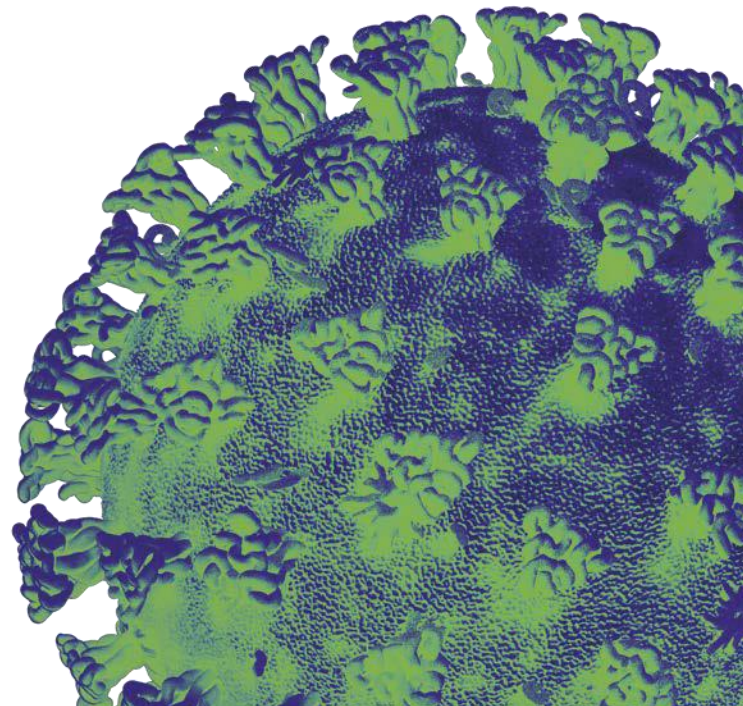
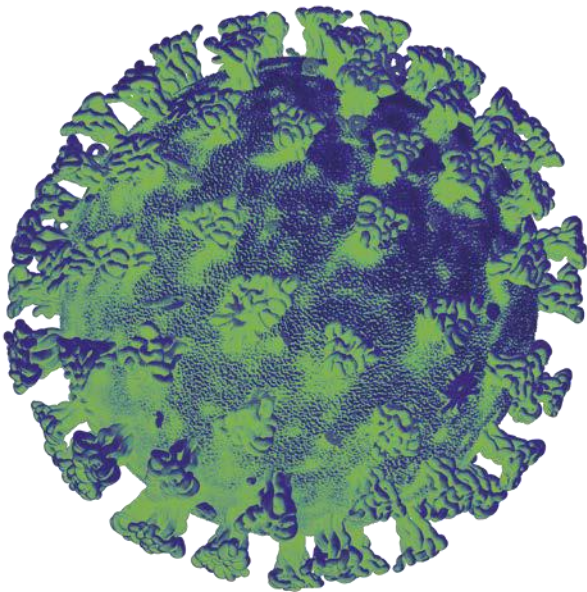
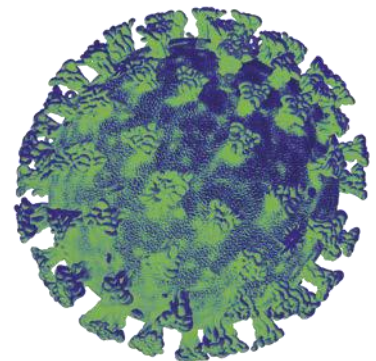




Advice from the Technical Advisory Cell and Chief Scientific Advisory for Health: 21-Day Review

4 February 2022



This advice has been drafted based on the available evidence at the time of writing and has been assembled in order to support policy colleagues and Welsh ministers. The purpose of scientific advice is to provide an overview of what we know from scientific and technical investigations, what we can infer indirectly from the evidence base or by a consensus of expert opinion. This is advice, not Welsh Government policy.

Summary

- Taking into account the current levels of direct and indirect harms from COVID-19 and the COVID-19 regulations in Wales, it would seem reasonable to continue the easing of protective measures in Wales.
- Recent surveillance data suggested the Omicron wave was receding; however the most recent data from the ONS COVID-19 Infection Survey suggests a potential secondary rise, as does the UCL Zoe symptom tracker and wastewater data.
- It was expected that an increase in infection rates would occur as protective measures were relaxed and schools returned.
- Omicron has reinforced our understanding of how a new variant can take hold quickly. The emergence of new variants in the future is the dominant driver of the medium to long term endemicity of COVID-19. It is not possible to [accurately] predict how a future variant may present in terms of severity, growth advantage or how it might interact with the immune landscape and, thus how many waves of infections, hospitalisations or deaths may result.
- A sublineage of Omicron, BA.2, is likely to become the dominant variant in the UK in the near future, although there are not yet enough data to assess the variant's impact on infection severity.
- Survey data suggest no obvious waning in adherence to protective measures in Wales, although this will be monitored in the coming weeks with the move back to alert level 0 (and removal of Plan B measures in England).

