COVID-19 Guidance: Clinical Advice

Feedback Summary

Background

Version 2.3 of the COVID-19 Clinical Advice document was published on the 3rd April 2020 on the Scottish Government website. This guidance is intended to guide the delivery of health and social care in Scotland in our communities, hospitals and critical care facilities during this COVID-19 pandemic. It is intended to be helpful to all staff working in these areas.

Version 3.0 of the COVID-19 Clinical Advice document for consideration at the EQIA, has been updated to reflect stakeholder feedback. Key changes include:

- Increased focus on human rights and equality obligations
- Recognition of the needs of individuals with protected characteristics, including disabilities
- Greater clarity that guidance should apply fairly to all patients, regardless of characteristics, capacity status or differential diagnosis
- Updated wording on clinical decision making taking into account considered feedback from a wide range of stakeholders
- Increased linkage to complimentary national guidance such as that from HPS to ensure clinicians have the most up-to-date information.
- Revision of the guidance to reflect current clinical situation which has changed significantly since the guidance was first published.

Process

To aid the further development of this document, the guidance team have:

- Reviewed newly available complimentary guidance, such as that issued by HPS
- In addition to the call for feedback on the original document, we have engaged in a detailed development process with the EHRC, SHRC, SCLD and Inclusion Scotland to develop the content around human rights and equality, to ensure that these were truly embedded in this guidance
- Further feedback has been invited from a range of stakeholders on the basis of a more recent drafted version, and where appropriate these comments have been reflected in the guidance

The final EQIA of the clinical guidance was carried out on the 25th June 2020 and is noted in the feedback summary table below.

KEY

Change	Colour
Before EQIA 1	White
Before EQIA 2	Green
Feedback from EQIA 2	Orange

THEMES	Source of Feedback	Key Recommendations	Response by Guideline Development Group
CLINICAL FRAILTY SCORE (CFS)	**Equality and Human Rights Commission, Scotland**	Limitations to the use of the CFS in Section 6.1 & 7.2 of the clinical guidance must be clarified and expanded upon in detail, and then emphasised in the Key Recommendations.	In version 2.5 of the Clinical Advice document the following recommendation has been added to key recommendations On admission to hospital all adults should be assessed for frailty, irrespective of COVID-19 status. The Clinical Frailty Score (CFS) should be used as part of a general assessment that is recorded clearly. Clinicians should have awareness of its limitations particularly in younger adults, or those with stable long-term disability. For these groups, alternative person-centred assessments may be more appropriate.
	Mental Welfare Commission	We suggest that the limitations of the CFS is added to the key recommendation to clarify that the CFS should not be used in those with stable long-term physical disabilities, learning disabilities and autism.	
	Learning and Disability and Autism Policy Unit, Scottish Government	To clarify that the CFS should not be used in those with stable long-term physical disabilities, learning disabilities and autism	
	Feedback from Professors from Centre for Mental Health and Capacity Law, Edinburgh Napier University & Professors of Healthcare and Medical Law at Glasgow Caledonian University	Concerns about the inappropriate use of the Clinical Frailty Scale (CFS) for adults with learning disabilities and autism. The point made at para 6.1 about the limitations of the CFS for younger and disabled patients also needs to be emphasised in the Key Recommendations.	This has been reiterated and further clarified in version 2.5 with the addition of the following paragraph under section 4 'Community Assessment & Referral to Secondary Care', section 6.2 'Assessment for Admission & under section 7.2 'Critical Care Admission' It should be noted that the CFS must not be used in younger people with stable long-term disabilities (for example cerebral palsy) learning disabilities or autism. In these

