Public Health Scotland COVID-19 & Winter Statistical Report

As at 04 April 2022

A Management Information release for Scotland

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## Contents

This is a Management Information publication  5
Introduction  6
Main Points  9
Incidence of Variants of Concern and Variants Under Investigation  10
The Omicron BA.2 Variant of COVID-19 in Scotland  11
COVID-19 Daily Data  15
Lateral Flow Device (LFD) Testing  20
COVID-19 Hospital Admissions  23
Hospital Admissions ‘because of’ COVID-19  26
Test and Protect  30
COVID-19 Vaccine  40
  COVID-19 Vaccination Uptake  41
  Vaccine Effectiveness  43
Hospital/ Wider System Pressures  47
Unscheduled Care  47
NHS 24  48
Primary Care Out of Hours (OOH)  48
Scottish Ambulance Service (SAS)  48
Accident & Emergency (A&E) Activity  49
Emergency Admissions  50
Waiting Times  52
Delayed Discharges  53
Wider Impact of COVID-19  54
Contact  56
Further Information  56
Next Release  56
Open Data
Rate this publication

Appendices
  Appendix 1: Background information
  Appendix 3: Hospital Admissions Notes
  Appendix 4: Contact Tracing
  Appendix 5: Lateral Flow Device Testing
  Appendix 6 – Hospital admissions ‘because of’ COVID-19
  Appendix 7 – Early access details
This is a Management Information publication

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Users should therefore be aware of the aspects of data quality and caveats surrounding these data, all of which are listed in this document. Therefore, the data presented are subject to change

Find out more about Management Information on the UK Statistics Authority website.
**Introduction**

Since the start of the Coronavirus-19 (COVID-19) outbreak Public Health Scotland (PHS) has been working closely with Scottish Government and health and care colleagues in supporting the surveillance and monitoring of COVID-19 amongst the population.

As part of our continuous review of reporting, as of 08 December 2021 Public Health Scotland has implemented changes to the COVID-19 Weekly Report to support the reader in drawing insights from a wider range of existing metrics around COVID-19 and winter pressures.

Caution should be used when making comparisons between metrics; each metric is calculated independently and may cover different time periods or cohorts of the population.

The consolidated report will include the following content weekly:

- **COVID-19**
  - Summary of tests and cases
  - Contact tracing
  - Hospital and ICU admissions
  - Testing in care homes
  - COVID-19 vaccination uptake summary
  - Covid-19 vaccination effectiveness
  - Adhoc reporting on topics such as: Covid-19 and Vaccination in pregnancy, Equality reporting etc

- **Hospital/ Wider System Pressures**
  - Unscheduled Care
- Waiting Times
- Delayed Discharges

Additional charts for a number of variables related to COVID-19 service use in the NHS, including some metrics previously presented in the weekly COVID-19 report, are available to view in our interactive dashboard. These include breakdowns by age, sex and deprivation. The variables currently available on the dashboard include:

- Positive cases per day and cumulative total
- COVID-19 hospital admissions
- COVID-19 patients admitted to ICU
- COVID-19 related contacts to NHS24 and the Coronavirus Helpline
- Community Hubs and Assessment Centres
- Scottish Ambulance Service incidents
- Contact tracing
- Health care workers
- Care homes
- Targeted community testing
- Travel outside of Scotland
- Quarantine Statistics
- NHS Protect Scotland App
- Lateral Flow Device (LFD) Testing
- COVID-19 Vaccine Certification
The Public Health Scotland **COVID-19 Daily Dashboard** publishes daily updates on the number of positive cases of COVID-19 in Scotland, with charts showing the trend since the start of the outbreak. From 26 February 2021 the Daily Dashboard also includes daily updates on vaccinations for COVID-19 in Scotland. From 04 April 2022, the Daily Dashboard also includes daily Hospital Occupancy (patients in hospital) for COVID-19 in Scotland.

There is a large amount of data being regularly published regarding COVID-19 (for example, [Coronavirus in Scotland – Scottish Government](https://www.gov.scot/Topics/Health/Coronavirus/HealthData/COVIDvaccination) and [Deaths involving coronavirus in Scotland – National Records of Scotland](https://www.nrscotland.gov.uk/covid-19-deaths)). This report complements the range of existing data currently available.

Please note that from week commencing 11 April 2022, the Scottish Government will no longer provide updates to the figures on this webpage, but will instead clearly signpost to the range of COVID-19 data published. All headline COVID-19 data can be sourced from Public Health Scotland’s **COVID-19 Daily Dashboard**.

In addition, the **COVID-19 State of the Epidemic Report – Scottish Government** brings together different sources of evidence and data about the epidemic in Scotland, and shows how Scotland currently compares to the rest of the UK.
Main Points

- In the week ending 03 April 2022, there were 48,199 COVID-19 cases (identified by PCR or LFD and including reinfections), a decrease of 32.9% from the previous week.

- In the week ending 03 April 2022, 5,097 (10.6%) of all cases reported that week were determined to be reinfections when applying the 90-day threshold.

- In the week ending 27 March 2022, 70,928 individuals were recorded in the contact tracing software, from which 30,128 unique contacts have been traced.

- In the week ending 29 March 2022, there were 1,343 admissions to hospital with a positive COVID-19 test (PCR or LFD), an increase of 14.8% from four weeks prior (week ending 01 March 2022). The highest number of new admissions are currently in those aged 80+.

- In the week ending 03 April 2022, there were 33 new admissions to Intensive Care Units (ICUs) with a laboratory confirmed test of COVID-19.
Incidence of Variants of Concern and Variants Under Investigation

The Omicron variant was originally detected in South Africa and BA.2 now represents the dominant variant in Scotland.

Further information on previous Omicron reporting can be found here.

Public Health Scotland (PHS) continues to monitor COVID-19 Variants of Concern, in collaboration with other Public Health Agencies in the UK.

The latest information on the number of such variants detected by genomic analyses across the UK is published by UK Health Security Agency (UKHSA).
The Omicron BA.2 Variant of COVID-19 in Scotland

On 19 January 2022, the UK Health Security Agency (UKHSA) designated the Omicron sub-lineage BA.2 a Variant Under Investigation (VUI-22JAN-01). The first specimen date reported for Omicron BA.2 in Scotland was 23 December 2021 and incidence of this new sub-lineage is increasing.

Unlike the Omicron BA.1 sub-lineage, BA.2 does not contain the deletion that leads to S Gene Target Failure in a widely used PCR testing platform available at UKGov Pillar 2 Lighthouse Laboratories. The majority of PCR tests in Scotland are undertaken at UKGov laboratories. Not all S gene positive samples will be the Omicron BA.2 variant of SARS-CoV-2 but as Omicron BA.1 was the dominant variant and has S Gene Target Failure, and no other S gene positive variant is circulating at high levels (e.g., Delta), S gene positive tests can be used as a reasonable proxy for tracking BA.2.

Figure 1 shows that BA.2 has taken over to make up nearly all of the recent S gene positive samples.

**Figure 1: Recent trends in the proportion of S gene positive samples by Whole Genome Sequencing result**
Current data based on Pillar 2 PCR laboratory testing show that S gene positives have increased as a proportion of newly daily reported cases.

Table 1 shows that of the new cases notified on 04 April 2022, S gene positives made up 97.7% of cases, up from 95.1% of cases 7 days prior.

**Table 1: Cases tested for the S gene since 1 November 2021 by S gene status**

<table>
<thead>
<tr>
<th></th>
<th>Notifying on 03 April 2022</th>
<th>Notifying on 04 April 2022</th>
<th>Cumulative Total (%) at 04 April 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>S Gene target failure cases*</td>
<td>81 (3.18%)</td>
<td>37 (1.64%)</td>
<td>367,762 (52.8%)</td>
</tr>
<tr>
<td>Unknown**</td>
<td>36 (1.41%)</td>
<td>14 (0.62%)</td>
<td>27,286 (3.92%)</td>
</tr>
<tr>
<td>Positive S gene cases</td>
<td>2,434 (95.4%)</td>
<td>2,208 (97.7%)</td>
<td>301,685 (43.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>2,551 (100%)</td>
<td>2,259 (100%)</td>
<td>696,733 (100%)</td>
</tr>
</tbody>
</table>

* S-gene Target Failure is defined as a positive SARS-CoV-2 PCR test where the N and Orf1ab genes have a Ct value <=30, but the S gene is called negative.

** Cases with tests that cannot be categorised into the UKHSA S gene definitions.

Figure 2 shows that S gene positives have taken over as the majority of Pillar 2 laboratory tested samples since the end of February.
A subset of samples is sent for Whole Genome Sequencing (WGS). This more accurately designates the lineage but is more resource intensive and there can be a time-lag of approximately 5-9 days between the sample being taken and the sequence information being reported. Currently over 50% of samples sent for PCR testing are getting sequenced. The number of WGS samples designated Omicron BA.2 is also increasing.

