EXECUTIVE COUNCIL

PUBLIC

Title:	Surveillance Swabbing for SARS-CoV-2 in the Falkland Islands during the COVID-19 pandemic.
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Responsible Director:	Director Health Services
Report Author:	Chief Medical Officer
Portfolio Holder:	MLA Ian Hansen
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Previous papers:	
List of Documents:	Appendix A: MLA Briefing Information Surveillance Swabbing

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Issue

To agree the policy for surveillance swabbing for SARS-CoV-2 in the Falkland Islands during the COVID-19 pandemic.

Recommendation

It is recommended that Executive Council:

a) *Review and accept the additional surveillance swabbing plan outlined in this paper which is included as part of the already approved COVID-19 testing, contact tracing and isolation policy.*

b) *Approve the policy as a basis for joint public health surveillance as agreed with BFSAI.*

c) *Authorise the Chief Medical Officer and KEMH Laboratory Manager to make minor amendments to this policy in line with any new international guidelines or recommendations that become apparent in relation to testing, contact*

tracing, isolation and surveillance swabbing as more information is learned about the SARS-CoV-2 virus and COVID-19 disease.

Background

1. 13 cases of COVID-19 have been detected in small clusters at Mount Pleasant Complex. To date no cases of COVID-19 have been seen in the civilian community in Stanley or Camp. Until an effective treatment for COVID-19 is found, or a suitable vaccine is in place, it is essential for the protection of the whole of the Falkland Islands that every effort is made to control the spread of the disease.

2. Until recently the KEMH did not have the ability to test for SARS-CoV-2 (the virus that causes COVID-19) in the laboratory. With the capacity to swab and diagnose people in-house, we are now in a position to undertake careful review and swifter diagnosis of symptomatic individuals, and implement a surveillance element to the detection of COVID-19.

3. This policy has been written to implement a structured approach when considering how to ensure that every effort is made to contain and/or delay the spread of the COVID-19 virus through the Islands.

4. The policy has been written using guidelines and advice from both the World Health Organisation and Public Health England (PHE). In addition to this, the policy has been reviewed by, and discussed with, consultants in microbiology and infectious disease control at PHE.

5. The document and its plan has been shared and agreed with colleagues at BFSAI to ensure that there is a clear approach to follow that can be applied consistently across the islands in both MoD and civilian communities. This will enable joint working and collaboration moving forward.

Reasons for recommendation

6. COVID-19 is an extremely contagious virus that can spread rapidly and often amongst individuals who may not display symptoms. Being able to detect a new case of COVID-19 quickly will enable swift public health measures to be activated to help delay or stop the spread of the virus.

7. We have had a robust, aggressive approach to swabbing people since the beginning of the COVID-19 pandemic. This approach is now also shared by MPC and aided by the faster turn arounds that occur as a result of on-Island PCR testing for the SARS-CoV-2 virus.

8. Currently all individuals who present with flu-like symptoms are swabbed and isolated. PCR testing for the SARS-CoV-2 virus in the KEMH laboratory has

enabled the clinical team to quickly determine a positive or negative result (usually within 24 hours) for people who are symptomatic.

9. In addition to swabbing symptomatic people, part of the public health approach used to control the spread of COVID-19 is to undertake surveillance swabbing to detect any COVID-19 disease that might be spreading amongst asymptomatic individuals.

10. It is clear that surveillance swabbing, used to hunt down and detect latent cases of COVID-19, is a new subject and only a handful of countries are starting to get into a position whereby they are rolling out their programmes for surveillance, and as such there are no hard and fast rules around how to proceed. Unfortunately, until now most countries have been swamped with managing suspect cases or have limited testing capacity.

11. The ability to undertake surveillance swabbing is driven by what the resource availability is in that country/territory. In the Falklands we are fortunate in that we have a small population and good resources to support a robust surveillance plan.

