Health Protection Scotland

Public Health Scotland

National Incident Management Team – 13/11/2020

JMcM – confirmed discussion content today would include education, the Deputy First Minister's statement in light of the impact of the levels in reducing the number of cases collectively, the projected number of cases in the community and hospital settings.

Situational Update

1357 new positive cases today.

Ayrshire & Arran – 77

Borders – 10

Dumfries & Galloway – 13

Fife – 148

Forth Valley – 80

Grampian – 50

Greater Glasgow & Clyde – 433

Highland – 13

Lanarkshire – 267

Lothian – 163

Tayside – 101

Shetland – 0

Orkney – 0

Western Isles – 2

Deaths – 56

JMcM – the cases are from the PHS information in which we had been considering a comparison of where we are now compared to last week's trend. Today's SG Watchlist paper showing information as a 7 day cumulative weekly incidence and the slides accompanying these will be used to take forward in our discussion today.

The slides demonstrate that most Local Authorities are close to very similar cumulative rates this week and last. Some reduction on 09/11/2020 by individual age groups with some evidence of reduction in the most elderly over the recent week.

Considering the trend in cumulative incidence by NHS board for those with Level 3 LA's, there is some perception of levelling out for many of the NHS boards with some difference of over 60s and under 60s but it would be fair to say that there is not a rapid reduction in rates.

In Level 2 also have some differences between those over 60s and those under 60s with different patterns within each NHS board.

DS – from an educational side, the next steps are to allow students to return home and the timeframe would begin in early December. All universities expressed interest in testing students before they headed home for Christmas. This will involve asymptomatic lateral swabbing where the student would do this, their details would be stored electronically to allow the results to students be sent electronically.

DS explained if positive student would self-isolate and contact tracing would commence and isolation for contacts would begin. Student would be asked to test 5 days later. If there are 2 negative results, it would get students home but there would potentially still be a risk for students working with vulnerable people and some living with vulnerable people.

Level 4 discussion bearing on student movement is difficult to say at the moment. DS is involved in discussion on what should happen at level 4, should students go to remote learning rather than face to face as remote learning does let them go home.

GS – Discussion continues about exemptions or approach as blanket of all higher education at level 4.

AL – we would need to consider that Stirling university prioritises sports studies which are inherently more difficult to deliver as an online study. Impact of restriction and alter in the tier would alter the level.

DS – to GS point, if we do move into Level 4 and completely online, ONS evidence shows students go home straight away so there is a need for a coordinated way.

EF – advocate for online teaching support exemptions to course as they cannot be postponed until next semester – sports could be changed to next semester. Accepting that any measure we implement with tiering in place currently is having an impact and wouldn't' have a further impact than previously.

AB noted a general comment from English colleagues this morning discussing this subject: "there is little point of taking an area up a Tier if people are not complying in the existing tier - you would be better off running a targeted behaviours campaign".

JMcM overview position – it is relatively clear we are seeing evidence of plateauing in cumulative incidence for many LA's.

To reduce the impact of COVID-19 on the population and from a Harm 1 health protection premise is there advice a move to level 4? Is this the right thing to advocate this or are prepared to wait or are we prepared to do something different. Initial feedback on Liverpool's mass testing, 52-53,000 with 295 positives within first set of testing.

EF – Can I ask, please, are we anticipating / observing any unintended consequences from the Liverpool testing - i.e. people with a negative result relaxing their behaviour further offsetting the benefits anticipated?

JMcM – I don't know if we have this analysis output yet.

MB – I have a call in with Terry Whalley this weekend who is directing Liverpool testing and will see if I can pick anything up.

DS – that is a key worry with the student testing

JMcM – Aware of DPH topic discussion today, right time to move to Level 4 and then consider for colleagues across the central belt. Can someone report back?

GD – Frank discussions on concerns of impact of virus escalating on clinical services and where we will be in January. Supress virus as quickly as possible and share from behavioural science of those who would not comply. In getting the virus down and as soon as possible, NHS GGC, NHS FV and NHS AA were supportive of this and an action to get us in the best and better place in January.

LDeC – by going up a tier and if we haven't fixed non-compliance where would we be? Low income workforce is impacted if not allowed to car share, can SG support this? Enhance compliance.

JT – we are not seeing the turnaround and we may not need to change immediately to higher restriction as it could cause others to move to travel. We need to think in a joined up way and with local authority understanding.

