Healthy London Partnership

Webinar: Homelessness services providers – preparedness for Omicron coronavirus variant

London Homeless Health Partnership

Tuesday 21 December 2021

Supported by and delivering for:

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

Overview

Agenda:
Omicron and the current news on COVID prevalence Who's at highest risk – how do we ensure we protect them most
What surveillance options are recommended What to do if someone is Covid positive?
Covid infection controls in homelessness settings
Vaccination uptake update and uptake of Covid and flu vaccinations
COVID isolation accommodation planning update
Q&A

Panel
Professor Andrew Hayward SAGE advisor University College London
Professor Alistair Story UCLH Find & Treat team
Gunveer Plahe London Coronavirus Response Cell, UK Health Security Agency
Dr Huda Yusuf NHS England & Improvement
Chaired by Jemma Gilbert Healthy London Partnership

Housekeeping:

- This session will be recorded and available on the HLP Covid resources webpage
- Attendees are in listen-only mode and can submit questions through the meeting chat box

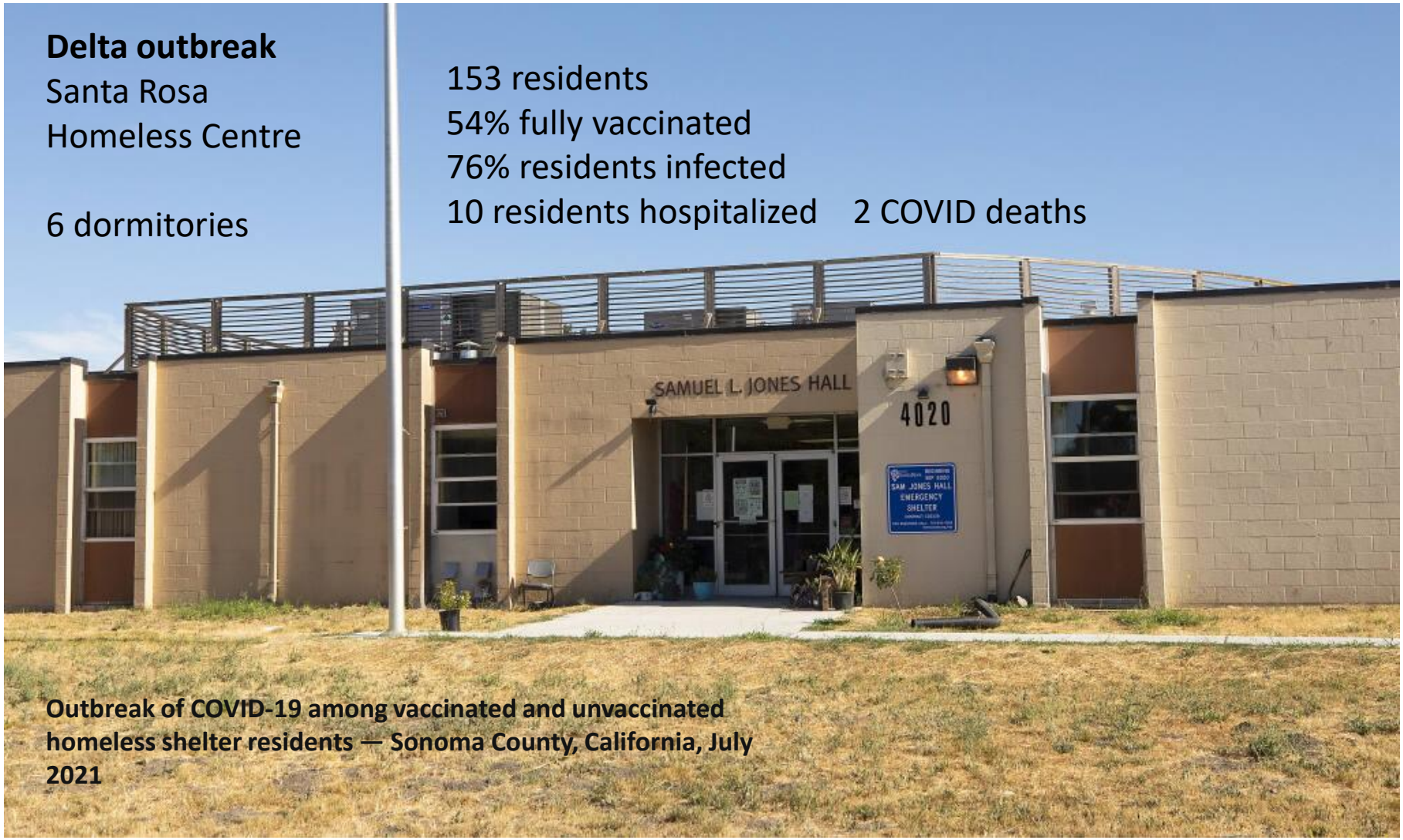
Omicron variant – what we know and clinical update

- Snapshot and current update on what we know about the Omicron coronavirus variant
- Who is at highest risk?
- How do we ensure we protect them most?
- Recommended surveillance options
- What to do if someone is Covid positive in settings?

