

#### **CURRENT STATE OF THE EPIDEMIC ('HARM 1')**

1. The information in this annex is drawn from the latest SG State of the Epidemic (published 11 March) and Modelling the Epidemic (published 10 March) reports, and (where available) more recent management information.
2. Public Health Scotland have notified us that due to a server error over the weekend, they are unable to report Covid data on 14 March, and as a result the latest data available relates to 11 March. The server error impacts daily data on cases and testing, deaths, hospital and ICU admissions and vaccinations. Only hospital occupancy data is available for 14 March. PHS are working hard to resolve this and hope to return to normal reporting on 15 March.
3. Key points include the following:

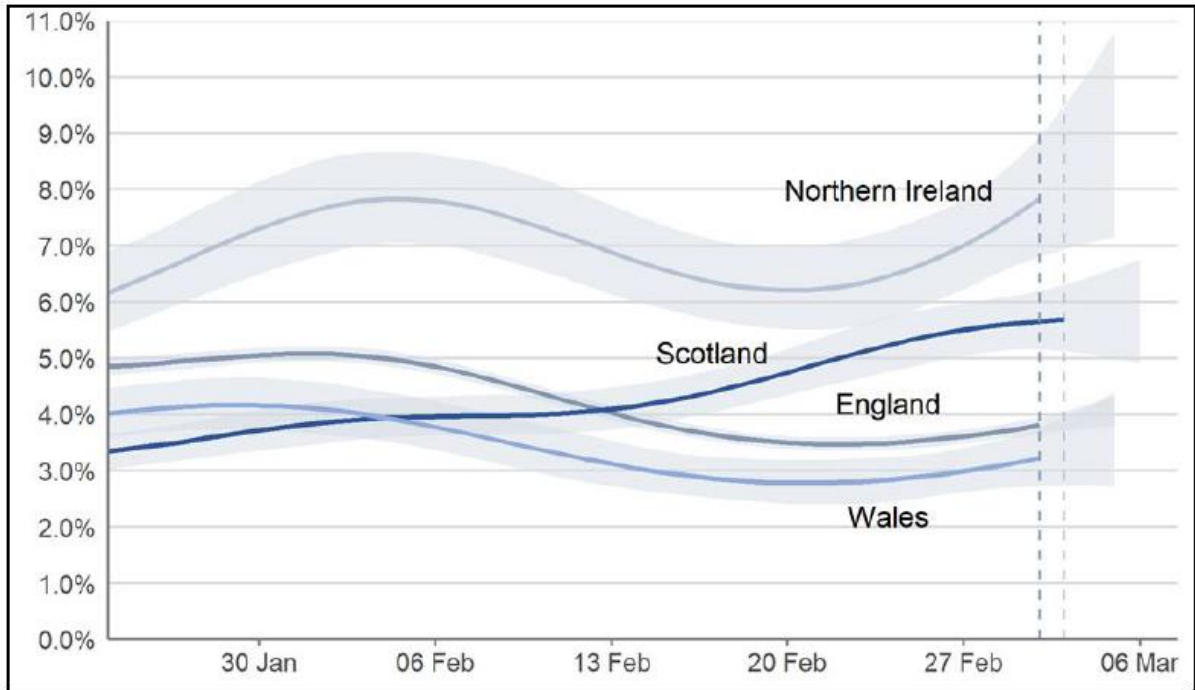
#### **Incidence**

- ◆ according to the ONS COVID-19 Infection Survey:
  - in the week 28 February to 6 March 2022, the estimated percentage of the population living in private residential households testing positive for COVID-19 in Scotland was 5.70% (95% credible interval: 5.13% to 6.31%), compared 5.33% in the week to 26 February (95% credible interval: 4.78% to 5.93%). The percentage of people testing positive in Scotland therefore continued to increase in the most recent week;
  - the percentage of people testing positive increased in the most recent week in Wales (3.22%), England (3.8%) and Northern Ireland (7.84%);
  - in the same week, it is estimated that 299,900 people living in private residential households in Scotland had COVID-19 at any given time (95% credible interval: 270,200 to 332,300); this equates to around 1 in 18 people (95% credible interval: 1 in 19 to 1 in 16).
  - the reported positivity estimates contain Omicron BA.1 and BA.2 variants and all other variants; in Scotland, the percentage of people testing positive with cases compatible with Omicron BA.2 has increased in the most recent week. The percentage of people testing positive with cases compatible with Omicron BA.1 has decreased;
- ◆ **Figure 1** from the ONS COVID-19 Infection survey depicts the overall COVID-19 positivity trends by nation. This latest data confirms that infections are rising in all four nations.
- ◆ **Figure 2** depicts the separate epidemic curves for BA.1 and BA.2, also from the latest CIS survey;
- ◆ the pace and timing of the increase in the share of BA.2 compatible infections varies across the four nations; these suggest that BA.2 became dominant first in Northern Ireland and has been slowest to pick up in Wales;
- ◆ the latest testing data from Scotland reports that 84.2% of cases notifying on 11 March were positive for the S-Gene, a proxy for BA.2. This testing data cannot

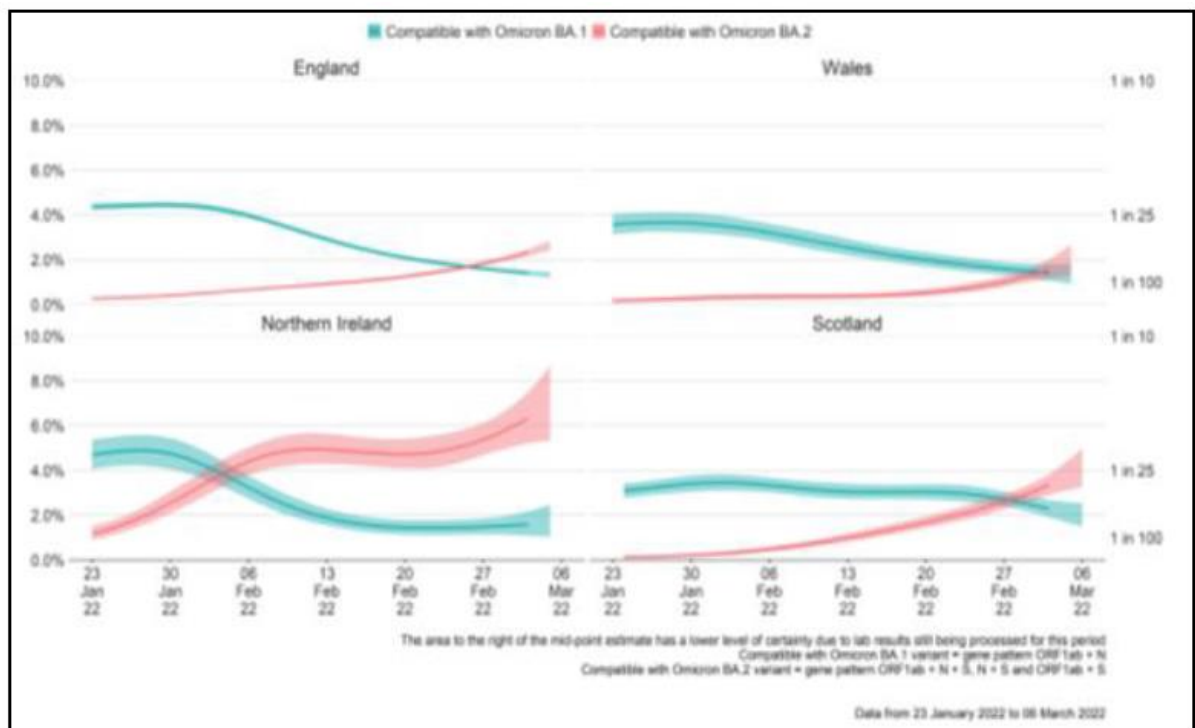
## Briefing for Ministers

be directly compared with results from the Covid Infection Survey but does indicate a continuing increase in the share of newly reported infections compatible with BA.2;

◆ further data will reveal whether and when peaks in infections might be expected and the role of BA.2 in driving these;



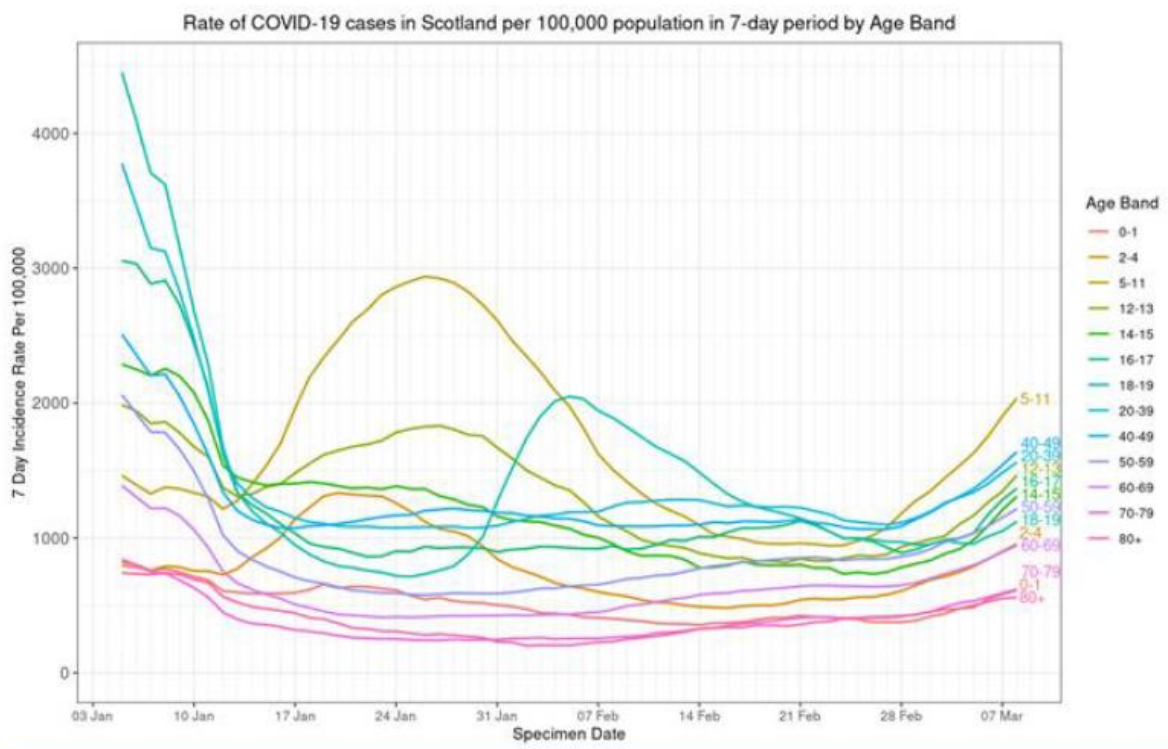
**Figure 1:** Modelled daily estimates of the percentage of people testing positive for COVID-19 in the four nations



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**Figure 2:** Percent of people testing positive for Covid-19 by nation, 23 January to 6 March, by BA.1 and BA.2

- ◆ nationwide, wastewater COVID-19 RNA levels have shown an increase in the latest week. The week ending 3 March saw levels of around 86 million gene copies per person per day (Mgc/p/d), up from 76 Mgc/p/d in the week ending 24 February;
- ◆ the 7-day moving average of daily cases by specimen date (combined PCR and LFD, and now including reinfections) stands at 10,142 daily cases on 8 March, a 42% increase from 7,133 on 1 March;
- ◆ the combined PCR and LFD case rate has been updated to include reinfections and stands at 1,258 per 100 000 at 8 March, an increase of 43% since 26 February. The reinfection rate remains relatively stable 9.8%.
- ◆ PCR test positivity is high at 31.2%; (PHS Management Information);
- ◆ as seen in **Figure 3**, in the week to 8 March, combined PCR and LFD case rates increased in all age groups. The highest case rate is seen in the 5-11 year old age group, followed by the 40-49, 20-39 and 12-13 year old age groups;
- ◆ the increases previously seen in younger age groups are now being reflected across all age groups including those who are 50 years and older;



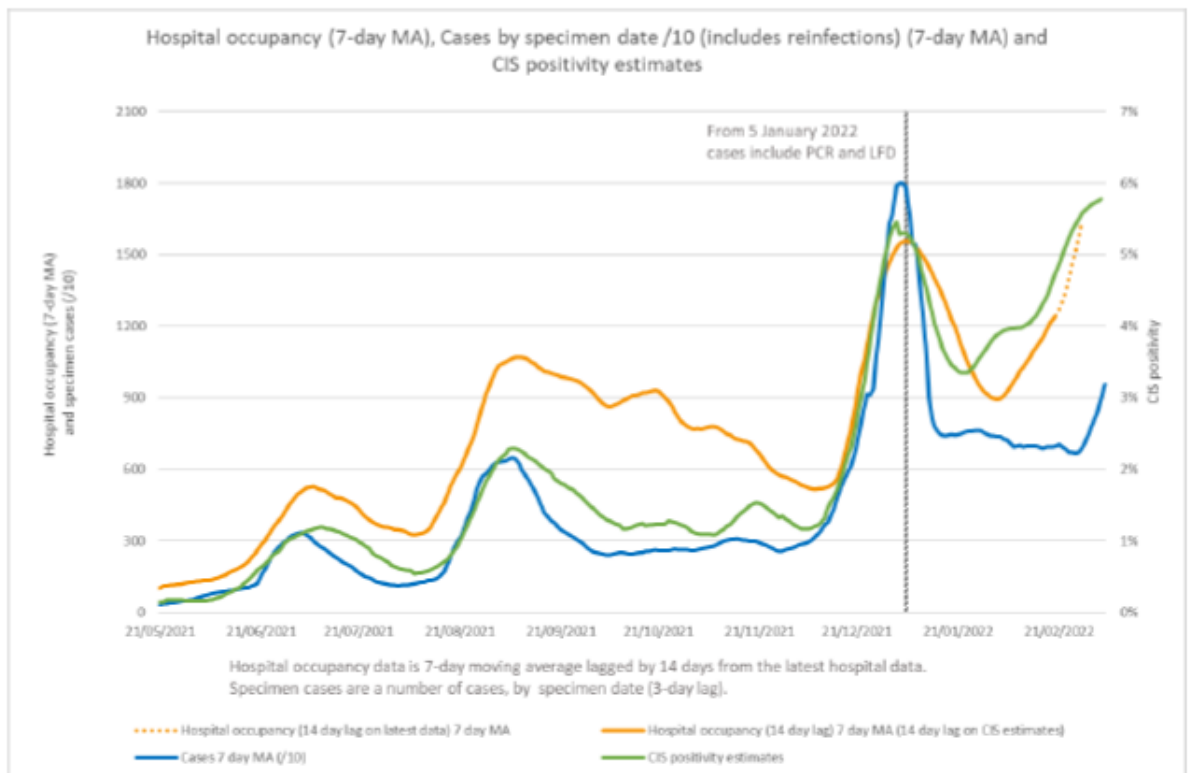
**Figure 3:** 7-day incidence rates of COVID-19 in Scotland by Age Band, data to 8 March; includes PCR and LFD case data (PHS MI)

## **COVID-19 Hospital Pressures**

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◆ **Figure 4** below charts daily case numbers by specimen date and the 7-day moving average (blue line, left axis), and ONS COVID-19 infection survey estimates of positivity (green line, right axis) alongside the 7-day moving average of hospital occupancy (orange line, left axis); the latter is lagged by 14 days; the daily case numbers plotted are actual case numbers divided by a factor of 10 for ease of comparability and use of the same axis as hospital occupancy;

◆ since hospital occupancy is lagged by 14 days, the data point comparable to the most recent ONS infection survey estimate is not yet available. However, **Figure 4** demonstrates that, of late, ONS positivity estimates correlate better with hospital occupancy than do cases by specimen date;



**Figure 4:** 7-day moving average of daily case numbers (actual case numbers divided by a factor of 10); ONS COVID-Infection Survey estimates of positivity; 7-day moving average of hospital occupancy lagged by 14 days

◆ as at 14 March NHS boards reported 1,805 patients in hospital with recently confirmed COVID-19 (including 27 in ICU for 28 days or less), an increase of 79 from the day before and an increase of 445 from the figure reported one week earlier on 4 March (1,360);

◆ the latest PHS hospitals admissions data have not been received. As at 11 March, after a recent increase, hospital admissions appeared to be stabilising; the latest data from PHS showed 908 admissions to hospital for people with confirmed COVID-19 in the week to 7 March compared to 961 in the week to 28 February;

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◆ hospital occupancy was declining up to 14 February but has since shown a sustained increase in the last four weeks. It is likely that a combination of factors is contributing to this increase, including admissions, the age profile of admissions, and the average Length of Stay of COVID-19 patients;

◆ in addition, the overall increase in infections in the community and the rapid increase of Omicron BA.2 are also likely to be contributory factors, which are reported to be driving increasing levels of hospital-associated infection, particularly across psychiatry, elderly care and long stay wards;

◆ PHS Management Information reports that an early analysis is being conducted to ascertain whether there are differences in Length of Stay between BA.1 and BA.2-confirmed patients;

◆ it will be important to closely monitor trends in infections and admissions among older age groups, for signs of vaccine waning;

◆ ICU occupancy has increased but remains low; as at 14 March NHS boards reported 27 recently confirmed patients in ICU (for 28 days or less), a decrease of 3 from the day before and an increase of 9 from the figure reported on 7 March (18);

◆ the latest PHS ICU admissions data have not been received. As at 11 March, ICU admissions appeared to be stable; the latest data from PHS showed 18 new COVID-19 patients admitted to ICU in the week to 10 March, compared to 20 in the week to 3 March;

### **Deaths (NRS weekly data)**

◆ in the week to 6 March, there were 110 deaths registered in Scotland where COVID-19 was mentioned on the death certificate, an increase of 30 from the previous week. Of these deaths, 7 deaths were aged under 65, 21 were aged 65-74 and there were 82 deaths in people aged 75 or over;

◆ The number of deaths where COVID-19 was identified as the underlying cause was 62;

◆ There was a small excess in average mortality reported in the latest week; the total number of deaths registered in Scotland in week 9 of 2022 was 1,178 (3% above average).