AB – EH call yesterday a comment was made in regard to the central belt saying it doesn't feel like much has changed for people living in the local authorities since September. So behaviours haven't shifted either

GF – need to think about getting the rates back down. Local authority awareness for action do this hard as there is need to do something to wake up and be aware, they need to follow the measures and we would see the change or slightly worse and if not with you it will be soon.

LMcN – rapid spiral down is key to major outbreak in Arran as 2 weeks ago COVID free. Echo JT.

GS – insights from these meetings are invaluable. There is a risk that IMT may have become tolerant of higher incidence and impact over time. The NIMT should not lose sight of the WHO aim to achieve a cumulative weekly incidence of below 50 of 100,000 - we may have lost sight of this. Further the NIMT should consider whether there is a possibility of evolving thresholds of the indicators we use. Advises that the NIMT should look at these targets and not become complacent. **Action PHS subgroup on data and modelling to consider**

JP – agree a review of indicators and thresholds would be helpful.

GD – JMcM could the IMT recommend clear goals for Scotland e.g. getting to a sustained level below 50 per 100.000 as quickly as possible for every area in Scotland?

GS – Liverpool - 90k tested. 430 (18%) pos just over 50% asymptomatic

GF – Could we set level less than 50 and test %positive less than five as key criteria for coming down a level (from any level)?

MB – Is there another premise Jim. Are we assuming that local measures work and will curtail spread to other areas? Are we sure of this?

Because if so then we need to put more emphasis on movement between areas.

We went into this taking it an area at a time to reduce impact of the measures. Do our assumptions still stand? (Open question)

GS – key point GF.

VW – health harm and wider harm, NHS DG are coping and we can tolerate busy but not overwhelmed, our care homes are higher rates and we have figures to go into level 1. How do we suppress virus and not feel level 2 would do this? Some concern about if Level 4 for central belt whether they would come down to Dumfries and Galloway.

JMcM – response about DPHs watch list information, said key question today but VW if we accept that premise you intervene early, in the expectation that this would be for a shorter time of measures in place.

Some parts of country have low incidence but may have a special case made about them; it is important to consider all. NHS FF and NHS TY cumulative incidence rates are increasing. Are we suggesting all of these should be in level 4 for health protection advice? No not currently.

NHS GR – SW: Level 2 and rising so applies across all levels

NHS LO – PC: East Lothian are currently level 3 and could down to level 2. Think about a different strategy rather than the balance approach, challenging with brief for one local authority moving down to level 2 but another one going up to level 4 for example.

NHS FV - GF– if option level 3 or level 4 would be level 4. Too many going about their business and pressures for compliance and not non-compliance. Bigger control on travel and encourage people not to work if they have symptoms.

JP – unsure if we have a list, based on information we know and unsure if we have time.

EF – wider than local approach as level 3 brings a degree of restriction not moving out, restricts travel and depends on being happy to stay in level 3. Restriction on travel are already in place. Role of testing discussed today or now – consider discussion now.

GS – fundamental important point is setting the level, variety of people in government. The review expected impact over the four arms of previous intended affect. If we adopt a first principle the premise of what we are operating looked at the interventions, there has been limited evidence of yet of levelling off cumulative incidence or of hospitalisation and ICU levelling off.

PHS – JMcM. From a Health Protection prospective: if the WHO goal aiming to achieve of course consider 50 per 100,000 rate, there is a mismatch in the thresholds we apply. I propose that the sub-group should re-examine thresholds and offer a later view.

NHS BR – TP: JMcM I think before you decide you need to agree what are the objectives. I am still not clear what these are. If it is around hospital capacity, then that should be the measure. If it is about vulnerable groups, then we don't know the percentage of these groups are affected. My preference is to focus on vulnerable groups. Using increased blunt restrictions to reduce spread in very low risks does not seem reasonable or indeed ethical.

GF – There are so many exemptions that virtually no travel reductions have occurred.

SW – GF, do you have evidence of travel contributing? We looked but it didn't add weight to increasing transmission.

GF - what we are seeing is most current positives are work related and very many are travelling between high and low prevalence areas.

TP – my understanding that excess deaths and morbidity from restrictions are significant so as public health professionals these harms must be considered in any decisions about levels.

JMcM – Additional data for considering in the NIMT should include Care home, hospital and ICU risk groups presenting, difficult to go over this in every sitting and important to go through key things. We need to assess if there is a problem and whether we need to do something else.