	Academy of Medical Royal Colleges, Scotland	Some deprived populations are at risk of early morbidity and mortality (shorter lives in sicker health; chronological age does not equal biological age so any guidance that uses age as a threshold is problematic in this regard)	situations, an individual risk assessment is recommended. The only age threshold used in the clinical advice guidance is in relation to the Clinical Frailty Score (CFS). We understand that frailty can affect people of any age, and has a strong association with socio-economic deprivation. Given that the CFS has been validated for use in those >65 and over, and is advised to be used as part of a person-centred assessment of an individual, we feel it is appropriate to reference age in this context.
	EHRC, SHRC, SCLD & Inclusion Scotland	Following the initial EQIA there was extensive engagement with the named stakeholders to ensure that all their feedback on the use of the CFS was considered. Where comments were not taken on board, an explanation was provided.	The wording on use of the CFS has been updated throughout the guidance document to provide information to clinicans on the apporpriate, fair and non-discrimainatory use of the CFS with particular emphasis on clarifying the limitations of use. Further guidance on the use of the CFS was added in to the document in the form of appendix 3.
	Consensus view amongst external stakeholders at EQIA **(SCLD, MWC, Scottish Care, Age Scotland, EHRC and Scottish Academy)**	There was broad agreement that previous concerns raised in relation to the use of the CFS, had been addressed within the revised versions of both guidance documents.	
ACCESSIBILITY OF CARE	**Academy of Medical Royal Colleges, Scotland**	The Academy highlighted the challenges with access to digital resources and healthcare delivery (due to lack of equipment, data, higher prevalence of cognitive impairment).	While the location and availability of care is outside the scope of this document, as part of the response to COVID-19, Near Me was made available in nearly every hospital and GP practice. Prior to March 2020, there were around 300 Near Me consultations a week:

			by June, it was nearly 17,000 a week. While it has helped deliver care during this COVID pandemic, there is recognition that it is not suitable for some. The Near Me team is running a public engagement exercise requesting feedback from the general public which is due to conclude at the end of July. This will help highlight some of the issues around challenges to access. We would also like to highlight the work being carried out by our colleagues in NES Digital service (NDS) as part of the Digital Health and Care strategy. NDS are developing a national digital platform for health and social care. One of the core intentions of the platform is that it will host information that people and their practitioners need at the point of care, and support the recording of shared decision-making conversations. It was due to be trialled in certain Health Boards this year but understandably this will be delayed. As NDS works to design and develop the platform, they are becoming increasing aware that the challenges of digital equality are of vital consideration and are exploring how they can adapt existing processes to better meet the needs of those that are most disadvantaged. To achieve this aim, they are working with the Equalities Leads across Health Boards and local authorities to explore how digital solutions can have a positive impact on inequalities. They are also working with the National Rural Mental Health Forum to understand in more depth

			some of the digital challenges faced by the 1 million people in Scotland living in rural areas.
	Academy of Medical Royal Colleges	There should be recognition that creating relationships of trust and being able to accept care, due to adverse childhood experiences (ACE) and cultural beliefs (e.g. gypsy traveller groups) may impact accessibility of care.	We recognise this important area of work, however this is outside the scope of this guidance to address. However, this is an ongoing area of work for the Scottish Government. The work of our colleagues who lead on the programme of work around ACEs has been put on hold since the start of the pandemic, as they work to support the immediate work of the Covid-19 Children & Families Leadership Group. However, we would like to highlight their long-term action plan which they should hopefully be able to return to in the near future 1. Providing inter-generational support for parents, families and children to prevent ACEs (e.g. tackling child poverty programme, Universal Health Visitor Pathway, Family Nurse Partnership Programme, perinatal and infant mental health support). 2. Reducing the negative impact of ACEs for children and young people (e.g. school counselling services, development of Barnahus concept for child victims). 3. Developing adversity and trauma-informed workforce and services (e.g. National Trauma Training Programme, Education Scotland work to support nurture and trauma-informed schools). 4. Increasing societal awareness and supporting action across communities (e.g.

			children's rights awareness raising, Families and Communities Fund and CashBack for Communities Fund). The exposure of our society to childhood adversity and psychological trauma will have increased significantly as a result of the COVID-19 virus and from the impact of social isolation and lockdown. This can have devastating and long-lasting effects on people's lives. Scottish Government is committed to developing a trauma-informed and trauma responsive workforce and services across Scotland to help to bring people together, rebuild relationships and give all members of the community a voice in planning for recovery. Scotland was one of the first countries in the world to develop a Knowledge and Skills Framework for Psychological Trauma, led by NHS Education for Scotland. This framework lays out the essential and core knowledge and skills needed by all tiers of the Scottish workforce to ensure that the needs of children and adults who are affected by trauma are recognised, understood and responded to in a way which recognises individual strengths, acknowledges rights and ensures timely access to effective care, support and interventions for those who need it. In 2018, a National Trauma Training Programme was established by NHS Education for Scotland to implement this knowledge and skills framework and to support all sectors of the workforce to upskill

