

A vibrant field of sunflowers under a bright blue sky with scattered white clouds. The sunflowers are in various stages of bloom, with bright yellow petals and dark brown centers. The background is partially obscured by white and blue decorative shapes.

WELCOME TO COVID
CLINICAL ECHO Week 18

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.

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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.

Overview

Preparing for Autumn

“COVID-19 is not socially neutral. SARS-CoV-2 exploits and accentuates inequalities.”

- Covid-19 update
- Your Questions
- Cambridge Study Barbara Antunes & Stephen Barclay
- Oxford CEBM
- ACP & conversations Update on APP Kathryn Mannix
- Curriculum Dates and topics til Christmas
- Chat Box Feedback & Resources

Chat Box

- Questions
- Potential Answers
- Resources
- Information /innovations
- Email clinical@hospiceuk.org

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



1,500 deaths across the UK in past **two** weeks. These COVID numbers are us... mothers, brothers, our colleagues and co-workers , friends, grandparents, children...

Week 18 COVID ECHO Update

Coronavirus (COVID-19) in the UK

Last updated on Tuesday 7 July 2020 at 3:55pm

Total number of lab-confirmed UK cases

286,349

Total number of people who have had a positive test result

Daily number of lab-confirmed UK cases

581

Number of additional cases on Tuesday 7 July 2020

Total number of COVID-19 associated UK deaths

44,391

Deaths of people who have had a positive test result

Daily number of COVID-19 associated UK deaths

155

Number of additional deaths on Tuesday 7 July 2020



COVID-19 associated deaths

Total number by nation

Scotland

2,488

England

39,815

Northern Ireland

554

Wales

1,534

Daily death total up from 15 to 155

"We discovered too many care homes didn't really follow the procedures in the way that they could have," the Prime Minister. "There were no procedures, so hard to fathom how they weren't followed," Care England



Total Confirmed

9,129,702

Confirmed Cases by
Country/Region/Sovereignty

2,312,413 US

1,106,470 Brazil

598,878 Russia

440,215 India

306,761 United Kingdom

257,447 Peru

246,963 Chile

Admin0

Last Updated at (M/D/YYYY)

6/23/2020 2:33:21 p.m.

188

countries/regions

Lancet Inf Dis Article: [Here](#). Mobile Version: [Here](#).

Lead by [JHU CSSE](#). Technical Support: [Esri Living Atlas team](#) and [JHU APL](#). Financial

24th June, 2020



2 million more infected
65,000 more died

Cumulative Confirmed Cases

Esri, FAO, NOAA

Global Deaths

472,793

120,402 deaths
US

51,271 deaths
Brazil

42,731 deaths
United Kingdom

34,657 deaths
Italy

Global Deaths

US State Level

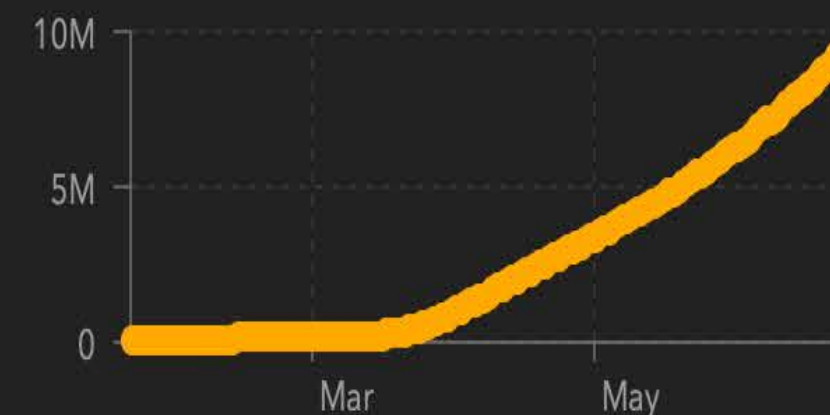
Deaths, Recovered

31,176
deaths, 69,710
recovered
New York US

12,974
deaths, 29,522
recovered
New Jersey US

7,873 deaths,

US Deaths,...



Confirmed

Logarithmic

Daily Cases

Total Confirmed

11,691,068

Confirmed Cases by
Country/Region/Sovereignty

2,963,244 US
1,623,284 Brazil
719,664 India
693,215 Russia
305,703 Peru
301,019 Chile
287,872 United Kingdom
261,750 Mexico
252,130 Spain
245,688 Iran
241,956 Italy
234,509 Pakistan
217,108 Saudi Arabia
207,897 Turkey
206,072 France
205,721 South Africa
198,284 Germany

Admin0 Admin1 Admin2

Last Updated at (M/D/YYYY)

7/7/2020 7:34:14 p.m.

188

countries/regions

Lancet Inf Dis Article: [Here](#). Mobile Version: [Here](#).

Lead by [JHU CSSE](#). Technical Support: [Esri Living Atlas team](#) and [JHU APL](#). Financial Support: [JHU](#) and [NSF](#). Resource support: [Slack](#), [Github](#) and [AWS](#). Click [here](#) to [donate](#) to the CSSE dashboard team, and other JHU COVID-19 Research Efforts. [FAQ](#). Read more in this [blog](#). [Contact US](#).

8th July, 2020



Cumulative Confirmed Cases

Active Cases

Incidence Rate

Case-Fatality Ratio

Testing Rate

Hospitalization Rate

Global Deaths

540,062

130,813 deaths
US

65,487 deaths
Brazil

44,476 deaths
United Kingdom

34,899 deaths
Italy

31,119 deaths
Mexico

29,936 deaths
France

28,392 deaths
Spain

20,159 deaths
India

Global Deaths

US State Level

Deaths, Recovered

32,236 deaths, 71,040 recovered
New York US

15,281 deaths, 30,729 recovered
New Jersey US

8,198 deaths, 93,157 recovered
Massachusetts US

7,026 deaths, recovered
Illinois US

6,787 deaths, 70,437 recovered
Pennsylvania US

6,465 deaths, recovered
California US

6,221 deaths, 52,841 recovered
Michigan US

4,338 deaths, 8,210 recovered
Connecticut US

US Deaths, Recovered



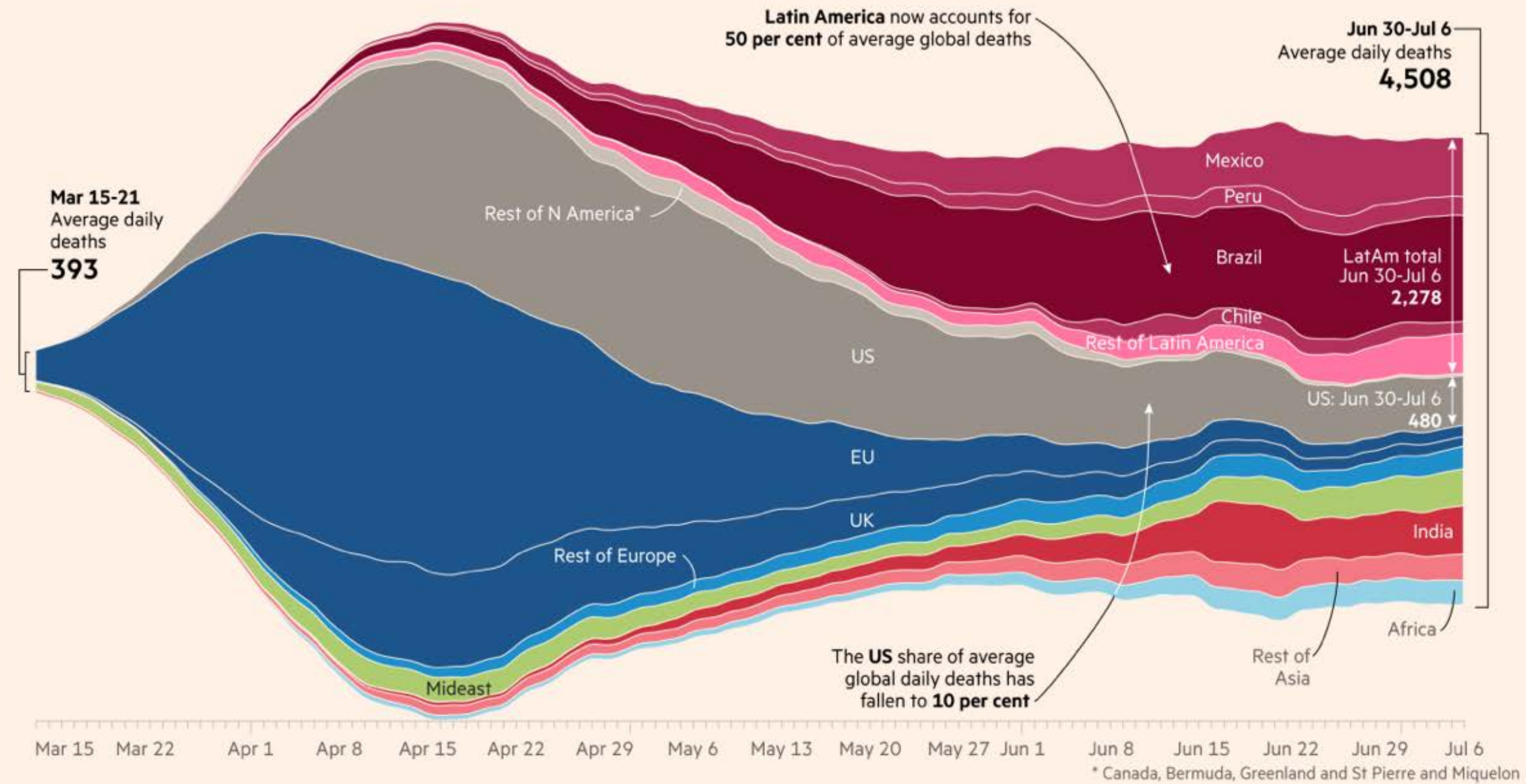
Confirmed

Logarithmic


Daily Cases

Surge in Latin America means global daily death toll on the rise once again

Daily deaths of patients diagnosed with coronavirus (7-day rolling average)



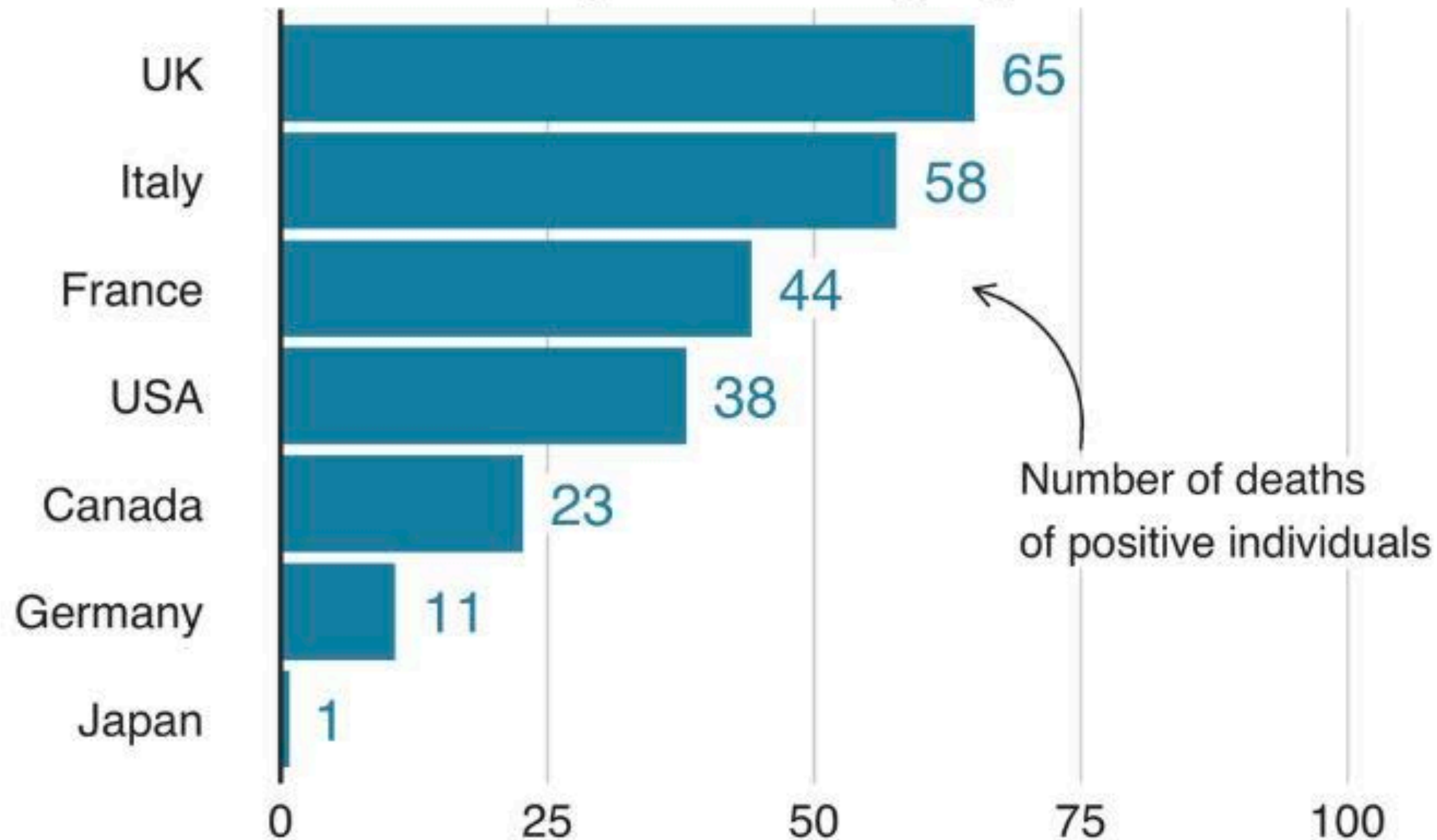
Death rates have climbed far above historical averages in many countries that have faced Covid-19 outbreaks

Number of deaths per week from all causes, 2020 vs recent years:  Shading indicates total excess deaths during outbreak



Source: FT analysis of mortality data. Data updated June 23

Covid-19 deaths per 100k population



Second waves

Melbourne locked down

Leicester locked down

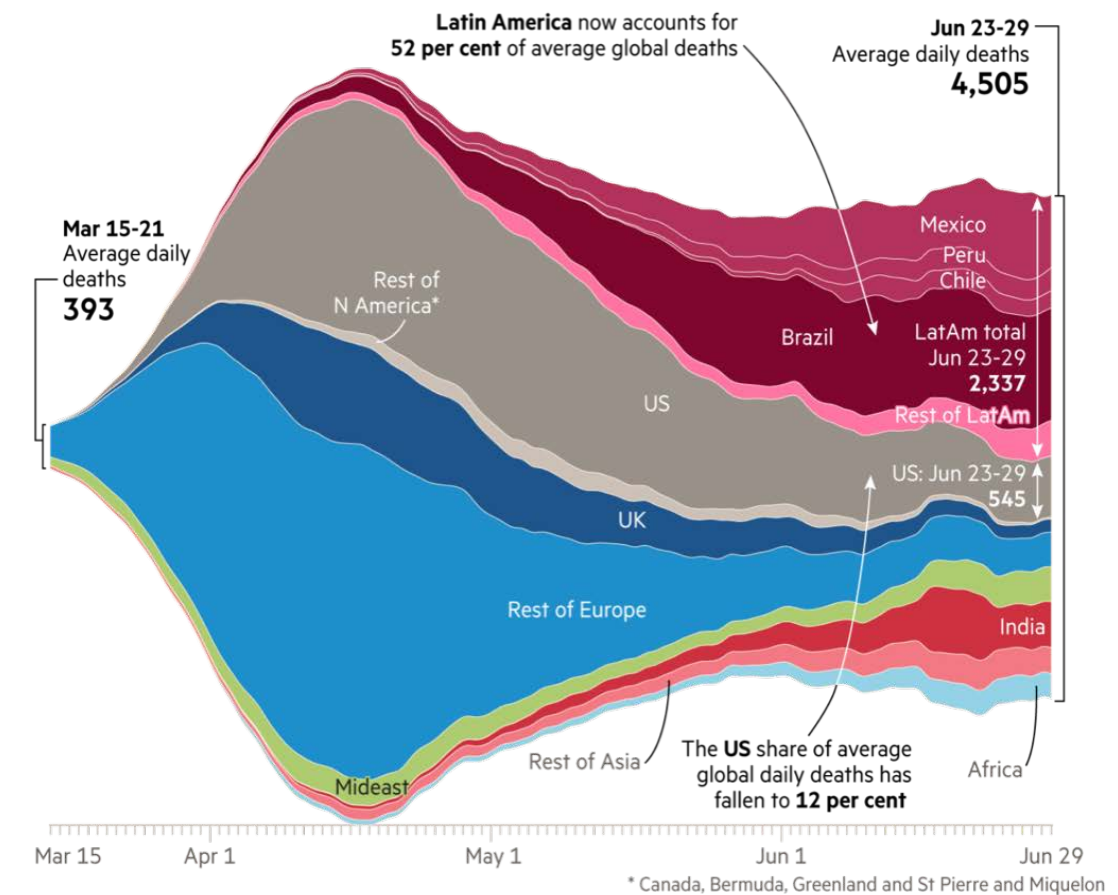
Berlin locked down

Bournemouth open

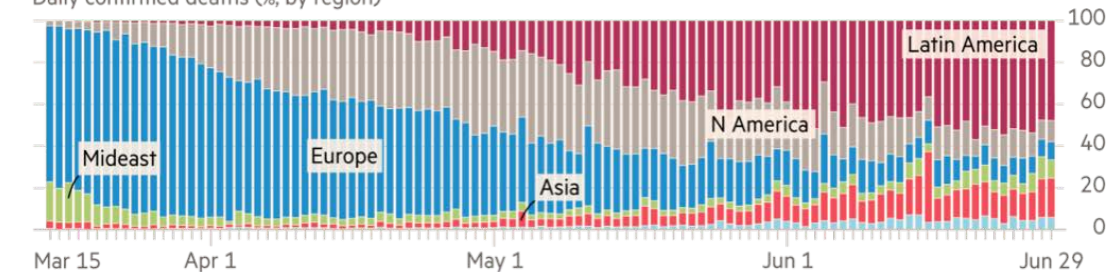


Surge in Latin America means global daily death toll on the rise once again

Daily deaths of patients diagnosed with coronavirus (7-day rolling average)



