Scottish Government COVID-19 Advisory Group

Input into the new Strategic Framework – February 2022

1. Question 1: What should our COVID testing and isolation regime be like in the longer term?

Group members recognised that the current level of testing is not sustainable in the long term and may no longer be necessary if the virus is endemic, with a decreased burden on the healthcare system.

The importance of testing in the health and social care system was noted. Hospital admission testing and healthcare workers testing will remain important to mitigate risk of nosocomial infection. Current testing within secondary care was recommended to remain in place, with a greater uptake of multiplex testing for a range of respiratory viruses in secondary care being essential. In the long term, the testing strategy in healthcare settings could move to a more flexible step up/step down approach, akin to flu testing on admission during winter months. This is currently under consideration by the Covid Nosocomial Review Group. Group members also noted the important role of regular lateral flow testing of healthcare staff and workers.

. Outside of healthcare settings, group members noted that the testing approach may need to change depending on the level of circulation of COVID-19, hospitalisation and ICU pressures, and the emergence of new variants. When appropriate, a more targeted approach, such as a symptom-based approach that gives strong advice to stay at home when experiencing respiratory symptoms consistent with COVID-19 or indeed other respiratory infection could be implemented. This would bring the COVID-19 guidance in-line with the current guidance around influenza, which may present the most practical solution for the longer term.

There was consensus in the group regarding the importance of continued surveillance. Retaining effective surveillance through PCR testing and DNA sequencing from hospital patients with respiratory symptoms will contribute to ensuring SARS-CoV-2 viral variants are detected in a timely manner, as well as providing epidemiological insight into other respiratory viruses such as influenza. In addition, the group was strongly supportive of continuing wider surveillance programmes such as test-based (e.g. ONS), symptom-based (e.g. ZOE) and genomic (COG-UK) surveillance, particularly if Pillar 2 testing should be halted or decreased.

Should mandatory self-isolation be removed, this should be with the caveat that it may need to be reintroduced during future waves. There was consensus that self-isolation could be encouraged rather than mandated between waves, with a focus on encouraging isolation of those symptomatic individuals.

2. How to enable and sustain the necessary behaviours and physical adaptations that will reduce transmission risk on an ongoing basis?

Healthcare settings and care homes will continue to require stringent infection prevention and control measures. For the general population, as the impact of COVID-19 lessens, the need for baseline measures such as the generalised use of face masks could decrease, though maintaining good ventilation should continue to be encouraged. As messaging around different measures shifts it will be important to maintain strong public health messaging around self-isolation if symptomatic.

To date, the public reaction to the increased perception of risk arising, for example, from new variants has been to adapt their behaviours in response to their personal perception of the risk to themselves and others. In future waves if additional protective measures are required once more, prompt communication of the risks and accessibility of the appropriate tools would once again enable individuals to manage their own risk.

It is important that messaging around behaviour change should be reviewed and updated regularly. We know from the evidence on infection prevention and control (IPC) in healthcare settings that multimodal strategies are needed for long term sustainable change and campaigns need to be reviewed and changed on an on-going basis. As an example, the work on Hand hygiene campaigns over the years internationally by WHO indicates that posters become 'wallpaper' and need refreshed annually for impact

The framing of public communication around changing measures will be especially important going forward. Group members noted that there will be different understandings of what 'living with COVID-19' means. For some, it may mean a return to pre-pandemic routines and acceptance of the risks associated with the virus. For others, it will mean that we should recognise the risks and take to heart the lessons we have all learnt over the last two years so that we can manage the threats posed by Covid through modifying our behaviour appropriately.

'Agency' can be understood as accepting one's actions having consequences and that therefore by adopting certain behaviours we are better able to exert control over the environment we inhabit. Such a sense of agency is important in at least two respects going forwards. First, it can encourage adherence with risk-reducing measures (whether they are mandated or not). Second, such a sense of agency and control can contribute to a sense of resilience and well-being. Both are relevant to successfully 'living with Covid'. Alongside this, it is important to emphasise that the lesson of the last two years is that we are inextricably interlinked such that individual choices can have far reaching consequences. It is also important to continue to remind people of the accomplishments made possible through people acting as thoughtful and responsible members of the community.