Delta outbreak
Santa Rosa
Homeless Centre

6 dormitories

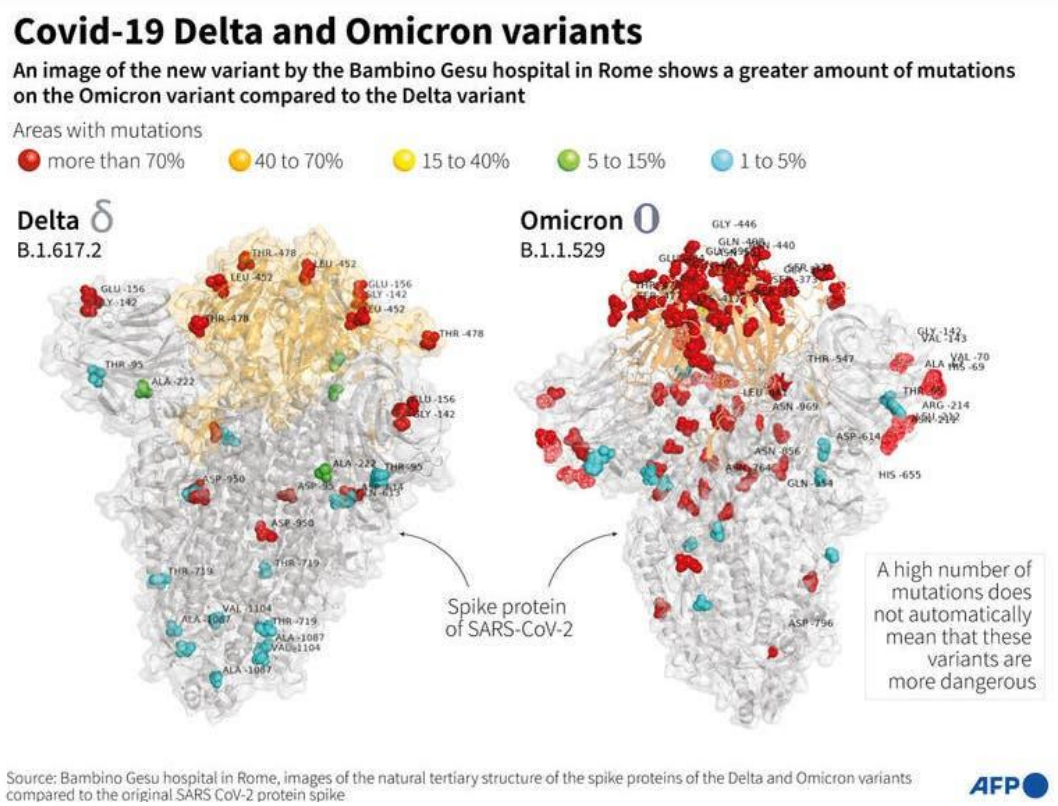
153 residents
54% fully vaccinated
76% residents infected
10 residents hospitalized 2 COVID deaths



Outbreak of COVID-19 among vaccinated and unvaccinated homeless shelter residents — Sonoma County, California, July 2021

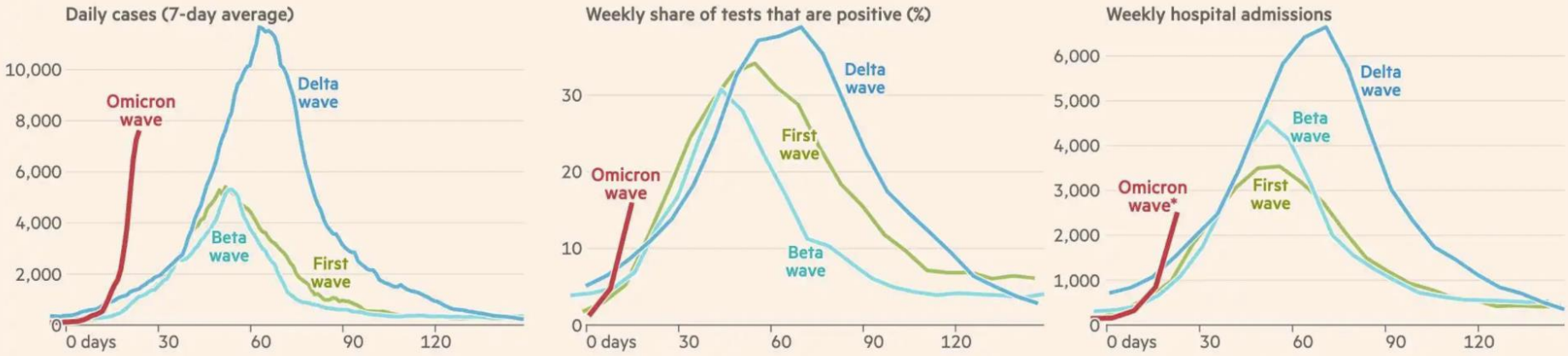
Omicron – The story so far.

