NHS GGC COVER PAPER TEMPLATE

NHS Greater Glasgow and Clyde	**Paper No. 21/80**
Meeting:	**NHSGGC Board Meeting**
Meeting Date:	**21st December 2021**
Title:	**COVID-19 Update**
Sponsoring Director/Manager	**Linda de Caestecker – Director of Public Health**
Report Author:	**Callum Alexander – Business Manager**

1. Purpose

The purpose of the attached paper is to: *The purpose of the paper is to update the Board on the overall position in respect of the NHS Greater Glasgow and Clyde (GGC) response to managing COVID-19 and provide assurance to Board members.*

2. Executive Summary

The paper can be summarised as follows: *The Board has received a COVID update throughout the pandemic. This paper considers some key ongoing issues in respect of COVID-19, specifically:*

- *Current COVID activity within hospitals*
- *Acute and HSCP updates*
- *Care Homes*
- *Test and Protect*
- *Vaccination*

3. Recommendations

The NHS Board is asked to consider the following recommendations: None

4. Response Required

This paper is presented for awareness

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- **Better Health** Positive
- **Better Care** Positive
- **Better Value** Neutral
- **Better Workplace** Neutral
- **Equality & Diversity** Neutral
- **Environment** Neutral

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity: *N/A*

7. Governance Route

This paper has been previously considered by the following groups as part of its development: *N/A*

8. Date Prepared & Issued

21.12.2021

NHS GREATER GLASGOW AND CLYDE

Response to COVID-19

NHS Board Summary 21st December 2021

1.0 PURPOSE OF PAPER

1.1 The purpose of the paper is to update the Board on the overall position in respect of the NHS Greater Glasgow and Clyde (GGC) response to managing COVID-19 and provide assurance to Board members.

2.0 ACTIVITY

2.1 The number of cases in NHS GGC has stabilised into an oscillating plateau pattern in recent weeks, though with an upward trend in recent weeks. Currently the 7 day incidence rate on 10th December 2021 is 386.9/100,000, this represents a significant fall from 1072.4/100,000 on 9th September 2021, which was the highest rate recorded, at any time during the pandemic.

2.2 The number of COVID-19 cases in hospital (using the all COVID-19 positive patients' definition) has continued to decline in recent weeks; however, there remains a sustained and substantial level of COVID-19 related occupancy. As of 10th December 2021, there are 691 inpatients across our hospital sites (using the all COVID-19 definition), 137 inpatient (using the <28 days definition) and 10 patients in ICU after testing positive for COVID-19.

Our highest day for COVID-19 positive inpatients remains the 27th January 2021, with 963 inpatients with COVID-19, of which 588 were less than 28 days since a positive test.

3.0 CURRENT POSITION

3.1. Strategic Executive Group (SEG)

3.1.1 The SEG, which meets three times a week, is overseeing the continued response to COVID-19 and the remobilisation process. In addition, the meetings now include reporting on progress on the delivery of the vaccination programme, the redesign of unscheduled care, care homes, test and protect, remobilisation and immediate issue relating to COVID-19, in hospital and across the community.

The following sections provide a high level update on key ongoing issues.

3.2 Workforce

3.2.1 We continue to see demands on both community and acute services and our workforce has continued to be flexible and adaptable. We had seen a downward trend in Covid-19 related absence into November to under 470 employees absent, however this

has returned to 539 employees. The majority of COVID absences remains those with Long COVID (50%) and our HR Support and Advice Unit continue to engage with those employees and their managers to ensure all appropriate support in place and also look at alternative solutions such as adjusted working arrangements.

3.2.2 Within the Board and across Scotland we have continued to see an increased level of sickness absence of 7.8% (up from 7.7%), which is higher than pre-COVID absence. Our Human Resources team and managers continue to ensure that all employees are contacted regularly and receiving appropriate engagement and support and looking at ways to support a safe return to the workplace. This remains the key priority area for Human Resources, ensuring additional support for managers who have a number of competing priorities.

3.2.3 We continue to progress with a large number of recruitment campaigns for both our substantive and bank workforce to support winter workforce planning, across all job families. From the investment allocation from the Cabinet Secretary for Health and Social Care we have appointed 183 individuals to strengthen our multi-disciplinary teams across the health and social care system, from the allocation of 222 for NHSGGC and have further recruitment activity underway to finalise this programme. We are also widening our campaigns beyond the UK through our new International Recruitment Team, funded by the Scottish Government, with a key focus on registered nursing and hope to see some position outputs from this programme, this also includes looking at opportunities to work with local support networks of refugees in our area and also linking in with local economic development teams to support individuals who may have been recently made redundant.

3.2.4 Our Test and Protect teams have increased activity created by localised outbreaks and the new variant. We continue to monitor and ensure that this service is resourced as required. Our vaccination team has been increased to support the delivery of the COVID booster and flu immunisation programme and we continue to build our workforce in this area to ensure a timely rollout against wider acute and community winter challenges. Recent campaigns have produced both internal and external candidates and dental students.