Daily confirmed deaths (% by region)



FT graphic: Steven Bernard / @sdbarnard

Source: FT analysis of ECDC and Covid Tracking Project data

© FT



Government of Western Australia
East Metropolitan Health Service

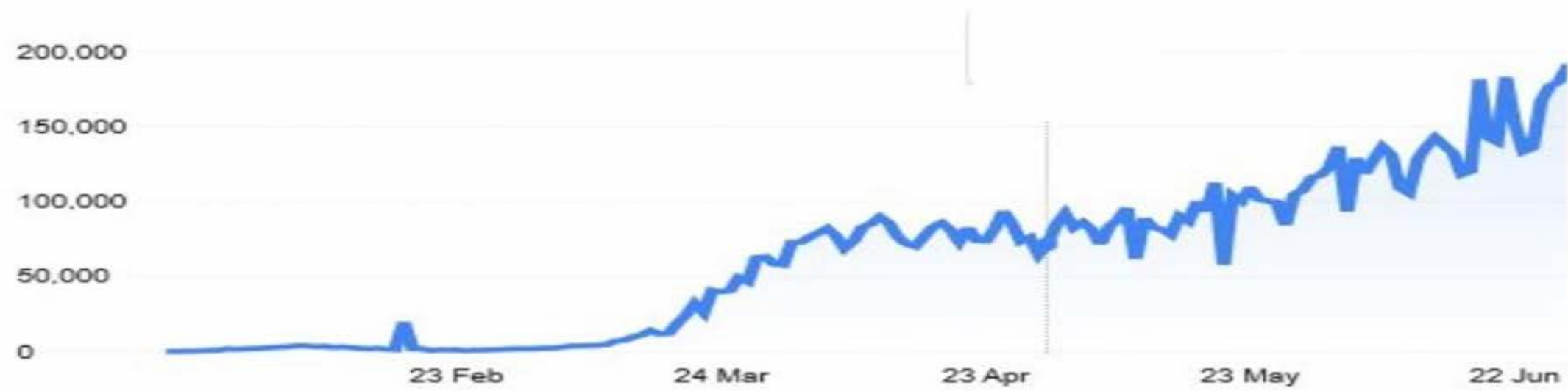
Royal Perth Bentley Group



»» MONTHLY UPDATE ON SARS-CoV-2

Prof Grant Waterer | Director Clinical Services RPBG

Daily change



COVID-math

- 10.7M confirmed cases
- Need 55-60% for herd immunity
 - Assuming at least medium term immunity
- World population 7.8 billion
 - 0.000002%
- UK 66.5 million, currently 313,000
 - 0.47%
 - Even if 10x number 4.7%
- USA 328 million, currently 2.74 million
 - 0.8%

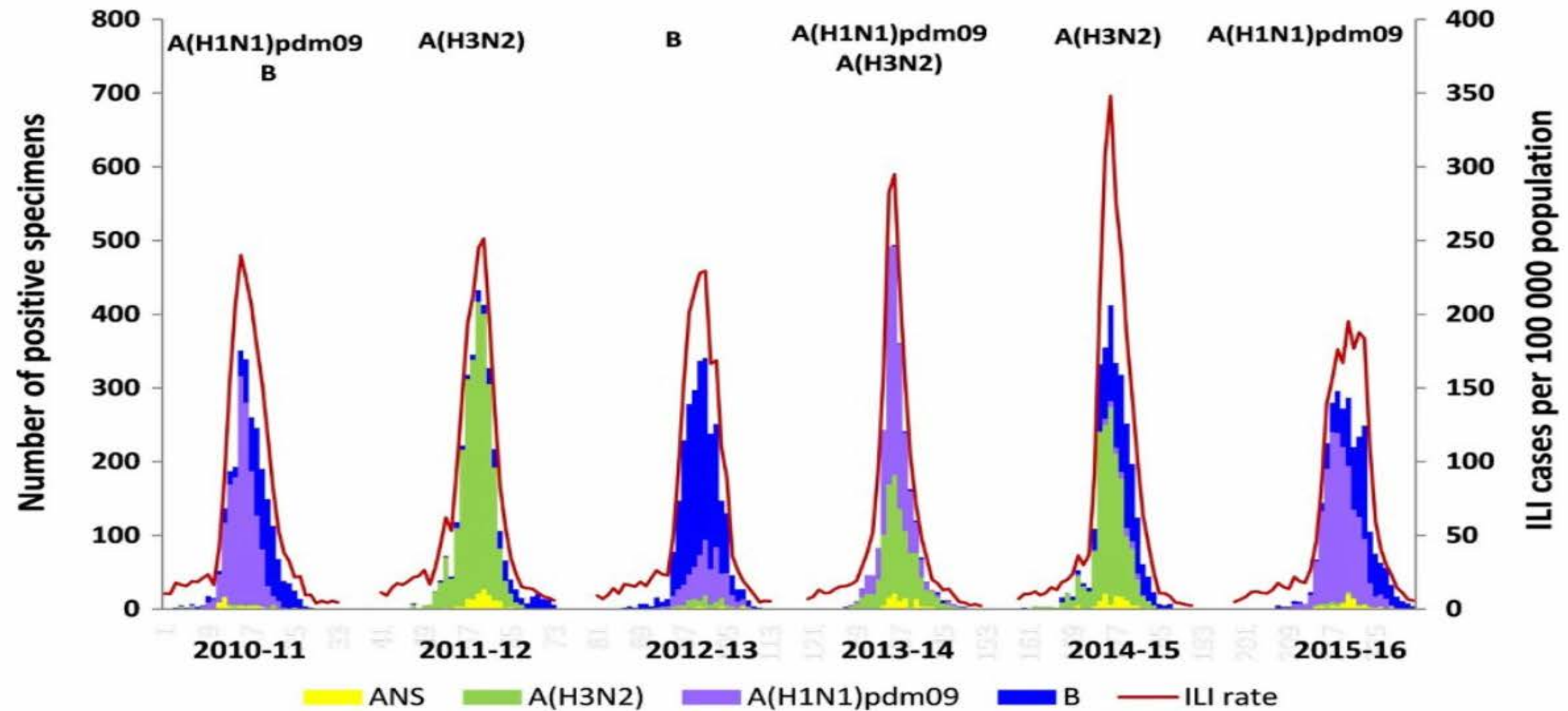
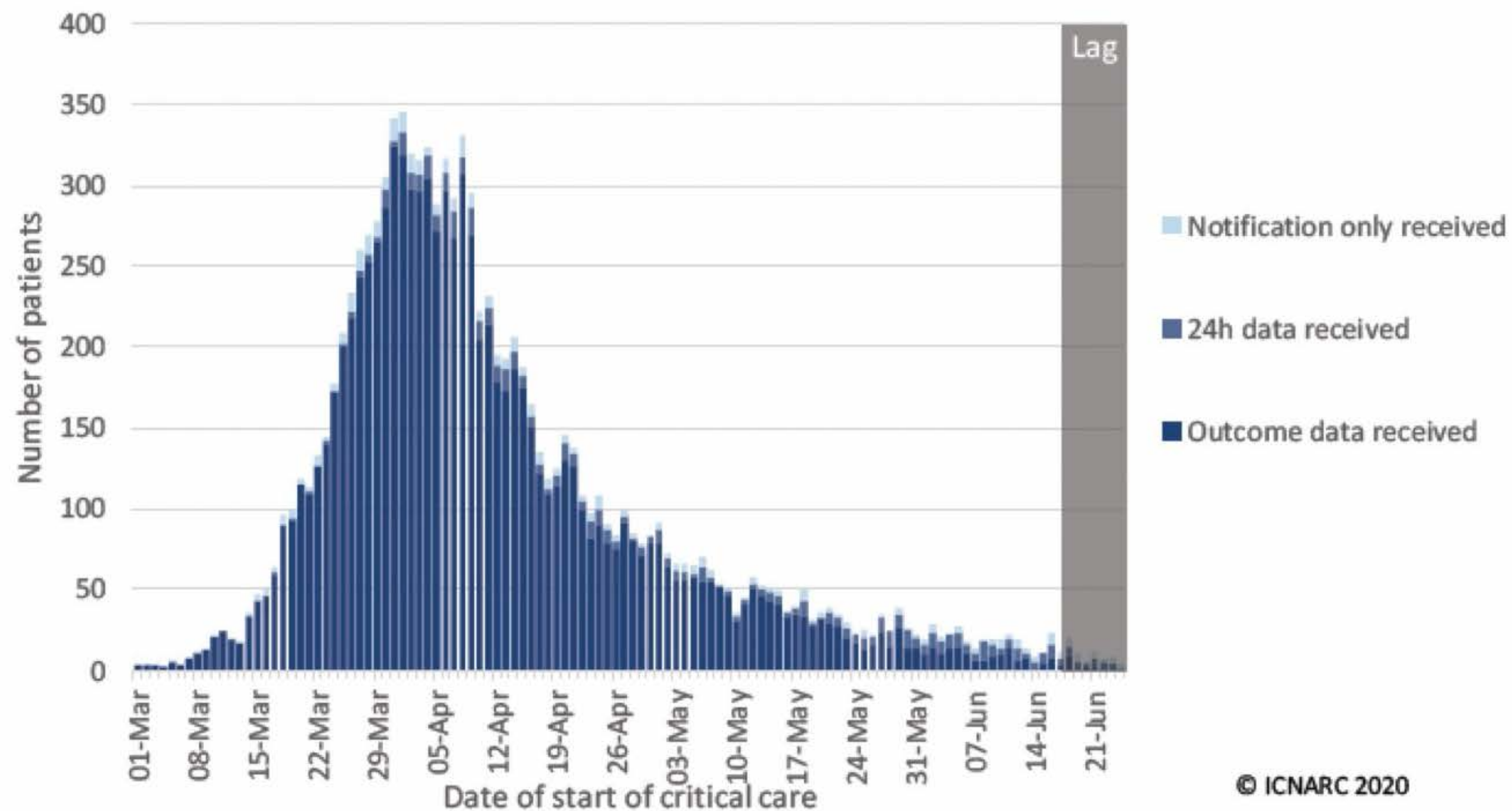


Figure 2 New patients included this week by week of start critical care



Data as June 26 2020

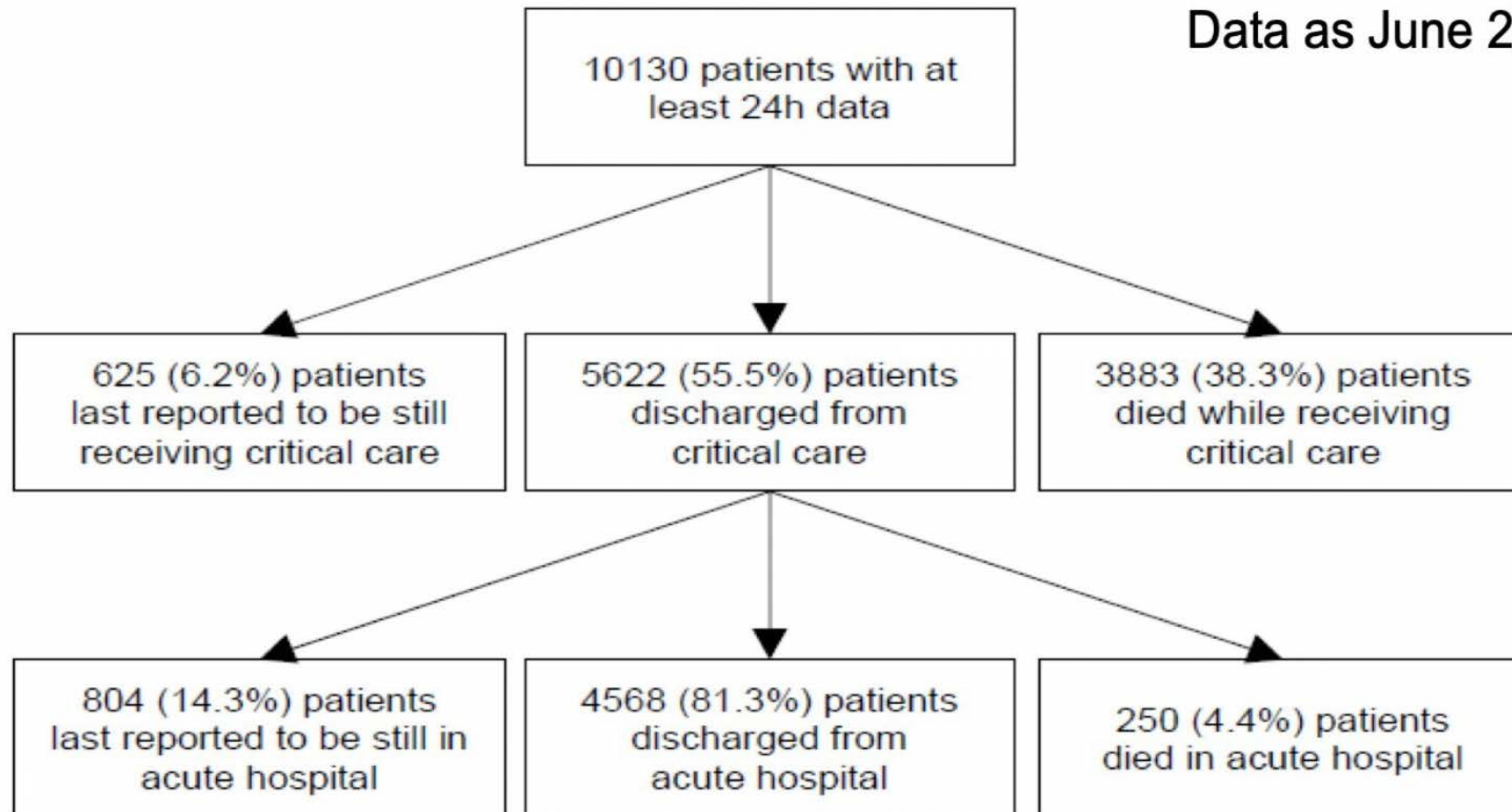
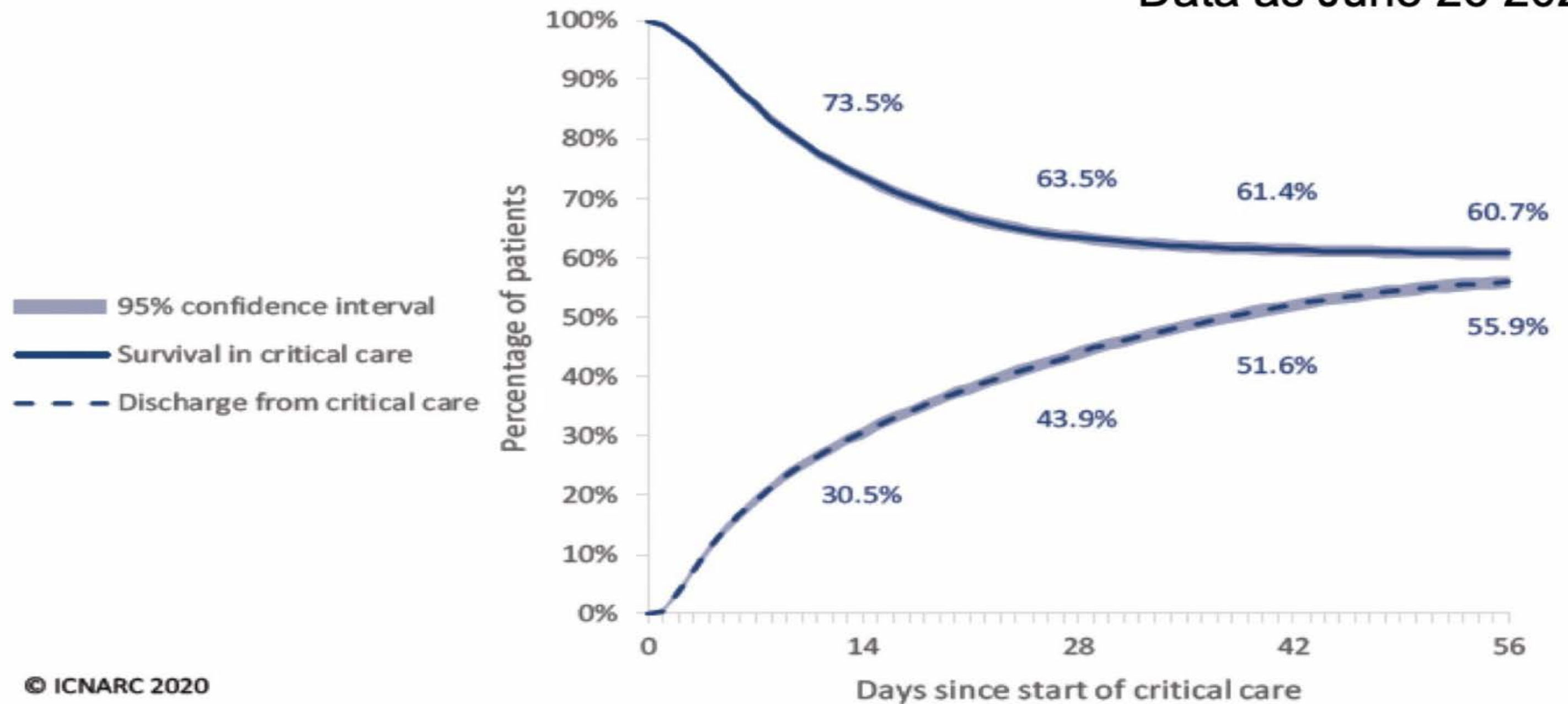


