NHS Greater Glasgow and Clyde	**Paper No. 22/02**
Meeting:	**NHSGGC (NHS Greater Glasgow and Clyde) Board Meeting**
Meeting Date:	**22 February 2022**
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 (Health and Social Care Partnership) 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: N/A

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

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

Date prepared: 16 February 2022.
Date issued: 18 February 2022.

NHS GREATER GLASGOW AND CLYDE

Response to COVID-19

NHS Board Summary 22nd February 2022

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 fallen in recent weeks, though with an upward trajectory in the past week. Due to changes to COVID-19 testing requirements nationally, the rate per hundred thousand comparisons should be read with consideration of this. Currently the 7-day incidence rate on 15th February 2022 is 728.8/100,000, this represents a significant fall from 2805.8/100,000 on 29th January 2022, 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 15th February 2022, there are 1076 inpatients across our hospital sites (using the all COVID-19 definition), 252 inpatient (using the <28 days definition) and 5 patients in ICU (Intensive Care Unit) after testing positive for COVID-19.

Our previous highest day for COVID-19 positive inpatients was surpassed in the omicron wave on 19th January 2022, with 1117 in patients with COVID-19, of which 528 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 has in recent weeks stepped down to meets two 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 February to under 726 employees absent from 1800 in January. The majority of COVID absences are those who have tested positive at 412. Previously, most staff absences were due to Long COVID, our HR (Human Resources) Support and Advice Unit continue to engage with those employees and their managers to ensure all appropriate support in place and look at alternative solutions such as adjusted working arrangements.

3.2.2 Within the Board and across Scotland we have in recent weeks seen a decreased in the level of sickness absence of 4.9% (down from 6.1%), 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 several competing priorities.

3.2.3 We continue to progress with many recruitment campaigns for both our substantive and bank workforce to support winter workforce planning, across all job families. 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 linking in with local economic development teams to support individuals who may have been recently made redundant.

3.2.4 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, most areas are remaining at 2 metres. Staff are also being encouraged to continue with regular Lateral Flow testing.

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 of 15th February 2022, there are 1076 COVID-19 inpatients in our hospitals of which 252 are under 28 days from a positive Covid-19 test. Following the peak in hospitalisations in January 2022, we have seen in recent weeks a stabilisation and fall in of COVID-19 related hospitalisations, with inpatient numbers persistently around c240-260 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 (High Dependency Unit) 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 too self-isolate. Infection control and social distancing protocols have continued to reduce the effective bed base of NHSGGC, with ward capacities reduced in places. During the winter peak 2022 the Acute Division had at time more than 30 wards closed to new admissions and COVID-19 cohort wards open. As of 15th February, NHSGGC had 12 wards closed and 7 cohort wards open, however, 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 reduced with focus on priority cases and time sensitive procedures only. The elective programme at this time is focused on

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 January, the Board achieved 76.6% against the four-hour emergency access target. This takes the year-to-date emergency access figure to 81.7%. As population public health restrictions eased, all our Emergency Department sites have seen an increase in attendances, which at times does exceed pre-pandemic levels of activity. These 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 taken 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 have 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 of 15th February 2022, there were 287 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 and declined substantially. 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.

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 (Health and Social Care Partnerships), 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 regarding COVID cases, PPE (PERSONAL PROTECTIVE EQUIPMENT), IPC (Infection Prevention and Control) (Infection Prevention and Control) 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 2 care homes flagged as Red and 26 as Amber across the HSCPs.

4.1.3 In addition to the DPH (Directors of Public Health) 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 of 15th February 2022, there were 29 homes with confirmed outbreaks and 8 awaiting confirmation. A total of 11 homes are closed to admissions and a further 28 are open but with control measures in place.

4.4 **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.

4.6 **Care Home Collaborative and Hub Development**

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. Considering 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 (Scottish Government) letter and finance will be ring fenced for this purpose.