12. As mentioned, the aim of surveillance swabbing is to try and detect latent disease within the community, and quickly isolate those infected, including their contacts. It is well known and well documented that the SARS-CoV-2 virus can remain in a community, undetected and being spread, for a considerable period of time via asymptomatic viral shedding. This is particularly seen in groups of young, healthy individuals. Surveillance swabbing is an addition to the priority of testing patients with symptoms and their contacts. According to PHE there are rough estimates of a third of cases being asymptomatic but there is some uncertainty around this and it could well be higher.

13. Following discussions with PHE it has been agreed that here in the Falklands we will undertake surveillance swabbing across our two main communities, Mount Pleasant Complex and Stanley. We will aim to swab 10% of the population every two weeks which would equate to approx. 130 people at MPC (presumed population 1300) and 275 people in Stanley (population approx. 2750). This will give us repeated snapshots of the prevalence in the general population.

14. The numbers of people being swabbed will be flexible. If we see new disease outbreaks the surveillance sample size will be increased every two weeks, and if we return consistently negative results the sample size will be reduced gradually. It is intended that for the first 8 weeks 10% of the population will be sampled every two weeks, then, if results are negative, this will reduce to 5% every two weeks for the next 8 weeks, and finally there will be an ongoing

surveillance plan of 5% of the population being screened every month, which will continue indefinitely.

15. There will be two arms to the surveillance swabbing plan. The first arm will focus on swabbing people who have 'high contact' jobs, e.g. health care workers (who will be swabbed most frequently and regularly), customs and immigrations staff, FIGAS pilots, police, teachers etc. Initially we will start our surveillance swabbing within these groups. Heads of departments and managers of private businesses will be contacted and asked to identify 10% of their working groups every two weeks for swabbing. The swabbing will be organised with the clinical team and times given for people to attend for swabbing. This will likely be as a 'drive-by' swabbing arrangement.

16. Part of this 'high contact' group will include the Stanley – MPC commuters as they are seen as a cross-contact group that transfer between our two bubbles. It is important that this group is regularly screened to ensure that there is no movement of COVID-19 between communities. As time progresses, and if negative swabs are persistently returned over the initial 8 week period, targeted swabbing of this group could reasonably stop.

17. The second arm of the surveillance swabbing will focus on a random cross-section of the community. This will be started by identifying people who are attending the KEMH for non-COVID related issues, be that to see the GP or to collect their prescriptions, and in time will move towards 'mobile clinics' where clinical staff will set up a swabbing station (e.g. in a car park or shop porch) and offer swabbing to anyone who is keen to have one done.

18. Initially swabbing will concentrate on high-contact individuals and then, after approx. 4-6 weeks we will aim to balance the swabbing plan between high-contact individuals and the general population on a roughly 50/50 basis. The figures will be flexible.

19. Other groups of people, who might not go out much or who live outside the Stanley or MPC, will be captured by offering swabbing through the Community Support team, or during GP visits to Camp. The surveillance plan will be publicised and once it is up and running people can contact the KEMH if they want to be swabbed.

20. It must be recognised that surveillance swabbing is a voluntary process and consent will be taken from every person who is swabbed.

21. Children will not be routinely swabbed whilst in school, but may be included in a swabbing programme as part of the general population if their parents/guardians agree for them to be swabbed e.g. during a GP consultation or at a community swabbing centre. Reasons for this include the fact that children, whilst being classic asymptomatic viral shedders, do not seem to

transmit the virus as effectively, as was first thought. Also teachers will be regularly swabbed in line with the high-contact surveillance swabbing arm.

22. It must be acknowledged that surveillance swabbing is unlikely to detect all COVID-19 in the community if there is another outbreak, so it is extremely important that the messaging continues around staying at home if you are unwell with flu-like symptoms and seeking medical advice.

23. **The approach to surveillance swabbing and testing must be flexible**, not only as new information is shared and the science develops, but also when considering the community approach – i.e. a swift response from the community is essential to contain the spread of a random outbreak. The population must be ready to step back up to more robust isolation and social distancing protocols very quickly. This is essential to help contain spread of disease, particularly when detected incidentally through surveillance testing.