			staff in trauma informed practice, as well as to embed and sustain this model of working. The programme of work is being led by NHS Education for Scotland (NES) and informed by people with lived experience, to create and deliver quality training resources.
DECISION MAKING PRINCIPLES	**Equality and Human Rights Commission, Scotland**	Guidance should explicitly state that blanket decision-making which could have a negative impact on protected characteristic groups such as disabled people or older people must not be permitted. We believe that a further qualification should be included in the guidance that makes clear a person-centred approach is applied for various groups, including disabled people, that takes into account their personal circumstances – not just their level of frailty.	The following paragraphs have been added under section 7.2 It is vital that no arbitrary clinical decisions should be made on the basis of a single characteristic, such as age, disability or the presence of existing health conditions or impairments that are unrelated to their chance of benefiting from critical care. (This has been reiterated as a key recommendation) Frailty or the existence of co-morbidities should only be considered relevant in triage decisions insofar as they will have an impact on the patient's potential to benefit from ICU admission and remaining survival time after discharge. Version 2.5 of the document contains the following additional information on what will guide decision making when considering admission to ICU. Each person will be considered for admission to ICU as an individual and have a multi-disciplinary holistic assessment carried out as part of the decision-making process which will include: -the type and severity of the patient's illness; -the presence of comorbidities and frailty;

			-the impairment of other organs and systems; and whether that impairment can be alleviated with intensive care treatment; -how long the patient is likely to require intensive care treatment for; -consideration of the patient's capacity to withstand the physical impact of intensive treatment (including mechanical ventilation); -long-term functional status should they survive -the patient's informed views on whether to undergo intensive therapies such as mechanical ventilation and the following paragraph has been added under section 10 'Ethical Considerations' Even when experiencing increased demand for healthcare, ethical advice and support will not be needed in most cases as clinicians will continue to make decisions by utilising their knowledge and experience, together with current scientific evidence, the wishes of patients and those closest to them, and in accordance with national guidance.
	EHRC & SHRC	The wording of this document was reviewed by EHRC, SHRC and Inclusion Scotland with key recommendations around clarity of how equality and non-discrimination is applied in the context of clinical decision making.	Through an iterative process, the guidance has been refined in discussion with EHRC, SHRC and Inclusion Scotland to derive wording that emphasises: ▪ the need for personalised holistic and non- discriminatory clinical decision making in practice. ▪ that no clinical decisions are made on the basis of any characteristic(s) of a patient, such as age, disability or the presence of existing health

			conditions or impairments that are not clinically relevant to the potential benefits of a course of treatment. ▪ that clinicians and decision makers must be mindful of the principle of non-discrimination and equity of access for people who could benefit from treatment escalation
	Consensus view amongst external stakeholders at EQIA **(SCLD, MWC, Scottish Care, Age Scotland, EHRC and Scottish Academy)** **Minority Ethnic Carers of People Project**	The revised versions of the clinical guidance documents were commended and the potential for positive impact through more personalised care for all vulnerable groups was emphasised. It was also suggested that the positive and inclusive approach taken by all those involved throughout this EQIA was an exemplar for future impact assessments. Ensure access to professional interpreting service within hospital/social care settings to ensure informed decision making.	This point has been acknowledged as being important to address within the clinical guidance and has been added as a recommendation, along with the caveat that these services may have to be provided through virtual platforms due to infection control measures.
	Academy of Medical Royal Colleges, Scotland	Poor levels of literacy, and health literacy may impact on people's ability to input into decisions about their health and wellbeing (patient information has to be adapted accordingly)	The guidance highlights that people should be supported to input into decisions about their health and wellbeing, and signposts to resources that are available externally to help clinicians and patients communicate effectively. In addition, the following piece of work is underway by our colleagues in the person-centred and participation team.

