Public health response to respiratory illness winter 2021/ 2022

Contents

1. Background

As the Covid-19 pandemic transitions to endemic transmission, the policy and strategic direction is moving towards accepting Covid-19 as a vaccine-preventable disease where immunisation is the most critical first line of defence, complemented by: isolation and testing of symptomatic individuals; surveillance and risk-based response to incidents and outbreaks of the infection. Ongoing monitoring of new variants will remain critical.

As a result of non-pharmaceutical interventions in place for Covid-19 (such as mask-wearing, physical and social distancing, and restricted international travel), influenza activity and other acute respiratory illness levels were extremely low in Wales and globally in 2020 to 2021. Therefore, a lower level of population immunity against influenza and other acute respiratory illness is expected in 2021 to 2022.

In the situation where social mixing and social contact return towards pre-pandemic norms, it is expected that winter 2021 to 2022 will be the first winter in the UK when seasonal influenza virus and other respiratory viruses will co-circulate alongside Covid-19.

Seasonal influenza and Covid-19 viruses have the potential to add substantially to the winter pressures usually faced by the NHS, particularly if infection waves from both viruses coincide. The timing and magnitude of potential influenza and Covid-19 infection waves for winter 2021 to 2022 are currently unknown, but mathematical modelling undertaken by the University of Warwick indicates the 2021-to-2022 influenza season could be up to 50% greater than that seen in previous seasons.

The impact on the NHS will in addition be compounded by the disturbance to the health and social care system and the backlog of non-Covid-19 activity. Health boards are already experiencing unprecedented demand equaling that normally seen in peak flu season.

2. Strategic Aim

The strategic aim of the respiratory response plan is to reduce harm of Covid-19 and influenza infections, including by reducing cases where possible.

This will be delivered through:

- Delivery of effective and timely influenza and Covid-19 vaccination programmes and other pharmaceutical interventions.
- Delivering a comprehensive surveillance programme that: provides timely intelligence on incidence of respiratory infections; allows for rapid detection of incidents and outbreaks and supports the public health system to take appropriate action to reduce harm.
- Delivering a sample and testing strategy that allows for rapid identification of causative virus in those who are symptomatic, supported by prioritised whole genome sequencing that both allows for detection of new Covid-19 variants and drift/shift of influenza viruses aligned to severity of illness
- Delivering a contact-tracing model which covers warning and informing and targets high-risk settings.

- Ensuring vulnerable settings such as health and social care, prisons and other critical services, are supported by appropriate guidance on management of respiratory outbreaks.
- Effective communication, supporting the public to reduce personal risk of respiratory viral illness through frequent hand washing, respiratory etiquette, social distancing and mask wearing where advised to do so
- Collective action to minimise wider harms incurred through our response to respiratory outbreaks or epidemics

3. Vaccination

3.1 Influenza vaccination

Influenza vaccination is critical this coming autumn to reduce morbidity and mortality associated with influenza, and to reduce hospitalisations during a time when the NHS and social care may also be managing winter outbreaks of Covid-19.

Last winter, uptake of influenza vaccination was the highest ever recorded in Wales and this coming season the challenge is to see influenza vaccination maximised in priority groups who are most at risk of catching flu and suffering severe outcomes, or who are at higher risk of infecting other people.

The priority groups for 2021-22 are:

- children aged two or three years on 31 August 2021
- children in primary school from reception class to Year 6 (inclusive)
- children in secondary school Year 7 to Year 11 (inclusive)
- people aged 50 years and older (age on 31 March 2022)
- people aged six months to less than 50 years in clinical risk groups. This year we are extending the offer to those aged 16 years on 31 August who are morbidly obese, in line with guidance on the Covid vaccination programme
- pregnant women
- carers
- people of all ages with any level of learning disability
- all adults resident in Welsh prisons
- healthcare workers (including healthcare students) with direct patient contact
- staff in nursing homes and care homes with regular client contact
- staff providing domiciliary care.

Influenza programme uptake ambitions

In planning for the forthcoming vaccination season, health boards and primary care partners should work closely together to maximise uptake and aim to achieve significant increases across all eligible groups. The following table provides the uptake achieved in 2020-21 and the ambition for 2021-22.

Eligible Group	2020-21 Uptake	2021-22 ambition
65 years and over	76%	80%
6 months to 64 years at risk	51% (in 6 months to 64 years at risk)	75%
Pregnant women	84%	90%
50 to 64 years (not in a clinical risk group)	25%	60%
Children aged 2 or 3 years	56%	75%
Primary school aged children	72%	80%
Children in school years 7 to 11	-	75%
NHS Wales Healthcare workers (direct patient/ client contact)	65%	80%
Social care workers (direct patient/client contact)	11,316* *no denominator available in 20/21	80%**

Monitoring uptake of flu vaccination

Public Health Wales monitors uptake of seasonal influenza immunisation each year. During each influenza immunisation programme (usually October - March), uptake is summarised every week in the **weekly influenza activity in Wales report** and is available both on an all-Wales level and by local health board areas.

Increasing the opportunities for social care staff to receive the flu vaccine

The uptake of flu vaccine in social care staff last winter was estimated to be approximately 30%. The flu vaccine is currently delivered to social care staff by community pharmacies.

