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Reference: ACP/PC/CV19

**NHS North Yorkshire Clinical Commissioning Group**  
Head Office  
1 Gimbald Crag Court  
St James Business Park  
Knaresborough  
HG5 8QB

8 April 2020

Dear Colleague

## **Re: Advice for Primary Care Clinicians on Advance Care Planning and Palliative Care of the Most Vulnerable in the Covid-19 Pandemic**

### **Introduction**

The CCG leaders for Frailty and End of Life Care have produced these guidelines to encourage the use of advanced decisions to aid patient participation in decisions about their care. The current pandemic situation has brought this into focus for a number of reasons:

1. There will be additional pressures on the acute sector and voluntary/care at home sector which will inevitably mean that where a patient can remain at home this would be preferable but may not always lead to a positive outcome for the patient unless this is what they have chosen.
2. During the pandemic situation the number of visitors that a patient can have in hospital is limited and therefore a patient with an underlying condition who deteriorates and becomes end of life during the pandemic may face a situation of dying in hospital alone if they are admitted during this period.
3. There will be a cohort of patients who have underlying conditions or co-morbidities whom may acquire Covid-19 and will suffer serious illness or death as a result of this. These patients will need to determine the extremes of treatment and intervention they would want in these circumstances.

An advance care plan discussion should not be considered as a means of asking patients to take decisions about their care and treatment which they do not want to take or to make them feel as though they are using treatments or facilities which may be better utilised by another patient. It is important that patients understand there is a strong possibility that there will be more demand for services and equipment than is available, for example ventilation and beds in an intensive care setting. Patients are not being asked to support



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the NHS in any 'rationing' of their services; they are however being asked to make their wishes known. It will then be the role of clinicians treating patients to undertake risk and ethics-based decision making should patient numbers outstrip equipment available.

There are specific ethics committees set up within acute Trusts who will be charged with making these sorts of decisions and inevitably the consideration has started with intensive care capacity and ventilation. Attached to this letter for your information is a document created by the Sue Urwin who is a Consultant in Anaesthesia and Intensive Care Medicine to help understand the way in which the Trust will start to prioritise resources.

### **Covid-19 considerations**

Covid-19 is mostly a mild or moderate illness. For those who are severely unwell and need intensive care the outcomes are particularly bad for the older, frailer patient with co-morbidities.

As a result we ask you to consider proactively talking to the high risk groups of patients, and their families if possible. They might include:

- The over 70s with co-morbidities especially hypertension, ischaemic heart disease and DM
- Those with a Rockwood score of 5 or more
- Those who have been deteriorating month on month over the last six months or so without a defined cause
- Those whose life expectancy is anticipated to be less than six months
- Those in care homes as a result of underlying health conditions. This cannot be applied as a blanket to those with LD and autism and who are in receipt of care
- Those with a DNACPR in place already
- Those with dementia – no matter how mild

If these conversations have not happened before the onset of illness, please try to engage the family (and patient if possible) in this discussion prior to arranging admission.

Many should be able to survive, but if sick enough to need admission, whatever excellent care they get in hospital, they are at greater risk of dying. The evidence is that most families and patients would value the opportunity to discuss staying and being cared for at home, in this sort of situation, there is no evidence it increases anxiety.

### **Having the conversation**

There is guidance below for GPs and Practice Nurses that covers the issues around these conversations. The general principles are these conversations cannot be forced on anyone, so check out expectations first. Be calm, listen, and use the communication skills you already have.



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These are tough conversations to have, so please ensure you are supporting yourselves and your colleagues by allowing debrief times within your team or with those outside.

The important thing to remember is that 'no hospital treatment does not mean no care'. Anticipatory medications are a great part of this. Ensuring we are controlling symptoms for these patients will help with maintaining confidence in the health service.

The BMA advises that all patients should be given compassionate and dedicated medical care including symptom management and, where patients are dying, the best available end-of-life care. Nevertheless, it is legal and ethical to prioritise treatment among patients. This applies where there are more patients with needs than available resources can meet.

There are guidance documents embedded within the ACP Proposal Document attached to this letter.

### **Recording the decision**

The HCV Clinical Ethics Cross-Sector Committee chaired by Dr Stuart Calder considered that there are a number of different approaches to recording this conversation in PCNs and other clinical arenas. The Committee did not wish to dictate the form to be completed by primary care as some are more familiar than others with the documentation.

The NHS national team have highlighted a form which is referred to as the EHCP form, which could cause some confusion as it has the same initial as an Education Health and Care Plan, in the event that you have a discussion with the families of young people with education plans.

There is also a specific form which was issued relating to advance care planning specifically related to Covid-19. The Committee considered the issue of ACPs specifically in the event of someone contracting Covid-19 and felt that it would be more appropriate for this to be a general advance care planning approach for the reasons described in the 'Introduction' section of this letter.

Again, there are some example documents for advance care planning on the ACP Proposal Document attached to this letter.

These decisions need to be recorded and shared. A copy should be left with the patient. Please use the EPaCCs EoLC template (listed below) to record the existence of DNACPR and EHCP. Once the Enhanced Consent for Summary Care Record tab is ticked in the template, this will inform both GP Out of Hours and NHS111/YAS to look out for them in the home.



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The following materials are to support you in this work:

- 1) [Guides to help having these conversations – Tops Tips](#) (link)
- 2) [Rockwood Score](#) (link)
- 3) Documents to record the decision and leave with the patient – [DNACPR](#) (link) and [EHCP](#) (link) **The EHCP is pre-populated, please personalise plans for each individual**
- 4) [Mental Capacity Assessment Templates from Ardens on both templates](#) (link)
- 5) Guide to symptom control – **Please use local guidelines where applicable** alternatively use guidance from [RCGP Community Palliative, End of Life and Bereavement Care in the Covid 19 pandemic](#) (link) or [BMA Covid 19 Ethics guidance](#) (link)
- 6) [Educational video](#) (link) (you may already have had it)  
**Password - Wembley1966**

This piece of work is going to be a vital part of ensuring that capacity is used to its best effect in the times of greatest need as we are anticipating the peak to hit over the next couple of weeks. So please act with urgency.

Yours sincerely



**Dr Charles Parker**  
**NHS North Yorkshire CCG**  
**Clinical Chair**



**Dr Nigel Wells**  
**NHS Vale of York CCG**  
**Clinical Chair**

## Enc

1. Ethical Framework, Sue Urwin
2. ACP Proposal Document
3. Scarborough and Ryedale End of Life resources:
  - 3a. Clinical guidelines for control of symptoms
  - 3b. Scarborough DNACPR Top tips
  - 3c. Shared decision tool
  - 3d. Covid-19 Act excess death provisions
4. Harrogate End of Life Resources:
  - 4a. Palliative care drug in HaRD pharmacies
  - 4b. Covid-19 specific symptom management guidance
  - 4c. Having difficult conversations by telephone



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- 4d. Palliative care team referral flowchart
- 5. South Tees End of Life Resources:
  - 5a. Palliative care guidelines
  - 5b. Community palliative care symptom guidance
  - 5c. [Northern Cancer Alliance palliative and eol resources](#) (link)



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