Figure 3 shows the recent rapid increase in the Omicron BA.2 sub-lineage in Scotland, with the most recent data through 26 March 2022.
Figure 3: Cumulative number of SARS-CoV-2 variants detected by WGS in Scotland (log scale)
The Public Health Scotland COVID-19 Daily Dashboard publishes daily updates (5-days per week, Monday to Friday) on the number of positive cases of COVID-19 in Scotland, with charts showing the trend since the start of the outbreak.

The total number of people within Scotland who have, or have had COVID-19, since the coronavirus outbreak began is unknown. The number of confirmed cases is likely to be an underestimate of the total number who have, or have had, COVID-19. The drop in the number of confirmed cases at weekends likely reflects that laboratories are doing fewer tests at the weekend.

On 05 January 2022, the Scottish Government announced that asymptomatic people who return a positive lateral flow test (LFD) no longer have to confirm their positive result with a PCR test. The statistics presented in this section reflect the change in case definition (including an individual's positive PCR of LFD from 05 January 22).

From 01 March 2022, PHS now include episodes of reinfection within COVID-19 reporting. Prior to this date COVID-19 cases were based on an individual’s first positive test result only. The new daily calculation includes both new infections and possible reinfections. Possible reinfections are defined as individuals who test positive, by PCR (polymerase chain reaction) or LFD (lateral flow device), 90 days or more after their last positive test.

This update to reporting will ensure that PHS’s surveillance data reflects underlying transmission rates. More information is available on the PHS website here.

On 15 March 2022, the Scottish Government announced forthcoming changes to COVID-19 regulations and published the Test and Protect transition plan.

In the week ending 03 April 2022 there were 48,199 COVID-19 cases by PCR or LFD (including reinfections), with a seven-day rolling average of 6,886 cases¹. This is a decrease of 32.9% from the previous week.
In the week ending 03 April 2022 there were 5,097 COVID-19 reinfections (two or more episodes). This represents 10.6% of all cases reported in that week.

**Figure 4: Number of positive cases (including reinfections) per day with 7-day average**

Correct as at 04 April, may differ from more recently published data in the previous week’s report and on the COVID-19 Daily Dashboard.
Figure 5: Number of PCR and LFD positive cases by episode of infection and specimen date, weeks ending 10 October 2021 to 03 April 2022

Figure 6: Number of positive cases (including reinfections) by test type per week, weeks ending 16 January 2022 to 03 April 2022*

* A positive case includes both new infections and possible reinfections. Possible reinfections are defined as individuals who tests positive, by PCR (polymerase chain reaction) or LFD (lateral flow device), 90 days or more after their last positive test. LFD tests are included in the case definition from 05 January 2022 to reflect the revised testing strategy. LFD positive cases that are followed by a negative PCR result within 48 hours will be denotified.
Figure 7 below shows the proportion of COVID-19 cases by PCR or LFD (including reinfections), by age group for the most recent three weeks.

**Figure 7: Proportion of COVID-19 cases (PCR or LFD and including reinfections) by age group, weeks ending 20 March 2022 – 03 April 2022**

The daily dashboard also includes data on Hospital Admissions (PCR or LFD) and ICU admissions (PCR only) for patients with COVID-19. Hospital admissions now include reinfections.

In the week ending 29 March 2022, there were 1,343 admissions to hospital with a PCR or LFD positive test of COVID-19.

In the week ending 03 April 2022, there were 33 new admissions to Intensive Care Units (ICUs) for PCR laboratory confirmed COVID-19 patients.

The number of daily positive COVID-19 cases (PCR or LFD) decreased from 12,358 to 9,761 between 22 March 2022 and 29 March 2022. During the same time period, the daily positive COVID-19 PCR or LFD hospital admissions has decreased from 217 to 192 (seven-day rolling average). The seven-day average of inpatients in hospital has increased by 11.5% (from 2,084 to 2,324).
2. Please refer to Appendix 3 - Hospital Admissions Notes for definitions of hospital admissions and inpatients. Note that prior to 05 Jan 2022 cases are PCR only.

Additional charts and data are available to view in the interactive dashboard accompanying this report.

Data is also monitored and published daily on the Scottish Government Coronavirus website. Please note that from week commencing 11 April 2022, the Scottish Government will no longer provide updates to the figures on this webpage, but will instead clearly signpost to the range of COVID-19 data published. All headline COVID-19 data can be sourced from Public Health Scotland’s COVID-19 Daily Dashboard.
Lateral Flow Device (LFD) Testing

There are numerous testing pathways using Lateral Flow Devices (LFD) - a clinically validated swab antigen test taken that does not require a laboratory for processing. This test can produce rapid results within 45 minutes at the location of the test.

Some of the areas using LFD tests are schools, health and social care workers, care homes and more. Public Health Scotland has collected the information on the number of LFD tests reported across Scotland and will now publish this information weekly. This section is the totality of LFD across Scotland and across strategies.

On 05 January 2022, the Scottish Government announced that people who do not have symptoms would no longer be asked to take a polymerase chain reaction (PCR) test to confirm a positive Lateral Flow Device (LFD) result. Instead, anyone with a positive LFD, who does not have symptoms, should report the result online as soon as the test is done. In order to ensure that we continue to provide the most accurate information, changes have been made to the national COVID-19 case definition to reflect this revised testing strategy.

On 15 March 2022, the Scottish Government announced forthcoming changes to COVID-19 regulations and published the Test and Protect transition plan. From 18 April 2022, the LFD Universal Offer for asymptomatic testing will end.

Since 19 November 2020, there have been 27,040,162 LFD tests reported in Scotland, of which 785,384 were positive (2.9%). Figure 9 below shows the weekly trend of tests reported from week ending 29 November 2020 to 04 April 2022.

There has been an 18.9% decrease in the number of tests (102,876 tests) reported from the week ending 27 March 2022 to the week ending 04 April 2022. Table 2 shows the number of LFD tests reported in Scotland by testing group. Data from 03 March 2022 have been re-categorised accordingly into two new categories: ‘Checking Covid-19 Status During Isolation’ and ‘Close Contact Eligible for Daily Testing’.
More detailed information can be found within the LFD section on our interactive dashboard. For additional details on Lateral Flow Device Tests, please see Appendix 5 – Lateral Flow Device Testing

**Figure 9: Trend of LFD tests reported in Scotland from 29 November 2020 to 04 April 2022**

![Trend of LFD tests reported in Scotland from 29 November 2020 to 04 April 2022](image)

**Table 2: Number of LFD tests reported by Test Group 19 November 2020 – 04 April 2022**

<table>
<thead>
<tr>
<th>Test Group</th>
<th>Test Reason</th>
<th>Number of tests reported</th>
<th>Number of positive tests</th>
<th>% LFD positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home Testing</td>
<td>Care Home - Visiting Professional</td>
<td>75,988</td>
<td>519</td>
<td>0.7%</td>
</tr>
<tr>
<td>Care Home - Visitor</td>
<td>1,111,313</td>
<td>3,031</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>Care Home Staff</td>
<td>2,437,663</td>
<td>11,885</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Community Testing</td>
<td>Community Testing</td>
<td>111,927</td>
<td>1,083</td>
<td>1%</td>
</tr>
<tr>
<td>Education Testing</td>
<td>Combined School Staff</td>
<td>71,778</td>
<td>900</td>
<td>1.3%</td>
</tr>
<tr>
<td></td>
<td>ELC Staff</td>
<td>416,786</td>
<td>7,306</td>
<td>1.8%</td>
</tr>
<tr>
<td></td>
<td>Primary School Staff</td>
<td>1,905,010</td>
<td>26,285</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Data extracted: 04 April 2022

From 23 March 2022 two additional categories have been added to Table 2 – ‘Checking Covid-19 Status During Isolation’ and ‘Close Contact Eligible For Daily Testing’. Data from 03 March 2022 have been recategorised accordingly.
COVID-19 Hospital Admissions

Hospital Admissions ‘with’ COVID-19

Since the start of the pandemic Public Health Scotland have been reporting on the number of people in acute hospitals with recently confirmed COVID-19. These admissions are identified from Rapid and Preliminary Inpatient Data (RAPID) and defined as the following: A positive PCR or LFD test of the episode of infection (including reinfections at 90 days or more after their last positive test) for COVID-19 up to 14 days prior to admission to hospital (emergency or elective), on the day of their admission or during their stay in hospital. If a patient's first positive PCR or LFD test of the episode of infection is after their date of discharge from hospital, they are not included in the analysis.

It is important to note, that the figures presented below may include patients being admitted and treated in hospital for reasons other than COVID-19. Additionally, these figures are correct as at 04 April 2022 and may differ from data published in previous weeks reports.

