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 March 2022
Testing to be axed
What now?

Boots to charge £5.99 for one lateral flow test as England ends free packs

Responding to Ukraine Suffering

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

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

March 9, 2022

RESPONDING

• Evidence Update Max Watson
• Resources
• Palliative Care Research Kate Flemming
• “The Amendment” Baroness Finlay
• Responding to Ukraine Suffering

Please share resources, powerpoint, links etc. with those who would benefit
MISSION TO GET UKRAINIAN HOSPICE CHILDREN TO SAFETY
EAPC Statement on the Ukraine Crisis
by pallcare

We are grateful for the support and offers of help for our palliative care colleagues and friends in Ukraine. After discussion by members of the global palliative care community, we recognise that the most urgent need is currently for supplies and funds to purchase essential medical equipment, medications, and supplies.

We have considered options on the best way to help with these needs, given the challenging and rapidly evolving dynamics on the ground. For many reasons we believe that the best support would be through donations via the following agencies with an active humanitarian presence in the region:

- International Committee of the Red Cross
- UNHCR
- Doctors without Borders/ Médecins Sans Frontières (MSF)

We know that our palliative colleagues in Ukraine will require our help and support in the weeks, months and years to come. When this help is needed, we trust that the global palliative care community is ready and willing to provide more targeted support to palliative groups in their challenging journey to restore essential palliative care services.
PallCHASE Statement on the Humanitarian Crisis in Ukraine

As a global humanitarian network, Palliative Care in Humanitarian Aid Situations and Emergencies (PallCHASE) is deeply concerned about the unfolding humanitarian crisis in Ukraine and its devastating impacts on families, children and vulnerable populations with serious pre-existing medical conditions. Even before the current crisis, nearly half a million children were living lives defined by eight years of war.

With the humanitarian situation growing beyond localized conflict to mass displacement in bordering countries, critical palliative care and life-saving treatment should be delivered as complementary interventions, in accordance with WHO guidelines and Sphere Minimum Standards for Palliative Care.

PallCHASE calls upon the United Nations Office for the Coordination of Humanitarian Affairs, the Health Cluster Ukraine, and all humanitarian actors (donors, resettlement agencies, implementing partners and civil society organizations) to take the following measures to alleviate serious health-related suffering and maintain the dignity of those with serious illness, alongside efforts to save lives:

1. Identify groups with priority palliative care needs, including: those at risk of life-threatening complications from disruptions to care, including those with HIV, TB, or noncommunicable diseases such as insulin-dependent diabetes, severe asthma, cancer, heart and lung diseases; those whose palliative care needs are unmet or exacerbated as a result of crisis; those who suffer acute non-survivable injury; and vulnerable groups including older persons, people with disabilities, and children.

2. Ensure neonates and children requiring palliative care and technology-based clinical interventions have access to a continuous power supply without which they cannot survive.

3. Implement a triage approach based on the patient’s medical condition and prognosis and availability of resources, ensuring relief of suffering and assuring the comfort and dignity of patients not expected to survive.

4. Avoid sudden treatment disruption for people diagnosed with life-limiting illness before the crisis, through the provision of essential medical supplies, devices and equipment.

5. Account for controlled medicines regulations that may delay availability of essential pain relief.

6. Establish a local referral system to manage acute complications and complex cases in secondary or tertiary care, and to palliative and supportive care.

7. Make use of Telemedicine for populations requiring critical care to access emergency palliative care services.

As the situation quickly evolves, PallCHASE is committed to ensuring palliative care is delivered alongside life-saving measures in the Ukraine humanitarian response. Through our broad network of practitioners with expertise in the delivery of palliative care, humanitarian actors can engage PallCHASE for advice and technical support on the timely and adequate provision of palliative care as part of relief interventions.