Implications

24. Not to implement a coordinated testing, isolation, contact tracing and surveillance swabbing process, will leave the Islands vulnerable to swift spread of COVID-19 through all communities. While the KEMH is prepared for caring for many ill people as a result of COVID-19 disease, it would be preferential for all to have a controlled spread of the disease should a new outbreak occur.

25. There are limited financial implications arising from this paper. Ongoing testing kits and reagents needed for detection of SARS-CoV-2 are currently being supplied by Public Health England through the UKOT's route. Although this link is active and being supported now, moving forward it is expected that the cost of the sundries and consumables will need to be met by FIG. It must be noted that the big expense (the testing platform itself) has been met by PHE/UKOT's group already.

Communications

26. The document has been shared with BFSAI colleagues and will continue to be reviewed by the KEMH Public Health team as new evidence emerges. Any major changes to the document will be brought to the attention of ExCo.

Background papers (not attached)

A. WHO's strategic objectives.

B. WHO's FFX and contact investigation protocol

C. PHE COVID-19: Guidance for health professionals

D. ExCo Paper 66/20 "On Island Testing for Covid-19 Policy" and Annexes

Appendix A: MLA Briefing Information Surveillance Swabbing

SARS-CoV-2 swabbing in the Falklands

We have had a robust, aggressive approach to swabbing people since the beginning of the COVID-19 pandemic. This approach is now also shared by MPC and aided by the faster turn arounds that occur as a result of on-Island PCR testing for the SARS-CoV-2 virus.

There has been joint working with MPC to agree mutually acceptable, and evidence based, definitions of the different levels of contacts. We have also worked with them in re-configuring aspects of their living arrangements (such as restricting choice of bathroom) so as to reduce the number of automatic Level 1 contacts to a manageable level.

We have trained 40 people as contact tracers at the KEMH (including two policemen), and MPC have trained 10. For each of us this represents 0.1% of our population compared to 21,000 contact tracers for 67 million people in the UK (0.03%). All of our contact tracers (except the two policemen) are people who are familiar with accessing the EMIS medical record system and all have signed up to the KEMH confidentiality policy. This means that we will be easily able to identify any contacts about whom we should be specifically concerned, perhaps due to their age or underlying health conditions.

There is resilience built into the system due to the numbers of individuals being trained and the provision of hot and cool teams. There will always be an experienced clinician available to give advice as needed.

However if we develop a widespread outbreak then contact tracing will cease, as it will no longer be a useful tool in the management of the situation as everyone will be a contact of someone. If this is the case, it will be reintroduced as appropriate, once the outbreak is past its peak and getting back under control. Contact tracing is used as a tool on the way up the curve and on the way back down again, but not during the peak.

SARS-CoV-2 surveillance swabbing plans

It is clear that surveillance swabbing, used to hunt down and detect latent cases of COVID-19, is a new subject and only a handful of countries are starting to get into a position whereby they are rolling out their programmes for surveillance, and as such there are no hard and fast rules around how to proceed. Unfortunately, until now most countries have been swamped with managing suspect cases or have limited testing capacity.

The ability to undertake surveillance swabbing is driven by what the resource availability is in that country/territory. In the Falklands we are fortunate in that we have a small population and good resources to support a robust surveillance plan.

As mentioned, the aim of surveillance swabbing is to try and detect latent disease within the community, and isolate those infected quickly, including their contacts. It is well known and well documented that the SARS-CoV-2 virus can remain in a community, undetected and being spread, for a considerable period of time via asymptomatic viral shedding. This is particularly seen in groups of young, healthy individuals. Surveillance swabbing is an addition to the priority of testing patients with symptoms and their contacts. According to Public Health England (PHE) there are rough estimates of a third of cases being asymptomatic but there is some uncertainty around this and it could well be higher.

Following discussions with PHE it has been agreed that we will undertake surveillance swabbing across our two main communities, Mount Pleasant Complex and Stanley. We will aim to swab 10% of the population every two weeks which would equate to approx. 130 people at MPC (presumed population 1300) and 275 people in Stanley (population approx. 2750). This will give us repeated snapshots of the prevalence in the general population.