3.2.5 The mental health and wellbeing of our staff continues to be a top priority. We have now launched our Peer Support Programme and are actively recruiting and training Peer Supporters and commencing the rollout of the Level 1 support for all staff. With additional funding from the Scottish Government we are also introducing free hot food provision for staff working at night in our main sites over the winter months following suggestions from staff and our Area Partnership Forum. There is an increase in support through the Occupational Health service and further initiatives being finalised to support community based staff.

3.2.6 Guidance on Physical Distancing remains in place with further local audits underway, the majority of areas are remaining at 2metres. The guidance is continually updated based on advice from Scottish Government and we are still encouraging staff to work from home where possible, given the increase in the new variant. Staff are also being encouraged to continue with Lateral Flow testing twice per week.

3.3 Acute Care

3.3.1 The Acute Tactical Group continues to meet regularly, in addition, daily informal calls are held with the Acute Directors. The Group constantly reviews the operational impact of COVID-19 activity and the challenges this poses to managing our inpatient sites, whilst also maintaining a focus on non-COVID activity. As at 10th December 2021 there are 691 COVID-19 inpatients in our hospitals of which 137 are under 28 days from a positive Covid-19 test. Following the peak in hospitalisations in October 2021, we have seen in recent weeks a stabilisation and fall in of COVID-19 related hospitalisations, with inpatient numbers persistently around c150-200 patients. At its peak, during the first wave of the pandemic, there were 86 patients in ICU beds across NHSGGC, 74 of which had COVID-19 and a total of 606 patients in acute hospital beds with a positive COVID-19 test. In the second wave we exceeded the 606 inpatient figure, by over 50% and pressure on critical care across ICU and HDU were again substantial.

3.3.2 Staff absences and Bed Capacity are the most significant challenges for the Acute Division through this latest peak in the pandemic. Significant numbers of staff have had to self-isolate. Infection control and social distancing protocols, have continue to substantially reduce the effective bed base of NHSGGC, with ward capacities greatly reduced in places. During the winter peak in January and February 2021 the Acute Division had at time in excess of 20 wards closed to new admissions and up to 30 COVID-19 cohort wards open. As at 10th December 2021, NHSGGC had 6 wards closed and 5 cohort wards open, however, unlike in previous waves our demand is now at pre-pandemic levels placing greater requirement on the Boards bed capacity.

3.3.3 As a result of the high COVID-19 activity across NHSGGC and the resulting pressure on staffing and bed capacity, the Boards elective programme continues to be substantially reduced with focus on priority cases and time sensitive procedures only. The elective programme at this time is focused towards cancer, urgent patients and trauma work. Staff from the elective programme have been supporting the delivery of urgent and emergency care across NHSGGC and will continue to do so in the short term.

3.3.4 Unscheduled care performance has been significantly challenged, a pattern which is repeated nationally. In November the Board achieved 76.7% against the four hour emergency access target. This takes the year to date emergency access figure to 82.6%. As population public health restrictions eased, all of our Emergency Department sites have seen an increase in attendances, which at times does exceeded pre-pandemic levels of activity. This higher attendances pattern has been observed across the United Kingdom, with England and Wales recording the highest Emergency Department attendances on record.

3.3.5 Lastly, with the high prevalence of COVID-19 in our community, NHSGGC has made the decision to reduce visiting on some sites and wards to one named visitor. This decision has been taken on the advice of our infection control team, and this difficult decision has been take to ensure we safeguard our patients. Any reduction to visitation is targeted and based on the advice of our infection control team, any reduction is continually reviewed with oversight provided by the Senior Executive Group.

3.4 Health and Social Care Partnerships

3.4.1 The Health and Social Care Partnership Tactical Group continues to meet weekly, enabling the six partnerships to work together, share good practice and develop common approaches where appropriate. The focus upon recovery continues, counterbalanced with meeting the changing demands presented by the remaining incidence of COVID-19 in our communities and the wider system pressures associated with winter.

3.4.2 Delayed discharges has been a key priority for our Health and Social Care Partnerships, working alongside acute colleagues. There is a daily delayed discharge huddle focussing across whole system on delays, planning discharge numbers, identifying and resolving key issues and feeding into wider improvement work. Of significant challenge, has been the delayed discharges resulting from adult with incapacity (AWI) and the legal complexity associated with transferring patients to an appropriate community care setting. As at 10th December 2021, there were 241 delayed discharges across NHSGGC, of which 80 were due to AWI's.

