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Targeted Community Testing: National Evaluation Evidence and Insights January to September 2021



HEALTH AND SOCIAL CARE



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Abbreviations

ATS	Asymptomatic test site (alternative term for CAT)
CAT	Community asymptomatic testing (alternative term for ATS)
LFT	Lateral flow test
MTU	Mobile testing unit (SAS operated)
NPI	Non-pharmaceutical Intervention
PCR	Type of test used for those with COVID-19 symptoms
PHS	Public Health Scotland
PPE	Personal protective equipment
SAS	Scottish Ambulance Service
SEPA	Scottish Environmental Protection Agency
TCT	Targeted community testing
VOC	Variant of concern
WW	Wastewater

Executive Summary

Since January 2021, the Scottish Government have been working in partnership with Public Health Scotland (PHS), local authorities, NHS boards and others to deliver a targeted community testing (TCT) programme for the general public as part of a response to a recognised failure to identify a large proportion of positive cases. TCT is aimed at those without symptoms of coronavirus¹ and without access to other asymptomatic² testing pathways, such as Health and Social Care pathways or Education pathways. It is also aimed at providing symptomatic testing in places people are most likely to be positive.

The community testing evaluation sets out the evidence and key insights from a national perspective covering the period from its launch on 18 January 2021 to 26 September 2021. Community Testing was aimed at targeting areas where the virus rate is high, quickly rising (spiking), or has been identified as high risk to find positive cases that would not otherwise have been detected. It combined the use of PCR testing for symptomatic and asymptomatic cases, as well as developing capabilities to carry out asymptomatic testing with Lateral Flow Tests (LFT).

This evaluation focused on case identification, qualitative understanding of features of successful targeting and uptake, including public motivations and barriers. Some data and qualitative evidence were also captured on models and aspects of operational delivery. The evaluation has drawn mainly on published PHS data, alongside primary qualitative research with NHS Board and local authority partnerships.

Key findings

Public Health Impact – between 18 January and 26 September 2021, TCT conducted a combined total of 699,219 PCR and LFT tests, of which 93,466 were positive. Around a third (31%) of these cases were in those without symptoms. These are cases that may not otherwise have been detected in the continuing absence of symptoms, or were identified earlier than they otherwise would have been via PCR-based testing once symptomatic.

Testing uptake and change over time - The trend for overall TCT testing uptake (PCR and LFT), as indicated by weekly number of TCT tests conducted, has generally tracked a similar pattern to testing across Scotland, reflective of the changing incidence of COVID-19 and relaxation of restrictions. The one exception is a peak in early April for TCT testing which is not so evident for all Scotland testing. A possible explanation for this is an initial push to get the community asymptomatic test sites (ATS) operational, supported by military assistance. LFT

¹ [Coronavirus \(COVID-19\): getting tested in Scotland - gov.scot \(www.gov.scot\)](https://www.gov.scot/topics/health/coronavirus/covid-19/getting-tested-in-scotland)

² Asymptomatic is defined as the absence of self-perceived or clinically recognisable symptoms combined with a positive COVID-19 test and could refer to people who may either have no symptoms at all, mild unspecified symptoms or symptoms but not the three classic recognised COVID-19 symptoms, or be presymptomatic - [Asymptomatic COVID-19 infection: diagnosis, transmission, population characteristics | BMJ Supportive & Palliative Care](#).

testing grew sharply, peaking by 7th March. There was a sharp decline after the end of March coinciding with the cessation of military support, and tests then became universally available from 26th April through the Universal Offer.

Targeted testing: effective case finding - Due to the targeted nature of community testing, the expectation is that it should be more effective at finding positive asymptomatic cases than untargeted or general population testing. There are tentative indications that this has indeed been the case as demonstrated by the percentage of cases identified via LFT per number tested compared to other LFT pathways.

TCT had a percent LFT positive of 0.9% up to 21 September 2021 which is one of the highest of the LFT pathways and above the 0.6% average for all pathways combined. To note, there are a number of caveats to interpreting this percentage positive data which are set out in the main report.

Targeted testing: features of success & challenges - In May 2021 local partnerships were asked their views on features that supported and challenged targeted testing. Overall, partnerships reported data driven location of sites and communications and engagement as key elements of success for targeted testing, as well as flexible and responsive models of operation. Key challenges mirrored aspects of success and included issues around communications and engagement, and lack of flexible testing models. The issue of multiple testing pathways was also raised, mainly in relation to adding to general confusion. Partnerships made suggestions for improvements.

Public motivations and barriers – key ones are presented in the table, more are described in the main report. Partnerships described a range of strategies and actions to target motivations and address barriers.

Motivations	Barriers
For reassurance	Don't see the need
To protect others	Worry about the test itself
To find out if they were positive because they had symptoms or had been in contact with a case or suspected case	Financial concerns, eg as a result of not being able to work

Models of delivery and lessons learned - Four evolutions of targeted community testing models are apparent between 18 January and the end of May 2021. Models have also continued to evolve over time. Three specific examples are described: the 'Hub and Spoke' model; fixed rotating sites using Fire and Rescue Stations; and a 'Flying Squad' model, alongside aspects of operational learning.

Conclusion - From this evaluation evidence, the indications are that the targeted community testing programme up to the end of September 2021 has been effective at finding cases, including asymptomatic cases, and thus likely to have helped reduce transmission. In addition, the creation of additional capabilities around testing and the targeted nature of the programme - combining data-driven, flexible location of test sites, consideration of community characteristics and geography, and sustained communication and engagement is likely to have enhanced access to testing and encouraged certain groups to engage more with testing.

1. Introduction

This report summarises evidence and insights at a national level from evaluation of targeted community testing (TCT). The report covers the period 18 January 2021 to 26 September 2021.

Targeted Community Testing Programme

Since January 2021, the Scottish Government have been working in partnership with Public Health Scotland (PHS), local authorities, NHS boards and others to deliver a targeted community testing (TCT) programme for the general public as part of a response to a recognised failure to identify a large proportion of positive COVID-19 cases. TCT is aimed at those without symptoms of coronavirus³ and without access to other asymptomatic⁴ testing pathways such as Health and Social Care pathways or Education pathways. It is also aimed at providing symptomatic testing in places people are most likely to be positive.

TCT targets communities/areas where the virus rate is high, quickly rising (spiking), or has been identified as high risk to find positive cases that would not otherwise have been detected. This is to help reduce the spread of the virus in local communities.

The programme provided funding to Local Authority and Health Board partnerships to develop the capabilities to conduct targeted asymptomatic testing; promote the use of data and local intelligence to target testing most appropriately; and enhance isolation and other support for those getting tested. The programme included funding for Scottish Ambulance Service (SAS) operated Mobile Testing Units (MTU) using PCR tests for symptomatic and asymptomatic testing, to expand the fleet and enable targeted placement of these by partnerships. Funding was also provided to the Scottish Environmental Protection Agency (SEPA) and Scottish Water to develop wastewater testing to improve monitoring and detection of virus trends in local areas, adding to the available data and intelligence.

After a pilot of asymptomatic testing with Lateral Flow Tests (LFT) and the targeted deployment of MTUs for symptomatic and asymptomatic testing in November/December 2020⁵, the TCT programme was launched 18 January 2021. It commenced with a number of Health Boards using Scottish Ambulance Service (SAS) operated Mobile Testing Units (MTU) which were deployed, as directed by local partnerships, to target areas to carry out both symptomatic and asymptomatic testing using PCR tests.

³ [Coronavirus \(COVID-19\): getting tested in Scotland - gov.scot \(www.gov.scot\)](https://www.gov.scot/topics/health/coronavirus/covid-19/getting-tested-in-scotland)

⁴ Asymptomatic is defined as the absence of self-perceived or clinically recognisable symptoms combined with a positive COVID-19 test and could refer to people who may either have no symptoms at all, mild unspecified symptoms or symptoms but not the three classic recognised COVID-19 symptoms, or be presymptomatic - [Asymptomatic COVID-19 infection: diagnosis, transmission, population characteristics | BMJ Supportive & Palliative Care](#).

⁵ [Community Asymptomatic Test site opens in Johnstone - gov.scot \(www.gov.scot\)/](https://www.gov.scot/topics/health/coronavirus/covid-19/community-asymptomatic-test-site-opens-in-johnstone)

From February 11, local partnership-operated asymptomatic only testing sites started to come into operation using Lateral Flow Devices to test (LFT).

Context

It is important to remember that TCT was being implemented at a time when Scotland was in a second full lock-down and the nature of restrictions changed considerably over the time period of the evaluation. Added to this was the roll out of the vaccination programme with increasing numbers being vaccinated week on week. Finally, opportunities for the general public to get tested, regardless of symptom status, were continuously evolving with the advent of the Universal Offer⁶, which launched in Scotland on 26th April and Pharmacy Collect on 7th June.

Evaluation

Local partnerships conducted evaluation activities to monitor and inform development of their own individual models of TCT. In addition, evaluation activities were undertaken to inform understanding of TCT from a national perspective and support policy development over time.

An initial evaluation framework and outline plan for how evidence requirements could be met was developed. This was intended to support creation of a national narrative but also provide guidance and consistency of data and evidence capture and use at a local level. Local and national evaluation efforts were further supported through creation of a Local Evaluation Leads Group which met regularly till September 2021. This was used to share experiences, challenges, solutions, approaches and evaluation tools.