1. Wales situation

- The latest fortnightly COVID-19 Situational Report dated 2 February 2022, containing the most recent data on epidemiological surveillance, NHS status, wastewater monitoring, education and children, international travel, mobility, vaccination and population immunity and forward projections for Wales is available [here](#).
- Case data from recent COVID-19 episodes suggests an increase across Wales, following a rapid decline from the recent peak. With the return to alert level 0 and move towards easement of protective measures, there is a need to continue monitoring surveillance trends.
- The ONS estimates the percentage of people testing positive for COVID-19 increased in the week ending 29 January 2022; during this time 139,000

people in Wales had COVID-19. This equates to 4.57% of the population who had COVID-19 or around 1 in 20 people.

- Data from the ZOE COVID Study suggests that COVID-19 cases have increased by 22% in the UK in the most recent week, to 195,069 new daily symptomatic cases in the UK on average, based on PCR and LFT test data from up to three days ago. The study also estimates R_t may currently be 1.1 in Wales.¹
- At a national level, data from wastewater samples collected up to 28 January 2022 show the normalised SARS-CoV-2 wastewater signal has stopped falling, and may be entering a period of stable oscillation. In South Wales, the wastewater signal is showing a slight uptick, following several weeks of consistent decreases. The uptick coincides with a small increase in reported COVID-19 cases in the region.
- Non-COVID-19 urgent & emergency pressures continue to result in high levels of hospital bed occupancy and escalation across hospital sites. The onset of Omicron has seen a significant increase in COVID-19 related patients occupying a hospital bed with 1,100 occupying a hospital bed on 1 February. In contrast to previous waves, the number of 'incidental' cases has increased significantly, with current operational data indicating that only 30% of these patients actively require treatment for COVID-19. Omicron has also increased the staffing challenge across the health and care system, with staff sickness absence rates currently approximately 2.5%, solely a result of COVID-19 and isolation, while medically fit for discharge patients remain a challenge, with nearly 1,000 still occupying a secondary care hospital bed. These factors continue to constrain flow through the whole health and care system resulting in extended waits for: ambulance in the community and in emergency departments.
- There is the potential for significant harm in the community (and our hospitals) for people with non-COVID-19 illnesses or injuries. Omicron levels have led to health boards having to postpone significant levels of routine elective activity in early 2022, which may exceed the direct harm from COVID-19 at this point in time.
- As at 26 January 2022, PHW reports the 7 day rolling sum of COVID-19 deaths have decreased to 41, a decrease of 36 since the previous 7 day period (19 January).
- According to the ONS the number of deaths registered in Wales in the week ending 7 January 2022 (Week 1) was 776; this was 217 more deaths than the previous week (Week 52 2021) and 8.9% below the five-year average (76 fewer deaths).
- The UKHSA consensus estimate of the reproduction number (R_t) for Wales is between 0.9 and 1.1 with a doubling time of 35 to 24 days to flat (as at 3 February 2022). PHW's R_t estimate is 1, with a halving time of 32.5 days (02 February 2022).

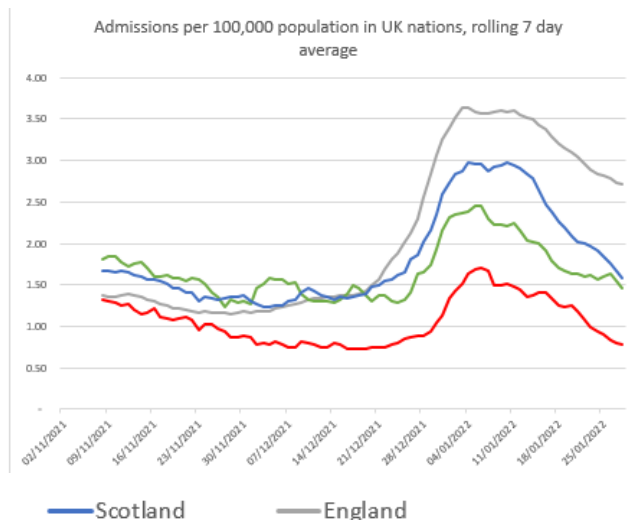
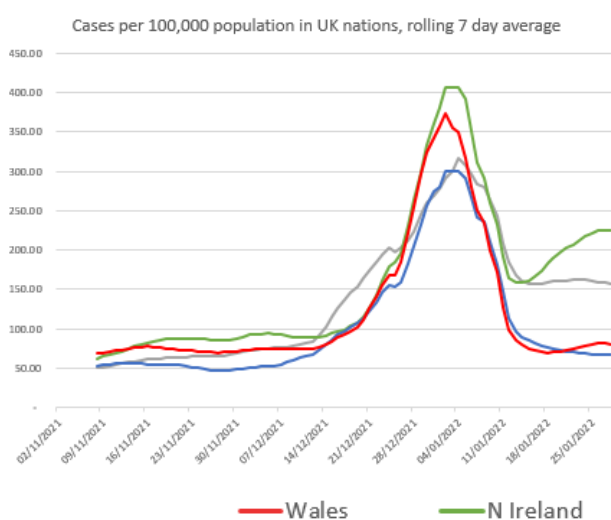
¹ [UK back to 200,000 a day \(joinzoe.com\)](https://joinzoe.com)