### **Behaviour**

◆ From the most recent Panel B cohort of the Scottish Contact Survey for the week ending 2 March:

- average contacts are at 5.0. This has remained at a similar level compared to the previous Panel B of the survey (week ending 16 February);

- Mean contacts within the 'Other' setting (contacts outside home, school and work) have increased by 11% within the last two weeks. Contacts

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within the home and work have remained at a similar levels over the same period;

- those within the 50-69 age groups have reported the biggest decrease in contacts, by at least 12%. This was largely driven by a reduction in contacts in the other and work setting. All remaining age groups have either reported an increase or a similar level of contacts over the same period;
- the number of people wearing a face covering where they have at least one contact outside of the home has increased in the last two weeks from 83% to 85%;
- approximately 76% of individuals had taken at least one lateral flow test within the last 7 days, decreasing from 79% two weeks prior;

◆ on testing and reporting behaviour, the distribution of lateral flow/LFD tests being reported continues to vary substantially by both age and deprivation status. Many fewer tests are reported in younger adults across all deciles of deprivation, and for children in more deprived deciles;

◆ the high level of LFD positivity in children in deprived deciles is marked, and when compared to the high number of positives amongst the least deprived, is consistent with under-ascertainment being concentrated in particular groups;

### **Evidence on Omicron BA.2**

◆ the Omicron variant of concern is currently the dominant variant circulating globally. Omicron contains several sub-lineages, each of them being monitored by WHO and partners. Of them, the most common ones are BA.1, BA.1.1 and BA.2. At a global level, the proportion of reported sequences designated BA.2 has been increasing relative to BA.1;

◆ BA.2 is now the dominant Omicron sub-lineage in Scotland. The percentage of cases notifying on 11 March positive for S gene target failure (a proxy for Omicron BA.1) stands at 14.9% and the percentage of S gene positive cases (a proxy for Omicron BA.2) stands at 84.2%;

◆ the number of cases in Scotland attributable to BA.2 by whole genome sequencing stands at 16,332 confirmed cases (cumulative) as at 11 March.

◆ there is no apparent reduction in vaccine effectiveness against symptomatic disease for BA.2 compared to BA.1

◆ the risk of admission to ICU/HDU from a lower level of care was 59% lower for patients admitted with Omicron compared to Delta. Evidence is still emerging on the infection severity of BA.2.

◆ BA.2 has demonstrated an increased growth rate compared to BA.1 in all regions of England;

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- ◆ secondary attack rates amongst contacts exposed in household and non-household settings (adjusted for factors including vaccination status) are higher for BA.2 than other sequenced Omicron cases: 13.6% vs 10.7% in households and 5.3% vs 4.2% in non-household settings;
- ◆ preliminary analysis finds no evidence of a greater risk of hospitalisation following infection with BA.2 compared to BA.1.
- ◆ a small number of potential BA.2 reinfections following a BA.1 primary infection have been detected. Further investigations are being undertaken to confirm and characterise these cases;

### **Evidence on Waning of Vaccine Effectiveness**

- ◆ vaccine effectiveness against symptomatic disease with the Omicron variant is substantially lower than against the Delta variant, with more rapid waning. There is no evidence of a difference in vaccine effectiveness against symptomatic infection, between BA.1 and BA.2. Vaccine effectiveness against all outcomes is restored after receiving the booster dose, with effectiveness against symptomatic disease ranging initially from around 60-75% 2 to 4 weeks after receiving either the Pfizer or Moderna booster and dropping to around 25-40% after 15 weeks;
- ◆ Vaccine effectiveness against hospitalisation after a Pfizer booster starts at around 90% dropping to around 75% after 10 to 14 weeks. The Moderna booster restored vaccine effectiveness against hospitalisation to around 90-95% up to 9 weeks after vaccination;
- ◆ we are therefore now in the window (12-16 weeks post-booster dose) whereby we may expect to see vaccine waning, particularly against symptomatic disease within more vulnerable cohorts;
- ◆ vaccine effectiveness against symptomatic disease wanes more quickly than vaccine effectiveness against hospitalisation; vaccine effectiveness is generally slightly higher in younger compared to older age groups;
- ◆ if Omicron (or a variant with similar immune escape) is still dominant, and the current vaccines are still being administered, we would expect to see another window of vaccine waning opening in July/August 2022;
- ◆ this scenario does not take into account the protection that will be gained from natural immunity due to infection. A high proportion of people in Scotland now have antibodies to SARS-CoV-2 and have some level of immunity. However, it is known that immunity wanes over time.

#### **DRAFT COVID THREAT ASSESSMENT FOR SCOTLAND, 15 MARCH 2022**

1. Assessing the COVID threat level in Scotland is a 2-stage process, resulting in an overall Threat assessment. The assessment draws on a range of evidence, but is ultimately a judgement. This judgement is separate from, but related to, the judgement that is to be made about the appropriate *response* to any assessed threat (which should take into account wider considerations, such as other of the ‘four harms’.)

2. To assess the COVID threat Scotland faces which is, by definition, forward looking, it is useful first to consider the current direct COVID harm that Scotland is experiencing. Where there are no deteriorating risk factors currently identified, the threat assessment will essentially be the same as the harm assessment.

3. We expect the threat assessment methodology to evolve over time as understanding of the epidemic changes. Our initial approach includes consideration of the following data sources:

- ◆ Infection Fatality Ratio
- ◆ Prevalence
- ◆ Prevalence of Long COVID
- ◆ Admissions data (hospital and ICU)
- ◆ COVID hospital occupancy data
- ◆ COVID death data

4. As the assessment framework evolves, the data will be examined in more detail to explore differences, both geographically and by important characteristics of the population. Where useful, additional data, in the form of estimates of the reproduction number, growth rates and doubling times for all relevant variants will be brought into the assessment.

#### **PART A: What is the current COVID harm status in Scotland?**

5. This is an assessment of current direct COVID harm at the population level. Harm is defined for these purposes as the product of (average) disease impact and (average) risk of infection in the near future.

##### ***i. What is current average infection risk in Scotland?***

6. Infection risk is first assessed on the basis of current prevalence, as indicated by the ONS COVID-19 Infection Survey positivity estimates, guided by the numbers as shown in Table 1 below. This provides an initial indication of whether infection risk in the near future (e.g. the next week or so) is low, medium or high. The numbers in the matrix should be seen as initial orientation marks or ‘range finders’ before judgement is applied; they are not rigid thresholds and judgement may ‘over-rule’ them.



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Average risk of infection:	Average Disease Impact: High (IFR>=0.5%)	Average Disease Impact: Medium (0.1%<IFR<0.5%)	Average Disease Impact: Low (IFR<=0.1%)
High (ONS => 1.0%)	High harm	Medium-High harm	Medium harm
Medium (0.25%<ONS<1.0%)	Medium-High harm	Medium harm	Medium-low harm
Low (ONS <=0.25%)	Medium harm	Medium-low harm	Low harm

**Table 1: COVID Threat/Harm Matrix with indicative numbers**

Note: the numbers shown for each proxy indicator are based on past experience and judgement and can be refined over time. 'ONS' refers to the prevalence data from the ONS Infection Survey. 'IFR' is the estimated infection fatality rate. Both are proxies for what they are measuring – risk of infection and disease impact respectively. An IFR of 0.1% or below might be judged as 'low' (but may be compared to an estimated IFR of seasonal flu of c. 0.04%).<sup>1</sup> Prevalence of 0.25% or below might be judged as 'low' – primarily based on our own experience of the pandemic (and may be compared to a 'medium' incidence rate for influenza like illnesses during a flu season of up to c. 0.1%).<sup>2</sup>

### *Assessment:*

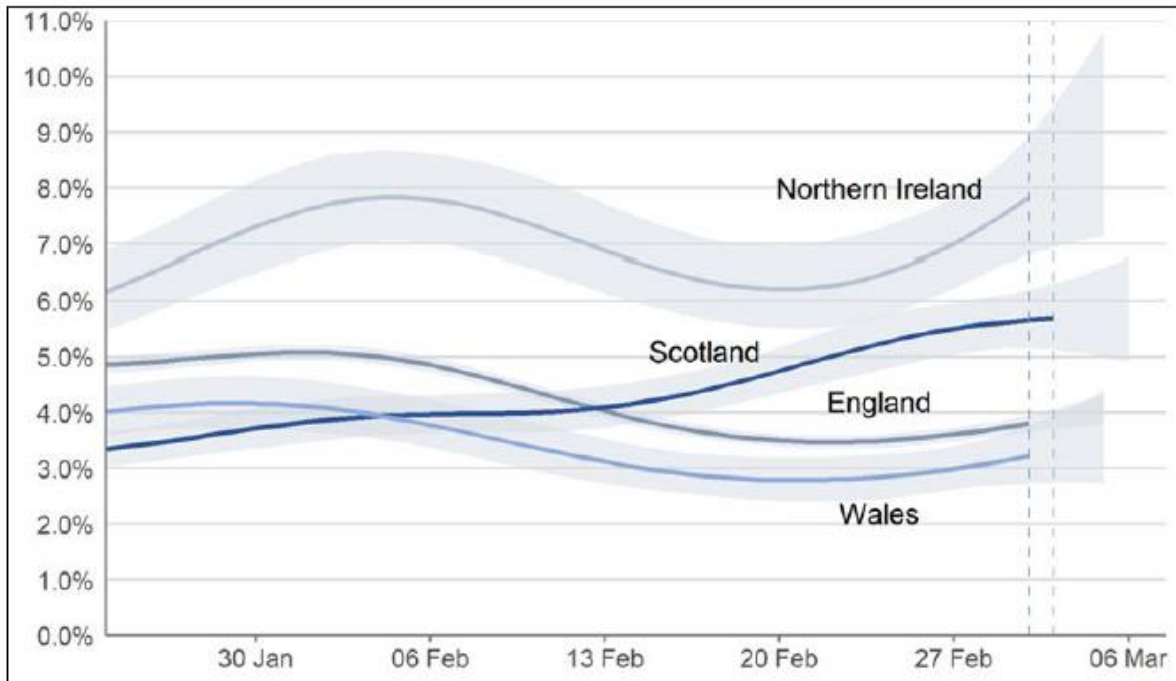
- ◆ In the week 28 February to 6 March 2022 the percentage of people testing positive in Scotland continued to increase; i, the estimated percentage of the population living in private residential households testing positive for COVID-19 in Scotland was 5.70% (95% credible interval: 5.13% to 6.31%).
- ◆ the percentage of people testing positive also increased in the most recent week in Wales (3.22%), England (3.8%) and Northern Ireland (7.84%) (**Figure 1**);
- ◆ in the same week, it is estimated that 299,900 people living in private residential households in Scotland had COVID-19 at any given time (95% credible interval: 270,200 to 332,300); this equates to around 1 in 18 people (95% credible interval: 1 in 19 to 1 in 16);
- ◆ the reported positivity estimates contain Omicron BA.1 and BA.2 variants and all other variants; in Scotland, the percentage of people testing positive with cases compatible with Omicron BA.2 has increased in the most recent week. The percentage of people testing positive with cases compatible with Omicron BA.1 has decreased;
- ◆ in Scotland, the percentage of people testing positive increased in the youngest age groups and those aged 40 years or over but was uncertain in other age groups in the most recent week.

<sup>1</sup> [How fatal is covid-19 compared with seasonal influenza? The devil is in the detail. | The BMJ](#)

<sup>2</sup> [Surveillance of influenza and other seasonal respiratory viruses in the UK. Winter 2020 to 2021](#)

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◆ ONS COVID-19 Infection Survey positivity estimates for Scotland have shown a steadily increasing trend as shown in **Figure 1** below;



**Figure 1: Modelled daily estimates of the percentage of the private residential population testing positive for COVID-19 in the four UK nations, between 23 January and 6 March 2022, including 95% credible intervals**

7. Based on these survey results, and with reference to the threat/harm matrix of Figure 1, the population of **Scotland is assessed as having a HIGH risk of infection.**

8. Judgement is then applied to take account of other data and considerations that may alter the assessment result.

### *Assessment:*

◆ nationwide, wastewater COVID-19 RNA levels have shown an increase in the latest week. The week ending 3 March saw levels of around 86 million gene copies per person per day (Mgc/p/d), up from 76 Mgc/p/d in the week ending 24 February;

◆ the 7-day moving average of daily cases by specimen date (combined PCR and LFD, and now including reinfections) stands at 10,142 daily cases on 8 March, a 42% increase from 7,133 on 1 March. This increase follows a plateau in the 7-day moving average of daily cases of approximately 7000 daily cases over the preceding 4 weeks to 1 March;

◆ the combined PCR and LFD case rate has been updated to include reinfections and stands at 1,258 per 100,000 at 8 March, an increase of 43% since 26 February. The reinfection rate remains relatively stable 9.8%. PCR test positivity is high at 31.2%; (PHS Management Information);

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◆ in the week to 8 March, combined PCR and LFD case rates increased in all age groups.

9. Wastewater data and daily case numbers indicate an increasing trend in infections in Scotland in the latest week and support the assessment based on estimates of positivity from the ONS COVID-19 Infection Survey that the current infection risk in Scotland is assessed as HIGH.

### ***ii. What is the current average disease impact in Scotland?***

10. The current disease impact is first assessed on the basis of the most recent estimated infection fatality rate (IFR) for COVID in Scotland, guided by the numbers as shown in **Table 1**. Again, none of the metrics represent rigid thresholds but provide initial orientation and can be adjusted over time as evidence/understanding change.

#### ***Assessment:***

◆ ONS infection survey results provide a statistically robust estimate of the number of new COVID-19 infections per week in the private residential population i.e. an estimate of incidence. This is related to subsequent COVID-19 deaths, where COVID-19 was mentioned on the death certificate (deaths involving COVID-19). For the calculation of the Infection Fatality Rate, the lag from infection to death is assumed to be 3 weeks;

◆ in the week ending 6 March, 110 deaths were registered in Scotland where COVID-19 was mentioned on the death certificate (deaths involving COVID-19)

◆ The ONS COVID-19 Infection Survey weekly incidence estimate that most closely corresponds to this 3 week lag is for the week ending 12 February. An ONS 'official' weekly estimate was not available for this week so was calculated using a daily incidence estimate for the mid-point of the week and multiplying up to a weekly value to give an estimate of 166,500 infections (lower CI 139,400 and upper CI 195,300);

◆ Dividing the number of weekly deaths involving COVID-19 by the estimate of the total number of weekly infections, 3 weeks prior, estimates that the Infection Fatality Ratio is 0.07% (range 0.06 to 0.08) relating to infections in the week ending 12 February and deaths in the week ending 6 March. This is an increase from an Infection Fatality Ratio of 0.05% in the previous week which is largely driven by an increase in deaths (110 compared to 80 in previous week) and only a slight increase in number of infections (166,500 compared to 164,500 in previous week);

◆ This increase in deaths is largely driven by a higher number of deaths among those older than 64

**11. On the basis of this Infection Fatality Ratio, the current disease impact is assessed as LOW.**

12. Judgement is then applied to take account of other data and considerations that might alter this assessment.

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13. Other data might include:

- ◆ Prevalence of Long COVID
- ◆ Average disease impact in different age groups
- ◆ Admissions data (hospital and ICU)
- ◆ COVID hospital occupancy data
- ◆ COVID death data

### *Assessment*

14. Estimates of the proportion of people in the private residential population in Scotland who experience long Covid symptoms are published by the ONS Covid-19 Infection Survey on a monthly basis<sup>3</sup>. The next scheduled release of long Covid data from the Covid-19 Infection Survey is expected on 7 April.

- ◆ In the four-week period ending 31 January 2022, an estimated 88,000 people (95% CI: 79,000 to 97,000) in the private residential population in Scotland (1.67%; 95% CI: 1.50% to 1.85%) who first had (or suspected they had) COVID-19 at least 12 weeks previously reported experiencing long COVID;
- ◆ the estimates presented in this analysis relate to self-reported long COVID, as experienced by study participants who responded to a representative survey, rather than clinically diagnosed ongoing symptomatic COVID-19 or post-COVID-19 syndrome in the full population. Further iterations of the assessment are expected to include alternative means of reporting experience with this condition;
- ◆ SG officials are awaiting analysis in due course of the number of people in Scotland diagnosed with long COVID and their use of health services, to help assess healthcare demand from those experiencing COVID symptoms post the acute phase;
- ◆ in the UK, long-COVID symptoms adversely affected the day-to-day activities of 989,000 people (65% of those with self-reported long COVID), with 281,000 (18%) reporting that their ability to undertake their day-to-day activities had been "limited a lot";
- ◆ fatigue continued to be the most common symptom reported as part of individuals' experience of long COVID (51% of those with self-reported long COVID), followed by shortness of breath (35%), loss of smell (34%), and loss of taste and difficulty concentrating (both 25%);
- ◆ as a proportion of the UK population, prevalence of self-reported long COVID was greatest in people aged 35 to 49 years, females, people living in more deprived areas, those working in teaching and education, social care or health care (likely reflecting increased exposure to COVID-19 infection in these sectors), and those with another activity-limiting health condition or disability;
- ◆ the latest data for hospital and ICU admissions describes a relatively stable trajectory for ICU admissions and an uncertain trajectory for hospital admissions.

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<sup>3</sup> [Prevalence of ongoing symptoms following coronavirus \(COVID-19\) infection in the UK : 3 March 2022](#)

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ICU occupancy has remained low but overall hospital occupancy has steadily increased over the last 4 weeks;

◆ as at 14 March NHS boards reported 1,805 patients in hospital with recently confirmed COVID-19 (including 27 in ICU for 28 days or less), an increase of 79 from the day before and an increase of 445 from the figure reported one week earlier on 4 March (1,360);

◆ the latest PHS hospitals admissions data have not been received. As at 11 March, after a recent increase, hospital admissions appeared to be stabilising; the latest data from PHS showed 908 admissions to hospital for people with confirmed COVID-19 in the week to 7 March compared to 961 in the week to 28 February;

◆ hospital occupancy was declining up to 14 February but has since shown a sustained increase in the last four weeks. It is likely that a combination of factors is contributing to this increase, including admissions, the age profile of admissions, and the average Length of Stay of COVID-19 patients;

◆ in addition, the overall increase in infections in the community and the rapid increase of Omicron BA.2 are also likely to be contributory factors, which are reported to be driving increasing levels of hospital-associated infection, particularly across psychiatry, elderly care and long stay wards;

◆ ICU occupancy has increased but remains low; as at 14 March NHS boards reported 27 recently confirmed patients in ICU (for 28 days or less), a decrease of 3 from the day before and an increase of 9 from the figure reported on 7 March (18);

◆ the latest PHS ICU admissions data have not been received. As at 11 March, ICU admissions appeared to be stable; the latest data from PHS showed 18 new COVID-19 patients admitted to ICU in the week to 10 March, compared to 20 in the week to 3 March;

15. The overall trend in deaths involving COVID-19 (NRS weekly registrations where COVID-19 is mentioned on the death certificate) is upwards;

◆ in the week of 28 February to 6 March 2022, there were 110 deaths involving COVID-19, an increase of 30 on the previous week, though still significantly below peaks experienced earlier in the pandemic;

◆ of deaths involving COVID-19 in the latest week: 57 were male, 53 were female, and 7 deaths were aged under 65, 21 were aged 65-74 and there were 82 deaths in people aged 75 or over;

◆ the number of deaths where COVID-19 was identified as the underlying cause was 62;

there was a small excess in average all-cause mortality reported in the latest week; the total number of deaths registered in Scotland in week 9 of 2022 was 1,178 (3% above average);

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**16. Taking account of this additional data, the current average disease impact score in Scotland remains at LOW.**

### ***iii. What is the overall population harm assessment for Scotland?***

17. Combining the results of the assessment of the average disease impact (LOW) and of the average infection risk in Scotland (HIGH), **the current COVID harm status is assessed as MEDIUM, according to the COVID harm matrix of Table 1.**

18. As at 17 February, the UKHSA recommended that the COVID Alert Level remain at Level 4. This describes an epidemic that is in general circulation; transmission is high and direct COVID-19 pressure on healthcare services is widespread and substantial, or rising. The Level remains unchanged in this latest week.