The main purpose of this evaluation was to provide timely evidence and insights at a national level to help inform the ongoing development of the programme. Local evaluations were similarly aimed at supporting locally focused ongoing community testing development.

The evaluation objectives set out in the initial evaluation plan were:

1. To understand how best to use data to identify sites for location of targeted community testing
2. To describe what targeted community testing models are put in place and capture key learning from implementation of different models
3. To assess if targeted community testing has encouraged uptake of testing in locations where it is offered
4. To assess if targeted community testing has identified 'hidden' asymptomatic cases

⁶ Universal Offer refers to the availability of LFT kits to anyone (without symptoms of COVID-19) wishing to order them. They can be ordered either online, by telephone or can be picked up from a local test centre

5. To determine if additional support provided by local areas as part of the package of community testing helps with levels of compliance with self-isolation and with non-pharmaceutical interventions (where offered)
6. To understand whether targeted community testing is likely to have supported a reduction in COVID-19 transmission in targeted localities
7. To understand any unintended consequences of targeted community testing, eg increase in risk behaviours/testing fatigue, and including any impact on health inequalities
8. To understand how to support creation of local capacity, resilience and capability to sustain community testing

The scale and rapid pace of development of the programme through multiple evolutions, combined with challenges around answering some of the original research questions, led to a focus for the national evaluation on objectives 3 and 4, ie case identification, qualitative understanding of features of successful targeting and uptake, including public motivations and barriers. Some data and qualitative evidence were also captured on models and delivery.

A range of the other objectives were met in a more timely fashion and in more depth using active learning via groups such as a Reference Group; Short Life Data Working Group and Mobile Testing Working Group, as well as through regular meetings between policy and partnerships, and partnership to partnership direct engagement. The evidence and learning via these processes has not been formally captured. Further information on the groups listed is available in [Annex A](#).

Key findings have been shared via regularly updated summary slide sets circulated to the Community Testing Programme Board, Reference Group and Local Evaluation Leads Group; a briefing note on early operational learning, and a number of presentations on the evidence. This report draws this evidence together, including an update on data to 26 September 2021.

The data: quality and caveats

The national evaluation has drawn mainly on published PHS data, alongside primary qualitative research with partnerships.

PHS published TCT relevant data weekly in their COVID-19 Statistical Report and on an accompanying interactive TCT dashboard. This included the number of symptomatic and asymptomatic tests conducted and cases found by TCT MTU testing, and asymptomatic tests conducted and cases found by community asymptomatic testing using LFTs⁷.

It is important to note that the data referred to above was not created for the purposes of evaluation. This was mainly operational data. Data has not been available for all measures desired and assumptions have often been drawn from incomplete data or data that does not measure exactly what needed to be

⁷ [Public Health Scotland COVID-19 Statistical Report](#) – Public Health Scotland , COVID-19 Statistical Report As at 27 September 2021, Publication date: 29 September 2021

assessed. Qualitative data is not nationally representative. Further considerations around data quality are highlighted, where relevant, in the findings sections.

Demographic data has been limited, so detailed information on who has been testing where and when was not available. This means partial understanding of how TCT has been used by different groups in terms of the protected characteristics and socio-economic status. To address this issue, at least in part, qualitative evidence on uptake as well as a number of the other research objectives was collected from partnerships at two time points. This information was collected using two different styles of Proforma – a framework setting out the types of information and evidence sought.

The first Proforma was distributed mid-March 2021 to 7 of the partnerships who were already underway with their proposals. All 7 submitted by the end of March, 10 weeks after launch. The second was distributed mid-May to 11 of the partnerships, with 8 submitted by the end of May 2021 to coincide with a review of the wider asymptomatic testing strategy.

In a similar way to an organisational response to a consultation exercise, Proforma responses were at the organisational level and generally required input from different people involved in the local partnership TCT, including different local authority partners, to provide a signed off partnership response. The submitted Proformas varied widely in the detail provided. Both Proforma templates are presented in [Annex B](#).

2. The Public Health Impact of Community Testing

Positive cases identified through Community Testing

Since its launch on 18 January and up until 26 September 2021, the TCT programme has detected a substantial number of positive COVID-19 cases – 93,466. Of these, almost a third (31%) were in those classed as without symptoms. These are cases that may not otherwise have been detected in the absence of symptoms, or were identified earlier than they otherwise would have been via PCR-based testing once symptomatic, see Table 1.

Table 1: Cumulative totals of TCT tests conducted, positive cases detected and percent positive 18/01 to 26/09 2021

Total tests	699,219
Total positive cases	93,466 – of which 29,387 (31%) were in those without symptoms
Percent positive	13.4% (combined symptomatic and asymptomatic)

A small majority of tests conducted were in those without symptoms, with a sizeable proportion of symptomatic tests carried out within the TCT programme, see Figure 1.

Figure 1: Proportion of TCT tests conducted by symptom status 18/01 to 26/09 2021

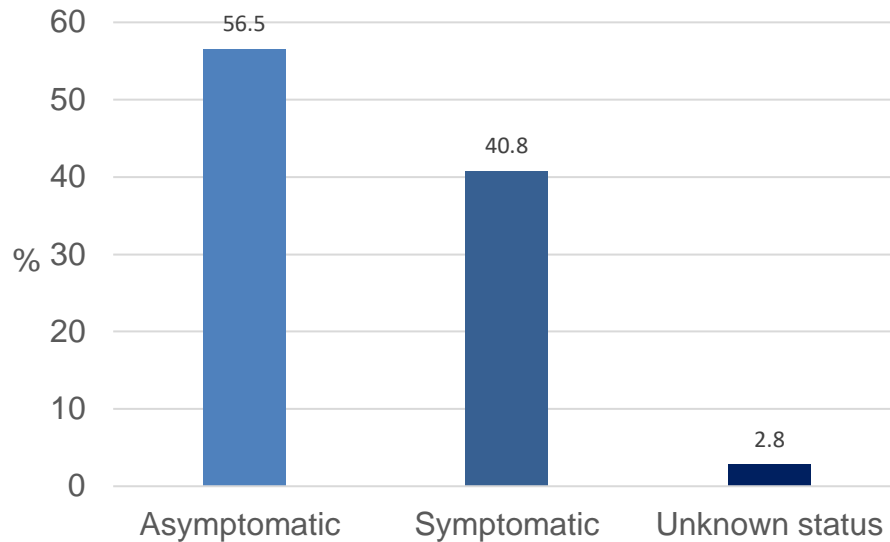


Figure 2: Cumulative total number of TCT tests by Health Board by whether asymptomatic or symptomatic 18/01 to 26/09 2021

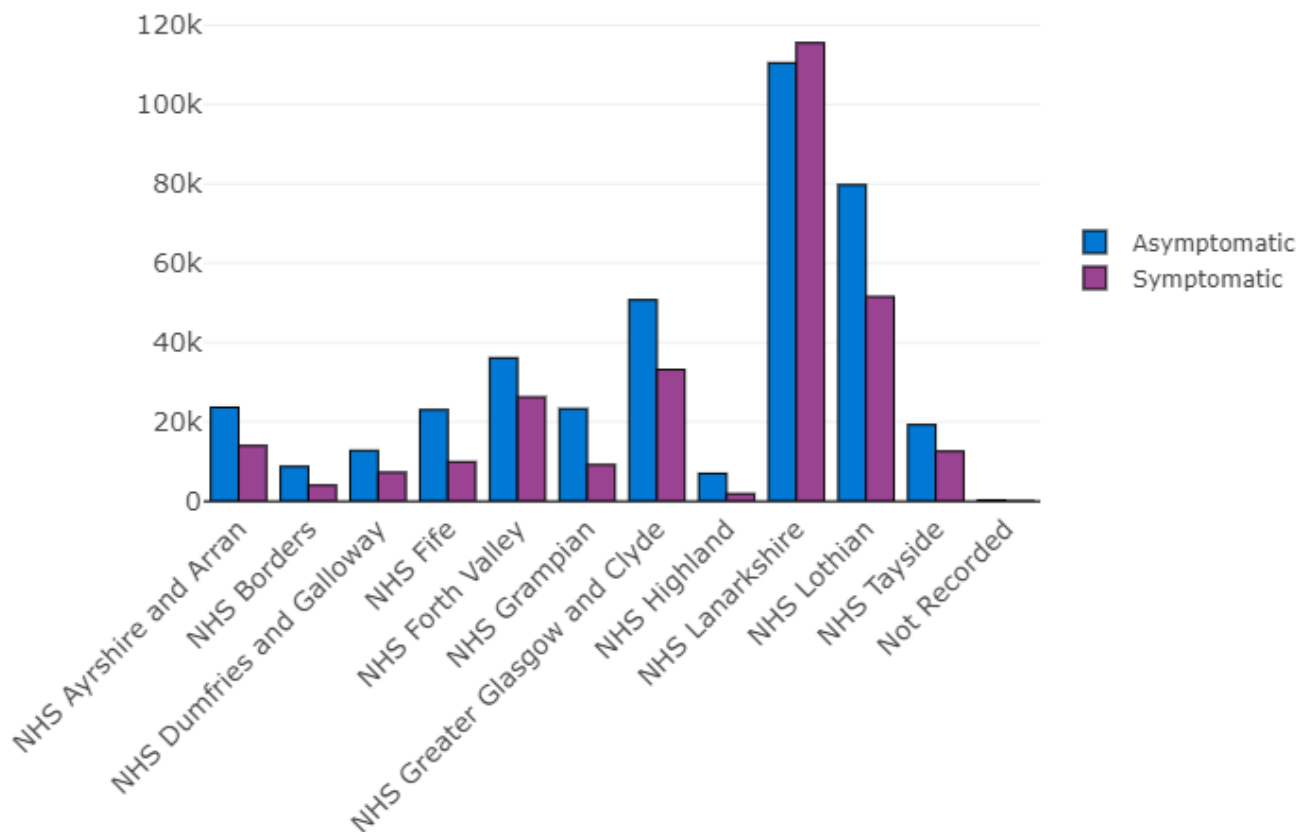


Figure 2 shows that asymptomatic testing was dominant to varying degrees in all partnership TCT programmes, with the exception of Lanarkshire.