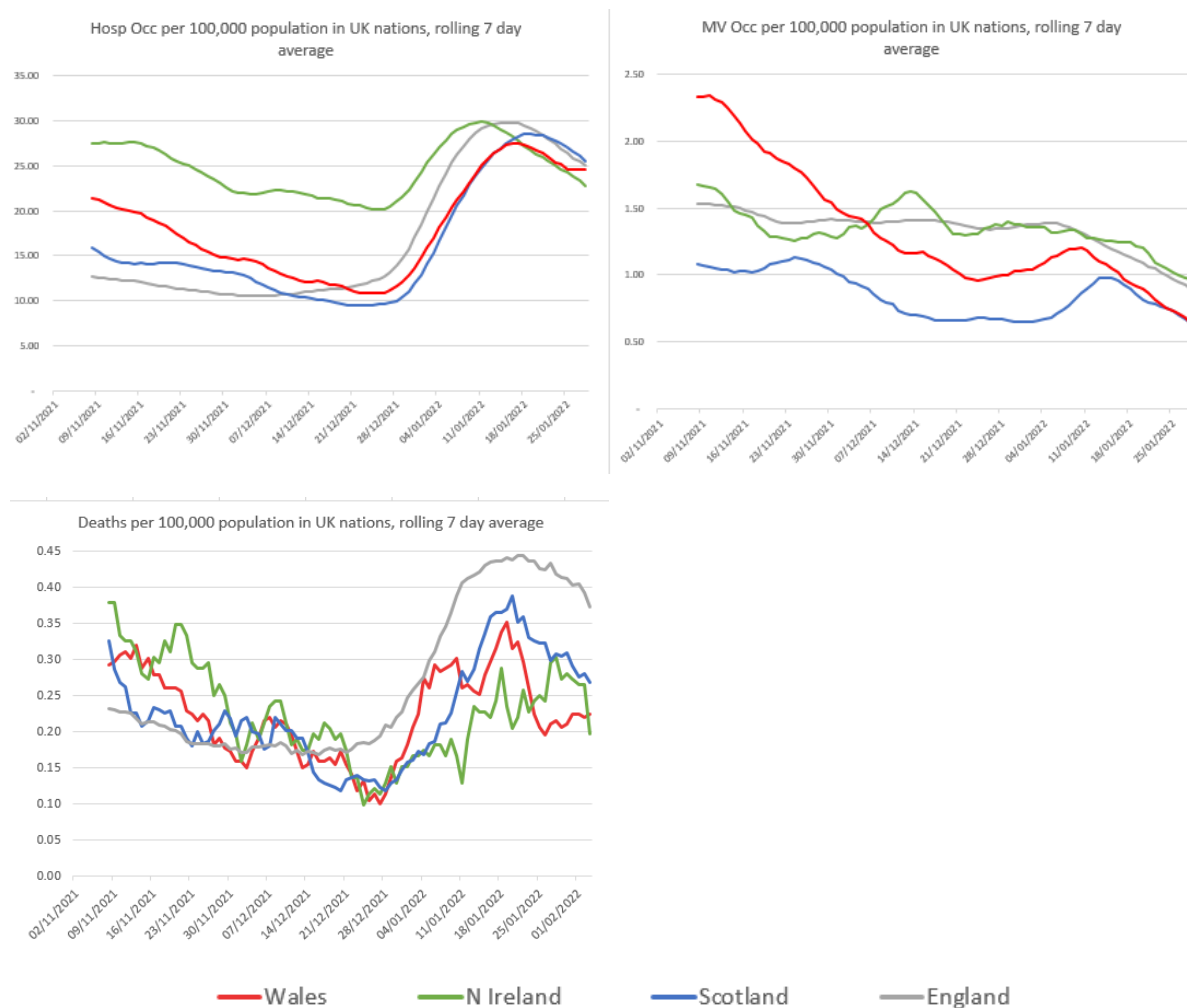
- As at 25 January 2022, Wales has had 49,020 (+12,344 compared to previous week) confirmed cases of the Omicron variant, 91,008 (+45) confirmed cases of Delta and 14,967 (+37) confirmed cases of confirmed cases of AY4.2 VUI-21OCT-01. No other variants of concern were confirmed by genomic sequencing in Wales.

