Safer Care Victoria

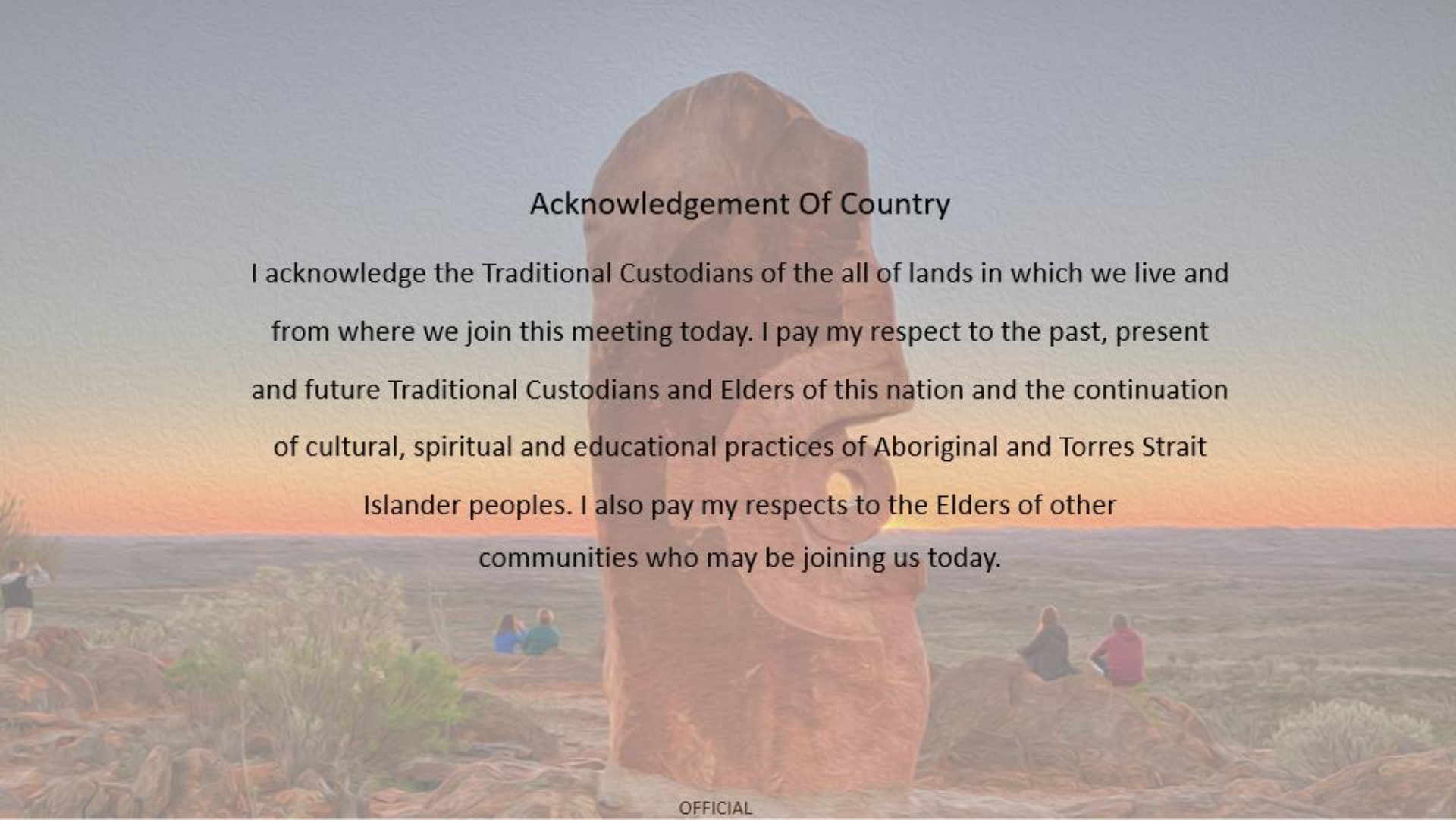
Wednesday 2 February 2022

COVID+ Pathway Learning Network webinar series

Webinar 14: Managing Omicron in the UK – *emergency care, critical care and antiviral treatment*

OFFICIAL

VICTORIA State Government



Acknowledgement Of Country

I acknowledge the Traditional Custodians of the all of lands in which we live and from where we join this meeting today. I pay my respect to the past, present and future Traditional Custodians and Elders of this nation and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples. I also pay my respects to the Elders of other communities who may be joining us today.

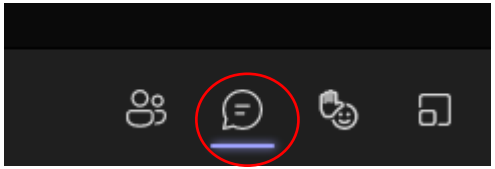
Webinar series purpose

- Showcase local clinicians who will share their experiences delivering the COVID+ Pathways model
- Provide a forum for sharing and collaboration to support the delivery of best practice

* To share your services' experiences, innovations and learnings in delivering the COVID+ Pathway at an upcoming webinar email centresofclinicalexcellence@safercare.vic.gov.au

Before we start

Throughout the webinar you can ask questions by typing your question into the chat.



There will also be a dedicated time for questions and discussions.

The presenters will do their best to answer your questions at the end of the presentation.

This session will be recorded and made available on the SCV website https://www.bettersafercare.vic.gov.au/support-training/learning-networks/covid-pathways

Overview

Topic	Presenter
National Clinical Evidence Taskforce update	A/Prof Steve McGloughlin
UK Omicron Data	Edmund King
Omicron in ED	Emma Roland Diana Lacey
Omicron in Critical Care	David O'Callaghan Dominic Spray
Testing, monoclonals and antivirals	Ailsa Willens Jane Fryer Prof Julia Wendon
Questions	

Safer Care Victoria Webinar
Taskforce Update

A/Prof Steve McGloughlin,
Executive Director

February 2, 2022

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

What is Paxlovid

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

- Paxlovid includes nirmatrelvir, which inhibits a SARS-CoV-2 protein to stop the virus from replicating, and ritonavir, which slows the breakdown of nirmatrelvir so it remains in the body for a longer period at higher concentrations.
- Approved by the TGA on 18 January 2022.
- Recommended for people with mild COVID-19, at high risk of severe disease, within first 5 days of symptoms
- Can be taken at home.
- The recommended dosage is 300 mg nirmatrelvir (two 150 mg tablets) with 100 mg ritonavir (one 100 mg tablet) taken together orally every 12 hours for 5 days.

New recommendations for Paxlovid

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Conditional recommendation

Consider using nirmatrelvir plus ritonavir within 5 days of symptom onset in unvaccinated adults* with COVID-19 who do not require oxygen and have one or more risk factors for disease progression.

Within the patient population for which nirmatrelvir plus ritonavir is conditionally recommended for use (see remark), decisions about the appropriateness of treatment with nirmatrelvir plus ritonavir should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, and COVID-19 vaccination status.

**Please note: Individuals who had received one or more doses of SARS-CoV-2 vaccine were excluded from the trial. The efficacy of nirmatrelvir plus ritonavir is unclear in partially or fully vaccinated individuals. See consensus recommendation for guidance on use of nirmatrelvir plus ritonavir in vaccinated patients or in immuncompromised patients regardless of vaccination status.*

New recommendations for Paxlovid

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Consensus recommendation

In addition to at-risk unvaccinated patients, also consider using nirmatrelvir plus ritonavir in patients within 5 days of symptom onset who do not require oxygen and:

- are immunosuppressed or not immunocompetent regardless of vaccination status; or
- have received one or two doses of vaccine and who are at high risk of severe disease on the basis of age and multiple risk factors.