Professor Andrew Hayward



Covid cases, test positivity and hospital admissions in Gauteng are rising far faster than in past waves

Cases, test positivity and hospital admissions in Gauteng province, by number of days since each wave began



*Hospital admissions adjusted to account for delay in data reporting
Source: FT analysis of data from South Africa's National Institute for Communicable Diseases
FT graphic by John Burn-Murdoch / @jburnmurdoch

Figure 1. Cumulative cases in England of variants indexed by days since the fifth reported case

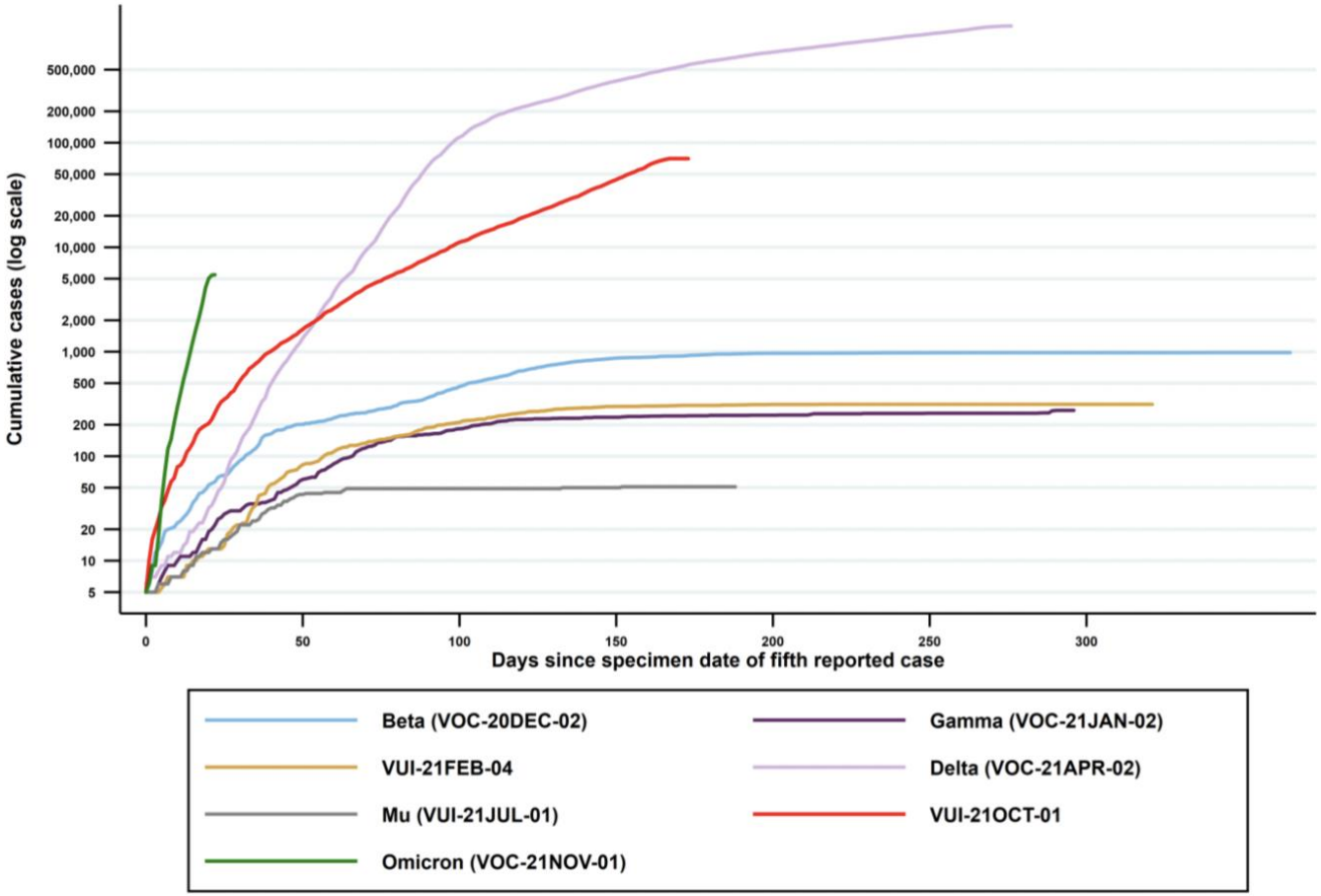
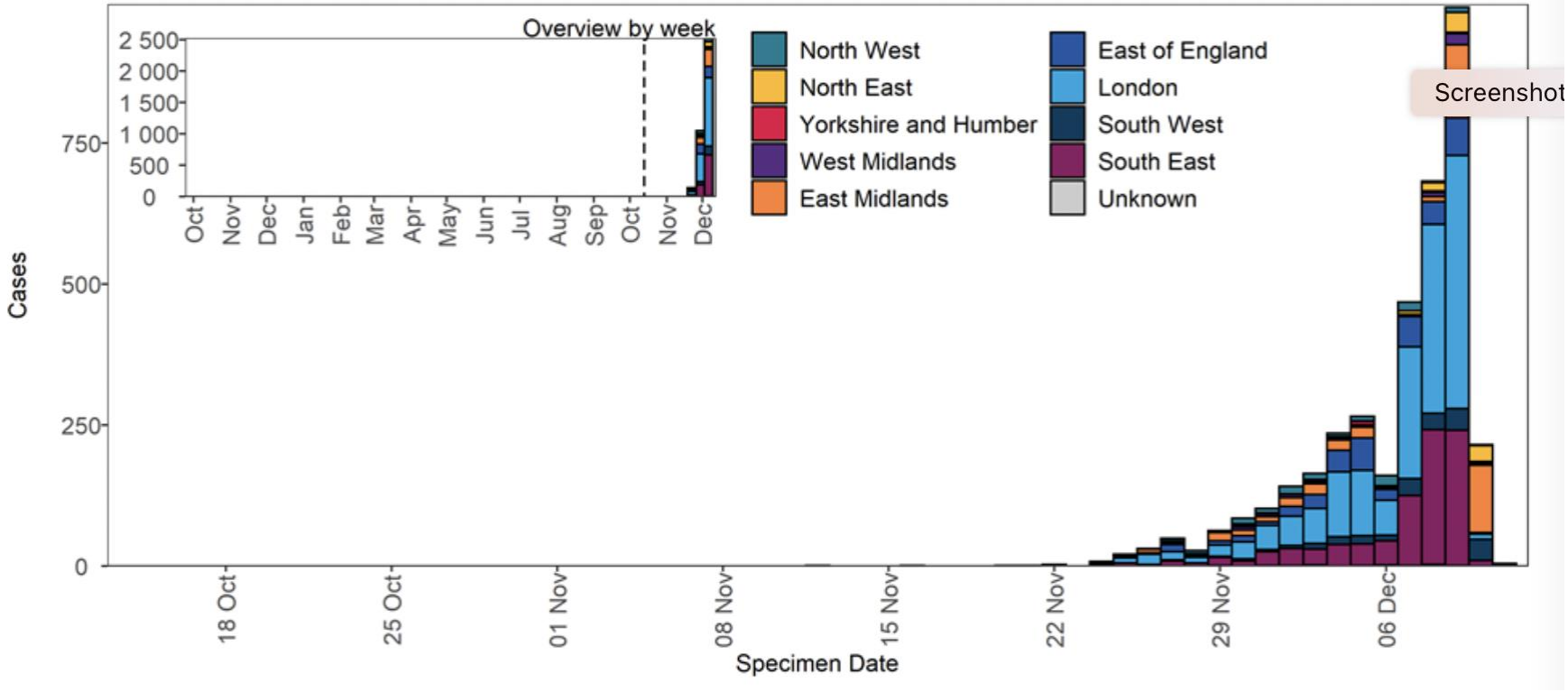


