SCOTTISH GOVERNMENT COVID-19 ADVISORY GROUP

Thirty Sixth Meeting

2 November 2020

16.00-18:00

MINUTES

1. Welcome

The chair welcomed group members and invited guests

Advisory Group Members: David Crossman, Tom Evans, Nick Hopkins, Jim McMenamin, Stephen Reicher, Chris Robertson, Aziz Sheikh, Gregor Smith, Devi Sridhar, Nicola Steedman, Mark Woolhouse.

Invited attendees: Mary Black, Name Redacted, Name Redacted

SG: Syed Ahmed, Richard Foggo, Derek Grieve, Daniel Kleinberg, Elizabeth Sadler

Secretariat: NR, NR

The chair noted that work is underway to publish papers considered by the group during June & July and working through a backlog. It has been announced to the Scottish Parliament that the Secretariat will work to produce fuller, more detailed minutes for publication, starting with this meeting.

2. Minutes and Actions

The vice-chair had agreed the minute of the previous meeting, which he had chaired. Members had no comments on the minutes of previous meetings.

3. Scottish Government Update

CMO provided an update on issues since the group last met, noting that the pace of developments and pressure of demands for advice had been extraordinary with a series of very difficult decisions having been made. CMO thanked the group, who had contributed enormously to this.

The rise in indicators such as case numbers and test positivity ratios in the central belt had been a concern for some time and SAGE advice on additional measures/ circuit breaker had been influential. Over the last week or so we had started to see the measures put in place having some impact. Indications are that the growth rate and R are decreasing, with Scotland now perhaps in a relatively better position than most of the rest of the UK. Those trends appear to be continuing but the key questions are whether the reduction is fast enough and whether it will plateau. This would need to be considered in light of the available data and the Westminster

announcement at the weekend (and the connection between that the ability to extend financial support).

The group noted that case ratios were going down, though that was fluctuating within some age cohorts for those aged under 30. The reduction for older age groups at greater risk should have a beneficial impact on hospital admissions and deaths. Key considerations were whether those improvements were as fast and effective as they needed to be and how we could improve the evidence base for future decisions. Tier 3 equivalent restrictions had been acting to reduce infection but there were concerns that lower levels may not have the same effect. This is not a short-term issue and sustainable measures are needed. The pandemic could stretch till next autumn and there needs to be engagement with the public on this.

Dexamethasone is having a positive impact. With other improved treatments, it has resulted in better outcomes than during the first wave. Hospital death rates had fallen from over 30% to around 10%, which is a huge improvement. Further incremental change and learning is likely to lead to better treatment. New innovations will be important in development of NPIs e.g. potential in UVC.

Analysis of the first wave suggests that most of those who will die in the second wave have not been infected yet and there is a need to consider what more can be done to protect the 5% most clinically at risk who account for 75% of deaths.

Key points for improvement in the coming weeks and months would be to detect more cases and improve compliance with self-isolation. Identifying more cases is difficult where so many are asymptomatic, but easier to spot clusters where prevalence is lower and new testing technologies should enable more asymptomatic cases to be picked up. In the absence of a vaccine, mass testing is likely to be key in avoiding long-term restrictions and risk of lockdown. Frequent testing, even with lower sensitivity, would identify more cases and uncover transmission routes/ increase isolation of positives.

There were concerns from the Group about the impact of travel – the data showed the impact of domestic and international travel when infection had been at a low ebb. Need to consider what can be done to inhibit imports and avoid getting into that situation again.

There are questions about reported poor compliance with self–isolation. ‘Supported isolation’, with assistance from government and through communities will be important in helping people live within the rules. Effectiveness is key for adherence and unrealistic demands will undermine it.

4. Winter Holidays

Elizabeth Sadler introduced the issues, referring to the papers tabled and noting that the winter holiday period covered Hanukkah, Diwali and other festivals as well as Christmas. The NHS winter plan was published last week and was being taken forward. This discussion was about other considerations in relation to the winter holidays including household gatherings, places of worship, retail and travel, including for students. Christmas will inevitably look different from what we are used to but expect there to be a call for some reduction in restrictions over the Christmas

period. Also, need to think about 4 Nations coordination, impact of new Westminster announcement and communications with the public.

The group noted that the science of virus spread is clearer; increased mixing over the Christmas period is highly likely to lead to a sharp increase in transmission and most importantly intergenerational mixing is most likely to impact on older people. There needs to be a clear message that people should minimise their contacts. Scaling restrictions back for a fortnight would present a significant risk of driving exponential growth in the virus. Some relaxation for a shorter period would be a commensurately lower risk, but would still present a risk. The extent of that risk will be dependent on the prevalence of the virus at that time.