Figure 11 Critical care and acute hospital outcomes among patients with at least 24h data received

Data as June 26 2020



© ICNARC 2020

Died while receiving critical care	0	2630	3590	3782	3814
Still receiving critical care	10024	4266	1926	908	469
Discharged from critical care	0	3031	4315	5078	5423
Censored	0	97	193	256	318

Figure 13 Survival and discharge among patients with at least 24h data received

Pharmacology

Coronavirus breakthrough: Wonder drug cures 90% of patients in groundbreaking trial

Aspen stock rises as world uncovers wonder drug that fights Covid-19

17th June 2020 by Jackie Cameron

Game-changing 'wonder-drug' made to fight ebola could be the world's first real weapon against Covid-19

Newsweek

Cuba Uses 'Wonder Drug' to Fight Coronavirus Around World Despite Sanctions

Japan's wonder drug and the race for Covid-19 medicine

Dexamethasone for COVID-19

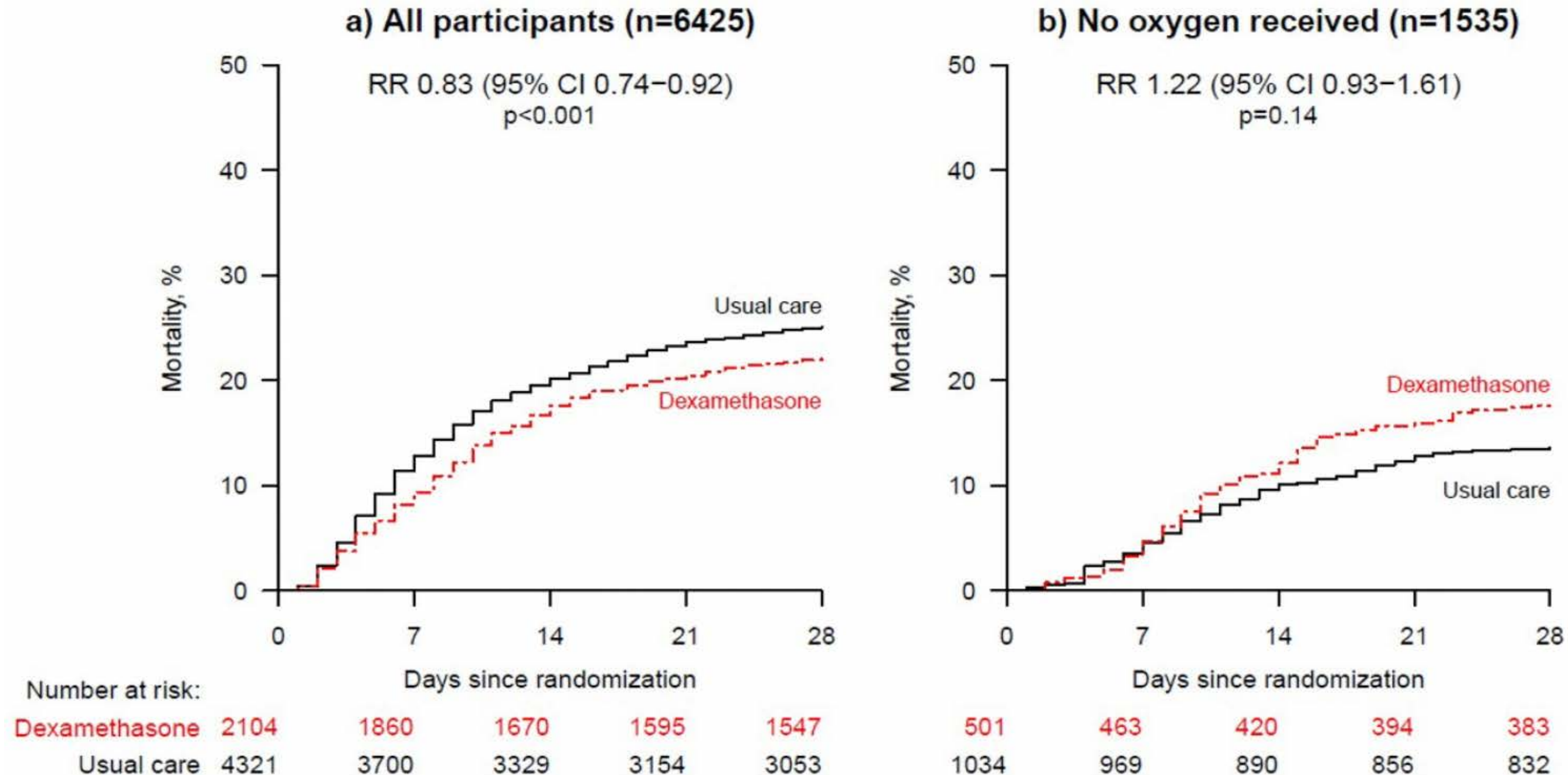
- One arm of the RECOVERY trial
- Open-label, adaptive platform trial
- Dexamethasone 6mg daily
 - Equivalent to prednisolone 40mg
 - Equivalent to methylprednisolone 32mg
 - NOT 500mg bd used in some early studies
- 2104 patients vs 4321 “usual care”

Table 2: Effect of allocation to dexamethasone on main study outcomes

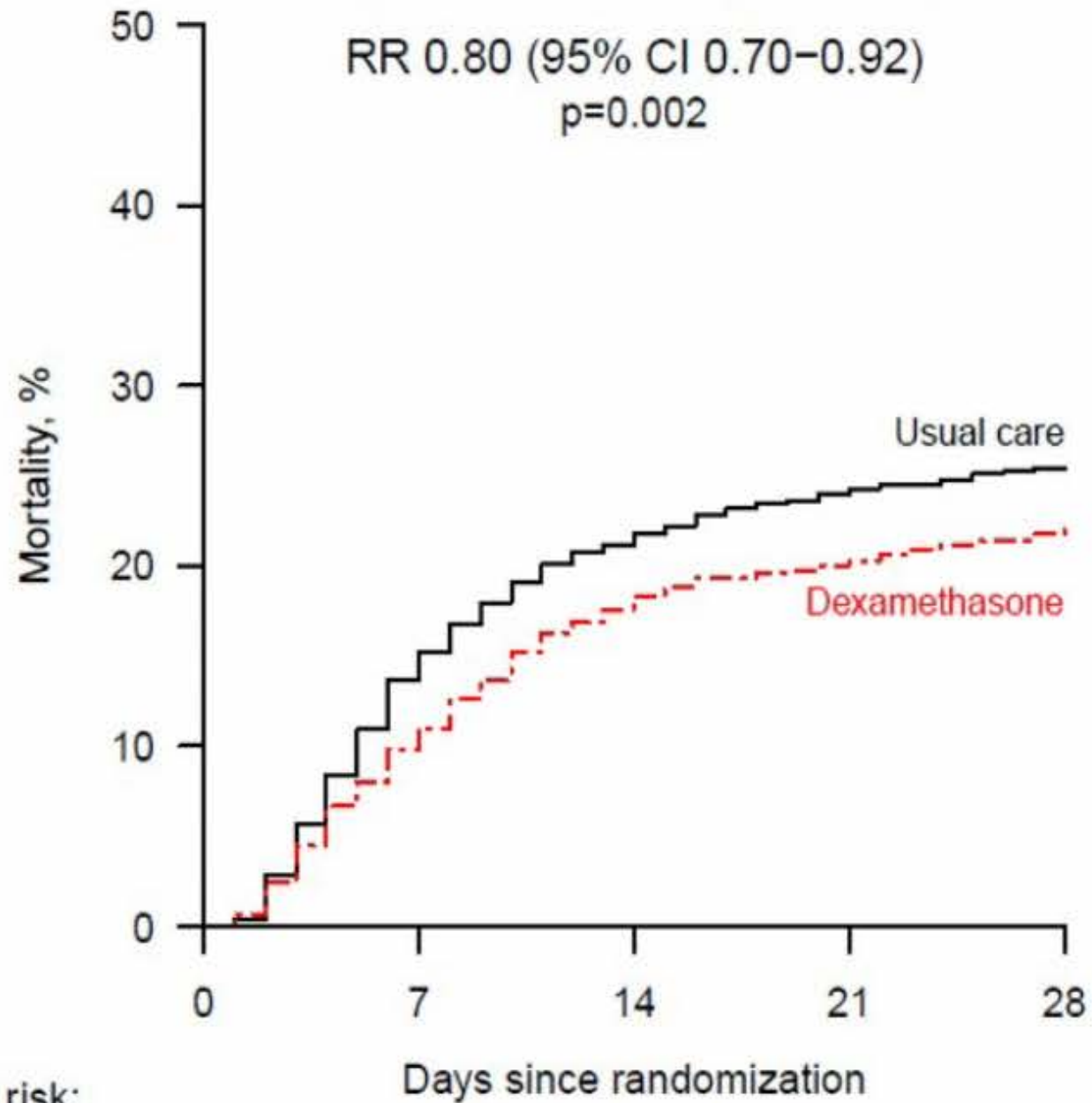
	Treatment allocation		RR (95% CI)	p-value
	Dexamethasone (n=2104)	Usual care (n=4321)		
Primary outcome:				
28-day mortality	454 (21.6%)	1065 (24.6%)	0.83 (0.74-0.92)	<0.001
Secondary outcomes:				
Discharged from hospital within 28 days	1360 (64.6%)	2639 (61.1%)	1.11 (1.04-1.19)	0.002
Receipt of invasive mechanical ventilation or death*	425/1780 (23.9%)	939/3638 (25.8%)	0.91 (0.82-1.00)	0.049
Invasive mechanical ventilation	92/1780 (5.2%)	258/3638 (7.1%)	0.76 (0.61-0.96)	0.021
Death	360/1780 (20.2%)	787/3638 (21.6%)	0.91 (0.82-1.01)	0.07

RR=Rate Ratio for the outcomes of 28-day mortality and hospital discharge, and risk ratio for the outcome of receipt of invasive mechanical ventilation or death (and its subcomponents). Estimates of the RR and its 95% confidence interval are adjusted for age in three categories (<70 years , 70-79 years, and 80 years or older). * Analyses exclude those on invasive mechanical ventilation at randomization.

Figure 1: 28-day mortality in all patients (panel a) and separately according to level of respiratory support received at randomization (panels b–d)



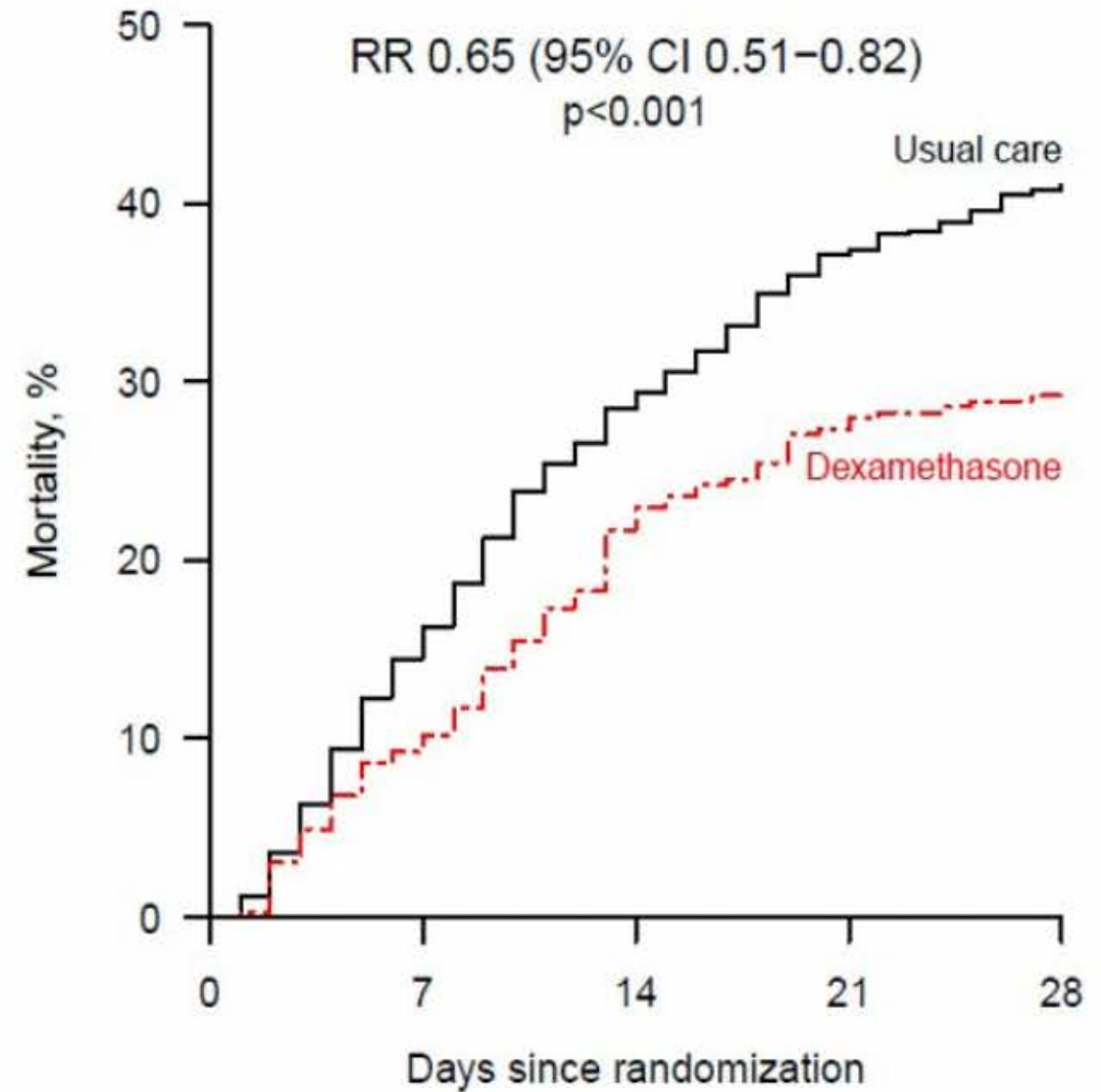
c) Oxygen only (n=3883)



Number at risk:

Dexamethasone	1279	1107	1004	971	940
Usual care	2604	2162	1965	1880	1832

d) Invasive mechanical ventilation (n=1007)



324	290	246	230	224
683	569	474	418	389

Steroids and COVID-19

- Mechanical ventilation
 - 40mg prednisolone per day or equivalent
- Rapidly deteriorating oxygenation - - > MV
- Just on O₂?
 - No mortality difference
 - Need 90-day
 - Impact of age?
 - Open label, assumption of survival on discharges

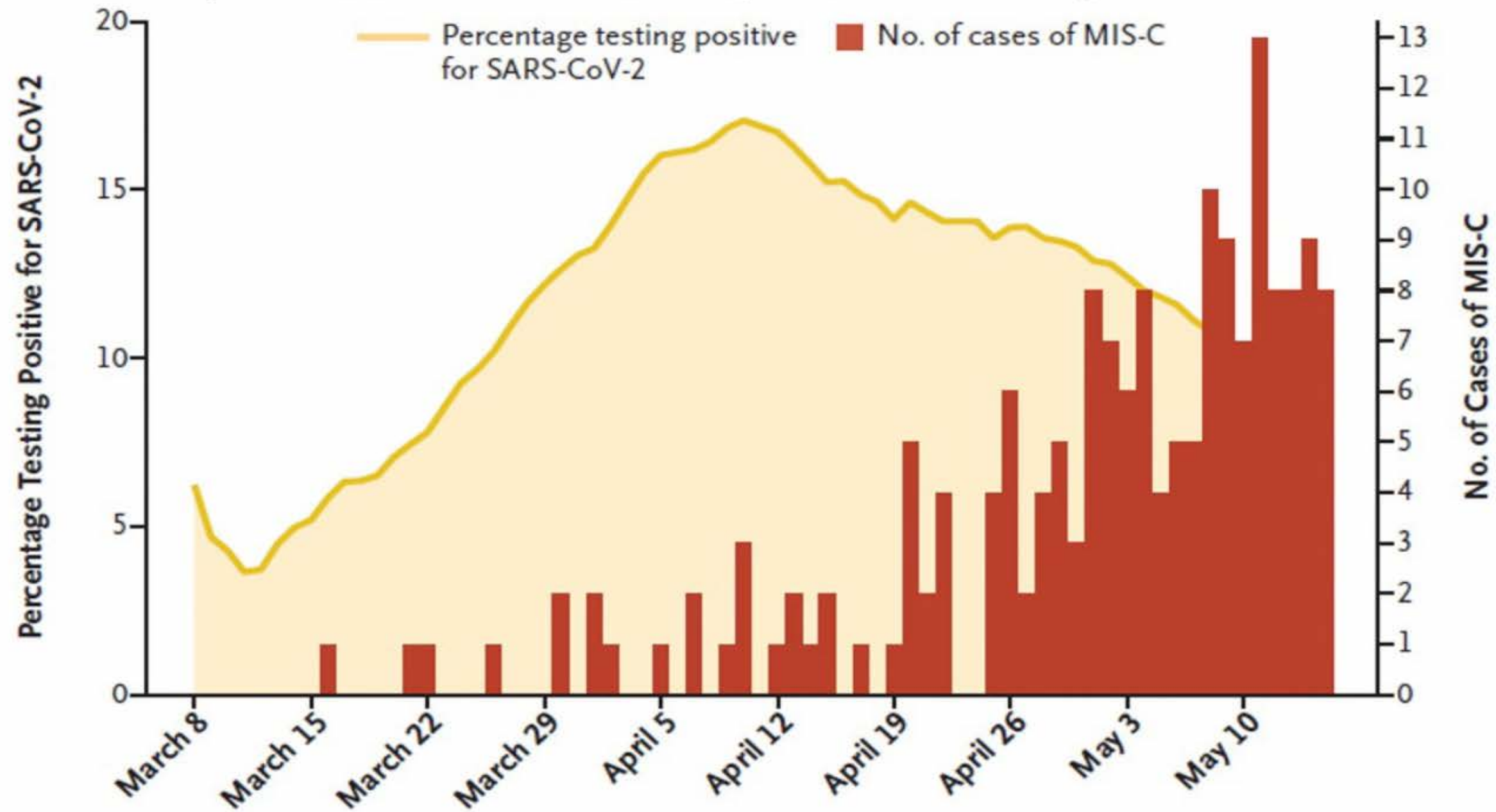
ORIGINAL ARTICLE

Multisystem Inflammatory Syndrome in U.S. Children and Adolescents

L.R. Feldstein, E.B. Rose, S.M. Horwitz, J.P. Collins, M.M. Newhams, M.B.F. Son, J.W. Newburger, L.C. Kleinman, S.M. Heidemann, A.A. Martin, A.R. Singh, S. Li, K.M. Tarquinio, P. Jaggi, M.E. Oster, S.P. Zackai, J. Gillen, A.J. Ratner, R.F. Walsh, J.C. Fitzgerald, M.A. Keenaghan, H. Alharash, S. Doymaz, K.N. Clouser, J.S. Giuliano, Jr., A. Gupta, R.M. Parker, A.B. Maddux, V. Havalad, S. Ramsingh, H. Bukulmez, T.T. Bradford, L.S. Smith, M.W. Tenforde, C.L. Carroll, B.J. Riggs, S.J. Gertz, A. Daube, A. Lansell, A. Coronado Munoz, C.V. Hobbs, K.L. Marohn, N.B. Halasa, M.M. Patel, and A.G. Randolph, for the Overcoming COVID-19 Investigators and the CDC COVID-19 Response Team*

This article was published on June 29, 2020,
and updated on July 2, 2020, at NEJM.org.