Figure 12. Cases of Omicron VOC-21NOV-01 (B1.1.529) in England by region as of 12 December 2021

(Find accessible data used in this graph in underlying data)



Omicron in the UK – compared to Delta

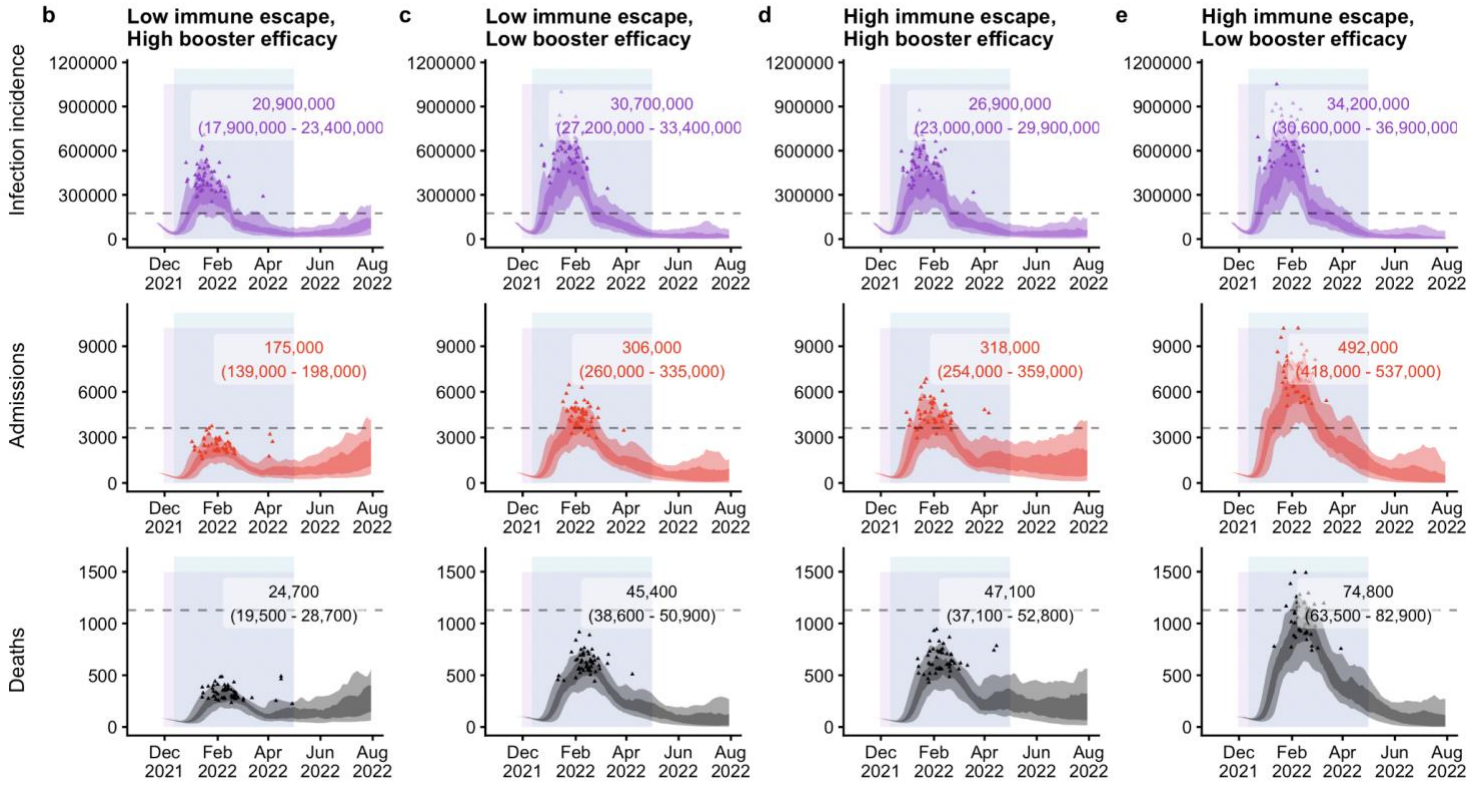
Household transmission increase	2.5-3.5 fold
Non household contacts as Delta increase	2 fold
Re-infection increase	3-5 fold
Lateral flow still works	
Antiviral drugs will still work	
no evidence of reduced hospitalisation rate (based on data from 15,000 cases)	