Immediate Priority: It has been recommended by the National Immunisation Action Group that social care staff should be able to receive the flu vaccine while at work in care homes when residents are being vaccinated or through their GP in addition to community pharmacies.

Future Priority: The Wales Immunisation Group will consider the merits of potential future expansion of the flu vaccination programme at its next meeting in November

3.2 Covid-19 vaccination

Vaccination is one of the most effective ways to protect people from Covid-19. At the time of writing, just over 2.4 million (87.9%) people in Wales aged 16+ have received a first dose of the Covid-19 vaccination, and over 2.2 million (81.3%) people have received a second dose (based on the 2020 mid-year estimates).

Efforts to boost take-up amongst those still unvaccinated against Covid-19 continues, with a range of actions in place to enable easy access and build trust, for example utilising outreach vaccination and pop up clinics in a targeted way.

Disparities in vaccination coverage between socio-economic, age groups and ethnic groups, as well as internationally, remain important and efforts continue to seek to address the underlying reasons for vaccine hesitancy such as historical marginalisation and concerns regarding safety and potential long-term effects on health. Examples include engagement events with religious/cultural groups, use of influencers, webinars in various languages and 'Ask the experts' public events.

Protecting the most vulnerable

Some individuals who are immunosuppressed due to underlying health conditions or medical treatment may not mount a full immune response to Covid-19 vaccination. The JCVI have advised that they be offered a third primary dose before being offered a booster dose later. We have identified these groups and are working with their clinicians to ensure they are offered the vaccine during periods of minimum immunosuppression (where possible) when they are more likely to generate better immune responses. The third primary dose should ideally be given at least eight weeks after the second dose, with special attention paid to current or planned immunosuppressive therapies.

The JCVI have also advised that children and young people over 12 years old who have specified underlying health conditions should be offered a two-dose primary schedule unless the individual is severely immunosuppressed when a three-dose primary schedule is advised in accordance with the latest JCVI advice on third primary vaccine doses.

Vaccinating Children with no underlying health conditions

The UK CMOs gave advice to the respective UK governments on the universal vaccination of 12-15 year olds against Covid-19. This recommendation was given after careful consideration, informed by independent senior clinical and public health input from across the UK. The Minister for Health and Social Services has accepted this recommendation and this group will be offered a first dose of Pfizer-BioNTech Covid-19 vaccine.

Letters inviting 12 to 15-year-olds are being issued and vaccinations started on 4th October. It's important that both children and parents have time to consider the information and have the discussion together before deciding whether to have the vaccine. We are aiming to offer the vaccine to all in this age group by 1st November.

We have a blended model of delivery with all health boards primarily inviting this age group to vaccination centres with some areas also providing vaccinations in special schools. The strength of this model is that it is informed by local knowledge and is flexible and agile so it can change dependent on the circumstances.

16 and 17-year-olds in Wales have all been offered a Vaccine (one dose only advised by the JCVI) and to date over 70% have taken up their offer. When they are three months from their 18th birthday they will be offered their second dose.

Booster programme

The JCVI has advised that individuals who received vaccination in Phase 1 of the Covid-19 vaccination programme (priority groups 1-9) should be offered a Covid-19 booster vaccine, no earlier than six months after their second dose. This includes:

- Those living in residential care homes for older adults
- All adults aged 50 years or over
- Frontline health and social care workers
- All those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe Covid-19 (as set out in the Green Book), and adult carers
- Adult household contacts of immunosuppressed individuals

JCVI have advised using mRNA vaccines for the booster; a Pfizer-BioNTech full dose or Moderna half dose, irrespective of which vaccine was given as a primary dose. The second choice of vaccine is an adenovirus vector vaccine (such as AstraZeneca or Janssen) according to availability and regulatory approval. This is in line with the stock procured and ordered for deployment by BEIS and we have received confirmation from vaccination task force colleagues that there is sufficient supply to cover Wales' eligible booster cohort.

Appointments for the booster programme began to issue from the week commencing 20 September. All Health Boards are now vaccinating residents and staff in care homes and are inviting others who are eligible to vaccination centres.

Co-administration with other programmes

The JCVI has made it clear that they do not wish the rollout of the booster programme to interfere with or disrupt the deployment of the annual flu vaccination programme, and advised co-administration where this would lead to operational expediency. For Wales, this will mean co-administration may only be likely in care homes and for frontline health and social care staff.

Waning immunity

Emerging evidence on waning immunity will need to be interpreted for Wales such that the predicted impacts are understood and used to guide action.

Future of seasonal vaccination programmes

There is much to learn from the rollout of the Covid-19 vaccination programme to date, which will have a bearing across the vaccination programmes. The integrated planning for the delivery of future programmes needs to start now, with the ambition of maximising uptake and reducing inequalities across the programmes informing future delivery models.