			Scottish Government, led by the CMO office, has published a Health Literacy Plan for Scotland which is strongly embedded in the principles of Realistic Medicine. The plan has been developed with the aim of: • removing the barriers to health and care system that get in the way of improving population wellbeing • Raising awareness amongst the workforce of the hidden problem of health literacy and helping them respond better, • building a go-to web place for health literacy news and tools • testing ideas for better designed services and more health literacy responsive organisations through a programme of work in NHS Tayside. It acknowledges that how low health literacy leads to poor health outcomes and sets out a range of actions to improve health literacy practice across the health and care system
	Inclusion Scotland	There may be a case for people providing communications support, or to enable supported decision-making, to be included as essential visitors (might the need for interpreters also be an issue for people whose first language isn't English?)	The current version of the clinical guidance signposts people to good practice in supported decision-making is provided by the Mental Welfare Commission for Scotland. In addition, following the EQIA, we have added a recommendation that patients should have access to communication support including professional interpreting service within hospital/social care settings to support them to make informed decisions about their care, with the caveat that this might have to be provided through virtual platforms due to current infection control measures.

ANTICIPATORY CARE PLANNING (ACP)	**Feedback from Professors from Centre for Mental Health and Capacity Law, Edinburgh Napier University & Professors of Healthcare and Medical Law at Glasgow Caledonian University**	The guidance needs to specify how ACPs can this be done in advance of admission to hospital and the tools to be used to achieve this	Version 2.3 of the document provides links to guidance and advice on ACP at Health Improvement Scotland iHub. It also signposts public awareness information about ACP available on NHS inform. Appendix 2 contains a template ACP from HIS.
		The role of supported decision-making is important in ACP and the form should require that evidence be recorded of all efforts being made to ensure that genuine access to this has been provided.	Version 2.5 includes the introductory page to the HIS ACP template for use in the COVID-19 pandemic (version 2.3 only had the template itself). The first page sets out the context to carrying out ACPs and encourages clinicians to have 'what matters' conversations that supports shared decision making. These conversations will be recorded in patient's notes while patient's wishes will be recorded in the ACP.
	Health and Social Care Alliance Scotland	It is stated that where anticipatory care plans have already been made these should be followed. However, in accordance with Health Improvement Scotland guidance[1] which makes it clear that anticipatory care plans can be updated at any time to reflect changes in thinking or circumstances, it must be clear that there should be an opportunity for further dialogue to reflect changes in thinking or circumstances.	Version 2.5 of the document takes this recommendation on board and under section 5 'Anticipatory Care Plans in COVID-19' includes the sentence. It should be noted that these anticipatory care plans can be updated at any time by the patient and those closest to them to reflect changes in thinking or circumstances

[1] https://ihub.scot/project-toolkits/anticipatory-care-planning-toolkit/anticipatory-care-planning-toolkit/advice-for-individuals/

		The clinical guidance notes that Anticipatory Care Planning (ACP) should take place with those at higher risk from COVID-19, but does not clarify how this should happen when lockdown and social distancing measures are in place, who should be undertaking these sensitive conversations, and what training and support will be available to them	Clinicians have been trained and encouraged to practice shared decision- making pre COVID-19 pandemic with the availability of a wide range of training resources. Version 2.3 of the document specifies that ACP conversations can be initiated by any member of staff, but must be communicated to the wider health and social care team involved in the care of that individual. During the lockdown these conversations can take place using telephone and digital communications or in person of admitted to hospital. **(detailing this is beyond the scope of this document)**
	Inclusion Scotland	All comments received by the Inclusion Scotland pertaining to ACP conversations including DNACPR were carefully considered.	Extensive clarifications were added to the section on ACPs in consultation with clinical and policy experts in the area. Links to further information and support on the topic have been added, signposting to resources on NHS inform, HIS and the Mental Welfare Comission.
TREATMENT ESCALATION AND LIMITATION PLANS (TELPS)	**Mental Welfare Commission**	Template Treatment Escalation and Limitation Plan (appendix 3) should include limitations to the use of the CFS We also suggest that the use of 'ADLs' (Activities of Daily Living) is also associated with a similar comment about its limitations in certain groups, as one of the markers regarding escalating care, in Appendix 3	The template TELP in appendix 3 has been included with permission from NHS Lanarkshire. It is to be used for ALL patients and requires clinicians to consider a range of factors when considering treatment escalation plans of which ADLs is just one.
	EHRC, SHRC & Inclusion Scotland	The list of factors including that the patient is a 'nursing home resident' or is dependant for ADLs should determine access to treatment escalation are potentially discriminatory and must be removed. This goes against the careful explanation of non-discrimination in the rest of the document.	This was a template reproduced with permission from NHS Lanarkshire and the guidance group are unable to make the recommended changes to it. Therefore, following discussions with CMO expert clinical advisors the decision was made to