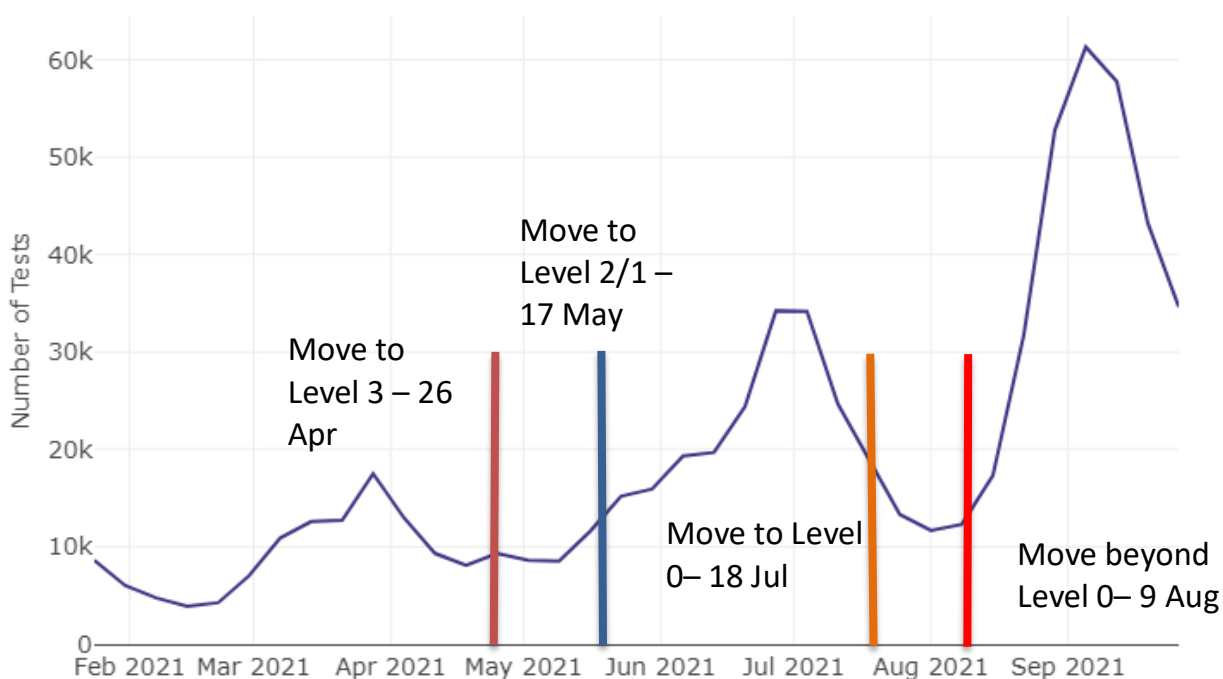
Although symptomatic testing has been available via local and regional testing sites outwith the TCT programme, the sizeable proportion of symptomatic testing within the overall TCT programme is indicative of how the programme has likely broadened (as intended) access to testing for some communities that may have found accessing local and regional test sites challenging.

In addition, the data covers a period when several local partnerships were implementing surge testing. Although LFT testing contributed substantially, the surge testing was mainly focused on PCR testing for symptomatic and asymptomatic people, particularly when the new Delta variant was starting to increase in prevalence with the associated requirement to track the variant.

Uptake of testing and change over time

The trend for overall TCT testing uptake, as indicated by weekly number of TCT tests conducted, has generally tracked a similar pattern to testing across Scotland⁸, reflective of the changing incidence of COVID-19 and relaxation of restrictions, see Figure 3.

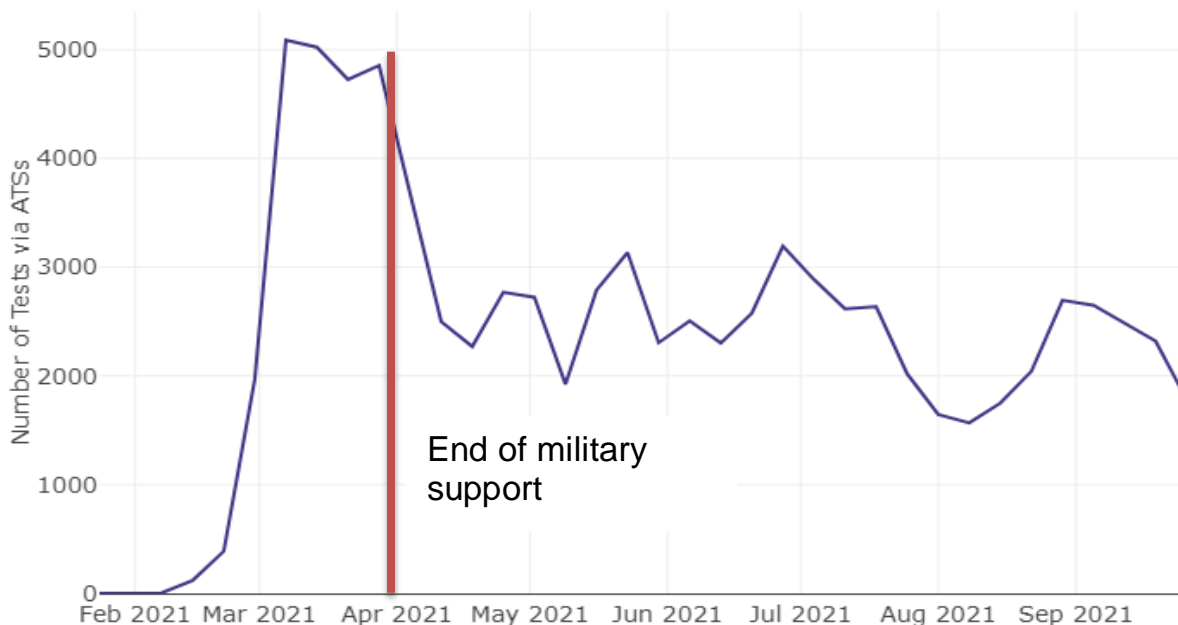
Figure 3: Weekly number of total TCT tests 18/01 to 26/09 2021



The one exception is the peak in early April for TCT testing which is not so evident for all Scotland testing. A possible explanation for this is an initial push to get the community asymptomatic test sites (ATS) operational, supported by military assistance. Figure 4 shows how the weekly number of targeted community tests that were conducted via ATS (ie LFT testing) grew sharply, peaking at just over 5000 by 7th March. There was a sharp decline after the end of March coinciding with the cessation of military support, and tests then became universally available from 26th April through the Universal Offer.

⁸ [COVID-19 Daily Dashboard | Tableau Public.](#)

Figure 4: Weekly number of TCT tests conducted via ATS 18/01 to 26/09 2021



Qualitative evidence from both Proforma returns, and a common theme at times during Reference Group discussions, indicated a sense from local partnerships that footfall through ATSSs was overall lower than expected. The overall capacity of the sites in the early stages was felt to be much under-utilised despite substantial communications and engagement efforts. This was even the case for partnerships who regarded their TCT programmes as successful. In part, this may be a reflection of the stage of the pandemic at that time with cases declining.

From Proformas, a wide range of communication methods were described to encourage attendance at TCT sites: social media, radio campaigns, leaflets, posters, message boards at transport links, letter drops, targeted communication with community and faith leaders and local businesses and schools local to test sites. This also included translations of some of these resources in several languages in some areas.

One partnership planned to employ a community links worker to develop grassroots connections, another had developed a group of COVID-19 Empowerment Champions to reach non-engaged communities. Another area was working with 'community influencers', community leaders and groups, whilst another was using local 'celebrities' and 'well kent'⁹ faces to publicise the test centre. There was also reported use of Council Environmental Health, Education, Communications teams and the voluntary sector.

Feedback reported in Proformas indicated social media, word of mouth, letters to households and AA route signage have been particularly effective, demonstrated via responses to test site Exit Interviews, or from increased attendance at sites after

⁹ Well known

certain communications activity. More on targeting, communications and engagement is presented below.

Targeted testing – effective case finding

One of the intentions behind community testing has been for testing capabilities to be targeted, particularly to areas with persistent high cases or where the cases are spiking, through use of data and local intelligence. In theory this should be more effective at finding positive asymptomatic cases than untargeted or general population testing. In addition, there is assistance at community test sites to support taking the test correctly and to ensure the results are recorded.