Immediate priority: Integrated planning across vaccination programmes

4. Surveillance

4.1 Key surveillance indicators

Public Health Wales currently produces a wide range of outputs covering the following areas:

- Community surveillance indicators of influenza-like illness (ILI) and acute respiratory infections (ARI)
- Surveillance of community acquired severe acute respiratory infection (SARI) and hospital in-patients
- Community and hospital surveillance of Covid-19 and suspected Covid-19 hospital and care home deaths
- Surveillance of severe outcomes of acute respiratory infections
- Intelligence on typing, sequencing and genomic analysis for surveillance of ARI and Covid-19
- Surveillance of Covid-19 and influenza vaccinations
- Surveillance of population susceptibility

Surveillance in the community

Public Health Wales has identified that community surveillance for influenza and other respiratory viruses needs to be strengthened. GP sentinel surveillance remains in place and has been updated to allow for submission of self-swabbing samples by post for patients consulting with GPs by telephone due to acute respiratory symptoms, but there remains a risk of under-reporting due to changes in patient care pathways. Additionally, sentinel surveillance in the community should be reinforced by surveillance schemes in other settings, particularly by setting up a sentinel care home surveillance scheme.

Without robust influenza surveillance, decisions around triggering use of antivirals for treatment and prophylaxis of flu in the community may be delayed. Timely detection to type and clade level is important in alerting to specific influenza viruses and associated impact on different settings (e.g. the impact of drifted influenza A(H3N2) clades on residential care homes) and informing future vaccine composition.

Surveillance in hospitals

The Public Health Wales SARI surveillance scheme has been rolled out in sentinel emergency departments in three health boards, but not yet been rolled out across all of Wales. There are therefore currently gaps by geography in hospital surveillance and this needs to be addressed rapidly to ensure we have qualitative data on symptoms and severity of acute respiratory infections.

Developments made over the past 18 months such as the use of record linkage for surveillance of Covid-19, will benefit wider surveillance of acute respiratory infections whilst minimising the additional burden on clinicians to provide active surveillance data. This is especially the case in investigating severe outcomes of infection and enhanced surveillances on vaccine effectiveness.

Priority: Reinforce primary care sentinel surveillance to ensure adequate sampling of community cases of influenza like illness.

Priority: Expand the existing severe acute respiratory infections (SARI) programme at pace to ensure all health boards participate in the data collection requirements.

Priority: Establish a sentinel network of care homes for older adults in Wales to allow systematic collection and analysis of data on symptoms, severity and outcomes of acute respiratory infections (ARI) and ARI outbreaks in care home residents.

Priority: Update existing surveillance strategy for influenza-like illnesses (ILI), acute respiratory infections (ARI) and severe acute respiratory infections (SARI), to include Covid-19. This will be of greater utility and efficiency than separate surveillance streams, whilst still allowing pathogen-specific analyses.

Priority: Further develop routine data linkage to help improve understanding of burden of respiratory infections in Wales. Explore the feasibility and usefulness of modelling approaches for acute respiratory infections, and short-term forecasting of trends during epidemics.

4.2 Surveillance reporting

Indefinite continuation of daily in-depth reporting on Covid-19 carries a risk of making small differences in trends appear more significant than they are and may disproportionately focus attention away from other important public health issues.

Weekly reporting should be the baseline for routine reporting. For some outputs, monthly or even quarterly reports will provide more meaningful and relevant messages. During periods of higher activity, where actions depend on it, more frequent reporting will be considered. However, the focus will remain on providing information essential to guide health protection response and public health actions. Reporting will be through a mixture of methods determined through stakeholder requirements. Reporting arrangements and surveillance outputs will reflect need and utility and will be amended to reflect both.

Priority: Rapidly review existing outputs to clarify utility and stop outputs that, with the agreement of stakeholders, are not deemed to provide significant benefit. Identify gaps and areas that require further development and would provide significant benefit over winter 2021-22.

Priority: A common set of outputs to be agreed between Public Health Wales and Welsh Government and published routinely.

5. Role of whole genome sequencing to support Covid-19 and Influenza programme

Genome sequencing is the only way to characterise new SARS-CoV-2 variants, and to unambiguously track and identify their arrival and spread in Wales.

Wales will maintain SARS-CoV-2 variant surveillance and outbreak support, seeking to dynamically target sequencing capacity to where it is most needed. This winter, other pathogens (such as influenza) will also be an increasingly important pressure on the NHS, and the considerable benefits from sequencing these other key pathogens must be considered alongside the allocation of capacity for sequencing SARS-CoV-2.

Prudent use of sequencing capacity

Wales will begin the winter by aligning to sequencing targets recommended by the UK Variant Technical Group, standardising surveillance sequencing to a UK-wide baseline. A clear order for prioritisation of SARS-CoV-2 cases for sequencing will be developed.

Using genomics to support the NHS this winter, whatever the pathogen

Moving to a clear target for the sequencing of SARS-CoV-2 cases in Wales means that sequencing capacity is likely to be made available to either cope with surges in testing, for example as part of a Covid-urgent scenario, and/or to enhance the surveillance for other pathogens of critical importance. Recognising that influenza surveillance is likely to be particularly important over the course of the winter of 2021-22, Wales should utilise sequencing capacity freed up through the adoption of sequencing targets to enhance current Influenza sequencing surveillance provision. This capacity should be used to provide information to support (WHO) influenza strain selection for seasonal vaccine composition and enhance genomic surveillance in Wales. (e.g., to track/identify patterns of drug resistance in Wales) and potentially to

support local outbreak response). Any uplift in influenza sequencing should be used to lay the groundwork for supporting updated influenza and SARS-CoV-2 surveillance activities by the WHO over the longer term.