*** Please refer to the remarks for critical information about:**

- dosage
- relevant risk factors
- important drug interactions
- confidence in evidence

What is molnupiravir (Lagevrio)?

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

- Molnupiravir works by introducing errors into the SARS-CoV-2 virus' genetic code, preventing the virus from further replicating.
- Approved by the TGA on 18 January 2022.
- Recommended for people with mild COVID-19 at high risk of severe disease, for whom other treatments aren't available/suitable, within first 5 days of symptoms
- Can be taken at home.
- The recommended dose of LAGEVRIO in adult patients is 800 mg (four 200 mg capsules) taken orally every 12 hours for 5 days.

New recommendations for molnupiravir (Lagevrio)

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Consensus recommendation

Consider use of molnupiravir within 5 days of symptom onset in unvaccinated* adults with COVID-19 who do not require oxygen and have one or more risk factors for disease progression, only where other treatments (such as sotrovimab or nirmatrelvir plus ritonavir) are not suitable or available.

Within the patient population for which molnupiravir is recommended for use (see remark), decisions about the appropriateness of treatment with molnupiravir should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, and COVID-19 vaccination status.

*Please note: Individuals who had received one or more doses of SARS-CoV-2 vaccine were excluded from the trial. The efficacy of molnupiravir is unclear in partially or fully vaccinated individuals. Additional recommendations for other patient groups are currently under development and will be included in a future version of the guideline.

Please refer to the remark for further critical information.

DISEASE-MODIFYING TREATMENTS FOR ADULTS WITH COVID-19

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

VERSION 2.0

PUBLISHED 31 JANUARY 2022

	Not requiring oxygen WITHOUT lower respiratory tract disease	Not requiring oxygen WITH lower respiratory tract disease	Requiring oxygen WITHOUT mechanical ventilation	Requiring invasive mechanical ventilation
DEFINITION OF DISEASE SEVERITY	**Mild** An individual with no clinical features suggestive of moderate or more severe disease: • no or mild symptoms and signs (fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhoea, loss of taste and smell) • no new shortness of breath or difficulty breathing on exertion • no evidence of lower respiratory tract disease during clinical assessment or on imaging (if performed)	**Moderate** A stable patient with evidence of lower respiratory tract disease: • during clinical assessment, such as – oxygen saturation 92-94% on room air at rest – desaturation or breathlessness with mild exertion • or on imaging	**Severe** A patient with signs of moderate disease who is deteriorating OR A patient meeting any of the following criteria: • respiratory rate ≥30 breaths/min • oxygen saturation <92% on room air at rest or requiring oxygen • lung infiltrates >50%	**Critical** A patient meeting any of the following criteria: • respiratory failure (defined as any of) – severe respiratory failure (PaO_2/FiO_2 <200) - respiratory distress or acute respiratory distress syndrome (ARDS) – deteriorating despite non-invasive forms of respiratory support (i.e. non-invasive ventilation (NIV), or high-flow nasal oxygen (HFNO)) – requiring mechanical ventilation • hypotension or shock • impairment of consciousness • other organ failure
RECOMMENDED			Use **dexamethasone** 6 mg daily intravenously or orally for up to 10 days (or acceptable alternative regimen) in adults with COVID-19 who are ***receiving oxygen*** (including mechanically ventilated patients).	

DMTs conditional recommendations for

CONDITIONAL RECOMMENDATION FOR

Not requiring oxygen WITHOUT lower respiratory tract disease	Not requiring oxygen WITH lower respiratory tract disease	Requiring oxygen WITHOUT mechanical ventilation	Requiring invasive mechanical ventilation
Consider using inhaled **budesonide** ***within 14 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression.		Consider using **remdesivir** in adults with COVID-19 who ***require oxygen but do not require non-invasive or invasive ventilation.***	
Consider using one of the following:			
Consider using **casirivimab plus imdevimab** ***within 7 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression. #	Consider using **casirivimab plus imdevimab** in ***seronegative*** adults hospitalised with moderate to critical COVID-19. *		
Consider using **sotrovimab** ***within 5 days of symptom onset*** in adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression. *Note: Refer to the related consensus recommendation for additional guidance.*		**Consider using one of the following:** Consider using **baricitinib** in adults hospitalised with COVID-19 who ***require supplemental oxygen.***	
Consider using **nirmatrelvir plus ritonavir** ***within 5 days of symptom onset*** in ***unvaccinated*** adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression. Within the patient population for which nirmatrelvir plus ritonavir is conditionally recommended for use (see remark), decisions about the appropriateness of treatment with nirmatrelvir plus ritonavir should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, and COVID-19 vaccination status. *Note: Refer to the related consensus recommendation for additional guidance.*		Consider using **tocilizumab** for the treatment of COVID-19 in adults ***who require supplemental oxygen,*** particularly where there is evidence of ***systemic inflammation.***	
		Consider using **sarilumab** for the treatment of COVID-19 in adults who ***require high-flow oxygen, non-invasive ventilation or invasive mechanical ventilation.*** *	

DMTs consensus recommendations for

	Not requiring oxygen WITHOUT lower respiratory tract disease	Not requiring oxygen WITH lower respiratory tract disease	Requiring oxygen WITHOUT mechanical ventilation	Requiring invasive mechanical ventilation
CONSENSUS RECOMMENDATION FOR	Within the patient population for which **sotrovimab** is conditionally recommended for use (as listed above), decisions about the appropriateness of treatment with sotrovimab should be based on the patient's individual risk of severe disease, on the basis of age or multiple risk factors^, and COVID-19 vaccination status. Consider using **sotrovimab** in unvaccinated or partially vaccinated patients and patients who are immunosuppressed regardless of vaccination status. Do not routinely use sotrovimab in fully vaccinated patients unless immunosuppressed.			
	In addition to at-risk unvaccinated patients, also consider using **nirmatrelvir plus ritonavir** in patients ***within 5 days of symptom onset who do not require oxygen*** and: • are ***immunosuppressed or not immunocompetent*** regardless of vaccination status; or • have received one or two doses of vaccine and who are at ***high risk of severe disease*** on the basis of age and multiple risk factors^.			
	Consider use of **molnupiravir *within 5 days of symptom onset*** in ***unvaccinated*** adults with COVID-19 who ***do not require oxygen*** and have one or more ***risk factors***^ for disease progression, only where other treatments (such as sotrovimab or nirmatrelvir plus ritonavir) are not suitable or available. Within the patient population for which molnupiravir is recommended for use (see remark), decisions about the appropriateness of treatment with molnupiravir should be based on the patient's individual risk of severe disease, on the basis of age and multiple risk factors, and COVID-19 vaccination status.			

On the Taskforce agenda this week

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

- Additional recommendations for molnupiravir to clarify its use in people who are fully or partially vaccinated;
- Revisions to the sotrovimab recommendations in light of the new recommendations for molnupiravir and nirmatrelvir plus ritonavir.

These new treatments will also be considered by our special population panels to determine whether additional specific recommendations are needed for these groups.