B Temporal Relationship between MIS-C and Covid-19 Activity in Persons <21 Yr of Age



This article was published on June 29, 2020,
and updated on July 2, 2020, at NEJM.org.

Table 1. Demographic and Clinical Characteristics of the Patients According to SARS-CoV-2 Infection Status.

Characteristic	Laboratory Confirmation of SARS-CoV-2 Infection (N=131)		Epidemiologic Link to Person with Covid-19 (N=55)*	All Patients (N=186)
	RT-PCR Positive (N=73)†	Antibody Test Positive, RT-PCR Negative or Unknown (N=58)		
Male sex — no. (%)	43 (59)	36 (62)	36 (65)	115 (62)
Median age (interquartile range) — yr	9.1 (4.8–14.2)	9.1 (4.1–11.7)	3.9 (1.4–11.6)	8.3 (3.3–12.5)
Age group — no. (%)				
<1 yr	6 (8)	0	7 (13)	13 (7)
1–4 yr	13 (18)	19 (33)	21 (38)	53 (28)
5–9 yr	21 (29)	14 (24)	11 (20)	46 (25)
10–14 yr	17 (23)	18 (31)	10 (18)	45 (24)
15–20 yr	16 (22)	7 (12)	6 (11)	29 (16)
Organ-system involvement — no. (%)				
Two systems	5 (7)	1 (2)	12 (22)	18 (10)
Three systems	14 (19)	10 (17)	12 (22)	36 (19)
Four or more systems	54 (74)	47 (81)	31 (56)	132 (71)
Detection of additional virus — no. (%)‡‡	6 (8)	2 (3)	1 (2)	9 (5)
Highest level of care — no. (%)				
Ward	11 (15)	5 (9)	22 (40)	38 (20)
Intensive care unit	62 (85)	53 (91)	33 (60)	148 (80)
Extracorporeal membrane oxygenation	6 (8)	1 (2)	1 (2)	8 (4)
Mechanical ventilation	23 (32)	8 (14)	6 (11)	37 (20)

Neurological and neuropsychiatric complications of COVID-19 in 153 patients: a UK-wide surveillance study

Aravinthan Varatharaj, Naomi Thomas, Mark A Ellul, Nicholas W S Davies, Thomas A Pollak, Elizabeth L Tenorio, Mustafa Sultan, Ava Easton, Gerome Breen, Michael Zandi, Jonathan P Coles, Hadi Manji, Rustam Al-Shahi Salman, David K Menon, Timothy R Nicholson, Laura A Benjamin, Alan Carson, Craig Smith, Martin R Turner, Tom Solomon, Rachel Kneen, Sarah L Pett, Ian Galea, Rhys H Thomas*, Benedict D Michael*, on behalf of the CoroNerve Study Group†*

Lancet Psychiatry 2020


Published Online

June 25, 2020

Varatharaj et al Lancet Psych 2020

- Web-based portal collecting case reports across Association British Neurologists, British Association of Stroke Physicians, Royal College of Psychiatrists
- 125 cases of COVID-19
- 77 Cerebrovascular event – ischaemic stroke in 57, 9 – intracranial haemorrhage, 9 encephalopathy, 7 encephalitis, 1 cerebral vasculitis
- 10 patients presented with new onset psychosis
- 6 presented with dementia-like syndrome

COVID-19 Is an Independent Risk Factor for Acute Ischemic Stroke

 P. Belani,  J. Schefflein,  S. Kihira,  B. Rigney,  B.N. Delman,  K. Mahmoudi,  J. Mocco,  S. Majidi,  J. Yeckley,  A. Aggarwal,  D. Lefton, and  A.H. Doshi

ABSTRACT

BACKGROUND AND PURPOSE: Coronavirus disease 2019 (COVID-19) is an active worldwide pandemic with diverse complications. Stroke as a presentation has not been strongly associated with COVID-19. The authors aimed to retrospectively review a link between COVID-19 and acute stroke.

MATERIALS AND METHODS: We conducted a retrospective case-control study of 41 cases and 82 control subjects matched by age, sex, and risk factors. Cases were patients who underwent stroke alert imaging with confirmed acute stroke on imaging between March 16 and April 5, 2020, at 6 hospitals across New York City. Control subjects were those who underwent stroke alert imaging during the same timeframe without imaging evidence of acute infarction. Data pertaining to diagnosis of COVID-19 infection, patient demographics, and risk factors were collected. A univariate analysis was performed to assess the covariate effect of risk factors and COVID-19 status on stroke imaging with positive findings.

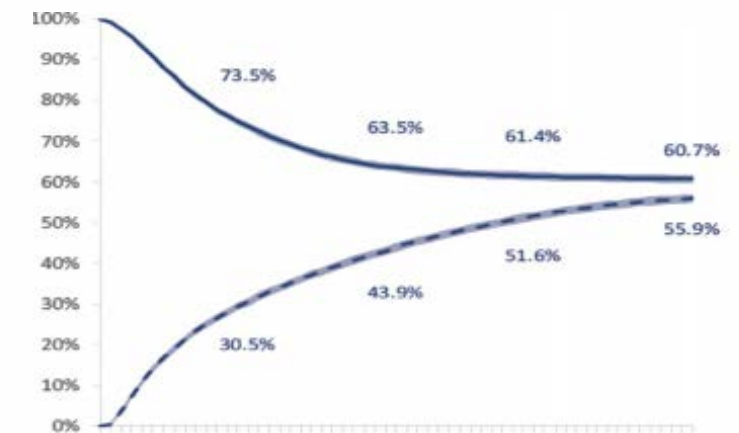
RESULTS: The mean age for cases and controls was 65.5 ± 15.3 years and 68.8 ± 13.2 years, respectively. Of patients with acute ischemic stroke, 46.3% had COVID-19 infection compared with 18.3% of controls ($P = .001$). After adjusting for age, sex, and risk factors, COVID-19 infection had a significant independent association with acute ischemic stroke compared with control subjects (OR, 3.9; 95% CI, 1.7–8.9; $P = .001$).

CONCLUSIONS: We demonstrated that COVID-19 infection is significantly associated with imaging confirmation of acute ischemic stroke, and patients with COVID-19 should undergo more aggressive monitoring for stroke.

ABBREVIATIONS: COVID-19 = coronavirus disease 2019; SARS-CoV-2 = Severe Acute Respiratory Syndrome coronavirus 2; RT-PCR = reverse transcriptase polymerase chain reaction

Other chronic health impacts

- Post ARDS fibrosis
- Post critical care myopathy and neuropathy
- Higher rates of AMI
- Higher rates of heart failure
- Major depression and suicide



COVID-19 in health-care workers in three hospitals in the south of the Netherlands: a cross-sectional study

Reina S Sikkema, Suzan D Pas*, David F Nieuwenhuijse, Áine O'Toole, Jaco Verweij, Anne van der Linden, Irina Chestakova, Claudia Schapendonk, Mark Pronk, Pascal Lexmond, Theo Bestebroer, Ronald J Overmars, Stefan van Nieuwkoop, Wouter van den Bijllaardt, Robbert G Bentvelsen, Miranda M L van Rijen, Anton G M Buiting, Anne J G van Oudheusden, Bram M Diederer, Anneke M C Bergmans, Annemiek van der Eijk, Richard Molenkamp, Andrew Rambaut, Aura Timen, Jan A J W Kluytmans, Bas B Oude Munnink, Marjolein F Q Kluytmans van den Bergh*, Marion P G Koopmans**

Lancet Infect Dis 2020

Published Online

July 2, 2020

Sikkema et al Healthcare workers

- Screened 12,022 health care workers in 3 hospitals between March 2 and March 12
- 96 tested positive
- Complete genome sequencing from 50 HCW and 10 patients
- Data supported community-acquisition, not nosocomial acquisition

SARS-CoV-2 viral load in hospitalised patients correlates with risk of intubation, mortality

- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral load among hospitalised patients is independently associated with the risk of intubation and in-hospital mortality, according to a study published in Clinical Infectious Diseases.
- Reed Magleby, MD, NewYork-Presbyterian Hospital, Weill Cornell Medical Center, New York, New York, and colleagues 678 hospitalised patients with coronavirus evaluated found that 35% of patients with a high SARS-CoV-2 viral load on admission died, compared with 17.6% of patients with medium viral loads and 6.2% of patients with low viral loads.
- The findings suggest that using cycle threshold (Ct) values, which are available when results from reverse transcription-polymerase chain reaction (RT-PCR) assays are reported to clinicians, could identify patients at highest risk of intubation and death and guide treatment accordingly.

[Viral load as predictor](#)

COVID-19 rapid evidence summary: vitamin D for COVID-19

Evidence summary

Published: 29 June 2020

www.nice.org.uk/guidance/es28

Key messages

The content of this evidence summary was up-to-date on 18 June 2020. See [summaries of product characteristics \(SPCs\)](#), [British national formulary \(BNF\)](#) or the [MHRA](#), [NHS](#) or [NICE](#) websites for up-to-date information.

Vitamin D is important for bone and muscle health. It has also been hypothesised that vitamin D may have a role in the body's immune response to respiratory viruses. Although sunlight exposure is the major source of vitamin D for most people, it can also be obtained from the diet or supplements. The 2 major forms of vitamin D, vitamin D3 (colecalciferol) and vitamin D2 (ergocalciferol), are licensed for the prevention and treatment of vitamin D deficiency. Vitamin D supplements are not specifically licensed for preventing or treating any infection, including the novel coronavirus infection that causes COVID-19.

This evidence summary sets out the best available evidence on vitamin D for preventing or treating COVID-19, or for the susceptibility to COVID-19 based on vitamin D status. Treating or preventing acute respiratory tract infections more generally was out of scope. The Scientific Advisory Committee on Nutrition (SACN) has published a [report on vitamin D and acute respiratory tract](#)

Advisory statement on likely place in therapy

There is no evidence to support taking vitamin D supplements to specifically prevent or treat COVID-19. However, all people should continue to follow UK Government advice on daily vitamin D supplementation to maintain bone and muscle health during the COVID-19 pandemic.

Rationale

To protect bone and muscle health, the [UK Government advises](#) that everyone needs vitamin D equivalent to an average daily intake of 10 micrograms (400 international units). They advise that all people should consider taking a daily supplement containing 10 micrograms vitamin D during autumn and winter months. They also advise that people whose skin has little to no exposure to sunlight and ethnic minority groups with dark skin, from African, Afro-Caribbean and South Asian backgrounds, should consider taking a vitamin D supplement all year round. This advice would also apply to people whose skin has little to no exposure to sunlight because they are indoors shielding or self-isolating. Therefore, UK Government advice during the COVID-19 pandemic is that everyone should consider taking 10 micrograms of vitamin D a day because they might not be getting enough from sunlight if they're indoors most of the day. See also [NICE guidance on Vitamin D: supplement use in specific population groups](#).

NICE VIT D Guidance in COVID



Two-thirds of people with coronavirus have no symptoms, ONS data shows

Analysis finds infection rates higher for those working in patient-facing healthcare or resident-facing social care roles

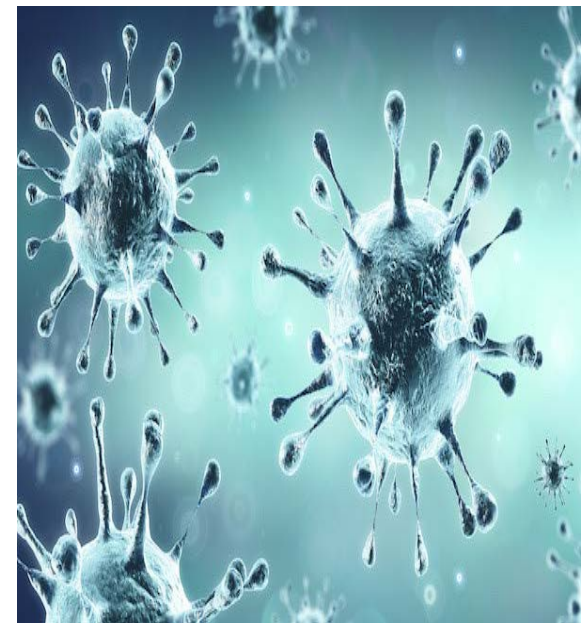
Chiara Giordano | 14 hours ago |



Two-thirds of people testing positive for **coronavirus** have no symptoms, according to **Office for National Statistics (ONS)** data.

The new figures suggest there is a potentially large number of **asymptomatic** cases – meaning the virus could be spread by people who don't realise they are carrying it.

Only 33 per cent of those testing positive for **Covid-19** reported any evidence of symptoms at the time of their swab test or at either the preceding or subsequent swab test, ONS analysis shows.



Global COVID-19 Prevention Trial of Hydroxychloroquine to Resume

By Kate Kelland

June 30, 2020

LONDON (Reuters) - A global trial designed to test whether the anti-malaria drugs hydroxychloroquine and chloroquine can prevent infection with COVID-19 is to restart after being approved by British regulators.

The Medicines and Healthcare Products Regulatory Agency (MHRA) took its decision on what is known as the COPCOV trial after hydroxychloroquine was found in another British trial to have no benefit as a treatment for patients already infected with COVID-19, the disease caused by the new coronavirus.

The COPCOV study was paused pending review after the treatment trial results.

It is a randomised, placebo-controlled trial that is aiming to enrol 40,000 healthcare workers and other at-risk staff around the world, and is being led by the Oxford University's Mahidol Oxford Tropical Medicine Research Unit (MORU) in the Thai capital, Bangkok.

U.S. President Donald Trump said in March hydroxychloroquine could be a game-changer and then said he was taking it himself, even after the U.S. regulator, the Food and Drug Administration (FDA), advised that its efficacy and safety were unproven.

The FDA later revoked emergency use authorisation for the drugs to treat COVID-19, after trials showed they were of no benefit as treatments.

But Oxford University's Professor Nicholas White, who is co-leading the COPCOV trial (<https://bit.ly/3ichtCR>), said studies of the drugs as a potential preventive medicine had not yet given a conclusive answer.

"Hydroxychloroquine could still prevent infections, and this needs to be determined in a randomised controlled trial," he said in a statement. "The question whether (it) can prevent COVID-19 or not remains as pertinent as ever."

White's team said recruitment of British health workers would resume this week, and said plans were under way for new sites in Thailand and Southeast Asia, Africa and South America. Results are expected by the end of this year.

The death toll from COVID-19 surpassed half a million people on Sunday, according to a Reuters tally, with the number of cases reported globally now more than 10 million.

Reuters Health Information © 2020

Cite this: Global COVID-19 Prevention Trial of Hydroxychloroquine to Resume - *Medscape* - Jun 30, 2020.



Offline: The second wave



Fabrice Coffini/AP/Getty Images

The spectre of a second wave of COVID-19 hangs over us. Some infectious disease specialists believe that SARS-CoV-2 might be losing virulence. Most are less sanguine. Dr Tedros Adhanom Ghebreyesus, WHO's Director-General, reported last week that "the pandemic is accelerating"—across the Americas, south Asia, and the Middle East. "The world is in a new and dangerous phase", he said. "The virus is still spreading fast, it is still deadly, and most people are still susceptible." The shadow of the 1918 influenza pandemic darkens our perspective. The first wave of that outbreak took place between March and July. It proved relatively mild. The second wave arrived in August. It was much worse. Most of the 50–100 million deaths caused by influenza took place during 13 weeks between September and December, 1918. The past century has incubated the idea that a second wave should justify mortal fear. Whether true or not, it is right to ask: what should we do to prepare?