Relevant resources:
- Sphere Handbook Humanitarian Charter and Minimum Standards in Humanitarian Response, Section on Palliative Care (2.7)
- WHO Guide on Integrating Palliative Care and Symptom Relief into the Response to Humanitarian Emergencies and Crises
- WHO Essential Medicines List for Palliative Care
- Website for Palliative Care in Humanitarian Aid Situations and Emergencies (PallCHASE)

Technical assistance inquiries: pallchase.advocacy@gmail.com
Media inquiries: pallchase.media@gmail.com
Lviv Sheptytsky Hospital Foundation is currently open 24/7, 7 days a week. We are providing medical services to more than 35,000 refugees. Our team of medic's doctors and nurses are providing the necessary medical care to both adults and children. The Hospital also has a palliative care unit, which is now being actively expanded, as other hospitals are sending palliative patients home en masse in order to increase the number of places for both civilian and military wounded. Some patients have no home to return to, as their family have left Ukraine and have gone to one of the neighbouring countries. Our geographical location, close to the border with Romania and other countries offering support has enabled us to organize a service for the reception and distribution of humanitarian aid. We are helping to meet the needs of Ukrainian hospitals by shipping medicines and the other necessary medical supplies they need. People ask how they can help us. We need both financial support and supplies. If you can help us, please click here to make contact.

Sheptytsky Hospital website
Sheptytsky Hospital YouTube
Global Palliative Care Community Statement on the Humanitarian Crisis in Ukraine
EAPC Statement on the Ukraine Crisis
International Committee of the Red Cross
UNHCR
Doctors without Borders/ Médecins Sans Frontières (MSF)
600 million more vaccinations administered, (2 Billion)

52 million infected in last month
(87 million in February)
**Covid-19 in the UK**

Daily cases: **61,900** (+22,900 vs last week ↑)

Daily deaths: **212**

Total deaths: **162,359**

**Vaccination rollout**

Dec 2020

- Received 1st dose: **78.5%**
- Received 2nd dose: **73.2%**
- Received 3rd dose: **57.2%**

Cases and deaths as published 8 Mar 2022. Vaccinations as % of total population, published 7 Mar 2022. *From 26th Feb 2022: no data published on Saturdays or Sundays and figures published on Monday will include three days’ data. Source: data.gov.uk.

**UK: people in hospital with coronavirus each day**

Data: data.gov.uk. ‘Hotspots’ shows cases per 100,000 in the seven days to 2 Mar 2022, assigned to date of test. ‘Change’ shows actual case numbers. ‘Vaccinations’ shows percentage of total population (including under 18s) who have had two doses. Scales are dynamic so change according to the range each day.
Percent of population testing positive each week by nation:
1 Aug 2020 to 26 Feb 2022
ONS Infection Survey (random testing)
Hospitalisations show exactly the same pattern with Scotland going up sharply.

While overall deaths within 28 days in UK are still falling, in Scotland they have started rising again.

Scottish cases increases have been in older adults.
No doubt now about the trajectory of hospital admissions with COVID. Up 16% in the last week. Daily numbers remain low but as always it is important to focus on the direction of travel.

Regional detail below. 1/2
What is the situation in England?

Masks are no longer legally required in most public spaces – although they are still recommended in some situations:

- face coverings remain a requirement in healthcare settings, such as GP surgeries, hospitals and care homes
- government guidance recommends that people still wear face coverings in enclosed or private spaces where they are mixing with people they don’t know
- many major retailers including Tesco, Sainsbury’s, Lidl, Waitrose and John Lewis have asked staff and customers to keep wearing masks
- face coverings are no longer mandatory on Transport for London’s tubes, trains or buses, but they are still “strongly encouraged”

What are the latest rules for face coverings and masks?

What is the situation in Northern Ireland?

Mask-wearing is no longer legally enforced in Northern Ireland. However, face coverings are still recommended in certain places, such as enclosed public spaces and health and social care settings.

- Northern Ireland’s last Covid rules are lifted
- What are the remaining Covid regulations set to go?

What is the situation in Scotland?

The legal requirement to wear face coverings in some settings in Scotland is set to end on 21 March, when all remaining Covid restrictions are due to end.

First Minister Nicola Sturgeon said “voluntary compliance” would be encouraged instead.

Under the current rules, masks must be worn in most indoor public spaces including public transport, shops and gyms (although they can be temporarily removed when exercising).

They are mandatory in pubs and restaurants when not seated or dancing, as well as in the workplace in communal areas and canteens.

They no longer have to be worn by secondary school students in the classroom - but are still required in “indoor communal areas” like corridors. Under-12s are exempt.
• As mask mandates are lifted, this is an important point to keep in mind:

• 1 person with N95/KN95/KF94: 90+% protection

• 1 person with surgical mask: ~50% protection

• 2 people with surgical mask: ~75% protection

• 2 people with N95/KN95/KF94: 99% protection
Dear Colleague,

This week we are contacting you regarding testing and isolation in Hospices.