Communication around any changes would be important and needs to be sensitive to equalities issues. There is a risk that relaxing the rules could send a negative signal but, on the other hand, temporary relief from restrictions could enhance compliance for the rest of the holiday period. There is a need to consider the impact of policies on the sense of equity, legitimacy and of hope.

A lot of people will want to travel 'home' for Christmas, including students. Many of those will want to travel within Scotland but others will want to travel from elsewhere in the UK and further afield and some of those currently living in Scotland will want to travel to homes outwith Scotland for the holiday period. Mass movement over the period will enable the virus to spread, particularly where travel is from areas of high prevalence to areas where it is lower, and is possible that new strains of the virus will be imported.

The peak time for travel 'home' is likely to be from Friday 18 December onwards. There is a need to consider what the prevalence of Covid and the R number will be by 17 December on current trends and whether further measures are needed in order to ensure that the impact of travel over the holiday period does not overwhelm us in the new year. The same considerations would apply to any further relaxation of regulations for all or part of the winter holidays.

Student movement is likely to be an issue from early December. A staggered departure of students before the main travel period for others could help alleviate risks. Planning for the new term should move as much as possible online but where not possible consider staggered arrivals, quarantine and testing provision.

5. Covid Vaccine Delivery

Derek Grieve introduced the paper for this topic, noting that planning is well in hand for potential vaccines. The front-runners may be available as early as December - initially in small quantities, though ramping up considerably over a couple of months. There are however huge uncertainties as vaccine supply and availability are dependent on successful completion of stage 3 trials, which are still underway. Deployment will be guided by the work of the Joint Committee on Vaccination and Immunisation. Further complexity may arise from the availability of further vaccines to add to the front-runners and policy may have to evolve over time, dependent on vaccine characteristics, and will consult the groups further if required.

The group noted that it was important to understand the effect of the vaccines and the extent to which that is proven by the trials, which is a complex process. A vaccine might prevent transmission, alleviate symptoms, prevent deaths and may have different efficacy for different groups, all of which might influence deployment. Some of this might be evident from clinical trials but other aspects – including understanding how long-lasting the vaccine's effects are - will require further studies following deployment and plans should take that into account. The effectiveness of any vaccines was likely to be related to natural immunity, which was not well understood at present in relation to Covid-19 though signs were not promising so far.

There may also be a need for different deployment strategies depending whether the prevalence of the virus was lower or higher as that may influence priorities; and, indeed, restrictions to manage prevalence might need to be aligned with vaccine readiness. Trust in Government would be a crucial factor in encouraging uptake of the vaccine and it was important to understand that priorities for vaccination will also influence trust. It will be important for communication to emphasise that vaccination does not do away with the need for NPIs and that distancing etc. will need to remain in place.

An effective digital solution for tracking will be important for data collection. The incredibly complex trials on multiple sites will mean that they will produce complex data to interpret but we have good systems in place to monitor impact through EAVE once data flows are in place. Real time data building on EAVE will be important in understanding the safety and effectiveness of vaccines.

6. Risk in hospitality settings

The chair thanked members who had contributed to the draft paper, noted that some of the issues had been discussed earlier in the meeting and invited members to submit further comments so the paper could be finalised.

7. Sub-Group Updates

Sheila Rowan reported that the Education sub-group advice had now been published. David Crossman noted that the Testing sub-group had discussed the use of low sensitivity tests and COG UK data on n4392K effects on antibody binding & virulence.

Jacqui Reilly reported that the summary update paper on aerosol transmission took account of the latest updates to SAGE and CIBSE guidance. The main messages were consistent with previous advice. The detailed recommendations had a new focus on carbon dioxide monitors and UV light. While there wasn't much evidence, carbon dioxide may be a risk indicator and the nosocomial sub-group has commissioned an evidence review on UV. SAGE may do further work on ventilation.

David Crossman noted that he had been approached about UV. It was potentially a good example of innovation on NPIs, which there was a need to promote more generally. UVC is germicidal and may be usable in non-health settings where ventilation is not feasible and research is looking at the possibility of using UV at a frequency that doesn't damage skin, though this was still experimental. The chair

noted that this should be an agenda item for a future meeting, with any new SAGE paper, involving Jacqui Reilly

8. SAGE Update

The Chair noted that time precluded discussion but that members had access to the latest SAGE papers.