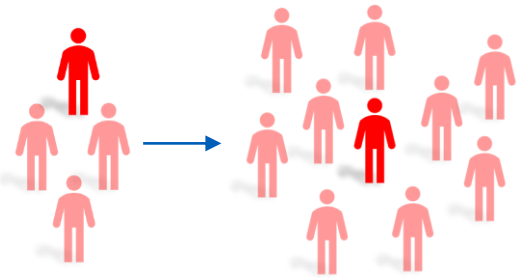
UK Presentations: Managing Omicron

Omicron Experience in the Emergency Department

Dr Emma Rowland; Emergency Medicine Consultant Homerton Hospital, Associate Medical Director IMRS Division
Diana Lacey; Director of Urgent and Emergency Care, NHS England / NHS Improvement (London Region)

Delta vs Omicron; key differences

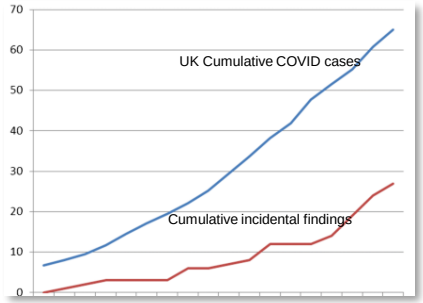
Greater infectivity



Impact on workforce

Vaccinated population

Incidental COVID



Delta vs Omicron; impact on people

Patients

- Milder disease
- More “Incidental” diagnosis
- Increase need for general and acute bed capacity
- Anecdotally less complications

- Disease profile similar to Delta
- Less ITU and NIV - unvaccinated patients rather than clinical picture?

Workforce

- Increased experience with COVID; more confident
- High levels of sickness and isolation
- Changes to the staffing models within the Emergency Departments and hospital wards

Delta vs Omicron; processes

Within ED

Admission

Discharge

Consequences

North West London
Integrated Care System
Working together for better health and care

North-West London Adult Critical Care update

David O'Callaghan, Shrey Thakran –
Updated 20th January 2022

NWL ICS

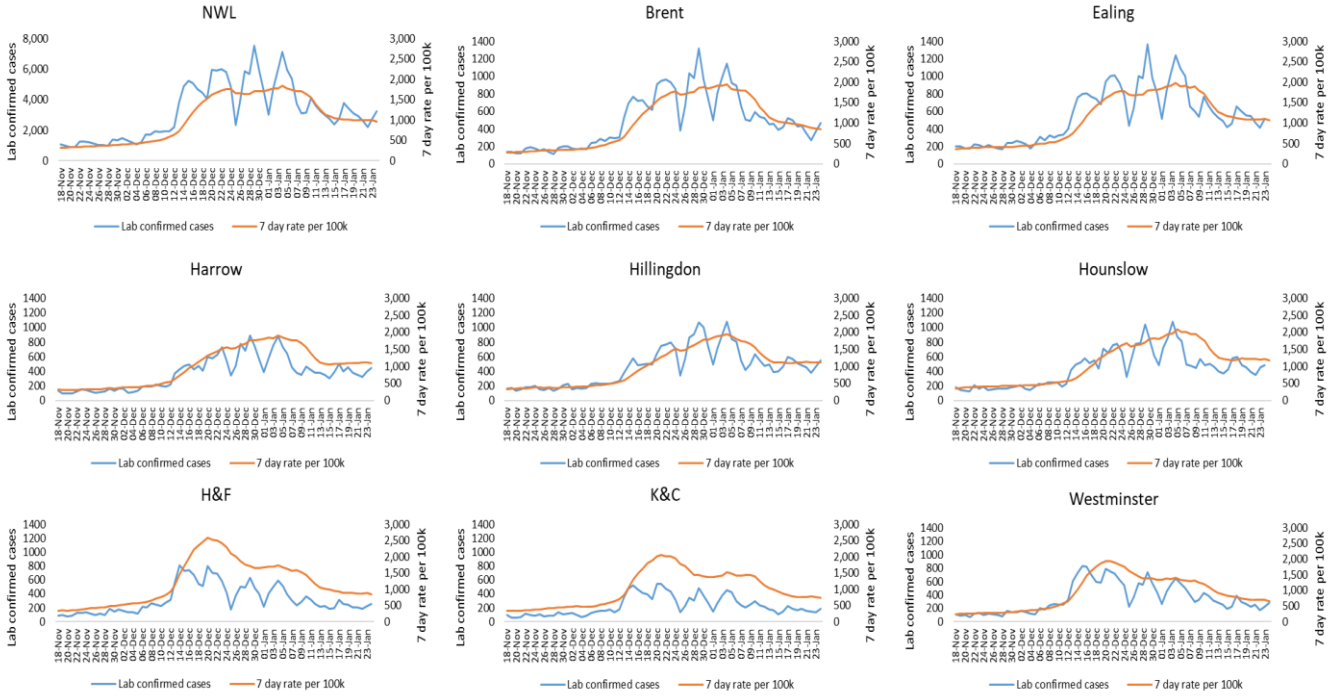
ICS	Current Baseline	Population	Current CC beds per 100k of population	Population (16+)	Current CC beds per 100k of population of 16+ population
NEL	181	2,200,000	8	1,870,000	10
NCL	189	1,600,000	12	1,360,000	14
NWL	141	2,400,000	6	2,040,000	7
SEL	273	2,000,000	14	1,700,000	16
SWL	130	1,500,000	9	1,275,000	10
LONDON TOTAL	**914**	**9,700,000**	**9**	**8,245,000**	**11**

North West London Integrated Care System

NWL COVID Leading Indicators Laboratory-confirmed cases (pillar 1 + 2 testing)

Pillar 1 = swab testing in Public Health England (PHE) labs and NHS hospitals for those with a clinical need, and health and care workers

Pillar 2 = swab testing for the wider population, as set out in government guidance



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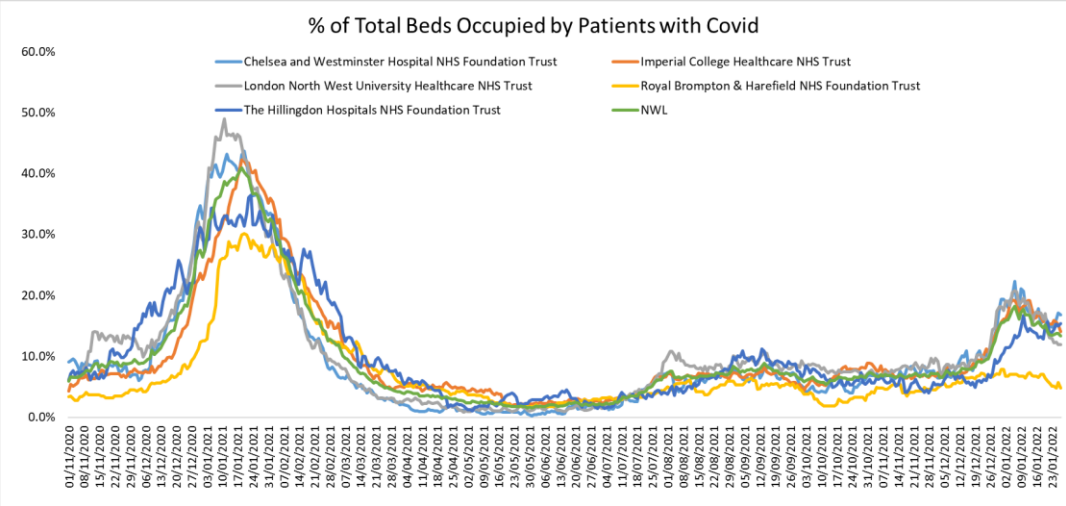
COVID bed occupancy trend by acute provider



% of Total Beds Occupied by Patients with Covid	21-Jan	22-Jan	23-Jan	24-Jan	25-Jan	26-Jan	27-Jan
Chelsea and Westminster Hospital NHS Foundation Trust	15.6%	15.2%	14.8%	15.0%	16.1%	17.2%	16.8%
Imperial College Healthcare NHS Trust	15.3%	15.4%	15.3%	15.9%	15.6%	15.2%	14.1%
London North West University Healthcare NHS Trust	13.9%	13.1%	13.0%	12.3%	12.3%	12.0%	12.0%
Royal Brompton & Harefield NHS Foundation Trust	6.0%	5.7%	5.1%	5.1%	4.8%	5.7%	4.9%
The Hillingdon Hospitals NHS Foundation Trust	15.7%	13.8%	14.0%	14.4%	15.3%	15.0%	15.4%