No change to ‘Stay at Home’ guidance

From today, there is no longer a legal requirement for people with COVID-19 to self-isolate. Guidance will be updated to remove references to the legal requirement, but the advice will continue to recommend that:

- anyone with symptoms should stay at home and get a PCR test
- those who test positive should stay at home and avoid contact with people

Staff

If a member of staff develops symptoms of COVID-19, they should not attend work and should do a PCR at home as soon as possible. If they test positive, they should not attend work (for 10 days) and UKHSA recommend they should stay at home and avoid people. The guidance remains the same that to return to the workplace before 10 days have elapsed, staff should have negative LFDs on two consecutive days, starting no earlier than day 5.

Full detail can be found in the Management of Staff guidance.

Patients

If a patient develops symptoms of COVID-19, they should self-isolate and have a PCR test. If they test positive, they should continue to self-isolate for 10 days from the onset of symptoms. If they test positive, they should continue to self-isolate for 10 days from the onset of symptoms (or the day of the test if asymptomatic). The guidance remains the same that to leave isolation before 10 days have elapsed, patients should have negative LFDs on two consecutive days, starting no earlier than day 5.

Full detail can be found in the Management of exposed patients guidance.

Visitors

Visitors or visiting professionals should continue to test before visiting in line with their testing regime, and those who test positive should not enter the care setting.
Post-COVID Syndrome (Long COVID)

Acute infection (acute COVID-19)
- Active viral replication and initial host response

On going symptomatic COVID
- Postacute hyperinflammatory illness
- Immune-mediated response
- Persistent viral replication
- Organ dysfunction

Post-COVID-19 syndromes
- The pathophysiology is not known, nor have the viral or immunological responses been defined in this phase

PROLONGED COVID-19
Number of People Living with Self-Reported Long Covid (at least 4 weeks) in the UK, Mar 6, 2021 to Jan 31, 2022
(Source: ONS Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK Reports)
Long-COVID

Data from the ZOE COVID Symptom Study App and National Core Studies on Health and Wellbeing

Claire Steves
Cohorts lead for CONVALESCENCE (NCS H&W)
PI, ZOE COVID Symptom Study on Long-COVID,
KCL Deputy Director TwinsUK, KCL
Practicing Geriatrician seeing patients with Long-COVID, GSTT
Insights from three sorts of population studies

All community dwelling populations
Small numbers of participants admitted to hospital

1. ZOE App – continuing to follow ~900,000 volunteer participants

2. Nine national longitudinal studies with pre-pandemic data to look for risk factors

How long did participants report symptoms?

Matched 4182 COVID+ cases with a negative symptomatic control group.

13.3% COVID+ had continuous symptoms >28 days
4.5% for >8 weeks
2.3% for >12 weeks.

Sudre et al, Nature Medicine
https://doi.org/10.1038/s41591-021-01292-y
People experiencing significant impacts* on daily life, 12 weeks after catching COVID-19

* Unable to function as normal

5% of Middle aged people (30-50 year olds)

1.2% of 20 Year Olds

Data has been analysed from multiple sources

10 Longitudinal Cohorts**

1.2 million Health Records**

** With data from 45,096 Study Participants + 1.2 million anonymous GP records. For more information visit www.ucl.ac.uk/covid-19-longitudinal-health-wellbeing/
Consistent risk factors for Long COVID

1. Age
2. Female sex
3. Poor pre-pandemic health
4. Psychological distress before the pandemic
5. Previous overweight and obesity
6. Previous asthma

Less consistent:

Ethnicity - lower risk in non-white groups

IMD – no signal in population based studies, but signal in EHR suggestive of access issues

Education – no clear effect
2. Do we know if vaccines cut the risk of developing Long Covid?

Double vaccination halves risk of Long COVID

Compared symptom profiles in 6,030 single vaccinated and 2,370 double vaccinated individuals with unvaccinated individuals infected at the same time.

Antonelli et al, Lancet Infectious Diseases
https://doi.org/10.1016/S1473-3099(21)00460-6

Effect may wane slightly after 3 months
Effect is again enhanced by the booster (unpublished data)
3. Is there a difference in recovery between those who were hospitalised, and those who were not?