Flexible sequencing and alignment with the wider UK

Sequencing is a key tool that supports pandemic management at a national level and outbreak management at a local level. The allocation of sequencing capacity should be managed by Public Health Wales, working with key stakeholders such as the Variants and Mutations of Concern Oversight Group, to flex dynamically with demand to meet the needs of the people and patients of Wales.

Immediate priority: Adopt a targeted sequencing approach that enables the dynamic adjustment of Covid-19 sequencing without compromising existing pathogen genomics services, or the ability to perform SARS-CoV-2 variant surveillance and outbreak response. This will focus on meeting Welsh needs, but where possible the Covid-19 sequencing approach should align to similar activities across the UK.

Priority: Utilise sequencing capacity freed by any adjustment of Covid-19 sequencing to increase sequencing of other pathogens (critically influenza) to support surveillance and/or outbreak response through the winter.

6. Test, Trace and Protect for Covid

Test, Trace, Protect (TTP) has played an essential role in helping to maintain downward pressure on Covid-19 case rates. Consequently TTP remains a crucial mitigation.

The strategy for TTP for Covid-19 for winter 2021-22 will be based on:

- Maintaining our testing capacity and infrastructure so that we can continue to test to diagnose, test to safeguard, test to find and test to maintain.

- Targeting contact tracing on where we can potentially have the greatest impact – protecting the vulnerable and being alert to possible importation of variants and mutations of concern.

- Continuing to support self-isolation through our protect programme as a critical means to preventing onward transmission.

6.1 Test

This winter, we will maintain widespread community testing. Indeed, given the additional risks posed this winter from influenza, we will increase testing for some high-

risk groups by using a test which can detect both influenza and Covid-19 (known as multiplex testing). Our approach over winter will continue to be based on:

- Test to diagnose with the inclusion of multiplex testing
- Test to safeguard, to also include multiplex testing for symptomatic cases in care homes.
- Test to find within the community.
- Test to maintain, ensuring resilience of services/psychological safety within education and workplace settings.
- Test to enable which will include testing requirements for the Covid Pass and international travel.

Testing capacity to support our testing purposes is at an all-time high and the laboratory network has been consistently delivering fast turnaround times. However, modelling indicates that if we experience a difficult winter, with high levels of respiratory viruses circulating, there is a risk that testing demand could exceed lab capacity across the UK. If this happens we may have to prioritise the use of PCR testing and look at how best we can utilise lateral flow tests.

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SARS CoV-2 PCR testing first became available within NHS Wales diagnostic laboratories in February 2020 and it is now embedded in their business as usual service. This testing capability then extended to the UK Government Lighthouse laboratory network. There are approximately 15000 PCR tests undertaken daily with approximately 5000 undertaken in Welsh NHS laboratories. The UK Government Lighthouse laboratory network tests for SARS CoV-2 only and does not currently have the capability to test for other respiratory viruses. In contrast all of the acute hospitals in Wales have the capability to test for SARS C0-19, Flu A, Flu B and RSV. A more comprehensive multiplex respiratory test is available for vulnerable patients that tests for additional microorganisms such as adenovirus, human meta pneumovirus, human parainfluenza virus, Mycoplasma pneumoniae, enterovirus and rhinovirus.

The most significant respiratory viruses that impact on health each winter are the influenza viruses and RSV. This winter we will also have co-circulation of Covid-19. Disease from any of these viruses will have many symptoms in common and there are

a number of valid reasons for ensuring that the correct diagnosis is made. For vulnerable individuals in the community and in closed settings, such as care homes, prompt diagnosis of influenza can lead to appropriate clinical management and use of antivirals both for treatment and prophylaxis. For those admitted to hospital with an influenza like illness (ILI) use of a multiplex assay allows for appropriate treatment and isolation/cohorting of patients. This is critical to avoid possible co-infection of influenza and Covid-19.

In addition to the laboratory tests, there are a number of point of care tests (POC) available which can play a crucial role in patient management particularly in Emergency Departments. It should be noted that if a patient requires admission and the POC test is negative the patient will require follow up with a laboratory test.

The use of the multiplex assay that can diagnose Covid-19, Flu A, Flu B and RSV comes at an additional cost and should be used where there is clinical need and public health gain.

While asymptomatic individuals with Covid-19 can pass the virus to others for the most part only those with symptoms will spread influenza so asymptomatic testing would have little or no value. For this reason, we describe below how our testing resource could be used this winter for asymptomatic testing for Covid-19 only (electives, emergency admissions etc.) and for management of ILI more broadly.

6.2 Trace

Our local contact tracing teams through their dedication and professionalism have helped to break chains of transmission and supported people faced with the challenge of having to self-isolate. With the isolation of contacts no longer the default position – fully-vaccinated adults and under-18s no longer have to isolate if identified as a close contact by TTP – we will focus contact tracing where it can have the most impact. Our revised approach to contact tracing entails:

- **Protecting vulnerable individuals**. Rather than automatically following up all cases and their contacts in person, contact tracing teams will focus on identifying those who work in vulnerable settings (such as health and social care workers or emergency services) or who are not fully vaccinated.

- **Working towards digital by default**. We will automate more of our tracing via digital contact and target calls at those who require tailored advice. We will use behavioural insights to make every contact count including how to communicate the importance of vaccination when tracers interact with unvaccinated cases/contacts, and signpost accordingly.