19. One further consideration relates to the dominance of the Omicron sub-variant BA.2. This has the potential to alter both the assessed average disease impact and the assessed infection risk.

- ◆ the Omicron variant of concern is currently the dominant variant circulating globally. Omicron contains several sub-lineages, of them, the most common ones are BA.1, BA.1.1 and BA.2. At a global level, the proportion of reported sequences designated BA.2 has been increasing relative to BA.1;

- ◆ BA.2 is now the dominant Omicron sub-lineage in Scotland. The percentage of cases notifying on 11 March positive for S gene target failure (a proxy for Omicron BA.1) stands at 14.9% and the percentage of S gene positive cases (a proxy for Omicron BA.2) stands at 84.2%;

- ◆ the number of cases in Scotland attributable to BA.2 by whole genome sequencing stands at 16,332 confirmed cases (cumulative) as at 11 March. As BA.2 is designated by whole genome sequencing, there is a known time-lag of approximately 5-9 days from obtaining a sample to reporting of BA.2 as the cause of infection in Scotland;

- ◆ BA.2 has demonstrated an increased growth rate compared to BA.1 in all regions of England;

- ◆ Preliminary analysis finds that secondary attack rates amongst contacts exposed in household and non-household settings are higher for BA.2 than other sequenced Omicron cases;

- ◆ a small number of potential BA.2 reinfections following a BA.1 primary infection have been detected

- ◆ there is no apparent reduction in vaccine effectiveness against symptomatic disease for BA.2 compared to BA.1

- ◆ preliminary analysis finds no evidence of a greater risk of hospitalisation following infection with BA.2 compared to BA.1.

**20. On the basis of this current evidence relating to BA.2, the COVID harm status score of MEDIUM remains unchanged.**

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### **PART B: What is the assessed COVID threat in Scotland?**

21. Assessing the current threat status follows a similar process to assessing the current harm status. The difference is that the threat-status is forward looking, to reflect identified risks, as opposed to a current snapshot. Where there are no substantive negative risk factors ahead, the threat assessment will essentially be the same as the harm assessment.

22. The matrix and its metrics are similarly defined as in Table 1. Now, however, they are assessing where Scotland is likely to move to in terms of harm status in the near future (measured broadly in terms of 2-3 weeks into the future).

#### ***i. What is infection risk expected to be in the near future?***

23. An assessment is offered of what the average infection risk is likely to be in the near future (2-3 weeks) given identified risk factors, and in light of recent trends in estimated prevalence. This assessment is based on multiple sources of data and wider evidence relating to the threat or threats currently being assessed. For the current purposes, these include:

- ◆ SG projections of prevalence that take account of what is known about the new threat(s), including how established it is within the Scotland/UK;
- ◆ (for variants) estimates of increased transmissibility/growth advantage;
- ◆ quantitative and qualitative intelligence from other countries where the threat is already established (such as vaccine waning; or the spread of a new variant or its ability to re-infect)

#### ***Assessment***

24. Medium term projections of modelled total new combined daily infections in Scotland, adjusting positive tests to account for asymptomatic and undetected infections, from Scottish Government modelling, based on positive test data reported up to 7 March, estimate that daily infections may be between 2,000 and 26,000 in late March.

25. These projections include the effect of booster take up and take account of any waning effect based on date of latest vaccination and evidence concerning the extent of waning through time.

- ◆ 'Central' assumes that transmissibility remains at current levels.
- ◆ 'Worse' assumes a higher transmissibility,
- ◆ 'Better' assumes a lower transmissibility.

26. The future trajectory of infections is uncertain. The updated baseline projection captures the increase in prevalence and incidence that has gained momentum since the end of February. This results in a projection in which both Central and Worse describe a further peak in infections very shortly, and in hospital occupancy (late March) even in the absence of further changes to protective measures.

## **Briefing for Ministers**

27. Under the Central and Worse scenarios, there are also expected to be small increases in deaths, before falling away through the month of April. The current position is nearest to Central for infections and for ICU occupancy (which assumes a 50% severity reduction from Delta).

28. The position for hospital occupancy is challenging to interpret and to model due to the many factors driving COVID occupancy levels. The projection captures those in hospital both with and because of COVID. There is the potential of a continued increase in occupancy from current levels under both the Central and Worse scenarios.

29. COVID ICU occupancy remains low currently and is expected to remain well below capacity thresholds for all scenarios, as are deaths.

30. The modelling aims only to illustrate the possible course of the epidemic, drawing upon the best available evidence at this point in time, and makes a number of assumptions. The accuracy of the modelling results will also be increasingly uncertain when looking further ahead.

31. In Scotland, approximately 50% of the population aged 60-80+ received a booster dose of COVID-19 vaccine between 18 October and 22 November 2021, with coverage reaching 90% before the end of December 2021.

32. Vaccine effectiveness against symptomatic disease with the Omicron variant is substantially lower than against the Delta variant, with rapid waning. Two to four weeks after a booster dose of either the Pfizer or Moderna vaccine, effectiveness against symptomatic disease ranges from around 60 to 75%, dropping to 25 to 40% from 15+ weeks after the booster.

33. Vaccine effectiveness estimates for the booster dose are very similar, irrespective of the primary course received. Vaccine effectiveness against hospitalisation after a Pfizer booster (after either primary vaccination course), started at around 90% dropping to around 75% after 10 to 14 weeks. After a Moderna booster (mRNA-1273) (after either primary vaccination course), vaccine effectiveness against hospitalisation was 90 to 95% up to 9 weeks after vaccination.

34. Therefore we are now in the window (12-16 weeks post-booster dose) whereby we may expect to see vaccine waning, particularly against symptomatic disease within more vulnerable cohorts;

35. Vaccine effectiveness against symptomatic disease wanes more quickly than vaccine effectiveness against hospitalisation and vaccine effectiveness is generally slightly higher in younger compared to older age groups;

36. An additional booster dose (fourth dose in total) of vaccine will be offered to high risk groups and adults aged 75 +around six months after the last dose. This is due to commence in April/May 2022, therefore, if Omicron (or a variant with similar immune escape) is still dominant, and the current vaccines are still being administered, we would expect to see another window of vaccine waning opening in July/August 2022.

37. This scenario does not take into account the protection that will be gained from natural immunity due to infection; a high proportion of people in Scotland now have antibodies to SARS-CoV-2 and have some level of immunity.



## **Briefing for Ministers**

**38. Overall, the assessment of infection risk in future weeks remains unchanged from the present and is assessed as HIGH.**

### ***ii. What is disease impact expected to be in the near future?***

39. This assessment is based on multiple sources of data and wider evidence relating to the threat or threats currently being assessed. These may include:

- ◆ quantitative and qualitative intelligence about disease impact from other countries where the threat (e.g. variant) is already established
- ◆ analytical projections of admissions and deaths that take account of what is known about the new threat(s)
- ◆ (for variants) estimates of inherent severity
- ◆ (for variants) estimates of realised severity given understanding of immune escape.

**40. In the near future, the disease impact from COVID-19 continues to be assessed as LOW**, contingent on the current understanding of the disease impacts of BA.1 and BA.2.

41. There are two epidemics in play; BA.2 has a growth advantage over BA.1 and the incidence of BA.2 is increasing; it is currently the dominant variant in Scotland.

42. There is no evidence of a difference in vaccine effectiveness against symptomatic infection, between BA.1 and BA.2. From preliminary animal studies and real world data, there is currently no evidence to suggest a difference in infection severity between BA.1 and BA.2. The risk of admission to ICU/HDU from lower level of care was 59% lower for patients admitted with Omicron compared to Delta<sup>4</sup>. Sequencing in Denmark and the UK has confirmed BA.2 reinfections following an initial BA.1 infection<sup>5 6</sup>. There have also been instances of recombination events between Delta and Omicron; and between BA.1 and BA.2<sup>7</sup>.

43. Evidence from Denmark<sup>8</sup> concludes that Omicron BA.2 is inherently substantially more transmissible than BA.1, and that it also possesses immune-evasive properties that further reduce the protective effect of vaccination against infection, but do not increase its transmissibility from vaccinated individuals with breakthrough infections.

44. Denmark had a large peak in daily new COVID-19 cases per head of population in January and early February which has now decreased, likely reflecting at least in part the growing presence of BA.2.

45. Changes seen in Denmark since the lifting of all restrictions on 1 February show that the number of COVID-19 patients in hospital has increased by 54%, with deaths involving COVID-19 having increased by 117% over the same period up to 7 March.

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<sup>4</sup> [SARS-CoV-2 variants of concern and variants under investigation \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

<sup>5</sup> [Occurrence and significance of Omicron BA.1 infection followed by BA.2 reinfection \(medrxiv.org\)](https://medrxiv.org)

<sup>6</sup> [Risk assessment for SARS-CoV-2 variant: VUI-22JAN-01 \(BA.2\) 26 January 2022 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

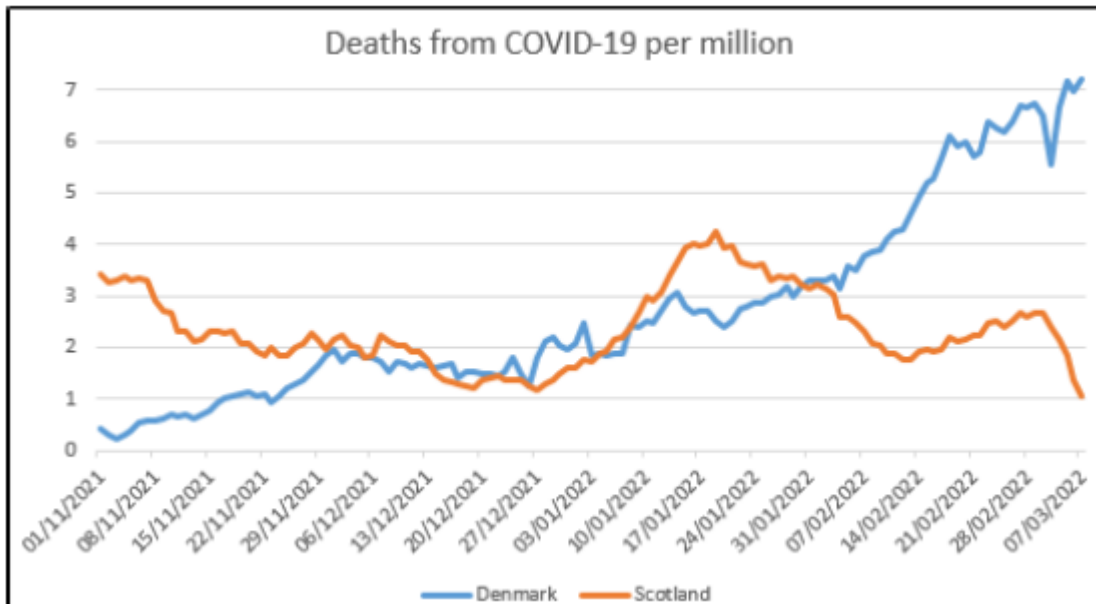
<sup>7</sup> [Weekly epidemiological update on COVID-19 - 8 March 2022 \(who.int\)](https://who.int)

<sup>8</sup> [Transmission of SARS-CoV-2 Omicron VOC subvariants BA.1 and BA.2: Evidence from Danish Households | medRxiv](https://medRxiv)

## **Briefing for Ministers**

Figure 2 below highlights COVID-19 death rates since the emergence of the Omicron variant in both Denmark and Scotland; BA.2 became prominent in Denmark earlier, reaching dominance in the second half of January 2022.

46. We continue to monitor the infection growth rate, infection severity and vaccine effectiveness associated with this sub-lineage BA.2, as well as emergence of new variants of concern.



**Figure 2: Deaths from COVID-19 per million: Denmark and Scotland (1 Nov 2021 to 7 March 2022)**

47. SPI-M-O produces projections of the epidemic, combining estimates from several independent models. These projections are not forecasts or predictions. They represent a scenario in which the trajectory of the epidemic continues to follow the trends that were seen in the data up to 7 March and do not include the effects of any future policy or behavioural changes.

48. The projections include the potential impact of vaccinations over the next few weeks and will take account of the presence of BA.2. Modelling groups have used their expert judgement and evidence from UKHSA, Scottish Universities, and Public Health Scotland, and other published efficacy studies when making assumptions about vaccine effectiveness.

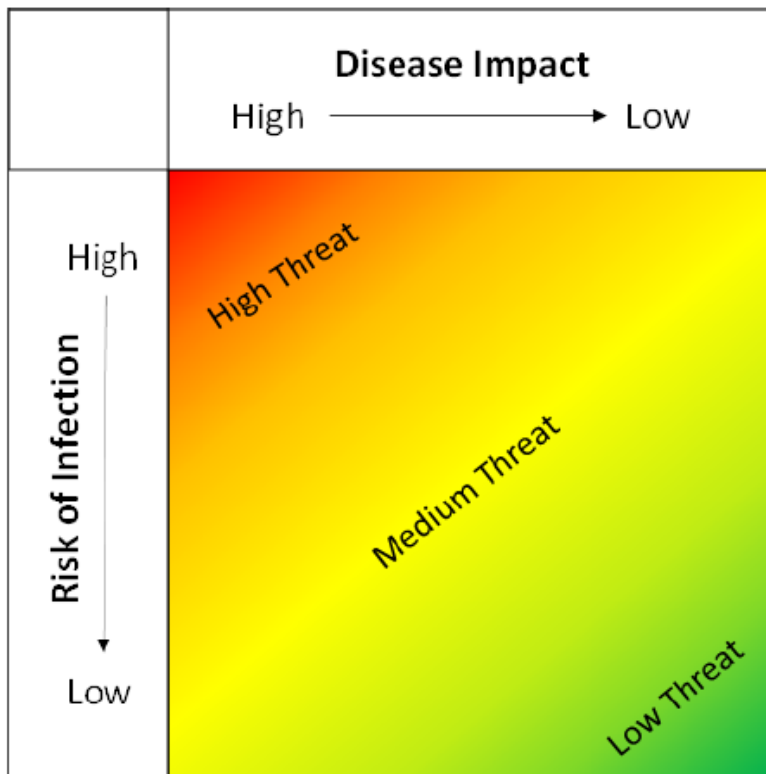
49. The median estimate for both hospital admissions and deaths is flat whereas the median estimate for hospital occupancy is a continued increase. This suggests that while some healthcare measures are steady, this is not the case for all which may see an increase in pressure on healthcare.

**50. On the basis of the available evidence concerning the disease impacts from current/known variants of COVID-19, including those present and dominant in Scotland, the assessment of impact in the coming weeks remains unchanged at LOW.**

***iii. What is the COVID threat assessment for Scotland?***

## Briefing for Ministers

51. A Covid Threat Assessment Matrix is set out in Figure 3 below.



**Figure 3 : COVID Threat Matrix**

52. The increasing dominance of BA.2 has likely contributed to the continued rise in prevalence and incidence in the latest week across all age groups. The modelling of future infections under both the Central and Worse scenarios indicates a further rise in infections before peaking during mid-March; this is associated with further pressures on the NHS later in March, and small rises in deaths involving COVID.

53. Admissions appear to be stabilising and overall levels of COVID patients in ICU and deaths involving COVID remain low. Hospital occupancy (both with and for COVID) has continued to increase and further work is underway to explore the reasons for this. There continues to be no concerning evidence in relation to disease severity of BA.2 relative to BA.1.

**54. Combining the assessment of expected future disease impact, with the assessed future infection risk supports a recommendation that the overall threat assessment for Scotland remains at MEDIUM.**

55. This recommendation is based on currently available evidence and data concerning trends and projections of infections, hospitalisations and deaths; and evidence on the presence and characteristics of Variants of Concern in Scotland and elsewhere.

56. A further assessment should be completed no later than 3 weeks from the date of this current assessment and ahead of the next review point.

COVID Co-ordination Directorate  
Central Analysis Division  
March 2022

## **Briefing for Ministers**

### **ANNEX C**

#### **[Redacted - Section 30(b)(i) (free and frank provision of advice)]**

1. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
2. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
3. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
4. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
5. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
6. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
7. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
8. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
9. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
10. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
11. [Redacted - Section 30(b)(i) (free and frank provision of advice)]
12. [Redacted - Section 30(b)(i) (free and frank provision of advice)]

**PRESSURES AND THE RESPONSE IN THE HEALTH AND SOCIAL CARE SYSTEM  
(HARM 2)**

**Response: Health and Social Care Pressures**

1. The health and care system across Scotland continues to experience significant pressure which is caused by a number of factors including high and increasing Covid demand, substantial non-Covid demand, delayed discharges, social care pressures, and workforce availability. For hospital sites, three issues that are contributing to high occupancy and flow challenges; increasing Covid demand, delayed discharges and non Covid admissions.

**Covid Demand**

2. Covid demand has increased sharply and modelling suggests it will continue to rise. However, patients are far less likely to translate through to requiring critical care. As at 10 March at 15:00, there were 107 wards and 632 patients affected by hospital acquired Covid-19 infection across NHS Scotland.

3. All admissions to hospital, whether being actively treated for Covid infection or not, are managed with clear infection prevention and control processes and protective equipment as required. This can, in some circumstances and to protect other vulnerable people, lengthen their stay in hospital. The requirement to keep Covid and non-Covid patients separate can cause considerable operating challenges as hospitals try to manage the complexity of different cohorting capacity which is impacting on safe and effective flow, and, when combined with other demands and flow issues, such as high general occupancy and delayed discharge levels, there is ongoing significant localised pressure. Officials are in regular communication with affected boards and any impact will be closely monitored.

**National Services**

4. Key issues for the ambulance service remain the significant levels of staff absence rates as a result of the Omicron variant and Hospital Turnaround times. The Ministry of Defence has informed SAS that military (MACA) support will be withdrawn early as a result of the situation in Ukraine. The MoD has confirmed that there will be a phased withdrawal of troops from the Service and will not result in any significant impact on performance in the weeks leading up to 31st March 2022. The Service has confirmed that any impact of losing the military should be offset by full implementation of their planned exit strategy and 150 additional technician students who are now fully trained and taking up operational shifts over the next two weeks as well as additional SFRS staff, who have been trained, and bank emergency drivers. SAS are currently undertaking a piece of modelling work which will provide modelled response times week by week for 2022/23 and a further update will be provided following these discussions.

