NHS Greater Glasgow and Clyde	**Paper No. 22/16**
Meeting:	**NHS Board Meeting**
Meeting Date:	**26 April 2022**
Title:	**COVID-19 Update**
Sponsoring Director/Manager	**Dr Emilia Crighton, Interim Director of Public Health**
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1. Purpose

The purpose of the attached 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:

- 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

Prepared on: 19 April 2022
Issued on: 19 April 2022

NHS GREATER GLASGOW AND CLYDE

Response to COVID-19

NHS Board Summary 26th April 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 within NHS GGC has fallen in recent weeks, though the fall in case number follows the highest community and Hospital prevalence during the pandemic. 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 13 April 2022 is 591/100,000, this represents a significant fall from 2805.8/100,000 on 4th 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 13th April 2022, there are 1076 inpatients across our hospital sites (using the <90 day definition), 610 inpatient (using the <28 days definition) and 3 patients in ICU (Intensive Care Unit) after testing positive for COVID-19.

3.0 CURRENT POSITION

3.1. Strategic Executive Group (SEG)

3.1.1 The SEG, which has in recent weeks been stepped back up to three times a week meeting, due to the impact of Omicron in February and March. SEG 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 Staff absence continues to be a key risk and focus. Whilst we continue to see an improved sickness absence position of 6.32% in February 2022, we have seen a sharp rise in COVID absence (from 728 to 1045 employees). The majority of COVID absences continue to be those testing positive (44%), followed by those with Long COVID (31%). We have established additional dedicated support within the HR Support and Advice Unit, to ensure managers and employees are

supported in dealing with COVID related absences. In particular, guidance has been developed to assist in managing the previously unknown condition of Long COVID. The guidance offers initial support via employee wellbeing calls when they first commence Long COVID absence and then follows the process and principles of NHS Scotland Attendance Policy to offer further support. Furthermore, work has been undertaken in conjunction with Occupational Health Services to ensure there is an appropriate and detailed management referral process for any employee absent due to Long COVID.

A specialist team of occupational therapists, physiotherapy, psychology and occupational health nursing has being established within the Occupational Health service. This service is for staff and devises individual assessment and treatment plans to support staff to return to work.

3.2.2 Core recruitment activity continues and we have recently welcomed a number of international nurses to the Board who have been recruited through our in-house International Team. Work continues on this area, as well as wider campaigns, virtual networking events and local and national recruitment fairs. We have also commenced our Newly Qualified Nursing (NQN) campaign targeting graduates from the October 2022 cohort as part of a revised and streamlined process.

3.2.3 We continue to implement our Mental Health and Wellbeing Action Plan. The Peer Support Worker framework is available across our services. This is provided across 3 levels:

- Universal – Online programme to support staff to increase their knowledge and skills
- Peer Supporter – 2 day programme building on the online skills programme enabling participants to be a nominated “Peer Supporter”
- Trainer – Programme designed to enable a small cohort to be trained to a level that would allow them to provide the “Peer Supporter” training thus ensuring the longevity and sustainability of the supports available.

3.2.4 The first group of non-medical staff have been trained as peer supporters, and the level 1 online training is now available to all staff, with a full programme of training planned for 2022. Medical staff had previously been trained in a slightly different model and the aspiration is to combine both programmes. The medical teams have trained a range of medical staff and have established a specific route for access to peer support. In addition we have converted a former coach, donated by “First Bus”, to provide the equivalent mobile Relaxation resources as those in the R&R Hubs based on sites.

3.2.5 The new Blended Working Guide has been developed and is currently being considered through Partnership governance routes. This sets out NHSGGC principles and aspirations as a flexible employer of choice and a phased and safety return to the workplace, whilst maximising and promoting hybrid ways of working, promoting NHSGGC as an employer of choice and developing a series of risk assessment and DSE online tools to support those working remotely.

3.2.6 As Scottish Government continues to review restrictions, we await further update on changes to Physical Distancing however this remains in place, the majority of areas are remaining at 2metres. Staff are also being encouraged to continue with Lateral Flow testing twice per week (changed from daily) and we are awaiting further guidance in relation to face masks. Staff and patient safety will continue to be at the forefront of any change in guidance.