Vaccine effectiveness

	Delta symptomatic infection	Omicron symptomatic infection	Delta hospitalisation	Omicron hospitalisation – best guess!
2 AZ (25 weeks later)	42% effective	0% effective	80% effective	70-80%?
2 Pfizer (25 weeks later)	64% effective	37% effective	>90% effective	80-90%?
2AZ plus booster	94% effective	71% effective	> 98% effective	90-95%?
2 Pfizer + booster	93% effective	76% effective	>98% effective	90-95%?

NB – Even a single vaccine dose will provide valuable protection against severe disease

Never too late to be vaccinated

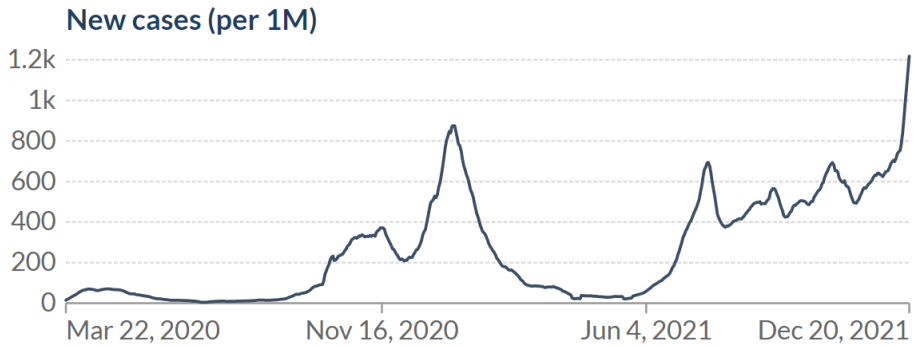

b
Low immune escape,
High booster efficacy
c
Low immune escape,
Low booster efficacy
d
High immune escape,
High booster efficacy
e
High immune escape,
Low booster efficacy
Infection incidence
Admissions
Deaths
20,900,000
(17,900,000 - 23,400,000
30,700,000
(27,200,000 - 33,400,000
26,900,000
(23,000,000 - 29,900,000
34,200,000
(30,600,000 - 36,900,000
175,000
(139,000 - 198,000)
306,000
(260,000 - 335,000)
318,000
(254,000 - 359,000)
492,000
(418,000 - 537,000)
24,700
(19,500 - 28,700)
45,400
(38,600 - 50,900)
47,100
(37,100 - 52,800)
74,800
(63,500 - 82,900)
Dec 2021
Feb 2022
Apr 2022
Jun 2022
Aug 2022

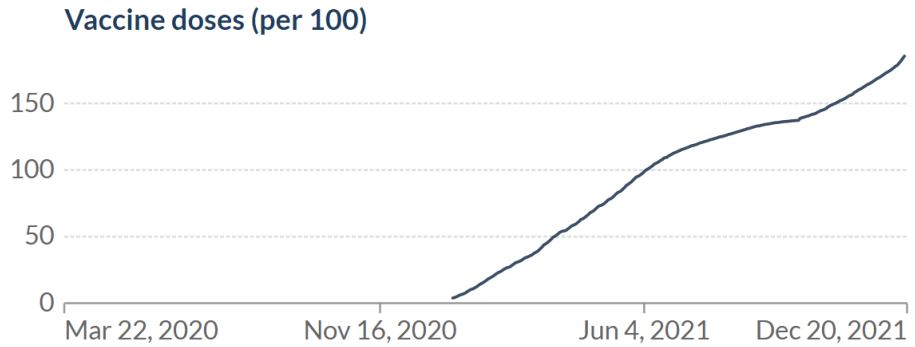
Scenarios with plan B and booster programe