LDeC – in central belt we know we need to do more. GF's points of travel and exceptions, close schools earlier, try mass testing and information on not understanding if just asymptomatic but what they spread. Do we have a national lockdown before Christmas?

VW – LDeC, I would support that

GF – lots and lots advocating for areas in central belt, not what shops open but what it does do to health protection. Point should be for stable or improvement as there are likely expectations in winter, respiratory restrictions.

Unfortunately, I cannot describe the local position in central Scotland as stable or improving. That is not what we are now seeing.

IK – I think we need more of both carrot and stick regards individual behaviours re: isolating, not going to work when waiting test result etc.

SW – It is not just about not going to work with symptoms but work from home if you can.

GF – Yes SW, or perhaps - stay at home and work if you can

AL – with JMcM being exemplary in that today!

EF – can we tie this up in package, can we say based on wave 1 and lockdown – can we give motivation to do their best for the next 4 weeks, and then have a more relaxed approach. Test and Protect.

IK – absolutely - but T&P are frequently coming up with cases who have failed to follow even the basic don't go out and about if you should be isolating.

JC - Does the group at SG looking at compliance have anything to inform us of? Are there questions being actively asked of compliance with different aspects of what is in the Tiers?

AMcI – IT's set out in the Strategic Framework - suppress to very low levels and keep it there

GD – evidence informed, Scotland tracking Spain and France, seen rise up and level and back up, also evolving evidence form North East England. What are people's intention to comply of restrictions? What can we do to get in front of the virus? Clear to take incisive measure to get a chance in festive period and after new year to contain. February and March little evidence from China and ???

VW – what is SG objective to supress as low as can be or continue as we are now, need clarity from SG – we are trying to separate but difficult.

GS – clear on SG trying to have case rate as low as possible, so 50/100,000 rate - yes WHO rate. The risk is we lose sight of this and became tolerant of the rates we are currently

observing. Need to separate out direct COVID harm and impact on NHS services of non-COVID harm. If virus allowed to run high, economy and low income population hit hardest.

EF – completely agree, GS. I would be uncomfortable going into the festive period at current incidence. Any doubt that level 3 is not going to impact that then I would be advocating level 4.

MW - not sure of the other islands but fairly certain we will not have good compliance from our population to move from Level 1 to 4 with the low numbers we have. Travel into the islands (both locals returning and visitors) is the underlying factor for our cases, but we need to travel for specialist medical care.

JP - we need to do everything to protect vulnerable groups to prevent infection in them and simultaneously also enhance support for those who are disproportionately affected by the restrictions, difficult balance to achieve

SW – MW, Shetland would be in the same position. We are looking at what else we can do locally

GF – everyone moves up one level?

VW – levels are wrong; tolerance need to be changed with serious needs to be done.

GF – or to put it another way, despite current levels almost no Authority has achieved an improving situation so suggest everyone resets to one level higher as a clear strategy to get us ready for Christmas.

SW – JMcM, we have been talking about travel for weeks now - can we agree a focused action to put forward some suggestions for consideration?

PC – CMO has been clear for driving rates down, level system would not achieve this. Keeping faith with local authority and public, their expectations are not to drive virus down. Need to be thoughtful and how approach is changed. SG always Scottish approach.

JMcM - what are we advising? Strong advice from DPHs. Levels within framework document are considered by Scottish Parliament. Further option in which if we are thinking our measure part successful and reduce to 50/100,000 – local authority applying the levels.

In addition consideration of the following;

Mindful of bigger control on travel – travel restriction and enforcements surrounding this

Revisiting exemptions

Consider trial testing

Motivational messages

Blunt tool is certainly easy to communicate

Everyone in level 3 currently advocating this consider having the same benefit.

NHS LO East Lothian should go down to level 2 but would support up to level 4, threshold not right.

EF – Dundee doing well other level 3 today. Changes to system we are working to – support and happy to go with new tier system.

JMcM – not worked out mechanism to do this. Local authority into level 3 and stay where they are, if they are moving down maybe stay in current level.

EF – advocating Tayside wide approach to stay 1 more week and then assess.

IK – looking at locally produced data, going down and where it starts from as a few have mentioned short lockdown pre-Christmas, where does that fit in?

