COVID + Learning Network Webinar Questions

OFFICIAL

Managing Omicron in the UK – emergency care, critical care and antiviral treatment

Questions and answers

Q1: In the context of the majority of COVID care being provided in the community, and the challenges associated with timely access to new treatments, particularly for at high-risk patients, what are the lessons from primary care in London that you're able to share?

A: We (King's College Hospital NHS Foundation Trust) have rolled out our treatment hubs for community patients offering both oral drugs and monoclonal antibody infusions – we are concerned regarding Paxlovid and drug interactions so are aligning close links between the treatment hubs/GP's and specialists. We are also involving specialty pharmacy and clinical teams regarding decision making of prescription options.

Q2: Victoria's Omicron peak has been in the middle of summer, and we are interested to hear a bit about how your experience has been having you peak over winter and the challenges that might present when you have other general illnesses around as well? Are there any insights from flu that we need to consider in the context of winter planning with existence of covid, noting the absence of flu in Victoria in the last 2 years?

A: Fortunately, winter hasn't been too cold this year. That aside, the paediatric element and RSV have been remarkably complex, and we need pathways to understand where the paediatric patients sit in ED and admission processes around where they are going to isolate. Pretty much all hospitals have less flexibility in the paediatric pathways purely due to number of beds vs adults. We are starting to reach an increase now with paediatrics and that is remarkably difficult. Then there are the winter challenges in general and COVID-19 is now an added extra where we have a new disease, infection control measures and less staff. It is certainly incredibly difficult; we have to take what we learnt from Delta. There are some advantages. The flu is down likely due to infection control measures, but it is also down within staff.

There has also been an increase in patients with Mental Health needs in paediatrics and adults. That on top of the admission processes within mental health services has become incredibly challenged and has really slowed down. The average length of stay for a mental health patient is incredibly high and as a result the 136 suites are incredibly full which leads to inefficiencies with isolation. Normally we would prioritise a mental health patient to a single cubicle, particularly a paediatric patient but now you need to decide if you put a mental health patient, a COVID patient or a chemotherapy in the cubicle? This is about risk and who is making those decisions and what processes and documentation can be put in place to support the team in the middle of the night to make those decisions especially for junior and nursing staff.

Q3: I'd be interested to hear about any data you may have on COVID deaths in the community, any mechanisms for reviewing/learning from these deaths and any system changes made as a result?

We (King's College Hospital NHS Foundation Trust) can bring out the data and bring to the next webinar if useful. This webinar will focus more on community management of omicron.

Q4: Ed's presentation implied that ED demand was less over December, but ED performance was down. Aside from staffing challenges, I am thinking that your characterisation of the increased complexity of pathways and roles would be a big factor?

A: Demand for Emergency Care has reduced and the most significant drop in the first wave of the pandemic occurred when our daily attendances across London fell from circa 14,000 each day to just 4,000. This increased as we came out of the first wave but has never fully recovered and for both the second and third waves we have seen a temporary reduction to circa 9,000 patients.

Falling performance against the 4-hour ED standard predates the pandemic in most organisations and has been acerbated. During the first wave of the pandemic attendances were low and we saw high performance, but in recent waves this has been reversed and we have seen an accelerated fall. This has resulted in very congested ED's and Ambulances have been unable to off-load patients which has impacted our ability to respond to a category 2, 999 call (e.g. heart attacks/stroke). The difference between the first wave and later waves is also the introduction of patient screening/swabbing and IPC guidance in ED and throughout the hospital. Our figures suggest we have relatively low bed occupancy and patients are waiting a long time for admission because we don't have the 'right' beds. The multiple different pathways mean we have stranded capacity that is not accessible to the ED patient and takes time to 'flip' from one pathway to another.

The additional factor in the third wave which we hadn't previously seen was staff sickness. Although staff sickness was suggested at circa 7% across the capital, many areas saw much higher levels of staff attrition because staff were infected/required to isolate. This was highest in the boroughs where there was a high case rate in the local population, and where we saw the greatest need for urgent and emergency care.

Q5: There is a strong message that there is a large component of admission with incidental COVID; Is the Department collecting this data in Victoria? Do we have data on ICU/Hospital cases by variant for Victoria?

A: At the moment DH collect data on whether a patient is or is not on a COVID ward, however, they do not currently collect data for patients admitted *from* COVID vs *with* COVID.

In regard to the case variants, it is understood that VIDRL type the variants in a sample of viruses from PCRs in the state and use this to extrapolate what is happening more generally in near real time. Last week, for example 100% of COVID cases in ICU were Omicron in late January. Unfortunately, the variant for each individual patient is not typed in real time or correlated with their clinical state.

Q6: Do you have the functionality to do real time genomic testing and therefore continue to use Ronapreve (in the setting of unwell deltas in ITU/ICU)?

A: Genotyping and tests for anti-spike antibodies on ICY (for Ronapreve treatment) come back within 24 hours. Full sequencing in public health laboratories takes even longer.

We get gene sequencing within a few days (TAT) and that allows separation of omicron and delta for B1 variant but won't for B2, thus it may be that Sotrovimab will come through as the optimal therapy for the infusion therapy offer.

Q7: Do you have a plan for identifying patients and distributing oral antivirals when they become available? Does this broadly mirror what you have used for the monoclonals? Can you expand on what NHS DIGITAL provides and how? Is it information distribution/connecting care for instance?

A: The CAS alert website is in the public domain and also has clinical guides. See link: CAS - Coronavirus (COVID-19) Alerts (mhra.gov.uk). NHS has a national policy for 3 groups including those admitted to hospital

with COVID related disease, incidental COVID / COVID identified for hospitalized patients and high-risk community identified positive patients.

- PCR COVID positive patients in hospitals samples are sent for genotyping and antibody status as per policy. Treatment is organised and patients are offered access to trials as appropriate.
- Regarding the hospital / identified cohort, the genotype is sent, and the hospitals work with their COVID Medicine Delivery Unit (CMDU). This integrated health system covers a population of approx. 1.7 to 2.2 million who have an MDT to support decision making within national policy.
- Regarding the community cohort, NHS digital is a national NHS body that has written an algorithm to identify high-risk cohorts based on clinical coding (it pulls a lot more than are actually high risk due to time of disease). The algorithm is run every 3 hours against PCR reporting and patient hits are "referred into a WebView." The WebView is accessed by the integrated care system staff CMDU.

The Pathway then includes:

1. Admin triage (are they within 5/7 days of PCR positive test as per policy?)
2. Clinical triage (phone call and decision re: suitability and treatment – antiviral oral drugs / Remdesevir or Sotrovimab)
3. Oral drugs are couriered to the patient
4. Infusion therapy: transport arranged to bring patient to CMDU
5. Both oral Rx and infused grp treatment decision / action informed to primary care and option / need for virtual ward or home oximetry
6. Treatment triage – assess on the day

Patients are also referred into CMDU by primary care staff and speciality doctors if they are aware of positive high-risk patients. We have a renal dialysis hub which has been very successful in delivering infusion therapies outside of the CMDU.

However, as of 10th February 2022 a number of changes will be introduced including PCR tests won't be necessary for referral, lateral flow tests for community patients need to be registered on government website, and genotyping for clinical decision won't be required the hospital-identified cohort. Paxlovid will also go online and Remdesivir will be available in the community.

High risk patients (identified through NHS digital) were written to. Their access to antivirals/nMABs and providing a PCR test was explained. All doctors were written to regarding policy and comms. A letter is also provided for specialist teams to send to their high-risk patients and newly diagnosed patients.