Length of time normal function affected after COVID-19
(1627 people with COVID from TwinsUK, of whom 30 were hospitalised (2%)

6% of non-hospitalised vs. 40% of hospitalised with 12+ weeks of symptoms that affected normal functioning
Long COVID-19 and Symptoms Clustering

- **Long COVID-19**: persistent symptoms for more than 12 weeks.

- **Inclusion criteria**: Patients reporting symptoms for at least 84 days, with no more than 7 days without reporting. All subjects reporting to be healthy in between two unhealthy periods are excluded.

- Both **systemic symptoms** and **demographic information** are included in the model.

**Project aims**

Using the self-reported symptoms, we aim to define clusters of symptoms phenotypes to:

1. Assess differences in symptom profiles and duration for Long COVID;
2. Investigate the influence of pre-conditions and demographic information in the duration of the long form of COVID-19.

*Example of a clustering grouping of variables – symptoms.*
Symptoms Profile in 336 participants experiencing symptoms for > 12 weeks

84 DAYS – 8 CLUSTERS
Variants and Long COVID

- Alpha variant – no change in risk
- Delta variant – no change in risk, though difficult to be sure due to vaccination
- Omicron – watch this space

What next?.... How long will Government fund services and research?

Research identifying immunological profiles....
Another life-saving Covid drug identified

By Michelle Roberts
Digital health editor

5 days ago | Comments

Coronavirus pandemic
The Randomised Evaluation of COVID-19 Therapy (RECOVERY) trial has demonstrated that baricitinib, an anti-inflammatory treatment normally used to treat rheumatoid arthritis, reduces the risk of death when given to hospitalised patients with severe COVID-19. The benefit was in addition to those of dexamethasone and tocilizumab, two other anti-inflammatory treatments which have previously been shown to reduce the risk of death in these patients.

Between February and December 2021, 4008 patients randomly allocated to usual care alone were compared with 4148 patients who were randomly allocated to usual care plus baricitinib. The dose of baricitinib was a 4mg tablet once daily for 10 days (or until discharge from hospital if sooner). At randomisation, 95% of patients were receiving a corticosteroid such as dexamethasone, 23% were receiving tocilizumab, and 20% were receiving the anti-viral drug remdesivir. Two-thirds (68%) of patients were receiving oxygen and one quarter (27%) were receiving additional respiratory support.

Treatment with baricitinib significantly reduced deaths: 513 (12%) of the patients in the baricitinib group died within 28 days compared with 546 (14%) patients in the usual care group, a reduction of 13% (age-adjusted rate ratio 0.87, 95% confidence interval [CI] 0.77 to 0.98; p= 0.026). The benefit of baricitinib was consistent regardless of which other COVID-19 treatments the patients were also receiving, including corticosteroids, tocilizumab, or remdesivir. There was no evidence that the short course of baricitinib used in RECOVERY increased the risk of other infections or of thrombosis (complications of blood clotting).

RECOVERY considerably strengthens the evidence from earlier trials that baricitinib is beneficial in severe COVID-19, and provides new evidence of the additional benefit of baricitinib on top of other immunomodulatory treatments.
RECOVERY
Randomised Evaluation of COVID-19 Therapy

Aspirin  Azithromycin  Baricitinib  Hydroxychloroquine  Lopinavir-Ritonavir

Colchicine  Convalescent Plasma  Dexamethasone  Tocilizumab  Regeneron's Monoclonal Antibody Combination
Testing
BACKGROUND: Rapid antigen diagnostic tests (Ag-RDTs) are the most widely used point-of-care tests for detecting SARS-CoV-2 infection. Since the accuracy may have altered by changes in SARS-CoV-2 epidemiology, indications for testing, sampling and testing procedures, and roll-out of COVID-19 vaccination, we evaluated the performance of three prevailing SARS-CoV-2 Ag-RDTs.

METHODS: In this cross-sectional study, we consecutively enrolled individuals aged >16 years presenting for SARS-CoV-2 testing at three Dutch public health service COVID-19 test sites. In the first phase, participants underwent either BD-Veritor System (Becton Dickinson), PanBio (Abbott), or SD-Biosensor (Roche Diagnostics) testing with routine sampling procedures. In a subsequent phase, participants underwent SD-Biosensor testing with a less invasive sampling method (combined oropharyngeal-nasal [OP-N] swab). Diagnostic accuracies were assessed against molecular testing.