5. NHS 24 has advised that the deterioration in performance is due to a combination of increased demand, staff COVID-19 absence remaining high and an annual leave rate maintained at 20% as staff take time off after busy festive period. NHS 24 continue to recruit at pace with a new centre expected to be fully staffed by end of March 2022.

## **Briefing for Ministers**

### **Scheduled and Unscheduled Care**

6. Unscheduled and emergency care performance over the last few weeks has deteriorated due to a combination of issues including low discharge levels and high patient acuity which is impacting significantly on flow in and out of hospital. Covid continues to have an impact on NHS services as explained above. Admission rates remain down on seasonal levels but this is balanced out by increased length of stay for emergency inpatients. This is indicative of deconditioned patients who have experienced delays in receiving medical treatment due to the pandemic.

7. We are working closely with local teams and expert groups to develop appropriate alternatives to attendance at A&E, minimise the need for admission, and reduce length of stay and increase options and processes for timely and appropriate discharge. These actions will help reduce pressure in A&E and have the potential to increase bed capacity which will in turn help to increase our ability to provide planned care. Officials also met with Chief Executives on 9 March to discuss the development of a refreshed collaborative Unscheduled Care Improvement Programme which will aim to deliver the Four Hour Target by developing high impact changes; utilising a range of data and improvement tools and setting national and local trajectories. The collaborative will launch at a national event in May.

8. In planned care, NHS Boards are continuing to prioritise P2 and urgent cancers with signs that a number of boards are restarting other elective activity. Covid, workforce, and bed capacity pressures continue. A delivery framework is now being developed that sets out the key components for recovery that will support the high level commitments in the NHS Recovery Plan, published last summer.

### **Social Care (including Delayed Discharges)**

9. Delayed discharges remain at a high level. Social care workforce capacity remains the major inhibitor with 21% care at home staff absent, which includes 7.6% vacancies. The number of care homes with COVID outbreaks has also increased slightly with 26% of homes affected. Our “discharge without delay” programme is now up and running in almost all Health Boards with only NHS Greater Glasgow & Clyde still to start, although a preliminary session is scheduled for 17 March. The programme aims to improve discharge planning arrangements as well as tackling delayed discharges “at source”, seeking to discharge people much earlier in their pathway and avoid any delay in discharge as their needs worsen with a prolonged hospital stay. We are planning an awareness session with Chief Officers on 23 March. Regular Ministerial meetings with Health Boards and Health and Social Care Partnerships are restarting, with a clear focus on delayed discharges and social care pressures.

10. Adult Social Care Gold Group has recently moved from meeting weekly to fortnightly. Work is ongoing, led by Social Work Scotland, to establish a framework for identifying, measuring and mitigating risks to the operational delivery of care. This ‘in extremis’ framework will constitute a process whereby individual HSCPs have the flexibility required to make appropriate operational decisions for their local populations, working closely with local partners, while operating to a common understanding across Scotland of the circumstances which may fall into each stage of escalation. A series of ‘lessons learned’ events are being planned with HSCPs to explore learning and sharing of best practice in responding to system pressures.

## Briefing for Ministers

### Workforce

11. Covid absence is largely driven by an increase in positive cases [an average of 2,964 staff were recorded absent per day due to Covid-19 positive test results]. Positive test results have increased by around 21.0% in comparison to the previous week, and we would anticipate the overall impact on staffing absence to reflect the epidemiological trajectory.

12. Of the 1,000 Health and Care Support Staff to be recruited pursuant to the Winter Pressures Statement on 05 October, boards report that to 04 March, over 1,000 posts have been offered (987 whole time equivalent), 796 of which have commenced in post. This recruitment is supported by £15m in-year funding. Supported by up to £4.5m funding, Boards also report that 69 registered nurses from overseas will be in Scotland and in post at 31 March, 102 at 30 April, 177 at 31 May, and 233 at 30 June. Thus far, a total of 318 nurses are agreed in MoUs/Contracts for 2022/23. This number will increase significantly as Boards build their infrastructure and plans for international recruitment beyond March 2022.

### [Redacted – Out of Scope]

13. [Redacted – Out of Scope]

### Summary

14. A map of acute system pressures by Health Board is presented at **Figure A**.

	Current Position	Previous Position*
NHS 24 Call Demand (w/e 13 March 2022)	37,806	34,835
NHS 24 Time to Answer (w/e 13 March 2022)	00:18:25	00:11:43
SAS Call Demand (w/e 06 March 2022)	19,771	19,643
SAS Turnaround Times (w/e 06 March 2022)	00:39:10	00:38:55
A&E Performance	69%	70.6%
A&E Long Waits (12hr+)	650	537
A&E Attendances	25,012	24,904
Covid-19 Occupancy	1,636	1,360
ICU Occupancy (Covid-19)	32	29
ICU Occupancy (Overall)	207	210
General Acute Occupancy	92%	91%
Delayed Discharges	1,623	1,646
Social Care Package Waiting List	12,931	13,356
Care Homes Closed to Admissions %	17.7%	15.3%
OP Elective Activity (% pre-Covid)	87%	77%
Mental Health Delayed Discharges	56	N/A
Care Home Workforce (Non C19 absence %)	8.2%	7.9%
Care Home Workforce (C19 absence %)	4.3%	3.2%
Care At Home / HSS (Non C19 absence %)	11.5%	11.2%
Care At Home / HSS (C19 absence %)	3.9%	3.2%
NHS Workforce (Non C19 staff absence %)	4.14%	4.36%
NHS Workforce (C19 absence %)	2.36%	2.09%

\*Time periods are not always directly comparable and will vary between service areas and indicators.



**FIGURE A - Health System Pressures as at Thursday 10 March 2022**

**INTERNAL MANAGEMENT INFORMATION ONLY**  
**Health System Risk Summary**

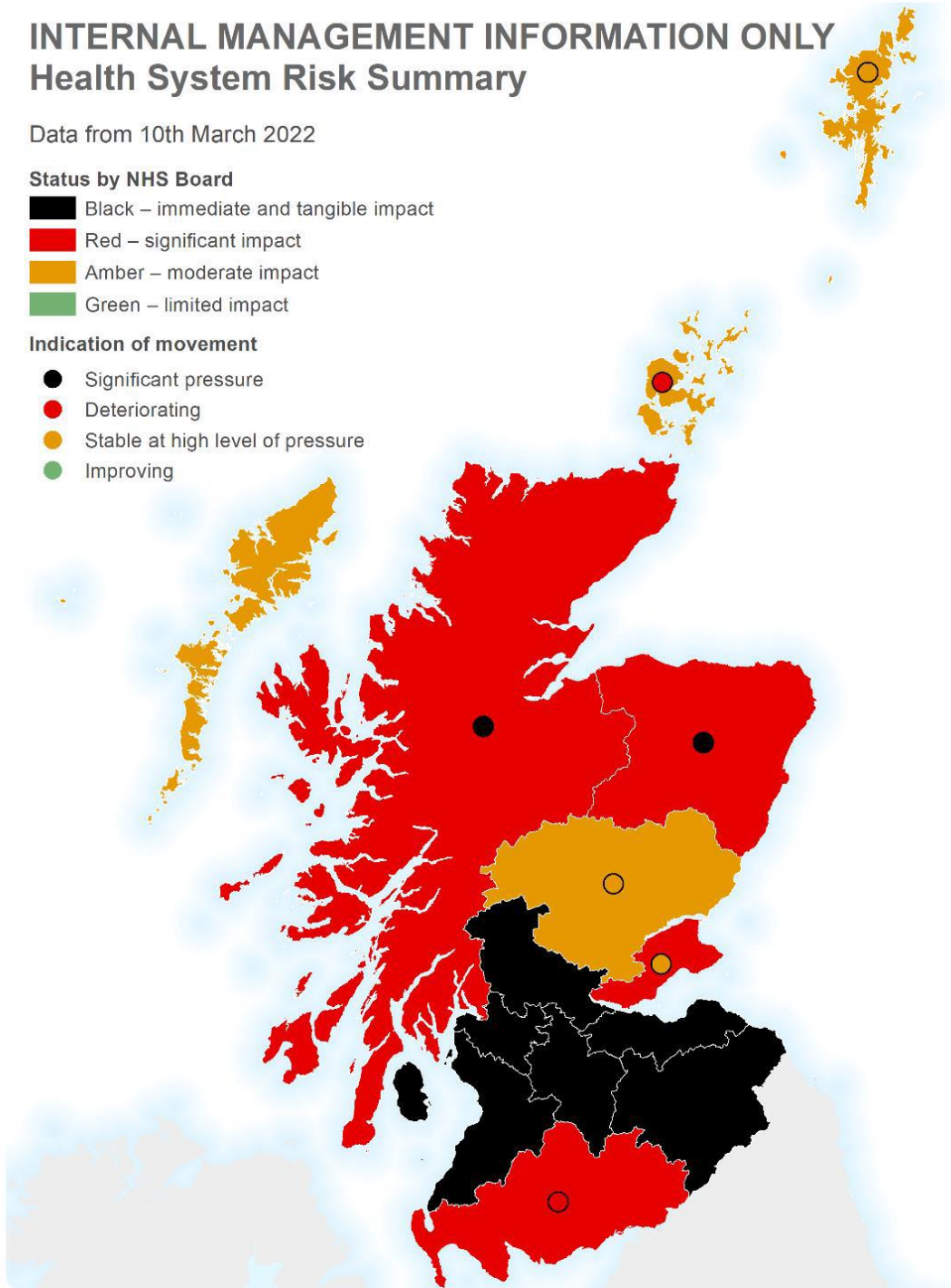
Data from 10th March 2022

**Status by NHS Board**

- Black – immediate and tangible impact
- Red – significant impact
- Amber – moderate impact
- Green – limited impact

**Indication of movement**

- Significant pressure
- Deteriorating
- Stable at high level of pressure
- Improving



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### **SOCIAL IMPACTS (HARM 3)**

#### **Update**

1. This week we include developments over the past week in relation to schools and Universities/Colleges/CLD. We also outline preliminary findings from a voluntary opt in consultation to seek public experiences and insights two years on from the beginning of the Covid-19 pandemic.

#### **Schools**

2. Engagement continued this week with education stakeholders regarding the potential relaxation of the remaining mitigations in schools and ELC settings, and the move to a set of routine protective measures. A Covid Education Recovery Group (CERG) meeting was held on Thursday 9 March to discuss the latest advice from the Advisory subgroup on Education and Children's Issues on this matter.

3. The body of evidence on the role of children in transmission continues to point to household transmission as the primary driver. There is also a continuing low risk of harm to children from COVID-19 infection, and severe health outcomes for all age groups are far less likely to arise while vaccination rates are high and the current variant is less severe. With that in mind, the sub-group agreed at its meeting on 8 March that it would be appropriate to move to routine measures in schools and ELC settings in a proportionate and responsible manner. This should commence when the threat level is assessed as being low or in line with any equivalent changes across wider society (i.e. the timetable set out in the revised strategic framework for COVID-19 (currently 21 March)), and all relevant changes should be in place no later than the return to school after the Easter break.

4. There was a broad recognition among stakeholders that routine measures in the education and ELC sectors should be aligned with those elsewhere in society, although some stakeholders remained firmly opposed to any early removal of the asymptomatic testing programme, mainly because of the potential negative impact on sector confidence and stability. This is in the light of the latest data which show that staff absence rates (see below) are close to their peak levels (similar to January 2022), and that there are ongoing concerns around workforce pressures.

5. In terms of pupil and staff absences in schools, pupil attendance currently stands at 88% (Tues 8th March). However, the percentage of pupils not in school due to Covid-related reasons has been increasing over the latest week, from around 2.3% of pupils not in school due to Covid-19 related reasons on Tuesday 1st March to 3.7% on 8th March. School staff absences due to Covid-related reasons has also risen over the past two weeks – with currently around 2,788 teaching staff (4.8%) absent due to Covid-related reasons and a further 1,888 school-based staff absent due to Covid-related reasons, as of Tuesday 8th March. These rates are reflected in increasing number of schools which are enacting local school closures (full or partial).

#### **Universities, Colleges and CLD**

## **Briefing for Ministers**

6. The Covid-19 Advisory Sub-Group on Universities and Colleges paper on Wider Harms has been discussed with stakeholders on the Advanced Learning Covid Recovery Group and is now being finalised. It will soon be publicly available on the sub-group's page on the SG website. The paper highlights the negative social and financial impacts of the pandemic experienced by many students, learners and staff across the FE, HE and CLD sectors, including a loss of learning as well as a deterioration in mental health and wellbeing.

7. Representatives from universities, colleges, CLD and student associations cited the reductions to in-person learning and teaching as the main reason for these effects. However, in the case of CLD the driver for this reduced in-person provision was not primarily due to adherence with guidance, but because of difficulties gaining access to buildings to enable in-person provision. Trade Union representatives had particular concerns around the safety of staff, particularly those who are clinically vulnerable.

8. These concerns have increased following the recent Scottish Government Strategic Framework Update, where the development of a framework to replace prescriptive sector-specific guidance will lead to Covid-related decision making being taken at a local level. The paper also highlights the good practice that has been established during the pandemic, particularly in relation to digital learning provision. It also notes the importance of institutions ensuring digital inclusion, because digital access, just like many other aspects of the wider harms on students and learners, disproportionately adversely affects the most socially disadvantaged and vulnerable students and learners.

### **Two years into the COVID-19 pandemic: public experiences and insights**

9. An online free-text survey (opt-in consultation, not representative, but directed towards people who may have heightened concerns) was launched on 24 January and closed on 13 February 2022<sup>9</sup>. Questions included: views on what measures people have found easier or harder to follow and why; how they currently feel at this point in the pandemic; how they feel about the year ahead; and what kind of help would enable people to feel safer and more supported.

10. It was publically available on the Scottish Government website and promoted through the Scottish Government Facebook page. A link to the survey was also shared by over 30 organisations including: Scottish Council for Voluntary Organisations, BEMIS (the national Ethnic Minorities led umbrella body), Home Start, Universities Scotland, Mental Health Scotland, the British Red Cross and others.

11. In total, 3161 responses were received. This included 70% who identified as female, a range of ages but most (51%) were aged between 35-54 years. A third (32%) were 55-69 years and 11% were under 35 years. 92% identified as White (Scottish, Irish, British or White Other). A quarter of the respondents identified as having a long-standing physical or mental impairment, illness or disability, and 22% stated that they were in an unpaid carer role. Most (60%) were in employment, 8% were self-employed and 15% were retired.

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<sup>9</sup> On 24 January the number of positive cases was 9,266 so a decrease from the record high at the end of December. Other key milestones during this period included on 25 January, Scottish Government announce that from Monday 31 January businesses can start hybrid working and on 10 February, Scottish Government announced high school pupils and staff will not be required to wear face coverings in classrooms [from 28 February 2022](#).

## **Briefing for Ministers**

12. Respondents were self-selecting, so it is not a nationally representative sample. The aim was to reach a diverse group of people with varied experiences and life circumstances to provide greater understanding of wellbeing and where additional support may be required.

### **Aim**

13. The 3 broad research questions that underpinned this research were:

- i. How do the public feel two years into the pandemic and what are their thoughts about the year ahead?
- ii. What influences people's capability, opportunity and motivation to adhere, or not, to the government measures and guidelines during the pandemic?
- iii. What support would people like in the future?

### **Focus on wellbeing**

14. For the purposes of this summary, we have focused on question one (how do the public feel). It should be noted that this is not intended to be a thorough analysis of responses to this question. The purpose is to provide a snapshot of emotions and challenges with the intention that the team will continue working on refining the analysis for inclusion in a wider report.

### **Data summary**

15. The following table groups the views into nine themes that offer insight into how respondents are currently feeling, a summary of why they are feeling that way and verbatim quotes from the survey to exemplify the point being made. The themes range from one extreme of people who are angry and frustrated to the other end of the spectrum where people feel safer and more optimistic. It is worth emphasising that not all respondents fall neatly into these groupings. For example, some were 'cautiously optimistic, or fed up but hopeful.

**Table 1 – Emotional response and exemplary quote**

<b>Emotion</b>	<b>Reasoning</b>	<b>Example</b>
Angry/frustrated	<ul style="list-style-type: none"><li>• Decisions are made on politics not science</li><li>• Feeling misled and lied to</li><li>• Issues around accessing health care</li><li>• At the behaviour of others – e.g. not following the rules</li></ul>	<i>"I am annoyed and angry at the lack of balance between 'the measures' and harm from the measures"</i>
Abandoned	<ul style="list-style-type: none"><li>• Concern that 'vulnerable' people will be/ are forgotten about</li></ul>	<i>"I no longer feel that we are in this together, and with the removal of restrictions, the onus is entirely on me to calculate an incalculable risk"</i>

### **Briefing for Ministers**

Sadness/grief	<ul style="list-style-type: none"> <li>• Loss during the pandemic</li> </ul>	<i>"I feel I need to revisit the two years passed... to try and understand and make sense of the hurt, separation and loss I experienced since the start of the Pandemic before I could begin to look forward"</i>
Exhausted/emotionally drained	<ul style="list-style-type: none"> <li>• Duration of the pandemic</li> <li>• Strain due to profession (e.g. key worker)</li> </ul>	<i>"I feel a bit exasperated at this point I think we need to start living again without restrictions, this can't go on for another 2 years"</i>
Fed up	<ul style="list-style-type: none"> <li>• Unnecessary restrictions/harsher restrictions</li> <li>• Desire for normality</li> </ul>	<i>"Fed up, with restrictions (that have been far more extreme than in England, since 2020) and with the current Scottish Government. These harsher restrictions have made no difference"</i>
Confused	<ul style="list-style-type: none"> <li>• Changing and contradictory restrictions</li> </ul>	<i>"It's contradictory -make children wear masks in schools but adults don't in nightclubs"</i>
Worried/concerned	<ul style="list-style-type: none"> <li>• Cost of living</li> <li>• Concerned that the majority of world still largely unvaccinated</li> <li>• Worried people wear masks will be targets of abuse</li> </ul>	<i>"Deeply concerned about the damage that has been done to the mental health of our nation in particular the children"</i> <i>"Tired, depressed, de-motivated, worried about money"</i>
Cautious/nervous	<ul style="list-style-type: none"> <li>• Resuming 'riskier' activities again</li> </ul>	<i>"Now we are being encouraged to return to the workplace and...I am nervous about this... going back to 'normal' does give me some anxiety"</i>
Safer/hopeful	<ul style="list-style-type: none"> <li>• Safer due to vaccine</li> <li>• Happier as can socialise more</li> <li>• Proud of way helped each other and good uptake of vaccine</li> </ul>	<i>"I believe we are slowly coming through the worse of this pandemic so therefore I have cause for optimism"</i>

### **Implications for Harm 3**

16. We know that a significant number of people report experiencing negative effects on their wellbeing. At a general population level, as restrictions are eased, wellbeing may start to improve but the impact of living through a pandemic remains. For some groups, the harm to their wellbeing has deeper effects and policies that encourage, for example, a return to the office may exacerbate negative effects for particular groups of people.