Shutterstock/Getty Images

In the UK, new infections are still taking place across the whole country. This week, Tim Spector, Professor of Genetic Epidemiology at King's College London, wrote to Prime Minister Boris Johnson. His COVID Symptom Study app has 3.9 million contributors across the UK. Those who have signed up to Spector's survey self-report their symptoms. These data are the most reliable information we have about the spread of coronavirus. The government's testing regime is missing two-thirds of people with COVID-19. If we could diagnose new infections more rapidly, we could exit lockdown faster and more safely. Spector argues that what is needed is a campaign to educate the public to suspect infection not when they have later stage symptoms of fever and cough, but when they have earlier signs of muscle pain, fatigue, headache, diarrhoea, and rashes. Self-isolation at this earlier stage would reduce the risk of others becoming infected. If all new infections could be identified within 48 h, there is every possibility that a second wave could be avoided. And once one gets to fewer than 1000 new infections per day—the current number is estimated to be 3612 per day—the embryonic test, trace, and isolate system would have the capacity to detect and follow up every new case.



Tim Spector app

Prolonged lockdowns are certainly not the answer to future waves of COVID-19. School closures are not sustainable. The economy cannot be refrigerated again. Risks to mental health are real. Work at the Institute for Health Metrics and Evaluation (IHME) in Seattle suggests that SARS-CoV-2 displays strong seasonality. In the Northern Hemisphere, IHME scientists predict that a second wave will arrive in September, peaking by the end of 2020. They expect the public will have less tolerance for future government mandates to shut down societies. So what if local outbreaks do take off? Modelling suggests that brief lockdowns (eg, for 2 weeks) followed by relaxations for between 2 and 6 weeks might be enough to cut lines of virus transmission. But one casualty of COVID-19 has been public and political trust in models attempting to forecast the course of the pandemic. Gabriel Leung's team at the University of Hong Kong has described one solution to managing a second wave—real-time tracking of transmissibility by closely monitoring the instantaneous effective reproduction number (R_t). Measurement of R_t should be supplemented by early diagnosis (Spector's data are important here), contact tracing, isolation, and continual efforts to keep public awareness high. In the UK, the test, trace, and isolate system is still not fully functional. There have been angry debates about whether physical distancing should be 1 m or 2 m. The lesson from the HIV pandemic is that no single preventive measure is adequate to control virus transmission. What matters is combination prevention—in the case of coronavirus, a mix of measures that include handwashing, respiratory hygiene, mask wearing, physical distancing (as much as is reasonably possible), and avoiding mass gatherings. So far, politicians and public health officials have not advocated the idea of combination prevention—they should. Another lesson from HIV is the importance of protecting key populations. COVID-19 is not socially neutral. SARS-CoV-2 exploits and accentuates inequalities. And on the dangers of a second wave to the most socially vulnerable, there has been not a word.

Richard Horton
richard.horton@lancet.com

What matters is combination prevention—in the case of coronavirus, a mix of measures that include handwashing, respiratory hygiene, mask wearing, physical distancing (as much as is reasonably possible), and avoiding mass gatherings. So far, politicians and public health officials have not advocated the idea of combination prevention—they should. Another lesson from HIV is the importance of protecting key populations. COVID-19 is not socially neutral. SARS-CoV-2 exploits and accentuates inequalities. And on the dangers of a second wave to the most socially vulnerable, there has been not a word.

www.thelancet.com Vol 395 June 27, 2020

Challenges for the female academic during the COVID-19 pandemic

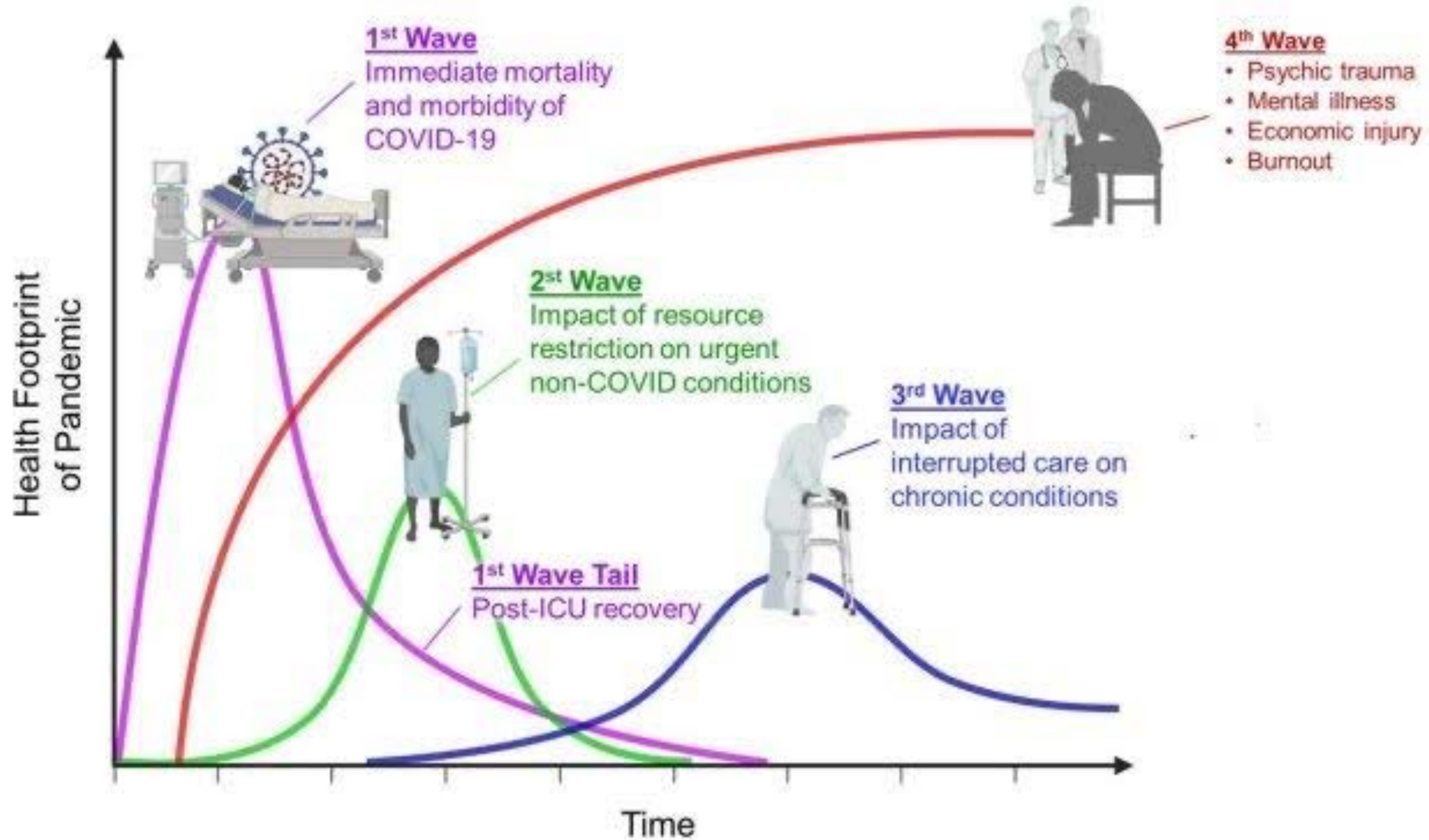
Science and innovation benefit from diversity. However, as the global community fights COVID-19, the productivity and scientific output of female academics are disproportionately affected, leading to loss of women's scientific expertise from the public realm.

www.thelancet.com Vol 395 June 27, 2020

Early data show that COVID-19 significantly affects women's publishing. Andersen and colleagues⁴ compared authorship of 1179 medical COVID-19 papers with 37 531 papers from the same journals in 2019. At 30%, 28%, and 22%, women's shares of overall, first, and last authorship in COVID-19 papers decreased by 16%, 23%, and 16%, respectively. In a Github analysis of arXiv and bioRxiv submissions, Frederickson⁵ showed that, although preprint submissions are increasing overall, the number of male authors is growing faster than the number of female authors. Female authorship in other research fields shows similar trends.⁶ Our analysis

[Covid impact on Publication Lancet](#)

Future effects



Future Covid-19 ECHOs Septe... 00:00:09

Attendees are now viewing questions 0 of 0 (0%) voted

1. How frequently would you like the HospiceUK Covid ECHO Network meetings to take place between September and December?

Two weekly (0) 0%

Monthly (0) 0%

Six weekly (0) 0%



Everyone a teacher, everyone a learner

*"You can't go back and
change the beginning,
but you can start
where you are and
change the ending."*

— C.S. Lewis



Upcoming COVID-19 (Clinical) ECHO sessions

* Every session will be 15:30 – 17:00 on a Wednesday

2020 Sessions

August 19th Rehabilitation & Day Care

September 16th Ambulance Service Connections

October 14th Clinical & economic evaluations of new services

November 11th New partnerships

December 9th Community services

Sessions also to include

Covid update

Examples of the “good new” retained

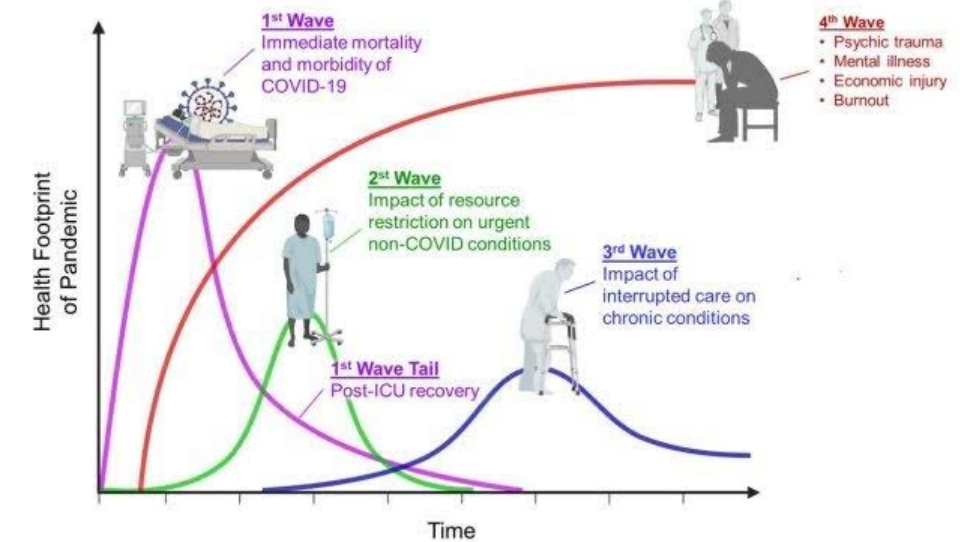
Examples of past let go

Responses to questions raised



Upcoming COVID-19 (Clinical) ECHO sessions

* Every session will be 15:30 – 17:00 on a Wednesday



2020 Sessions

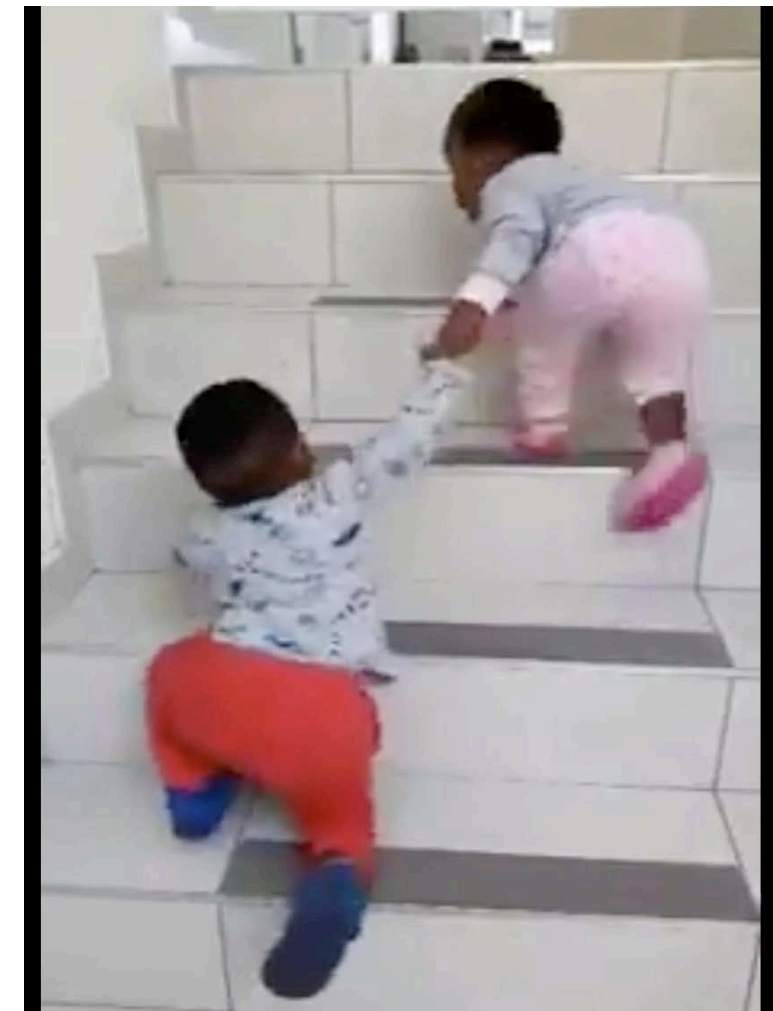
August 19th Rehabilitation & Day Care

September 16th Ambulance Service Connections

October 14th Clinical & economic evaluations of new services

November 11th New partnerships

December 9th Community services





Can Anticipate

Know more

Nuanced

Workforce planing

PPE

Remote working

Clinical evidence

Collaborative

Can protect the vulner

Public Accounts Committee - Committee demands detailed plan for PPE from DHSC within 2 months, ahead of potential second Covid wave

Wed, 8 July 2020 | Commons Select Committee Press Release

View item on [DeHavilland](#) | [Source](#)

CONTENT

Committee demands detailed plan for PPE from DHSC within 2 months, ahead of potential second Covid wave

8 July 2020

* Read the report summary

[<https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/344/34403.htm>]

* Read the conclusions and recommendations

[<https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/344/34405.htm>]

* Read the full report

[<https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/344/34402.htm>]

Virtual Project ECHO Immersion Training 2020

Training Cohort 1 - September 9th, 17th & 23rd

Training Cohort 2 - October 7th, 15th & 21st

Training Cohort 3- November 4th, 10th & 18th

Training Cohort 4 - December 2nd, 10th & 16th



To find out more please
contact echo@hospiceuk.org



Your questions...

- Here we take a look at some of the questions raised at the ECHO on 24 June and others emailed to us between these sessions
- Please use the Chatbox if you have any responses to the questions raised – we are wiser together.

Your questions, our thoughts

- *“Does anyone know of any evidence comparing face shields / visors as an alternative to cloth face coverings to mitigate risk in public transmission? There would be advantages to communication in terms of being able to see faces and to lip-read.”*
- No currently available to identify differences in effectiveness (as far as we are aware)





- WHO place face shields in the same category as eye protection not as masks
- https://apps.who.int/iris/bitstream/handle/10665/331498/WHO-2019-nCoV-IPCPPE_use-2020.2-eng.pdf
- Face shields suggested as useful as cloth face coverings as part of a group of measures (including distancing, hand hygiene etc) in helping prevent community transmission (Perencevich et al 2020)
- <https://jamanetwork.com/journals/jama/fullarticle/2765525> The logo for JAMA Network, featuring a red circle with the letters "JN" in white, followed by the text "JAMA Network" in black.

Your questions, our thoughts

“In relation to the special edition VoD training during the Covid-19 pandemic - what do we do with lines, tubes, drains, patches and pumps? Do we remove or leave in prior to undertakers coming?”



Your questions, our thoughts



Special Edition of Care After Death: Registered Nurse
Verification of Expected Adult Death (RNVoEAD) guidance

https://www.hospiceuk.org/docs/default-source/What-We-Offer/Care-Support-Programmes/Care-after-death/rnvoad-special-covid-19-edition-final_2.pdf

Lie the patient flat.

Leave all tubes, lines, drains, medication patches and pumps, etc. in situ (switching off flows of medicine and fluid administration if in situ), and spigot off as applicable and explain to those present why these are left at this time.

To ensure the patient is flat ahead of rigour mortis.

To ensure all treatments are stopped prior to the verification of death examination.

These may be removed after the verification of death examination and only if the death is not being referred to the coroner¹⁹

Your questions, our thoughts

In response to a number of questions about antibody testing we thought it might be helpful to share the results of a new Cochrane review on the effectiveness of antibody testing

Cochrane Review

**Antibody tests for
identification of current
and past infection with
SARS-CoV-2**



<https://www.cochrane.org/news/new-cochrane-review-assesses-how-accurate-antibody-tests-are-detecting-covid-19>



The review shows that antibody tests could have a useful role in detecting if someone has had COVID-19, but that timing is important. The tests were better at detecting COVID-19 in people two or more weeks after their symptoms started, but we do not know how well they work more than five weeks after symptoms started. We do not know if this is true for people who have milder disease or no symptoms, because the studies in the review were mainly done in people who were in hospital. In time, we will learn whether having previously had COVID-19 provides individuals with immunity to future infection.

Your questions, our thoughts

We are struggling with having ACP conversations with patients and with the risks of further COVID impact it is so hard to have such conversations without people feeling they are being asked to exclude themselves from expensive treatments. We were really excited to hear in the ECHO of the Kathryn Mannix app with its public health approach. What happened to it?? Any updates??

Sharing community wisdom

We know that fit testing is important “no one size fits” all are hospices training their own staff to undertake fit testing and has this been easy to access the training for staff to do this in house?