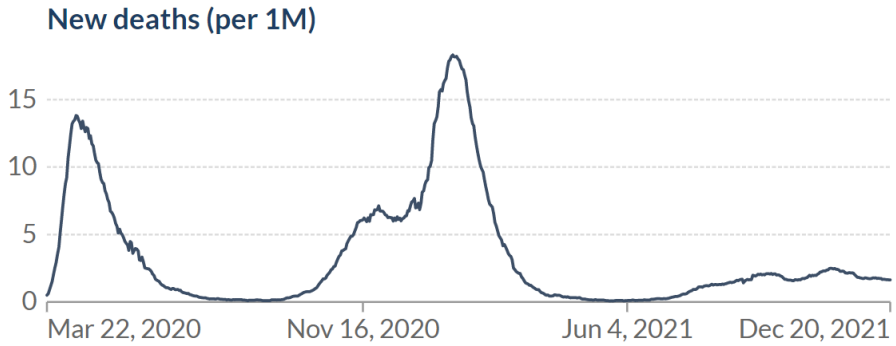
	Low immune escape – High booster efficacy.	Low immune escape – High booster efficacy	High immune escape – High booster efficacy	High immune escape low booster efficacy
Total Infections	21 million	31 million	27 million	34 million
Peak daily Infections	600,000	700,000	800,000	900,000
Total hospitalisations	175,000	306,000	318,000	492,000
Peak daily hospitalisations	> 3000	>5000	>6000	>8000
Total deaths	24,700	45,400	47,100	74,600
Peak daily deaths	> 400	> 600	> 700	> 1100

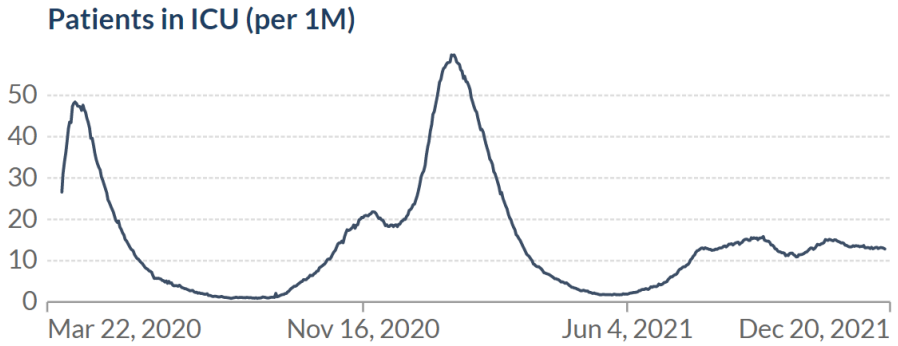
Based on Delta assumes less than 1 in 100 go to hospital and 1 in 1000 die
If severity is half that of delta then can half the number of hospitalisations and deaths

Outbreak caused by the SARS-CoV-2 Omicron variant in Norway, November to December 2021. Euro Surveill. 2021;26(50):pii=2101147. https://doi.org/10.2807/1560-7917.ES.2021.26.50.2101147


New cases (per 1M)
1.2k
1k
800
600
400
200
0
Mar 22, 2020
Nov 16, 2020
Jun 4, 2021
Dec 20, 2021


Vaccine doses (per 100)
150
100
50
0
Mar 22, 2020
Nov 16, 2020
Jun 4, 2021
Dec 20, 2021


New deaths (per 1M)
15
10
5
0
Mar 22, 2020
Nov 16, 2020
Jun 4, 2021
Dec 20, 2021


Patients in ICU (per 1M)
50
40
30
20
10
0
Mar 22, 2020
Nov 16, 2020
Jun 4, 2021
Dec 20, 2021

Symptoms

- Runny nose
- Headache
- Fatigue
- Sneezing
- Sore throat

Symptom onset

- Original = 5-6 days
- Alpha = 5 days
- Delta = 4 days
- Omicron = 3 days

Hospitals, care homes and other high-risk environments such as prisons and homeless shelters are extremely vulnerable to Omicron.

Enhanced prevention and control measures, along with more **frequent testing**, are urgent and essential, in addition to **increasing levels of vaccination**, to reduce potential for and severity of outbreaks, and to prevent outbreaks spilling back into the community

