The group discussed whether the list of those who receive the flu vaccine should be expanded. Groups that could be considered for inclusion are those aged over 50, and teachers. There may need to be procurement of additional flu vaccine supplies if vaccination is extended to additional groups.

It was noted that public misunderstanding around the flu vaccine persists. Clear public communication will be needed to reinforce that vaccination is about protecting the NHS and appealing to a sense of public duty could increase vaccination uptake.

Covid symptom complex – this is being reviewed by the four UK CMOs.

Group members noted a paper being drafted by NERVTAG on respiratory viral infections and interactions with covid-19. The AMS paper was discussed. The recommendations in the paper are in line with the group's discussions.

ACTION – Harry Burns will contact Directors of Public Health and others to plan for the practicalities around preparing for winter and report findings in 3 weeks' time.

ACTION – Jim McMenamin to share NERVTAG paper once this is available.

4. Data and Intelligence for Local Outbreak Management

Scenario planning for winter is being undertaken by the Scottish Government Covid-19 Analytics Hub.

A research service is being developed, bringing in granular data to enable public sector partners to raise questions to better understand the path of the virus.

A dashboard that brings together Test and Protect data to make it available to local contact tracing teams is now live. Currently this takes too long (36-48h in some cases) but also because information is inconsistent as it comes from different systems. Public Health Scotland and Health Boards are working on this.

Now in place are a range of early warning indicators that make information available at a relatively low level of geography. The Scottish approach focusses on allowing those who need the data to access it, to be able to build a local picture. The system went will be expanded with additional data later this month.

A challenge noted is that dashboards currently do not include epidemiological interpretations, it was noted that this would be a useful addition.

A forecasting model is being worked on that includes travel patterns and the interconnectedness of neighbourhoods. It should be ensured that data flows allow hospitals and care homes to access this. Data integration from a wide range of sources remains a challenge. Roger Halliday noted that he would like to seek input from group members to gain a better understanding of the relative risks of local covid-19 risks and other sociodemographic and situational risks.

The group briefly discussed using waste water sampling as part of early indicators, similarly to how this is done for polio. Analysis of sludge from sewage works has been promising and there is developmental work ongoing with to include this in future analysis.
Sequencing will be important to help provide epidemiological links between outbreaks.

The group was informed that the Scottish Government will begin working with the JBC.

The chair noted that DELVE data scientists may be able to provide support with data integration.

ACTION – Roger Halliday to provide access to dashboard to group members.

5. Paper on Risk

Local area covid-19 risk is something the government is looking to make public. Input would be welcomed from group members to ensure the messaging is right on this.

The chair asked how policy colleagues are discussing risk, noting that Wales has a taskforce that considers risk. The Scottish Government assesses the risk in relation to the four harms, as each review point is approach. This is then published on the Scottish Government website.

SAGE is discussing the concept of covid-19 security – a scoring of different environments and the risk these present.

The group discussed the QCOVID algorithm, noting that it does not take into account background risk but a future iteration of the algorithm will hopefully include this. It is important to determine how this tool will be used by clinicians as the tool is not planned to be public facing.

The use of tools in the stratification of high risk groups and health and social care workers was discussed, noting that a Welsh Government tool for this is now live and used to determine whether patient-facing work should be carried out by individuals. The British Medical Association has asked for this type of tool to be implemented. The group noted that this type of tool will be needed in Scotland.

A tool to manage risk can be very valuable to clinicians, examples include tools used in cardiology. Tools such as these are effective at modifying behaviour and are particularly useful to show that you are being consistent in your actions across population when you can demonstrate that someone is above a risk threshold. It is important that interventions to mitigate risk are clearly articulated, along with the provision of resources for these.

Group members noted a forthcoming Public Health Scotland paper on this topic.