHS history, requiring every part of England to provide specialist palliative care.

“This new amendment is a fantastic step forward in changing that situation, by ensuring for the first time that those who lead our healthcare system are legally required to consider palliative care.”

Craig Duncan, Hospice UK Interim CEO
“specialist multi-professional palliative care services” must include the provision of support in *every setting* - private homes, care homes, hospitals, hospices, community settings (w. local clinical teams)
in-patient pall. care beds when required, including *urgent* admission advice at *all times of day every day*,
skilled *workforce, equipment and medication* available,
a *point of contact*, for people with palliative care needs if their usual source of support is not accessible,
*systems to share information* about the person’s needs,
patients and their families can have *open conversations about what matters* to them,
*education and training* of workforce,
participate in *relevant research and disseminate evidence-based innovations.*
Things Learned in COVID
New Zealand’s Covid strategy was one of the world’s most successful – what can we learn from it?

*Michael Baker and Nick Wilson*

This pandemic and future pandemic threats will remain challenging - New Zealand needs to build on its achievements.
1. **Principles matter.** During the course of the pandemic the New Zealand government has emphasised that the response is primarily focused on protecting public health. This reinforces a number of key principles, notably: leadership that listens to the science; a focus on equity and partnership with Māori; use of the precautionary principle in the face of uncertainty; and the need to create legacy benefits for public health systems.

2. **Framing and effective communication matter.** By their very nature, pandemics are a shared threat. The behaviour of individuals affects others. This was a strength of the elimination strategy in that it could rightfully celebrate the benefits of working together (the “team of 5 million”).

3. **Transparency and political consensus matter.** During the initial phase of the response, efforts were made to achieve multi-party agreement on the response.

4. **Infrastructure matters.** Public Health in particular.

5. **Effective Pandemic Tools matter**

6. **Safe indoor environments matter**
Hospice UK Conference Glasgow 22\(^{nd}\) to 24\(^{th}\) November

Contribute to our conference by displaying a poster or giving an oral presentation.

Closing date: 23:59 on 16 May

No extensions to the closing date.
Mentorship scheme & getting in touch

New mentorship scheme introduced this year to support people who are new to the business of writing abstracts

Mentorship applications deadline is 9 May.

If you have any questions about the call for papers or mentorship scheme, contact Stuart Duncan at: s.duncan@hospiceuk.org
Find out more

To submit an abstract, find out more about the process, access FAQs and learn about the mentorship scheme, visit:

https://www.hospiceuk.org/professionals/courses-conferences/national-conference/call-for-papers
Aimed to investigate the prevalence of anticipatory grief among family caregivers of people with life-threatening illnesses

Systematic review of studies that:

- reported the prevalence of anticipatory grief using a validated measurement tool
- related to the cases of life-threatening illness or conditions
- were conducted with adult caregivers

10.1136/bmjspcare-2021-003338
What they found

- 18 studies from 3189 screened
- International literature but no studies conducted in the UK
- Anticipatory grief tools used were:
  - 10 studies used PG-12 (n=10)
  - 5 MM-CGI (n=5)
  - 1 x BRI, ICG-PL & PGDS
- 5470 caregivers of people (74% female, 30-72 years)
- Diagnosis mostly cancer, dementia and vegetative state
- Time since diagnosis ranged from 1 to 6.83 years
What they found

• Nearly 25 out of 100 caregivers experienced anticipatory grief

• Much higher prevalence rate than post-loss grief in the general population (9.8%) or people bereaved by cancer (14.2%)

• Moderated by age, gender, marital status showing prevalence of anticipatory grief was higher in:
  • People who are married (regardless of gender)
  • Females

• Older carers tend to have less anticipatory grief
Implications for clinical practice

• Caregivers are known to have a substantial burden and personal losses due to daily caregiving activities

• Interventions may focus on the patients and not sufficiently address the pre-loss grief experienced by the caregivers

• Assessment and recognition of caregivers’ grief is important so that appropriate bereavement support can be provided

• Be more sensitive to the needs of younger, female and married caregivers
Welcome to Palliative Discovery. 
You’ve come to the right place.
An inspired and ambitious space working to improve palliative care.

Palliative Discovery is designed to provide Clinical Nurse Specialists (CNSs) with the knowledge, skills, resources and support to enhance and flourish in their careers and continue to provide the very best palliative care.

The Palliative Discovery team

Prof Heather Richardson
Maggie Riset
Marie Cooper
Malise Vandelinde

https://palliativediscovery.stchristophers.org.uk/
Palliative care for people who are homeless with unsettled immigration status

UK-wide online survey of hospice staff to hear their experiences of supporting people in this situation.

We are interested in hearing UK hospice staff’s experiences of supporting adults with no recourse to public funds who are destitute, homeless or at risk of homelessness with advanced ill health.

This could include:
- people who are undocumented migrants
- people who have overstayed their visas
- people whose asylum applications have been refused
- EU migrants without settled status
- people who are vulnerably housed (e.g. sofa surfing or living in hostels or other forms of temporary accommodation) or sleeping on the streets who have no recourse to public funds.

https://comms-mariecurie.org.uk/1IUE-7P236-VFOFSW-4R8JSC-1/c.aspx
Equitable Care for All
Ethnicities Audit

Audit team:
Dr Sabrina Bajwah & Dr Gemma Clarke (joint Leads)
Dr Jamilla Hussain
Dr Zoobia Islam
Professor Jonathan Koffman
Dr Catriona Mayland
Dr Matthew Allsop
Why are we doing this?