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 13th April 2022, there are 1076 COVID-19 inpatients in our hospitals under 90 days from a positive test, of which 610 are under 28 days from a positive Covid-19 test. Following the peak in hospitalisations in March 2022, we have seen in recent weeks a stabilisation and small reduction in of COVID-19 related hospitalisations, with inpatient numbers persistently around c600-700 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. In this latest wave driven by Omicron we have exceeded all previous inpatient hospitalisation numbers, though demand for critical care remains substantially below the first wave of 2020.

3.3.2 Staff absences and limited 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. The Acute Division continues to regularly have c20-30 wards closed to new admissions and COVID-19 cohort wards open. As of 13th April, NHSGGC had 15 wards closed and 10 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. As such, the Boards elective programme must unfortunately continue to be reduced with focus on priority cases and time sensitive procedures only. The elective programme at this time is focused on patients who require very urgent, time sensitive, operations. 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 March, the Board achieved 71.1% against the four-hour emergency access target. This takes the year-to-date emergency access figure to 80.4%. 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 and across Scotland.

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 13th February 2022, there were 301 delayed discharges across NHSGGC, of which 117 were due to AWI's.

3.4.3 The Community Assessment Centres (CACs) which were established in the first wave of the COVID-19 pandemic – with the first patients treated on the 23rd March 2022, have as of the 26th of March 2022 been decommissioned. Over the two years of the pandemic a total of 8 CACs were established. There were a total of circa 46,000 CAC attendances – circa 5,000 were referred to Acute Services giving a referral rate of 12%. The majority of patients seen at a community assessment centre were directed to isolate at home with a minority referred to SATA, the proportion referred to SATA had declined throughout the pandemic. The CACs played a pivotal role in supporting our community throughout the first two years of the pandemic.

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 latest report up to the 31st March 2022 there was 0 care homes flagged as Red and 34 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 14th April 2022, there were 36 homes with confirmed outbreaks and 3 awaiting confirmation. A total of 13 homes are closed to admissions and a further 30 are open but with control measures in place.

4.2 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.

5.0 EPIDEMIOLOGY

5.1.1 Overall COVID-19 incidence

Since the last update on the 10th of February 2022, the daily number of COVID-19 cases notified to Test and Protect increased from mid-February to mid-March 2022. The upswing in COVID-19 cases was likely driven to large extent by an increasing proportion of BA.2 sub-lineage (which has a higher transmissibility than BA.1), as well as a general increase in mixing. The following case statistics for GGC include any re-infections after a period of 90 days since a previous infection. The highest average number of daily cases of 2570 was recorded for week 14th to the 20th of March 2022 (Figure 1). The 7-day cumulative incidence of COVID-19 positive cases per 100,000 of population also increased over the same period, from the second week of February up to mid-March 2022, in NHSGGC and all of the Local Authority areas. The highest 7-day cumulative incidence in NHSGGC during this wave was recorded at 1617 per 100,000 of population for 15th March 2022. Since then up to date, a decreasing trend of 7-day cumulative incidence was recorded in NHSGGC. As of 12th April 2022, the rolling 7-day cumulative incidence for NHSGGC decreased to 631/100,000 population, the highest incidence was recorded in Inverclyde at 694 per 100,000 of population, and the lowest in Glasgow City at 567/100,000 population (Figure 2).

The decreasing trend in daily number of COVID-19 cases continued in recent weeks. In the latest week from the 6th to the 12th April 2022, a total of 7,463 COVID-19 cases were notified to the case management system (CMS) of Test and Protect, which was a 24% decrease compared to the previous week, a 25% decrease compared to the same week in February and a significant decrease of 57% compared to the same week in March 2022.

Although, an average (mean) of contacts per completed case resident in NHS GGC recorded by Test and Protect decreased compared to the previous reporting period, the number of contacts recorded are not representative now. The shift in approach to contact tracing might have contributed to the underestimation of the number of contacts per case recorded. From 21st March 2022, Test and Protect in all boards moved to FOCUS PLUS level by continuing contact tracing by phone for high risk cases and related to outbreaks in high risk settings, reduced call attempts and digital contact tracing.