## **Briefing for Ministers**

17. This research highlights, two years into a pandemic, the range of emotions that people are feeling. The sustained reported deterioration of wellbeing (even with most restrictions being eased) is noted. However, the roll out of the vaccine programme has generated hope and optimism.

18. The benefit of this research is that it incorporates a potentially wider diversity of experience and views. Due to the open 'free-text' nature of the survey, it allows us to capture the impact of the pandemic on a wide range of issues, including wellbeing but set within the context of someone's life and values. We will report further findings from this work in the coming weeks.

### **YOUNGOV POLLING**

19. The latest findings on attitudes and behaviours from Yougov polling and the Scottish Contact survey were set out in the Cabinet Information Note on 8 March. These findings remain the most recent and are set out again here.

#### **Attitudes and Behaviours**

20. Polling from Yougov (conducted between March 1st and 2nd) found that:

#### **Compliance**

◆ 68% report 'high' compliance<sup>10</sup> (6-7 on a scale of 1 (not at all) to 7 (completely)) an increase from 64%, 2 weeks ago. 27% report complete compliance (7 out of 7), broadly consistent with recent weeks/months.

#### **Trust**

◆ 50% trust the Scottish Government to decide when and how its best to lift and re-impose restrictions and 32% disagree (similar to two weeks ago).  
◆ 62% agree they *don't* trust other people to do what is needed to keep the virus at bay (58% in February).

#### **Perceived effectiveness of response**

◆ 56% support the way the pandemic is being handled in Scotland. 53% agree it feels like the measures and guidance in Scotland are working (22% disagree). All these figures are similar to 2 weeks ago.  
◆ 23% agree they think it's sensible for the UK Government to lift all remaining restrictions in England including the rule to self-isolate if you test positive and 59% disagree (also similar to two weeks ago).  
◆ 53% agree the rules and guidance currently in place in *Scotland* are about right (29% think much/slightly too strict) and 22% agree rules and guidance in place in *England* are about right (similar to two weeks ago).

#### **Public mood**

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<sup>10</sup> Question - Thinking about ALL of the guidance on what to do and what not to do during the Coronavirus pandemic (including distancing, protection measures and all and all restrictions)... On a scale of 1-7, where 1 is 'Not at all' and 7 is 'Completely', to what extent do you feel you are following the regulations and guidance?

## **Briefing for Ministers**

- ◆ Optimism has increased slightly. 56% agree that things will start to get better soon (53% two weeks ago).
- ◆ 38% are worried about the Coronavirus situation (a decrease from 42% two weeks ago).
- ◆ 40% reported 'high' anxiety an increase from 34% in February and 36% in January. Those aged 18-44 score higher (48%) than those aged 45 plus (35%)<sup>11</sup>.
- ◆ 38% agree thinking about resuming more activities as restrictions ease makes them feel anxious, similar to February.
- ◆ Respondents were asked 'Thinking about the overall impact of the pandemic, how long do you think it will be before your life returns to normal? My life has returned to normal -10%, 0-6 months -13%, less than a year -25% and more than a year 35%.

### **Personal responsibility**

- ◆ 40% agree and 39% disagree that 'it's time for people to make their own decisions about what measures to take to keep themselves and others safe'. This is similar to 2 weeks ago.

### **Lifting restrictions**

- ◆ 60% agree (23% disagree) even when it is no longer required by law to wear a face covering in indoor public places, they will continue to do so.
- ◆ 50% agree they support the introduction of these changes (26% disagree).

Office of the Chief Social Adviser  
Learning Directorate

March 2022

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<sup>11</sup> High anxiety (6-10 on a scale 1-10)

### **ECONOMIC IMPACTS (HARM 4)**

1. The general domestic economic situation has improved in terms of economic output but the global economic outlook is increasingly uncertain as a result of the situation in Ukraine. The most immediate effect is likely to be felt through higher inflationary pressures as a result of rising prices for oil, gas and other commodities, exacerbating the current cost of living crisis.
2. Overall economic output in Scotland, as measured by Gross Domestic Product (GDP), recently returned to its pre-pandemic level of February 2020 for the first time in November and output remained above pre-pandemic levels in December, despite a contraction in December. Latest monthly data show Scotland's GDP fell 0.4% in December and is 0.1% above its pre-pandemic level (UK: 0.0%). However, GDP grew 1.3% over the fourth quarter of 2021 as a whole. Figures for the UK in January 2022 show that the GDP bounced back from a contraction in December and grew 0.8%. Equivalent data for Scotland is published on 16th March.
3. Labour market indicators are strong, reflecting the impact of the furlough scheme in protecting jobs. The latest labour market statistics for October to December show that 2.65 million people were employed in Scotland, an employment rate of 74.1% (up 0.8 percentage points over the year), and the unemployment rate was 4.1% (down 0.5 percentage points over the year).
4. However, the economic impacts of the pandemic continue to be felt unevenly across sectors, with those most affected by protective measures being the hardest hit. Consumer facing service sectors, such as hospitality, remain notably below pre-pandemic levels. Economic output in December in hospitality was 12.7% below pre-pandemic levels of output, and output in arts, culture and recreation services was 11.4% below.
5. Cities remain hardest hit in terms of loss of retail footfall. Google data for the week to 3 March shows visits to recreation and retail are down 11% compared to pre-pandemic levels, with Edinburgh 22% below and Glasgow 20% below pre-pandemic levels.
6. This difficult position in consumer facing sectors is confirmed by the most recent data from BICS (covering 7-20 February). This shows that 27.1% of businesses reported a decrease in turnover compared with what is normally expected, with this share rising to 40.8% in the Accommodation & Food Services industry sector.
7. Business resilience remains a key challenge: Business Insights and Conditions Survey (BICS) data for the period 24 January to 6 February show that 18.2% of hospitality businesses have less than three months of cash reserves.
8. Rates of absence from the workforce due to Covid has remained around the same level since February. BICS data (covering the period 7-20 February) shows that 1.9% of the workforce were estimated to be on sick leave or not working because of coronavirus (COVID-19) symptoms, self-isolation or quarantine, broadly in line with the previous period (2.2% in the period 24 January to 6 February). The Administration & Support Services industry sector reported the highest absence share at 2.9%.

## **Briefing for Ministers**

9. Whilst the business community have welcomed the fact that remaining restrictions are likely to be lifted on 21st March, they are calling for this to happen without further delay. Sectors impacted by certification are pleased that this requirement has now been lifted. Discussions so far suggest that most businesses will not carry out voluntary certification, but guidance is in place to support this should they wish to do so.

10. Businesses have noted that remaining measures are still having an impact on profitability, mainly due to impact on consumer confidence. Businesses are looking for clear messaging that it is safe to return to hospitality and tourism and are calling for Government to support this message with business visits and communications which show life getting back to as much normality as possible. The tone and content of guidance in place when legal restrictions are removed will be critical to improving consumer confidence.

11. Businesses have noted the wider difficult operating conditions due to the war in Ukraine and the cost of living crisis. All of these issues mean that business conditions will be challenging in coming months and the business community are keen for the protective measures in regulations to be removed to help remove one of the potential challenges.

12. The Federation of Small Businesses (FSB) report some discomfort amongst members about how they will deal with customers refusing to comply with individual businesses protective measures, if they continue to have them in place after all restrictions are removed. Guidance being developed will help with this.

13. With regard to ongoing delivery of the £375m of business support and the additional £4m reprioritised from existing Scottish Government funding for tourism and events:

- ◆ Confirmation of how a further £39.5m will be allocated was announced during Budget Stage 3;

- ◆ On 21 February, the First Minister announced £80m for a Local Authority Covid Recovery Fund, £3m additional funding for the City Centre Recovery Fund, a further £3.3 million for the childcare sector and a £2.4 million top-up for the outbound travel sector. This final allocation of funding to local authorities means we have fully allocated the £375 million of business support funding in 2021-22, and used underspend from some of the funding allocated, where business demand has been less than initially forecast. The purpose of the Local Authority Covid Recovery Fund is to empower local authorities to direct support as they consider necessary or justified to support continued economic recovery actions as the country emerges from the acute phase of the pandemic. Funding will be transferred to local authorities as a general revenue grant in the last two weeks of March;

- ◆ We are publishing weekly management information on Omicron support, with the most recent published on 9 March showing at 25 Feb £109.7m has been paid to businesses, alongside the £16m allocated and made available to public transport services;

- ◆ One of the key challenges to this is the constraints of the Scotland Reserve. Given the corporate funding position across the whole Scottish Government there is currently no space in the reserve to carry forward any underspend on the £375m to support expenditure in 2022-23. The Cabinet Secretary for Finance and Economy has written to HM Treasury to request



## **Briefing for Ministers**

approval to carry forward underspend outside of the reserve but this has not been granted as yet, and HM Treasury has given no indication that it will be. There is currently no budget allocated to Covid-19 business support in the 2022-23 budget allocations, so without this approval from HM Treasury, any expenditure in 2022-23 would add to the already significant budget pressure for next year;

◆ FSB requested that as we move into recovery that funding support could be facilitated in conjunction with economic agencies.

Office of the Chief Economic Adviser  
March 2022

**UPDATE ON DEVELOPMENTS IN AND ENGAGEMENT WITH UK NATIONS**

**Introduction**

1. In the last week planning for longer-term configuration of testing, surveillance, and contingency measures has remained the most significant focus at Four-Nations level. UK Government is still to confirm planning being made by UKHSA on these policies, as well as the consequences for funding available for Devolved Administrations configuring decisions around their own measures.

2. [Redacted – Out of Scope]

**[Redacted – Out of Scope]**

3. [Redacted – Out of Scope]

4. [Redacted – Out of Scope]

5. [Redacted – Out of Scope]

6. [Redacted – Out of Scope]

**UK Government domestic measures**

7. Following publication of the UK Government “Living with COVID-19 Strategy” on 21 February, UKG has begun the transition into regulation or lifting of the remaining domestic regulations in place in England.

8. UKG are in process of completing a transition period lasting to the end of March, over which time they will work on producing simplified COVID guidance so that it can be incorporated into routine public health advice. Accordingly on 1 April UKG will do the following:

- ◆ remove current guidance on voluntary COVID-status certification in domestic settings, and no longer recommend that certain venues use the NHS COVID Pass.
- ◆ update guidance setting out the ongoing steps that people with COVID-19 should take to minimise contact with other people.
- ◆ no longer provide free universal symptomatic and asymptomatic testing for the general public in England.
- ◆ consolidate guidance to the public and businesses, in line with public health advice.
- ◆ remove the health and safety requirement for every employer to explicitly consider COVID-19 in their risk assessments.
- ◆ replacing the existing set of ‘Working Safely’ guidance with new public health guidance.

9. Discussion remains underway at Four-Nations level on the future of testing and surveillance, as well as funding available for Financial Year 2022/23. Separate briefing is being provided on transition plan for Scotland to bring COVID testing, tracing and

## **Briefing for Ministers**

isolation towards a steady state, indicating the dependencies with UKG's planning on the National Testing Programme.

10. At a Four-Nations Health Ministers' Forum on 11 March, UK Health Secretary undertook to write to his opposite numbers in the devolved administrations to set out how the allocated funding will be spent, including the fair and equitable distribution of testing and surveillance assets in accordance with the testing Memorandum of Understanding, and the functioning of future procurement arrangements where devolved administrations wish to go further than UKG measures, eg on maintaining a ready stock of LFDs.

### **[Redacted – Out of Scope]**

11. [Redacted – Out of Scope]

12. [Redacted – Out of Scope]

13. [Redacted – Out of Scope]

14. [Redacted – Out of Scope]

15. [Redacted – Out of Scope]

### **[Redacted – Out of Scope]**

16. [Redacted – Out of Scope]

17. [Redacted – Out of Scope]

18. [Redacted – Out of Scope]

Covid Co-ordination Directorate  
March 2022

## **MODELLING THE EPIDEMIC**

### **Baseline Scenarios**

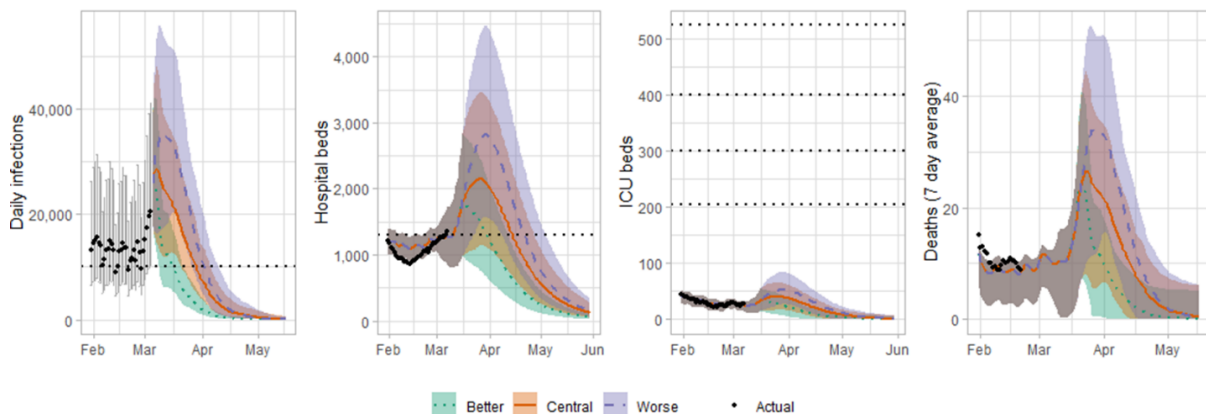
1. Forward projections have been developed to offer scenarios for the future path of cases, hospital and ICU occupancy, and of deaths in the absence of further changes to restrictions (beyond those already in place in the form of baseline mitigations) through to May 2022. These baseline projections have been updated for outturn data over the most recent week.

2. Assumptions on the reproduction number,  $R$ , will pick up some of BA.2's transmission advantage over BA.1; assumptions are otherwise as for BA.1, given there is as yet no confirmed evidence of different disease severity. Further details of the assumptions and full details are included within the modelling documentation.

3. As in previous weeks, 'Better', 'Central', and 'Worse' projections have been modelled for each outcome variable. The assumptions are based on:

- ◆ Better – Transmissibility is lower than current levels. For Omicron vaccine effectiveness reduction to 60% with no reduction in patients admitted to hospital and a 50% reduction in patients admitted to ICU.
- ◆ Central - Transmissibility remains at current levels. For Omicron vaccine effectiveness reduction to 60% with no reduction in patients admitted to hospital and a 50% reduction in patients admitted to ICU.
- ◆ Worse - Transmissibility is higher than current levels. For Omicron vaccine effectiveness reduction to 60% with no reduction in patients admitted to hospital and a 50% reduction in patients admitted to ICU.

4. The baseline projection scenario is set out in Figure 1 below.



**Figure 1: Daily infections, hospital and ICU COVID occupancy, deaths involving COVID assuming current mitigation policies continue, data up to 10 March**

5. The updated baseline projection captures the increase in prevalence and incidence that has gained momentum since the end of February. This results in a projection in which both Central and Worse describe a further peak in infections very shortly, and in hospital occupancy (late March) even in the absence of further changes to protective measures.

## **Briefing for Ministers**

6. Under the Central and Worse scenarios, there are also expected to be small increases in deaths, before falling away through the month of April. The current position is nearest to Central for infections and for ICU occupancy (which assumes a 50% severity reduction from Delta).

7. The position for hospital occupancy is challenging to interpret and to model due to the many factors driving COVID occupancy levels. The projection captures those in hospital both with and because of COVID. There is the potential of a continued increase in occupancy from current levels under both the Central and Worse scenarios.

8. COVID ICU occupancy remains low currently and is expected to remain well below capacity thresholds for all scenarios, as are deaths.

### **Policy Scenarios**

9. This week the policy scenarios explore the impact of lifting the remaining baseline mitigation measures from 21 March. Two permutations of this change are modelled and set out below. The first assumes behaviour reverts to pre-pandemic behaviour over a period of six weeks from 21 March; the second assumes this behaviour change occurs more gradually, over a 12 week period.

10. There is some evidence that behaviour is shifting markedly already in some parts of Scotland. Announcements and changes made in other of the UK nations will also influence what people listen and respond to.

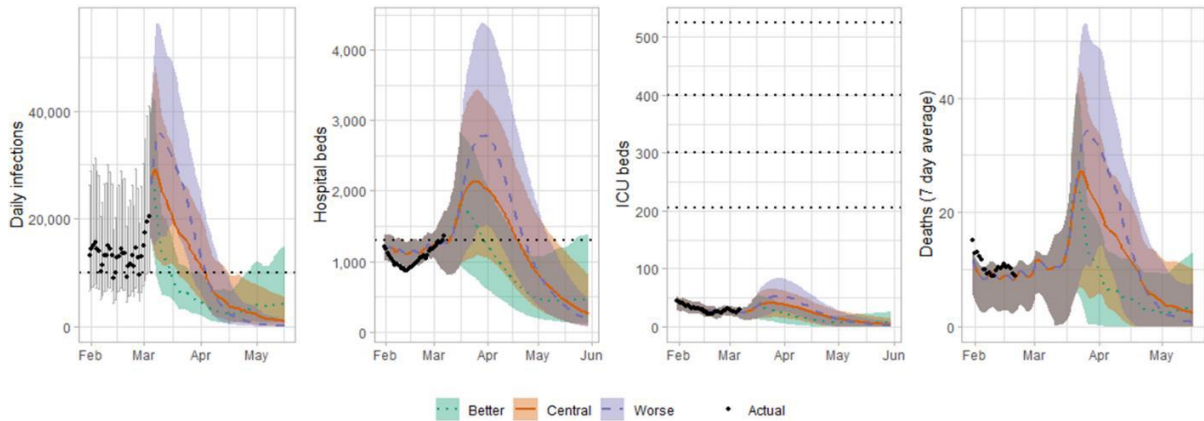
11. It is unlikely that the behaviour of all individuals would fully revert to pre-pandemic patterns. In reality, some individuals will continue to act more cautiously, observing published guidance and practicing mitigations much as they do now. Across the population we might expect there to be a distribution of behavioural responses.

12. The lifting of all restrictions from 21 March is around the time of peak in infections, but there is always uncertainty about the exact timing of any peak. The change in policy may result in higher levels of Covid-19 infections coming down off the peak. If change in behaviour happens more quickly this could lead to an exit wave, if it happens more slowly this is unlikely to occur e.g. over 12 weeks. At the upper bound(Worse scenario) this may be significant enough to cause pressure on healthcare services.