Figure 10 below shows the weekly trend of hospital admissions with COVID-19 from week ending 05 January 2021 to 29 March 2022.

Figure 10: Trend of hospital admissions ‘with’ COVID-19 in Scotland
Table 3 below shows a breakdown of people admitted to hospital across all ages and by age group for the most recent four weeks. Data from March 2021 is available on the COVID-19 Statistical Report website.

**Table 3: COVID-19 hospital admissions by age as at 29 March 2022**

<table>
<thead>
<tr>
<th>Age Band</th>
<th>23 February - 01 March</th>
<th>02 March - 08 March</th>
<th>09 March - 15 March</th>
<th>16 March - 22 March</th>
<th>23 March - 29 March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>116</td>
<td>145</td>
<td>172</td>
<td>185</td>
<td>151</td>
</tr>
<tr>
<td>18-29</td>
<td>57</td>
<td>52</td>
<td>79</td>
<td>88</td>
<td>84</td>
</tr>
<tr>
<td>30-39</td>
<td>71</td>
<td>77</td>
<td>97</td>
<td>109</td>
<td>79</td>
</tr>
<tr>
<td>40-49</td>
<td>71</td>
<td>82</td>
<td>87</td>
<td>92</td>
<td>84</td>
</tr>
<tr>
<td>50-54</td>
<td>58</td>
<td>54</td>
<td>62</td>
<td>72</td>
<td>65</td>
</tr>
<tr>
<td>55-59</td>
<td>61</td>
<td>70</td>
<td>91</td>
<td>89</td>
<td>59</td>
</tr>
<tr>
<td>60-64</td>
<td>74</td>
<td>77</td>
<td>75</td>
<td>107</td>
<td>92</td>
</tr>
<tr>
<td>65-69</td>
<td>80</td>
<td>92</td>
<td>108</td>
<td>103</td>
<td>118</td>
</tr>
<tr>
<td>70-74</td>
<td>96</td>
<td>119</td>
<td>151</td>
<td>123</td>
<td>112</td>
</tr>
<tr>
<td>75-79</td>
<td>138</td>
<td>149</td>
<td>164</td>
<td>185</td>
<td>149</td>
</tr>
<tr>
<td>80+</td>
<td>348</td>
<td>341</td>
<td>439</td>
<td>368</td>
<td>350</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,170</strong></td>
<td><strong>1,258</strong></td>
<td><strong>1,525</strong></td>
<td><strong>1,521</strong></td>
<td><strong>1,343</strong></td>
</tr>
</tbody>
</table>

Source: RAPID (Rapid and Preliminary Inpatient Data)

3. Please refer to Appendix 3 – Hospital Admissions Notes for explanatory notes regarding RAPID Hospital Admissions.

In the last four weeks, there has been a 14.8% increase in the number of new admissions. In the latest week, 26.1% of admissions are in those aged 80+ years and 11.2% are in those under the age of 18. For those under 18, in the week ending 29 March 2022, 91 admissions (60.3%) out of 151 admissions pertained to those aged 5 and under.

In recent months, the proportion of all people who were admitted to hospital within 14 days of a COVID-19 positive test (PCR or LFD) has remained relatively stable. Figure 11 shows that in the most recent week ending 20 March 2022, 2% of people were admitted to hospital within 14 days of a COVID-19 positive test.
Figure 11: Proportion of weekly cases admitted to hospital within 14 days of a first positive test
Hospital Admissions ‘because of’ COVID-19

As previously reported, not all people hospitalised with a recent COVID-19 diagnosis will be in the hospital setting because of this infection. It is important, though, to be able to differentiate between patients in hospital who are admitted to hospital ‘because of’ their COVID-19 as opposed to patients who are admitted to hospital coincidentally ‘with’ their COVID-19 diagnosis. Knowing this information can help signal whether population-level changes in public health measures may be warranted, such as a tightening or easing of restrictions. It can also help us to predict whether we are likely to see future pressures on hospital systems based on recent patterns of infections in the surrounding community.

Preliminary clinical audit data

In light of the rapid increase in Covid-19 case numbers in Scotland that were observed at the end of 2021, of which more than 90% were estimated to be the new Omicron variant. A clinical audit of hospital admission records was undertaken to monitor the distribution of people in hospital ‘because of’ as opposed to coincidentally ‘with’ COVID-19. This provided an opportunity for a timelier understanding of the characteristics of people in hospital with a recent COVID-19 diagnosis.

At the end of January 2022, Public Health Scotland published a final report of clinical audit data on people with a recent, community-acquired COVID-19 diagnosis admitted to hospital in selected NHS Boards. (NHS Dumfries and Galloway, NHS Grampian, NHS Greater Glasgow and Clyde and NHS Tayside). Findings from this report concluded that 64% of patients were in hospital ‘because of’ COVID-19 during the period December 2021 to January 2022.

SMR01 (acute inpatient and day case activity) analysis

In September 2021 Public Health Scotland developed analysis from SMR01 to calculate the proportion of people in hospital ‘because of’ COVID-19. A limitation of this approach is that there is typically a two-to-three-month lag in receiving SMR01 discharge summaries from NHS boards.
To estimate the proportion of patients in hospital ‘because of’ COVID-19, analysis was carried out using the national SMR01 dataset using the clinical diagnosis information recorded from the patient discharge summary. A hospital admission ‘because of’ COVID-19 is defined as an admission where acute COVID-19 illness is recorded as the main reason that the patient required treatment (including reinfections).

At a time when the Delta variant of COVID-19 was responsible for nearly all circulating infections in Scotland, 70% of COVID-19 admissions in November 2021 were in hospital ‘because of’ their COVID-19 infection. This has decreased to 60% (Table 4) in December 2021, during the period when Omicron rapidly became the dominant variant.

**Updated SMR01 analysis**

The analysis on hospital admissions (Table 4) ‘because of’ COVID-19 is based on data from six NHS Boards, with good quality and complete data up to end December 2021. The aggregated data for these six NHS Boards is used as a proxy to represent the Scotland position. These six NHS Boards are listed in **Appendix 6**.

Table 4 below shows that as at December 2021, 60% of acute hospital admissions ‘with’ COVID-19 had a primary diagnosis of COVID-19.

The average length of time a patient is spending in hospital ‘because of’ COVID-19 has decreased from 8.1 days in July 2021 to 6.5 days in December 2021. More detailed information by age group is shown below in Figure 12.
Table 4: SMR01 COVID-19 Hospital Admissions with a primary diagnosis of COVID-19

<table>
<thead>
<tr>
<th></th>
<th>Jul-21</th>
<th>Aug-21</th>
<th>Sep-21</th>
<th>Oct-21</th>
<th>Nov-21</th>
<th>Dec-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of hospital admissions ‘because of’ COVID-19</td>
<td>75%</td>
<td>67%</td>
<td>74%</td>
<td>72%</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>Average length of stay ‘with’ COVID-19 (days)</td>
<td>7.9</td>
<td>8.9</td>
<td>9.5</td>
<td>9.6</td>
<td>8.5</td>
<td>6.7</td>
</tr>
<tr>
<td>Average length of stay ‘because of’ COVID-19 (days)</td>
<td>8.1</td>
<td>9</td>
<td>9.5</td>
<td>9.1</td>
<td>8.3</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Source: SMR01 (Scottish Morbidity Records –Acute Inpatient & Day case) & ECOSS. Notes and definitions can be found in Appendix 6

Figure 12: Percentage of COVID-19 hospital admissions with a primary diagnosis of COVID-19, and average length of stay

Figure 13 below shows a breakdown of the average length of stay in days for December 2021 for COVID-19 hospital admissions with a primary diagnosis of COVID-19.
Figure 13: Average length of stay of SMR01 COVID-19 hospital admissions with a primary diagnosis of COVID-19 by age band; December 2021
Test and Protect

Scotland’s approach to contact tracing has continued to adapt throughout the pandemic to reflect changing circumstances, variability in cases, and increasing proportion of the population fully vaccinated since the roll out of the vaccination programme. The most recent Strategic Framework issued by the Scottish Government in February 2022 sets out how Scotland will continue to adapt now that we are in the phase described as “beyond level zero”. That will require a constant review of the associated management information compiled in the weekly report. The information we produce will change over time to reflect the most critical information to help understand, plan, and deliver contact tracing at any given point in time.

World Health Organisation (WHO) current guidance on “Contact tracing in the context of COVID-19” focuses on targeted approaches to contact tracing based on transmission patterns, engaging communities, and prioritising follow-up of high risk cases when it is not possible to identify, monitor and quarantine all contacts. For further information, please refer to Appendix 2.

On 15 March 2022, the Scottish Government announced forthcoming changes to COVID-19 regulations and published the Test and Protect transition plan. From 01 May 2022, contact tracing will end.