PHS publishes data on the number of LFT tests, number of positive results and test positivity for a wide range of the pathways using LFT testing, including for the LFTs carried out through TCT¹⁰. This allows a degree of comparison between the different pathways to indicate how effective they are at identifying positive asymptomatic cases. However, some caution is advised in interpreting this data as the different pathways are not directly comparable. In some pathways tests are administered, whilst in others they are self-test which could affect the sensitivity of the test. Also, not all pathways will have similar reporting of positive and negative results, with lower likelihood of recording negative results (negative recording bias) for self-test which will tend to inflate the percent LFT positive. Finally, LFT is a small part of the testing conducted via TCT. A large number of asymptomatic tests are carried out using PCR so this comparison is only of part of the TCT programme.

Between 19 November 2020 and 21 September 2021¹¹, a total of 85,837 LFT tests were conducted via TCT sites. Cumulatively, a total of 780 positive cases were identified with a percent LFT positive rate of 0.9%. For comparison to LFT tests via all pathways see Table 2.

Table 2: Cumulative totals for LFT testing across all LFT pathways 19/11/2020 to 21/09/2021

Total no. of LFT tests	11,555,190
Total no. positive	71,192
Total percent positive	0.6%

Challenges with the data notwithstanding, TCT had a percent LFT positive of 0.9% up to 21 September 2021 and was one of the highest of the LFT pathways and above the 0.6% for all pathways combined, suggesting tentatively that the targeted approach has been effective.

¹⁰ [Public Health Scotland COVID-19 Statistical Report](#) p27

¹¹ This includes data from the pilot

This is also likely to be an underestimate of the contribution of TCT because ATS and MTU sites have promoted the use of the Universal Offer and Pharmacy Collect and distributed Universal Offer packs as part of the TCT programme. The data are not linked back to TCT, but instead recorded as Universal Offer. Thus TCT efforts will also be reflected in the data for the Universal Offer, which had the highest percent LFT positive at 2.6%.

Targeted testing – reaching the right groups

Another feature of targeting is to reach groups that may be more challenging to engage with testing. For example, Liverpool and Welsh pilots of mass testing indicated that younger people, men and those from more deprived area were less likely to get tested¹². Scottish Government commissioned polling, which included questions around general testing attitudes and behaviours. This also indicated men and lower occupation grades reported being less likely to have a test, order or use Universal Test kits¹³. Funding was provided as part of the programme to improve understanding of local communities to improve reach.

A robust assessment of reach to different groups has not been possible for a variety of reasons, including that many TCT sites are typically transient and it is difficult to describe a precise population that is being targeted in each area. This is in part due to multiple other pathways in operation to which many in a geographical area will have access. Some of the models of the TCT programme also included promotion and drop off of Universal Offer LFT kits where the data is not linked back to TCT.

There is greater understanding with respect to age, gender and level of deprivation (as indicated by SIMD) because this data is requested when recording a test result (although not always completed). However, there is no good quality data on other population characteristics and a wide variety of population groups have been identified as at risk or likely to be less engaged with testing eg migrant populations; those whose first language is not English; ethnic minority groups; gypsy and other traveller groups.

Although there is no robust evidence around effectiveness of reach for this report, qualitative data collected from partnerships via the Proformas enable reporting on their experiences and perceptions around efforts to engage with a range of population groups.

Targeted testing – features of success, challenges and suggestions for improvement

In the May 2021 Proforma, local partnerships were asked their views on features that supported and challenged targeted testing and suggestions for how to improve

¹² [Liverpool Covid-SMART Community Testing Pilot Evaluation Report 17 June 2021; Evaluation of the Lateral Flow Device Testing Pilot for COVID-19 in Merthyr Tydfil and the lower Cynon Valley \(cwmtafmorgannwg.wales\)](#)

¹³ [Public attitudes to coronavirus: tracker - data tables - gov.scot \(www.gov.scot\)](#)

targeting. Presented below is a summary of key messages which includes supplementary evidence from March Proformas.

Overall, partnerships reported data driven location of sites and communications and engagement as key elements of success for targeted testing, as well as flexible and responsive models of operation.

Key challenges mirrored aspects of success and included issues around communications and engagement, and lack of flexible testing models. The issue of multiple testing pathways was also raised, mainly in relation to adding to confusion.

Communications and engagement key messages (see also earlier entry)

Communications need to be clear, locally relevant, wide-ranging with engagement through multiple channels; Also, constant and dynamic. One partnership response encapsulated this by stating:

“Good communication via a range of media channels with clear messaging about the local context and reasons for getting tested, as well clear instructions on how to access and book for both symptomatic and asymptomatic testing.”

Social media appears as consistently one of the main sources for public awareness - based mainly on exit surveys of attendees, but also social media analytics and site staff feedback. However, it is worth highlighting that this should be interpreted as the main sources of information for those engaging or attending. This may not be the same as for those not attending.

Communication was highlighted as a key to success, but also one of the main challenges to success if it was not done well. Some issues with communication highlighted within Proforma returns include:

- Conflicting messaging of national ‘stay at home’ advice versus local ‘come and get tested’
- Inaccurate and non-user friendly Government websites
- Challenges around engaging the disengaged and understanding who they are
- Confusion for the public (and professionals) on understanding the multiple pathways available for testing, where and when you can or should get a test; also changing expectations around what should happen at a TCT site as a result of the introduction of the Universal Offer and expectation to just be able to walk away with a kit rather than test there and then. There was some concern that confusion impacted on footfall.
- Tackling misinformation, such as on social media

Suggestions for improvement

- Increased local and targeted communications and use of more communication channels (eg outdoor advertising; advertise community drop off at high rise flats where residents may have mobility problems, and at social housing)
- Engagement - build stakeholder relationships, wider community outreach and use of outreach teams

- Scottish Government website to take a triage approach with users answering a series of Y/N questions to reach correct site information
- National campaigns about the benefits of testing
- Promotion of testing at the point of vaccination
- Conduct seasonal campaigns (eg at Halloween and Christmas)
- Create videos for social media to target specific groups (several have already done this with reported success)

Use of data and local intelligence key messages

A wide range of data and local intelligence has been, and continues to be, used to effectively target key areas of concern through regular intelligence discussions and reviews in the local partnerships.

The range of data used varies between areas but can include:

- Public health monitoring data such as total number and trends for cases and positivity rates
- Public demand/footfall – eg tests per day per site
- Cases per site
- Indicators of ‘community vulnerability’ or ‘community of interest’ assessment
- Availability of centres to site testing
- Wastewater virus analysis
- Car access and rurality considerations
- Contact management system (CMS) to locate and support a local outbreak
- Scorecard ratings that combine testing rate and incidence with social/clinical and demographic vulnerability (highest rating of 5 indicating lowest comparative rates of testing and highest incidence signalling an issue)
- Colorado social distancing index to identify at risk communities

Important aspects to note around the use of data, that came through from Proformas, are:

- Local intelligence is key and data alone is insufficient, the data needs to be placed in context
- Sites can't always be located according to data due to the lack of an available site
- Setting up of local monitoring systems has helped mitigate shortfalls in UKGov data

Local knowledge came through as key to placing any of the data in context to deploy test sites appropriately. For example knowing that a rapid rise in cases is associated with either a school or care home. This knowledge is important to understand if an observed spike is a real issue or not and understanding that they have other routes for testing. In some geographical areas testing uptake may appear low but this is due to many people living in this geographical area having access to testing through workplace programmes such as NHS or Education

Testing systems were established to track tests taken and results specific to TCT. However, in some areas the set-up of local monitoring systems was felt to have helped mitigate shortfalls in the UKGov testing data and the availability of this data.

This approach was only possible in areas where the analytical resource to support this was available.

Wastewater testing

Wastewater testing involves collecting samples of wastewater at various locations and analysing them to detect levels of COVID-19 RNA. This can give an indication of the level of virus circulating in the population of the area served by the wastewater sampling site¹⁴. Early on in the TCT programme, views from local partnerships using it were that it was a useful adjunct to other public health monitoring data, primarily to confirm suspicions. It has also shown value in early warning of an area of concern when public health data had not yet shown any issues. Some pros and cons expressed by partnerships are set out in Table 3.

Table 3: Wastewater pros and cons based on partnership feedback March 2021

Pros	Cons
confirms suspicions based on positivity results	variability in results
insight independent of testing strategy	infrequency of sampling
may be useful as warning signal when case numbers/testing low	timing of availability - results lag or run in parallel to positivity results
	geographies for testing do not match those required
	uncertain value in addition to standard surveillance methods (cases)
Partnership example - confirmed case rates were not high and testing uptake was average. "Alerted by SEPA to levels being amongst the highest they had ever seen. Two MTUs deployed and, for both, people came forward for testing and cases were found."	Partnership comment - "Local data so far doesn't suggest that WW RNA levels have risen before a signal is seen in case numbers"

Approaches to testing

Pros and cons were raised around both mobile and fixed models of operation.

Observations were made that fixed sites could have significant lead in times to set up and start operations, and may also end up located where they are not necessarily most required due to availability of suitable sites. Mobile testing was seen to address many of these drawbacks by being more responsive and flexible.

¹⁴ [S0908_Wastewater_C19_monitoring_SAGE.pdf \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/90908/S0908_Wastewater_C19_monitoring_SAGE.pdf)

However, there were recognised challenges for the mobile model as well in terms of effective and timely communications to the public; the transient nature for anyone wishing to access them repeatedly; and the challenge of rapid identification of suitable sites.