		No explicit reference to the need to consider the patient's views (whether capable or otherwise) and provide appropriate support for decision-making The document needs significantly expanded to provide space to record the basis of decisions	remove this template TELP from the guidance
EQUALITY & DISABILITY	**Equality and Human Rights Commission, Scotland**	Both the Clinical Advice Guidance and the Ethical Advice and Support Framework must be revised to incorporate the principles of equality and non-discrimination from the outset to support frontline staff when making challenging healthcare decisions while fulfilling their legal duties.	The following sentences have been added to version 2.5, under 7.2 'Critical Care Admission' Clinicians and decision makers must be mindful of the principle of equity of access for people who could benefit from treatment escalation, and the principle of support for autonomy for people who want to be involved in decisions. Decision-making should not be disease specific – i.e. the presence or absence of COVID-19 should not be a limiting factor in treatment decisions. To ensure that patients are not subjected to potentially traumatic and futile interventions of no benefit, a realistic assessment of outcomes for different treatment options must be communicated to patients and those closest to them, in order to facilitate shared decision-making

	Health and Social Care Alliance Scotland	Socio-economic equality should also be at the forefront of strategic decision-making, with the Fairer Scotland duty and related impact assessment in operation to minimise any disadvantage to patients living in areas of deprivation People with disabilities, including those with mental disabilities, are likely to be particularly affected by the ethical and clinical issues of resource allocation and equal treatment, and it is vital (and indeed required by Convention on the Rights of Persons with Disabilities (CRPD)[2]) that guidance particularly affecting them is drawn up in consultation with disabled people. It is essential that the Clinical Guidance and Ethical Guidance are both much clearer about the legal and wider human rights imperatives that govern the exercise of duties and responsibilities of those making healthcare decisions affecting persons with mental illness, dementia or learning disability. It is critical that equal access to these facilities is ensured, including that of groups and individuals who are often marginalised and unseen. We believe that the Scottish Government should clarify how people who are furthest from accessing support and services will receive information about the local hubs and centres.	And the following has been added under section 10 'Ethical Considerations' The COVID-19 pandemic may however result in changes to healthcare scope and delivery across the UK, for all patients. It is important that if this happens, decisions are made fairly and equitably and all individuals should be treated with care, compassion and respect. A Fairer Scotland Duty assessment is being carried out on the clinical guidance with stakeholders involved in this EQIA consulted. The report will be published shortly. These recommendations have been addressed by the equality impact assessment of the document. **Beyond the Scope of this clinical guidance document**

	EHRC, SHRC & Inclusion Scotland	The wording of this document was reviewed by EHRC, SHRC and Inclusion Scotland with key recommendations to ensure it is consistent with human rights and equality obligations.	Through an iterative process, the guidance has been refined in discussion with EHRC, SHRC and Inclusion Scotland to derive wording that emphasises non- discriminatory clinical decision making in practice.
	SCLD, MWC, Scottish Care, Age Scotland & EHRC	It was noted that stakeholder feedback, particularly from SCLD and Inclusion Scotland, has helped refine the language in the guidance around disability.	
	Minority Ethnic Carers of People Project	The higher risk of COVID-19 on BAME communities was highlighted both from a patient perspective and from being a clinician/health & social care worker perspective. The growing evidence around the impact of the COVID-19 virus on BAME communities was acknowledged, but there was a reflection that there is limited evidence around how to best support and care for BAME communities differently. Further work was required with the BAME community in terms of awareness raising.	For groups where English is not their first language, hyperlinks to accessible resources on NHS Inform have been included within the clinical guidance. It was noted that this may not always be sufficient. Of note, a targeted marketing campaign was run by the Engagement and Insights Team from the COVID-19 and Ethnicity: Expert Reference Group. This campaign utilised community broadcast media where possible and highlighted the availability of translations of information resources. The learnings from this campaign has been shared with marketing colleagues across Scottish Government to ensure that minority ethnic communities continue to receive core COVID-19 public health messages. In addition, direct engagement with communities and grassroots organisations continues to be a major focus for the Scottish Government.