5.0 Epidemiology

5.1 COVID-19 incidence

Since the last update on 08 December 2021, the daily number of COVID-19 cases notified to Test and Protect increased rapidly over the course of December 2021 and the beginning of January 2022, in association with the emergence of a new variant of concern, Omicron, at the end of November. This variant is associated with a lower vaccine effectiveness, as well as a higher risk of re-infection compared to previous variants, and the following case statistics for GGC from November now include any re-infections after a period of 90days since a previous infection. The highest average number of daily cases of 4247 was recorded for week 29/12/2021 – 04/01/2022 (Figure 1). The 7-day cumulative incidence of COVID-19 positive cases per 100,000 population also increased steeply over the same period, with the highest 7-day cumulative incidence recorded at 2805/100,000 population for 4 January 2022. Since then up to date, a decreasing trend of 7-day cumulative incidence was recorded in all the Local Authority areas except for East Renfrewshire which saw a slight increase in late January before starting to decline again in the most recent weeks (Figure 2). A change in testing advice from 6 January was associated with a significant reduction in uptake of PCR (Polymerase Chain Reaction) testing. Absolute numbers of case notifications before and after 6 January should therefore be compared with caution. However, other sources not subject to changes in testing approach (e.g., asymptomatic PCR testing in care home staff) confirmed a large decline in incidence from the beginning of January.

The decreasing trend in daily number of COVID-19 cases slowed down in recent weeks. In the latest week from 2 to 8 February 2022, a total of 8,866 COVID-19 cases were notified to the case management system (CMS) of Test and Protect, which was a 4% decrease compared to the previous week and a significant decrease of 68% compared to the first week in January. The median of 1243 daily cases for the first week of February was much lower compared to median of 4237 daily cases for the first week of January. Occasional data flow issues contribute to peaks and troughs in daily notifications, in particular a slowdown in processing times at the UK Lighthouse lab resulted some fluctuations during the festive period.

From 8 December 2021 to 8 February 2022, an average (mean) of 1.1 contacts per completed case resident in NHS GGC were recorded by Test and Protect, which decreased compared to the previous reporting period from 13 October to 7 December, in which an average of 1.8 contacts per completed case were recorded. To accommodate the high volume of case notifications, Test and Protect in all boards moved to FOCUS level, from mid-December, with contact tracing by phone for high-risk cases and related to outbreaks in high-risk settings, and digital contact tracing using the CO3 app for all other cases. This shift in approach is likely to have contributed to the change in average numbers of contacts per case recorded.

Figure 1: Number of Covid-19 cases by date of notification and local authority, including reinfections after 90 days, NHSGGC 01/11/2021 to 09/02/2022 at 8:00am