- **Managing risks from international travel**. The increasing relaxation of international travel requirements poses a significant risk of importing cases and variants of concern from abroad. It remains critical that arriving travellers into Wales are contact traced to ensure those who are required to isolate are aware of their legal duty to do so. We will better utilise resource to follow-up those who

do not respond to digital interventions to monitor compliance with mandatory testing arrangements.

6.3 Protect

The ultimate aim of TTP is to support self isolation in order to reduce and prevent onward spread. Identifying those who need to isolate is an essential element but so too is delivering the support that helps people to do the right thing and comply with that requirement. Supporting self isolation will continue to be a critical element of TTP, financial support remains through the self-isolation support payment and local authorities and the third sector continue to provide wider support mechanisms.

7. Non-pharmaceutical interventions (NPIs)

NPIs are actions –that, in addition to getting vaccinated and taking antivirals - individuals, communities, businesses and services can take to help slow the spread of respiratory viruses such as Covid-19 and influenza.

7.1 Self-isolation when symptomatic

Staying at home when ill with respiratory symptoms is the most effective way to break the chain of transmission of the virus.

The guidance on self-isolation if symptomatic with Covid-19 is very clear. If individuals have any coronavirus symptoms (a high temperature, a new continuous cough or a loss or change of taste or smell), they must self-isolate at home and get a test. They must not go to a GP surgery, pharmacy or hospital. The self-isolation period is 10 days. If they have tested positive for Covid-19, or have been told to self-isolate by the NHS Wales Test, Trace, Protect (TTP) service, they must stay at home. They are breaking the law and could be fined if they do not stay at home and self-isolate.

It has always been advised that individuals who have an ILI should stay at home, however, this has never been as clearly articulated to the general public as the 10-day self-isolation guidance for Covid-19 infection. There is confusion, too, as to how long to stay at home. Many individuals with ILI return to work while infectious to others.

Experts generally agree that it is best to stay home with an ILI as long as an individual has severe symptoms, like a cough with mucus, vomiting, diarrhoea, fever or fatigue because you may be contagious. It is generally accepted that an individual is infectious to others for 24 hours before and three to four days after onset of symptoms.

This autumn and winter there is an increased risk that individuals who have respiratory symptoms and who test negative for Covid-19 will not continue to self-isolate while infectious to others from other respiratory viruses. To mitigate, at least in-part, against this risk a communication strategy should seek to educate and encourage staying at home when symptomatic with ILI and Covid-19 test is negative. Further detail is provided in section 12.

If compliance of self-isolation for ILI improves and this behaviour is understood by all and becomes the norm, the need for community symptomatic testing for Covid-19 would be much reduced.

7.2 Face coverings

In Wales, face coverings must be worn in all indoor public places (with the exception of hospitality venues). This includes on public transport and taxis. While face coverings themselves may be of limited public health value it is generally agreed that it reinforces the message that Covid-19 has not gone away and reminds individuals of other beneficial behaviours, such as frequent hand-washing. The use of face coverings in all indoor public places should continue to be encouraged throughout winter 2021-22.

Further details on requirements for use of face coverings are set out in the Welsh Government guidance: Face coverings: guidance for public | GOV.WALES

7.3 Working from home where possible

Throughout the pandemic, many people had to work from home to slow the spread of the virus. At Alert Level 0 Welsh Government continues to encourage people to work from home where possible.

7.4 Covid-secure measures adopted by businesses and industry, and other places of gathering such as places of worship, museums etc

The Welsh Government has for some time imposed a particular legal requirement on people responsible for workplaces and for premises open to the public to ensure that reasonable measures are taken to minimise the risk of exposure to, or the spread of, coronavirus by those who have been at those premises. This legal requirement forms part of the public health response to the coronavirus pandemic and applies in addition to existing occupational health requirements under health and safety law.

In general terms, there are five main ways to minimise risk. These are often described as the “hierarchy of controls”. This provides a framework against which to assess risks and consider reasonable measures to take to minimise those risks.

Mitigation measures adopted by people responsible for workplaces and premises open to the public include the use of screens, social distancing, cleaning of surfaces, improved ventilation and use of face coverings. It is likely that these measures are having an effect at slowing the rate of transmission. Maintaining or improving “Covid security” will be important over the coming months.

7.5 Reducing opportunities for super spreading events at high risk venues

Throughout the pandemic we have seen multiple reports of super spreading events, which are associated with both explosive growth early in an outbreak and sustained transmission in later stages. Super spreading events have been associated with the night time economy including nightclubs, sport events, festivals, and parties.

In addition to adherence to Covid-19 secure measures there are two strategies that can be utilised by event organisers to mitigate, in part, against the risk of a super spreading event.

Where events are pre-ticketed, organisers may asking attendees to complete a pre-attendance health check questionnaire or provide evidence of a negative Covid-19 test or of being fully vaccinated. The use of lateral flow tests is one way that minimises risks of infected people entering and spreading coronavirus. Organisers may also wish to consider asking all those attending the event site to undertake a voluntary at home rapid Covid-19 test (lateral flow device) in order to help protect themselves, others and the safe delivery of the event. Neither proof of a negative Covid-19 test nor proof of being fully vaccinated is currently mandated in Wales but is being kept under review so that it may be mandated if the situation deteriorates.