		The provision of care to gypsy travellers was recognised as a challenge due to the complexity of their practical and cultural needs. The importance of being innovative in how we provide care to this population was emphasised.	It was agreed that addressing this was out with the scope of this clinical guidance, but something clinicians should continue to be aware of.
		For BME and Gypsy/Traveller communities, can guidance include contact details for trusted community organisations that may be able to offer advice, support and assistance?	It was agreed that it is important to highlight this point and he following sentence has been added to the clinical guidance: ***It is important that healthcare professionals are aware of and are able to signpost patients with protected characteristics to community organisations that will be able to provide them with further, advice, and support should they require it.*** As the clinical guidance is intended to provide high level recommendations on providing clinical care, and a majority of the support for these communities will be sought at a local level, we felt highlighting specific organisational contact details would not be feasible within the guidance.
	Mental Welfare Commission	There are differential impacts on LGBT people as a consequence of COVID, for example, the fact that the LGBT community is both more likely to experience mental ill-health and less likely to feel connected to their local community, but community Covid support responses are mainly locality-based and therefore less likely to reach them.	While out with the scope of this guidance, these points were acknowledged as being very important to note. One of the biggest changes in care delivery through the pandemic has been the increase in remote consultations and use of technology, and it was hoped that these innovations will go some way to mitigate some of the impacts highlighted. While addressing the point made on mental health and social connection in the LGBT

			community is not within the scope of this guidance document, it is an important point to note and raise awareness of.
	Inclusion Scotland	Clinicians themselves, members of the NHS workforce themselves, may have health conditions that put them at high risk of adverse outcomes should they contract Covid-19. They may themselves be in the official shielding group. They may be disabled people and/ or from BAME communities, who in both cases evidence seems to be suggesting are at higher risk.	Addressing these concerns is beyond the scope of this guidance. However, Scottish Government Workforce Directorate have provided the following resources which we hope will help: • On 30 March, Scottish Government published guidance for staff and managers on Coronavirus, that directs staff to verified sources of advice. This will inform a standard approach to occupational health, for application across NHS Scotland. This advice contains information on risk assessments. (https://www.staffgovernance.scot.nhs.uk/coronavirus-covid-19/guidance/) • The Scottish Government's Clinical Guidance Cell has published detailed information on definitions of underlying health conditions to support Health and Social Care and Emergency Service Workers understand the risks associated with their health conditions. https://www.staffgovernance.scot.nhs.uk/media/1701/guidance-for-health-and-social-care-and-emergency-servive-workers-with-underlying-health-conditions-30-march-2020.pdf • The Scottish Government's Clinical Guidance Cell is updating its guidance on risk assessments, to reflect the current situation and the latest clinical advice. • Our future policy approach will facilitate individualised decision-making,

			that considers a range of known risk factors, the nature of an employee's work, steps taken to reduce risk, the expectations of employees, and the prevalence of the virus. • The Business Disability Forum have reviewed our National Wellbeing Hub (www.promis.scot) and made available a suite of resources to support disabled staff which includes resources on everyday needs at work.
	Inclusion Scotland	if it's possible to stop referring to people at high risk as 'vulnerable', that would be appreciated. It positions people at risk as passive, fragile and needy rather than active, equal citizens.	We acknowledge your concerns on the use of the word "vulnerable" to describe those at high risk. You raise an interesting point. In terms of the guidance, the term "vulnerable" is used to describe objective vulnerability as a measure of risk. It is an established use of the word in medical literature and guidance and is widely used and recognised by clinicians. For this reason, we do not see benefit in changing the use of the word vulnerable. You do raise an interesting point that perhaps requires wider discussion and debate with the clinical community, and it is a point we shall keep in mind as we develop our future programme of work.
	Inclusion Scotland	There's a general point on the importance of providing for inclusive communications that applies in many places throughout the guidance (an issue applicable both to disabled people who are patients and disabled people who are members of the NHS workforce) and which could usefully be flagged. For example – section 3 on Covid-19 telephone triage and local Covid-19 assessment centres, face-to-face assessments, guidance, documents, BSL signing for videos, carrying out CFS/ holistic assessments, etc.	We have signposted clinicians to patient information on NHS inform which hosts information in a variety of languages including BSL, easy read format as well as audio versions. In addition, Scottish Government Equality Policy Unit have provided funding for Glasgow Disability Alliance, the British Deaf Association, and Deafblind Scotland to ensure that Scottish Government advice is