Suggestions to improve targeting and uptake

- Offer testing at community based events (could help reach young males)
- Target holiday spots
- Work with local businesses/employers to encourage staff testing (where not already available)
- Dual testing capability (PCR and LFT) in all types of mobile units to enable flexibility of what can be offered at sites
- Explore co-location with vaccination centres
- Offer incentives to get tested (eg local business vouchers)

3. Attitudes and Behaviours

This section presents findings from Proforma returns on partnership understanding of people's motivations and barriers to take up testing. For motivations, partnerships based their responses mainly on results from exit interviews/questionnaires with attendees carried out at sites or accessible afterwards online. Most relate to ATS. It should be noted that those completing exit questionnaires are likely to be the most engaged and are not of a representative population.

Partnership responses in relation to barriers is based on a mix of exit interviews/questionnaires, community surveys, site staff focus groups, a workplace case study and anecdotal evidence from operational staff.

Although the methods have many limitations we can have reasonable confidence in them due to the consistency of findings across the partnerships for the top 5 motivations and barriers, and similarities to findings in other testing research.

Motivations to get tested

The main motivations to get tested as part of the TCT programme came across as:

- for reassurance;
- to protect others; and
- to find out if they were positive because they had symptoms or had been in contact with a case/suspected case.

These are similar to the findings from an evaluation of asymptomatic testing pathways¹⁵ and in Scottish Government commissioned polling on testing in general¹⁶. The top motivations in the asymptomatic testing evaluation (including

¹⁵ Scottish Government (2021) Asymptomatic Testing Programme Evaluation: November 2020 – June 2021

¹⁶ [Public attitudes to coronavirus: tracker - data tables - gov.scot \(www.gov.scot\)](https://www.gov.scot/public-attitudes-to-coronavirus-tracker-data-tables)

findings from TCT) were: for reassurance, to protect others, for practical reasons and because testing is encouraged/ required (reflective of the nature of some of the pathways included). The main motivations in Scottish Government polling have been: for reassurance; to protect others; and as part of regular testing.

The notable difference was the motivation in TCT to “find out if have symptoms/been in contact” which could be a reflection of the inclusion of symptomatic testing in the TCT programme.

A number of other motivations were also highlighted in Proforma returns but to a lesser degree:

- Sent for test by workplace or NHS
- Just wanted a test
- Decided on the spur of the moment
- Checking before meeting people or travel
- To contribute to public health knowledge or work out local rate
- To learn how to use the kit under guidance

Barriers to testing

From Proformas, the main barriers to TCT were identified as:

- Don't see the need;
- Worry about the test itself; and
- Financial concerns, eg as a result of not being able to work.

In March Proformas, more detail was provided on some of the early barriers encountered and the following were raised that relate to “concern around tests/testing”:

- Belief that NHS resources are better spent elsewhere
- Fear of infection
- Conflicting messaging of national ‘stay at home’ versus local ‘come and get tested’
- Perception of lack of accuracy of tests
- Concerns re false positives
- Tests are meaningless as could contract COVID-19 the next day

Again there are similarities with what was found from the evaluation of asymptomatic testing pathways and in Scottish Government polling on testing in general. Both also found a perception of not being at risk (aligned to not seeing the need) with polling respondents reporting they were not seeing people, had been vaccinated, did not feel at risk or were generally not worried. The asymptomatic testing evaluation also found a key barrier to be concern about the test (accuracy and discomfort).

The main difference was the emergence of financial concerns as a key barrier in TCT but not in the other sources. This may be indicative of efforts to target particular types of populations known not to be so engaged with testing.

A number of other barriers were also highlighted across both Proforma returns:

- Personal impacts
- Concern about social implications, attending socials
- Impact of testing positive on providing care for others (on family; caring responsibilities)
- Concern about mental wellbeing
- Not being able to access existing support networks

Practical considerations

- Difficulty in isolating at home
- Reluctance to attend alone
- Reluctance to go out
- Not being able to afford to get to the test centre

Public understanding

- Public confusion over testing options and terms; Not sure who is eligible to be tested
- Don't understand the benefits
- Lack of awareness of how to get a test
- Not knowing what help is available
- Unsure if it costs money

Addressing barriers and motivations

In the May Proforma, partnerships were asked how barriers and motivations were being addressed and what communications and engagement have been effective. In summary, partnerships reported taking action to address issues as they arise, such as correcting incorrect information on websites, providing signage when highlighted as a barrier, and monitoring of comments and feedback used to inform messaging. Examples of a range of other actions taken include:

- Development of resources in different languages including videos posted on social media
- Social Media adverts targeted to only those who lived in an area that had a local testing centre or mobile unit
- Use of 'community influencers' - One example was a video with a local Imam
- Ongoing communications & engagement activities, via regular COVID-19 Community Champions Network meetings and via outreach teams able to answer questions raised by local communities/specific groups. COVID-19 Community Champions raise issues on behalf of their own groups/networks during weekly meetings, then either Public Health colleagues respond immediately (including circulating/signposting to relevant sources of information) or appropriate people who can respond attend a subsequent meeting.
- Social media seen as useful for answering queries directly

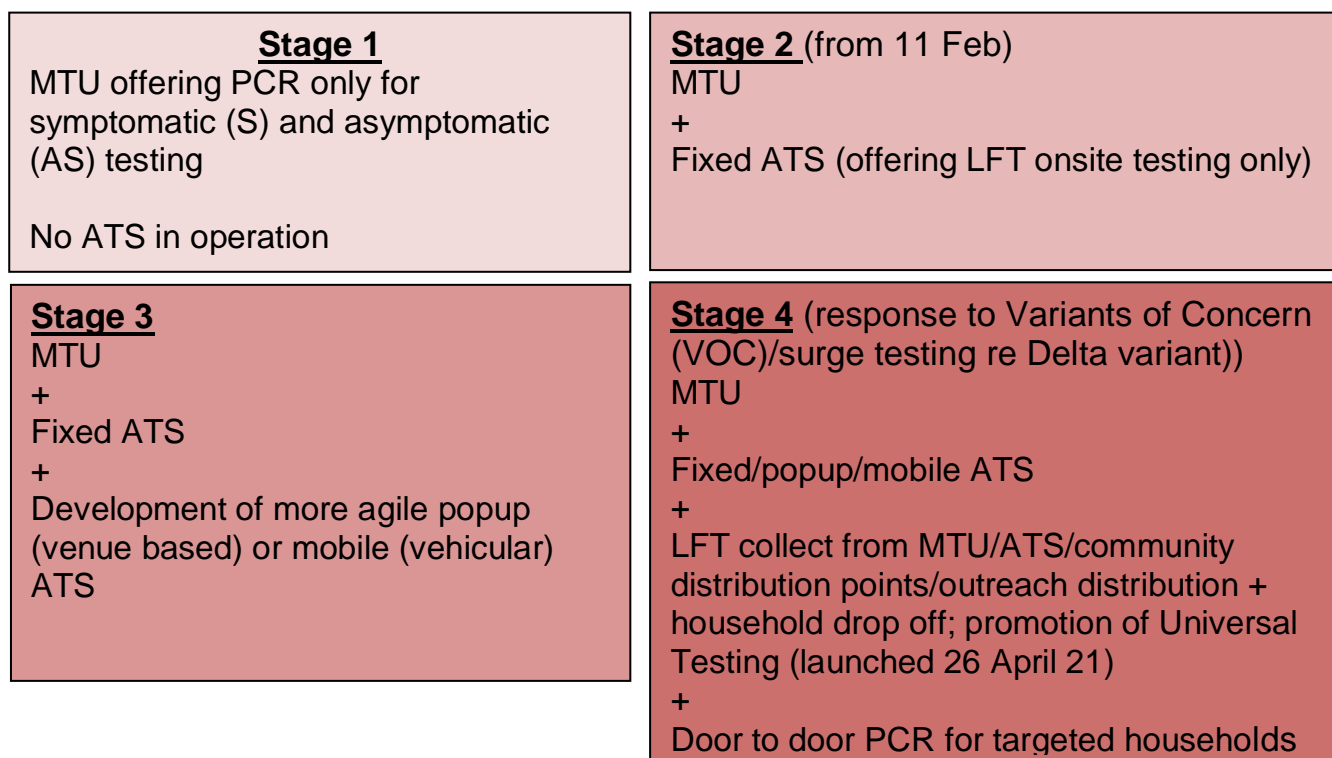
- Marketing of specific messages to specific groups and targeting specific groups eg at foodbanks. A suggestion was also made to target high rise flats where residents may have mobility problems
- Engagement with third sector groups such as organisations for the blind and deaf blind to disseminate information and use of Voluntary Action groups to help push messaging
- Providing alternative forms of support to help address where people do not qualify for the isolation support payment and ensuring support is included in all messaging
- Offering a suite of testing options to enable people to choose an option that best suits them, eg “universal testing kit delivered to home may suit a young working family whereas attending an ATS might suit a retired person who is unsure how to carry out the test or how to order it”
- Actively promoting community testing to assist with events opening, regarded as one way of advertising the programme but also integrating community testing into everyday life
- Community drop-off service to target harder to reach communities

4. Models of delivery and lessons learned

Four evolutions of targeted community testing models have been apparent between 18 January and the end of May 2021, an overview of which is set out in Figure 5 below. Precise dates are not applicable as changes were occurring at different times in different areas. This may not capture all models in operation to the end of May 2021 due to the fast pace of change. Also, it is worth remembering that models have continued to evolve since this point in time.