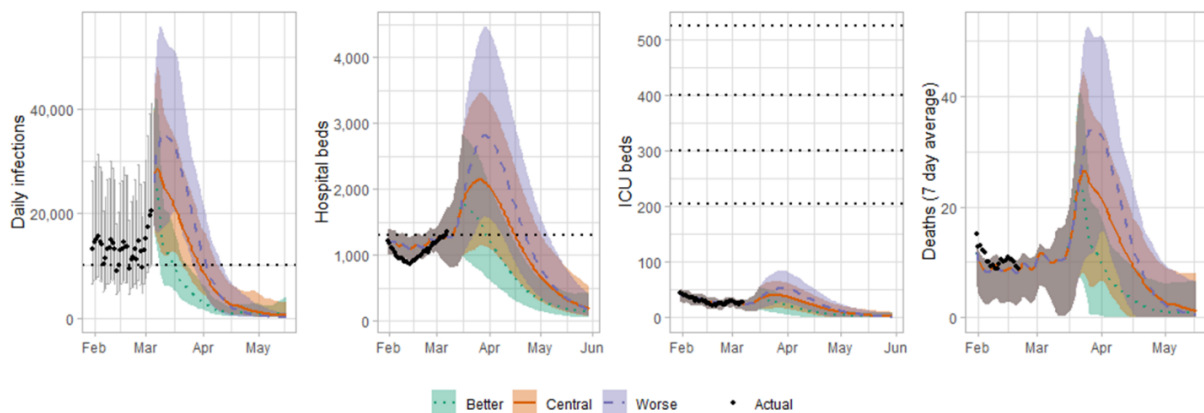
13. Infections and hospital occupancy are likely to decrease more slowly than in the baseline and remain at higher levels following the lifting of restrictions if behaviour changes more quickly, eg over 6 weeks. ICU occupancy is likely to remain under capacity limits, even where behaviour changes more rapidly, under Better/Central and Worse.

14. The results for the scenario exploring the lifting of all restrictions from 21 March assuming behaviour changes more slowly, over 12 weeks, do not differ greatly from the baseline scenario. Infections and hospital occupancy might be expected to decrease slightly more slowly than in the baseline. ICU occupancy is likely to remain under capacity limits for all scenarios where behavioural changes more slowly.

## Briefing for Ministers



**Figure 2: Daily infections, hospital and ICU COVID occupancy, deaths involving COVID assuming regulations are lifted on 21 March and behaviour responds quickly over a six week period, data up to 10 March**



**Figure 3: Daily infections, hospital and ICU COVID occupancy, deaths involving COVID assuming regulations are lifted on 21 March and behaviour responds more gradually over a 12 week period, data up to 10 March**

### Test and Protect

15. A set of policy scenarios explore the impact on infections, hospital and ICU occupancy, and deaths, of the Transition Plan for Test and Protect. The key element of the transition is moving from a response with a major element focused on population wide case ascertainment and tracing infection (to reduce transmission), toward a targeted response focused on reducing severe impacts of the virus.

16. The changes and their timing are as follows:

- ◆ From the end of March, population-wide asymptomatic LFD testing will cease
- ◆ From mid-May population level symptomatic testing, tracing and isolating from mid-May.

17. The changes, by reducing identification of positive cases will reduce the numbers of infected individuals isolating, thereby leading to upward pressure on transmission. Due to the timing of the changes; from 1 April and 16 May, much of the risk period will have passed if the timing of behavioural change does not lead to an exit wave after this point in time.

## **Briefing for Ministers**

18. If an exit wave occurs as the remaining legal restrictions are lifted there is a risk that infections could penetrate into vulnerable populations and lead to upticks in hospitalisations and potentially deaths.

### **Assurance**

19. The projections are approved by senior management then 10 weeks of one of Better/Central/Worse is sent to SPI-M-O via a validator. This is normally Central. Checks are done and then SPI-M-O review the baseline projections from all the modelling groups and form a consensus. If the SG projection is within the consensus this is used as the baseline for policy modelling.

20. If it is not, the modelling is rerun and resubmitted to be reassessed. SPI-M-O take the decision on the time horizon of the projection that is then published. This tends to be 3 or 4 weeks, of the 10 weeks modelled.

21. Assumptions in the model are updated regularly e.g. vaccine effectiveness based on the best evidence available at the time. This is provided as papers via SPI-M and is normally discussed during the SPI-M-O meetings. Comparisons are also made with outturn data, as this becomes available to evaluate model performance.

### **Conclusions**

22. The updated baseline projection captures the increase in prevalence and incidence that has gained momentum since the end of February. This results in a projection in which both Central and Worse describe a further peak in infections very shortly, and in hospital occupancy (late March) even in the absence of further changes to protective measures. Under the Central and Worse scenarios, the possibility of small increases in deaths remains, before falling away through the month of April. The current position is nearest to Central for infections and for ICU occupancy (which assumes a 50% severity reduction from Delta).

23. The lifting of all restrictions from 21 March may result in higher baseline levels of Covid-19 infections if behaviour change occurs more rapidly. On the upper bound this may be significant enough to cause pressure on healthcare services. Due to the timing of the change around testing - from 1 April and 16 May much of the risk period will have passed if the timing of behaviour change does not lead to an exit wave after this point in time.

Covid Co-ordination Directorate, Central Analysis Division, March 2022

**3-WEEK REVIEW OF PROTECTIVE MEASURES THAT REMAIN IN REGULATIONS**

**Introduction**

1. There is currently a small number of remaining regulatory measures which are:
  - Requirement to collect and share visitor information
  - Requirement to have regard to Scottish Government guidance about minimising risk of exposure to coronavirus on its premises
  - Requirement to take reasonably practicable measures, as set out in the guidance, to minimise incidence and spread of coronavirus
  - Face covering requirement in most indoor public places and on public transport

2. The February update to the Strategic Framework said:

*On 21 March (indicative date, to be confirmed at preceding review), we plan to remove the legal requirement for face-coverings in indoor public places and on public transport. Again, some settings and service providers may wish to maintain face-covering policies to help to protect their customers and staff. Other remaining legal requirements will convert to guidance and good practice as appropriate.*

3. As part of the associated announcement on 22 February the First Minister said:

*“as of 21 March - assuming no significant adverse developments in the course of the virus - we expect that the legal requirement to wear face coverings in certain indoor settings and on public transport will be converted to guidance”*

4. As the current Covid threat assessment (Annex B) notes, there has been some deterioration in case numbers, but no change to the severity of the disease with ICU admissions remaining low. It is therefore a matter of judgment as to whether this can be considered a “significant adverse development”.

5. This paper sets out options for next steps on protective measures in that context. These are broadly:

- Option A: Retain the current position until the state of the epidemic improves
- Option B: Remove some regulatory requirements
- Option C: Remove all regulatory requirements and replace with strong guidance

6. A Four Harms assessment related to these options is given in **Appendix I.1**, attached.



## **Briefing for Ministers**

### **Considerations**

#### **Four nations**

7. The other nations of the UK are each pursuing their own updates to measures with a focus on how remaining regulations are transferred into COVID-specific guidance, and then, at what is judged to be the appropriate point, either incorporated into overarching public health guidance or removed completely. In each case the intention is a more sustainable configuration for managing COVID beyond the acute stage of the pandemic. However the pace at which the changes are being made varies across the nations.

8. UK Government on 24 February transferred into guidance all their domestic measures that remained in regulation, including the requirements on self-isolation, as flagged by the Prime Minister three days previously when he announced the UKG strategy “Living with COVID-19”. This transitional phase of having specifically COVID measures in guidance in place is due to last until 1 April, when UKG will consolidate and reduce their COVID body of guidance to the public and to businesses, and incorporate it into public health guidance for winter respiratory illnesses such as flu.

9. **[Redacted – Out of Scope]**

10. **[Redacted – Out of Scope]**

11. Similarly to our Strategic Framework Update, the UK and Welsh strategies also set out protective behaviours in the longer term. Principal actions recommended align in most cases – for example on vaccinations, ventilation, and following good hygiene – but UKG presses less firmly on testing and, while recommending that individuals should stay at home if feeling unwell, the strategy does not refer to working from home.

Public and Stakeholder opinions

12. Business stakeholders have highlighted the wider economic position regarding rising costs and the potential impact of the conflict in Russia and Ukraine and are keen to promote customer confidence in this challenging context. With that in mind they are keen to see positive messaging from Government at this time signalling an end to protective measures, as has been seen elsewhere in the UK. In particular sectors have expressed high levels of concern regarding any continuation of measures such as a requirement to wear face coverings and associated distancing in workplaces, in particularly in offices.

13. Latest polling shows that 60% of the public say that they will continue to wear face coverings in indoor public places, even when no longer required by law. Opinion continues to be split on whether it is time for people to make their own decisions about what measures to take to keep themselves and others safe, with a similar proportion disagreeing (39%) as agreeing (40%). Those who disagree that it's time for this are more likely to agree that that they don't trust others to do what's necessary to keep the virus at bay (80%).

14. Stakeholders representing disability groups have highlighted that those with disabilities may be particularly vulnerable to COVID and are very concerned about a full lifting of restrictions and the impact this will have on public attitudes and behaviours. A recent survey by Disability Equality Scotland (week beginning 28 February) highlights this with 66% of respondents expressing concern about lifting of legal restrictions (especially among those at clinical high risk).

## **Briefing for Ministers**

15. There is strong evidence to show that vaccines are offering significant protection to people on the Highest Risk List from becoming severely ill. A review of this evidence will be published at the end of March and communicated to people on the HRL to offer reassurance as to the clear rationale behind decision-making. The offer of new treatments to people who are eligible provides another mitigation to reduce risk. Clinicians are of the view that revoking the regulations will not significantly increase the risk for people on the HRL, including those who are immunosuppressed or immunocompromised.

### **Options**

#### **Option A: Retain the current position until the state of the epidemic improves**

16. Evidence from earlier in the epidemic suggests that adherence to measures is highest when they are in regulation. Given the current high levels of prevalence detailed at Annex A and the hospital occupancy rates shown at Annex D there would be harm 1 and 2 benefits in maintaining the current regulatory requirements for a further short period.

17. Maintaining the current position is likely to be poorly received by business and places of worship stakeholders who have an expectation that these will be lifted on the 21 March following publication of the Strategic Framework Update and the announcements by the First Minister. However it has always been clear that lifting of restrictions were dependent on the data, and given recent upward trends it may be appropriate to conclude that the data does not support a further reduction in protective measures at this time.

18. While prevalence and hospital occupancy rates are high, there is no evidence to suggest that there has been any increase in severe illness and ICU admissions remain low. It may therefore be disproportionate to retain all the current regulatory measures at this time.

#### **Option B: Remove some regulatory requirements**

19. Given the continued high prevalence but low levels of severe illness there may be scope to remove some but not all of the current regulatory requirements. Of the remaining measures the requirement to wear a face covering is one of the most effective public health measures. It therefore follows that particular caution may be appropriate when considering removing this requirement. Should it be retained there are two options that could be pursued.

- i. Retain the requirement in its current form – this would have the greatest harm 1 and 2 benefit but is likely to face significant challenge
- ii. Amend the current requirement so that face coverings are only required in certain settings – A differentiated approach would continue to deliver some harm 1 and 2 benefits but may be harder to communicate and face challenge on rationale.

20. Advice was provided to Cabinet on 15 and 22 February on a possible approach to requiring a Face Covering in some settings, this advice suggested that the requirement could be retained in settings where there is likely to be a lower element of choice. This

## **Briefing for Ministers**

would mean a differentiation between hospitality and leisure settings and settings where people are less likely to have scope to make risk based decisions. This would include:

- Retail
- Education
- Work place
- Health and social care settings
- Prisons
- Public transport

21. There is a significant risk of legal challenge should a requirement to wear a face covering be retained, particularly in light of the positions of the rest of the UK. This may come from Faith Groups, some of whom consider the requirement to be a disproportionate interference with acts of worship. However the retention of face coverings is likely to be welcomed by disability groups where there is anxiety about lifting of restrictions.

22. The requirement to continue to wear face coverings in most indoor public places and on public transport is considered to have harm 3 and 4 impacts. The current exemption that allows people to remove face coverings in communal workplace areas requires people to distance by 1m or use a screen. This is considered by stakeholders to be a barrier to returning to full productivity and a greater degree of normality. It should also be noted that continued constraint of workplace capacities will have ongoing impacts on city centre economies. This is also having an impact on public services including local and Scottish Government as office capacities would likely remain low.

23. Any differentiated approach is likely to face significant challenge and a clear rationale would be needed to justify the position. The current position could be considered to be simpler and as the public are more familiar with that position there could be higher levels of adherence if that was maintained. However a move to a requirement in some settings is likely to be better received by some stakeholders as representing positive progress.

### **Option C: Remove all regulatory requirements and replace with strong guidance**

24. This option would best align with public and stakeholder expectations as well as the approach taken by other nations. It represents the highest levels of harm 3 and 4 benefits but could result in increased transmission, particularly in the context of high prevalence. However this should, again, be considered in the context of lower levels of significant illness and death.

25. While this option would remove the regulatory requirements the guidance would continue to advise people and organisations on COVID safe behaviours. Guidance would encourage individuals and organisations to make informed, risk based judgements as to the appropriate COVID mitigations in any given situation. The guidance would strongly recommend use of measures such as face coverings where appropriate and would follow the following principles

#### *Guidance for businesses, service providers and places of worship*

- support organisations to carry out risk assessments to consider factors such as
  - ventilation

## **Briefing for Ministers**

- crowding and pinch points
- health and safety duties as they relate to staff and customers
- Noise levels
- Based on the risk assessment additional mitigations should be implemented as appropriate. This could include
  - Asking customers and/or staff to wear a face covering
  - Adjusting layout or installing screens
  - Improving ventilation
  - Increasing distance between desks/tables/seats
  - Use of certification scheme
  - Hybrid working
- Promoting awareness of the distance aware scheme and how organisations can help support clinically vulnerable
- Simplified guidance to replace some sector specific guidance with central Safer Workplaces guidance which would cover all workplaces

### *Guidance for individuals*

- Individuals advised to consider COVID risk factors such as:
  - personal circumstances - personal health risks and those of people they are in close contact with
  - the setting they are in - ventilation, crowding etc
  - the behaviours and vulnerabilities of others
- Additional mitigations that would be strongly recommended include
  - Wearing of face coverings
  - Distancing
  - Opening windows
  - Testing
- Promoting awareness of the distance aware scheme and how individuals can help support clinically vulnerable people

### **Differentiated impacts**

26. Throughout the pandemic we have seen that COVID has had a greater impact on certain sectors of society. A removal of regulatory requirements may have a significant impact on public behaviours which could result in increased transmission risks. An Equalities Impact Assessment is in the process of being carried out to support a potential lifting of regulatory measures. It should be noted however that the differentiated impacts of COVID go beyond some of the protected characteristics, for example many on the Highest Risk list would not be considered to meet this definition. It remains important to consider those in society who may be more impacted by the changes under consideration. It is worth noting that the UK Government are currently facing a legal challenge regarding the level of consideration given to the particular impact recent changes will have on those with disabilities.

27. Some sectors and socio economic groups have experienced greater financial hardships than others. Many of these will also be facing further challenges as the cost of living rises. Most of the differentiated impacts on this group have largely been alleviated as some of the more restrictive measures have been lifted. However some working in the hospitality or service industry could benefit from the improvement in city centre economies associated with increased capacities in offices, which are limited due to distancing requirements when Face Coverings are not worn. It should also be noted that

## **Briefing for Ministers**

people in this group may be less likely to be able to isolate if infected, many in this group will also be in customer facing jobs with higher numbers of contacts, and also more likely to take public transport, which could mean that there will be increased transmission risks within this group.

28. A significant proportion of older people and those with certain health conditions which make them particularly vulnerable to the impacts of COVID, have experienced increased anxiety and poorer health outcomes. **Annex J** explores the particular impacts on those on the Highest Risk List. There will be some overlap between the Highest Risk list and protected characteristics such as disability but there are many on the list who do not have a disability and there will be many who have a disability who are not considered to be at highest risk.

29. As set out in **Annex J**, the risk that COVID poses to those at highest risk has reduced substantially thanks to the roll-out of vaccines. However, there has been lower vaccine uptake among certain ethnic minorities, due to reasons including cultural, although SG continues to work with Health Boards and others to support vaccination. The immune suppressed are still at increased risk but should already be following individualised medical advice regarding measures to protect themselves for COVID and other illnesses, and are being prioritised for a second booster and new treatments. Some of those at highest risk continue to be anxious and removing regulatory measures could increase levels of anxiety and cause more people to avoid mixing with others and public spaces, and exacerbate isolation and poor mental health within this group.

30. Removing face coverings will have a benefit for several sectors of society, particularly those with developmental or communication challenges, this will include people with some disabilities. This is also likely to have a positive impact on the development of children, in addition, close to half of young people (44%) believe it is harder to connect with others while wearing a face covering, with girls more so than boys, which impacts on social interaction.

31. There are also some sectors of society that are less likely to have the full protection offered by vaccinations, this includes some ethnic minorities and younger people. Work is ongoing through communication and marketing campaigns to encourage uptake of vaccinations and boosters, particularly in these groups.