Sharing community wisdom

Is anyone employing a rotational medical job planning model across the IPU, Community and outpatients?

If so how do you ensure cross cover for annual leave and how frequently do you rotate across the different settings? If anyone has any experience to share we would love to hear from you



Hospice responses

A brief look at some of the ways in which hospices are responding to COVID-19 and supporting local communities.



Bereavement support

Fast response bereavement call back service has been launched by St Michael's Hospice in Hastings

No previous contact with the hospice is required in order to access the service

Find out more at:

<http://stmichaelshospice.com/about/news>

New Family Liaison Officer roles

- Saint Michael's Hospice (Harrogate) introduced these new roles to help relatives to remain close to the day-to-day care of their loved ones, even when they have been unable to visit them.
- The FLOs call families every morning to give an update, help arrange appointments and help people keep in touch by doing things such as printing out photos of family members.
- <http://www.saintmichaelsospice.org/blog/2020/06/harrogate-hospice-charity-introduces-new-family-liaison-officers-to-help-families-during-covid-19-and-beyond/>



Anticipatory prescribing in community end-of-life care in the UK and Ireland during the COVID-19 pandemic: online survey

Bárbara Antunes ¹, Ben Bowers ¹, Isaac Winterburn,¹
Michael P Kelly,¹ Robert Brodrick,^{2,3} Kristian Pollock,⁴ Megha Majumder,¹
Anna Spathis,¹ Iain Lawrie,^{5,6} Rob George,^{7,8} Richella Ryan,^{1,2}
Stephen Barclay ¹

<https://spcare.bmj.com/content/early/2020/06/15/bmjspcare-2020-002394>

Background

- **Palliative and end of life care** aims to alleviate suffering and care for the person and their family, in their preferred place of care, throughout the disease trajectory and after death
- **Anticipatory prescribing** medications prescribed ahead of clinical need “just in case” for administration by nurses and doctors if symptoms arise in the final days of life.
 - National NICE Guidelines + Regional guidelines dependent on context, resources, training → variation in practice



Evidence of best practice is scarce

Add a pandemic!

To investigate the experiences of clinicians in UK and Ireland regarding changes in AP during the COVID-19 pandemic and their recommendations for change

Methods

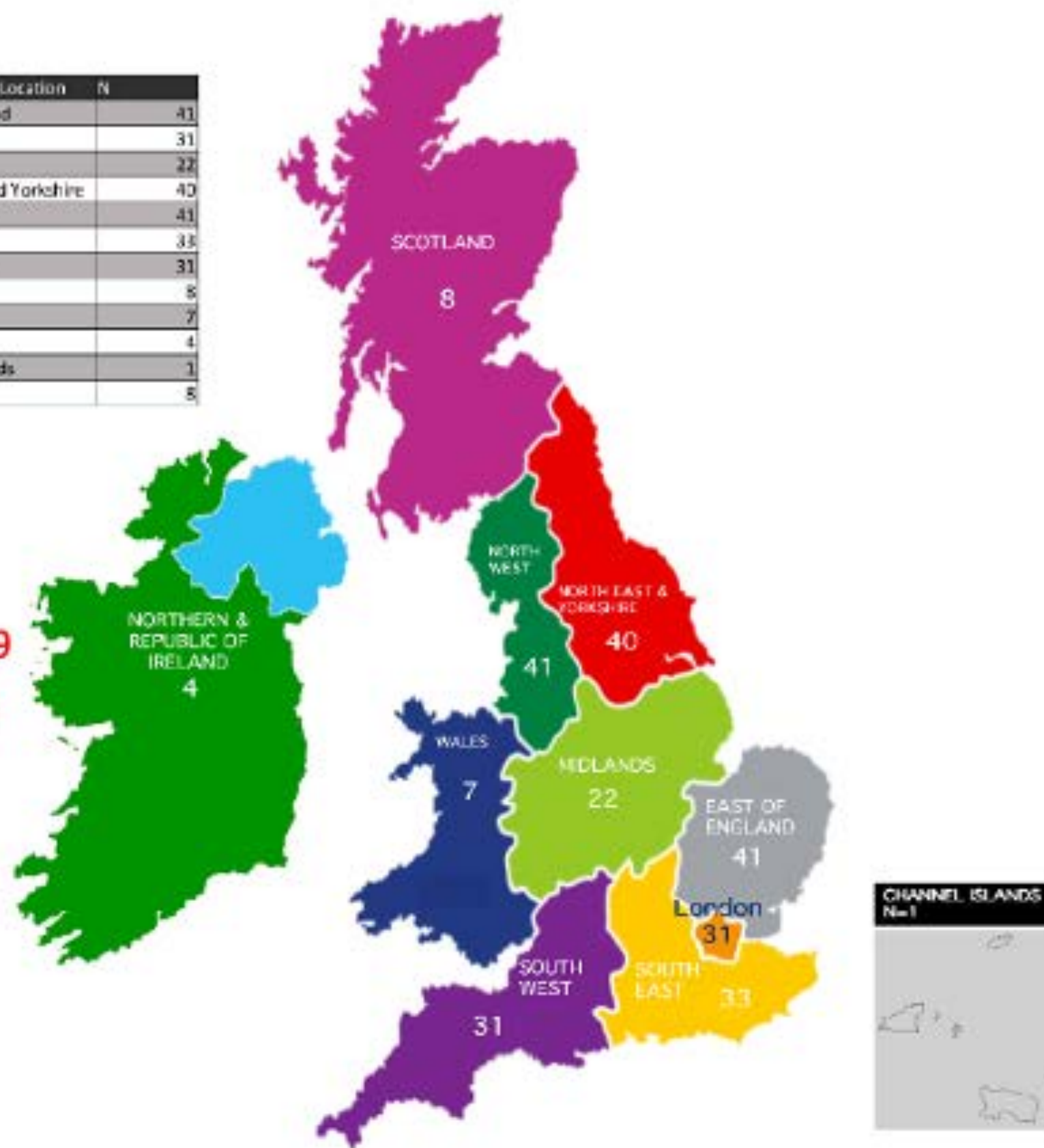
- Online survey
 - participants from previous AP national workshops
 - members of the Association for Palliative Medicine of Great Britain and Ireland
 - other professional organisations

snowball sampling

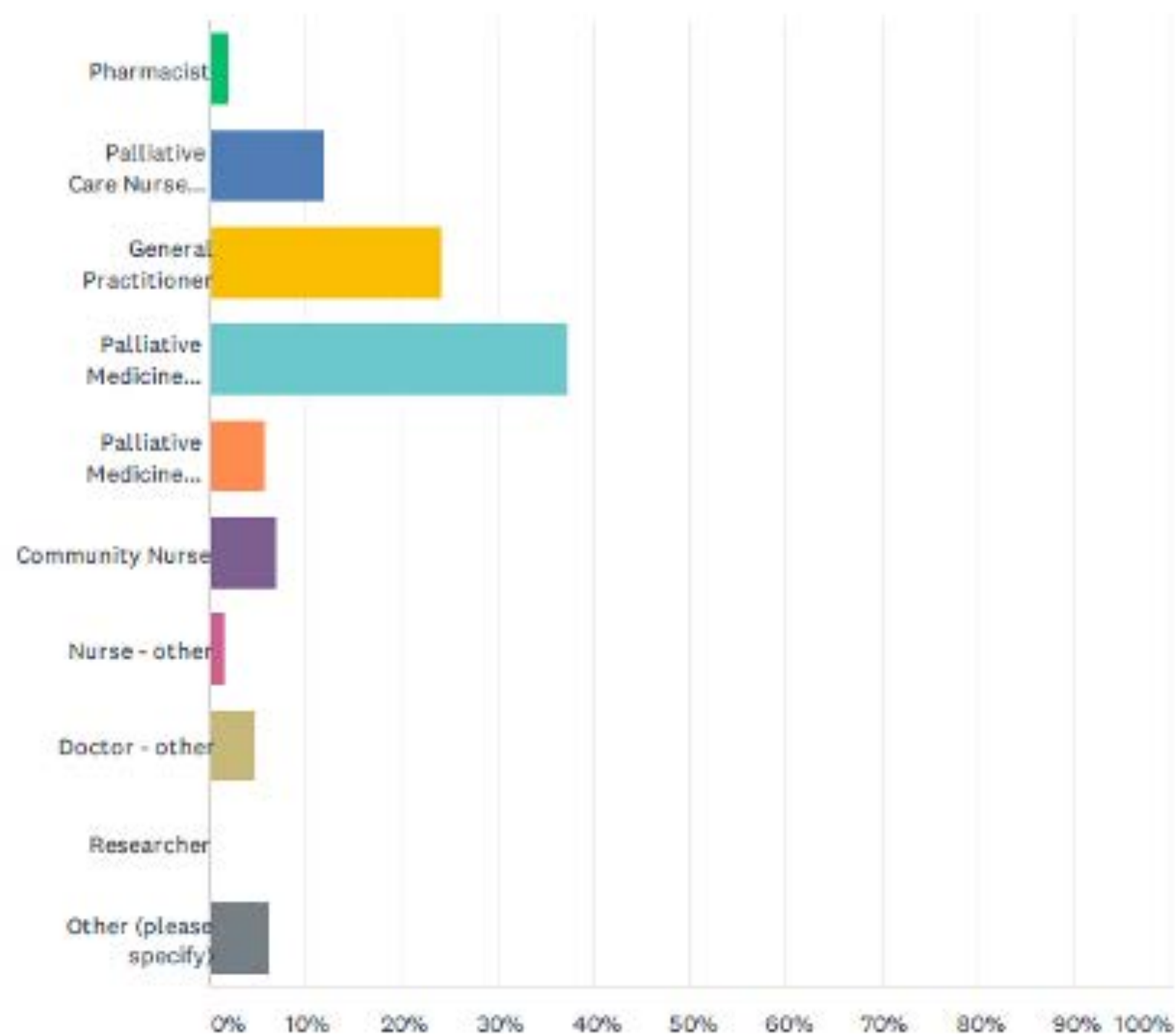
Results

Geographical Location	N
East of England	41
London	31
Midlands	22
North East and Yorkshire	40
North West	41
South East	33
South West	31
Scotland	8
Wales	7
Ireland	4
Channel Islands	1
Other	5

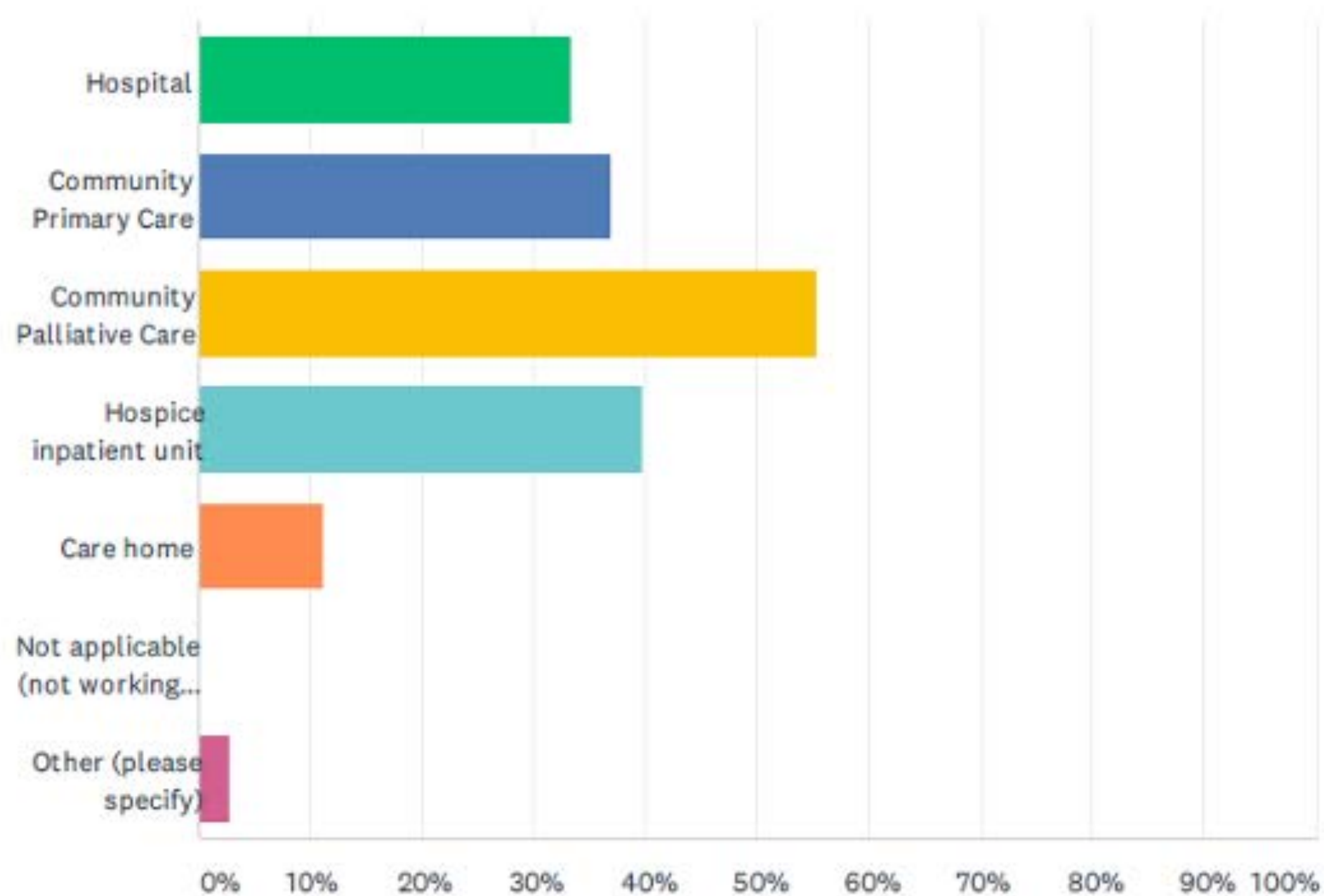
261 respondents between 9 and 19
April 2020 working in community,
hospice and hospital
settings