Please note, PHS has moved to weekly reporting of this data and cumulative data is available in the interactive dashboard. Data for the most recent week, previously included as provisional, is no longer included as this is variable due to cases, which are still open because (either contact tracing is still underway or the NHS Board is still managing the case for a particular reason). Only finalised data will be included within the report going forward.

Index cases

Further background information and definitions are available in Appendix 4.

An index case is generated for each positive result with a test date on or after 28 May 2020. This includes tests derived from Scottish and UK Government, as well as self-reported LFD’s.
An individual is a unique person who has had a positive test. An individual can have multiple positive tests which results in multiple cases within the test and protect system. In these figures, each person is only counted once.

Contact Tracing figures for the week ending 27 March 2022 (based on test date), are detailed in Table 5 below, which provides a recent time trend. A longer time trend is available on the interactive dashboard.

Table 6 provides details of the status of the index cases for each week.

In the week ending 27 March 2022, there were 73,556 Index Cases, of which 49,200 (66.9%) had completed contact tracing by telephone or other digital methods.

Table 5: Contact Tracing trend information, by week ending 1,2

<table>
<thead>
<tr>
<th></th>
<th>20 Feb</th>
<th>27 Feb</th>
<th>06 Mar</th>
<th>13 Mar</th>
<th>20 Mar</th>
<th>27 Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Index Cases1</td>
<td>50,598</td>
<td>47,273</td>
<td>63,910</td>
<td>88,776</td>
<td>86,436</td>
<td>73,556</td>
</tr>
<tr>
<td>Individuals2</td>
<td>48,732</td>
<td>46,040</td>
<td>62,286</td>
<td>86,552</td>
<td>83,237</td>
<td>70,928</td>
</tr>
</tbody>
</table>

1. Does not include “Excluded” cases, which are those where a decision has been made that the case should not have been created within the contact tracing system.
2. A count of unique individuals with a positive test. An individual can have multiple positive tests which results in multiple cases within the contact tracing system.

Table 6: Contact Tracing trend information by status, by week ending 1,2,3,4

<table>
<thead>
<tr>
<th>Status of cases</th>
<th>20 Feb</th>
<th>27 Feb</th>
<th>06 Mar</th>
<th>13 Mar</th>
<th>20 Mar</th>
<th>27 Mar</th>
<th>Cumulative (from May 2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/ Not yet started1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>12</td>
<td>53</td>
</tr>
<tr>
<td>% New/ Not yet started</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>In progress2</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>% In progress</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Complete3</td>
<td>37,604</td>
<td>35,998</td>
<td>42,930</td>
<td>50,500</td>
<td>54,899</td>
<td>49,200</td>
<td>1,317,980</td>
</tr>
<tr>
<td>% Complete</td>
<td>74.3</td>
<td>76.1</td>
<td>67.2</td>
<td>56.9</td>
<td>63.5</td>
<td>66.9</td>
<td></td>
</tr>
<tr>
<td>Incomplete4</td>
<td>12,986</td>
<td>11,275</td>
<td>20,980</td>
<td>38,275</td>
<td>31,535</td>
<td>24,336</td>
<td>472,137</td>
</tr>
<tr>
<td>% Incomplete</td>
<td>25.7</td>
<td>23.9</td>
<td>32.8</td>
<td>43.1</td>
<td>36.5</td>
<td>33.1</td>
<td></td>
</tr>
</tbody>
</table>
1. New – New/not yet started cases within the contact tracing system.
2. In progress – The case is still in progress with either the case interview to be completed, or contacts related to the case to be followed up.
3. Complete - The case is complete, and all achievable contact tracing has been carried out.
4. Incomplete - Unsuccessful attempts to reach or carry out a case interview via the telephone, or for the index case to provide contacts via digital contact tracing.

Method of Contacting Index Cases

The data within this section are based on the number of completed cases, which are recorded in the contact tracing software; these figures are preliminary and may be updated in subsequent publications.

Public Health Scotland works closely with National Services Scotland (NSS) and the Scottish Government to enable local NHS Boards and the National Contact Centre (NCC) to carry out COVID-19 contact tracing effectively. The approach to contact tracing has adapted as restrictions and policy have changed throughout the pandemic in order to best meet the needs of the Scottish population. As numbers of new cases have increased, the method has changed from attempting to phone all new cases and contacts - to prioritising the highest risk cases for telephone calls and sending public health advice by SMS text or email to all others, who have tested positive for COVID-19 and their close contacts.

The introduction of SMS messaging was designed to get public health advice about isolation to cases and contacts as quickly as possible; this is especially pertinent when daily case numbers are very high. The approach was part of a deliberate decision to manage resources through an agreed framework and is in keeping with the evidence-informed advice of the European Centre for Disease Control.

All index cases will receive an initial SMS or email containing Public Health information and advice, which will then be followed by contact either by telephone, additional SMS or email messages containing further Public Health information and advice.

Table 7 below shows a breakdown of the methods used to contact completed index cases over time.
In the week ending 27 March 2022, 42.5% of index cases received a telephone call.

**Time for a Positive Index Case to be Contact Traced**

The data within this section are based on the number of completed cases, which are recorded in the contact tracing software; these figures are preliminary and may be updated in subsequent publications.

The three measures shown are:

- the time between a sample being taken and the positive individual being contacted (i.e., interviewed by a contact tracer or completing the online tracing form)

- the time between the record appearing in the CMS and the positive individual being contacted (i.e., interviewed by a contact tracer or completing the online tracing form)

- the time between the record appearing in the CMS and contact tracing being closed (i.e., contacts have been interviewed, attempted to be interviewed or contacted digitally)

These figures are now weekly measures; data are available for previous weeks within the interactive dashboard.

Table 8 and Figure 14 below describe the timeliness of contact tracing by calculating the hours between a test sample being taken and the index case being contacted by Test and Protect either by phone or SMS.

---

1. SMS includes those cases deemed low risk and have completed the Co3 online form, every other completed case is categorised as Telephone.
Table 8: Time (hours) between date test sample taken (specimen date) and the positive index case being contacted, for cases completed

<table>
<thead>
<tr>
<th>Hours taken</th>
<th>Week Ending 27 March 2022</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Complete Index Cases</td>
<td>% Of Total Complete Cases</td>
<td>% Of Total Complete &amp; Incomplete Cases</td>
</tr>
<tr>
<td>0-24</td>
<td>17,020</td>
<td>34.6</td>
<td>23.1</td>
</tr>
<tr>
<td>24-48</td>
<td>13,881</td>
<td>28.2</td>
<td>18.9</td>
</tr>
<tr>
<td>48-72</td>
<td>9,186</td>
<td>18.7</td>
<td>12.5</td>
</tr>
<tr>
<td>Over 72</td>
<td>8,713</td>
<td>17.7</td>
<td>11.8</td>
</tr>
<tr>
<td>Not recorded - SMS</td>
<td>192</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Not recorded – Phone</td>
<td>208</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Total Complete Cases</td>
<td>49,200</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Incomplete Cases</td>
<td>24,336</td>
<td></td>
<td>33.1</td>
</tr>
<tr>
<td>Total Complete &amp; Incomplete Cases</td>
<td>73,536</td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

5 For further information and additional notes on Contact Tracing, please see Appendix 4 – Contact Tracing
Figure 14: Trend in time (hours) between date test sample taken (specimen date) and the positive individual being called for cases completed; by week

Figure 14 shows that more positive cases were contacted over 72 hours after their test sample was taken in June 2021, August 2021, and December 2021, which corresponds with a rise in cases over the same periods.

Table 9: Time (hours) between case created in CMS and the positive individual being contacted\(^5,6\)

<table>
<thead>
<tr>
<th>Hours taken</th>
<th>Week Ending 27 March 2022</th>
<th>% Of Total Complete Cases</th>
<th>% Of Total Complete &amp; Incomplete Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-24</td>
<td>29,366</td>
<td>59.7</td>
<td>39.9</td>
</tr>
<tr>
<td>24-48</td>
<td>6,746</td>
<td>13.7</td>
<td>9.2</td>
</tr>
<tr>
<td>48-72</td>
<td>8,544</td>
<td>17.4</td>
<td>11.6</td>
</tr>
<tr>
<td>Over 72</td>
<td>4,167</td>
<td>8.5</td>
<td>5.7</td>
</tr>
<tr>
<td>Not recorded – SMS</td>
<td>192</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Not recorded - Phone</td>
<td>185</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Total Complete Cases</strong></td>
<td><strong>49,200</strong></td>
<td><strong>100</strong></td>
<td><strong>33.1</strong></td>
</tr>
<tr>
<td>Incomplete Cases</td>
<td>24,336</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Total Complete & Incomplete Cases | 73,536 | 100

5 For further information and additional notes on Contact Tracing, please see Appendix 4 – Contact Tracing
6 Includes being interviewed by a contact tracer or submitting preliminary information via a CO3 form