RESULTS: Six thousand nine hundred fifty-five of 7005 participants (99%) with results from both an Ag-RDT and a molecular reference test were analysed. SARS-CoV-2 prevalence and overall sensitivities were 13% (188/1441) and 69% (129/188, 95% CI 62-75) for BD-Veritor, 8% (173/2056) and 69% (119/173, 61-76) for PanBio, and 12% (215/1769) and 74% (160/215, 68-80) for SD-Biosensor with routine sampling and 10% (164/1689) and 75% (123/164, 68-81) for SD-Biosensor with OP-N sampling. In those symptomatic or asymptomatic at sampling, sensitivities were 72-83% and 54-56%, respectively. Above a viral load cut-off (=5.2 log10 SARS-CoV-2 E-gene copies/mL), sensitivities were 86% (125/146, 79-91) for BD-Veritor, 89% (108/121, 82-94) for PanBio, and 88% (160/182, 82-92) for SD-Biosensor with routine sampling and 84% (118/141, 77-89) with OP-N sampling. Specificities were >99% for all tests in most analyses. Sixty-one per cent of false-negative Ag-RDT participants returned for testing within 14 days (median: 3 days, interquartile range 3) of whom 90% tested positive.

CONCLUSIONS: Overall sensitivities of three SARS-CoV-2 Ag-RDTs were 69-75%, increasing to =86% above a viral load cut-off. The decreased sensitivity among asymptomatic participants and high positivity rate during follow-up in false-negative Ag-RDT participants emphasise the need for education of the public about the importance of re-testing after an initial negative Ag-RDT should symptoms develop. For SD-Biosensor, the diagnostic accuracy with OP-N and deep nasopharyngeal sampling was similar; adopting the more convenient sampling method might reduce the threshold for professional testing.
Conclusions The proportion of infectious people with SARS-CoV-2 missed by LFTs is substantial enough to be of clinical importance. The proportion missed varied between settings because of different viral load distributions and is likely to be highest in those without symptoms. Key models have substantially overestimated the sensitivity of LFTs compared with empirical data. An urgent need exists for additional robust well designed and reported empirical studies from intended use settings to inform evidence based policy.
Virus
The Omicron subvariant BA.2 is definitely dominant in England and NI and most likely in Scotland and v soon in Wales. In England, it's highest in London and SW.

No vax difference for BA.1 or BA.2 but even boosters wane quite fast against Omicron (mostly infection but hosp) 5/8
Latest estimates of vaccine efficacy against Omicron (no difference between BA.1 and BA.2)

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Vaccine
Safety of mRNA vaccines administered during the initial 6 months of the US COVID-19 vaccination programme: an observational study of reports to the Vaccine Adverse Event Reporting System and v-safe

Hannah G Rosenblum, MD  •  Julianne Gee, MPH  •  Ruiling Liu, PhD  •  Paige L Marquez, MSPH  •  Bicheng Zhang, MS  •  Penelope Strid, MPH  •  et al.  Show all authors

Published: March 07, 2022  •  DOI: https://doi.org/10.1016/S1473-3099(22)00054-8
Summary

Background In December, 2020, two mRNA-based COVID-19 vaccines were authorised for use in the USA. We aimed to describe US surveillance data collected through the Vaccine Adverse Event Reporting System (VAERS), a passive system, and v-safe, a new active system, during the first 6 months of the US COVID-19 vaccination programme.

Methods In this observational study, we analysed data reported to VAERS and v-safe during Dec 14, 2020, to June 14, 2021. VAERS reports were categorised as non-serious, serious, or death. Reporting rates were calculated using numbers of COVID-19 doses administered as the denominator. We analysed v-safe survey reports from days 0–7 after vaccination for reactogenicity, severity (mild, moderate, or severe), and health impacts (ie, unable to perform normal daily activities, unable to work, or received care from a medical professional).