The Covid Pass was used over the summer to facilitate international travel and by businesses and events here and elsewhere in the UK as one of the reasonable measures in place to minimise the risk of the transmitting the virus.

7.6 Covid-19 Pass

From 11 October 2021, as in the case in many European and countries across the world, adults in Wales are required to prove that they are either fully vaccinated or have had a negative lateral flow test if they wish to enter the following premises:

- Nightclubs
- Indoor, non-seated events for more than 500 people, such as concerts or conventions
- Outdoor non-seated events for more than 4,000 people
- Any setting or event with more than 10,000 people in attendance

Making the pass a mandatory requirement in these settings assists in decreasing the pressure on our health and social care system and enable events to continue taking place through autumn and winter.

8. Pharmaceutical interventions

8.1 Antivirals for influenza

Antivirals for treatment of influenza

Oseltamivir and zanamivir are recommended by NICE, within their marketing authorisations, for the treatment of influenza in adults and children if **all** the following circumstances apply:

- national surveillance schemes indicate that influenza virus A or B is circulating
- the person is in an 'at-risk' group
- the person presents with an influenza-like illness and can start treatment within 48 hours (or within 36 hours for zanamivir treatment in children) of the onset of symptoms as per licensed indications.

- people 'at risk' are defined as those who have one of more of the following:
    - chronic respiratory disease (including asthma and chronic obstructive pulmonary disease)
    - chronic heart disease
    - chronic renal disease
    - chronic liver disease
    - chronic neurological conditions
    - diabetes mellitus.
- People who are aged 65 years or older and people who might be immunosuppressed are also defined as 'at-risk'

Antivirals for prophylaxis

NICE has also provided guidance stating that oseltamivir and zanamivir may be used for prophylaxis of persons in at-risk groups (see above) following exposure to a person in the same household or residential setting with influenza-like illness when influenza is circulating in the community.

As per NICE guidance, prophylaxis should be issued if the contact is not adequately protected by vaccination, either because the vaccination is not well matched to the circulating strain, or there has been less than 14 days between vaccination and date of first contact with influenza.

In addition, the guidance also states that if the individual has been exposed as part of a localised outbreak (such as in a care home), antiviral prophylaxis may be given regardless of vaccination status.

Usage of antivirals in Wales

The use of antivirals for either treatment of or prophylaxis against influenza has always been very low in Wales. In 2018 a Directed Enhanced Service (DES) for antivirals for prophylaxis of seasonal influenza in care home outbreaks was agreed with GPC Wales. The request was that general practitioners implement NICE guidance providing antiviral prophylaxis to residents of care homes where influenza is known or believed to be circulating, following the notification from the Chief Medical Officer to commence prescribing. However, this DES has little impact on the response to influenza outbreaks in care homes. A contributory factor is likely to be the time lag between exposure and the general practitioner identifying those who are eligible for prophylaxis such that the 48-hour window for the antiviral to be effective is passed.

Immediate priority: For the coming flu season, there is an urgent need to revisit the DES and develop a model such that the individuals at risk in care homes who would be eligible for either treatment of influenza or prophylaxis can be identified at the start of the season with delayed prescriptions available to support a prompt response when influenza is circulating in the care home.

Priority: The need for timely notifications to prompt the effective use of antivirals should be reinforced at regular intervals

8.2 Monoclonal antibodies for treatment/ prevention of Covid-19

A monoclonal antibody, Ronapreve, has been licensed as safe and effective for use for the treatment and prevention of Covid-19 in some clinically defined situations. The stock is in limited supply and its use will need to be carefully focused on those individuals who will be able to derive significant clinical benefit from it. As a newly available intervention, it will be kept under careful clinical evaluation to ensure that it is deployed as effectively and equitably as possible.

9. Key Settings

Key settings, such as hospitals, care homes, education settings and prisons need to be supported by appropriate guidance on management of respiratory outbreaks.

9.1 Hospitals

The NHS in Wales is now moving towards the autumn / winter of 2021/22, with a successful Covid-19 vaccination programme in place, but with significant challenges to deliver non-Covid care and address waiting lists. Infection prevention and control measures remain a key component of practice to ensure the safe return of all healthcare services and the avoidance of nosocomial transmission of Covid-19 and other infections, such as influenza, RSV and norovirus. The UK Infection Prevention and Control guidance may be found here.

The 'Operational guide for the transition of healthcare environments in preparation for Autumn/Winter 2021/22 incorporating Covid-19 Measures' has been developed and issued to health boards and trusts to provide practical guidance on how hospitals and healthcare facilities can be reconfigured to provide public confidence and allow the NHS to return to delivering all the services it needs to and to protect services from the spread of infections including SARS CoV-2.

9.2 Care homes

Public Health Wales have issued an advice note on the future management of outbreaks of Covid-19 within care homes. The proposal (being considered by Welsh Government at the time of writing) aims to align with existing guidance, accounting for the high level of vaccine coverage in both staff and residents, and ensuring a more proportionate response that safeguards the holistic wellbeing of residents.