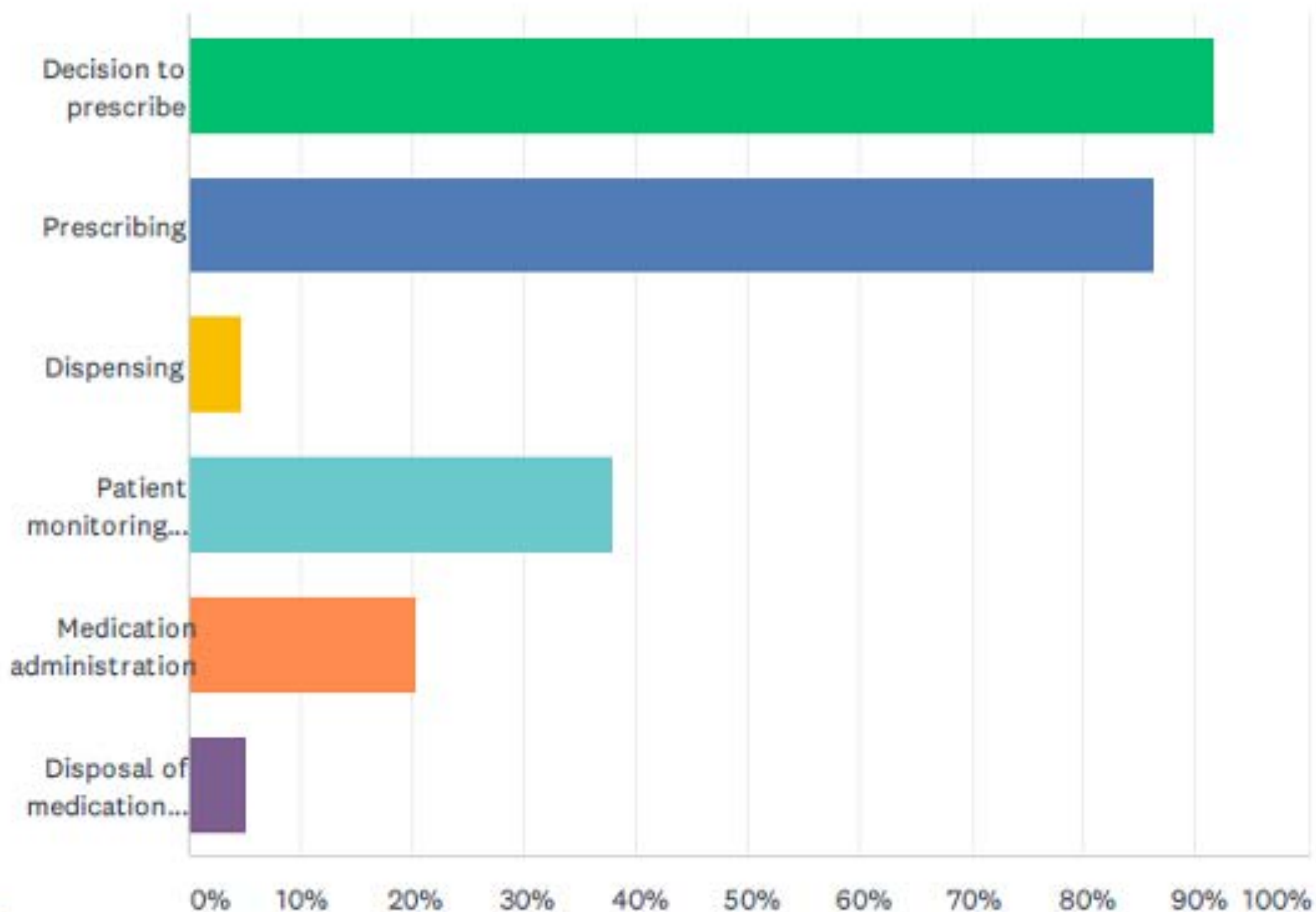
Results: professional roles



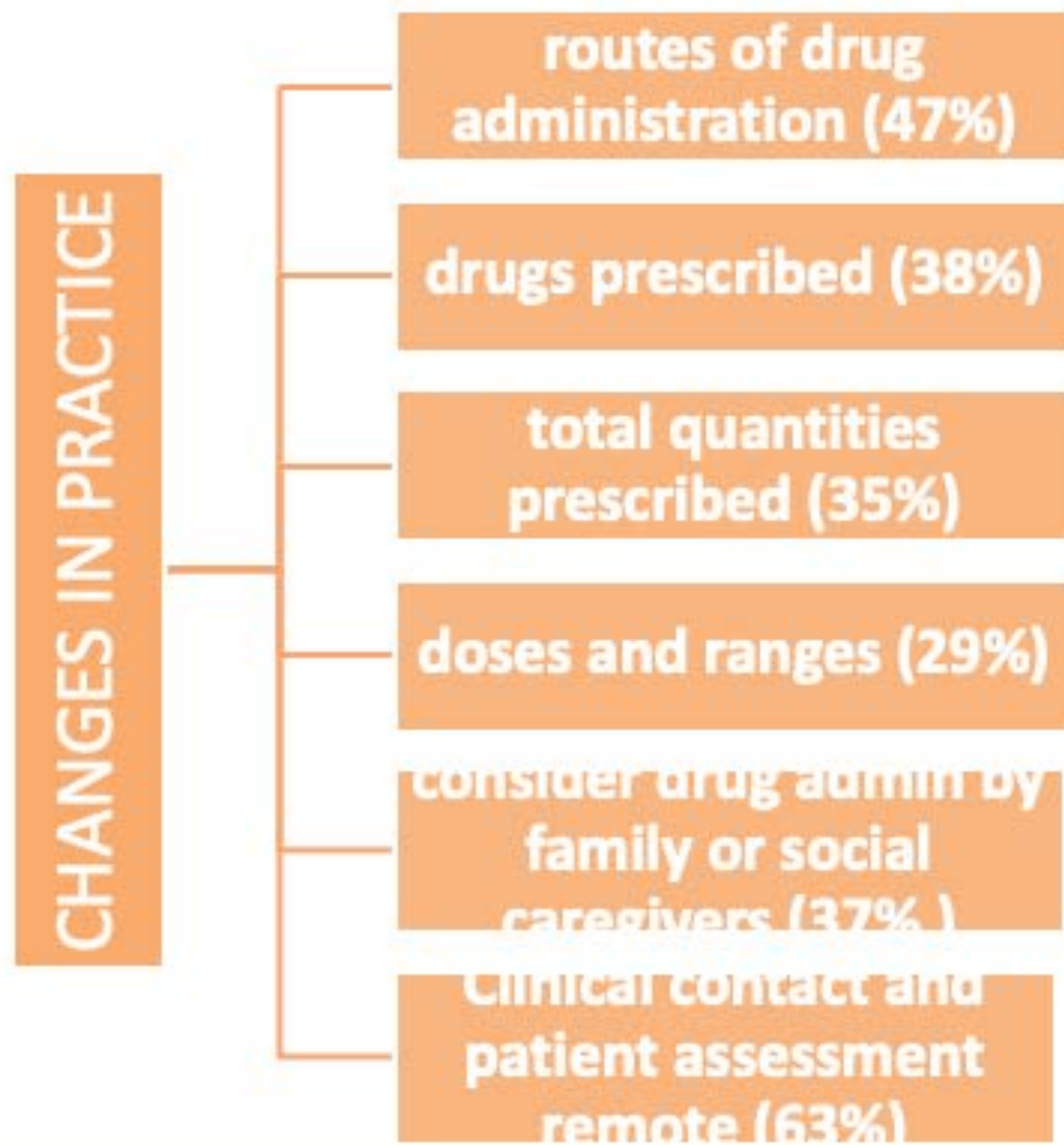
Results: clinical settings



Results: involvement in stages of AP process



Results: changes in AP practice during the pandemic



Results: open question

Strong recommendations for regulatory changes to permit drug repurposing and easier community access

“This is our opportunity to secure legislative change for the establishment of centralised supplies, the ability for clinical staff to have sensible safe boxes and for the return of safe, unused drugs to pharmacies ... This is a known and appalling waste that must stop now and be permanent. There has never been a cogent justification.” #100 CONS

Discussion

- People at home or in care home are at risk of dying from COVID-19 requiring larger than usual drug doses



current guidance to prescribe drugs in small amounts and close to anticipated death could be problematic

- Wider and more ready community drug access might ease this difficulty but presents legislative and logistical challenges

Conclusions

- The challenges of the COVID-19 pandemic for UK community palliative care has stimulated rapid innovation in AP
- The extent to which these are implemented and their clinical efficacy need further examination
- How much they will persist after the pandemic?

Future work.

We are planning follow-up interviews in early autumn by zoom with a purposive sample of the over 100 respondents that indicated a willingness to do so.

bc521@medschl.cam.ac.uk

sigb2@medschl.cam.ac.uk



- NAMDET has put together a short survey & questionnaire to gauge the issues people may be having with failing 9 volt alkaline batteries used in T34 syringe drivers. [Link to the survey.](#)
- This '3 minute' survey will help us gather information, gauge the situation and help feedback to the battery suppliers, MHRA, NHSI and help inform the manufacturer too. Julys NHS: MDSO webex also shared the 'June 2020' report on battery testing and this too will be available for all MDSO to access and download via the MDSO 'forum' pages.

COVID-19 related rapid reviews in palliative care



Nick Jones, GP & Wellcome Trust Doctoral Research Fellow

<https://www.cebm.net/covid-19/>
[#EvidenceCOVID](#)

nicholas.jones2@phc.ox.ac.uk
[@drnrjones](#)

The post-pandemic future for city centre office space

July 6, 2020

Richard Darby and Tom Darby

On behalf of the Oxford COVID-19 Evidence Service Team
University of Oxford

Correspondence to: richardddarby@darbygroup.co.uk

VERDICT

Working from home has environmental and social benefits.

Offices are still needed for innovation, collaboration, learning and networking though.

Smaller, local offices could reduce commuting and promote more inclusive workplaces.

This productivity opportunity would then provide economic benefits as well.

Environmental Weather Conditions and Influence on Transmission of SARS-CoV-2

July 3, 2020

Spencer EA, Brassey J, Jefferson T, Heneghan C.

Environmental Weather Conditions and Influence on Transmission of SARS-CoV-2

Included in Analysis of the [Transmission Dynamics of COVID-19: An Open Evidence Review](#)

VERDICT

Weather conditions appear to influence transmission of SARS-CoV-2, although evidence is not sufficient nor consistent enough to allow causation to be definitely inferred. Available studies, of low to moderate quality, tend to report lower transmission at warmer temperatures, and higher transmission in colder temperatures typical of the winter season, along with exacerbating effects of humidity, high levels of pollution, and low wind speed.



How to tell a patient to take a photo of their throat

Dr Gandhi RCGP

ht

YouTube GB

Search

eGPelearning
SUBSCRIBE

Focus with flash

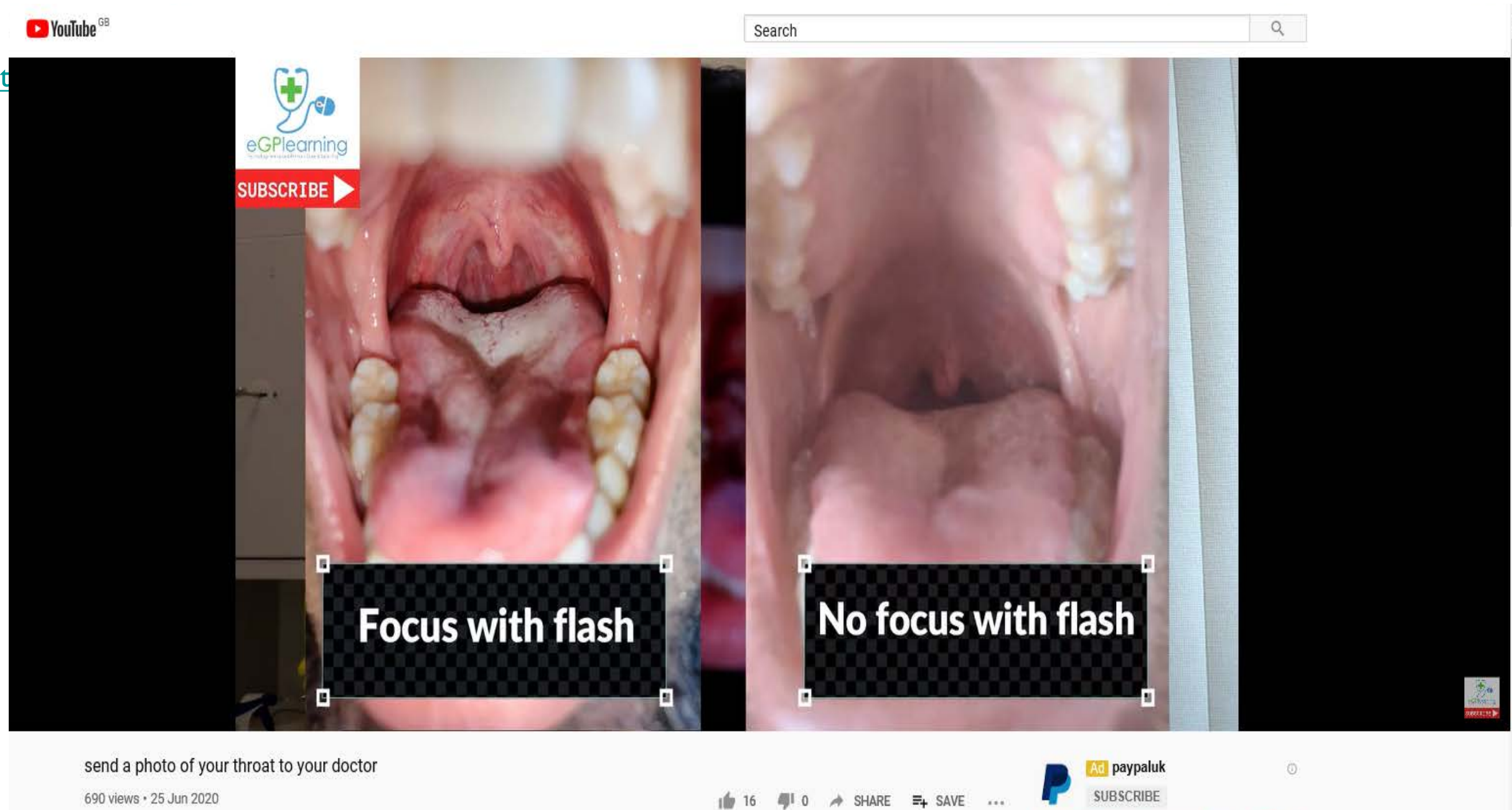
No focus with flash

send a photo of your throat to your doctor

690 views • 25 Jun 2020

16 0 SHARE SAVE ...

Ad paypaluk
SUBSCRIBE



Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020

Provisional analysis of deaths involving the coronavirus (COVID-19), by different occupational groups, among men and women aged 20 to 64 years in England and Wales.

Table of contents

1. Main points
2. Overview of coronavirus-related deaths by occupation
3. Men and deaths involving COVID-19, by occupation
4. Women and deaths involving COVID-19, by occupation
5. Deaths involving COVID-19 among men and women health and social care workers
6. Deaths involving COVID-19 by occupation, before and during the lockdown
7. Factors that may be associated with COVID-19-related deaths by occupation
8. Coronavirus (COVID-19) related deaths by occupation data
9. Glossary
10. Measuring the data
11. Strengths and limitations
12. Related links

Variable	Description	Level of Current Evidence
Age	Risk increases with age	Evidence known
Sex	Men have higher risk than women	Evidence known
Deprivation	Risk is greatest in the most deprived	Evidence known
Ethnicity	Risk is greater in ethnic minority groups compared to White ethnic groups	Evidence known
Obesity	People with obesity are at increased risk	Evidence known
Comorbidities	People with comorbidities are at increased risk	Evidence known
Occupation	Health care staff are at increased risk (key workers increased risk of infection)	Limited evidence
Housing	Overcrowded and multigenerational housing may increase transmission	Limited evidence
Environmental Pollution	Air pollution is associated with respiratory diseases and may play a role in viral transmission.	Limited evidence
Genetics	Some genetic variations may be associated with infection susceptibility and diverse clinical presentation of COVID-19	Limited evidence
Lifestyle	Smoking, alcohol intake, diet and physical activity contribute to comorbidities	Evidence lacking
Vitamin D	Low vitamin D is associated with some non-communicable diseases and increased susceptibility to infectious disease	Evidence lacking
Structural/Racial Discrimination	Structural discrimination may impact on health seeking behaviours and challenging work conditions	Indirect evidence
Behaviour	Social distancing, shielding, wearing of facemasks etc. can reduce transmission risk.	Evidence lacking

July 3, 2020

The Independent Scientific Advisory Group for Emergencies (SAGE)

The Independent SAGE Report 6

Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review of the evidence and recommendations for action

SAGE REPORT

Who are most affected by COVID-19?

DEPRIVED POPULATIONS

People who live in deprived areas have higher diagnosis rates and death rates than those living in less deprived areas. Mortality rates in the most deprived areas are around double the least deprived areas.



ELDERLY

Diagnosis and mortality increases with age. People over 70 are around 2.5 times more likely to die from COVID-19 than those under 70.



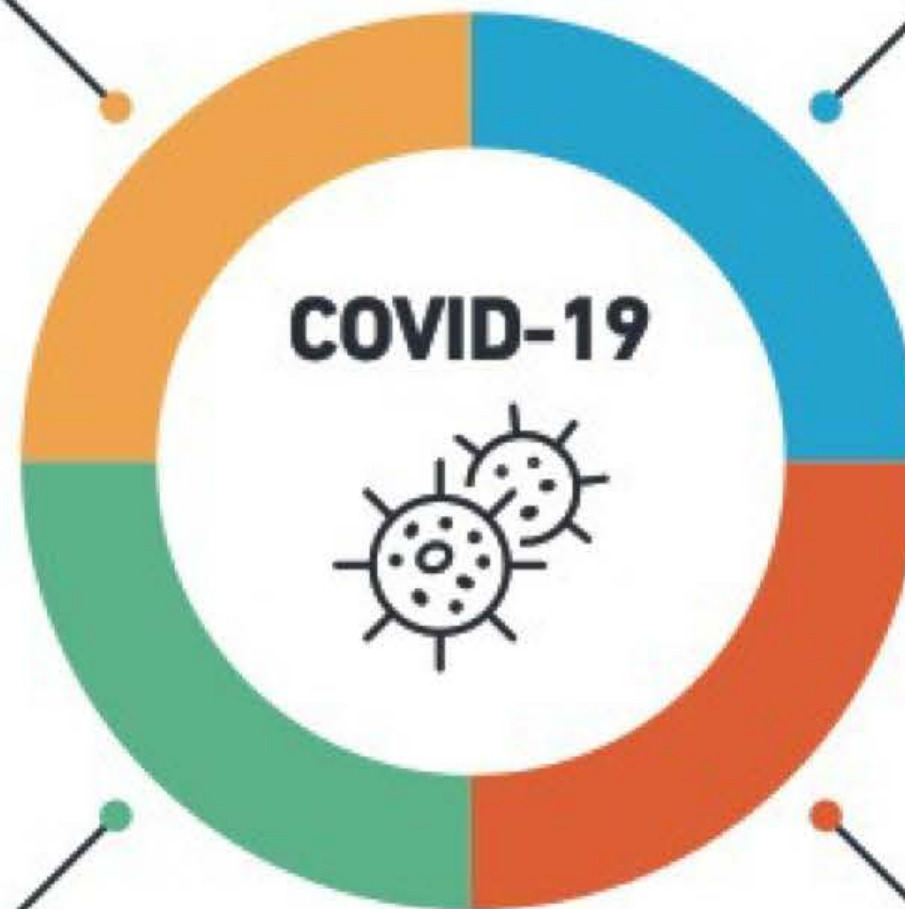
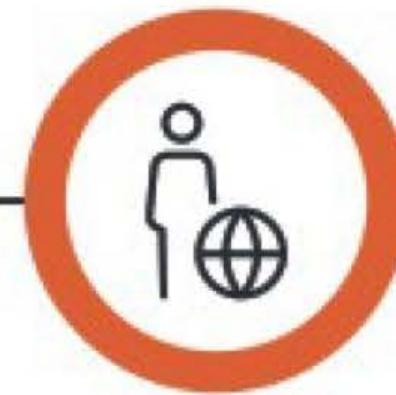
MALES