2. Situation in the UK and comparator regions

UK Overview

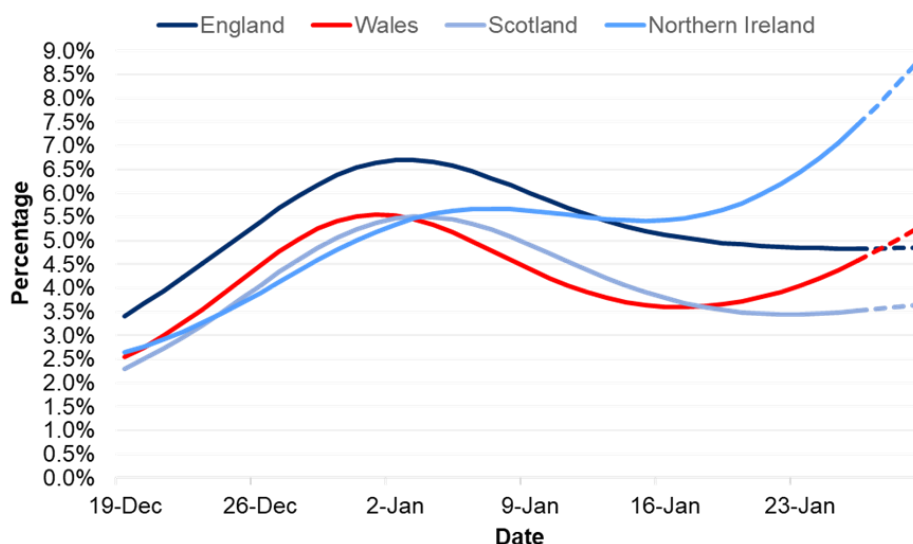
- As at 28 January weekly case rates per 100,000 population appear to be stable in all UK nations, although cases may be increasing in younger age groups.
- The number of COVID-19 patients admitted to hospital is decreasing in all four nations. Hospital occupancy is decreasing in England, Scotland and Northern Ireland and stable in Wales. Mechanical ventilated bed occupancy is decreasing in all four nations and admissions to ICU due to COVID-19 continue to be lower than previous waves as a proportion of hospital cases.
- Death rates appear to be decreasing in England and Scotland, stable in Wales and rising in Northern Ireland.
- Vaccine rollout has slowed following the increase over the festive period but continues across the four nations, with booster dose coverage for the population aged 12 and over as at 1 February at 65% for England, 59% for Northern Ireland, 69% for Scotland and 69% for Wales. Second dose coverage is at 84% for England, 82% for Northern Ireland, 86% for Scotland and 86% for Wales.





Data source: [UK Summary | Coronavirus \(COVID-19\) in the UK \(data.gov.uk\)](https://data.gov.uk/dataset/coronavirus-covid-19-in-the-uk)

- The ONS headline estimates of the percentage of the community population in the UK nations testing positive for the coronavirus (COVID-19) for the week ending 28 January 2022 are provided below. Only private households are included in the sample, with residents in care homes, communal establishments and hospitals not included.
- In Wales, the percentage of people testing positive for COVID-19 increased in the week ending 29 January 2022; it is estimated that 139,000 people in Wales had COVID-19 (95% credible interval: 119,800 to 159,300). As noted above, this equates to 4.57% of the population who had COVID-19 (95% credible interval: 3.94% to 5.24%) or around 1 in 20 people (95% credible interval: 1 in 25 to 1 in 20). This compares to 1 in 20 people in England, 1 in 15 in Northern Ireland and 1 in 30 people in Scotland.



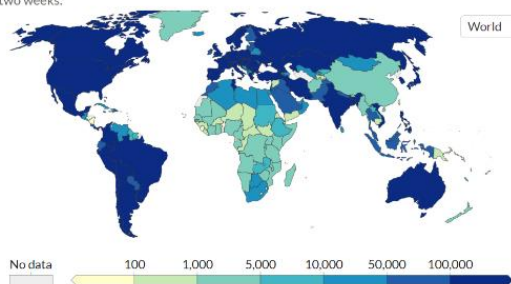
Source: [COVID-19 Infection Survey, ONS, 02/02/22](#)

3. International overview

- Overall, weekly confirmed COVID-19 cases appear to have peaked as at 24 January, although cases continue to grow in many geographic areas. The most recent wave was due almost exclusively to Omicron, which has outcompeted the now declining Delta variant and there is a very low or non-existent level of circulation of other variants.