Figure 1: Number of Covid-19 cases by date of notification and local authority, including re-infections after 90 days, NHSGGC 01/11/2021 to 13/04/2022 at 8:00am

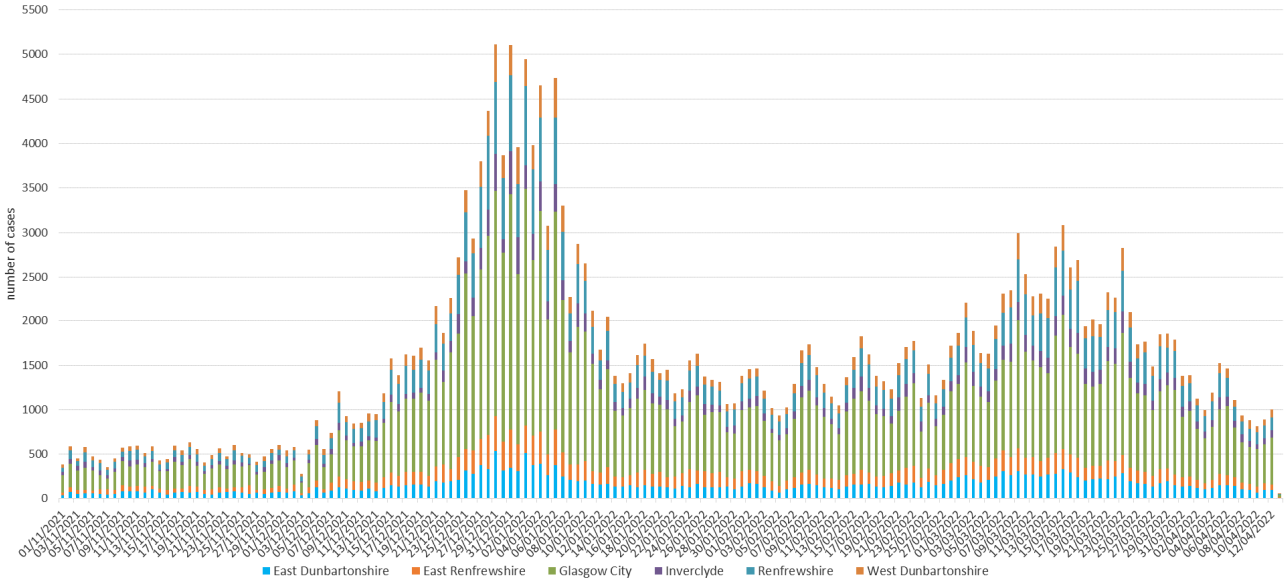
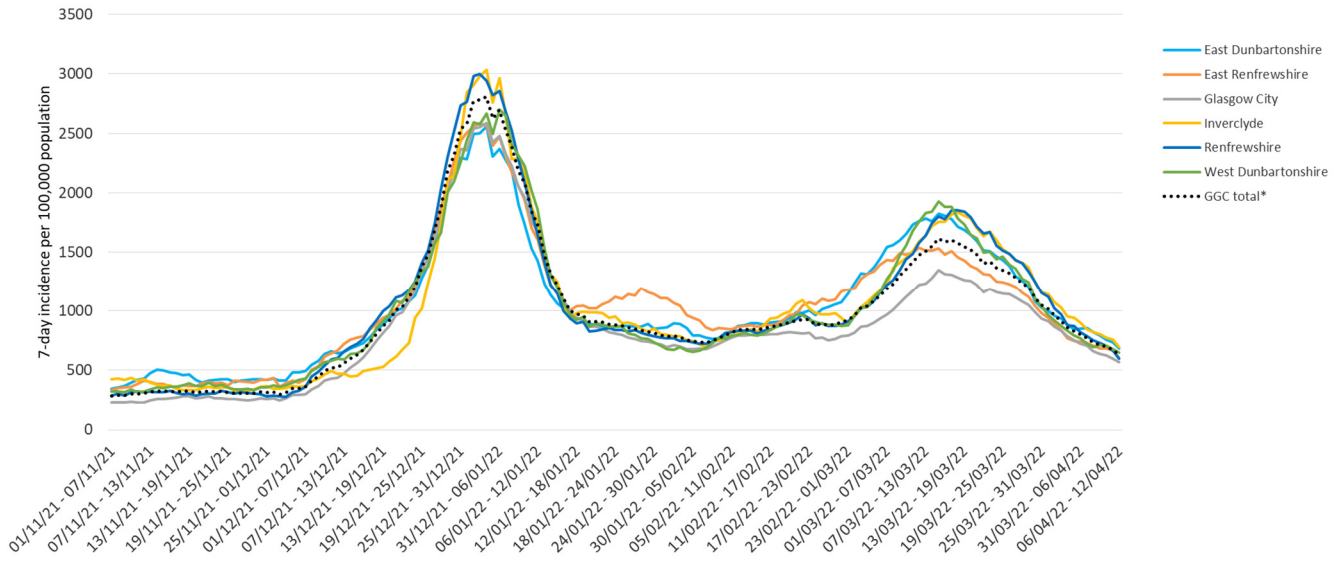