JP – My point was similar to IK - how can we distinguish the merits of a national lockdown versus all of us going one level higher? Also a caution about (evidence informed - Clydesdale and Inverclyde) that variable levels within a board area might not be sustained favourably.

EF – very supportive of national collective approach.

GS – I don't envisage a national lockdown.

SW – could we take the list that DM has set out and identify what we can do to address - currently levels don't address many of these issues

GF – I agree - not a lockdown but a collective move from containment to reduction. Everyone moves up a level unless already at the Level 4; advocate aim is cases less than 50 per 100,000 and % positive <5%.

EF – helpful, thanks GS, in which case recommend status quo for Tayside and close monitoring

GF – appeal to stick together.

JMcM – some suggestions about do together collectively or some areas feel they are getting to grips or invoking a change and may yet see an effect.

NHS HG – JW: There are concerns of travel imported from aboard or UK if we are not addressing this or not significant to level 1. Additional risks are indoor events and back to travel, increase will worsen if we don't increase tiers - DM and GF support these travel restrictions as well.

NHS DG – VW: we could be in level 1 - message to public. We are content at this level but people dying in care homes, over 60s may have caused increase. Concerns of central belt in terms of people coming into region. Levels not comfortable but until national lockdown it would be hard to group as PC said.

NHS WI – MW: issue is travel; 2 cases have travel links. Enforcement if we can with no lockdown. MW confirmed NHS OR and NHS SH share same concerns as ours.

JMcM – We have a strong positon to express for a move from level 3 versus up to level 4 in this discussion. Strongest is for one approach as evidenced during the DPHs prior meeting. Travel restriction is an important consideration as well as enforcement and compliance.

Testing – developing array of test to consider in due course. NIMT and DPHs advice formulating a lot to discuss with local authority colleagues, our colleagues today SOLACE and COSLA may have been wanting to express gave opportunity for us to discuss.

MB – One thing to consider re mass testing. Anywhere you bring it in the numbers will go up very fast. As you pick up more cases.

It would put those areas into a higher category through case finding. The hope then is case finding would eventually have a bigger impact and drive no's down but initially it would likely affect banding levels.

DM - we are seeing: people are not getting tested with mild symptoms, people are going to work with symptoms and often sharing transport (and that is significant in H&SC), employers are not telling people to work at home or stay at home and low paid staff feel they have to go to work due to low numbers of people qualifying for financial support. What levers do we have to influence/enforce actions by employers very quickly? (along with any change of levels or change in thresholds related to levels which I support).

COSLA/SOLACE - S Grimmond – in terms of narrative of managing this, SG colleagues set of recommendations sit uneasily, not disagree with discussions as strategic approach today.

COSLA/SOLACE - N Dickie – stage management and get right data out. Greater Glasgow and Clyde and Lanarkshire won't be surprised, Lothian and Edinburgh City, and Inverclyde are in better position be too cold could be difficult to land.

Review of Action Notes: leave action list today and JMcM will review.

DONM: JMcM - schedule early on Monday, set time as 11:00 allow our colleagues on 7-day cumulative incidence.

GD – not expecting announcements over weekend but at beginning of next week.

PC – figure data: could this be shared in tabular form and threshold data not be shared as screen shot? PC to share with text with KH and this will be conveyed to colleagues.

JP – we have had similar issues with differences in ECOSS data and would appreciate further discussion on this.

GF – PC, we faced the same issues with data. The trends do reconcile over time but SG announcements use day of result wheras PHS data uses day of test. We just try not to get too focussed on day to day changes and look at overall trends. 5 cases can change the rate per 100,000 dramatically in a small LA.

PC - thanks very much GF, we've been comfortable with small differences in the spirit of your suggestion above. We're exploring some larger discrepancies today (although none which would change our consideration of levels).

LDeC – Inverclyde: case to keep level 3 as reacting differently as to other local authorities, think about balance.

JMcM – option: Inverclyde, East Lothian and all of Tayside.

Thank you for your updates, we are making best of data available to us and unsure of behavioural compliance and not complying. Festive period in mind for DPHs, I think challenging week ahead.

Elected rep – FM decision, advocate on behalf constituency they represent.

MB is PHS Incident Director this weekend, hope down time for all.

DM – if these are continuing 3 times per week can we send out appointments for the whole week/month ahead please? always easy to remove if not needed.

JMcM - flexible on this, we will be able to put out time ahead approach planning ahead.