Biweekly confirmed COVID-19 cases, Jan 29, 2022

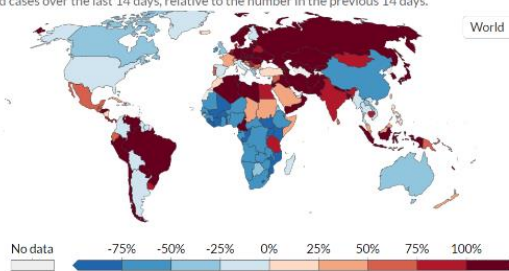
Biweekly confirmed cases refer to the cumulative number of confirmed cases over the previous two weeks.



Source: Johns Hopkins University CSSE COVID-19 Data - Last updated 2 February, 08:04 (London time)
OurWorldInData.org/coronavirus • CC BY

Biweekly change in confirmed COVID-19 cases, Jan 29, 2022

The biweekly growth rate on any given date measures the percentage change in the number of new confirmed cases over the last 14 days, relative to the number in the previous 14 days.



Source: Johns Hopkins University CSSE COVID-19 Data - Last updated 2 February, 08:04 (London time)
OurWorldInData.org/coronavirus • CC BY

- Despite this, there appears to be a lower risk of severe disease and death following Omicron infection compared with other variants. However, due to the very high numbers of cases, many countries have seen a significant increase in the incidence of hospitalisation, putting pressure on healthcare systems. Death rates lag cases and continue to increase, with 131,000 deaths in the most recent two week period. While vaccination and booster programmes continue in the wealthier countries, approximately three billion people still have not received a single dose to date in the developing countries. Overall, however, the high level of vaccination coverage or naturally acquired immunity (by previous infection) has had a major effect on reducing the death rate and the cases/death ratio.

Source: [Coronavirus Pandemic \(COVID-19\) - Our World in Data](#)

- Omicron has several sub lineages but BA.1 accounts for 98.8% of sequences submitted to GISAID as of 25 January 2022, although a number of countries have reported recent increases in the proportion of BA.2 sequences. The UK (3.5%), Denmark (60%), India (70%), Singapore (55%) and the Philippines (70%) are all experiencing increasing percentages of the BA.2 variant. The US detected just a few cases (<1%). The WHO has asked officials to investigate the BA.2 variant to determine its risk factors, including immune escape properties and virulence.
- In Denmark, BA.2 has rapidly taken over from BA.1, likely due to an advantage in transmission and a higher secondary attack rate. This has resulted in the highest incidence to date. Nevertheless, all protective measures have recently been lifted, despite increasing COVID-19 cases, hospitalisations and to a lesser extent deaths, although ICU admissions are falling. This appears to be with the support of the majority of the Danish public, with less than three in 10 (28%) reporting they do not feel comfortable with the measures being abolished². An advisor to the Danish government has suggested this can be attributed to high public trust in vaccines and authorities and the weakened link between infection and severity. There is also evidence of a continued motivation to take precautions by helping those at risk, with intention to keep distance from the elderly and those at risk remaining high among the Danish population³.
- Similarly, a paper recently published in the Lancet⁴ suggests efforts to build public trust is something that a government can prepare for and earn in a crisis, and doing so may be crucial to mount a more effective response to future pandemic threats.

4. Omicron Variant of Concern – BA.2 (VUI-22JAN-01) sub-lineage Update

- BA.2 is a sister lineage to BA.1, the dominant version of the Omicron variant in the UK, although both lineages are defined as the Omicron variant. The majority of globally sequenced Omicron cases have been BA.1, although BA.2 appears to be growing in a number of countries with plausible evidence of higher secondary attack rates but limited apparent immune evasion relative to BA.1.
- PHW analysis has confirmed 94 sequenced BA.2 cases in Wales as at 2 February, with the earliest case on 30th December. There are currently 30 cases in Cardiff and Vale, 14 in Aneurin Bevan, 11 in Cwm Taf Morgannwg, 18 in Hywel Dda, 10 Swansea Bay, 9 Betsi Cadwaladr and 2 Powys. The median age of BA.2 cases in Wales is 32 years old (range 5 – 82 years old).