3.4.3 Activity within our Community Assessment Centres (CACs) continues to be monitored regularly through the CAC Operational group and at SEG. CAC attendance closely reflected the trend in community prevalence of COVID-19, therefore, as expected, we saw a substantial increase in CAC attendances, in line with community cases in the autumn months, but more recently has stabilised. Patients attending the CACs are presenting less acutely unwell than in previous waves of the pandemic and as such, though the late summer spike the number of onward referrals to acute sites has decreased. At present, there has not been a measurable impact on the CACs from the Omicron variant.

4.0 CARE HOMES

4.1 Governance

4.1 Across NHSGGC there are 186 registered care homes, 141 of these care homes provide services to older people. Following the first wave in spring 2020, Directors of Public Health were asked to provide additional public health support and monitoring of care homes. This involved the tripartite assessment of all care homes with Public Health, HSCPs, and the Care Inspectorate. From 18th May 2020 the Nurse Director became responsible for the provision of nursing leadership, support, and guidance within the Care Home sector, this responsibility will be kept in place until at least March 2022.

4.1.2 As part of NHSGGC assurance framework and ongoing monitoring, the weekly Public Health questionnaire on Care Homes continues to be submitted to Scottish Government. Care homes are assessed under four key questions and rated Red, Amber or Green in regards to COVID cases, PPE, IPC knowledge & practice and staffing. The return also captures assurance activity and is utilised to inform local thinking and action planning, additional consistency and clarity of chronology in the weekly returns is supported by an SBAR format which is completed for all Red and Amber rated care homes

each week. In the week ending 03/12/21 there was 3 care homes flagged as Red and 15 as Amber across the HSCPs.

4.1.3 In addition to the DPH weekly paper, the daily TURAS Safety Huddle summary data provides real time updates on outbreak status, identifying homes that have no outbreaks, those awaiting confirmation of tests, and those who have a confirmed outbreak status or where there is an outbreak that has now been declared over. As at 07/12/21 there were 6 homes with confirmed outbreaks.

4.2 **Vaccinations**

Older Peoples Care Home Covid-19 Booster and Autumn Flu vaccination programme was undertaken in line with the successful model used to roll out the first and second round of vaccine in early 2021, and following JCVI advice that Covid-19 booster vaccine should be administered six months following the second dose of vaccine. Commenced on the 24th September 2021, Residents and staff in care homes were offered a covid-19 booster, and simultaneously offered the seasonal flu vaccine. By 7th November 2021, all eligible residents and staff in older peoples care homes across NHS GGC had been offered a covid-19 booster and also a seasonal flu vaccination.

4.3 **Visiting**

Oversight and governance processes continue to support care homes to safely operationalise the various Tiers of visiting guidance and specifically 'Open with Care – Supporting meaningful contact in care homes.' Guidance remains under regular review and is a standing item at the care home governance and assurance meeting.

4.4 **Assurance Visits in Care Homes**

Aligned to the Executive Nurse Directors responsibilities set out by Scottish Government to provide nursing leadership, professional oversight, implementation of infection prevention and control measures, use of PPE and quality of care within care homes, the Care Home Assurance Tool (CHAT) visits now form part of a regular schedule of Bi-annual visits to support all care homes. The visits provide additional specific infection control, nursing support and guidance to care homes in the provision of high quality personalised care for residents. The CHAT visits highlight good practice and areas for improvements with care homes taking ownership of the actions required and working in collaboration with their HSCP teams to achieve improvement in Key themes from recently published CHAT report quality of care.

Outputs from the CHAT visits undertaken in care homes across NHSGGC during 2021 are analysed and reported through governance routes identifying key themes which have worked to drive the improvement agenda. Key themes from recent CHAT reports show areas of continuing good practice relating to Infection prevention across communication, environment and guidance for visiting. Some areas noted for improvement and continued support were around PPE, social distancing, cleaning of equipment. Other areas of strength relating to residents heath and care needs were, falls risk assessment, and management of indwelling devices. A general area for improvement in the CHAT visits

was noted to be the need for a consistent approach to assurance visits to understand findings and support prioritisation of quality improvement.

4.5 **Care Home Collaborative and Hub Development**

In order to support the requirement for professional oversight to Care Homes across 6 HSCPs the Care Home Hub Model was agreed across NHSGGC as a way forward to support care homes during and in recovery from the COVID19 Pandemic. As the model developed there was recognition across all stakeholder groups that a Care Home Collaborative, which the hubs would form an integral part of, would more effectively describe the shared purpose. In light of the commitment and continued investment in professional oversight for Care homes the Collaborative model has been further revised and strengthened to reflect the importance of continuous quality improvement and the shared purpose of enabling the best possible lives for care home residents aligned to what matters to them.

The staffing model offers a range of added expertise that support and promote, person centeredness, tissue viability, quality improvement, professional leadership and education. The model will enable greater ability to support provision of safe, effective and person centred care in care home settings.

A phased approach to recruitment is underway. This will allow the landscape to further evolve and amendments to be made to the staffing model to ensure added value. Any revision to the model will remain within the financial envelope received. Support will continue to be provided from local and central teams to deliver against the requirements of the SG letter and finance will be ring fenced for this purpose.