Covid Co-ordination Directorate  
March 2022

#### FOUR HARMS ASSESSMENT

1. This Annex covers the overall impact of replacing the regulations listed above with guidance on how to reduce risk from infection.
2. In the current context, case rates are steadily increasing and the increase in estimated infection levels has correlated with the increasing prevalence of the Omicron BA.2 variant in Scotland since early February. Since 2 February, the proportion of Covid-19 related hospital admissions have increased among those aged 60 or older, who represented 56% of admissions in the week to 1 March. This age group has also seen increased COVID-19 case rates throughout the same period, however, case rates are now increasing in all age groups. **If baseline restrictions are removed we may expect this to have a negative impact on case rates and hospital admissions (Harms 1 & 2).**
3. COVID-19 hospital occupancy has been increasing since mid-February with just over 1,500 patients in hospital with COVID-19 as at 9 March. This is around the peaks seen in January 2022 (Omicron wave) and April 2020, but remains below the peak of last winter, when over 2,000 patients were in hospital in January 2021 (Harms 1 & 2). In contrast, the number of patients in ICU remains low.
4. Scientific evidence on the Omicron variant, both the BA.1 and BA.2 sub-lineages, show reduced disease severity compared to Delta<sup>12 13 14</sup> and the risk of COVID-19 related death was 67% lower for Omicron versus Delta<sup>15</sup>. However, vaccine effectiveness against symptomatic disease with the Omicron variant is substantially lower than against the Delta variant, with rapid waning<sup>16</sup>. Protection against hospitalisation remains high, particularly after three doses of vaccine and vaccine effectiveness is generally slightly higher in younger compared to older age groups.
5. Given the decreased disease severity of Omicron, the main concerns at present, should not be Harm 1 alone. As detailed above, all evidence supports the view that Omicron is less severe than previous variants, but risks still remain, especially when considering transmission to older age groups who may soon be subject to vaccine waning.
6. The biggest change in restrictions over the past few months has been the commencement of hybrid working. The most recent update of the Scottish contact survey<sup>17</sup>, published 10 March, shows that contacts within the community have increased by 11% with interactions in the work and home remaining at similar levels to the previous week. Those within the 50-69 age groups have reported the biggest decrease in contacts, by at least 12%. All remaining age groups have either reported an increase or a similar level of contacts over the same period. Across all age groups visits to a non-essential shop have shown the biggest increase, increasing from approximately 40% to

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<sup>12</sup> [12 January 2022 Risk assessment for SARS-CoV-2 variant: Omicron VOC-21NOV-01 \(B.1.1.529\) \(publishing.service.gov.uk\)](#)

<sup>13</sup> [Risk assessment for SARS-CoV-2 variant: VUI-22JAN-01 \(BA.2\) 26 January 2022 \(publishing.service.gov.uk\)](#)

<sup>14</sup> [Risk of COVID-19 related deaths for SARS-CoV-2 Omicron \(B.1.1.529\) compared with Delta \(B.1.617.2\) | medRxiv](#)

<sup>15</sup> [COVID-19 vaccine surveillance report - week 9 \(publishing.service.gov.uk\)](#)

<sup>16</sup> [COVID-19 vaccine surveillance report - week 9 \(publishing.service.gov.uk\)](#)

<sup>17</sup> [Coronavirus \(COVID-19\): modelling the epidemic \(issue no.93\) - gov.scot \(www.gov.scot\)](#)

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44% in the last two weeks. Overall however the average number of contacts remains around 5, substantially lower than pre-COVID-19.

7. This pattern of interaction shows that while the public are engaging in more activities out with the home, this is happening in a gradual way suggesting a degree of caution. Online polling conducted by YouGov for the Scottish Government<sup>18</sup> from 1-2 March, shows that 38% agree thinking about resuming more activities as restrictions ease makes them feel anxious, however, exactly the same proportion have no such concerns at all.

8. Further polling (1-2 March) shows that while at least two thirds would be comfortable going to some venues or events in the next month (bar/pub, cinema/theatre, outdoor sporting event in a stadium, outdoor music festival), far fewer say that they would be very comfortable. Comfort levels in going to cinema/theatre (68%) and outdoor sporting events (67%) are both much higher than when last measured in 2021 (50% and 42% respectively). Comfort in going to a pub or bar is also high at seven in ten (71%), although caution is evident around indoor music concerts/gigs, with comfort at 55%, the lowest of all events/venues presented. 71% are happy to follow some rules and guidance if that means they can do the things that matter to them, down slightly from 76% in early February.

9. Opinion continues to be split on whether it is time for people to make their own decisions about what measures to take to keep themselves and others safe, with a similar proportion disagreeing (39%) as agreeing (40%).

**10. Given the current relatively high rate of cases and hospitalisations this could lead to increased levels of infection and hospitalisations if there were large increases in the numbers of people mixing with no protective measures thus having a negative impact on Harms 1 and 2.** Measures such as face coverings and measures to minimise the risks of exposure do have an impact on reducing transmission. However, the majority of the public continue to support the wearing of face coverings and may continue to do so after the requirement has been lifted. Online polling conducted by YouGov for the Scottish Government on 1-2 March indicated that (79%) agree that protective behaviours such as cleaning hands and wearing a face covering still have an important role to play. 60% agree that even when it is no longer required by law to wear a face covering in indoor public places, they will continue to do so. **In contrast, the collection of contact details is not being rigorously implemented and may not be particularly effective depending on the future of test and trace activities.**

**11. Removing all measures will remove any real or perceived barriers to economic activity enabling everyone to participate as they did pre-COVID-19, thus having a positive benefit on Harm 4. This may also reduce the costs for business, another benefit on Harm 4.**

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<sup>18</sup> The sample is demographically and geographically representative of adults 18+ across Scotland, with c.1000 responses each week fieldwork is conducted

## **Briefing for Ministers**

**12. It should also be noted that removing all regulations and only relying on guidance may cause discomfort within the population, potentially impacting Harms 2 & 3.** It leaves that section of the population who are particularly vulnerable at higher risk when participating in a wide range of activities. It would also be necessary to carefully monitor the most vulnerable cohorts such as older individuals and people considered to be at the highest clinical risk, who may soon be subject to vaccine waning. Individuals may not be ready to fully return to pre-COVID-19 activity, and as detailed above, recent polling reported that 38% agree thinking about resuming more activities as restrictions ease makes them feel anxious, thus having a negative impact on Harm 3. **So the removal of restrictions, will have both positive mental health and wellbeing impacts as well as negative ones, in terms of anxiety and worry.**

13. Under our COVID-19 Strategic Framework, the Scottish Government is committed to ensuring that improving mental health and wellbeing is an underpinning principle as we take strategic decisions (Harm 3). We have also committed that evidence on the likely effects on mental health will be specifically assessed as part of our future decision-making. The likely negative effects on mental health of any future protective measures will be weighed against the public health benefits of doing so.

**14. Overall, there are likely to be mental wellbeing benefits from a lifting of remaining restrictions (Harm 3).** This will allow for easier social contact, which might contribute to an enhanced sense of normality about socialising. The lifting of restrictions may have a bigger positive impact on people whose social contact has been limited over the pandemic, especially those who have been living alone. However, these reductions may cause some anxiety and concern among people who may have reservations about lifting the remaining measures. There may be particular negative effects on the mental wellbeing of vulnerable groups and those at highest clinical risk, given the prevalence of COVID-19 remains high.

15. Certain sectors of the population would remain more at risk (Harm 1) and some degree of societal unease may be experienced if measures remain in guidance only with some people complying and others not (Harm 3).

**16. From a Harm 4 perspective a slower release of protective measures would continue to incur costs.** There is the opportunity for businesses to ask customers to voluntarily comply but the position of staff would need to be considered. Of course depending on the customer base of an individual business they may find retaining some measures encourages more custom.

**17. If the remaining restriction measures are lifted this may negatively impact Harms 1, 2 and 3, however, they will also positively impact Harms 3 & 4.** It is essential that people on the Highest Risk List are provided continued support when the restrictions are removed. As detailed in the Strategic Framework, Equalities and Fairer Scotland Impact Assessment (EQFSIA)<sup>19</sup>, the physical and mental health and wellbeing of people at highest clinical risk has been particularly affected, we are working to develop support for those who need additional help to recover, to reconnect with people and things they were doing before the pandemic, and to benefit from the current lifting of protective measures.

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<sup>19</sup> [Coronavirus \(COVID-19\) Strategic Framework Update February 2022: Equalities and Fairer Scotland Impact Assessment \(EQFSIA\) \(www.gov.scot\)](https://www.gov.scot/publications/equalities-and-fairer-scotland-impact-assessment-2022/pages/19-coronavirus-covid-19-strategic-framework-update-february-2022-equalities-and-fairer-scotland-impact-assessment-eqfsia.aspx)



## **Briefing for Ministers**

18. Continued importance will be placed on promotion of safer behaviours to encourage the general public to take a personal risk assessment to their everyday actions that embeds public health protective actions. Similarly for businesses and organisations, supporting adaptations to their activities that will support and encourage safer spaces will ultimately rebuild consumer confidence.

### **Retaining the requirement in regulations relating to the wearing of face coverings**

19. **An option to remove all restrictions bar the wearing of face coverings in certain higher risk settings (education, health and social care settings, prisons, public transport, retail and work place) would achieve the same overall aim but stagger implementation in a stepped approach with two additional steps. Overall this approach would maintain some lower degree of Harm 1 and 2 protection through the continuation of one measure (wearing of face coverings) in regulation while sending out a more cautionary note** by retaining other measures in guidance. Retaining face coverings in health services and care homes and retail, for example, may increase the confidence of the public in accessing these services.

20. The main challenge with adopting a stepped approach to removing further restrictions is complexity. For example, it may be difficult to explain why face coverings should be worn in some settings and not others. How do you decide what is essential to an individual? As with the option to remove all remaining restrictions in one step, certain sectors of the population would remain more at risk and some degree of societal unease may be experienced if measures remain in guidance only with some people complying and others not.

21. The wearing of face coverings continues to be recommended by SAGE and the WHO, as well as in the scientific literature as an important and easily adopted requirement to reduce the risk of transmission (Harm 1). **During the winter/spring this will have additional benefits in helping to prevent the transmission of flu and other RSVs which will also have a positive impact on Harm 2. Previous assessments of the wearing of face coverings have identified very low social and economic harms (Harm 3 and 4 ) arising from the wearing of face coverings.**

22. It is recognised that the experience of wearing face coverings will vary for different groups within society. The Regulations already exempts those who are unable to wear a face covering because of any physical or mental illness, impairment, disability or distress and a free exemption card is available under the scheme. Wearing face coverings may provide some security for those who are more vulnerable to COVID-19 infections and severe illness however it may also cause some difficulties for those that rely on non-verbal communication.

23. Wearing face coverings in indoor venues will further reduce the risk of transmission (Harm 1 & 2). Vaccination reduces but does not entirely eliminate the risk that, if infected, people can transmit the virus to others; wearing a face covering will provide an additional degree of protection.

24. Maintaining requirements for face coverings is unlikely to have significant Harm 3 effects, however, it could cause some social unrest if some people are seen not to comply with no consequences. **The success of this measure may be influenced by social norms.** That is, when people see others wearing face coverings they may feel more obliged to follow. **The comfort provided to some individuals by maintaining**

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**the regulation to wear face coverings within retail may also have a positive benefit to Harm 4.**

25. Further data will be published in an evidence paper titled 'Assessment of Impact of Revoking the Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021 on people on the Highest Risk List and Mitigations' and in an Equality Impact Assessment (EQIA) on the 'Revocation of the Health Protection Regulations'.

Scottish Government Central Analysis Division

COVID Co-ordination Directorate  
March 2022

**HIGHEST RISK LIST – EVIDENCE, POLICY IMPACTS AND MITIGATIONS**

**Assessment of Impact of Revoking the Health Protection (Coronavirus) Requirements (Scotland) (Regulations) 2021 on People on the Highest Risk List and Mitigations**

**Purpose**

1. The purpose of this annex is to consider the impact of revoking the remaining legal requirements of the Health Protection (Coronavirus) Requirements (Scotland) (Regulations) 2021 on those on the Highest Risk List (HRL), including those who are immunosuppressed or immunocompromised, specifically the proposals to remove the following requirements:

- ◆ to wear face coverings in specified public places and on public transport (regs 5, 6, 7)
- ◆ on businesses to collect and share customer information (reg 3)
- ◆ on businesses, services and places of worship to have regard to guidance on minimising exposure to coronavirus (reg 4(1)(a)); and, to take measures in guidance as are reasonably practicable (reg 4(1)(b))

2. This annex sets out the composition of the Highest Risk List, the background to how we have provided protection and support to this group throughout the pandemic, the potential impacts from revoking the remaining regulations, and the measures that have already been (or will be) put in place to mitigate any impacts.

**Composition of the Highest Risk List**

3. As at 7 March 2022, there were 176,898 people on the Highest Risk List (around 3.2% of the population). The includes people with the following conditions:

<b>Number of individuals on the Highest Risk list by group (as at 7 March 2022)</b>	
<b>Highest Risk Group<sup>^</sup></b>	<b>On highest risk list</b>
1 (Organ transplant recipients)	6,653
2 (Specific cancers)	25,448
3 (severe respiratory conditions)	69,807
4 (Rare diseases, including people with Downs Syndrome)	10,605
5 (On immunosuppression therapies)	36,217
6 (Pregnant with heart disease)	82
7 (GP or clinician identified)	50,653
<sup>^</sup> The same individual may be counted in one or more of the highest risk groups.	

4. Of this group:

- ◆ 51% are 65 years of age or over
- ◆ 56% are women
- ◆ there are 1,377 children aged under 16
- ◆ some people will be disabled but we don't have numbers

## **Briefing for Ministers**

- ◆ some people will be from minority ethnic communities but we don't have numbers
- ◆ Almost half (48%) live in the two most deprived Scottish Index of Multiple Deprivation quintiles

### **Background to the Highest Risk List**

5. In March 2020, people who were identified as being at highest risk of severe illness if they caught COVID-19 were added to a Shielding List and advised to shield for 18 weeks until 31 July. The Scottish Government continued to provide advice and support to everyone on the shielding list, mainly through letters from the Chief Medical Officer, leaflets, on-line advice and an SMS text messaging service. From October 2020, the Chief Medical Officer provided additional advice about daily interactions such as working, shopping, transport and social contacts, aligned to the 5 protection levels introduced by the first Strategic Framework. In January 2021 when Scotland went back into lockdown, everyone on the Shielding List who could not work from home was advised not to go into the workplace or use public transport until this lockdown was lifted on 26 April 2021.

6. In July 2021, we changed the name of the Shielding List to the Highest Risk List to reflect the fact that we were no longer advising people to shield, and everyone was advised that they could now follow the same advice as the rest of the population, based on the impact of the vaccination programme and other public health protective measures.

7. Since July 2020, our aim has been to provide information, advice and support to enable and empower people at highest risk to make their own decisions about their own daily lives and activities. However, there has been an understandably disproportionate impact on their mental health and wellbeing<sup>20 21</sup>. Although people have not been advised to shield since July 2020, we know from user research<sup>22</sup> and a more recent survey by PHS of people on the HRL (13,581 responses) (results remain confidential until publication due on 30 March 2022<sup>23</sup>) that:

- ◆ 81% respondents agree with the statement that they still make decisions that are mainly driven by fear of COVID-19 infection and 36% still try to minimise all physical contact with other households.
- ◆ This is despite seven in ten (71%) respondents reporting that they are less afraid of COVID-19 infection since they have been fully vaccinated.

8. The advice from the Chief Medical Officer is that in the context of the updated Strategic Framework, people on the HRL can continue to follow general population health guidance and advice unless advised otherwise by their GP or clinician. Given the wide range of circumstances and health conditions of people who are on the HRL, clinicians can best provide person-centred care appropriate to the individual's clinical circumstances as they would have before the pandemic. This advice is based on evidence about the efficacy and effectiveness of the vaccination programme and other

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<sup>20</sup> [COVID-19 Shielding Programme \(Scotland\) Impact and Experience Survey - Publications - Public Health Scotland](#)

<sup>21</sup> [scottish-health-survey-2020-edition-telephone-survey-volume-1-main-report.pdf](#)

<sup>22</sup> [Coronavirus \(COVID-19\): highest risk - survey report - July 2021 - gov.scot \(www.gov.scot\)](#)

<sup>23</sup> Please note these statistics are confidential in advance of pre-release on 23 March and publication on 30 March.

## **Briefing for Ministers**

mitigating factors including the emergence of new treatments. An evidence review will be published in due course.

9. There is now strong evidence that the vaccination programme is offering significant protection and preventing people on the Highest Risk List from becoming severely ill from COVID-19 and the CMO has now also advised everyone on the Highest Risk List that we're undertaking a review of who still needs to be on the HRL, as set out in the Strategic Framework. Our priorities going forward are therefore to continue to:

- provide information, advice and support to people as they are removed from the list, including how to reconnect with people and things they were doing before the pandemic; and,
- identify those who remain at highest risk on an ongoing basis in order to enable future priority for vaccination, treatments, and any other additional advice or protective measure required.

10. Overall, our aim is that everyone who is on the Highest Risk List will benefit from the lifting of restrictions as much as everyone else.

### **Impacts for those at Highest Risk**

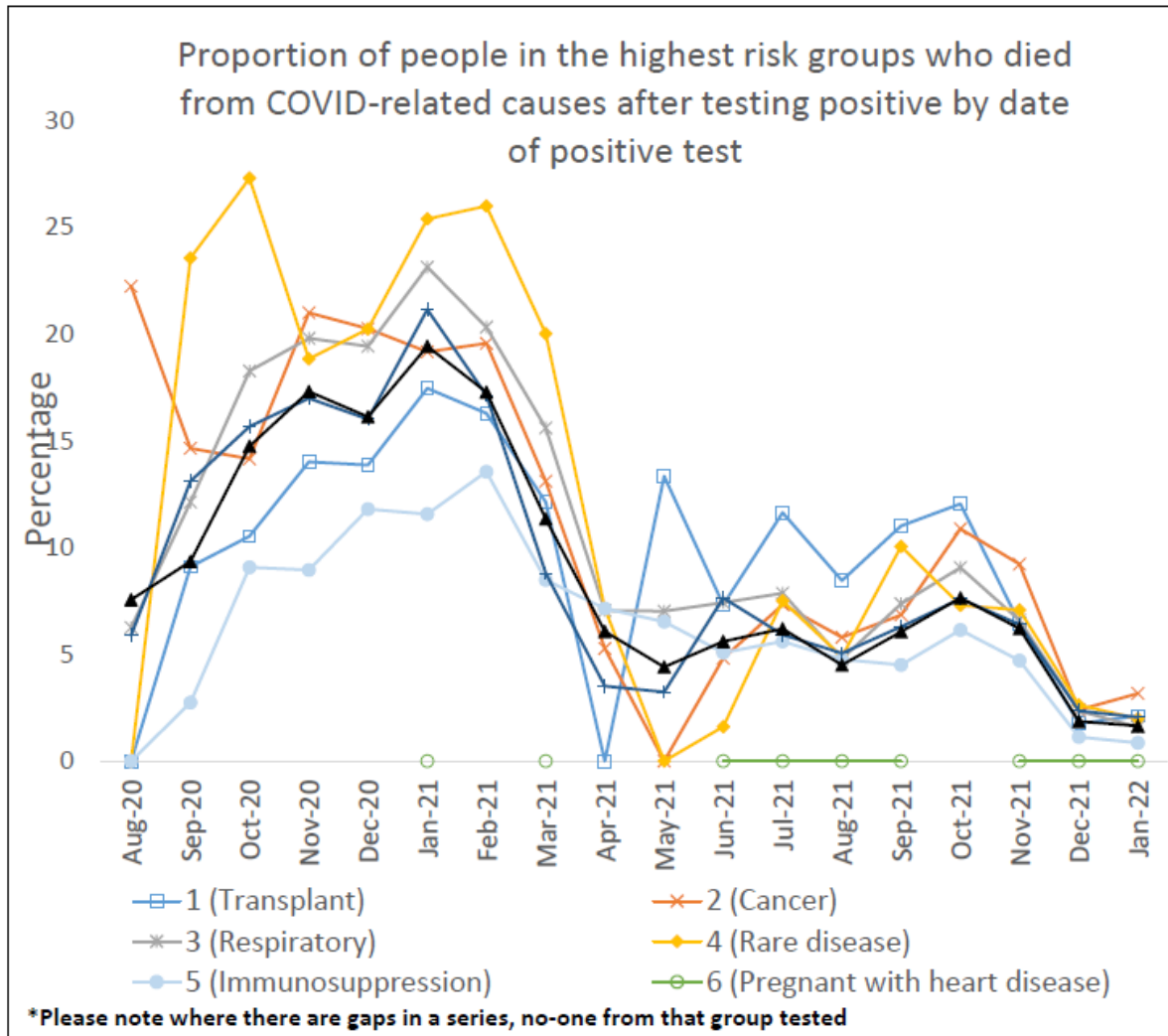
11. It is likely that the removal of any remaining regulations, as with any loosening or lifting of restrictions throughout the pandemic, will cause anxiety for some people on the Highest Risk List, including affecting their decisions to self-shield or restrict activities and interactions, and therefore their quality of life and mental health and wellbeing.