² [Not everyone is comfortable with the reopening - it's a bit of an experiment, says Professor - TV 2](#)

³ https://twitter.com/M_B_Petersen/status/1488392005281628160?s=20&t=--YNfwSdjaZsVN91z3mipQ

⁴ [Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021 - The Lancet](#)

- A PHW analysis dated 28 January reports that for those BA.2 cases for whom vaccine status is available (37/47), 7 cases were unvaccinated (6/7 are under 20 years old, 1 case is 20-25 years old), 3 cases had 1 dose, 8 cases had 2 doses and 19 cases had a booster. Only one individual has been hospitalised; a 5-9 year old child who was discharged the day after admission.
- UKHSA has published an updated risk assessment for BA.2, with a Red RAG rating given to growth advantage and transmissibility and an amber status for immune evasion, although this is with medium/low confidence. There is not enough data to assess the variant's impact on infection severity.
- UKHSA estimates of vaccine effectiveness against symptomatic disease for BA.2 relative to BA.1⁵ suggest vaccine effectiveness is higher for BA.2. 25 weeks after a second dose (unboosted) vaccine effectiveness is at 9% (7-10%) and 13% (26-40%) respectively for BA.1 and BA.2. 2 weeks after a booster dose this is increased to 63% (63-64%) for BA.1 and 70% (58-79%) for BA.2, although confidence intervals for BA.2 are wide due to limited numbers.
- Data from Denmark may support this finding, showing higher transmission from unvaccinated primary cases in BA.2 households, while this pattern of increased transmission has not been observed for vaccinated and primary cases.
- Overall this suggests that BA.2 is likely to become the dominant UK strain in the near future. It is unclear whether this will result in another wave of infections or a stabilisation of cases at current levels, however the high levels of population immunity following the recent Omicron wave, along with increased booster uptake and no evidence of increased immune evasion for BA.2, mean that trends are likely to diverge from previous Omicron waves.

5. Swansea University COVID-19 Modelling

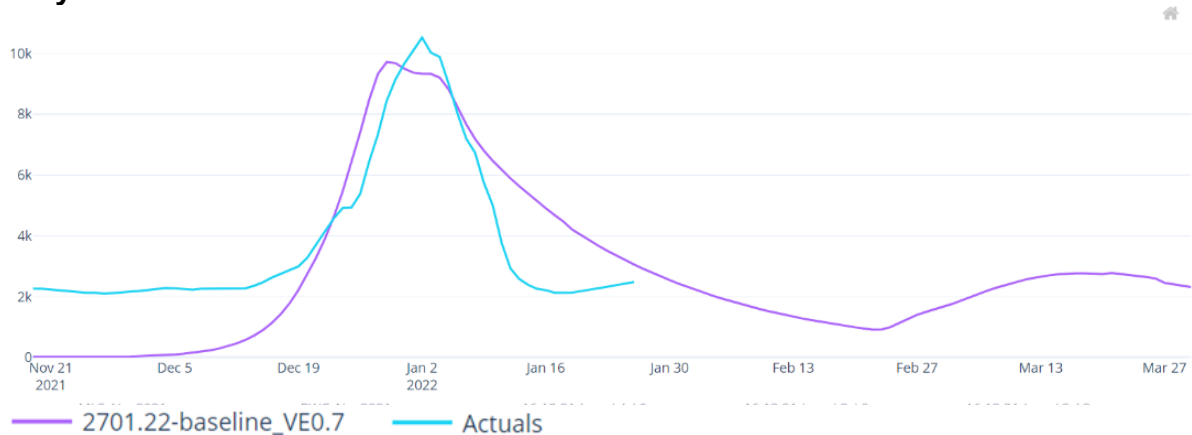
- Modelling from Swansea University was updated on 27 January 2022 to fit to initial omicron Rt rise more closely, faster booster rollout, and most recently to fit to the ONS prevalence data dated 26 January 2022 (since the testing policy change affects the PCR case data previously fitted to).
- The model is a new Omicron model and the model results on the charts start and end at zero, but in reality cases will not go back down to zero. Model scenarios are only likely to be robust for the next three weeks and are being continuously refined. Models are fitted to mid-vaccine efficacy scenarios (70% vaccine efficacy against infection). Models assume alert level 2 restrictions for four weeks from 26 December 2021, followed by a return to alert level 0.
- Overall, current models and data suggest the Omicron wave will recede in the short-term. However, there may be an increase as restrictions are released and as cases in school-aged children increase. Modelled scenarios will be

⁵ [COVID-19 vaccine surveillance report - week 4 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/103422/covid-19-vaccine-surveillance-report-week-4.pdf)