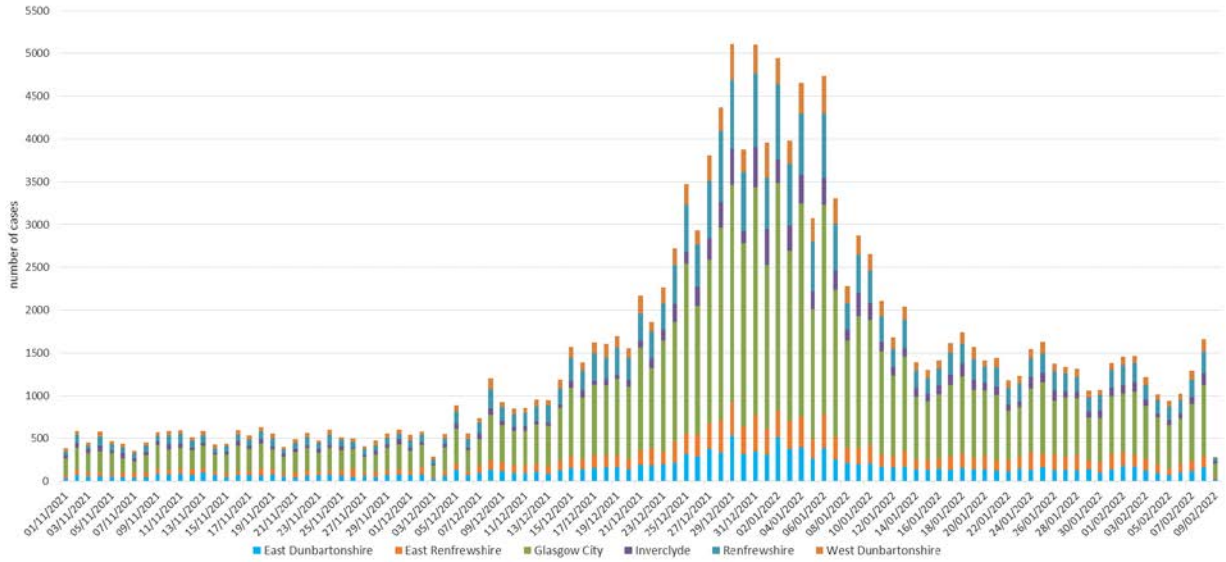
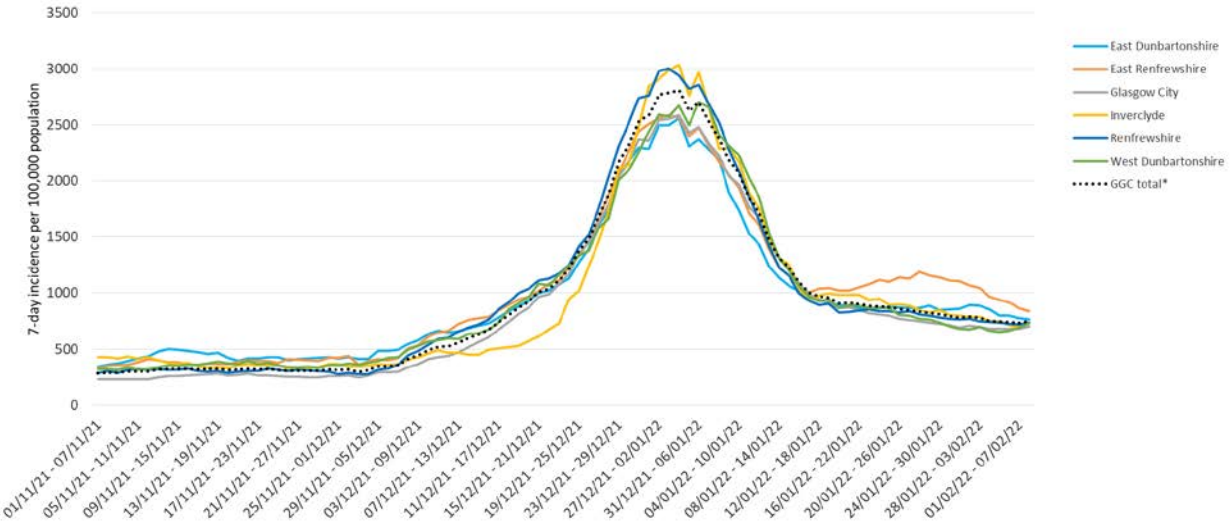


Figure 2: Rolling 7-day cumulative incidence of Covid-19 cases per 100,000 population by date of notification and Local Authority, including reinfections after 90 days, NHSGGC 01/11/2021-08/02/2022