NWL	14.1%	13.6%	13.4%	13.5%	13.7%	13.8%	13.3%

North West London Integrated Care System

Adult Critical Care – at 10 January 2022

London	7 day average	3 day average	2 day change [Today to Prior day]		Today
Covid	(1%)	-%	↑ 10	5%	220
Suspected	1%	1%	↓(9)	(30%)	21
Non-Covid	1%	(1%)	↑ 8	1%	583
Total	-%	(1%)	↑ 9	1%	824
CPAP/NIV outside of ACC	Covid		↓(11)	(14%)	66
	Total		↓(11)	(14%)	66

Stretch	% Covid	Actual Nurse to patient ratio is:	MV	Critcon 0B - 2	
Over 90% - 9	Over 30% - 13	Below Theoretical required ACC nurse ratio - 25	Over 50% - 18	Critcon 1B - 2	
Over 100% - 10	Over 50% - 4	Matched to the Theoretical required ACC nurse ratio - 2	Over 70% - 4	Critcon 2B - 4	Decompression requested - 3
		Stretched above Theoretical required ACC nurse ratio - 6		Critcon 2A - 11	

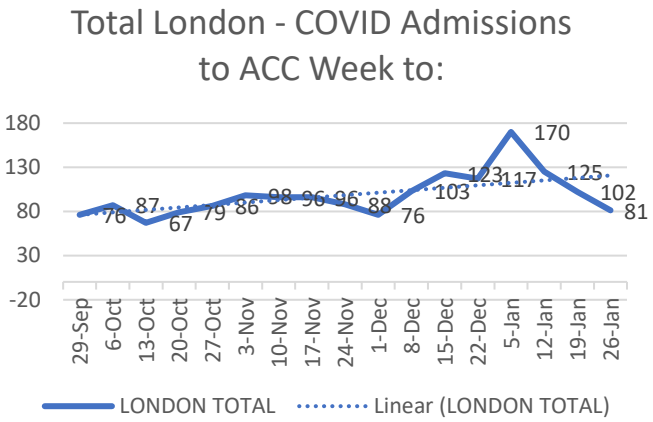
Hospital	Baseline	COVID+	Total Occupied Beds	Occupied Stretch Above Baseline	<<<< ICS Totals	% Covid	<<<< ICS Totals	Theoretical required ACC Nurse to Patient ratio based on acuity (1:x)	Actual ACC Nurse to patient ratio - (1:x)	Actual All Nurse to patient ratio - (1:x)	MV patients as a % of occupied	<<<< ICS Aver.	RRT	CPAP/NIV patients outside of ACC	CPAP/NIV patients outside of ACC % Covid	Critcon	Require decompression transfer
King George	8	7	8	100%		88%		1.1	1.0	1.0	75%		0	6	50%	2A	N
Queen's [Romford]	44	12	44	100%		27%		1.4	1.8	1.8	39%		6	7	57%	2B	N
The Royal London	44	15	53	120%		28%		1.5	1.3	1.3	38%		9	14	50%	2A	N
Newham University	7	8	13	186%		62%		1.4	1.9	1.9	38%		1	6	67%	2B	Y
Whipps Cross	17	5	12	71%		42%		1.3	1.0	1.0	58%		2	9	56%	1A	N
St Bartholomew's	53	3	29	55%		10%		1.6	1.0	1.0	28%		8	3	33%	1A	N
Homerton	8	7	15	188%		47%		1.3	1.0	1.0	60%		0	1	100%	2A	N
NEL	181	57	174		96%		33%				41%	57%	26	46			
North Middlesex	20	8	20	100%		40%		1.3	1.1	1.1	55%		6	Unknown	Unknown	2A	N
Royal Free	46	10	46	100%		22%		1.3	1.0	1.0	57%		12	0	-	2A	N
Barnet	23	5	20	87%		25%		1.7	1.2	1.2	15%		1	1	100%	2A	N
UCLH	78	6	55	71%		11%		1.4	1.0	1.0	40%		4	0	-	2A	N
Whittington	10	7	11	110%		64%		1.3	1.0	1.0	55%		1	0	-	2A	Y
Royal National Orthopaedic	12	0	2	17%		0%		2.0	1.0	1.0	0%		0	0	-	0A	N
NCL	189	36	154		81%		23%				44%	35%	24	1			
Chelsea and Westminster	11	2	14	127%		14%		1.1	1.1	1.1	86%		2	9	56%	1A	N
West Middlesex	9	3	9	100%		33%		1.3	1.0	1.0	56%		4	7	29%	0A	N
Hammersmith	28	6	30	107%		20%		1.3	1.2	1.2	50%		4	0	-	2B	Y
Charing Cross	24	6	30	125%		20%		1.2	1.0	1.0	63%		3	2	100%	1B	N
St Mary's	32	4	29	91%		14%		1.3	1.0	1.0	55%		2	3	100%	0A	N
Ealing	6	3	6	100%		50%		1.2	1.0	1.0	67%		1	4	50%	2A	N
Northwick Park	22	8	23	105%		35%		1.2	1.0	1.0	61%		3	8	38%	2A	N
Hillingdon	9	3	11	122%		27%		1.2	1.4	1.0	73%		3	11	45%	1A	N
Royal Brompton	36	10	25	69%		40%		1.3	1.2	1.0	56%		3	4	0%	0A	N
Harefield	34	1	26	76%		4%		1.2	1.2	1.2	62%		7	3	0%	1A	N
NWL	211	46	203		96%		23%				45%	65%	32	51			
King's College	83	12	81	98%		15%		1.3	1.2	1.2	58%		19	5	100%	1B	N
Princess Royal University	10	3	8	80%		38%		1.2	1.0	1.0	63%		3	2	0%	0A	N
Queen Elizabeth	18	3	13	72%		23%		1.4	1.1	1.1	46%		2	6	17%	0B	N
Lewisham	18	6	16	89%		38%		1.5	1.5	1.5	38%		5	11	45%	0B	N
Guy's and St Thomas'	87	19	60	69%		32%		1.4	1.1	1.1	47%		11	0	-	0A	N
SEL	216	43	178		82%		24%				61%	41%	40	24	-		
St George's	66	22	69	105%		32%		1.3	1.4	1.4	58%		5	6	17%	2B	N
Croydon	15	6	11	73%		55%		1.2	1.6	1.2	64%		2	3	0%	1A	N
The Royal Marsden	16	0	6	38%		0%		1.5	1.0	1.0	33%		0	0	-	0A	N
Kingston	12	4	11	92%		36%		1.1	1.0	1.0	82%		3	5	40%	2A	N
Epsom and St Helier	21	6	18	86%		33%		1.4	1.6	1.2	44%		3	11	36%	0A	N
SWL	130	38	115		88%		33%				57%	47%	13	25			
London Total	927	220	824		89%		27%				51%		135	147			

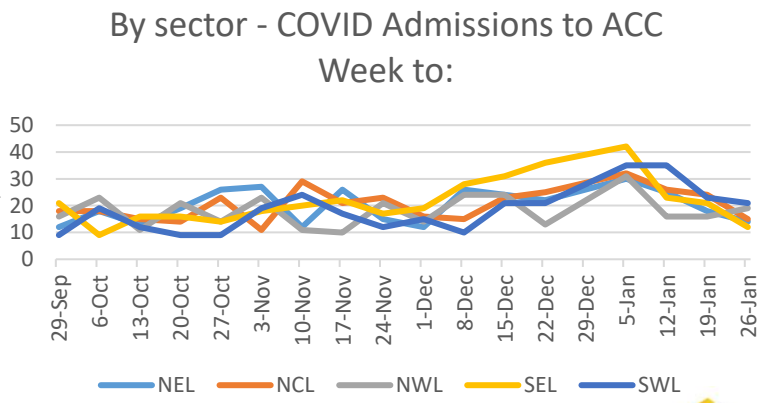
1. CPAP/NIV outside of ACC is from Friday 07 January 2022 and compared to Thursday 06 January 2022 data.