In addition, home PCR tests kits have been used throughout by some areas, either drop off or posted or given out at sites for those presenting with symptoms or for confirmatory PCR for those testing positive. This is not included in descriptions.

Figure 5: Evolution stages of targeted community testing 18/01 to 31/05 2021



Models

Each partnership, and even different local authorities within partnerships, developed their own approaches to suit the population, geography and resources of their local area, as well as adapting to what was happening with the pandemic and restrictions more broadly. Some partnerships were more advanced with their proposals than others at the time of this research. Hence, it is challenging to provide a comprehensive picture of the models in place at this time. Instead, three types of models are described in broad terms offering some insights into the setup of TCT at this time.

The hub and spoke model

This was an approach taken by a number of the local areas within and across partnerships. It comprised of a blend of fixed sites with popup and/or mobile options.

The fixed sites tended to be set up and serve more populated areas to ensure good footfall. They were perceived to create a presence, helping to advertise regular community testing, whilst the popup/mobile assets enabled a flexible and adaptable response for rapid deployment to where they were most needed.

The mobile option was seen as addressing issues around a lack of a suitable/available site or venue at locations suggested by data. In addition, the time it takes to set up an ATS not always being responsive enough such that case rates may have declined at that location whilst spiking elsewhere in the intervening period.

Fixed sites using Fire and Rescue Stations

One partnership developed a model which operated from fixed Fire and Rescue station locations. When prevalence was low, testing operated from the sites on a fixed timetable, but with the capability to alter the timetable to target specific stations in high risk areas as data dictated.

The rationale behind this model was to provide broad geographic coverage for a relatively dispersed population in sites that are typically within walking distance. This model was perceived to be effective at targeting those in areas of deprivation, as this is often where Fire and Rescue stations are situated.

Flying Squad – LFT outbreak response

The final model is one described by the local area as the 'Flying Squad'. This involved the rapid deployment of a popup LFT site to a specific place or organisation with an outbreak. It offers LFT tests to non-symptomatic and non-contacts as an adjunct to MTU-based outbreak PCR testing to provide rapid detection of additional cases that may be asymptomatic.

In the case study described, people in the target population were encouraged to test 4 times over a period of 10-11 days. Cases found this way were requested to get PCR confirmation. The partnership that developed this regarded it as very successful and planned to keep this in addition to operating a hub and spoke model.

Balance between MTU and ATS testing

Overall MTU appears to have dominated TCT up to 26 September 2021. Cumulatively, testing via MTUs has seen a total of 613,280 tests (87.7% of total tests classed as via TCT) with 85,939 tests classed as through TCT ATs (12.3%), also see Figure 6.

Week by week since early July, the proportion of LFT testing recorded as taking place via ATS has declined so that by 26 September, it was only around 5% of TCT testing taking place (Figure 7) and [Annex C](#) for data table. However, with the launch of the Universal Offer and Pharmacy Collect, the opportunity to obtain LFTs by the general public was no longer limited to TCT. TCT itself evolved to incorporate promotion and distribution of the Universal Offer kits as outlined in stage 4 of Figure 5 above. The data from the Universal Offer is not linked back to TCT, hence the true extent of TCT ATS is ultimately unknown. It is clear though that, through the TCT programme, significant capabilities have been developed to conduct locally targeted testing, both for LFT and PCR testing

Figure 6: Total number of TCT tests carried out by TCT MTU and ATS in each Health Board 18/01 to 26/09 2021

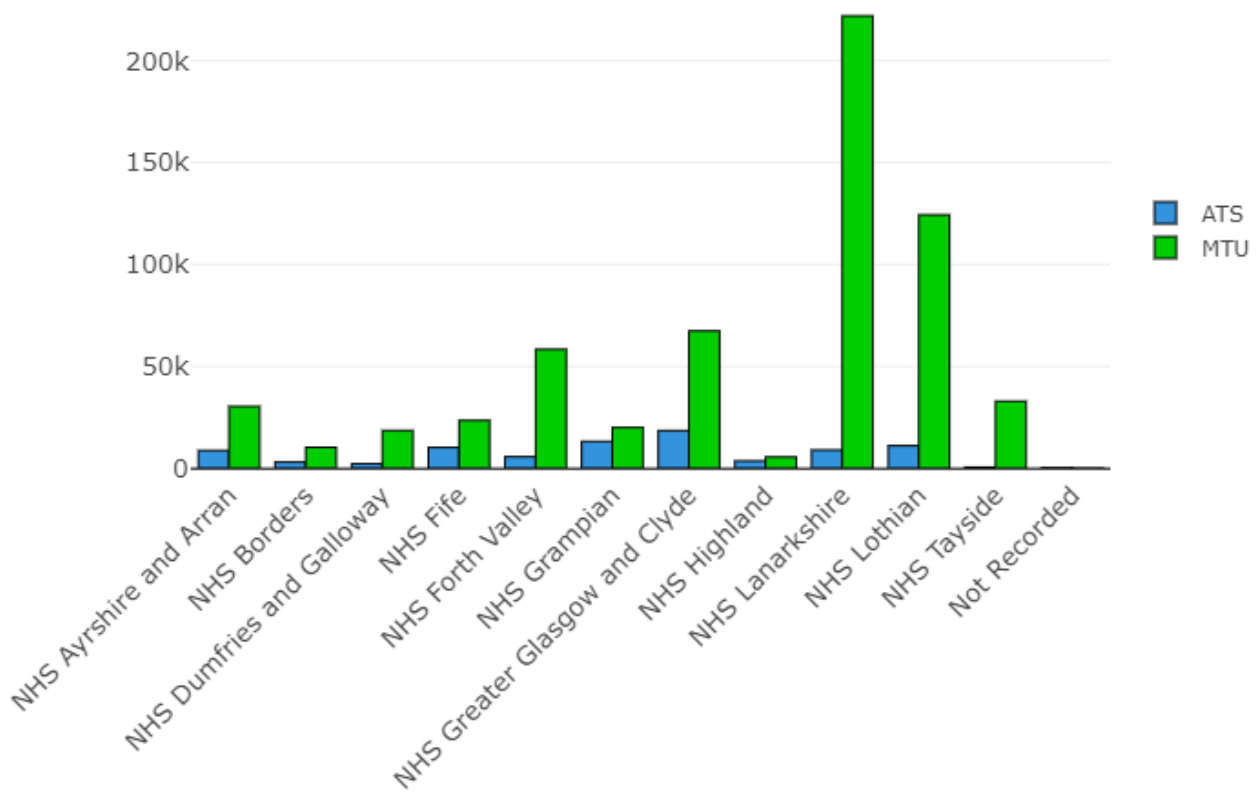
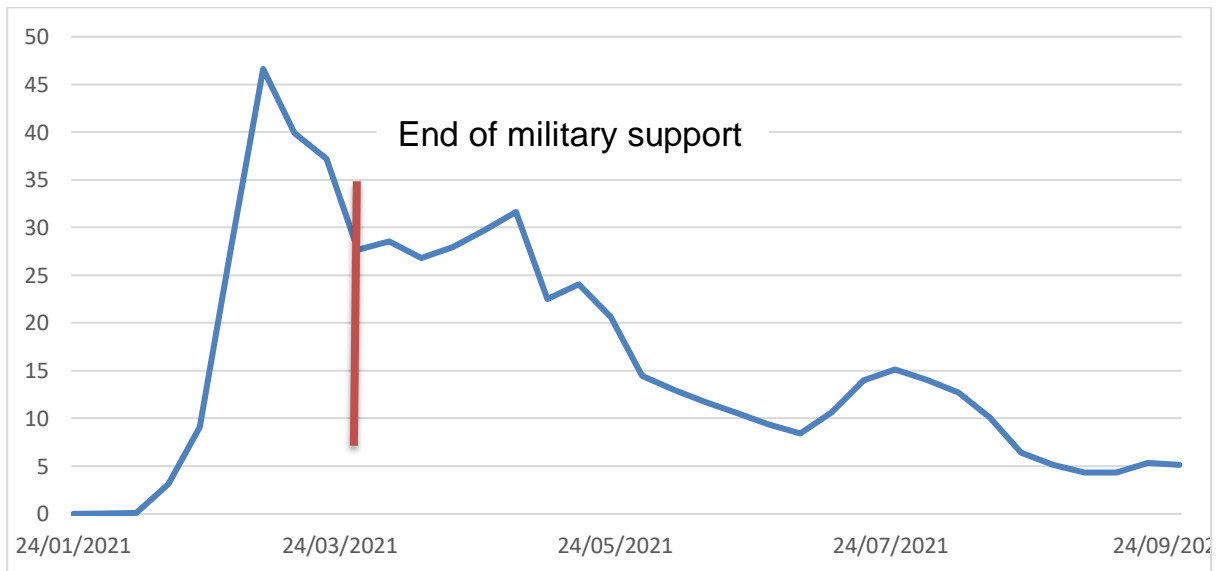


Figure 7: Weekly proportion of tests classed as via ATS 18/01 to 26/09 2021



Operational lessons and suggestions

The final section of this report summarises findings from both Proforma exercises around operational aspects of TCT. The reader is reminded that these cover the first few weeks and early months of implementation.