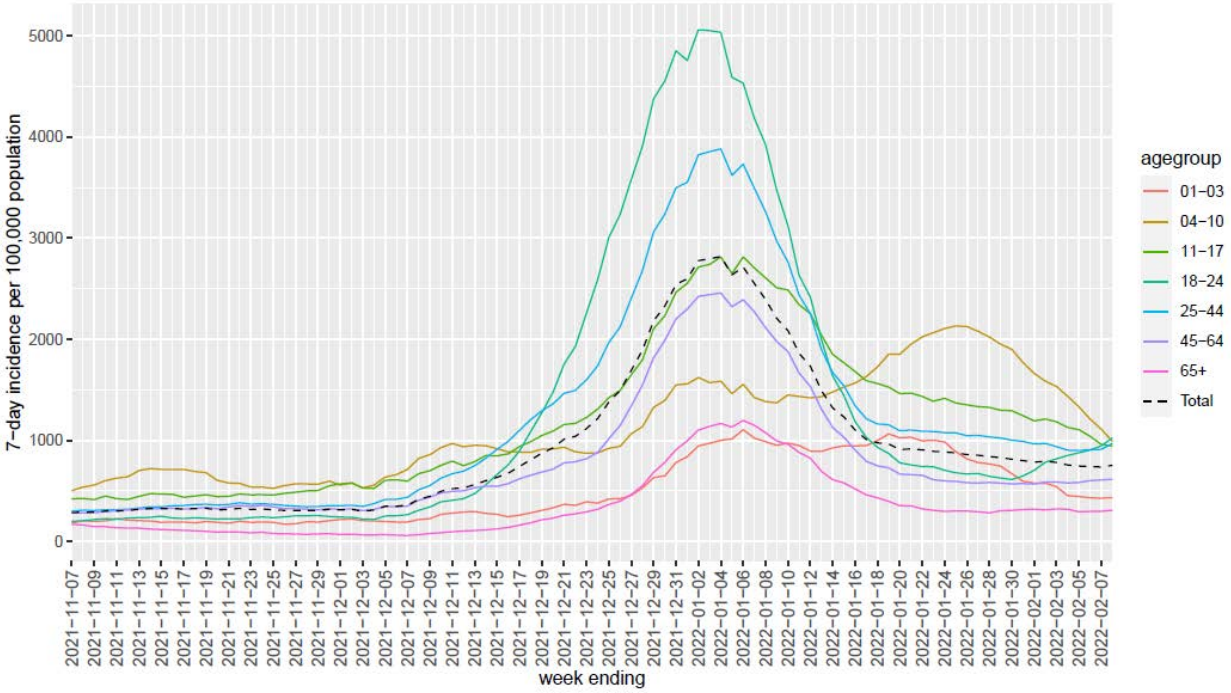


5.2 Incidence by age group

The rolling 7-day cumulative incidence across all age groups remained stable over the course of November 2021 but showed a distinct upward trend from early December 2021 to early January 2022. The biggest absolute and relative increase in the 7-day cumulative incidence was observed in the week 29/12/2021-4/01/2022 in the young adult age group of 18-24 years old followed by the age group of 25-44 years old. The 7-day cumulative incidence decreased in all age groups since then, except for the age group of 4-10 years old, which continued to increase till late January. The incidence in primary school group 4-10 decreased since late January but retained the highest

incidence among all age group until the most recent week. In the most recent week, increases were observed in the young adults (18–24-year-olds) and the older working age group 45-64, with minor rise also observed in the 25-44 age groups. The highest incidence is now in the 18–24-year group, followed by the primary school group for the latest week (Figure 3).

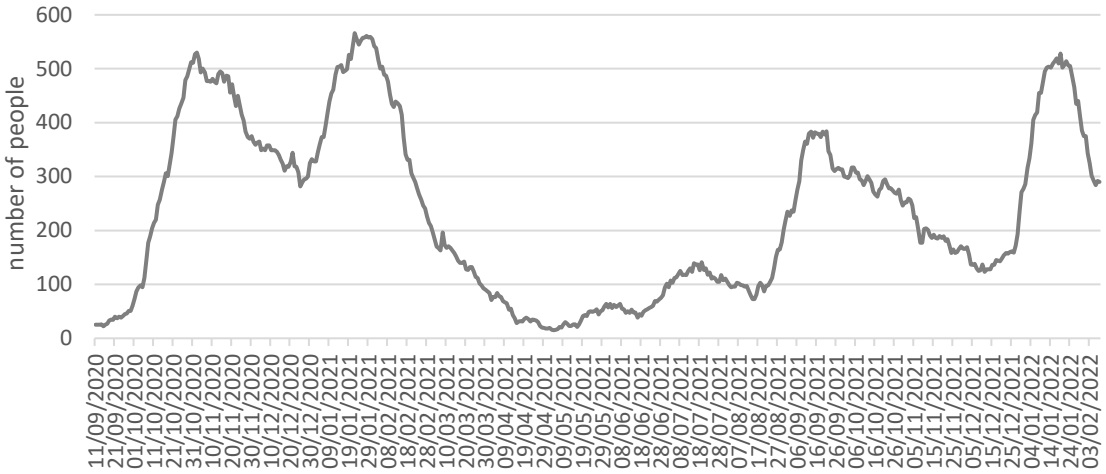
Figure 3: Rolling 7−day cumulative incidence of Covid−19 cases per 100,000 population by date of notification and age group, including reinfections after 90 days, NHSGGC 01/11/2021- 08/02/2022