Table 10: Time (hours) between case created in CMS to its closure\(^5\),

<table>
<thead>
<tr>
<th>Hours taken</th>
<th>Week Ending 27 March 2022</th>
<th>% Of Total Complete Cases</th>
<th>% Of Total Complete &amp; Incomplete Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Complete Index Cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-24</td>
<td>28,430</td>
<td>57.8</td>
<td>38.7</td>
</tr>
<tr>
<td>24-48</td>
<td>7,257</td>
<td>14.8</td>
<td>9.9</td>
</tr>
<tr>
<td>48-72</td>
<td>8,770</td>
<td>17.8</td>
<td>11.9</td>
</tr>
<tr>
<td>Over 72</td>
<td>4,670</td>
<td>9.5</td>
<td>6.4</td>
</tr>
<tr>
<td>Not recorded* – SMS</td>
<td>42</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Not recorded* - Phone</td>
<td>31</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total Complete Cases</strong></td>
<td><strong>49,200</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
<tr>
<td>Incomplete Cases</td>
<td>24,336</td>
<td></td>
<td>33.1</td>
</tr>
<tr>
<td><strong>Total Complete &amp; Incomplete Cases</strong></td>
<td><strong>73,536</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

5 For further information and additional notes on Contact Tracing, please see Appendix 4 – Contact Tracing
7 Measured by the time taken to complete the final contact interview for high-risk settings/contacts and those completed via SMS

Incomplete index cases

Table 11 and Figure 15 below show the different reasons why an index case is categorised as incomplete (previously referred to as failed) within the contact tracing system.

Incomplete cases are defined as: unsuccessful attempts to carry out a case interview via the telephone, or for the index case to provide contacts via digital contact tracing. This would include scenarios where the mobile/home phone/email address provided by the case was incorrect and no other method of contact could be established; where SMS/telephone call attempts to the case had been made but not been successful in eliciting a response from the index case; where the index case has
failed to pass relevant data protection identity checks and where the index case has refused to participate in the contact tracing process.

For operational purposes, some index cases are categorised as incomplete because the telephone process has started, but does not complete for the reasons outlined in Table 11 below. Public Health information is typically sent by SMS to 99% of the incomplete index cases.

**Table 11: Number of incomplete index cases by reason**

<table>
<thead>
<tr>
<th>Reason for Incompletion</th>
<th>Week Ending 27 March 2022</th>
<th>% Of Incomplete Index Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed ID &amp; verification</td>
<td>24</td>
<td>0.1</td>
</tr>
<tr>
<td>No response to call</td>
<td>2,031</td>
<td>8.4</td>
</tr>
<tr>
<td>No/incorrect phone number</td>
<td>208</td>
<td>0.9</td>
</tr>
<tr>
<td>Refused to provide contact details</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Declined to participate / unable to recall contacts</td>
<td>136</td>
<td>0.6</td>
</tr>
<tr>
<td>Timed out</td>
<td>21,939</td>
<td>90.2</td>
</tr>
<tr>
<td>Total incomplete cases</td>
<td>24,339</td>
<td>100</td>
</tr>
<tr>
<td>% Incomplete as proportion of all index cases</td>
<td></td>
<td>33.1</td>
</tr>
</tbody>
</table>

Timed out cases refers to the closure of cases older than 72 hours. These cases will receive public health information and support signposting via SMS/email communications from Test and Protect. This process allows contact tracing staff to prioritise higher-risk cases and contacts.

In week ending 27 March 2022, 8.4% of incomplete index cases were due to the index case not responding to calls from Test and Protect.
Contacts

The Test and Protect system ensures all positive index cases are asked to identify their close contacts, whether they were contacted by telephone and/or SMS. Table 12 below shows the recent trend information of contacts reported to Test and Protect by the index case.

Table 12: Contact Tracing contacts trend information, by week ending\(^1,2\)

<table>
<thead>
<tr>
<th></th>
<th>20 Feb</th>
<th>27 Feb</th>
<th>06 Mar</th>
<th>13 Mar</th>
<th>20 Mar</th>
<th>27 Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Primary Contacts(^1)</td>
<td>53,932</td>
<td>50,207</td>
<td>61,297</td>
<td>62,059</td>
<td>47,147</td>
<td>35,127</td>
</tr>
<tr>
<td>Unique Primary Contacts(^2)</td>
<td>44,411</td>
<td>41,468</td>
<td>50,552</td>
<td>52,747</td>
<td>40,301</td>
<td>30,128</td>
</tr>
<tr>
<td>Average number of primary contacts per case</td>
<td>1</td>
<td>1</td>
<td>0.9</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

1. Total number of primary contacts recorded in the contact tracing system.
2. Unique number of primary contacts each week. A contact may have been in close contact with multiple index cases.
Contacts not required to self-isolate

Following the Scottish Government announcement on 05 January 2022, from 06 January 2022 fully vaccinated adults and those under the age of 18 years and 4 months do not need to self-isolate as long as they return a negative LFD test result for 7 consecutive days and remain fever free. This applies to both household and non-household contacts. If any of the LFD tests are positive, the contact will be managed as an index case and will not need to book a follow-up PCR to confirm the positive LFD result.

Since the beginning of contact tracing, a small proportion of primary contacts who were successfully contacted were advised they did not need to isolate. Up to 27 March 2022, a total of 3,456 cumulative primary contacts, pertaining to completed index cases, were not advised to self-isolate. This represents 1.1% of the total 309,192 cumulative primary contacts for which this information is known. Some reasons why contacts do not need to isolate include children under the age of 16, contact was wearing PPE or did not come into close contact with a positive case.

In the week ending 27 March 2022, of the 30,107 unique contacts recorded, 3,062 (10.2%) went on to test positive (PCR or LFD) within ten days of their contact with an index case.
COVID-19 Vaccine

On 08 December 2020, a COVID-19 vaccine developed by Pfizer BioNTech was first used in the UK as part of national immunisation programmes. The AstraZeneca (Vaxzevria) vaccine was also approved for use in the national programme, and rollout of this vaccine began on 04 January 2021. Moderna (Spikevax) vaccine was approved for use on 08 January 2021 and rollout of this vaccine began on 07 April 2021. These vaccines have met strict standards of safety, quality and effectiveness set out by the independent Medicines and Healthcare Products Regulatory Agency (MHRA).

For the latest information on COVID-19 vaccines, including information on eligibility, please see our COVID-19 vaccine information and resources pages.

Information on uptake across the vaccine programme is available on a daily basis via the PHS COVID-19 Daily Dashboard, 5 days a week at 2pm (Monday to Friday). This provides a cumulative picture of the position nationally and locally.

The dashboard provides total uptake nationally with breakdowns by Joint Committee on Vaccination and Immunisation (JCVI) age based cohorts and non-age based cohorts for priority groups 1-9.

The vaccination content of this weekly publication is kept under continual review and specific editions have contained more in-depth analyses of uptake by particular groups or characteristics, including uptake by ethnicity and deprivation category, for teachers, for prisoners and for pregnant women.
COVID-19 Vaccination Uptake

As of 04 April 2022, there has been over 12.0 million Covid-19 vaccine doses administered in Scotland since the programme began on 08 December 2020. As part of PHS’s continuous review of reporting, some revisions to vaccine uptake statistics have been made. From 24 March 2022, the deceased and those no longer living in Scotland have been removed from vaccine uptake statistics. Further details can be found here.

- 4.36 million people protected through their first dose of the COVID-19 vaccination: 91.8% of those aged 18 and over and 90.4% of those aged 12 and over
- 4.10 million people provided with further protection by receiving their second dose, 88.6% of those 18 and over and 85.6% of those aged 12 and over
- 3.46 million people have received their dose 3, 77.5% of those aged over 18 and over and 72.2% of those aged 12 and over
- 110,111 people have received their dose 4 of the COVID-19 vaccination

More detailed age information can be in Figure 16.

Daily Vaccination uptake information is available via the PHS Covid Daily Dashboard.
Figure 16: Covid-19 Vaccine uptake – percentage coverage by age group in Scotland, as at 04 April 2022
Vaccine Effectiveness

Public Health Scotland has a **COVID-19 vaccine surveillance strategy** to monitor the effectiveness, safety and impact of all approved COVID-19 vaccines in Scotland. The key measure of the success of the vaccination programme in protecting against severe disease, hospitalisations and deaths is vaccine effectiveness.

Vaccine effectiveness is a scientific method used to measure how well a vaccine protects people against outcomes such as infection, symptoms, hospitalisation, and death in the ‘real-world’. Vaccine effectiveness analysis accounts for potential biases in the data and risk factors such as age, sex, prior infection, co-morbidities, socio-economic status, and time since vaccination. This method is the most robust way to measure if a vaccine is working.