Vaccination will likely remain important for some time. This will need to be kept under review as additional data on the waning of immune protection and emergence of new variants continues to emerge. Targeted booster roll out will be supported by the science. Strong messaging around vaccination will thus need to be maintained.

3. How should we judge when it is appropriate to remove the remaining legal requirements and rely on responsible behaviour from people and organisations? (This links to the proportionality of COVID measures compared to the management of other diseases, in light of immunity and treatments.)

A number of group members considered that we may now be at the point where the remaining legal requirements could be removed. Group members offered several recommendations to support decision makers in their decision on when it would be considered appropriate to remove the existing legal requirements.

Group members drew on the example of the impact of influenza (e.g. the infection fatality rate for influenza) to provide a benchmark of when legal requirements could be fully removed. Group members commented that current legal requirements appear closely linked to NHS capacity and that the level of hospitalisations and ICU pressure resulting from COVID-19 should be a factor in decision making. There remain a number of unknown variables, including the level of seasonal variation from COVID-19, how quickly the virus will evolve, and the speed of waning of immunity. Continued public health messaging to reinforce COVID-19 mitigation practices such as ventilation and handwashing will be particularly important when legal requirements are lifted

Some group members pointed to the need for planning in the health and care systems, with IPC guidance needing to be adapted accordingly. From this perspective, a minority of group members suggested legal requirements could be removed after the winter of 2022/23.

4. What are the key data or intelligence that we should be looking at to judge when protective measures should be strengthened?

Decisions to strengthen protective measures will require ongoing surveillance from testing and sequencing to monitor spread as well as to detect potential new viral variants. Collaboration across Government, the NHS and private sector including the use of common communication and trustworthy data sharing platforms will be critical for responding quickly to outbreaks.

Coordinated data feeds available providing detailed and near-real time information diagnostic data on hospital admissions will be essential. Currently available data are often only accessible post discharge, some with up to a 6-week time delay.

This healthcare data capture should allow any threat to hospital capacity to be monitored, although of course this will lag behind any change in community prevalence. Therefore data capture from community cases of respiratory illness will be essential. Group members suggested that the current EAVE 2 system should be built upon, and the sentinel schemes for influenza within GP practices could be expanded to COVID-19. Monitoring of respiratory / gastrointestinal signs and symptoms via NHS 24 is also a key trigger for the implementation of infection prevent and control measures in care homes and hospitals each year and this could be leveraged for COVID-19. In addition, the wastewater screening programme could also provide important sentinel indications of changing patterns of viral spread, and should be maintained as far as possible.

Given the impact that waning immunity could have on the level of hospitalisations from COVID-19 research into this should continue. The evidence base on long COVID should also continue to be expanded.

With regards to trigger points for the reintroduction or reinforcement of protective measures, it was noted that the wide range of possible scenarios make a fixed set of trigger points challenging. Advanced planning for a range of possible scenarios should be carried out. Sharing details of these plans could support stakeholders to implement measures to minimise disruption to their institutions, businesses, and individuals.

Once a new VOC appears, multiple information streams will need to feed into decision-making, including: molecular biology and phylogenetics; clinical assessment of early cases; epidemiological data on cases and hospitalisations; data on immune status of the population; mathematical modelling; and the current status of the NHS.

An example of the timeline we may see with future variants and possible trigger points along this is:

- A new variant of concern is identified anywhere in the world, but there is considerable uncertainty about how big a threat it poses.
- The variant of concern is identified in travellers to UK/Scotland.
- Community transmission is detected in Scotland.
- Data accumulate first on transmissibility then on severity and finally on impact of vaccination.

As with current and previous waves of COVID-19, public health decisions may again need to be made quickly and with limited information.