Figure 2: Rolling 7-day cumulative incidence of Covid-19 cases per 100,000 population by date of notification and Local Authority, including reinfections after 90 days, NHSGGC 01/11/2021-12/04/2022

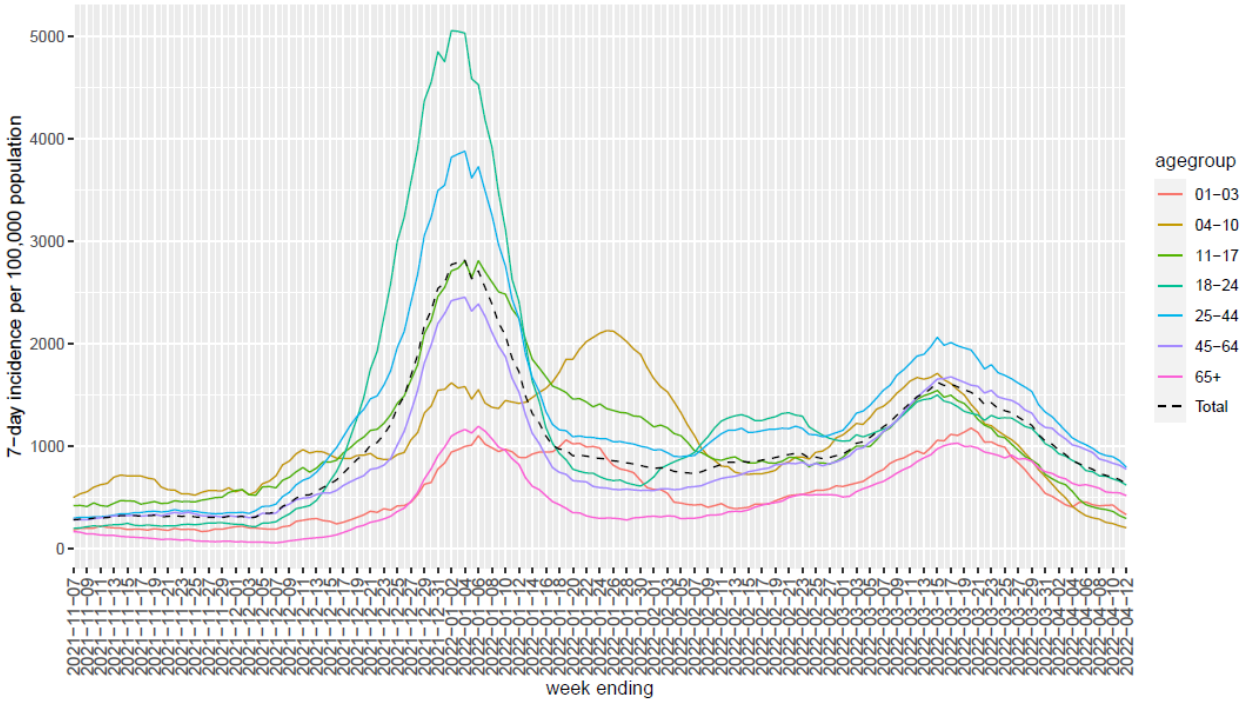


5.1.2 Incidence by age group

The rolling 7-day cumulative incidence across all age groups remained relatively stable in the course of November 2021, but showed a distinct increase from early December 2021 to early January 2022. The incidence across all the age groups decreased to the beginning of February and remained relatively stable over the last three weeks of February 2022. The most recent increase in 7-day incidence in all of the age groups was recorded from early to mid-March 2022. During this peak, the biggest absolute and relative increase in the 7-day cumulative incidence was observed in the week the 9th to the 15th of March 2022 in the age group of 25-44 years old, followed by the age group of 4-10 years old. The third highest incidence was recorded in the age group of 45-64 years old in the week of the 11th to the 17th March 2022. In the second half of March 2022, the 7-day cumulative incidence started to drop in all of the age groups and continued to decrease to date. In the most recent week, from 6th to the 12th April 2022, the biggest absolute

decrease was seen in the two working age groups. The highest incidence was observed in the age group of 25-44 years old, followed by the age group of 45-64 years old, and the lowest incidence was recorded in the age group of 4-10 years old (Figure 3).