Findings During the study period, 298792852 doses of mRNA vaccines were administered in the USA. VAERS processed 340 522 reports: 313 499 (92·1%) were non-serious, 22 527 (6·6%) were serious (non-death), and 4 496 (1·3%) were deaths. Over half of 7 914 583 v-safe participants self-reported local and systemic reactogenicity, more frequently after dose two (4 068 447 [71·7%] of 5 674 420 participants for local reactogenicity and 4 018 920 [70·8%] for systemic) than after dose one (4 644 989 [68·6%] of 6 775 515 participants for local reactogenicity and 3 573 429 [52·7%] for systemic). Injection-site pain (4 488 402 [66·2%] of 6 775 515 participants after dose one and 3 890 848 [68·6%] of 5 674 420 participants after dose two), fatigue (2 295 205 [33·9%] participants after dose one and 3 158 299 participants [55·7%] after dose two), and headache (1 831 471 [27·0%] participants after dose one and 2 623 721 [46·2%] participants after dose two) were commonly reported during days 0–7 following vaccination. Reactogenicity was reported most frequently the day after vaccination; most reactions were mild. More reports of being unable to work, do normal activities, or of seeking medical care occurred after dose two (1 821 421 [32·1%]) than after dose one (808 963 [11·9%]); less than 1% of participants reported seeking medical care after vaccination (56 647 [0·8%] after dose one and 53 077 [0·9%] after dose two).

Interpretation: Safety data from more than 298 million doses of mRNA COVID-19 vaccine administered in the first 6 months of the US vaccination programme show that most reported adverse events were mild and short in duration.
CLINICAL
Elective Surgery Still Needs to be Avoided Within 7 Weeks of Positive COVID-19 Test

The COVIDSURG Collaborative

Rob Hicks, MB BS | Disclosures | 24 February 2022

Anaesthesia and surgical experts have issued an update on the timing of elective surgery following emergence of the Omicron SARS-CoV-2 variant, emphasising how non-urgent surgery should still be avoided within 7 weeks of a person testing positive for COVID-19.

A global collaboration of over 15,000 surgeons and anaesthetists (the COVIDSurg Collaborative) identified, in March 2021, an increased risk of poor outcomes and mortality for those who underwent surgery within 0 to 6 weeks of testing positive for COVID-19. As a consequence, a recommendation was made - published in the journal Anaesthesia - that surgery should be avoided within 7 weeks of the diagnosis of COVID-19 infection.

Now the same journal has published updated guidance on behalf of Association of Anaesthetists, the Centre for Perioperative Care, the Federation of Surgical Specialty Associations, the Royal College of Anaesthetists, and the Royal College of Surgeons of England.

The guidance makes 11 recommendations including:

- Patients should avoid elective surgery within 7 weeks of SARS-CoV-2 infection unless the benefits of doing so exceed the risk of waiting
- Patients with elective surgery planned within 7 weeks of SARS-CoV-2 infection should have their mortality risk calculated, a careful risk-benefit assessment performed, and a shared decision made
- Surgical patients should have received pre-operative COVID-19 vaccination, with three doses wherever possible, with the last dose at least 2 weeks before surgery
- Elective surgery should not take place within 10 days of diagnosis of SARS-CoV-2 infection, predominantly because the patient may be infectious, which is a risk to surgical pathways, staff, and other patients
The Coronavirus Act 2020, which introduced easements to death certification processes and cremation forms, expires at midnight on 24 March 2022. Some changes have been retained on a permanent basis through other measures, and other processes revert to previous practice.

The following provisions are continuing after 24 March 2022:
• The period before death within which a doctor completing a Medical Certificate of Cause of Death (MCCD) must have seen a deceased patient will remain 28 days (prior to the coronavirus pandemic, the limit was 14 days).
• It will still be acceptable for medical practitioners to send MCCDs to registrars electronically.
• The government’s intention is that the form Cremation 5 will not be re-introduced after the Coronavirus Act expires.

The following emergency provisions are changing with the expiry of the Act:
• The provision temporarily allowing any medical practitioner to complete the MCCD, introduced as a temporary measure by the Coronavirus Act, will be discontinued.
• Informants will have to register deaths in person, not remotely.
Dear colleagues,

As you are aware the Department of Health and Social Care have committed to extending the provision of free PPE to the health and care sector to 31 March 2023, or until the UK Infection Prevention Control guidance is withdrawn or significantly amended, whichever is sooner. Since hearing that news we have been waiting to hear how the PPE will be supplied and distributed moving forward and are delighted to say that hospices will now be able to order PPE through the national PPE portal. More details about how this transition will be managed and what hospices need to do is in the attached guidance.