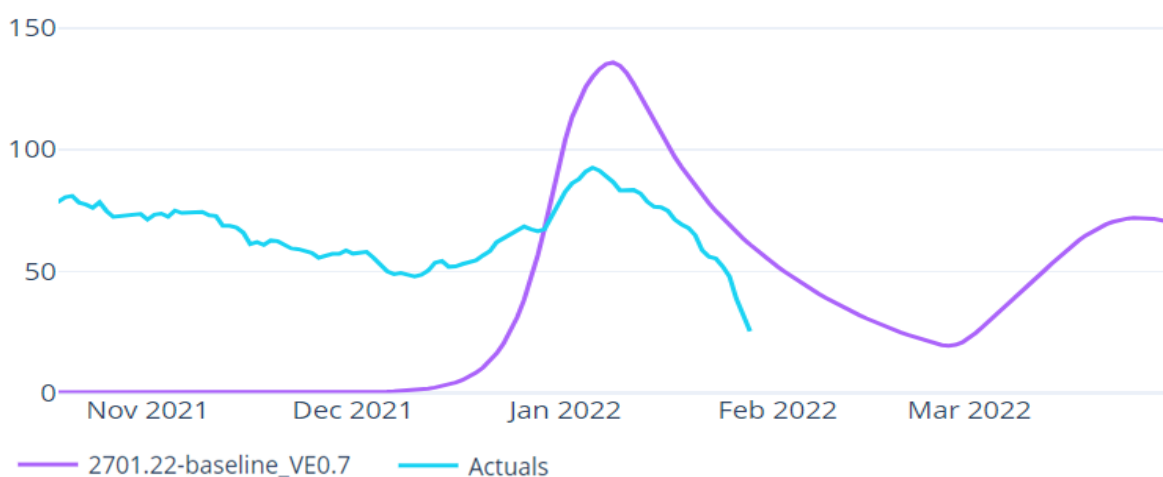
updated to take into account current trends and this may change future outputs.

- The ONS COVID-19 Infection Survey dated 28 January estimates around 4.57% prevalence for Wales, an increase from the previous week. Wales did not see the prevalence levels of other parts of the UK that have peaked, with London and North West England peaking at around 10%, so may still have a large number of susceptible individuals left. There is uncertainty over how many more people are susceptible to infection in the Omicron wave, with the historical timings of infection, reinfection and vaccination being very complex across the population.
- There will be a need to try to quantify the additional harms that have happened in the omicron wave in terms of Long Covid and other sequelae of infection.