If agreed, the notion of a "Red" home and all the associated "rules" will stop. Instead, the focus will shift to identifying when there is an ongoing outbreak in a setting, and determining through a risk-assessed approach, the most appropriate measures to bring the outbreak to a close.

Whole home testing will not form part of routine outbreak management. Once the causative organism in an outbreak has been identified, the home will focus on strengthening IP&C measures and early identification and isolation of newly symptomatic residents. As a result, declaring an outbreak over will be based on these measures rather than reliance on testing.

Individuals requiring admission to a home will be assessed to determine the risk of both acquisition and onward transmission of Covid-19 infection. This will enable homes to identify the mitigating factors that will support admission of residents (even during outbreak periods where appropriate) and return to normal living arrangements, thus avoid lengthy hospital stays, delayed admissions, and lengthy restrictions on the lives of these individuals.

The proposed approach to managing an incident or outbreak of Covid-19 in a care home aligns with the well-tried approach to managing incidents or outbreaks of influenza. For the coming autumn/winter it has been agreed that symptomatic residents and staff will be offered the 4-plex test (testing for SARS C0-19, Flu A, Flu B and RSV) so that appropriate clinical care can be provided. NHS local health protection teams will lead on the identification and management of respiratory outbreaks in care homes, as per agreed testing and response pathway.

Immediate priority: The pathway for the testing of staff and residents with respiratory symptoms and response to incidents and outbreaks of influenza and Covid-19 is shared with health boards and care homes and its application closely monitored

9.3 Education

The Local Covid-19 infection control decision framework for schools for autumn 2021 sets out arrangements for the delivery of learning in schools enabling them to tailor interventions to reflect local risks and circumstances. In recognising the balance of benefits and harms to learners and staff the guiding principles is to enable schools to operate as 'business as usual' as far as possible. The approach set out was required to be adopted by 20 September 2021.

Twice weekly lateral flow device (LFD) testing will continue to be offered at the start of the academic year to staff in primary schools and staff and learners in secondary schools. The use of LFD testing will kept under review as schools transition to the Framework.

To provide further confidence to the educational sector and to limit time out of school, on the 6th October the Minister for Education announced that students in secondary school or college who are a household contact of someone who has tested positive for Covid-19 will be advised to take daily lateral flow tests for 7 days. This is in addition to the current advice for all close contacts to take a PCR test on day 2 and day 8.

In recognition of the specific challenges special schools and colleges face staff who are identified as a close contact will require a negative PCR test before they return to the workplace, followed by daily lateral flow testing for 10 days.

Schools will need to ensure that regular Covid-19 risk assessments continue to be undertaken. The assessment should directly address risks associated with Covid-19, to enable measures to be put in place to control those risks. Any decision to recommend the reintroduction of tailored interventions for a period of time, such as face coverings or contact groups, would be taken locally with the school in discussion with public health, TTP and local authority officials.

An Incident Management Team or Outbreak Control Team will not be established as a matter of routine like with other communicable diseases. They will typically only be established following consideration by the partners as outlined in Section 10 below.

9.4 Prisons

Health boards providing health services within prisons are expected to include prison health services within their own winter planning arrangements. Health boards are delivering influenza and Covid-19 vaccine programmes to prisoners in Wales. All prisoners in Wales are eligible for these vaccines regardless of age or health status although those at greatest risk of disease will be given priority. Prison-employed staff are able to access influenza vaccination via HMPPS occupational health process. Public Health Wales will support by producing surveillance on influenza and Covid-19 vaccine coverage by site and are producing additional comms to encourage vaccine uptake.

This winter, clusters and outbreaks will need to be managed in the context of relaxed restrictions and more closely to pre-pandemic operation and that will make management of spread more complex. The challenge will be to contain infections early as possible. Prisons are experienced in identifying and managing cases and clusters of respiratory infection (testing, isolating, cohorting) and these processes will remain in place throughout the winter. Prisons will continue with a low threshold for testing, isolating and cohorting based on presentation of respiratory symptoms. Weekly Covid-19 screening (voluntary) for prison staff and prisoner workers will remain available throughout the winter to support early detection of asymptomatic infection.

Existing groups established to support the response to Covid-19 in prisons in Wales are now including influenza within their remit. These include the All-Wales Covid-19 Prison Management Meeting, HMPPS Wales Covid-19 Strategic Management Group and the Wales Prisons Covid-19 Fortnightly Catch-up.

Public Health Wales will continue to support through the production of surveillance reports to provide intelligence on incidents and outbreaks and will remain in close contact with each prison to support and advise on Covid safe regime delivery.

Immediate priority: Public Health Wales to rapidly review and adapt for Wales any updated guidance on the management of communicable diseases in prisons and distribute to all prisons and prison health care providers.

Immediate priority: Health boards to ensure sufficient resource is allocated to prison healthcare teams in remand prisons as these will need to keep up vaccination pace for the entire winter due to their rapid turnover of admissions.

10. Management of outbreaks and incidents

The Communicable Disease Outbreak Plan for Wales (“The Wales Outbreak Plan”) provides the template for managing all communicable disease outbreaks, including respiratory outbreaks, with public health implications across Wales.