5.0 Epidemiology

5.1 Overall COVID-19 incidence

5.1.1 Since the last update on 14 October 2021, the daily number of COVID-19 cases notified to Test and Protect oscillated around an average of 512 (Figure 1). The 7-day cumulative incidence of COVID-19 positive cases per 100,000 population started to decrease from early September and continued to decline up to the end of October 2021. At the beginning of November, the 7-day incidence in NHSGGC increased and then remained relatively stable with an average of 315 per 100,000 population over the past three weeks (Figure 2), before starting to rise further in the most recent week.

5.1.2 In the latest week from 1 to 7 December 2021, a total of 4,161 COVID-19 cases were notified to the case management system (CMS) of Test and Protect, which was a 12% increase compared to the previous week (last week of November) and an increase of 2% compared to the same first week in October. The median of 566 daily cases for the first week of December was higher compared to median of 468 daily cases for the first week of November and 505 daily cases for the first week of October. Occasional data flow issues contribute to peaks and troughs in daily notifications, in particular the exceptionally high daily case number of 895 on 5 December was due to data feed issue at the end of the previous week.

5.1.3 From 13 October to 7 December, an average (mean) of 1.8 contacts per completed case resident in NHS GGC were recorded by Test and Protect, which was relatively stable compared to the previous reporting period from 1 August to 12 October, in which an average of 2.0 contacts per completed case were recorded.

Figure 1: Number of Covid-19 cases by date of notification and local authority, NHSGGC 21/08/2020 to 08/12/2021 at 8:00am

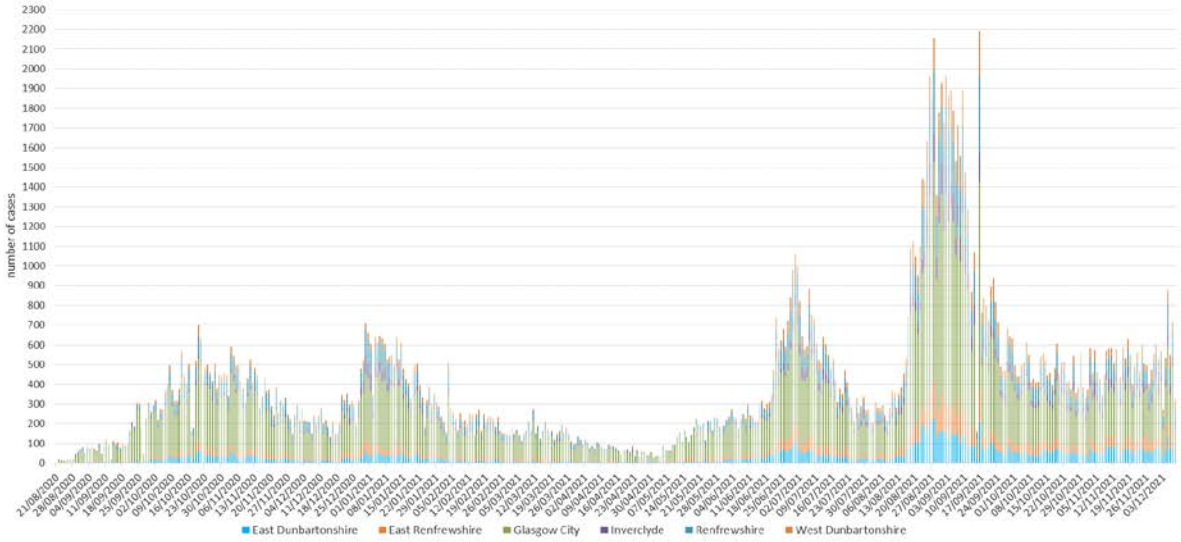
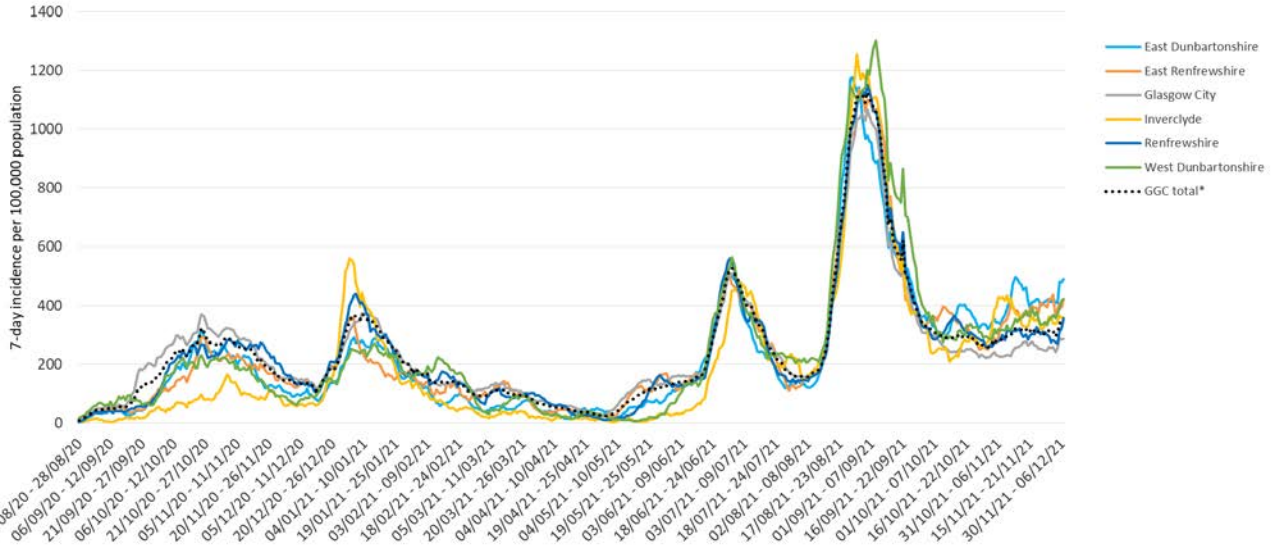