Setting up and running a site

- There was perceived to have been good collaboration with military colleagues in all areas, with military colleagues providing training and expertise that allowed ATSs to operate successfully. Some areas initially staffed ATS with only military colleagues and trained up local authority staff over time. This allowed for a quick and smooth set up of ATS due to military colleagues having previous setup experience.
- Initially some experienced issues with equipment while setting up ATS, some areas had to build their own booths because those that were delivered were of poor quality. Some areas also reported delays with PPE and testing kits.
- Staff working at the ATS have typically been seasonal workers, temporary employees or redeployed from other areas where the service was paused due to the pandemic (for example, leisure). A key issue for many was the return of these staff to their original duties as restrictions eased. One Health Board suggested targeted recruitment of skilled, long-term unemployed to involve in the TCT programme.
- In one area staff were given the option to train for different site roles, this was perceived to have helped with team building, variety for the staff and meant there was wide ranging competence of site staff.
- Communication was a key theme, and many aspects have been covered elsewhere. The one addition here, based on feedback on the May Proforma was more from an operational perspective highlighting challenges from having multiple sources of information – “There are so many data sets and guidance documents circulating/ being updated - this has made it difficult for everyone to understand the aim of the community testing programme, and has caused juxtapositions, confusion and delay.”

Maintenance of TCT over time

A common concern in the March Proformas was the ability to maintain community testing over time for a number of reasons:

- Availability of sites as lockdown starts to ease and centres begin to open for other purposes. This concern was one of the driving forces behind development of mobile ATSs and the establishment of the Mobile Testing Working Group. One area described attempting to use non-Council venues but experienced longer lead-in times and planned to explore co-location with vaccination venues.

- Staffing and maintaining a service with many staff currently used being furloughed and redeployed staff who will return to other duties. One area described using bank staff and creating contingency plans with volunteer services.
- An opinion was expressed that dedicated staff are required rather than this being an add on to existing day jobs. One area carried out rapid recruitment of temporary staff from the local community due to constraints on using staff from elsewhere. The majority were on full-time temporary contracts, however, a risk was highlighted of attrition of such staff.
- The buy in of public going forward to continue to attend ATS centres.
- The cost-benefit balance if prevalence is low.

Test site user experience

- On Proformas, partnerships reported high satisfaction with their experience across areas from test site attendees (>90% for those areas reporting exit survey results).
- Improvement suggestions from the public included: improving the registration process on UK Gov website and a suggestion to enable creation of a profile to simplify getting tested repeatedly; more publicity about the sites, signage (directing people to the site and better/bigger signs at the test site) and parking.
- While most people said they found the test easy to do themselves, some areas reported higher numbers of people who struggled with tests and worried they might not have done the test right or were surprised they were not supervised during taking the test and thought they may have done this incorrectly.

General Practical Suggestions

- Have a paper backup system for when IT systems are down
- Consider a waiting room for those without a mobile phone to wait for results (or provide a phone and topup, as was implemented in one area)
- Display site code and guidance in queuing area to facilitate self-registration
- Make sure iPads & phones can connect to the internet
- If staff are working outside in the dark, they should have high-visibility vests and a radio and preferably work in pairs
- Check the communications are accurate, some areas reported issues with incorrect ATS opening times advertised on social media.

Models and Reach

- Co-locating an MTU with an ATS enables convenient and rapid access to confirmatory PCR. Experience was reported of confirmatory PCR not always being done when home tests kits are supplied or people are directed to other PCR sites

- It was suggested that sites should be able to offer the spectrum of testing choices to improve access, effectiveness and cost–effectiveness
- One Health Board reported that their rural communities have been difficult to target due to lack of suitable accommodation, the deployment of a full ATS squad for small population numbers and the time which is required to set up an ATS with little return.

5. Conclusion

From the evidence presented here, the indications are that the targeted community testing programme up to the end of September 2021 has been effective at finding cases, including asymptomatic cases, and thus likely to have helped reduce transmission. A total of 93,466 positive cases were detected between 18 January and 26 September 2021, 31% of which were in those classed as asymptomatic (29,387).

In addition, the creation of additional capabilities around testing and the targeted nature of the programme - combining data-driven, flexible location of test sites, consideration of community characteristics and geography, and sustained communication and engagement is likely to have enhanced access to testing and encouraged certain groups to engage more with testing.

TCT is ongoing as part of the continued testing strategy, one of the four pillars supporting efforts to contain the coronavirus pandemic. Considerations for the ongoing programme include:

- Sustained and continuous communications with clear messaging on different pathways and eligibility, along with targeted messaging for specific groups to encourage engagement
- Simplification of the testing system and associated information such that people do not need to think about whether they qualify or not for the range of opportunities on offer
- The demonstrated importance of interpretation of data in the context of local intelligence and understanding of the unique requirements of local populations
- Continued development of mobile and flexible response capabilities that can respond to different stages of the pandemic

Annex A – TCT communication, learning and actions groups

Reference Group – A Scottish Government policy led group with open invitation to all partnership TCT programme leads and associated colleagues to attend. Held weekly via Teams and used as an opportunity to update the partnerships on SG programme developments; showcase partnership approaches to implementing the programme in different areas; forum to discuss challenges and solutions and for local areas to feedback their experiences.

Short Life Data Working Group – Public Health Scotland led group with open invitation to partnership analysts and attendance also by PHS, SG and SEPA analysts to discuss issues specific to the development of a restricted dashboard for partnership use to monitor and track virus data trends at test site and neighbourhood level to support targeting of testing resources. Initially envisaged as a short-life group but a core membership continued to work on the dashboard development for several months.

Mobile Testing Working Group – Scottish Government policy led group. This was a sub group of the Reference Group specifically set up to look at development of vehicular based mobile asymptomatic testing solutions.

Annex B – Qualitative Partnership Proformas

March 2021

Community Testing Evaluation Reporting Proforma March 2021

This reporting Proforma has been agreed with local partnership evaluation leads group and Scottish Government policy to trial in March and will be used to inform a national evaluation and Scottish Government Community Testing policy. This is the first version of the Proforma. Feedback on completing this is invited to help improve reporting in future months.

Please complete as much as possible from the data and evidence you have and **return by 30th March**

Health Board/Local Authority: - Contact: - Email: - Date: -
--

Model of CT Implemented

MTU and ATS placements data to end of March expected to be provided by PHS additional analysis or presented as cumulative data on dashboard

Self-isolation additional support and promotion of compliance with NPIs
--

Description of additional support and activity to promote compliance with NPIs and/or self-isolation.

Evaluation of CT

Five key themes for evidence reporting:

1. Data use to identify locations to site CT
2. Implementation of CT
3. Testing uptake and identification of cases
4. Attitudes and Behaviours to testing, isolation and compliance with NPIs
5. Impact on transmission

*** Where a *narrative description* is suggested please use bullets, be concise and limit content to key points to share (issue/solution). Further detail can be referred to in your own local area evaluation reports. ***

Theme	Sub-theme	Findings	Data source
Data	<p>Key learning from how used data to locate and monitor sites eg most valued indicators (<i>narrative description</i>)</p> <p>Of particular interest:</p> <ol style="list-style-type: none"> 1. Which community testing sites (MTU/ATS) to date have been sited using WW analysis (either alone or in conjunction with other indicators)? 2. If not used, why not? 3. What do you consider the challenges and/or benefits are of using WW analysis? 		
	<p>Key learning – Operational from set up and running of site, eg around staffing; guidance; training; equipment; site issues; major changes to plans etc (<i>narrative description</i>)</p>		
Implementation	<p>Key learning – Operational Has staffing CT impacted on other services?</p>		
	<p>Learning about how deploying MTU and ATS (where applicable) <i>Why one and/or other type; conditions best suited to either; length of deployment etc (narrative description)</i></p>		
	<p>Key learning - Attendance experience what worked well; what could be improved; key issues; key solutions <i>Narrative description</i></p>		
	<p>Key learning – Attendance experience booking; access; experience at test site <i>Quantitative data – core indicator</i></p>	<ul style="list-style-type: none"> • Proportion reporting satisfaction with the testing experience 	
	<p>Key learning around additional activity to support self-isolation <i>Narrative description</i> <i>Quantitative data where this exists</i></p>		
	<p>Key learning around activity to support compliance with NPIs <i>Narrative description</i></p>		
Testing Uptake & Case	<p><i>Stats to date for Local Partnership (no. tested by MTU/ATS, symptomatic, asymptomatic, cases etc)</i></p>	<p><i>No requirement to complete unless you wish to - An analysis to mid or end of March is expected to be</i></p>	

Identification		<i>provided by PHS, either as an additional analysis or from cumulative figures presented on the dashboard</i>	
	Who is getting tested? Please provide a summary overview and key quantitative data if available		
	Who is not getting tested? Please provide a summary overview and key quantitative data if available		
	Are those getting tested as expected according to local public health aims, objectives and outcomes of targeted CT?		
	Reasons for not taking up tests		
	Action that has been taken to improve uptake in targeted groups and general learning about how to improve uptake		
Attitudes & Behaviours	Compliance with self-isolation <i>(from any local level of engagement or research carried out)</i>		
	Compliance with NPIs <i>(from any local level engagement or research carried out)</i> Eg activities and social contacts of those testing negative		
Transmission	What is happening to indicators of disease transmission where CT has been introduced? <i>(It may be that only general trends for larger geographies are likely to be possible here due to declining numbers)</i>	<u>Description of trends (with any charts or supporting data in an Annex optional):</u> <ul style="list-style-type: none"> • Absolute number of cases in LA Jan to Mid-March • Cases rate per 100K head of population in LA Jan to Mid-March • C19 Hospitalisations per 100k head of population in LA Jan to Mid-March • Wastewater viral load pre, during and Jan to Mid-March to best matched geography 	
Open comment	Opportunity to provide other feedback on how the programme is operating or impacting in your local area or any other observations.		

