Care at Home in Somerset: Our joint approach to keeping people where they are best supported.

When should we move from Home?

We want to ensure that people only come to hospital if they will benefit and wish to come. Most people can manage their illness at home, some with support. For many approaching the end of their life, it will be better to have care where they live, at home or in a care setting. Those who need to move from home to hospital, due to COVID or other conditions, are unlikely be allowed visitors and will be alone but for the professionals caring for them. As a county we are all in this together. Public and professional.

Knowing a person's wishes on the treatments which would be options for them, knowing what is important to them, is going to be key. Before they get ill.

The **clinical picture** for people who are **affected by COVID** is challenging. Evidence is forming but for all diagnosed cases it is thought (Zhou et al):

- The majority will get better or not be infected. Self-isolation and appropriate shielding advice is still the best medicine.
- Only about 1 in 5 people will need to come to hospital
- Once in hospital most will need oxygen, antibiotics and other treatment
- Of those admitted only about 1 in 4 people will be admitted to ITU for ventilation
- For any condition, an ICU stay often produces poor outcomes, with half dying and many likely suffering long term problems. Outcomes are uncertain for COVID ICU patients.

***People should come to hospital if they would benefit from doing so*. This benefit will need to be balanced at the time of need by the resources available and what a person's wishes are. For those who would not benefit or do not want to come, we need to know this in advance.**

Decisions on hospital admission are not the same as decisions that are made in secondary care, for example about intensive care. You are not expected to make complex decisions alone. We will contact you again to discuss how we plan to share the most difficult decisions within Somerset between primary and secondary care colleagues.

Why focus on older and unwell?

The Italian COVID *diagnosed* population has a median age of 63. The median age of all people who *died* from COVID is 80.

75% of those who died had 2 or more comorbidities; half had 3 or more.

Older and those with comorbidities have worse outcomes if respiratory effects are seen.

Deaths occurred on average 8 days after onset of symptoms.

For people who went to hospital they did this, on average, 4 days after symptoms started. Those who died had a 4 day average hospital stay. ITU interventions made a single day improvement in longevity for those who do not recover. 96.5% of deaths had acute respiratory distress syndrome.

It is important therefore that patients that are frail with comorbid conditions are given the opportunity to make informed decisions around the level of treatment they would wish for, and that would be effective for them - part of that decision making should occur as soon as possible if it has not already. Each vulnerable person should have a STEP decision including hospital admission.

Details or differential decisions can be documented on the rear of the STEP form and in added notes within patient records on EMIS.

We are therefore asking GPs to do three things:

1. For acutely unwell patients with probable Covid-19 consider whether hospital admission would be in their best interests. *A flow chart is included to include help on the WHO/WHAT/WHERE for an individual.* If you are confident in having those conversations please document your decision making process and ensure that you provide appropriate care in order to manage the patient at home.
2. For patients with other medical problems which might benefit from hospital admission consider that the patient is entering an environment where they are highly likely to be exposed to Covid-19 – it is important to have an open and honest discussion about the pros and cons of admission.
3. Use the EMIS searched lists to identify which patients most at need have existing STEP decisions *and* whether the current STEP is reasonable. More joint working will be required on this in the next days. Thank you for your support so far.

Support for highly challenging cases will be available through a shared decision making hub which we will be in contact about that next week. This aims to provide help with difficult decisions around hospital admission. It is separate to decisions on ITU (primary care will not routinely make these) but will be able to link with that process.

What is everyone else doing to help?

Advance care planning:

1. Secondary care are to start a similar process of ensuring STEP forms completed by them are available on the primary care record if not already. A list for your practice will be collated next week from secondary care. This will include teams for illness specific and cancer site specific focus. Where a STEP is present on secondary care records its detail will be sent by email to your practice, to be added to the EMIS record by practice staff. This should help make an imperfect system as easy as possible. All people known to hospice services have also been through the same approach.
2. Everyone will need a STEP from in paper form at home. Our advice is to stick to the fridge with a magnet so it is easily seen.
3. For people who may need a discussion regarding their escalation who are well known to a specialist team these teams will engage in these discussions and send the outcomes back to the practice or direct to the EMIS record if able. This information will come back to practice on an individual basis but also in the form of a collated list for your reference.
4. Volunteer support for Advance care planning. If you know your list and have identified people who will need to engage urgently with advance care planning this can be started by a trained group of Marie Curie volunteers, and/or by the LARCH team for those in residential and nursing homes. Further information will follow about this process but it will help you to focus on those who need specialist conversations from your existing primary care relationship.

Symptom control at home: Guidance on approaches and support to end of life care and symptom control will be present on the CCG website early next week. In the meantime please use existing guidance on just in case medications for those who need it. This advice will be updated to improve care and ease of access for patients.

Verification of expected death: An online training package to meet local requirements will be available from next week for any registered health professional to gain competency.

Learning from deaths during the pandemic: Learning quickly from issues raised from deaths associated with COVID. A short but informative process is being collated for use across our community by professionals completing after death paperwork for people dying during the pandemic. More information will follow but we thank you for your help in advance with improving our services, symptom control and support for people affected by COVID personally or professionally.

After death care: guidance has been published as part of the 'Coronavirus bill 2020' and will be interpreted locally for primary care use. It is likely to have key changes to help us in the formal processes and paperwork. More information will follow from the LMC.

Thank you: we will be in contact in the next days to update and improve the work above for care at home and end of life care. We are all together on this between primary and secondary care. Look after each other and stay safe. Please remember, even if you are feeling isolated you are not alone.

Dr Charlie Davis – on behalf of the Somerset COVID end of life group.

References:

https://www.epicentro.iss.it/coronavirus/bollettino/Report-COVID-2019_20_marzo_eng.pdf

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext

Attached:

1. 'Hospital Admission decision making aid for those unwell with suspected COVID infection' – flow chart