Figure 2: Rolling 7-day cumulative incidence of Covid-19 cases per 100,000 population by date of notification and Local Authority, NHSGGC 28/08/20 - 07/12/2021

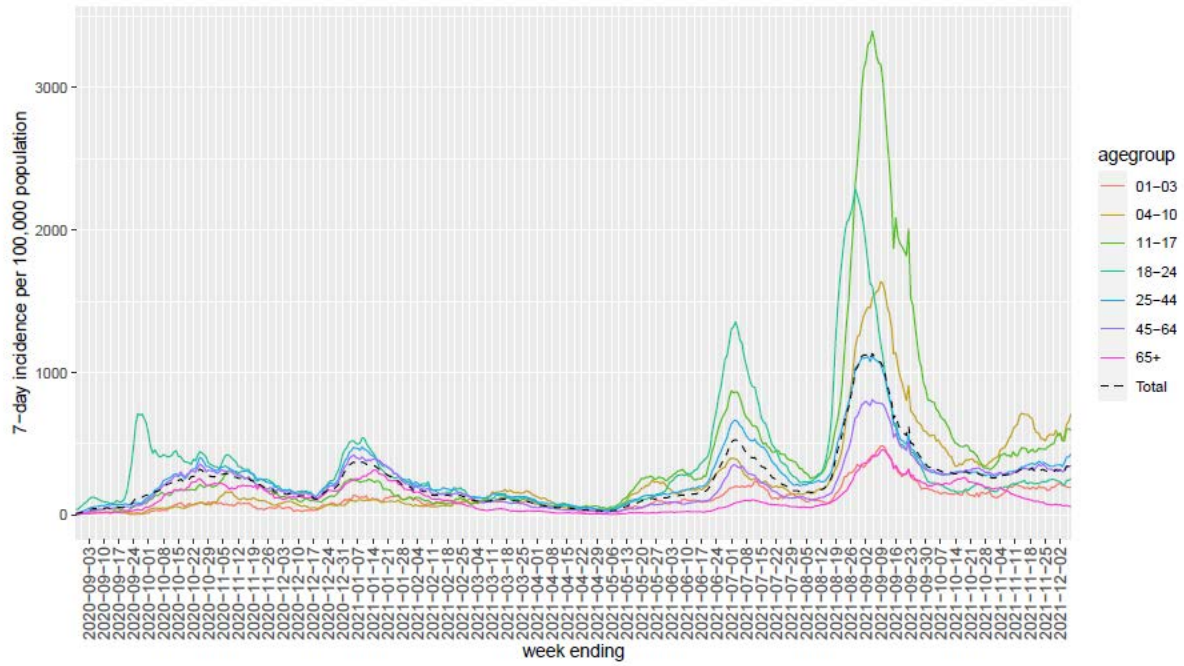


5.2 Incidence by age group

5.2.1 The rolling 7-day cumulative incidence of COVID-19 cases per 100,000 population increased across all age groups from mid-August and continued to increase to the last

week of August in the age group of 18-24 years old, to the first week of September in the age group of 11-17, 25-44 and 45-64 years old and to the second week of September 2021 in the age group of 4-10 and 65+ years old. In the following weeks, the 7-day cumulative incidence started to decrease in all age groups up to the end of October 2021. From early November 2021, the 7-day cumulative incidence in the age group of 4-10, 11-17 and 25-44 years old has been recorded with a predominantly upward trend, but in the age group of 1-3, 18-24 and 45-64 years old has remained relatively stable. The incidence in the age group of 65+ years old continued to decrease. In the most recent week, there were increases in incidence in all of the age groups except for the 1-3 and 65+ years old groups, for which incidence has decreased slightly. The biggest relative increase was recorded in the primary school group of 4-10 years old followed by the age group of 25-44 years old. The primary and secondary school aged children remain the two groups with the highest incidences among all of the age groups for the latest week (Figure 3).