12. It is also necessary to consider if lifting the remaining restrictions will impact on their clinical risk. We have seen significant improvement in outcomes since vaccination, and this is also seen, although to a slightly lesser extent, within people who are immunosuppressed or immunocompromised. While vaccine efficacy may not be as high for people on the Highest Risk List, it still provides a good level of protection from becoming severely ill.

13. The Public Health Scotland dashboard data shows (as at 4 March 2022) 90.5% of people on the HRL have had their third dose or booster; and, 91.5% of those who are severely immunosuppressed have had their third dose or booster. In addition, over 72% of everyone over 12 years of age and over 77% of everyone over 18 years of age have now received their third dose or booster.

14. We know there has been a significant reduction in the number of deaths from COVID-19 across all groups within the Highest Risk List since the roll-out of Scotland's vaccination programme. Before the vaccination programme around 20% of people on the Highest Risk List who tested positive for COVID-19 sadly died from COVID-related causes. Since April 2021 that figure has fallen to 2% in January 2022, the lowest in the time series. The largest reduction has been for those in the rare disease group with 2% of those testing positive in January 2022 dying of COVID-related causes compared to 25% in January 2021.

## Briefing for Ministers

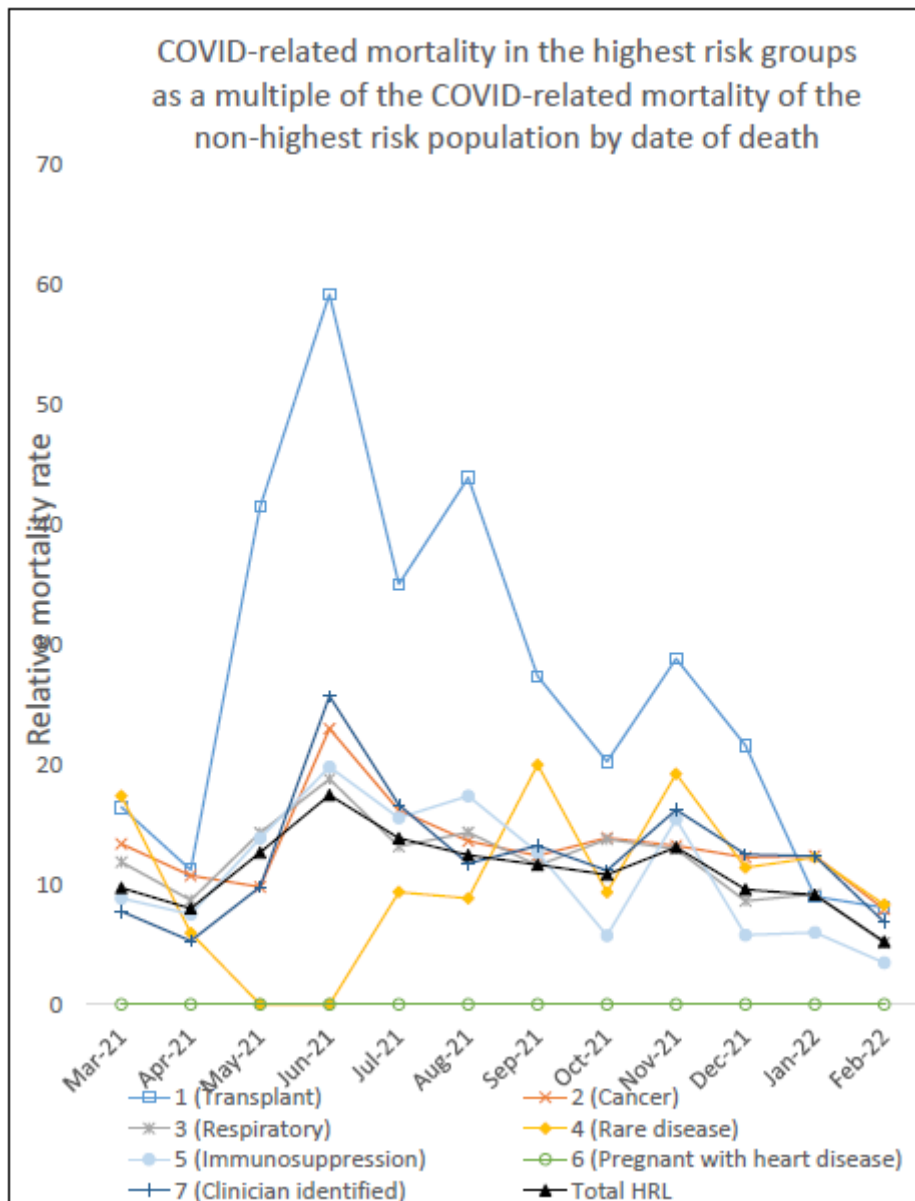


15. COVID-related mortality within the Highest Risk List was 9 times higher than in the rest of the population in January 2022. This ratio has fallen in the last few months, from 17 times higher in June 2021.

16. A national-level study<sup>24</sup> on the efficacy of two doses of the vaccine on those with risk conditions carried out between 1st December 2020 to 19th August 2021 found that vaccine efficacy against severe COVID-19 following two vaccine doses was 73% for those designated as clinically extremely vulnerable, compared to 89% for those with moderate risk conditions and 94% for people without risk conditions.

<sup>24</sup> McKeigue, PM., McAllister, DA., Robertson, C., Hutchinson, S., McGurnaghan, S., Stockton, D., and Colhoun, HM. [Efficacy of two doses of COVID-19 vaccine against severe COVID-19 in those with risk conditions and residual risk to the clinically extremely vulnerable: the REACT-SCOT case-control study](#). PRE-PRINT. Accessed 4 November 2021.

## Briefing for Ministers



NB. This study is a pre-print and has not been peer-reviewed. Findings should therefore be considered cautiously until it has been appropriately reviewed and approved for publication.

17. As at 7 March 2022, a total of 13,391 COVID-related deaths have been registered across the population. Twenty-one per cent (2,833) of these deaths were of those on the highest risk list. From November 2020 to February 2021, around 18% of recorded deaths involving persons on the highest risk list were COVID-related. Between March 2021 and August 2021 this figure reduced to around 4% and since September 2021 it has been approximately 10%<sup>25</sup>. During the same period, around 20% of recorded deaths in the general population were COVID-related. Between March 2021 and August 2021 this figure reduced to around 3% and since September 2021 it has been approximately 8%<sup>26</sup>.

## Mitigating Actions

<sup>25</sup> [https://publichealthscotland.scot/media/12034/22-03-02-covid19-winter\\_publication\\_report.pdf](https://publichealthscotland.scot/media/12034/22-03-02-covid19-winter_publication_report.pdf)

<sup>26</sup> [Deaths involving coronavirus \(COVID-19\) in Scotland | National Records of Scotland \(nrsotland.gov.uk\)](https://nrsotland.gov.uk/deaths-involving-coronavirus-covid-19-in-scotland)

## **Briefing for Ministers**

### **Mental Health and Wellbeing**

18. With regard to mental health and wellbeing, it is now two years since people originally identified for the Shielding List were asked to shield, and ongoing self-shielding and restrictions on day to day life by some of those people will continue to cause harm to them and their families. It is important to provide evidence and reassurance to those people so that they can recover and rebuild their lives.

19. We will be publishing an evidence review to show how the vaccination programme has made a significant difference, and while letting people know that they are being removed from the list may cause anxiety for some, it should in the longer term support them to understand they are no longer at highest risk and can get back to a more normal way of life. Our approach throughout the pandemic has been informed by user research and PHS surveys, and this will continue to inform how we communicate with and support people on the HRL,

20. We are also exploring with delivery partners in local authorities and health and social care partnerships what more we can do to support people to recover and reconnect with people and things they were doing before the pandemic. Third sector partners are also crucial in providing support, exemplified by the British Red Cross Connecting with You Service. Funded through the Social Isolation and Loneliness Fund, this service is open to anyone experiencing issues with loneliness but has been targeted at those on the HRL to provide one-to-one support to remake those connections.

21. We have and will continue to provide advice about daily life including shopping and going to work and have encouraged employers to consider the needs of those on the HRL as they implement flexible and hybrid working. We have developed workplace guidance specifically for people at highest risk, including support to get back to working, at [mygov.scot/covid-highest-risk/work](https://mygov.scot/covid-highest-risk/work).

### **Vaccination Programme**

22. With regard to clinical risk, as outlined, vaccination uptake is high but could be improved further. The CMO has consistently and strongly advised everyone on the HRL, including through his regular letters, to take up vaccines offered and prioritised. There are very few people who may not be suitable for getting COVID vaccinations, the main reason being those who are allergic to the ingredients, and anyone who is unsure has been advised to consult with their clinician.

23. In addition, over 77% of everyone over 18 years of age have now received their 3rd dose or booster<sup>27</sup>, meaning that population wide immunity is high from infection or vaccination providing greater protection for everyone.

24. A spring booster dose has been announced and will be offered at least 24 weeks after the last vaccine dose to:

- adults aged 75 years and over;
- residents in care homes for older adults; and
- individuals aged 12 years and over who are immunosuppressed.

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<sup>27</sup> [COVID-19 Daily Dashboard | Tableau Public](#)



## **Briefing for Ministers**

25. In addition support with transport to vaccinations has also been a consistent offer to people on the HRL since February 2021.

### **New treatments**

26. We will continue to respond to scientific and clinical advice regarding COVID treatments, making sure that those who we know will benefit most from them are able to access them. Individuals identified as being at high risk from coronavirus and with a clinical condition prioritised for treatment are eligible for direct access to new treatments to minimise the impact of Covid-19, should they contract it, and will have ongoing access to testing to ensure they receive these treatments as quickly as possible.

### **New Guidance and Future Threat Levels**

27. New guidance for businesses and individuals to replace the regulations on ongoing protection measures will strongly encourage ongoing NPI measures such as face coverings, ventilation, hygiene and distancing, alongside the ability to strengthen and scale up measures if needed in response to any increased threat.

### **Ongoing advice and support for self-isolation**

28. A Test and Protect Transition Plan will be published on 15 March which will include consideration of people on the HRL. In the meantime, PCR testing for those who are symptomatic will continue and we will continue to advise and support self-isolation when someone tests positive, including access to Self-Isolation Support Grants.

### **Distance Aware Scheme**

29. We know through our user research in July 2021<sup>28</sup> that of the 59% of respondents who were uncomfortable about the move towards level 0 and beyond in Scotland, all of them cited concerns about the behaviour of others. 73% of respondents also indicated that they would like the offer of a small wearable item to indicate to others they would like them to keep a distance.

30. In response, we developed the Distance Aware Scheme as a voluntary measure to enable people to wear a badge or lanyard to indicate they would like more space and care around them for any reason. It is open to anyone who feels this would give them greater confidence and comfort for whatever reason when they are out and about in public places and the workplace.

31. This has been promoted widely with free badges and lanyards available in all community and mobile libraries, as well as ASDA making badges available in their stores. Following distribution of more than 100,000 badges and lanyards through libraries, we have ordered more for distribution through local authority partners. This scheme has also been promoted to businesses and other organisations to encourage awareness raising about being considerate and responsible amongst staff, customers and members. This will complement existing guidance or regulations on protection measures. There is more information at Coronavirus (COVID-19): distance aware scheme - gov.scot ([www.gov.scot](http://www.gov.scot))

### **Conclusion**

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<sup>28</sup> [Coronavirus \(COVID-19\): highest risk - survey report - July 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/coronavirus-covid-19-highest-risk-survey-report-july-2021/pages/10/)

## **Briefing for Ministers**

32. There is strong evidence to show that vaccines are offering significant protection to people on the HRL from becoming severely ill. Clinicians are of the view that revoking the regulations will not significantly increase the risk for people on the HRL, including those who are immunosuppressed or immunocompromised, and the mitigating actions outlined will also contribute to reducing risks for this cohort. There are also potential benefits to removing regulations so that everyone, including those on the Highest Risk List, can feel less restricted in how they go about their daily lives, while promoting and maintaining behaviours that are caring and considerate of others.

33. However as we transition to living with Covid, for some people on the HRL there will still be some anxiety as we lift remaining restrictions. The impact of vaccinations and new treatments, along with the range of mitigation measures outlined, are designed to provide ongoing protection and support and ultimately provide reassurance to those on the HRL that they can move to a more normal way of life.

Covid Highest Risk Policy Division

March 2022

### **REVIEW OF THE HEALTH PROTECTION (CORONAVIRUS, RESTRICTIONS) (DIRECTIONS BY LOCAL AUTHORITIES) (SCOTLAND) REGULATIONS 2020**

1. These Regulations (“the LA Direction Regulations”) are a key part of the mechanisms available particularly to deal with local outbreaks of COVID-19. These Regulations give local authorities power to make directions relating to specified premises, events and public outdoor places in their area. For example, local authorities may use these powers to give a direction imposing restrictions to specific premises in their local authority area.

2. These directions must be necessary and proportionate and local authorities must have regard to Scottish Ministerial guidance before they can make a direction. The Scottish Government has provided specific guidance on the use of these powers, but in making their decision on what is necessary and proportionate Local Authority officers must consider all Scottish Government guidance relevant for the premises. Any directions require to be reviewed at least once a week and must be revoked or replaced when it is determined on review that the requirements of necessity and proportionality are no longer met. When issued, directions must include an expiry date no more than 21 days following the date they come into force, as well as a process for appeal.

3. These Regulations also contain an enforcement provision including the ability of a local authority designated officer or constable to take certain action, including the power of a constable to remove a person from a place and to use reasonable force when doing so. A power of entry for local authority designated officers is also provided.

#### **Current position and extension of the Regulations**

4. The LA Direction Regulations are due to expire on 25 March and Ministers agreed that as an important part of our response to the pandemic they should not be allowed to fall on that date. The Health Protection (Coronavirus, Restrictions) (Directions by Local Authorities) (Scotland) Amendment Regulations 2022, if approved by Parliament, will extend the expiry date for the LA Directions Regulations to 24 September 2022. These ‘extension’ Regulations were laid in draft under the affirmative procedure with an expedited timetable. They are due to be debated by the Covid-19 Recovery Committee on 17 March with a debate in the Chamber to be arranged. If approved, the Regulations will come into force on 24 March 2022.

5. The draft extension regulations were considered by the Delegated Powers and Law Reform Committee (DPLRC) at their meeting on 1 March. The main issue raised by the Committee was why Local Authorities still need these powers given where we are with regard to the pandemic. The Committee approved the Regulations by majority. The vote was 3 for the regulations, 2 against and 0 abstentions.

#### **Justification for keeping these Regulations in place**

6. Local Authorities have issued 27 Directions under the regulations, compared to 63 notices under the Requirements Regulations (and their predecessor regulations) and 1465 warnings. This highlights that the powers are used only as the last step under the ‘4Es’ approach to enforcement (Engage, Explain, Encourage and Enforce). Two examples of Directions issued include a hospitality premises being instructed not to show sport, following a widely publicised incident where controls failed, and a dental practice being instructed to close due to a serious lack of controls. In particular, the

## **Briefing for Ministers**

dental practice had been linked to a number of positive cases. Upon investigation, officers observed there were no controls in place, a dentist was working while positive, and staff were not following self-isolation requirements. This led officers to make the judgement that closure until the issues had been addressed was necessary to protect public health.

7. The Direction Powers allow local authorities to take action where they identify it is necessary to manage the risk of incidence or spread of coronavirus, and a direction is proportionate and necessary. The powers allow local authorities to manage local outbreaks and risks at a local level and could avoid Scottish Government having to implement more wide-ranging and restrictive measures. For example, if cases increased in a particular area and specific businesses could be seen to be posing a risk, the local authority could make a direction under these powers to instruct them to take particular action to reduce risks.

8. Under the Requirements Regulations (the regulations that contain the current baseline legal measures) Local Authorities have enforcement powers for use when an operator breaches requirements and therefore put their employees and members of the public at risk. If Cabinet decides that those requirements should be revoked, the power to issue directions under the Local Authority Directions Regulations will continue to allow them to take proportionate action where there is a risk but other enforcement powers have been removed.

9. Concerns were raised at the DPLR Committee about the possibility of directions being issued in relation to public parks. While it is acknowledged that there is a lower risk of transmission outdoors, with sufficiently large crowds the risk of transmission increases. Continuing the powers to issue directions in relation to public spaces allows local authorities to manage the risk of large outdoor gatherings during localised outbreaks. It should be noted that for public parks, local authorities are responsible for their operation, and during the pandemic at points took action to manage/ limit entry to certain parks when they identified specific risks. This action was taken without the need to use directions powers, which allow them to manage other non-LA owned spaces.

10. From engagement with Local Authority representatives we know that they consider that having these powers available is optimal at this stage of the pandemic and without the powers in the LA Direction Regulations would leave local authorities with no powers to control local outbreaks. While local authorities and health boards do have powers under existing public health legislation, there is concern within Local Authorities that these do not allow them to take the actions that may be necessary to address the risks around COVID-19, which is why the Directions Regulations were provided in response to the pandemic. A review of Local Authority powers in this regard is being considered.

### **Review of these regulations**

11. These Regulations require to be reviewed at least every 42 days. Given the connections between these Regulations and those contained within the Health Protection Requirements Regulations this requirement for review every 42 days has been scheduled to coincide with the three-week review of the current statutory measures. The LA Direction Regulations were last reviewed on 1 February 2022 when Cabinet decided that these measures should remain in place.

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12. It is considered that these regulations which provide for local authorities to make directions relating to specified premises, events and public outdoor places are still required in order that effective tools to respond to outbreaks remain available.

### **Recommendation**

**It is recommended that at this point in the epidemic these regulations should remain in force.**

Covid Co-ordination Directorate  
March 2022