• The COVID-19 pandemic has demonstrated the importance of ethnicity data in monitoring racial and ethnic inequalities.

• Good quality ethnicity data is consistent, complete and the recorded ethnic group should be self-determined.

• Valid and consistent data can be used to demonstrate the extent, nature and impact of ethnic inequalities in society and improve services.
What do we want to do?

• UK wide audit (led by King’s College Hospital)
• We aim to investigate the validity and consistency of recorded ethnicity groups across palliative care relevant UK health databases using patient self-definition
• We will use this audit to inform development of an intervention to improve ethnicity data collection in the future.
How will we do this?

• We will recruit audit sites from palliative centres (hospitals, hospices and community teams) across UK
• One day audit during a two week period (13/06/22-24/06/22)
• We will assess validity of recorded ethnic group by comparing patient self-defined ethnic group (collected directly from patients on day of audit) with ethnic group recorded in healthcare databases
• All data will be collected anonymously centrally at King’s College Hospital for analyses. On analyses, sites and individual patients will not be identifiable.
We would like to take part, who should we contact?

• The audit is being led by Dr Sabrina Bajwah (Consultant Palliative Care, King’s College Hospital) and Dr Gemma Clarke (Marie Curie Senior Research Fellow).

• Please email to express your interest to Gemma Clarke on g.c.clarke@leeds.ac.uk
Welcome to the 2022 Palliative Care Congress

Recovering, Rebounding & Reinventing

Developing excellence in palliative care

PCC 2022 is kindly sponsored by:

NAPP
BD
GRIEF IS THE THING WITH FEATHERS

MAX PORTER
I will review experience with Covid breathlessness.

This will be a personal selection and contain a little science.

Previous speakers will have brought mastery of specific areas that I do not.
Developing excellence in palliative care

PCC 2022 is kindly sponsored by:

NAPP
All’s wool that ends wool

https://blogs.bmj.com/spcare/2022/04/05/alls-wool-that-ends-wool/
Chat Box

• What are your major workforce issues in your service?

• How are you planning to meet your workforce challenges?

• What would be most helpful to support your workforce?
THANK YOU
Certification of death

It should be noted that the provision for any medical practitioner to complete the medical certificate of cause of death (MCCD), introduced as a temporary measure by the Coronavirus Act 2020, discontinued at midnight on 24 March 2022, therefore attendance requirements will revert to those prior to the Act. In all cases, without exception, only a medical practitioner who has attended the deceased for their last illness, and can state the cause of death to the best of their knowledge and belief, will be allowed to complete a MCCD. In addition, the attending medical practitioner must meet the requirements set out in paragraph 1(b); if not, paragraph 1(c) will apply. It is recommended that electronic transfer of MCCDs is used as standard practice to accelerate processes.
Supporting your recovery after COVID-19

As you find yourself recovering from COVID-19 you may still be coming to terms with the impact the virus has had on both your body and mind.

These changes should get better over time, some may take longer than others, but there are things you can do to help.

Your COVID Recovery helps you to understand what has happened and what you might expect as part of your recovery.
Arrivals from Ukraine: advice for primary care

The UK Health Security Agency (UKHSA) have published [guidance to help primary care professionals assess and address the health needs of patients ordinarily resident in Ukraine](https://www.gov.uk/government/publications/ukhsa-guidance-for-primary-care-professionals-on-ukarrivals-from-ukraine) who have arrived in the UK in response to the conflict between Ukraine and Russia.

Soon after individuals and their families arrive in the UK from Ukraine, they should be supported to register with a GP practice and attend a [new patient consultation to assess their health and care needs](https://www.gov.uk/government/publications/ukhsa-guidance-for-primary-care-professionals-on-ukarrivals-from-ukraine). Doctors of the World have produced several resources including the [Safe Surgeries Toolkit](https://www.gov.uk/government/publications/ukhsa-guidance-for-primary-care-professionals-on-ukarrivals-from-ukraine) to support practices with new registrations. Migrants may have been exposed to trauma prior to, during and following their migration journey. This guidance describes how adopting a [trauma informed approach](https://www.gov.uk/government/publications/ukhsa-guidance-for-primary-care-professionals-on-ukarrivals-from-ukraine) will ensure individuals feel safe and supported.

Resources for Ukrainians arriving in the UK


Next session: May 11 2022

15:30 – 16:30
Evidence Update Max Watson
Palliative Care Research

Equitable care for all Ethnicities
Audit.

Sabrina Bajwah

APM Update from Palliative Care Congress

Matt Dore

Discussion and Feedback Max, Kate and Matt

Chat Box
- Your Questions
- Resources
- Information /innovations
- Email clinical@hospiceuk.org

Please share resources, powerpoint, links etc. with those who would benefit.

April 13, 2022

Workforce How?
Why you won't be THIS lucky again until 2188: Alignment of Jupiter and Neptune could bring good fortune for months, astrologers say

- The planets of Jupiter and Neptune aligned on Tuesday, as they do every 13 years
- But their meeting yesterday was extra rare as it was in the constellation of Pisces
- Such a meeting last happened in 1856 and won't happen again until year 2188
“Hope” is the thing with feathers -  
That perches in the soul -  
And sings the tune without the words -  
And never stops - at all -  

And sweetest - in the Gale - is heard -  
And sore must be the storm -  
That could abash the little Bird  
That kept so many warm -  

I’ve heard it in the chilliest land -  
And on the strangest Sea -  
Yet - never - in Extremity,  
It asked a crumb - of me.

Emily Dickinson