Outbreak management will remain, as now, a joint partnership approach. An outbreak is declared jointly by the Director of Public Protection (DPP), the Consultant in Communicable Disease Control/Consultant in Health Protection (CCDC/CHP) and the Health Board Clinical Lead for Microbiology, in conjunction with the Health Board Executive Director of Public Health (EDPH), after these individuals have jointly considered the information available. However, any one of these can declare an outbreak if required. If an outbreak is declared and Outbreak Control Team (OCT) will be convened.

The primary objective of the OCT in the management of an outbreak is to protect public health by identifying the source and/or main determinants of the outbreak and implementing necessary measures to prevent further spread or recurrence of the infection. The protection of public health takes priority over all other considerations and this must be understood by all members of the OCT.

The secondary objective is to improve surveillance, refine outbreak management, add to the evidence collection, and learn lessons to improve communicable disease control for the future.

The Core members of all OCTs are the DPP, the CCDC/CHP, the health board Clinical Lead for Microbiology and the Executive Director of Public Health for the health board (HB). The Lead Officer for Communicable Disease of the LA is also a core member of the OCT.

11. Role of Incident Management Teams (IMTs)

Responding to the pandemic has required an integrated response from partner agencies across Wales. Health boards have worked jointly with LAs and other partners to draw up co-ordinated local prevention and response plans. To support delivery of these plans all health board areas have an IMT in place. These IMTs have, throughout the pandemic, maintained oversight of transmission of Covid-19 in their area, investigated and managed incidents and outbreaks and worked closely with businesses, educational settings, closed settings and critical services to reduce the spread of the virus. Through regular SBAR reporting to Welsh Government they have provided invaluable intelligence on the impact of Covid-19 in their health board areas and provided a forum for raising issues of concern or clarification.

As we navigate our way from pandemic to endemic Covid-19 the NHS and other local partners will continue to work together to maintain oversight of, and manage risks from Covid-19. Local prevention and response plans will require revision to reflect the guidance and regulations in effect for Covid-19 at alert level zero, the changing focus of contact tracing and the challenges facing the NHS and public services this autumn and winter. The IMTs, through contingency planning, will ensure that resources are available to investigate and mange any upsurge of cases, outbreaks and incidents or the introduction of a new variant of interest or concern.

Priority: IMTs meet fortnightly and submit an SBAR to Welsh Government after these meetings. IMTs may report in at any time by exception. (The SBAR

reporting template has been revised to reflect the changing focus of contact tracing).

12. Communications

12.1 Flu and Covid-19 booster vaccinations campaign

To support the roll-out of the winter flu and Covid-19 booster vaccinations programme, Public Health Wales will be delivering an integrated marketing campaign. This launched on 28 September, with the initial paid-for campaign running for six weeks. This will encompass TV, radio, bus rears, digital, social and public relations activity to maximise paid and earned channel coverage.

The campaign is based on behavioural insights to encourage eligible people to have their flu and Covid-19 booster vaccines. The campaign re-frames how people view viral illnesses, and will show how getting these vaccinations when they are due will help people to 'keep your life open' so they can do the things they enjoy.

Outside of the paid-for campaign activity, Public Health Wales will also be delivering organic social media outputs, PR support, extensive leaflets, posters and other print collateral, plus a well-developed stakeholder plan to exploit available owned and shared channels. Full downloadable resources are available from this link: Respiratory Virus Vaccination (padlet.com)

12.2 Keep Wales Safe campaign

The Welsh Government's Keep Wales Safe campaign will continue throughout the autumn/winter reminding promoting the message that everyone has an ongoing role in helping to stop transmission by maintaining behaviours as set out in the Covid code.

The Covid–Code: Working together to keep Wales safe

1. Stay at home (self-isolate) if you feel ill; if you have Covid-19 symptoms get a PCR test.

2. Self-isolate if you have Covid-19, or have been advised to do so by NHS Test Trace Protect.

3. Provide as much support as you can to help other people self-isolate.

4. Get all of your Covid-19 vaccines and boosters, and encourage those around you to get theirs too.

5. (Where possible): Minimise the number of face-to-face contacts you have, and the time spent with them.

6. Meet-up outside, but if you are indoors, open doors and windows. 7. Wear a face covering in crowded, and indoor, public spaces. 8. Wash/sanitise your hands regularly and always sneeze into your elbow. 9. Work from home when you can

12.3 Help Us Help You campaign

The Welsh Government's Help Us Help You campaign will increase activity during autumn/winter and will have three key themes of NHS access, self-care and wellbeing. The campaign will use paid-for advertising to promote appropriate ways to access NHS services, as well as encouraging people to take action self-care and look after their mental and physical wellbeing.

Both campaigns will consist of high profile paid-for advertising, media relations, amplification through trusted voices such as influencers and partners. Stakeholders will also be supported with toolkits and resources to promote local services / support at a local level whilst supporting the national messages. Both campaigns are insight led and informed by behavioural science.

Priorities

Explore opportunities for public messaging to reinforce existing expectations that those with symptoms of a flu like illness should stay at home for at least five days from onset of symptoms and longer if severe symptoms persist.

Work with Covid-19 testing service and TTP to maximize the opportunity to reinforce the above message when individuals receive a negative Covid-19 test result.

Employers encouraged to remind those who are absent from work with an ILI that they should not return for at least five days from onset of symptoms. For the coming flu season NHS Wales, including Public Health Wales, could promote this and act as an exemplar to others.