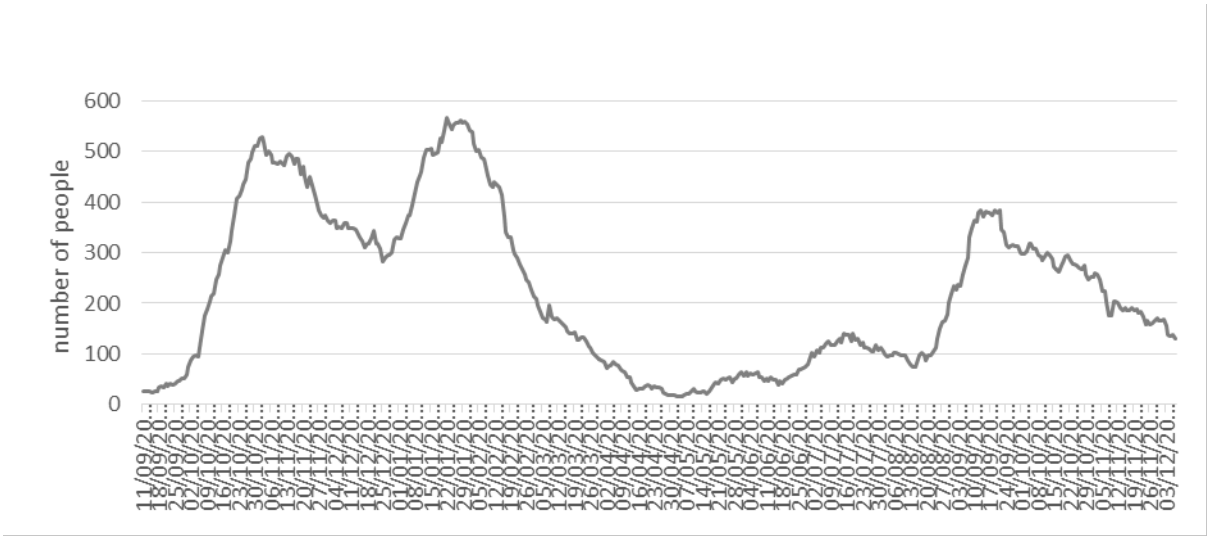
Figure 3: Rolling 7−day cumulative incidence of Covid−19 cases per 100,000 population by date of notification and age group, NHSGGC



5.3 Inpatients with recently confirmed COVID-19

5.3.1 The last significant increase in COVID-19 incidence, observed from mid-August to early September 2021, was followed by a steep increase in the daily number of people in hospital with confirmed COVID-19 (<28 days since positive test). The daily COVID-19 cases in hospital peaked at 384 on 21 September, followed by a fairly steep decline to 299 cases on 1 October, and an ‘oscillating plateau’ of COVID-19 cases in hospital in GGC was observed through October. The number of COVID-19 hospital inpatients started to decline gradually form the end of October and has decreased through November with an average of 194 daily cases compared to an average of 285 daily admissions in October. Over the most recent week, the daily number of people in hospital with recently confirmed COVID-19 continued to fall steadily with an average of 147 daily cases in hospital in GGC.

Figure 4: Daily number of people in hospital with recently confirmed COVID-19 (<28 days since positive test) in NHS GGC



5.4 Omicron

5.4.1 A SARS-CoV-2 variant with a high number of mutations compared to the original virus was detected at the beginning of November 2021 by scientists in South Africa. On 26 November 2021 the variant was designated a variant of concern (VOC) and assigned the label Omicron by the World Health Organization (WHO).

5.4.2 The European Centre for Disease Prevention and Control (ECDC) has published an initial risk assessment on the implications of the emergence and spread of Omicron. In summary, the Omicron variant is the most divergent variant that has been detected so far during the pandemic, raising serious concerns that it may be associated with significant reduction in vaccine effectiveness and increased risk for reinfections. The high observed growth rate of this variant might indicate that this variant is significantly more transmissible than Delta and/or that the growth rate could be due to immune escape. Preliminary information indicates that currently no unusual symptoms have been associated with the Omicron variant, and similar to other variants, some individuals are asymptomatic, not identifying any change in infection severity. Further virological investigations and vaccine effectiveness studies are needed at this stage.

5.5 Enhanced response

5.5.1 Public Health Scotland in collaboration with local Health Protection Teams has developed interim guidance to support the enhanced response to Omicron. The aim of this enhanced response is to slow any onward transmission of this variant of concern while we learn more about the threat it may pose.