**Vaccinated individuals can still be infected with COVID-19**

The current evidence suggests that you may test positive for COVID-19, or be reinfected even if you are vaccinated, especially since the emergence of the Omicron variant in the UK. The major benefit of vaccination against Omicron is to protect from severe disease, see below. For the latest COVID-19 guidance, please visit the [NHS Inform website](https://www.nhsinform.scot/covid-19).

**COVID-19 vaccines protect most people against severe outcomes, but some people will still get sick because no vaccine is 100% effective**

Evidence suggests the COVID-19 vaccines are very effective at preventing a severe outcome of COVID-19. COVID-19 hospitalisations and deaths are strongly driven by older age, with most deaths occurring in those over 70 years old and those with multiple other illnesses. But overall, you are less likely to be hospitalised if you are vaccinated with a booster.

**Vaccine effectiveness against symptomatic disease**

Analyses from Scotland show that the booster and third dose of the COVID-19 vaccines are associated with 57% reduced risk of symptomatic infection with the Omicron variant compared to those who are more than 25 weeks post-second dose of COVID-19 vaccine.
There has been an increase in the number of cases with the Omicron variant sub-lineage known as BA.2 (VUI-22JAN-01). This variant was identified at the start of January 2022. Analysis by the UK Health Security Agency (UKHSA) shows no apparent reduction in vaccine effectiveness against symptomatic disease when compared to the first Omicron variant (BA.1).

To note, the studies described above do not account for severity of symptoms. For example, one person may only have mild symptoms such as a runny nose for one day and another person severe symptoms such as long-term fatigue and breathing issues. These people would have different outcomes of infection, but they would both be recorded as having symptoms. This could result in an under or overestimate of vaccine effectiveness.

**Vaccine effectiveness against hospitalisation**

A number of studies have estimated COVID-19 vaccine effectiveness against hospitalisation and have found high levels of protection against hospitalisation with all COVID-19 vaccines against the Alpha and Delta variants (1,2,3,4,5).

Vaccine effectiveness against hospitalisation with the Omicron variant is slightly lower than the Delta variant, but the booster or third dose of COVID-19 vaccine still provides excellent protection against COVID-19 related hospitalisation.

**Vaccine effectiveness against mortality**

COVID-19 vaccines are estimated to significantly reduce the risk of COVID-19 mortality; however, a small number of COVID-19 deaths are still expected in vaccinated people, especially in vulnerable individuals where the vaccine or the immune response may not have been effective.

Evidence has shown that vaccination is highly effective in protecting against death from COVID-19. A paper from Israel examined the effectiveness of the Pfizer (Comirnaty) booster vaccine and found that adults who had received their booster dose five months after their second dose had a 90% lower risk of mortality due to COVID-19 than adults who hadn’t received their booster dose five months after their
second dose. Data from the UKHSA also shows that after two or more weeks following a booster vaccine effectiveness was 95% against mortality.

**Vaccine effectiveness in at-risk groups**

**A study from England** (VIVALDI) found the COVID-19 vaccines were 85.4% effective against COVID-19 hospitalisations and 94.4% against COVID-19 death among care home residents between two and 12 weeks after the second dose. This declined to 54.3% against hospitalisations and 62.8% against death from 12 weeks after the second dose. However, a booster vaccination restored protection with vaccine effectiveness estimated to be 89.9% against hospitalisations and 97.5% against death among care home residents.

**Other vaccine studies**

**A review by UKHSA** shows that people who have had one or more doses of a COVID-19 vaccine are less likely to develop long COVID-19 than those who remain unvaccinated.

**Vaccine effectiveness summary**

**UKHSA publish** a summary of current vaccine effectiveness in their weekly COVID-19 vaccine surveillance report. The latest evidence can be found below, which suggests the COVID-19 booster/third dose vaccine lowers your risk of a severe outcome compared to the second dose.

The Office for National Statistics (ONS) has also published research into the risk of testing positive for COVID-19 by vaccination status and deaths involving COVID-19 by vaccination status.
### Figure 17: UKHSA consensus estimates of vaccine effectiveness against the Omicron variant

<table>
<thead>
<tr>
<th>Vaccine product for primary course</th>
<th>Outcome</th>
<th>Second dose: 0 to 3 months (%)</th>
<th>Second dose: 4 to 6 months (%)</th>
<th>Second dose: 6+ months (%)</th>
<th>Booster dose: All Periods (%)</th>
<th>Booster dose: 0 to 3 months (%)</th>
<th>Booster dose: 4 to 6 months (%)</th>
<th>Booster dose: 6+ months (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AstraZeneca</strong></td>
<td>All Infection</td>
<td>30% (10 to 50%)</td>
<td>0 to 35% (range only)</td>
<td>Insufficient data</td>
<td>See individual periods</td>
<td>50% (40 to 60%)</td>
<td>30% (20 to 40%)</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Symptomatic</td>
<td></td>
<td>40% (30 to 50%)</td>
<td>20% (5 to 30%)</td>
<td>5% (0 to 5%)</td>
<td>See individual periods</td>
<td>60% (50 to 70%)</td>
<td>40% (30 to 50%)</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Hospitalisation</td>
<td></td>
<td>85% (60 to 90%)</td>
<td>70% (50 to 75%)</td>
<td>65% (45 to 85%)</td>
<td>See individual periods</td>
<td>90% (85 to 95%)</td>
<td>85% (85 to 95%)</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>See individual periods</td>
<td>90% (85 to 98%)</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Transmission</td>
<td></td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
<tr>
<td><strong>Moderna</strong></td>
<td>All Infection</td>
<td>30% (20 to 40%)</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>See individual periods</td>
<td>50% (40 to 60%)</td>
<td>30% (20 to 40%)</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Symptomatic</td>
<td></td>
<td>55% (35 to 75%)</td>
<td>30% (15 to 35%)</td>
<td>15% (10 to 20%)</td>
<td>See individual periods</td>
<td>65% (55 to 75%)</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Hospitalisation</td>
<td></td>
<td>85 to 95% (range only)</td>
<td>75 to 85% (range only)</td>
<td>55 to 90% (range only)</td>
<td>See individual periods</td>
<td>85 to 95% (range only)</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Transmission</td>
<td></td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
<tr>
<td><strong>Pfizer</strong></td>
<td>All Infection</td>
<td>30% (20 to 40%)</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>See individual periods</td>
<td>50% (40 to 60%)</td>
<td>30% (20 to 40%)</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Symptomatic</td>
<td></td>
<td>50% (30 to 65%)</td>
<td>20% (15 to 30%)</td>
<td>15% (10 to 15%)</td>
<td>See individual periods</td>
<td>65% (55 to 75%)</td>
<td>45% (35 to 55%)</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Hospitalisation</td>
<td></td>
<td>90% (85 to 95%)</td>
<td>80% (75 to 85%)</td>
<td>70% (55 to 90%)</td>
<td>See individual periods</td>
<td>90% (85 to 95%)</td>
<td>85% (85 to 95%)</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>See individual periods</td>
<td>90% (85 to 98%)</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
<tr>
<td>Transmission</td>
<td></td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>0 to 25% (range only)</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
<td>Insufficient data</td>
</tr>
</tbody>
</table>

**Key: Confidence rating scale**

<table>
<thead>
<tr>
<th>Confidence Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Confidence</td>
<td>Evidence from multiple studies which is consistent and comprehensive</td>
</tr>
<tr>
<td>Medium Confidence</td>
<td>Evidence is emerging from a limited number of studies or with a moderately low level of uncertainty</td>
</tr>
<tr>
<td>Low Confidence</td>
<td>Little evidence is available at present and results are inconclusive</td>
</tr>
</tbody>
</table>
Hospital/ Wider System Pressures

NHS services across NHS Scotland are subject to increased demand during the winter period. The information presented in this section aims to support the reader in drawing insights from a wider range of existing metrics around COVID-19 and winter pressures.

Unscheduled Care

As individuals in Scotland make contact with Unscheduled Care Services, data about who they are, where they have come from, what is wrong with them and what happens to them are collected, mainly to inform their care. This provides a good picture of the potential unscheduled care journeys that an individual may travel through.

Pressures on unscheduled care services are a familiar sight during the winter. Increased incidence of respiratory infections, alongside an increased acuity of illness and demands on primary care leads to increased demand on unscheduled care.

NHS inform is Scotland’s digital health and care resource, providing the up-to-date standardised information on COVID-19 from a health perspective. Information is provided in a range of languages and alternative formats (17).

Additional information can be found on the wider impacts dashboard and also in our interactive dashboard.
NHS 24

During COVID-19, there has been a rapid reconfiguration of primary and community care services. As part of this NHS 24’s 111 service has been reconfigured as an in-hours (as well as out-of-hours) route for COVID-19 triage for rapid access to care via local COVID-19 assessment hubs. In addition to this, from 1st December 2020, the national Redesign of Urgent Care Programme introduced new pathways from NHS 24 to Flow Navigation Centres, with the aim of reducing the numbers of people attending A&E and diverting to more appropriate care closer to home. This is available as part of a 24/7 service, further increasing NHS 24 in-hours activity (Monday to Friday, 8am to 6pm).

