SCOTTISH GOVERNMENT COVID-19 ADVISORY GROUP

Thirty Eighth Meeting

3 December 2020

MINUTES

1. Welcome

The chair welcomed group members and invited guests, noting that the approval of a vaccine was an important inflection point for the work of the group.

Advisory Group Members: Andrew Morris, Dave Caesar, David Crossman, Tom Evans, Nick Hopkins, Jim McMenamin, Jill Pell, Stephen Reicher, Jacqui Reilly, Chris Robertson, Sheila Rowan, Aziz Sheikh, Devi Sridhar, Nicola Steedman, Mark Woolhouse.

Invited attendees: Mary Black, Name Redacted

SG: Pauline Aylesbury, Derek Grieve, Daniel Kleinberg, NR Niamh O'Connor.

Secretariat: [REDACT: NR

2. Minutes and Actions

The Chair noted that the first of the extended format minutes to be published had attracted press interest. All comments on the draft minutes of the previous meeting to be sent to the secretariat so they can be finalised ahead of publication.

3. State of the Pandemic

The Chair introduced the item, referring to the papers tabled, which provided an overview of latest developments. Latest indications were that level 4 was having a potentially significant impact, while experience in other areas was mixed. The different levels in place and the changes in those levels meant that UK level modelling had difficulty capturing the detail of the arrangements at a Scottish level and therefore focused on west/central Scotland & main population centres.

Mark Woolhouse introduced his paper on 'COVID-19 Death Rate In Scotland During The 2nd Wave'. That analysis of deaths during the second wave indicates that the trend in Scotland has been in the middle range when compared to elsewhere in Europe. However, numbers have been higher than modelling projections since October and recent figures may be increasing faster than elsewhere. Looking more widely, the difference in outcomes in Europe compared to SE Asia may be best explained by differences in adherence to self-isolation.

Compared to the first wave, trends in death rate by week have been lower for those aged 85+ and also much lower for those in care homes. This indicates that measures put in place over the course of the pandemic have been more effective in protecting the most vulnerable and those in care homes than during the first wave. An examination of the pattern of differences in reporting of deaths daily and on a weekly basis shows a shift when comparing the two waves and suggests that daily reporting is now more accurate than during the first wave due to increased levels of testing. A question about participation in the VIVALDI study in Scotland was raised. Further, more detailed study would be needed to confirm if the necessary data is available in sufficient detail.

Further analysis indicates that Scotland has experienced a high ratio of cases to deaths during the second wave. The figures in the paper suggest a higher fatality rate when compared to elsewhere in Europe - 42% higher than Switzerland. Different possible causes for that were discussed – from the data capture through to the link to pre-existing excess mortality issues in Scotland. Additionally, weather may have an impact (e.g. myocardial infarction is more common in winter) but Norway, Sweden and Denmark are not marked by the same pattern. Analysis indicated that co-morbidities were similar to the first wave but the incidence of disease in areas of greater deprivation may be more marked in the second wave. Such differences could be down to reporting differences, different detection rates or be a signal of a different case fatality rate

The group noted that PPE, IPC measures, testing & guidance had much improved in care homes and adoption of dexamethasone has likely had a major impact. There is a need to be careful drawing conclusions: there may be some impact from immunity within some settings but the extent, if any, is currently unknown and the implications of the first wave for age cohorts may have impacted on figures. It was agreed to give the matter further consideration.

4. Covid Vaccine

Derek Grieve opened the discussion, referring to the significance of the decision to grant Pfizer a supply licence for their vaccine, highlighting the importance of the guidelines set out in the JCVI statement and noting that work is in hand on prioritisation of groups not covered by that advice. Supplies of the vaccine are expected imminently and would go straight to NHS Boards in Scotland. Initial priorities are vaccinators followed by healthcare workers and care home workers. The latest advice on handling the vaccine provides more flexibility to implement JCVI recommendations and take the vaccine to care homes. There is a lot to learn about the vaccine, including impact on transmission, and policy will evolve with our understanding and with the impact of other vaccines.

NR spoke about the evidence base and principles underpinning the communications priorities supporting delivery of vaccinations and the need to be able to address misinformation and disinformation. Information sufficiency is important but messages need to be simple, factual & honest. Anti-vaccination views are only a small proportion but others are hesitant and have questions and need

access to the facts. First phase for communications is older residents in care homes and health care workers, who need more information than the general public. In the longer term, the approach would evolve over time to respond to different audiences.