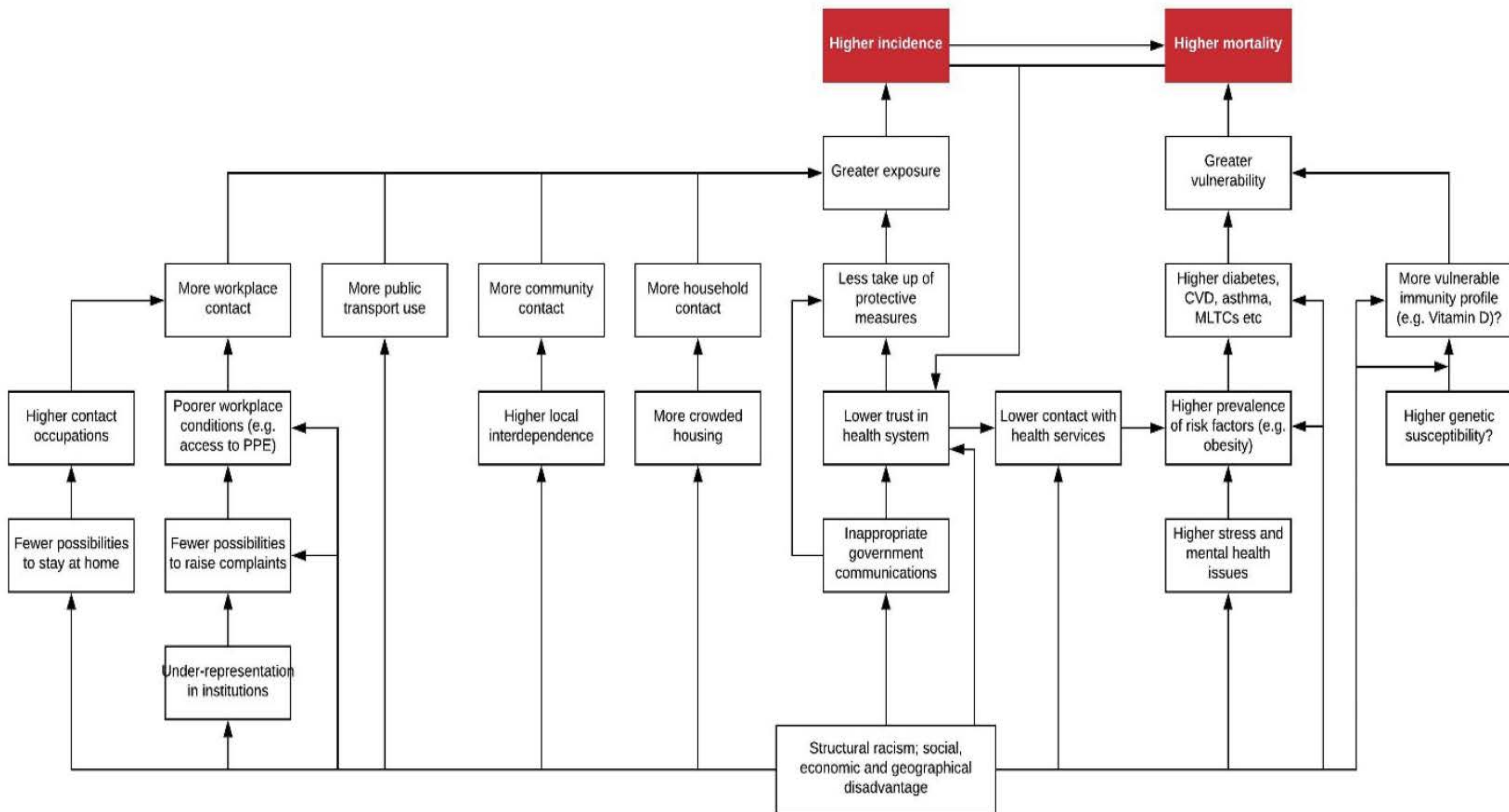
Men are around 1.8 times more likely to die from COVID-19 than women.



BAME

BAME populations are more likely to die from COVID-19 than white ethnic groups. South Asian and Black groups are at 1.5 to 2 times increased risk compared to white.





update

Welcome to Update, a monthly round-up of news relevant to palliative care in Scotland, brought to you by the Scottish Partnership for Palliative Care.

- [Policy](#)
- [Practice](#)
- [Public-facing information](#)
- [Academic and Research](#)
- [SPPC News](#)
- [Other News](#)
- [Courses and Events](#)

[Pal Care Updates Scotland July](#)

Supporting the spiritual care needs of those who are nearing the end of life

Key points for health and social care staff during the Coronavirus (COVID-19) pandemic

This guidance is designed to help health and social care staff meet the spiritual care needs of people who are approaching the end of life during the COVID-19 pandemic. It cannot provide detailed information on every belief community; rather it outlines key points and principles, and signposts to where you can find more specific information as required.



Spiritual Care

- Spiritual care is a core aspect of holistic, person-centred care and should be available to everyone regardless of their views or background in an equal and fair way. Spirituality means different things to different people. It can, but does not always, include one's personal beliefs or religious faith.
- Restrictions put in place due to COVID-19 may prevent families, representatives of the belief communities or local chaplains from offering usual forms of spiritual support to those who are sick or dying. This might cause people to find themselves without their usual networks and hence they may find it more challenging to engage in practices or rituals aligned to their beliefs.
- Not knowing what to say, or the fear of saying the wrong thing, could lead health or social care professionals to avoid conversations about spiritual care altogether. However, asking some simple questions about a person's beliefs and wishes can provide comfort not only to the person who is dying, but also those who are close to them. Failure to acknowledge such needs may contribute to a person's sense of isolation and distress. It can also be upsetting for families, and can add to their grief, if they feel that their relative's spiritual care needs were not met.

Documents



[Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19](#)

HTML



[COVID-19: guidance for young people on shielding and protecting people most likely to become unwell if they catch coronavirus](#)

HTML



[COVID-19: guidance on protecting people most likely to get very poorly from coronavirus \(shielding\) - an easy-read guide](#)

Ref: PHE publications gateway number: GW-1392

PDF, 2MB, 18 pages

[Shielding Documents](#)

Adults

- **MIND** - mental health charity with fantastic resources, including a specific area for COVID related mental health issues - <https://www.mind.org.uk>
- **Beating the isolation blues** - wellbeing pack developed in the North West to help deal with wellbeing during COVID - <http://documents.manchester.ac.uk/display.aspx?DocID=49000>
- **Helpers** - 6-week course using psychological theory to support mental health during COVID - <https://www.helpers.tools>
- **Coping with coronavirus** - Self-help guides and information written by psychologists from UCL - <https://www.copingwithcoronavirus.co.uk/self-help-guides.html>
- **Headspace** - mindfulness app - <https://www.headspace.com/covid-19>
- **Sleep council** - for all things sleep-related - <https://sleepcouncil.org.uk/advice-support/>
- **Sleepstation** - sleep improvement programme, now free in some parts of the UK via NHS support - <https://www.sleepstation.org.uk>
- **CalmHarm App** (good for young people too) - to help manage self-harm urges - <https://www.nhs.uk/apps-library/calm-harm/>
- **SHOUT** - 24/7 crisis helpline - just text to 85258 <https://www.giveusashout.org>
- **Bereavement support** - NHS search engine to find services in your area - <https://www.nhs.uk/service-search/other-services/Bereavement%20support/LocationSearch/314>
- **Bereavement support** through CRUSE - <https://www.cruse.org.uk>
- **Relationship difficulties** - free online sessions through <https://www.careforthefamily.org.uk/courses/marriage-courses-the-marriage-sessions>
- **Exercise** - free exercise plans/videos including pilates, yoga etc. through NHS - <https://www.nhs.uk/conditions/nhs-fitness-studio/pilates-for-beginners/>
- **Breathing with your belly** - abdominal breathing to reduce stress and anxiety - <https://www.guysandstthomas.nhs.uk/resources/patient-information/therapies/abdominal-breathing.pdf>

Children and young people

- **Think Ninja** - mental health support app for 10-18 year olds - <https://www.nhs.uk/apps-library/thinkninja/>
- **Princes Trust** - excellent signposting information for mental health issues for young people - <https://www.princes-trust.org.uk/help-for-young-people/who-else/housing-health-wellbeing/wellbeing/mental-health>
- **Happy Maps** - excellent website with information, resources and signposting for children of all ages and parents - <https://www.happymaps.co.uk>
- **Young Minds** - mental health support for children and young people, up to age 19 - <https://youngminds.org.uk>
- **CHUMS** - mental health support for children and young people - <http://chums.uk.com>
- **Book recommendation for children with anxiety** (very good for parents too!) - 'What to do when you worry too much. A kid's guide to overcoming anxiety.' by Dawn Huebner, published by the American Psychological Association

Support for you and your colleagues

- **Headspace** - mindfulness training - free to all clinical and non-clinical NHS staff - <https://www.headspace.com/nhs>
- **Permitted to pause** - website to support wellbeing for health care workers - <https://www.permittedtopause.co.uk/#>
- **Free wellbeing apps for NHS staff** - <https://www.nhsemployers.org/news/2020/03/free-access-to-wellbeing-apps-for-all-nhs-staff>
- **Our frontline** - round the clock one-to-one support for key workers - <https://www.mentalhealthatwork.org.uk/ourfrontline/>
- **Looking after you too** - coaching support for primary care staff - <https://people.nhs.uk/lookingafteryoutoo/>
- **RCGP support for GP wellbeing** (especially have a look at the Note Cards from WorkWell doctors - really good brief simple reminders on how to deal with emotions - just what we tell our patients but sometimes aren't so good at doing ourselves!) - <https://elearning.rcgp.org.uk/mod/page/view.php?id=10501>
- **Book from Dr Catherine Sykes** (mentioned on the webinar) - The Exhausted Trajectory - deals with burnout and exhaustion - <https://www.amazon.co.uk/Exhausted-Trajectory-Tired-Energy-Purpose-ebook/dp/B087D49ZSN>
- **PTSD webinar** recently produced to help primary care clinicians - <https://vimeo.com/427005151/3a40d3edfb>

Own Mental health

MANAGE YOUR ENERGY, NOT YOUR TIME

from Harvard Business Review, October 2007
Tony Schwartz and Catherine McCarthy

physical energy



- enhance your sleep by setting an earlier bedtime and reducing alcohol use
- engage in some form of exercise every day
- eat small meals and light snacks every three hours
- pay attention to signs of flagging energy
- take brief, regular breaks from work at 90- to 120-minute intervals



spiritual energy

- identify your "sweet spot" activities that give you feelings of effectiveness, effortless absorption, and fulfilment, and find ways to do more of these
- allocate time and energy to what you consider most important in your life
- live your core values by practicing them intentionally



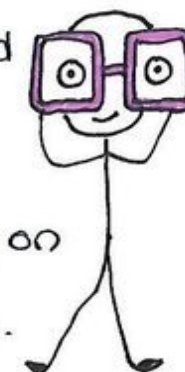
emotional energy

- defuse negative emotions, such as irritability through deep abdominal breathing
- fuel positive emotions in yourself and others by regularly expressing appreciation
- look at upsetting situations through new lenses:
 - ➔ REVERSE LENS "what would the other person in this conflict say, and how might they be right?"
 - ➔ LONG LENS "how will I likely view this situation in six months?"
 - ➔ WIDE LENS "how can I learn and grow from this situation?"



mental energy

- reduce interruptions by working on high concentration tasks away from phones and email. Switch them off.
- respond to voice mails and emails at set times during the day
- select the most important challenge for the next day the night before. Then make that your first priority when you start work.



Sketchnote by Hayley Lewis
@Haypsych June 2020

We have arranged for hospice staff & volunteers to access mental health support programmes, Daylight and Sleepio - <https://www.hospiceuk.org/hospice-iq/services/details/big-health>

CHATBOX

Wellness

- [What causes wellness | Sir Harry Burns | TEDxGlasgow ...](#)



Building Back Better

Build Back Safe

*Reducing the likelihood of mortality and morbidity in future events is u
any recovery and reconstruction in the aftermath of an event.*

Build Back Fast

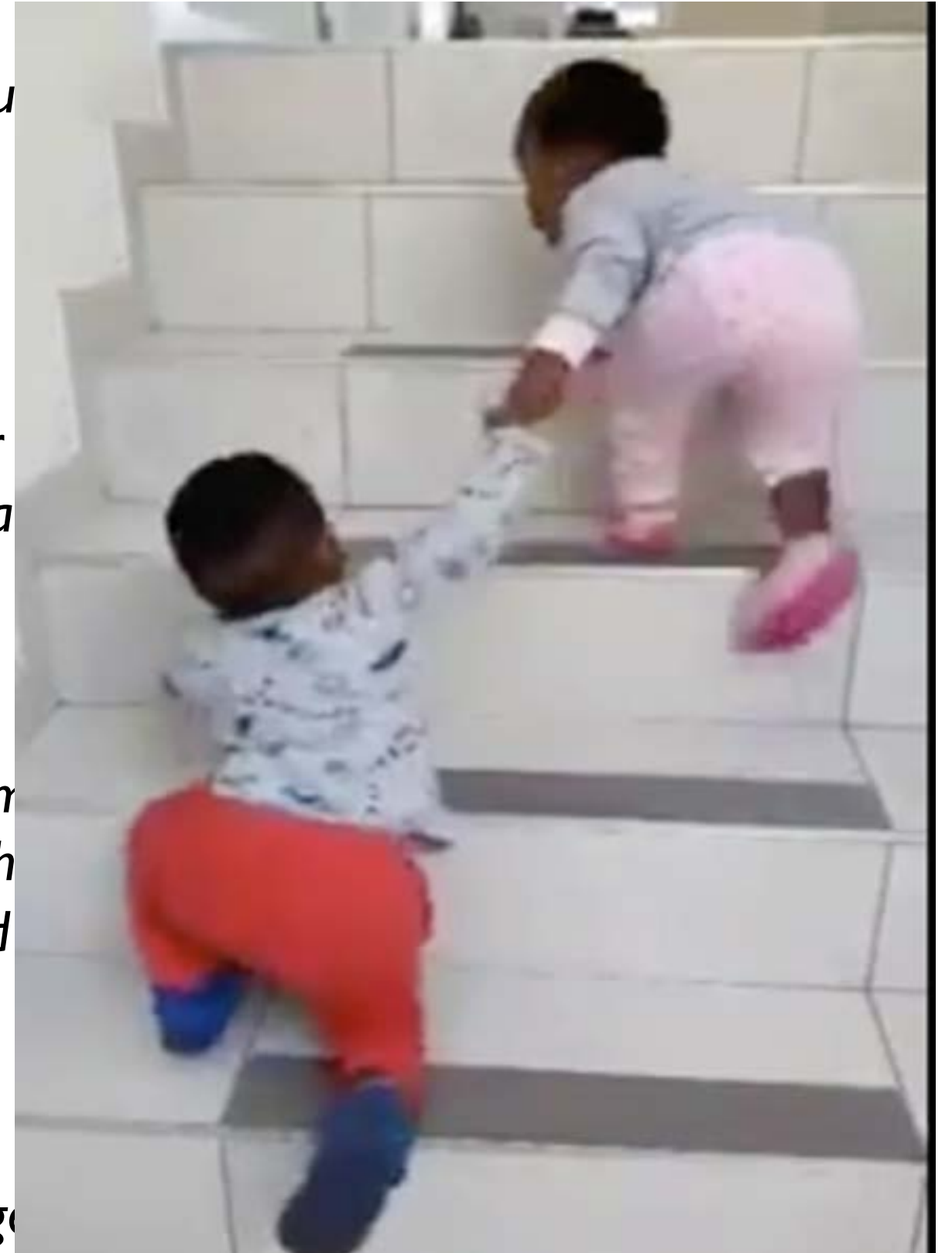
*Rebuilding faster is another fairly obvious and uncontroversial goal for
is that the quest for speed is often in conflict with some of the other a*

Build Back Fair

*A recovery that is fair and inclusive—that is, one that benefits all segm
yet another apparent and obvious objective. In this connection, a pleth
recoveries frequently exclude the most vulnerable, disadvantaged, and*

Build Back Potential

Beyond fair, fast, and safe, post-disaster recovery should also aim to g



Adlestrop by Edward Thomas

Yes. I remember Adlestrop—
The name, because one afternoon
Of heat the express-train drew up there
Unwontedly. It was late June.

The steam hissed. Someone cleared his throat.
No one left and no one came
On the bare platform. What I saw
Was Adlestrop—only the name

And willows, willow-herb, and grass,
And meadowsweet, and haycocks dry,
No whit less still and lonely fair
Than the high cloudlets in the sky.

And for that minute a blackbird sang
Close by, and round him, mistier,
Farther and farther, all the birds
Of Oxfordshire and Gloucestershire.



Hap

BY THOMAS HARDY

If but some vengeful god would call to me
From up the sky, and laugh: “Thou suffering thing,
Know that thy sorrow is my ecstasy,
That thy love's loss is my hate's profiting!”

Then would I bear it, clench myself, and die,
Steeled by the sense of ire unmerited;
Half-eased in that a Powerfuller than I
Had willed and meted me the tears I shed.

But not so. How arrives it joy lies slain,
And why unblooms the best hope ever sown?
—Crass Casualty obstructs the sun and rain,
And dicing Time for gladness casts a moan. . . .
These purblind Doomsters had as readily strown
Blisses about my pilgrimage as pain.

As imperceptibly as Grief
The Summer lapsed away –
Too imperceptible at last
To seem like Perfidy –
A Quietness distilled
As Twilight long begun,
Or Nature spending with herself
Sequestered Afternoon –
The Dusk drew earlier in –
The Morning foreign shone –
A courteous, yet harrowing Grace,
As Guest, that would be gone –
And thus, without a Wing
Or service of a Keel
Our Summer made her light escape
Into the Beautiful.

Sonnet 18: Shall I compare thee to a summer's day?

BY [WILLIAM SHAKESPEARE](#)

Shall I compare thee to a summer's day?
Thou art more lovely and more temperate:
Rough winds do shake the darling buds of May,
And summer's lease hath all too short a date;
Sometime too hot the eye of heaven shines,
And often is his gold complexion dimm'd;
And every fair from fair sometime declines,
By chance or nature's changing course untrimm'd;
But thy eternal summer shall not fade,
Nor lose possession of that fair thou ow'st;
Nor shall death brag thou wander'st in his shade,
When in eternal lines to time thou grow'st:
 So long as men can breathe or eyes can see,
 So long lives this, and this gives life to thee.