Information on COVID-19 related contacts to NHS24 and the Coronavirus Helpline are presented in our interactive dashboard, which supplements this report.

Primary Care Out of Hours (OOH)

Across Scotland, NHS Boards provide Primary Care Out of Hours (OOH) services for patients’ when their registered GP practice is closed. Information is available via the Wider Impacts dashboard.

Scottish Ambulance Service (SAS)

Key statistics on unscheduled care operational measures across Scotland, including trends in the number of unscheduled care incidents, responses, conveyances to hospital, response times and hospital turnaround times is available from the Scottish Ambulance Service (SAS) weekly-unscheduled care operational statistics release.
Accident & Emergency (A&E) Activity

Additional information on Accident and Emergency (A&E) performance is available via the weekly A&E activity and Waiting Times publication, which provides an update of key statistics on attendances at Accident and Emergency (A&E) services across Scotland. Accident and Emergency waiting times and activity reporting on performance against the 4-hour waiting time standard, and the target to reduce attendances at Emergency Departments.

Large decreases in attendances at A&E services in NHS Scotland were observed in spring 2020 winter 2020/21 due to the measures put in place to respond to COVID-19. Since spring, 2021 attendances at A&E have been rising and are getting closer to the pre-COVID levels. However, from the summer of 2021 performance against the four-hour standard has dropped below 80% and has remained at this rate for a prolonged period of time.
Emergency Admissions

The information presented in this section aims to provide a better understanding of the underlying trends in emergency admissions during this period.

Figure 18 below shows the overall weekly trend of emergency acute hospital admissions (including COVID-19) from week ending 05 January 2021 to 29 March 2022.

**Figure 18: Trend of all Emergency Acute Hospital Admissions in Scotland**

Table 13 below shows a breakdown of Emergency Admissions to acute hospital across all ages and by age group for the period 02 March 2022 to 29 March 2022.
Table 13: Emergency Hospital Admissions by age as at 29 March 2022

<table>
<thead>
<tr>
<th>Age Band</th>
<th>02 March - 08 March</th>
<th>09 March - 15 March</th>
<th>16 March - 22 March</th>
<th>23 March - 29 March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>1,308</td>
<td>1,337</td>
<td>1,277</td>
<td>1,235</td>
</tr>
<tr>
<td>18-29</td>
<td>749</td>
<td>689</td>
<td>759</td>
<td>630</td>
</tr>
<tr>
<td>30-39</td>
<td>769</td>
<td>779</td>
<td>715</td>
<td>701</td>
</tr>
<tr>
<td>40-49</td>
<td>842</td>
<td>809</td>
<td>777</td>
<td>776</td>
</tr>
<tr>
<td>50-54</td>
<td>581</td>
<td>596</td>
<td>553</td>
<td>541</td>
</tr>
<tr>
<td>55-59</td>
<td>755</td>
<td>684</td>
<td>650</td>
<td>619</td>
</tr>
<tr>
<td>60-64</td>
<td>717</td>
<td>750</td>
<td>809</td>
<td>716</td>
</tr>
<tr>
<td>65-69</td>
<td>796</td>
<td>782</td>
<td>803</td>
<td>776</td>
</tr>
<tr>
<td>70-74</td>
<td>989</td>
<td>968</td>
<td>974</td>
<td>849</td>
</tr>
<tr>
<td>75-79</td>
<td>989</td>
<td>988</td>
<td>1,010</td>
<td>1,002</td>
</tr>
<tr>
<td>80+</td>
<td>2,138</td>
<td>2,266</td>
<td>2,104</td>
<td>2,101</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,633</strong></td>
<td><strong>10,648</strong></td>
<td><strong>10,431</strong></td>
<td><strong>9,946</strong></td>
</tr>
</tbody>
</table>

Source: RAPID (Rapid and Preliminary Inpatient Data)

3. Please refer to Appendix 3 – Hospital Admissions Notes for explanatory notes regarding RAPID Hospital Admissions.

In the latest week, there has been a decrease of 4.6% in the number of emergency admissions, with those aged 80+ years having the highest number of admissions. Also, in the latest week, 54.7% of the hospital admissions related to patients aged 60+
Waiting Times

Waiting times are important to patients and are a measure of how the NHS is responding to demands for services. Measuring and regular reporting of waiting times highlights where there are delays in the system and enables monitoring of the effectiveness of NHS performance throughout the country.

Public Health Scotland routinely publish a range of statistics on Waiting Times, including: waiting times for diagnostic tests, new outpatient appointments, inpatient and day case treatments.

These statistics continue to be affected by the COVID-19 (Coronavirus) pandemic. At the start of the outbreak, many services were paused or reduced and there were fewer referrals. Boards started to resume relevant services, from June 2020. However, as a second wave of COVID-19 cases emerged through the autumn and winter months, many Boards had to temporarily pause non-urgent diagnostic tests during the months of January and February 2021. Access to services has generally increased since then but some Boards may have been temporarily impacted by a return to high infection rates in recent months as lockdown restrictions eased.
Delayed Discharges

Timely discharge from hospital is an important indicator of quality. It is a marker for person-centred, effective, integrated and harm free care.

For most patients, following completion of health and social care assessments, the necessary care, support, and accommodation arrangements are put in place in the community without any delay and the patient is appropriately discharged from hospital.

A delayed discharge occurs when a patient aged 18 years and over, clinically ready for discharge, cannot leave hospital because the other necessary care, support, or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place.

Public Health Scotland publish monthly statistics on Delayed Discharges in Scotland. These figures provide the number of hospital bed days associated with delayed discharges and the number of discharges from hospital following a period of delay. Information is also provided on the number of people experiencing a delay in discharge from hospital at the monthly census point.

Delayed Discharge figures in NHS Scotland have been affected by measures put in place to respond to COVID-19. The marked fall in delayed discharges during 2020 is likely due to patients being moved out of hospital to increase capacity.
Wider Impact of COVID-19

The COVID-19 pandemic has direct impacts on health as a result of illness, hospitalisations, and deaths due to COVID-19. However, the pandemic also has wider impacts on health, healthcare, and health inequalities. Reasons for this may include:

- Individuals being reluctant to use health services because they do not want to burden the NHS or are anxious about the risk of infection.
- The health service delaying preventative and non-urgent care such as some screening services and planned surgery.
- Other indirect effects of interventions to control COVID-19, such as changes to employment and income, changes in access to education, social isolation, family violence and abuse, changes in the accessibility and use of food, alcohol, drugs and gambling, or changes in physical activity and transport patterns.

More detailed background information on these potential impacts is provided by the Scottish Public Health Observatory in a section on Covid-19 wider impacts.

The surveillance work stream of the Public Health Scotland social and systems recovery cell aims to provide information and intelligence on the wider impacts of COVID-19 on health, healthcare, and health inequalities that are not directly due to COVID-19. The wider impact dashboard can be viewed online and includes the following topics:

- Hospital and unscheduled care
- Accident and Emergency attendances
- NHS 24 completed contacts
- Out of hours cases
• Scottish Ambulance Service
• Excess deaths
• Outpatient appointments
• Healthcare for cardiovascular disease
• Healthcare for mental health
• Women booking antenatal care
• Healthcare for birth and babies
• Termination of pregnancy
• Child health
• Cancer
• Substance use
• Injuries

These analyses are based on a selected range of data sources that are available to describe changes in health service use in Scotland during the COVID-19 pandemic. More detailed information is available at NHS Board and Health and Social Care Partnership (HSCP) level.
Contact
Public Health Scotland:

phs.covid19data&analytics@phs.scot

Further Information
COVID surveillance in Scotland:

Scottish Government

Daily Dashboard by Public Health Scotland

National Records of Scotland

UK and international COVID reports:

Public Health England

European Centre for Disease Prevention and Control

WHO

Weekly National Seasonal Respiratory Report:

Weekly national seasonal respiratory report - Week 12 2022 - Weekly national seasonal respiratory report - Publications - Public Health Scotland

Next Release
The next release of this publication will be 13 April 2022.

Open Data
Data from this publication is available to download from the Scottish Health and Social Care Open Data Portal.

Rate this publication
Let us know what you think about this publication via the link at the bottom of this publication page on the PHS website.
Appendices

Appendix 1: Background information

In late December 2019, the People’s Republic of China reported an outbreak of pneumonia due to unknown cause in Wuhan City, Hubei Province.

In early January 2020, the cause of the outbreak was identified as a new coronavirus. While early cases were likely infected by an animal source in a ‘wet market’ in Wuhan, ongoing human-to-human transmission is now occurring.

There are a number of coronaviruses that are transmitted from human-to-human which are not of public health concern. However, COVID-19 can cause respiratory illness of varying severity.