5.5.2 Like the Alpha variant (dominant in the UK from January 2020 to May 2021), Omicron has a mutation that leads to failure of one of the three targets (S-gene target failure) in the PCR used by UK Government Lighthouse Laboratories and the Scottish NHS Regional Hub Laboratories. S-gene target failure (combined with positive detection of the other two target genes) has therefore been identified as a reasonable proxy for Omicron variant in the UK, and facilitates enhanced public health action for cases and their contacts prior to confirmation through Whole Genome Sequencing (WGS).

5.5.3 Current case definitions, contact tracing approach and isolation requirements are set out briefly below, but it should be noted that interim guidance is changing rapidly, as the situation evolves.

5.6 Case definitions

- COVID-19 cases with S-gene target failure (SGTF) are classed as possible Omicron cases.
- SGTF COVID-19 cases with travel history to current red list countries (where Omicron is thought to be prevalent), or who are known contacts of a confirmed Omicron case are classed as highly probable Omicron cases.
- A confirmed case of Omicron is defined by the results from WGS.

5.6.1 Contact tracing and isolation requirements

Omicron cases (possible, probable and confirmed) are required to isolate for 10days from date of onset of symptoms (or date of test, if asymptomatic), in the same way as all other COVID-19 cases.

The definition of close contacts remains the same as for other COVID-19 cases, with the exception of individuals under 18 years for whom the same rules apply as for adults. i.e. no high-risk / low risk division of contacts for individuals under 18 (which can result in isolation of large numbers of children identified as contacts e.g. entire class groups in primary schools or nursery settings).

Under current interim guidance, close contacts of all (possible, probable and confirmed) Omicron cases are asked to isolate for ten days, regardless of their vaccination status, recent positive test or age i.e. contacts of Omicron cases cannot end their isolation early.

5.7 Current situation

5.7.1 from 1 November to 6 December 2021 1700, a total of 178 Omicron cases (30 confirmed, 15 highly probable, 133 possible cases) were notified for GGC residents. Of the cases for whom presence or absence of symptoms were known (n=140), 69% cases were symptomatic. As of 6 December, none of these cases had been admitted to hospital. Of all 178 cases, 19% were unvaccinated, 4% partially vaccinated, 69% fully vaccinated, and 8% had received their booster. National work to assess the effectiveness of the vaccine against Omicron is ongoing.

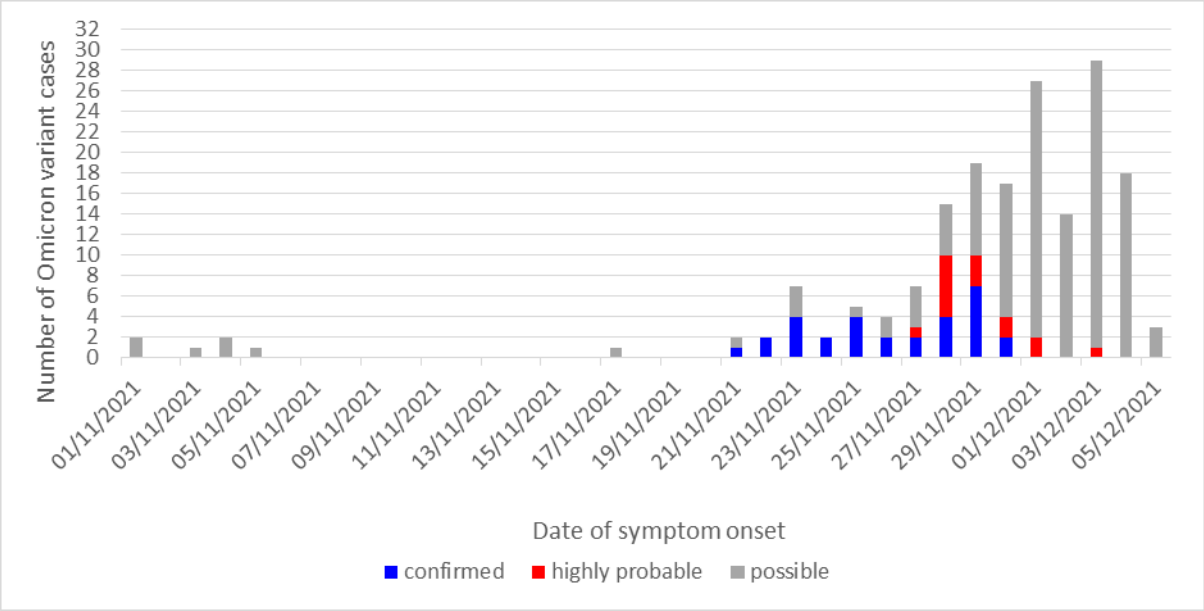
5.7.2 As shown in Figure 5, Omicron cases started to rise rapidly from the 21 November (and continue to do so). Only two of the GGC cases notified to 6 December (2 highly probable cases) travelled to a red list country in the 14 days before onset. The majority of Omicron cases detected in GGC to date do not have a history of travel to a red list country (nor any known links to individuals with a travel history), indicating community transmission. A number of the initial cases detected were linked to attendance of a private event, as well as attendance of a public concert. Multiple clusters of cases in a range of settings including schools and workplaces have been identified since.