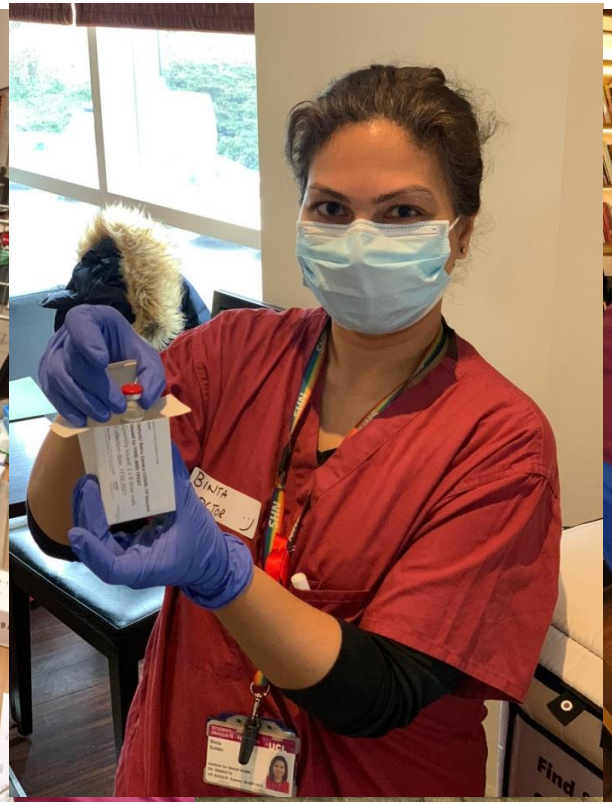
SAGE

Recommended additional mitigation measures

- Training and ongoing support to increase vaccination and regular testing of staff and residents
- Staff home testing and supporting residents to self-test twice weekly using Lateral Flow tests (LFT) with supported isolation of positives, clinical triage and confirmatory PCR testing

Contacts = Been within 1 metre of a PCR confirmed COVID-19 case for 1 minute or longer

From 14th December, people who have had at least two doses of any approved COVID-19 vaccine who are contacts of a PCR positive COVID-19 case can take a LTF every day for 7 days as an alternative to 10 days self-isolation



FIND & TREAT

We're here for you

Contacts of COVID-19 cases

Contacts of COVID-19 cases must isolate for 10 days unless they meet one of the following:

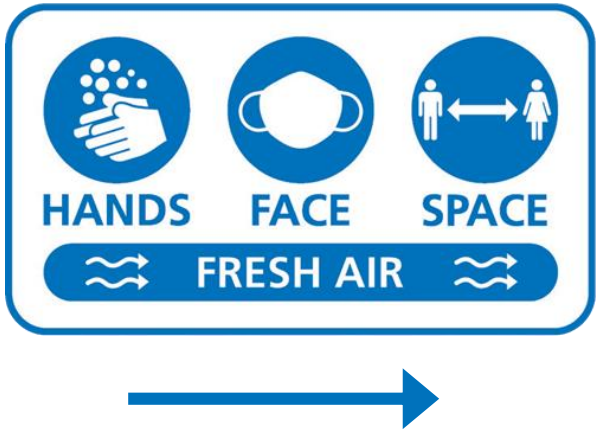
- Fully vaccinated
- Below 18 years 6 months
- Part of an approved COVID-19 vaccine trial
- Unable to get vaccinated for medical reasons

However, contacts should have a PCR test as soon as possible and should follow the advice for household or non-household contacts as a precaution

- ✓ **If they are 5 years and over and not legally required to isolate they are strongly advised to take a LFD test every day for 7 days or until 10 days since the last contact with the person who tested positive if this is earlier**
- ✓ limit close contact with other people outside their household, especially in enclosed spaces
- ✓ wearing a face covering in enclosed spaces and where it's not possible to maintain social distancing
- ✓ limiting contact with anyone who is clinically extremely vulnerable

Infection prevention & control

- Testing/isolation
- Hand hygiene
- Respiratory hygiene
- Cleaning
- Face coverings
- Social distancing
- Ventilation
- Vaccination



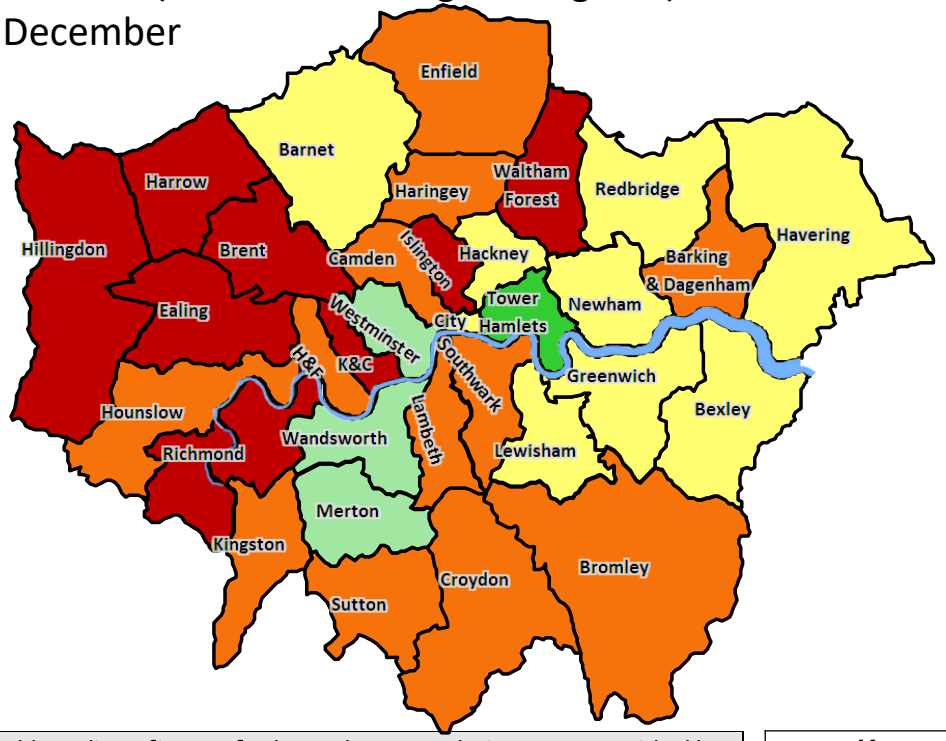
"Residents must wear face coverings by law when in communal indoor spaces in hostels, unless they are exempt for health, disability or other reasons."