North West London Integrated Care System

Covid Admissions

ICS	COVID Admissions to ACC Week to: 13-Oct	20-Oct	27-Oct	03-Nov	10-Nov	17-Nov	24-Nov	01-Dec	08-Dec	15-Dec	22-Dec	05-Jan	12-Jan	19-Jan	26-Jan	Variance from 19 Jan	Variance from 19 Jan %
NEL	13	19	26	27	12	26	15	12	26	24	22	30	25	18	14	(4)	(22%)
NCL	15	14	23	11	29	21	23	16	15	23	25	32	26	24	15	(9)	(38%)
NWL	11	21	14	23	11	10	21	14	24	24	13	31	16	16	19	3	19%
SEL	16	16	14	18	20	22	17	19	28	31	36	42	23	21	12	(9)	(43%)
SWL	12	9	9	19	24	17	12	15	10	21	21	35	35	23	21	(2)	(9%)
Total	**67**	**79**	**86**	**98**	**96**	**96**	**88**	**76**	**103**	**123**	**117**	**170**	**125**	**102**	**81**	(21)	(21%)

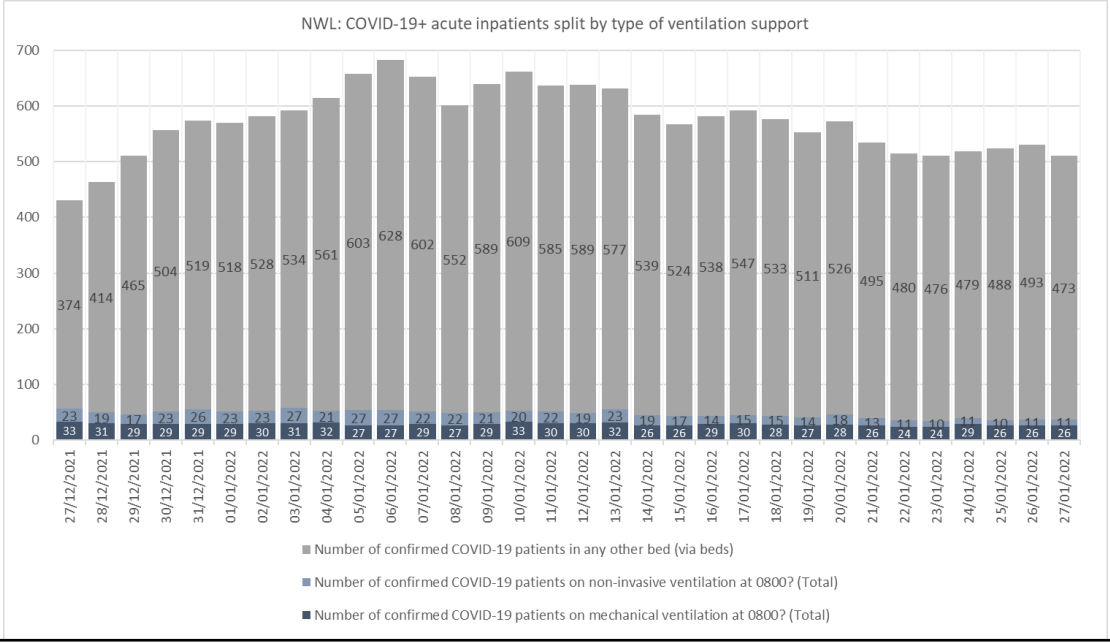




Note: see Appendix for graphs for longer periods of time

North West London Integrated Care System

Confirmed COVID patients on MV, NIV and G&A at 08:00



This graphs shows the patients on MV/NIV/G&A at 08:00 hours. Reason for variation between this slide and confirmed beds is that confirmed beds is over the last 24 hours whilst patients is a snapshot as at 08:00.

North West London Integrated Care System

ITU Occupancy: Elective, Emergency, Covid & Non-Covid split

- Based on weekly NHSE/I London spot audit data from trusts.
- As of 26th January 2022, out of the total ITU beds occupied:
  - 65% of patients were Non-Covid emergency cases (lowest at 53% on 22nd Sep 2022)
  - 14% of patients were Non-Covid elective cases (lowest at 7% on 24th Nov 2021)
  - 21% of patients were Covid positive confirmed or suspected cases (lowest at 6% on 14th May 2021)