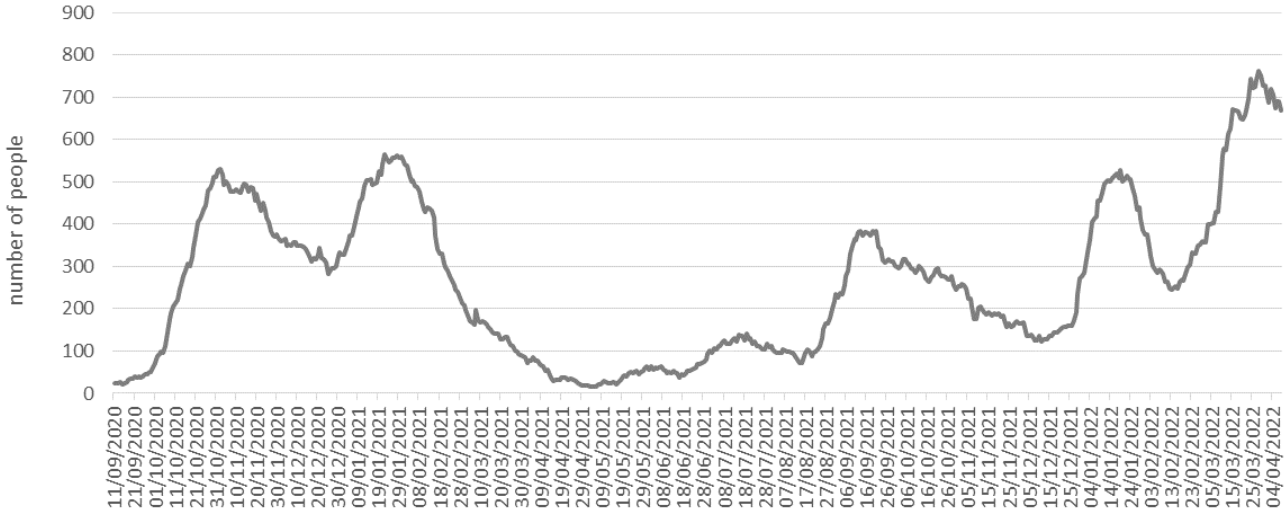
Figure 3: Rolling 7–day cumulative incidence of Covid–19 cases per 100,000 of population by date of notification and age group, including re-infections after 90 days, NHSGGC 01/11/2021-12/04/2022



5.1.3 Inpatients with recently confirmed COVID-19

A significant upward trend in the daily number of people in hospital with recently confirmed COVID-19 was observed from mid-December 2021 to mid-January 2022 and associated with the rapid spread of the Omicron variant (BA.1 sub-lineage). The daily COVID-19 cases in hospital peaked at 528 on 19 January and started to decline from the next day, until the 16th February 2022, when they reached 248 cases. The most recent steep increase in the number of COVID-19 hospital inpatients was observed from the 17th of February up to the 28th of March 2022 with a peak of daily COVID-19 cases in hospital of 762. Since then, the daily COVID-19 cases in hospital showed a decreasing trend, though with significant daily oscillation, reaching 670 on the 8th of April 2022 (Figure 4). From 01 March 2022, episodes of re-infection were included within COVID-19 inpatient reporting. Prior to this daily COVID-19 inpatients were based on an individual's first positive test result only. The new daily calculation includes both new infections and possible re-infections. The number reported does not take into account the reason for hospitalisation.