On the 30 January 2020, the World Health Organization declared that the outbreak constitutes a Public Health Emergency of International Concern.

Extensive measures have been implemented across many countries to slow the spread of COVID-19.

Further information for the public on COVID-19 can be found on NHS Inform.


The WHO initially produced guidance on “enhanced criteria to adjust public health and social measures in the context of Covid-19” in May 2020. The relevant extract from the criteria about the effectiveness of contact tracing within the context of public health surveillance at that time was:
At least 80% of new cases have their close contacts traced and in quarantine within 72 hours of case confirmation. These indicate that the capacity to conduct contact tracing is sufficient for the number of cases and contacts.

Source: https://apps.who.int/iris/rest/bitstreams/1277773/retrieve

In response to questions about whether the Scottish Government had been incorrectly comparing Scottish performance with the WHO “standard” (on the basis that counting in Scotland might start at the wrong point in the process), an assessment was undertaken at the start of 2020, and is available within Appendix 2 of the Weekly Covid-19 Statistical report (publication date 27 January 2021).

Please note this “standard” has subsequently been replaced with further WHO guidance issued in February 2021, reflecting the evolution of the state of the pandemic. This revised guidance now focuses on targeted approaches to contact tracing based on transmission patterns, engaging communities, and prioritising follow-up of high-risk cases when it is not possible to identify, monitor and quarantine all contacts.

Appendix 3: Hospital Admissions Notes

RAPID (Rapid and Preliminary Inpatient Data)

From 01 March 2022, PHS now include episodes of reinfection within COVID-19 reporting. Prior to this date COVID-19 cases were based on an individual’s first positive test result only. The new daily calculation includes both new infections and possible reinfections. Possible reinfections are defined as individuals who tests positive, by PCR (polymerase chain reaction) or LFD (lateral flow device), 90 days or more after their last positive test. This update to reporting will ensure that PHS’s surveillance data reflects underlying transmission rates. More information is available on the PHS website here.

The number reported does not take into account the reason for hospitalisation. Therefore, people that were admitted for a non COVID-19 related reason (and tested positive upon admission) may be included.
RAPID is a daily submission of people who have been admitted and discharged to hospital. These data include admissions to acute hospitals only and do not include psychiatric or maternity/obstetrics specialties. Figures are subject to change as hospital records are updated. It can take 6-8 weeks or longer before a record is finalised, particularly discharge details.

In the data presented here, an admission is defined as a period of stay in a single hospital. There may be multiple admissions for a single patient if they have moved between locations during a continuous inpatient stay (CIS), or if they have been admitted to hospital on separate occasions.

**Hospital Inpatients (Scottish Government Data)**

Number of patients in hospital with recently confirmed COVID-19, identified by their first positive LFD test (from 5 January 2022) or PCR test. This measure (available from 11 September 2020 and first published 15 September 2020) includes patients who first tested positive in hospital or in the 14 days before admission. Patients stop being included after 28 days in hospital (or 28 days after first testing positive if this is after admission). Further background on this new approach is provided in this Scottish Government blog.

This is based on the number of patients in beds at 8am the day prior to reporting, with the data extract taken at 8am on the day of reporting to allow 24 hours for test results to become available. Where a patient has not yet received a positive test result, they will not be included in this figure. Patients who have been in hospital for more than 28 days and still being treated for COVID-19 will stop being included in this figure after 28 days.

All patients in hospital, including in intensive care, and community, mental health and long stay hospitals are included in this figure.

**Appendix 4: Contact Tracing**

**Definitions**
An **index case** is generated for each positive result with a test date on or after 28 May 2020. This includes tests derived from Scottish and UK Government laboratories, as well as self-reported LFD’s.

An **individual** is a unique person who has had a positive test. Before the 5th of January 2022, only positive PCR tests were counted, but LFD tests are included after that point to identify unique individuals. An individual can have multiple positive tests which results in multiple cases within the test and protect system. In these figures, each person is only counted once.

A **contact** may be contacted more than once if multiple positive cases list them as a contact.

**Completed cases** are cases, which are marked as completed in the case management system, which means that all contacts have been followed up and completed. It excludes cases marked as failed, excluded, in progress or new. In the latest weeks there will be cases which are still open either because contact tracing is still underway (particularly for the latest week), or the NHS Board is still managing the case as part of an open outbreak.

Weekly data presented from Monday to Sunday in order to be consistent. Figures are provisional and may change as the test and protect tool is updated by contact tracers.

**Individuals unable to be contacted**: This information is only available for index cases that have been recorded on the CMS. The CMS went live on 22 June 2020 with NHS Boards migrating on a phased approach with all Boards using CMS from 21 July 2020. Prior to a Board migrating to CMS, data was recorded in a Simple Tracing Tool, which did not give the level of granularity required to report on these measures. These data are developmental, and an extensive data quality assurance exercise is underway, and data may be revised in subsequent publications. Please note the methodology has changed as of 1 November 2020, a refined method has now been applied to identify unique indexes.
Contact tracers will contact index cases by telephone, and by default, all close contacts will receive an automated SMS. This approach ensures high quality calls can continue to be prioritised for index cases. Even when SMS is defaulted to, in these scenarios, a number of close contacts are still telephoned, following clinical risk assessment, particularly if they are linked to complex cases. When close contacts of index cases are contacted via SMS text message, the GOV.UK Notify Service is used which means it is known if the SMS has been received by the mobile phone, not just that it has been sent. Where the SMS is not received, a contact tracer will attempt to contact the individual through other means.

Appendix 5: Lateral Flow Device Testing

UK Gov other includes any LFD result, which has come through the UK Government route (NHS Digital) which has the test site code “Other”. Please note the universal offer results up to 28 July 2021 are reported via this method. From 28 July 2021 onwards, universal offer results are reported separately as Universal Offer.

The Attend An Event, High Cases In Local Area, Lives With Someone Who Is Shielding, Travel Within UK and Universal Offer categories only include data from 28 July 2021 onwards. From this date, these categories are now options when entering a non-work LFD result via the UK Gov portal. Please note that it is up to the user to select the Attend An Event, High Cases In Local Area, Lives With Someone Who Is Shielding or Travel Within UK category, these are not part of any defined testing programme such as Community Testing or University Testing.

University Testing Site tests are tests which took place at a university-testing site, generally in the 2020/21 academic year, though there are still a small number of tests each week in this category. Tests in the university students and university staff categories are tests via the UK Gov portal for someone entering a test to attend their place of work/education; these tests are from 28th July 2021 onwards and will be for the 2021/22 academic year.
For information regarding LFD testing during term time as part of the Schools Asymptomatic Testing Programme, please visit the COVID-19 Education Surveillance Report.

Please note bulk uploading functionality is not yet available so data is likely to be an undercount. Data will be update and revised in future publications.

Other is any result entered via the gov.uk website where “none of the above” has been selected. Please note anyone requesting a LFD test via the general population offer, will currently report their results via this category.

Appendix 6 – Hospital admissions ‘because of’ COVID-19

The SMR01 dataset comprises episode-based patient records relating to all inpatients and day cases discharged from non-obstetric, non-psychiatric specialties and excluding geriatric long stay records. Data are updated on a monthly basis and include clinical and non-clinical data.

Analyses are based on month of admission.

Average length of stay is the mean length of stay (in days) of a patients entire continuous inpatient stay (CIS). A CIS is an unbroken period of time that a patient spends as an inpatient. However, a patient may change consultant, significant facility, specialty, and/or hospital during a continuous inpatient stay.

A COVID-19 hospital admission ‘with’ COVID-19 is defined as: A patient’s first positive PCR test for COVID up to 14 days prior to admission to hospital, on the day of their admission or during their stay in hospital.

A hospital admission ‘because of’ COVID-19 is defined as an admission with a diagnosis of laboratory confirmed (U07.1) or clinically diagnosed 5 COVID-19 illness (U07.2) in the primary diagnostic position of the SMR01 record, within the first episode of the Continuous Inpatient Stay. As SMR coding is done on discharge, ‘main condition’ reflects that which is considered retrospectively to be primarily
responsible for the patient’s need for treatment, rather than necessarily the condition with which they presented. Data using this definition prior to 1st June 2021 will include a greater proportion of COVID-19 admissions, as prior to this date COVID-19 was more likely to be assigned to the ‘main condition’ position due to the coding guidance at that time.

ICD-10 COVID-19 diagnostic codes used: U07.1 and U07.2.

The six NHS Boards included in the analysis are: NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Grampian, NHS Greater Glasgow & Clyde, NHS Lothian and NHS Tayside.

Appendix 7 – Early access details

Pre-Release Access: Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", PHS is obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access.

Standard Pre-Release Access:

Scottish Government Health Department

NHS Board Chief Executives

NHS Board Communication leads