The group agreed that there was a need to distinguish between those implacably against vaccinations and those who have legitimate questions. It is normal that there will be questions from the hesitant. That is perfectly reasonable and positive – not the same as being anti-vaccination. There is a need to listen to, understand and respond to people's questions and the two way conversation needs to be open about potential adverse events. There would be a need, once more vaccines become available, to consider how we answer questions about the use vaccines with different characteristics and for clear messaging about the reasons for and benefits of those selected for use.

Trust is critical and communication needs to be grounded in reliable sources of information and avoid anything which sounds like political point scoring. There is a need also to be prepared for debate on values when tackling misinformation e.g. consider how vaccination supports individual freedoms. Mainstream media are generally responsible in reporting on e.g. side-effects and can benefit from briefings on the science to counteract any misinformation. GP experience suggests many people will have questions relating to fertility and pregnancy issues.

Most literature suggests the most effective communicators are members of the group being communicated to; generally not celebrities. Polling in Scotland shows that people are likely to respond positively to the delivery of campaigns from the NHS in Scotland.

Generally, there is a need to ensure good communication that normalised the asking of questions was prioritised; that co-production would be central and that this is immediate. There are small numbers of people and groups competing to answer those questions with misinformation already active and seeking to influence the rest of society.

We need a strategy to communicate with those who consider themselves at less risk – e.g. the under 65s. Covid is very different from flu. It is a multi-system disease with implications for lungs, heart, kidneys, brain and blood vessels. Given that most deaths are in the not clinically extremely vulnerable group, the incidence of 'long Covid' and PIM-S, there could be serious harms associated with seeking to achieve herd immunity via uncontrolled natural infections in the under 50s. Longer term, vaccination will need to cover other groups in addition to the most at risk risk and the communication strategy needs to widen to cover that wider group. As the vaccines haven't been tested on children, ongoing consideration needs to be given to PIMS and other possible effects of Covid on them.

More data & modelling is needed to determine how and whether we get to herd immunity as we don't yet know what the immunity threshold is for Covid. Until that is known, vaccine 'passports' can't be recommended but it is vital that records can show who has been vaccinated.

It takes time to build up long term safety information about new vaccines and Scotland does not have a big enough population base to assess safety data without alignment with UK and international initiatives. Until then, procedures are in place to ensure any issues which arise during vaccination will be fully investigated. Communications will need to be ready to explain those procedures and address any concerns. Group members with an interest in pharmacovigilance will share experience and links into discussions across the UK.

5. Mass Testing

Niamh O'Connor introduced the discussion, referring to Cabinet Secretary's statement to Parliament on 25 November on testing expansion. Lateral flow tests are now available in large volumes; lighthouse labs and NHS hubs are expanding capacity; all emergency admissions now being tested and planned admissions will be tested; twice weekly lateral flow testing for some health care workers; care home workers and some visitors are being tested; student testing has started with plans being made for return in January; and there will be learning for future expansion from the asymptomatic testing pilots, one including lateral flow, currently running.

The group welcomed these developments. The announcement of a significant scaling up of testing was a further inflection point in our response to the virus. The need now was to scale up the pilots and consider how we can best use waste water testing. A key question would be how we use testing in the era of vaccination, which would be discussed at the Testing subgroup. The group noted that there were lessons to be learned from international experience, Slovakia for instance, and from the pilot in Liverpool. In all cases, subsequent support for isolation is likely to be critical.

The Clinical Cell would be discussing the use of Lateral Flow Testing.

6. Deep Dive on 2021 Planning – Update

The Chair noted that a session had been arranged with Sir Jeremy Farrar, Ministers, officials and group members on 16 December. The group's planned meeting the following day will not go ahead.

7. Issues to note

Jacqui Reilly drew the group's attention to the recent SAGE paper on air cleaning devices which touched on issues being considered by the Chief Scientist – innovations in the use of UVC may be helpful for poorly ventilated spaces but needed further research, as the group had previously advised.

8. Subgroup Updates

It was reported that the Education & Children's Issues subgroup had discussed advice on school holidays. An announcement had been made by the Scottish Government and the subgroup's advice published. A report from the subgroup had been shared with authorities in New York and had been valued in supporting their decision for primary schools to return. The Testing subgroup will be discussing testing in the era of vaccination while the Nosocomial subgroup were discussing adherence to IPC measures.

9. SAGE Update

The Chair noted that SAGE had confirmed that R was below 1, though measurement was difficult, while work was underway on a comparison of lateral flow and PCR testing. Full minutes would be circulated as usual.

10. AOB

It was suggested that the group should discuss clinical services for 'long covid' at a future meeting.