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



To monitor changes in disease severity, and inform planning, we estimated the proportion of admissions occurring 'with COVID-19' as an incidental finding (not the cause of their admission), as opposed to admissions occurring 'because of COVID-19' as a clinical presentation. For the time period 3rd of January to 13th of March 2022, out of the admissions to GGC hospitals with recent COVID-19 diagnosis (date of test from 14 days before up to 48h after admission) a mean of 44% of admissions were estimated to have COVID-19 as an incidental finding. There was substantial week on week variation, but overall an increasing trend was observed, with 48% in the first two weeks of March, estimated to have COVID-19 as an incidental finding, compared to 42% in the four weeks of January.

These estimates were based on categorisation from routine data available on or close to admission including emergency department presentation, admission type and admission ward. This method is less precise than final discharge coding in differentiation admissions 'with COVID-19' from those 'because of COVID-19', but estimates could be generated in a more timely fashion, as there are delays in discharge data being coded and becoming available. This method generates a conservative estimate (underestimate) of the proportion of admissions 'with COVID-19' as an incidental finding. It should also be noted that regardless of admission reason, all admissions with recent COVID-19 diagnosis contribute significantly to hospital pressures in association with the required infection prevention and control measures.

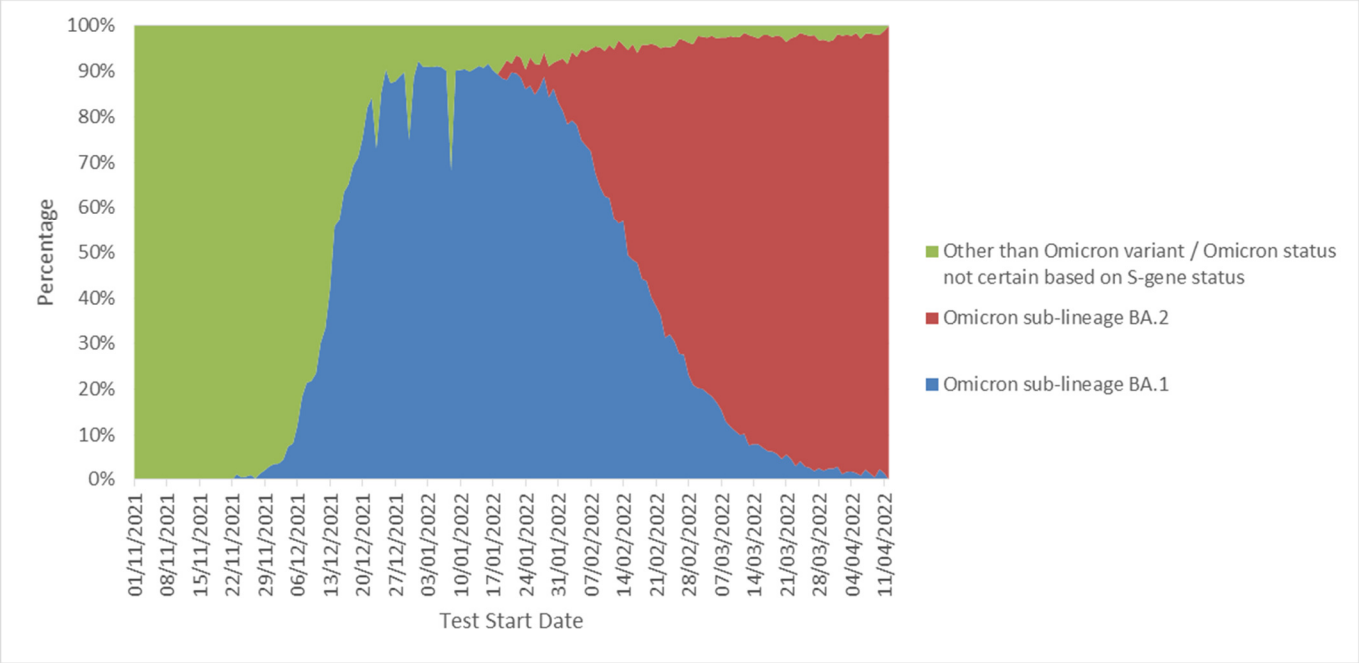
5.2 Omicron BA.1 and BA.2

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 the 26th of 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 BA.1 cases in Scotland, reported from the 25th of November (including cases residing in NHSGGC), 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. The BA.1 sub-lineage of Omicron 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. Omicron BA.1 became dominant in NHSGGC 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.

As shown in Figure 5, since the end of January, the proportion of samples with S-gene target failure started to drop. This is associated with increasing proportions of a second sub-lineage of Omicron called BA.2 (also known as 'stealth Omicron'). BA.2 was declared a variant under investigation (VUI-22JAN-01) on 19 January 2022 and does not contain the mutation that leads to S-gene target failure. As of mid-February 2022, the proportion of samples positive for the S-gene and likely to be the attributable to Omicron BA.2 exceeded 50%. The BA.2 sub-lineage became the new dominant SARS-CoV-2 variant in Scotland reaching 97% on 8 April 2022. Omicron BA.2 increased across the UK, and this growth advantage for BA.2 is thought to be due to its higher transmissibility.

Figure 5: Proportion of COVID-19 cases by variant including Omicron sub-lineages and test date, NHSGGC, 01/11/2021 - 12/04/2022 (data for last 4 days may not be complete)