			available in a variety of accessible formats so that as many people as possible are able to receive key health messages.
	Inclusion Scotland	There is recent evidence that disabled people are disproportionately represented in deaths from Covid-19. Assessment of deaths by Coronavirus recorded during the period of March 2 to May 15 by the Office of National Statistics (ONS) in England and Wales found two in three people who have died from coronavirus are disabled. There are breakdowns of these figures by age and gender and identification of additional risk factors for infection rates for disabled people	In terms of wider actions taken to mitigate against the impact of COVID-19 on the disabled community, Scottish Government Social Justice Strategy Unit have highlighted some of the measures in place to support individuals, including those who are disabled, to access food and other essentials during this COVID-19 pandemic including: 1. Establishing a national helpline and providing £15 million of funding for local authorities to extend support for those at risk until the end of September. This is in addition to £30 million allocated in April, and £12.6 million allocated to extend Free School Meal provision over the summer holidays. 2. Publishing guidance on the support available to help people overcome the challenges in accessing and affording food and other essentials during this crisis. This includes information on gift cards to enable others to shop on their behalf, food boxes and prepared meal delivery options, and sources of help for those struggling to afford food, including the Scottish Welfare Fund. The guidance also highlights other sources of support to protect the wellbeing of people affected by virus. In addition, the Chief Statistician's Office have advised that they are producing a report work that looks at which patients are at highest risk factors for getting, needing hospitalisation, critical care admission,

			requiring mechanical ventilation and dying from COVID-19. This piece of work explores the importance of environmental factors (such as occupation/industry, housing, deprivation), socio-demographic factors (sex, age, ethnic background, religion), and health factors (other health conditions, disability) on morbidity and mortality related to COVID-19.
DNACPR	**Health and Social Care Alliance Scotland**	We believe that more detailed guidance should be issued by the Scottish Government to GPs and other members of primary care, clearly outlining when and how DNACPR discussions should take place. There also needs to be explicit direction about actions that can never be clinically and ethically justified during the COVID-19 crisis, such as the blanket use of DNACPRs on care home residents or assumptions about futility of treatment being made solely on the basis of the existence of a physical or mental disability	**Beyond the scope of this guidance** **Beyond the scope of this guidance**. Public statement addressing these concerns forthcoming. The last point has been addressed in version 2.5 as described previously in this document under theme 'CFS & Decision-making principles'
TESTING	**Health and Social Care Alliance Scotland**	More detail should be made available on the process for COVID-19 testing, including the settings people will expect to be managed within and how long test results are likely to take to come back	**Beyond the scope of this guidance**. Guidance on testing is available at Health Protection Scotland
STAFF WELLBEING	**Health and Social Care Alliance Scotland**	The clinical guidance notes that "physical and mental wellbeing of all staff should be supported" but does not clarify how. We believe that more information on approaches, what works and what is possible should be published to allow for health and social care systems to adopt, share and collaborate	**Beyond the scope of this guidance.** There is a body of work ongoing at board and national level to support staff mentally and physically through this pandemic and during recovery.
DEATH AND DYING	**Minority Ethnic Carers of People Project**	Preparations for death and dying are different within Minority Ethnic communities – how can hospital/social care settings accommodate this?	It was acknowledged that preparations for death and dying are different within Minority Ethnic communities and it is important that support for patients and their families in this

			context is individualised. Addressing this specifically is beyond the scope of this guidance, but the clinical guidance contains the vital message of the importance of providing person centred care throughout the document and particularly in 'end of life care' section. In addition, it highlights a valuable resource from the Royal College of Physicians which delves further into the ethical principles around providing end of life care during the COVID-19 pandemic.
SHIELDING	**Scottish Academy of Medical Royal Colleges**	How does the guidance impact on the shielded population – both in terms of vulnerable patients and staff.	Beyond Scope of this guidance. It was noted that comprehensive shielding guidance is being produced by colleagues and there is an intention to undertake an equality impact assessment on that guidance
MONITORING THE IMPACT OF CLINICAL GUIDANCE	**EHRC**	It is important that we measure the impact of the clinical guidance	We shall discuss the impact of the guidance with NHS Boards to help us understand how they have used the guidance to inform local care pathways. We will also monitor the impact of the clinical guidance by inviting the public and stakeholders to alert us to any concerns or positive experiences regarding how clinicians are making decisions about the treatment and care about people with COVID-19 using this guidance. We shall provide a contact email address within the guidance to send feedback to.