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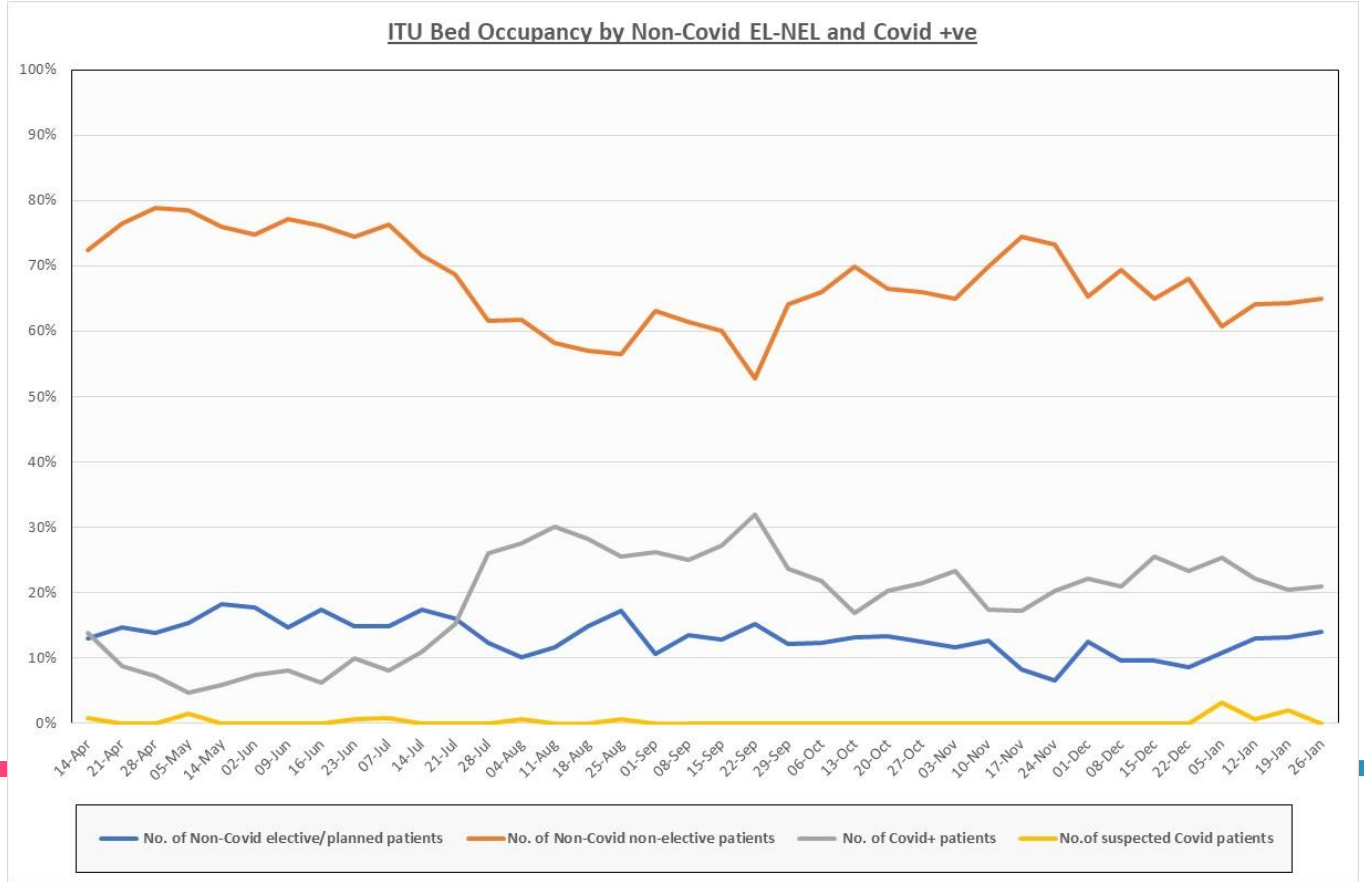
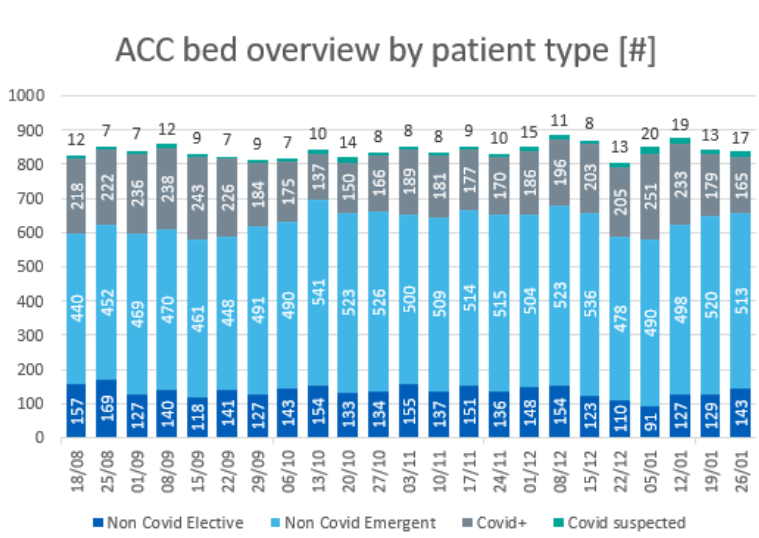
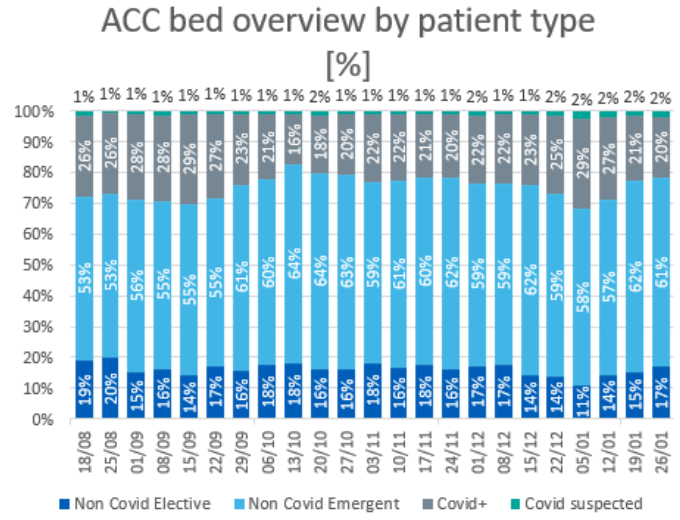


ACC Bed Overview by Patient Type

In total, there are 165 Covid+ patients on 26 January, compared to 179 Covid+ patients on 19 January.
Compared to 19 January:

- Non-Covid elective activity – totals 143 patients – has increased by 14 patients.
- Non-Covid emergent activity – totals 513 patients – has decreased by 7 patients.
- Covid activity – totals 165 patients – has decreased by 14 patients.
- Covid suspected – totals 17 patients – an increase of 4 patients.