From 19 January to 12 April 2022, 48381 infections (including 758 duplicates) were caused by Omicron BA.2 in NHSGGC based on UK Government Lighthouse PCR results. There is evidence that, 628 out of 47623 Omicron BA.2 cases had Omicron BA.1 infection previously, approximately 1.3%. On average, there were 75 days between two Omicron sub-lineage infections, ranging from 3 to 122 days.

5.3 Outlook

On the 15th of March 2022, in a statement to the Scottish Parliament, the First Minister announced changes to Test and Protect coming into force on the 18th of April 2022:

- most people without symptoms will no longer be asked to take COVID-19 tests,
- free lateral flow devices (LFDs) for the purposes of twice weekly routine testing will no longer be available for the general population, but will continue to be free for any purpose for which testing continues to be advised,

- until the end of April, people with symptoms should still isolate and get a PCR test,
- Vaccinated close contacts of someone with COVID-19 should continue to test daily for seven days with LFDs.

These forthcoming changes in testing strategy will make interpretation of trend data for community incidence increasingly challenging, and surveillance will transition to increasingly focus on severe presentation (hospitalisation and deaths).

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. Vaccination uptake continues across all age groups, with the over 75 year old 'Spring Booster; programme underway.

6.2 All NHS Greater Glasgow and Clyde, Health and Social Care Partnerships have started to vaccinate in care homes and for those who cannot travel to a vaccination clinic. The level of COVID infection in care homes means that this programme will take several weeks to conclude. The 'Spring Booster' for those who are immunosuppressed will start after Easter. The programme aims to have the majority of this phase completed by the end of June; this will leave a gap of at least 12 weeks, prior to the start of any autumn or winter Booster programme beginning at the end of September.

6.3 At present the Board continues to run a wide range of clinics from drop-ins to booked appointments for all types of vaccination, across all ages and NHSGGC continue to deliver vaccinations daily.

7.0 CONCLUSION

7.1 At this moment in time we are returning to an oscillating plateau of COVID-19 demand but with persistently high rates of both community and hospital COVID-19 figures. Our hospitals remain extremely busy with COVID-19 cases, high staff absences rate and system wide service pressures. However, we are at present beginning to see a downward trend in inpatient COVID occupancy. The Omicron variant in combination with the gradual removal of COVID-19 restrictions and the return to pre-pandemic social mixing in the community means 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.

7.2 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 have, and will, serve us well in the coming months and years.

7.3 As a Board, we will continue to lead and adapt to these challenges, to serve our patient and support our colleagues and partners.