The numbers of people being swabbed will be flexible. If we see new disease outbreaks the surveillance sample size will be increased every two weeks, and if we return consistently negative results the sample size will be reduced gradually. It is intended that for the first 8 weeks 10% of the population will be sampled every two weeks, then, if results are negative, this will reduce to 5% every two weeks for the next 8 weeks, and finally there will be an ongoing surveillance plan of 5% of the population every month which will continue indefinitely.

There will be two arms to the surveillance swabbing plan. The first arm will focus on swabbing people who have 'high contact' jobs, e.g. health care workers (who will be swabbed most frequently and regularly), customs and immigrations staff, FIGAS pilots, police, teachers etc. Initially we will start our surveillance swabbing within these groups. Heads of departments and managers of private businesses will be contacted and asked to identify 10% of their working groups every two weeks for swabbing. The swabbing will be organised and times given for people to attend for swabbing. This will likely be as a 'drive-by' swabbing arrangement.

The second arm of the surveillance swabbing will focus on a random cross-section of the community. This will be started by identifying people who are attending the KEMH for non-COVID related issues, be that to see the GP or to collect their prescriptions, and in time will move towards 'mobile clinics' where clinical staff will set up a swabbing station (e.g. in a car park or shop porch) and offer swabbing to anyone who is keen to have one done.

Other groups of people, who might not go out much or who live outside the Stanley or MPC, will be captured by offering swabbing through the Community Support team, or during GP visits to Camp. The surveillance plan will be publicised and once it is up and running people can contact the KEMH if they want to be swabbed.

It must be recognised that surveillance swabbing is a voluntary process and consent will be taken from every person who is swabbed.

In summary

The ongoing swabbing, isolating, contact tracing and surveillance testing will continue and will centre on the following assumptions:

· **Importance of continuing to swab any symptomatic people** – anyone who has even mild symptoms will continue to be encouraged to contact the KEMH and report their symptoms. A low threshold for swabbing should be undertaken – i.e. even very mildly symptomatic people should be swabbed and isolated until a result is known.

· **Importance of continuing to recognise and isolate contacts of symptomatic people** – (in line with our guidance already produced). During the surveillance period, it is important to try and contact trace others who have come into contact with symptomatic individuals. All level one contacts (as listed in our contact tracing documents) should be swabbed and isolated until the results of the symptomatic person are known. Any high-risk contacts (be they level two or three contacts) should also be swabbed and isolated. All other contacts should be swabbed. Information gathering and clear documentation of contacts should be held - this can be a useful way of recognising "cool" contacts.

· **Recognition and surveillance swabbing of high risk professions** – understanding which professions are recognised as being at higher risk of contracting COVID-19, e.g. healthcare workers due to their increased exposure to the disease, or teachers due to their job meaning they often work at close proximity to lots of others. All health care workers should be swabbed frequently and regularly.

· **Random central surveillance** –There are various approaches to undertaking random surveillance across communities (mixed random samples or longitudinal surveillance) however in the Falklands random swabbing of a selection of asymptomatic patients who present across all health care settings is considered the best way to undertake this. This random collection of swabs from asymptomatic individuals will be rolled out across different work spaces/places as well, to try and get a true cross-section of society.

· **Using the term 'COVID-free' should be avoided** – even if all swabs are consistently returned negative, whilst there is still COVID active all around the world and in the countries we have links with, regular surveillance swabbing, social distancing advice, and hygiene advice must be maintained, until such time as a vaccine is in place and available, or better treatments are in place to treat COVID-19.

• **Be flexible in the approach to surveillance swabbing and testing** – not only as new information is shared and the science develops, but also when considering the community approach – i.e. a swift response from the community is essential to contain the spread of a

random outbreak. The population must be ready to step back up to more robust isolation and social distancing protocols very quickly. This is essential to help contain spread of disease, particularly when detected incidentally through surveillance testing.