May 2021

Local to National Reporting Proforma – Community Testing Evaluation

Please submit by 1st June 2021

To support further understanding of the Targeted Community Testing programme at this stage, we welcome your response to a number of questions. These are presented below a broad summary of understanding of Community Testing to date.

Health Board/Local Authority:

Contact: -

Email: -

Date: -

Programme level understanding to date

Context in Scotland

Restrictions are easing, compliance has improved recently after previously declining since January and contacts have increased – cases may be expected to rise, already being observed in some areas with concern about variant B.1.617.2 (“Indian variant”). Hospitalisations and deaths are low.

A sizeable gap still remains between modelled cases and those detected by testing.

A large proportion of the adult population has been vaccinated but many still remain at risk and vaccination impact on transmission is still to be fully understood.

Community testing is just one of many pathways of testing. Pathways are being developed continuously and of particular relevance is Universal testing, which was fully launched 26 April enabling anyone to obtain an LFD test kit by ordering online, or collecting from local/regional test sites and increasingly from MTUs. The vast majority to date have been ordered online.

Targeted community testing is intended to be data driven placement of testing capabilities to best support identification of cases, especially hidden (non-symptomatic) cases to stop chains of transmission.

Building capability is intended to help create the infrastructure to be able to detect cases now, but also better manage potential future rise in cases or outbreaks.

Models of testing

Models are varied across and within local partnerships and have evolved over time. Key changes are as follows, but different models exist in each local area:

- MTU only - the expansion of targeted community testing initially involved deployment of MTUs offering PCR tests only and testing both symptomatic and non-symptomatic people.

- MTU +/- ATS - From 11th February ATS started to be established in a few health boards and has since grown offering LFD testing for non-symptomatic people in targeted communities. Not all Boards have offered both.
- MTU +/- Pop-up/mobile ATS - ATS tended to be fixed but increasingly pop-up versions have been created. The next evolution has been to develop mobile ATS to reduce time to set up and avoid issues around availability of appropriate sites.
- MTU with LFD collect +/- mobile ATS - Most recently has been the addition of offering LFD kits to collect from MTUs in addition to their PCR testing. Only a few boards are trialling this at present.

Community testing understanding and impacts

Cases identified – to 9 May 6,989 (2114 of which were non-symptomatic)

Targeting – Community testing has consistently had the highest positive case rate (0.7% as at 10 May) for its LFD testing when compared to other LFD pathways such as University testing (0.3%) and Healthcare workers (0.1%) and for total LFDs (0.1%).

Community testing has shown early encouraging signs of reaching more deprived groups (SIMD1) which other research indicate are typically less likely to come forward for testing. However, further analysis is required.

Community testing trends – testing had decreased from a peak in March in line with decreasing incidence. There is a tendency towards increased proportion of testing taking place through MTUs.

Influences on uptake – Overall, capacity appears much underutilised, but context is important to understanding this better and may change if prevalence increases again.

A range of barriers and motivations have been described and are being addressed through enhanced communications nationally and locally with communications and engagement remaining a key aspect of targeting.

Unintended consequences – a positive consequence is that some partnerships have used community testing as another opportunity to engage with some groups and offer wider well-being support.

Questions

As much as possible, please state the evidence on which your responses are based (where applicable) and feel free to illustrate with data

NB: We acknowledge that partnerships are at different stages with Community Testing with different resources. Please complete as far as possible, but we accept there may be some gaps.

What helps support targeting to achieve case identification and good reach

1. Given the primary aim of Community Testing is to find cases and break chains of transmission, how successful or not do you feel you have been at finding cases and why?
2. How have you assessed success?
3. In your experience what has helped most to achieve good case detection?
4. What has not worked so well?
5. Any suggestions for changes to improve targeting? Eg what you may be planning to try or for others to consider?
6. Have you experienced any limitations on your ability to conduct effective targeted community testing? **Yes/no**
 - a. If yes – please describe what these are/have been
 - b. What solutions, if any, have you planned or applied?
7. How aware are local communities of community testing in their neighbourhoods?
8. What is helping most to ensure awareness and how do you know?

Public attitudes and behaviours

9. In your area, what is the level of public acceptability of community testing and willingness to get tested?
10. What is the level of people's understanding of where and how to get a test depending on whether they are symptomatic, a contact or have been offered asymptomatic community testing?
11. Are there particular population groups who are not engaging either due to low awareness or for other reasons? **Yes/No/Don't know**
 - a. If yes – what groups and why?
12. What are:
 - a. the top 5 motivations for getting tested at the community testing sites?
 - b. the top 5 barriers to get tested?
 - c. What evidence are the responses to a and b based on?
13. Are there particular motivations and/or barriers evident for specific population groups? **Yes/No/Don't Know**
14. If yes, please describe what you understand these to be and based on what evidence
15. How are barriers and motivations being addressed?
16. What has worked well with communications and engagement around barriers and motivations, and how do you know?

17. Do you offer additional support to help self-isolate as part of community testing over and above what was already on offer in your area? (ie something more than additional signposting)? **Yes/no/not sure**
 - a. If yes, what is additional?
 - b. What, if any evidence, is there of whether it is helping or not?

Community testing in the longer term

18. How has the Universal Available Offer impacted how community testing is operating in your area?
19. What, if any, any unintended consequences are you aware of from community testing (both positive or negative)?

General

20. If you wish, please provide comment on the understanding presented at the beginning and how that relates to your local partnership.
21. If you wish, please provide any other feedback on community testing.

Annex C – Data tables

Table 4: Weekly TCT test data extracted from PHS published community testing dashboard, extracted 4 October 2021 (ND = No data; P – provisional)

Week ending date	No. of TCT Tests	No. of positive tests	No. of TCT MTU tests	No. of TCT ATS tests	% via MTU	% via ATS ⁵	Cumulative total LFT positive	Weekly no. of LFT positive
	Data extracted from PHS published TCT dashboard on <u>4 October 2021</u> NB - Wednesday updates change many figures, hence note date of extraction.				Derived from extracted data		From PHS weekly statistical reports	Derived
24/01/2021	8604	998	8604	0	100	0	ND	ND
31/01/2021	6024	683	6023	1	100	0	ND	ND
07/02/2021	4747	674	4743	4	99.9	0.1	ND	ND
14/02/2021	3885	480	3765	120	96.9	3.1	ND	ND
21/02/2021	4258	572	3871	387	90.9	9.1	ND	ND
28/02/2021	7049	618	5078	1971	72	28	ND	ND
07/03/2021	10912	693	5825	5087	53.4	46.6	ND	ND
14/03/2021	12585	897	7564	5021	60.1	39.9	97	97
21/03/2021	12708	835	7983	4725	62.8	37.2	146	49
28/03/2021	17516	1017	12663	4853	72.3	27.7	181	35
04/04/2021	12958	680	9258	3700	71.4	28.6	212	31
11/04/2021	9318	512	6820	2498	73.2	26.8	234	22
18/04/2021	8116	437	5847	2269	72	28	244	10
25/04/2021	9333	441	6565	2768	70.3	29.7	255	11
02/05/2021	8602	299	5879	2723	68.3	31.7	272	17
09/05/2021	8548	388	6625	1923	77.5	22.5	281	9
16/05/2021	11584	519	8796	2788	75.9	24.1	292	11
23/05/2021	15180	621	12047	3133	79.4	20.6	300	8
30/05/2021	15922	995	13618	2304	85.5	14.5	315	15
06/06/2021	19315	1376	16811	2504	87	13	329	14
13/06/2021	19687	1732	17385	2302	88.3	11.7	338	9
20/06/2021	24384	2498	21808	2576	89.4	10.6	348	10
27/06/2021	34239	5374	31045	3194	90.7	9.3	378	30
04/07/2021	34177	6635	31291	2886	91.6	8.4	419	41
11/07/2021	24647	4347	22030	2617	89.4	10.6	457	38
18/07/2021	18877	3279	16241	2636	86	14	490	33
25/07/2021	13322	2084	11304	2018	84.9	15.1	515	25
01/08/2021	11675	1756	10031	1644	85.9	14.1	538	23
08/08/2021	12306	2024	10738	1568	87.3	12.7	547	9
15/08/2021	17302	2854	15552	1750	89.9	10.1	564	17
22/08/2021	31762	5984	29720	2042	93.6	6.4	597	33
29/08/2021	52758	10342	50063	2695	94.9	5.1	634	37
05/09/2021	61302	10836	58654	2648	95.7	4.3	682	48
12/09/2021	57759	9111	55272	2487	95.7	4.3	722	40
19/09/2021	43252	6115	40934	2318	94.6	5.4	762	40
26/09/2021P	34607	4760	32827	1784	94.9	5.1	ND	ND
Totals	699220	93466	613280	85940	NA	NA	762	762

Table 5: Cumulative TCT tests by symptom status 18/01 to 26/09 2021

	No. of tests	proportion of tests
Asymptomatic	394867	56.5
Symptomatic	284966	40.8
Unknown status	19386	2.8
Total	699219	100.0



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