"It is compulsory for staff to wear a face covering in areas of hostels that are open to the public and where they come or are likely to come within close contact of a member of the public, unless they are exempt for health, disability or other reasons."

Homeless population: Cumulative % of fully vaccinated within total target population

Boroughs	Values	% Change
City of London	52.6%	
Barking and Dagenham	26.1%	
Barnet	52.6%	
Bexley	49.1%	
Brent	7.5%	
Bromley	35.0%	
Camden	**26.9%**	**+ 2.1%**
Croydon	37.9%	
Ealing	13.1%	
Enfield	**25.7%**	**+ 7.6%**
Greenwich	43.6%	
Hackney	52.6%	
Hammersmith and Fulham	**27.0%**	**+ 4.3%**
Haringey	33.2%	
Harrow	0.0%	
Havering	**42.9%**	**- 0.4%**
Hillingdon	17.0%	
Hounslow	23.0%	
Islington	6.3%	
Kensington and Chelsea	8.1%	
Kingston upon Thames	27.3%	
Lambeth	33.4%	
Lewisham	43.1%	
Merton	61.0%	
Newham	**45.9%**	**- 4.3%**
Redbridge	41.3%	
Richmond upon Thames	2.9%	
Southwark	24.8%	
Sutton	20.1%	
Tower Hamlets	**83.4%**	**+ 0.5%**
Waltham Forest	**11.4%**	**+ 0.6%**
Wandsworth	68.6%	
Westminster	64.9%	

34% of target population in London have received both doses (38% local intelligence figures) as of 15 December



Local baselines figures for homeless populations are provided by ICSs and are subject to change
Due to the nature of the homeless cohort data, some double counting is likely as data is captured from multiple sources and different providers;
The data may not reflect the entirety of local vaccination activity
All %'s are calculated against local intelligence denominator figures

Key:
0-19%
20-39%
40-59%
60-79%
80-100%

Why is it important to vaccinate health inclusion groups

- **Vaccination uptake**: we have made considerable progress but need to prioritise health inclusion groups
- High underlying **clinical vulnerability levels** in this group mean **high risk of hospitalisation and death**
- **High risk of outbreaks** in shared accommodation settings
- New variant: **Omicron**

Vaccines continue to remain our best line of defence

2 doses of vaccine is highly effective **and**

the booster vaccine is highly recommended

How can you help us?

Prioritisation

of health inclusion groups for both flu and COVID vaccinations

- buy-in of service teams appears linked to higher uptake

Partnership

working with public health, CCG, voluntary sector, rough sleeping and homelessness leads

- estimating local denominator and sharing it with ICS and vaccination leads
- working with your vaccination borough lead to jointly plan and actively monitor offers and uptake to maximise uptake

Provision

- support data collection and vaccination uptake
- support the planning of a vaccination 'outreach' or 'drop in', and work in advance to encourage vaccination. Use peer support where possible
- outreach teams have a key role **identifying, encouraging and escorting** rough sleepers to 'drop in' provision including PCN sites and pharmacies. Please look at your local ICS website for up-to-date information

COVID isolation accommodation planning/ update

Guidance for residents contracting COVID is to isolate there where feasible

1.

-Find&Treat refer all clinically vulnerable COVID+ve patients to the GP for follow-up in oximetry@home pathway

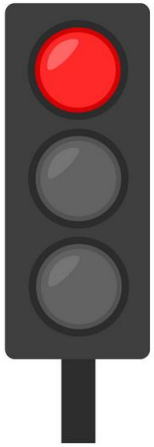
-Provide mobile phone + oximeter for clin vulnerable to access oximetry@home monitoring

-Support COVID+ve clinically vulnerable without GP registration until registered with GP, this is a very small minority of patients now.

-Escalate to A&E if acutely unwell

2.

Referrals into Mildmay or other local accommodation provisions for isolation



3.

Contact 999 if client is acutely unwell: new onset difficulty breathing/chest pain/non-responsive

Call 111 if any other concerns and not able to contact F&T for advice eg out of hours

COVID Protect / Isolate

COVID Protect

Each local area will have different arrangements. Local authorities are receiving £28m nationally

Additional 66 beds diverted from SWEP and brought on line pan-London to increase capacity - pan-London beds prioritised to the most Clinically vulnerable

Crisis at Christmas also supporting COVID protection

Supporting COVID Protect (-ve cases) isolation for people not currently in suitable accommodation

Rapid hospital discharge

Each London ICS will have additional hospital discharge capacity

COVID Isolate

Pan London Mildmay Hospital Current provisions of 10 stepdown and 4 COVID +ve care beds for people with the most complex care needs

Local isolation facilities Each ICS will be working with local housing teams to identify additional spot purchasing or accommodation sites