5.3 Inpatients with recently confirmed COVID-19

The number of hospital inpatients with recently confirmed COVID-19 fluctuated throughout October 2021 and decreased throughout November 2021 with an average of 194 COVID-19 inpatients compared to an average of 285 COVID-19 inpatients in October. The number of hospital inpatients with recently confirmed COVID-19 started to increase again from mid-December 2021 and increased rapidly throughout late-December 2021 and mid-January 2022 to a peak of 528 admissions on 19 January 2022, with an oscillating plateau of cases in hospital observed over the middle two weeks in January. COVID-19 inpatient numbers have since been decreasing steadily to an average of 304 cases in the week ending 08 February 2022 in GGC.

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



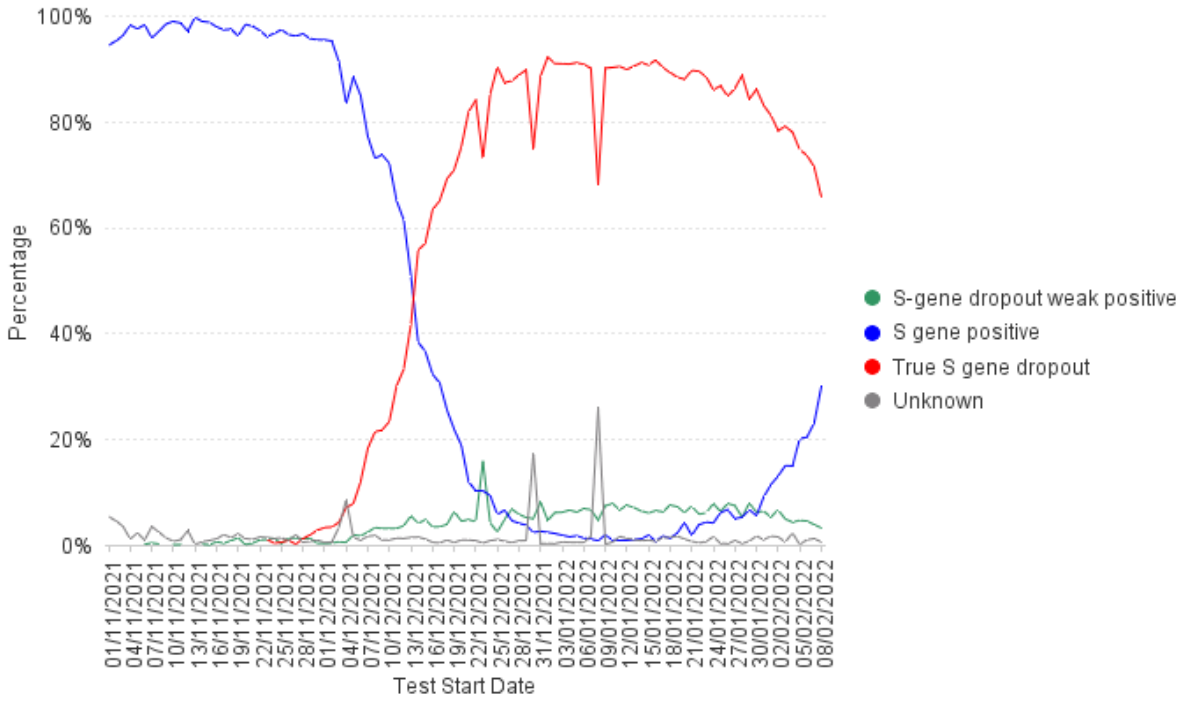
5.4 Omicron BA.1 and BA.2

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). The first confirmed Omicron cases in Scotland, reported from 25 November (including cases residing in NHS GGC), and were linked to a cluster in Central Scotland associated with three events/settings (a private gathering, a mass gathering and a workplace) in the central belt. Omicron displays substantial immune evasion properties in the current population context (increased rate of re-infections and reduced vaccine effectiveness compared to Delta), but it is also associated with a reduction in the relative risk of hospitalisation per case. Available data suggests that the observed reduction in risk of hospitalisation in adults is likely to be partly a reduction in intrinsic severity of the Omicron variant and partly to protection provided by prior infection.