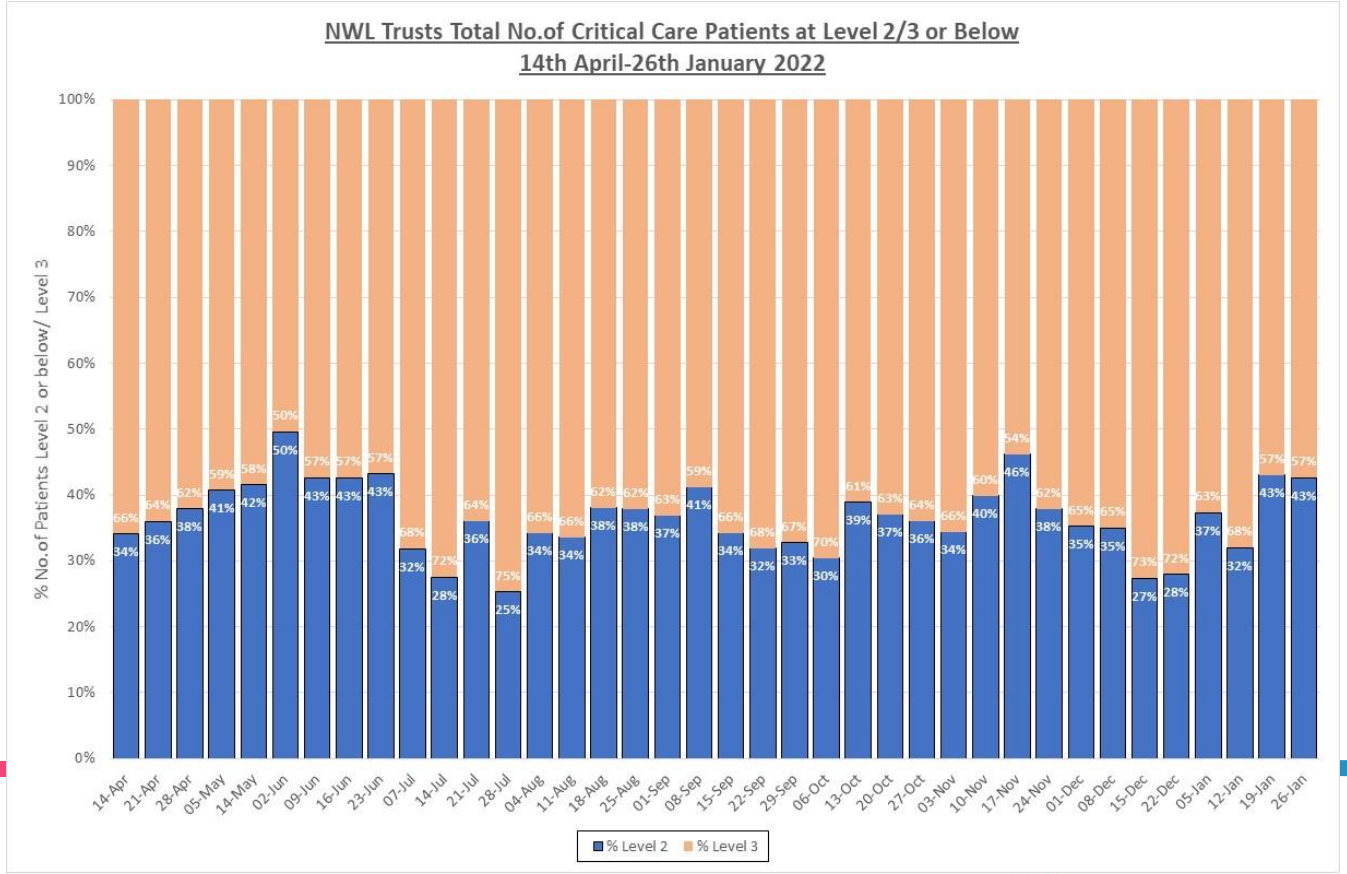




North West London Integrated Care System

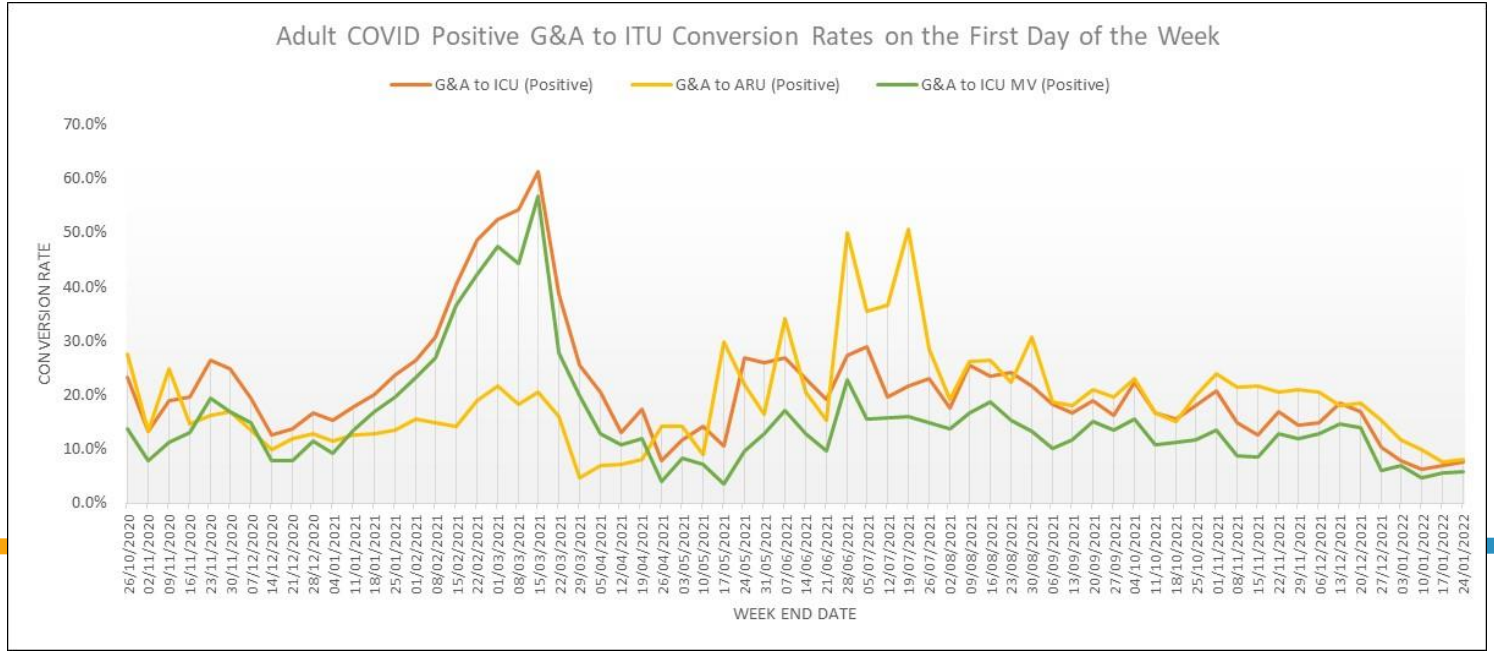
NWL aggregate – Level of Acuity (L3/2 % split trend)

- Acuity % split for NWL has varied between 50%:50% to 75%:25% (L3:L2).
- On average from April 2021 to date the split has been 64%:36% (L3:L2)
- As of this week the acuity has slightly reduced at 57%:43% and is lower than the average.



G&A to ICU and ARU conversion

- Data point: first day of the week **(26/10/2020 – 24/01/2022)**
- G&A to ICU conversion for Covid positive patients has been lowest at 8% this week (in comparison to 61% highest in March 2021) – has been decreasing since March 2021
- G&A to ICU conversion for Covid positive patients who needed mechanical ventilation has decreased since March 2021 as well (6% now to 57% on 15th March 2021) and has been decreasing in the recent few weeks.
- These data may suggest that a lower rate of mechanical ventilation for the current cohort of Covid positive patients in G&A beds.



North West London Integrated Care System

Omicron vs Delta cases in ITU and Length of Stay

- As of 12th January 2022, out of the total Covid positive cases in ITU beds:
  - 35% were Omicron variant cases
  - 50% were Delta/other variants
  - Average length of stay was 16 days (highest at Northwick Park and the lowest at Hillingdon Hospital)
  - There were 7 patients on the day with a length of stay of over 40 days (long-stay patients).

	12th January 2022						
Trust	Total Number of Covid+ patients in ICU	Total Number of Covid+ patients in ICU with Omicron variant	Total Number of Covid+ patients in ICU with Delta/Any Other variants	Average Length of Stay for Covid+ patients in ICU	Number of Covid+ patients exceeding the average length of stay currently	Any Covid+ patients with length of stay over 40 days in ICU (any variant)	**Comments**
Chelsea And Westminster Hospital NHS FT	4	1	2		0	0	
Chelsea & Westminster Hospital	2	1	1	17.5 days	0	0	
West Middlesex Hospital	2	0	1	20 days	0	0	1 unknown variant at present
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	15	6	5		6	4	
St Mary's Hospital	4	1	3	18 days	2	1	58 days
Charing Cross Hospital	5	2	1	17 days	2	2	86 and 57 days
Hammersmith Hospital	6	3	1	18 days	2	1	79 days
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	12	3	9		7	3	
Northwick Park Hospital	8	2	6	25 days	4	3	We have two known Delta patients who have been in for 40 and 44 days respectively at NPH ICU.
Ealing Hospital	4	1	3	7.75 days	3	0	
The Hillingdon Hospitals NHS FT	3	2	1	3 days	0	0	
NWL	**34**	**12**	**17**	**16 days**	**13**	**7**	

North West London Integrated Care System

Vaccination Status data for Covid+ patients in ITU

- As of 19th January 2022,
  - 56% of the Covid positive patients in ITU were unvaccinated.
  - 27% of the Covid positive patients in ITU were fully vaccinated including the booster dose.
  - 10% of the Covid positive patients in ITU were those who have had 1 or 2 doses but not due for a booster yet.
  - 7% of the Covid positive patients in ITU were those who are due a booster dose but haven't had one yet.

Spot check on unvaccinated or no booster jab - 19th January 2022						
Trust	Total number of Covid patients in ICU*	Number of Covid ITU patients fully vaccinated inc. booster	Number of Covid ITU patients who are unvaccinated (no jabs)	Number of Covid ITU patients who are due a booster jab but haven't had one	Number of Covid ITU patients with 1 dose or 2 doses but not due for a booster jab	Comments
Imperial	10	2	6	1	1	
ChelWest	5	3	2	0	0	
LNWHT	14	2	7	2	3	
Hillingdon	3	1	2	0	0	1 patient is unknown mail and vaccination status cannot be verified
RBHT	9	3	6	0	0	
Total	**41**	**11**	**23**	**3**	**4**	

COVID-19 Testing, monoclonals and antivirals

Ailsa Willens, *Pathology program director NHSE London region*

Jane Fryer, *Deputy medical Director London region NHSE*

Professor Julia Wendon, *Consultant Intensivist Kings College Hospital, Kings College London*

COVID-19 Testing

- COVID-19 testing remains a key part of our IPC measures:
  - Patient testing pre-admission; at frequent intervals during inpatient stay; and prior to discharge to other care settings.
  - Twice weekly asymptomatic staff testing
  - Daily staff testing in the event of a COVID-19 contact has helped with staff absences

- NHS has built (and is funded) to provide PCR testing capacity to meet the majority of its needs, this is complemented by mass population testing commissioned and built by the UKHSA.