This means that the regional hub network that has existed for nearly two years can come to an end and the current 4 week ordering via the regional hubs will cease on 4 March 2022. **Hospices need to sign up to the portal by 4 March 2022.** It is recognised though that there will be a period of transition to ensure all eligible hospices are signed up and using the portal but it is important to note that as from 1 April Hospice UK and the regional hubs will be stood down, and all PPE enquiries and information will be provided directly by the NHS PPE Portal.

I would like to take this opportunity to acknowledge what has been achieved by the regional hub network. The setting up and then the ongoing management has been a truly remarkable and has only been possible because hospice colleagues responded to our call for help and volunteered their premises and staff resources for what was thought at the start to be an interim measure for a few weeks. Collectively we have ensured that over 1 million items of PPE have been distributed to hospices each week for nearly two years. I would like to thank everyone in the regional hubs that have played a part in making that happen.

With best wishes,

Rowena Lovell
Director of Strategy and Governance
Hospice UK
Things Learned in COVID

Prof Becky Malby
Health System Innovation Lab
London Southbank University
2021
We have sorted:

- Staff being properly valued and supported
- Using 21st Century tools
- With connected, visible, engaged leaders
- Care basics and inefficiencies have been fixed and sorted

We have seen:

- Local health systems have joined up together to get things done
- Staff working brilliantly together as real teams
- Staff have stepped up and acted with professionalism and autonomy

And now we have:

- A system that can make decisions based on needs and think pro-actively
- Making mutual decisions with patients as partners
- Working in close collaboration with its community

Conditions for Change

London South Bank University
Which of the 10 leaps have you seen and have they stuck?

- Fast track of new tools
- Proactive, needs based decisions
- Stepping up and professionalism
- Joined up local health care
- Close community collaboration
- Leaders more visible
- Patients as partners
- Some care basics fixed
- Staff working together as great teams
- Staff being properly valued

- Yes, on-going
- Yes, but fading
- Not seen
Things that haven’t gone well and we don’t want to go back to

“The realisation that NHS cutbacks had gone too far and lasted too long.”

“The abject neglect of care homes and staff by the system.”

“The amount of bureaucracy that has been avoided is stunning. NICE guidance updated in 3 days; virtual clinics made possible, far fewer futile pretend-work emails sent. Products manufactured in days, not years, clinical trial protocol approval and recruitment in days and weeks, not years.”

“I am wondering how much value we have been adding with all the annual chronic disease checks with QOF.”

“Some obtuse targets have disappeared, let’s not reinstate them.”

“Too much information coming from lots of different sources – e.g. CCG, LMC, PCN, BMA, etc – overwhelming.”

“Never bring back face to face appts unless necessary. Never bring back onerous assessments for discharge.”

“Never let services move back to Monday to Friday provision only.”

“Patients seem to have discovered the ability to self-care with only the lightest of remote support – maybe doctors had encouraged dependency before this?”
The impact of the intervention is dependent upon the internal condition of the interner.

Bill O'Brien
The fatigue of the pandemic

Erodes our capacity for Clarity
Erodes our capacity for Compassion

Learning for our response to Ukraine Invasion?

Purposeless sympathy generates hopelessness
News Media Industry uses fear and anger to keep us engaged constantly by triggering deep emotions
Social media used by many people as a means to express their own emotional turmoil, anger and fear and seek validation
Managing our emotional economy crucial to maintaining our critical capacity to act in positive ways. “Our steadiness matters”
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 postloss 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
Hillington Palliative Care Resources
“This virus feeds off inequality and it drives inequality, and that needs to be borne in mind at all times through this.”

*Chief Scientific Advisor Sir Patrick Vallance*
“We are not hard to reach but easy to ignore communities”

Fatima Elguenuni
Want to improve your engagement with Inclusion Health groups?

What is “Inclusion Health”?

Inclusion Health is a field which seeks to prevent and address the health and social inequalities experienced by groups of people at risk of or living with extremely poor health as a result of poverty, marginalisation, multi-morbidity and social exclusion.

The reasons vary by group, but include the impact of discrimination and stigmatisation, the complex nature of health systems and the effects of the wider social determinants of health. The groups experiencing the worst health inequalities include:

- Gypsies, Roma and Travellers,
- people experiencing homelessness,
- vulnerable migrants,
- sex workers,
- people in contact with the criminal justice system,
- people with learning disabilities and more.

Inclusion Health tool
THANK YOU
Next session: April 13 2022

15:30 – 17:00
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