Like the Alpha variant (dominant in the UK from January 2020 to May 2021), Omicron BA.1 has a mutation that leads to failure of one of the three targets in the PCR used by UK Government Lighthouse Laboratories and the Scottish NHS Regional Hub Laboratories (S-gene target failure). S-gene target failure (combined with positive detection of the other two target genes) was identified as a reasonable proxy for the Omicron BA.1 variant in the UK and facilitated enhanced public health action for cases and their contacts prior to confirmation through Whole Genome Sequencing (WGS), in the early part of the response. Omicron BA.1 became dominant in NHS GGC in mid-December, when the proportion of S-gene target failure samples from NHSGGC cases exceeded 50% of all tested for the S-gene and continued to rise until the end of December when the proportion of S-gene target failure samples reached and stayed at ~90% until late January.

Since then, the proportion of samples with S-gene target failure started to drop. This is associated with increasing proportions of a second variant of Omicron, BA.2 (also known as 'stealth Omicron') which does not present with S-gene target failure. As of 08 February 2022, the proportion of samples positive for the S-gene and likely to be the attributable to Omicron BA.2 increased to 30% (Figure 5). Omicron BA.2 has been increasing across the UK, and this suggests a growth advantage for BA.2 (compared to the BA.1 variant of Omicron that has been dominant to date). Similar observations have been made internationally, but not in all countries where BA.2 has been reported. Preliminary analysis also suggests BA.2 may have a higher household secondary attack rate than BA.1. It is too early to conclude whether any growth advantage is a result of an increase in inherent transmissibility or other factors, and early observations of new variants should be interpreted with care. Initial estimates of vaccine effectiveness against symptomatic disease (from a small number of infections) do not indicate a significant difference compared to effectiveness against BA.1.

Figure 5: Proportion of cases tested for the S gene, by S gene category, NHSGGC, 1 November 2021 – 08 February 2022



5.5 Outlook

Work is underway to review the future of contact tracing in Scotland, as part of the overall update to the Scottish Government strategic intent and testing strategy, which is due to be published on 22 February.

6.0 COVID-19 Vaccine

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

6.2 NHSGGC has now given a first dose to 91.3%, second doses to 87.0% and boosters to 81.9% of eligible over 18s. This represents a significant achievement and the largest vaccination programme ever undertaken by the Board.

6.3 At present the Board continues to run a wide range of clinics from quickly visit to by appointment for all types of vaccination. We continue to deliver vaccinations daily.

6.4 All those aged 5 to 11 are to be offered 2 doses of vaccine 12 weeks apart. Detailed guidance is awaited but this is expected to start in March. There are 86,000 people in this group in GGC. Delivery will be in community clinics and is likely to be offered over a month, so it includes at least some of the school holidays.

6.5 The Flu programme has recommenced with 113 community pharmacies have registering to offer seasonal flu vaccination to those who still wish it.

8.0 CONCLUSION

8.1 At this moment in time we are seeing an oscillating plateau of COVID-19 demand but with at a far lower level of demand than the peak in January 2022. Our hospital remains extremely busy with COVID-19 cases in addition to normal non-COVID winter patients service pressures. However, we are at present seeing a downward trend in inpatient COVID occupancy. The Omicron variant however, with greater social mixing in the community we must remain vigilant. Therefore, NHSGGC will continue to focus on delivering our vaccination programme, utilising new and improving treatment options and apply the lessons learnt in 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 As a Board, we will continue to lead and adapt to these challenges, to serve our patient and support our colleagues and partners.