COVID + Learning Network Webinar Questions

OFFICIAL

COVID + Pathways: Critical updates and discussion

Questions and answers

Q1: Can clinicians have access to the dashboard so that we can see the system and issues as part of the team?

A: Yes, I (Shannon Wight) can certainly take that on notice to first understand what the distribution is and how do we get that level of visibility in the system for our clinicians. I will come back to the group on that one. Thank you.

Q2: What difference will the code brown make to me as a frontline clinician?

A: I (Shannon Wight) think the change you will see is timely system decisions being made when things are escalated and communicated down the line. When a problem arises it's normally a problem that most people are sharing, it's just that someone has got to it first. We need to understand the problems to solve and use the various parts of the Department of Health (DH) and expertise in our clinician group to bring issues back down in a timely way so that the clinicians delivering and overseeing the care can implement it. As an example, there could be decisions made around oncology, haemodialysis, elective surgery, category one's, all these things that need to be understood as we proceed and how we manage our situation if the numbers go up into the thousands of admitted COVID-19 patients. There are also decisions needed around support for where health services decide staff need to be to deliver care. Again, if there are major changes as a system, we need to move together. It's very difficult being in a health service when you know that the health service down the road is doing something different to what you're doing. As a system we need to partner together on this work.

Q3: Can you comment on the increasing use of private hospitals resources?

A: Yes, the private hospitals have been incredibly supportive, and we are back in the partnership with the public private agreement. As part of the pandemic code brown, the documentation and requests that have gone out to the privates and conversations on a daily basis are around expanding their COVID streaming capacity. We know that most of the privates will come in and partner with us on this. Some of the privates are taking non-COVID patients to support the health services around their COVID demand and capacity. This is around the health service partnership and relationships. The privates are being supportive and partnering with us. DH will continue to work with them as a system no matter if it's COVID care or non-COVID care. Again, it's one team here.

Q4: Having gone into a Code Brown, some systems have been suffering more than 50% depletion in workforce, is there going to be an assessment and provision of resources to provide strain point related assistance?

A: Yes, our workforce is exhausted. It's been such a challenge the last couple of years, and we've got a bit more to go. There has been a lot of conversations around leave and support for leave. The health services and line managers

will support people around their leave management and how we can make sure we have a workforce to be able to deliver care. I think the calling of the pandemic code brown enables health services again to move in partnership with the workforce and the employee can move to where that care is required. The question around how do we prop up frontline workforces? I know there's been lots of conversation and action around alternative workforces under supervision models and I think we need to keep doing more of the same. It's really important that the conversations around supporting leave, whether it's shorter periods of leave, people coming back a little earlier from leave, whatever the decisions are in the operational/clinical line should be for the best outcome and the best person turning up to the shift on that particular day. There's no silver bullet to this. We don't have other workforce coming to us at this point. I think it's just one foot in front of the other as we proceed and try to maintain some energy and some optimism to say that we will get through this next wave and this peak.

Q5: Do we have an idea of % hospitalisations are avoided with timely and indicated use of Sotrovimab?

A: Sotrovimab probably decreases the incidence of hospitalisation (42 fewer hospitalisations per 1000 patients (RR 0.24, CI 95% 0.11 to 0.55; 1057 patients in 1 study)), the composite outcome of hospitalisation (for longer than 24 hours) or death (46 fewer per 1000 patients (RR 0.20, CI 95% 0.08 to 0.48; 1057 patients in 1 study)) and serious adverse events (40 fewer per 1000 patients (RR 0.35, CI 95% 0.18 to 0.68; 1049 patients from 1 study)). We are unsure if Sotrovimab impacts death or the requirement for invasive mechanical ventilation. Sotrovimab probably has little impact on ICU admission, the requirement of non-invasive ventilation or HFNO, or adverse events.

Additionally, the New England Journal of Medicine trial showed an 85% risk reduction and a Number Needed to Treat of 17 but the data is unclear for Omicron. See link: https://www.nejm.org/doi/full/10.1056/NEJMoa2107934

Q6: What are the recommendations for Fluvoxamine?

A: This is a fascinating area and recommendations will be coming out soon.

Q7: Who is eligible for Sotrovimab? The efficacy of Sotrovimab in Omicron is possibly less than it was for the Delta variant. So where do we go with that and is there an active process that is continually deciding whether we need to continue with regional Sotrovimab centres? And if we do, what will be the eligibility criteria for those people? Or is that something we would defer back to the national group?

A: Yes, I (Louise Galloway) think it all needs to link up. Firstly, there is supply and secondly, how do we make sure that we're focused on those who will most benefit from it? The challenge is identifying people through the pathways and connecting them to the clinics within the time frame and while the drug is actually effective. Testing the secure messaging coming out into primary care will be useful as GPs know their patients best and they will know if a person is high risk. The survey that is sent out includes a question to identify those who are immunosuppressed so to me it's two parts; who should we be giving it to including the clinical indication and prioritisation? and how do we get those people connected into the services as quickly as possible?

Q8: Are the clinical risk assessments on the RAT notification form active now?

A: Yes, this has gone live. The process is that if it's a PCR test, you receive a text message to fill in a survey and we don't get 100% completion. We are now working to increase the completion rate because the faster we can identify and connect those at high risk the better. When you report a RAT test for yourself or a family member all fields are mandatory, so we can collect 100% of the information.

Q9: What do you think is going to change next in the COVID pathways? Or do you see these COVID pathways are now set in stone for the next period of time? Or is this a continuing process and we need to update this every week?

A: I (Louise Galloway) think that my experience with many things in COVID are the same as my colleagues on the frontline that we are continually changing, adapting and improving. We need to continue to look and review. I think the biggest thing is how do we adapt for capacity? This will be a continued thing. We will look to refine the use of Health Direct and secure messaging which I imagine will adapt over time so it will be useful to regularly update this group.