5.7.3 The proportion of all COVID-19 cases notified for GGC, which are S-gene target failures (classed as possible Omicron cases) is continuing to increase rapidly, from 0.2%

as of 30 November to 10.8% as of 8 December 2021. For Scotland overall, the proportion of COVID-19 cases that are SGTF increased from 0.1% to 6.9% over this time.

5.7.4 A local Incident Management Team (jointly with NHS Lanarkshire, chaired by NHS GGC) has been stood up, and NHS GGC contributes to the National Incident Management Team for Omicron

Figure 5: Number of COVID-19 cases by Omicron status, NHSGGC and day of symptom onset*, 1 November – 6 December 2021 17:00 (data for last 2 days incomplete).



*For cases without date of symptom onset available, the day on which the sample was taken was used.

5.8 Outlook

5.8.1 The steeply increasing number of Omicron cases is resulting in significant workload for Test and Protect as well as the Public Health Protection Team, to support the enhanced response for contact tracing and management of clusters.

5.8.2 Different advice for contacts of Omicron cases, compared to cases of the (currently still) dominant Delta variant, is prone to result in confusion for the public especially when cases of both variants occur within the same setting (e.g. a school). This is compounded by guidance changing fast to adapt to the evolving situation, and national work to update all partners is ongoing.

5.8.3 Isolation requirements (absence of exemptions from isolation) for contacts of Omicron cases, and the absence of distinction between high and low risk contacts for individuals under 18 is likely to result in staffing pressures for Health and Social Care, as Omicron case numbers continue to increase. This also applies to other settings, and is likely to result for example in temporary school closures due to the inability to maintain safe staffing levels.

5.8.4 Continuous adaptation (and prioritisation) of the response is required, in light of rapidly increasing numbers of cases of the Omicron variant, which (based on the current trajectory) is likely to become the dominant circulating COVID-19 variant in Scotland over the coming weeks. NHS GGC continues to contribute emerging findings to the relevant national IMT for Omicron, as well as the overall National IMT (NIMT) for COVID-19, to advise on and help shape the national response.

6.0 COVID-19 Vaccine

6.1 The vaccination programme has continues to evolve and adapt to the changing evidence, regularly updated national policy and the state of the pandemic.

6.2 During November adults aged 40-59 were invited to book an appointment for their flu vaccination and a booster dose of COVID via an on line portal or via the national phone line. As key element of our vaccine programme has been the sending of texts and letters to those who have not yet received their vaccine or have not booked an appointment to ensure that people were aware that they would not receive an appointment directly.

6.3 At the end of November it was decided that those aged 18-39 would also be offered a booster dose of COVID vaccine and that young people aged 12-15 could be offered a second dose 12 weeks after their first. In addition, people who are severely immunosuppressed are now eligible for a booster three months after their third dose. Furthermore, the time period between the second dose and booster was reduced from 24 weeks to 12 weeks.

6.4 The vaccination team have reacted quickly to all the changes and been supported by local authority and other stakeholders to significantly increase the number of appointments available. This has required more staff to be recruited and trained as part of the vaccination bank and this has been supported by staff from across the organisation

6.5 To date over 2.1 m doses of COVID vaccine have been given and 460,000 doses of flu vaccine.

8.0 CONCLUSION

8.1 At this moment in time there is a high degree of uncertainty and high levels of complexity for NHSGGC in tackling COVID-19. Our hospital remain extremely busy with COVID-19 cases in addition to our non-COVID patients and this is creating substantial service pressures. However, we are at present seeing a downward trend in inpatient COVID occupancy. The Omicron variant however, presents a new and at present unknown challenge. Therefore, NHSGGC will continue to focus on delivering our

vaccination programme, utilising new and improving treatment options and apply the lessons learnt in nearly two years of living with COVID-19.

8.2 As a Board we continue to act dynamically and at pace to respond to the significant challenges associated with the COVID-19 pandemic. Our colleagues have done an outstanding job in continuing to provide kind, safe and excellent care throughout the pandemic and embracing new and innovative working; as a Health Board we are enormously grateful for their efforts. Across health and social care in NHSGGC, we have strengthened our relationships and strengthened partnerships, which has, and will, serve us well in the coming months and years.

8.3 The effects of COVID-19 on communities, our staff and those directly affected by this illness, are likely to become significant legacy challenges, many of which, are at present unknown. As a Board, we will continue to lead and adapt to these challenges, to serve our patient and support our colleagues and partners.