- Lateral flow testing is widely available, NHS use cases include asymptomatic staff testing, daily contact testing, visitor and maternity testing. In an ED setting it is normally used in conjunction with diagnostic quality testing.

- Genotyping has been used to identify which variant of COVID-19 a patient has to inform treatment decisions including for antivirals and monoclonal antibody therapies.
  - NHS pathology networks conduct genotyping of positive samples via a central hub. Samples are also sent to UKHSA to be sequenced for epidemiological purposes.

Monoclonal Ab and antivirals : 3 delivery cohorts/models

Blueteq forms for all prescribing

1) Treatment of in-hospital patient cohort

Admitted with COVID

Standard management plus option for monoclonal antibody

antibody negative (within 10% of range), PCR positive

delta vs omicron (sotrivimab vs Ronapreve)

2) Treatment of community patient cohort

Via Covid-19 monoclonal delivery units **CMDU's**

various models – London all hospital based

triage, clinical discussion, prescription, administration / drug delivery

Identified trough NHS digital and local specialist teams/ GPs

Clearly identified groups (appendix 1 of policy)

3) Treatment of hospitalized incidental / hospital acquired COVID

Identified groups as group 2 + if thought COVID may destabilize of disease process

Antibody status taken but not required to be negative

1. **Consider prescribing and administering an antiviral or monoclonal antibody treatment in line with the published policy and associated clinical guide to non-hospitalised patients where:**

   - SARS-CoV-2 infection is confirmed by either:
     - Polymerase chain reaction (PCR) testing; OR
     - Lateral flow test (registered via gov.uk or via 119)

     AND
   - Symptomatic with COVID-19[2] and showing no signs of clinical recovery

     AND
   - The patient is member of the 'highest' risk group as set out in the policy

   The updated UK-wide clinical commissioning policy **(for implementation from 10 February 2022)** applies to non-hospitalised patients with COVID-19 who are symptomatic and showing no evidence of clinical recovery. It provides the following treatment options:

   - First-line**:** PF-07321332(Nirmatrelvir) plus Ritonavir (antiviral) OR Sotrovimab (nMAB), as clinically indicated
   - Second-line: Remdesivir (antiviral)
   - Third-line: Molnupiravir (antiviral)

Hospitalised patients

This policy applies to hospitalised patients with COVID-19 that are symptomatic and showing no evidence of clinical recovery and covers the following populations:

1) **Group 1. Patients hospitalised for acute COVID-19 illness**:

   For treatment with casirivimab and imdevimab (an nMAB combination)[1]

   Patients admitted to hospital due to COVID-19 who are ineligible for casirivimab and imdevimab may be considered for entry into the RECOVERY trial, which is studying sotrovimab versus standard of care.

2) **Group 2. Patients with hospital-onset COVID-19**

   For treatment with one of the following:

   - First-line: PF-07321332 (may also be known as nirmatrelvir) plus ritonavir (Paxlovid, antiviral)[2]
   - Second-line: Remdesivir (antiviral)
   - Third-line: Sotrovimab (nMAB)

   Further information on selecting the most appropriate treatment can be found in the Clinical Guide which accompanies this policy

Appendix 1: Patient cohorts considered at highest risk from COVID-19 and to be prioritised for treatment with nMABs and antivirals

- Coronavirus » Interim clinical commissioning policy: neutralising monoclonal antibodies or antivirals for non-hospitalised patients with COVID-19 (england.nhs.uk)

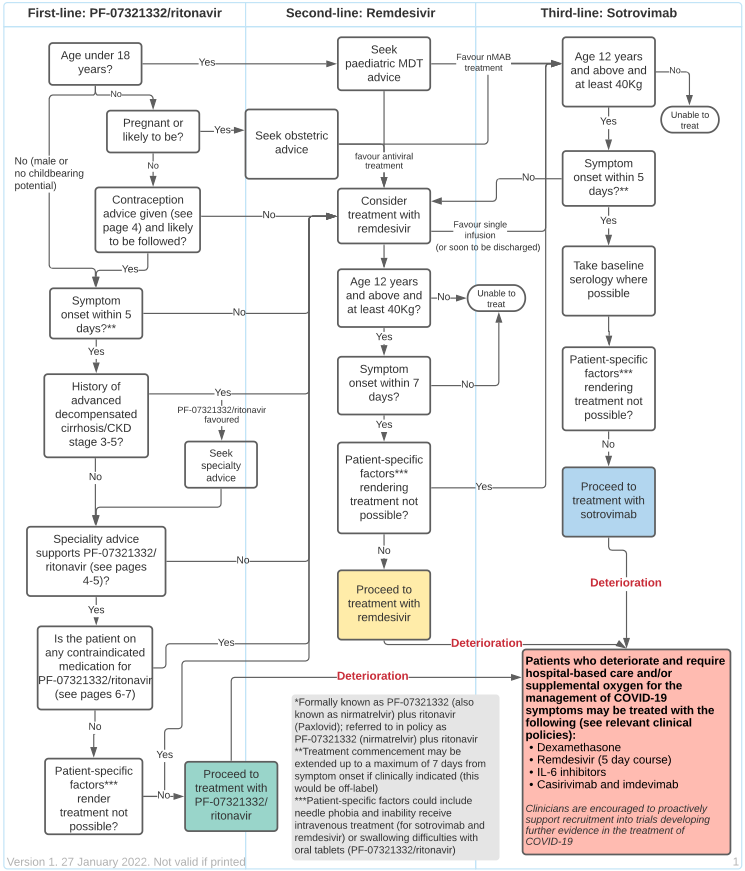
- Refer to appendix 1 for specific detailed description by cohort.

- Down's syndrome
- Patients with a solid cancer
- Patients with a haematological diseases and stem cell transplant recipients
- Patients with renal disease
- Patients with liver disease
- Patients with immune-mediated inflammatory disorders (IMID)
- Immune deficiencies
- HIV/AIDS
- Solid organ transplant recipients
- Rare neurological conditions

UK Interim Clinical Commissioning Policy
Therapies for patients with symptomatic hospital-onset COVID-19

Consider access to this clinical pathway under the following conditions:

- Hospitalised for indications other than for the management of acute symptoms of COVID-19
- Onset of symptoms of COVID-19 within the last 5 days (for PF-07321332/ritonavir* and sotrovimab) or 7 days (for remdesivir), remains symptomatic and with no signs of clinical recovery
- SARS-CoV-2 infection is confirmed by either PCR or lateral flow test
- The patient is a member of a 'highest' risk group (see page 2) OR COVID-19 infection presents a material risk of destabilising a pre-existing condition or compromising recovery from a procedure (as determined by MDT assessment)
- The patient is not requiring new supplemental oxygen specifically for the management of COVID-19 symptoms



Questions

Please type your question into the chat

Get in contact

- Please complete our short survey
- To register for future webinars email us: centresofclinicalexcellence@safercare.vic.gov.au
- If you have specific questions relating to the COVID+ Pathways please email the Department of Health at covid+pathways@health.vic.gov.au

Resources

- Learning Network webinar recordings and slides
- COVID Clinical Shared Resources SharePoint page - Secure site for sharing, with permission, health service developed COVID-19 resources.
  - To register for access and to share resources contact centresofclinicalexcellence@safercare.vic.gov.au
- Department of Health COVID-19 clinical guidance and resources