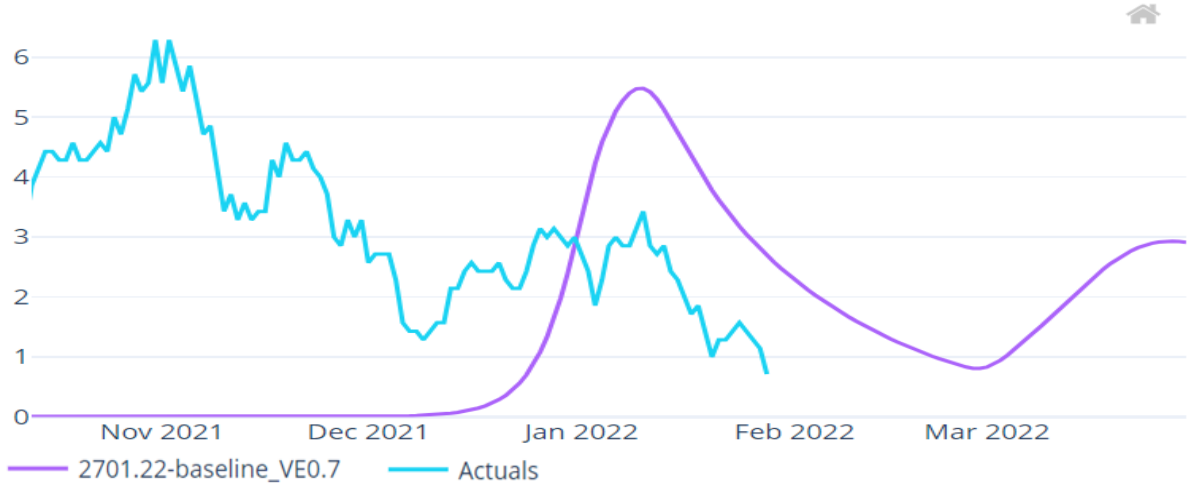
Daily COVID-19 cases



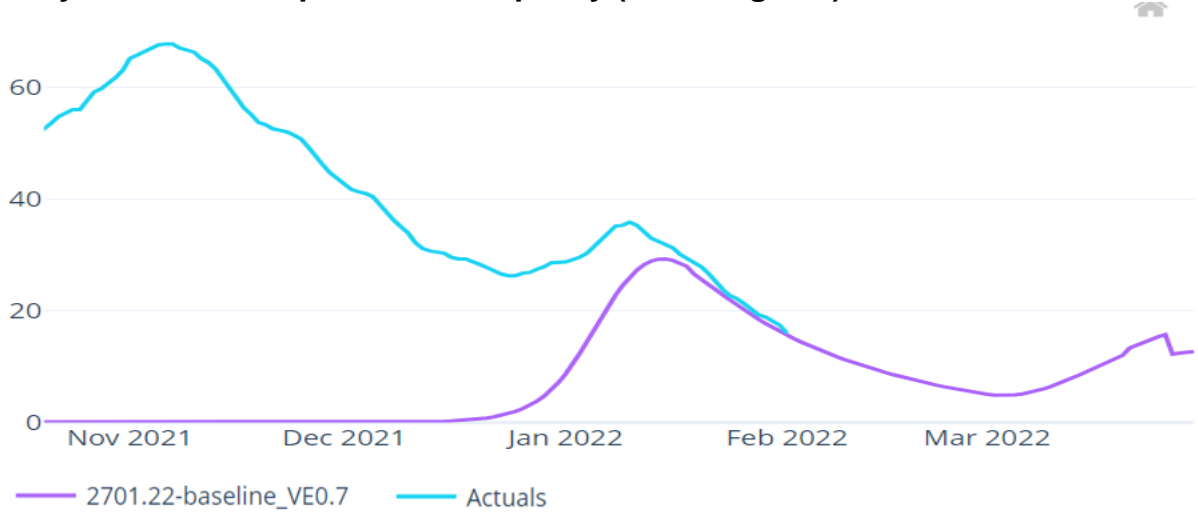
Daily COVID-19 hospital admissions (Including ICU admissions)



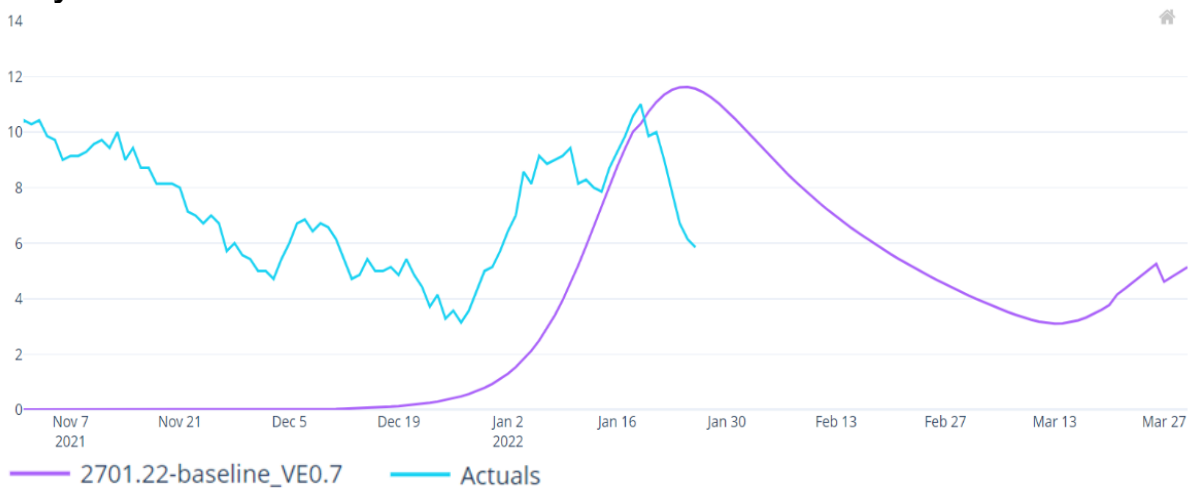
Daily COVID-19 ICU admissions



Daily COVID-19 hospital bed occupancy (Including ICU)



Daily COVID-19 deaths



6. Advice on Non-Pharmaceutical Interventions (NPIs)

- TAC have been asked to consider a move to the phased removal of COVID-19 protective measures in Wales and the impact on cases and hospitalisations. When considering the ordering of the removal of baseline measures, it is important to consider the public health risks, benefits and uncertainties.
- Early evidence searches from work conducted as part of the Wales COVID-19 Evidence Centre work programme⁶ highlight the following two studies which model the impact of different NPIs on Rt, chosen here because they include data from the second wave as opposed to the first. It is important to note these studies do not consider data from an Omicron context:
 - Estimates of the effectiveness of government interventions in Europe ([Sharma et al, 2021](#)) suggest that business closures, educational institution closures, and gathering bans reduced COVID-19 transmission, but by less in the second wave than they did in the first wave. The authors suggest this difference is likely due to organisational safety measures and individual protective behaviours, such as distancing, which made various areas of public life safer and thereby reduced the effect of the closures and gathering bans. Specifically, smaller effects on transmission were found for closing educational institutions, suggesting stringent safety measures made schools safer in the second wave compared to the first wave.
 - A modelling study ([Laydon et al, 2021](#)) using evidence from July to November 2020, suggests that interventions at least as stringent as Tier 3 in England (which included but were not limited to no indoor mixing, closure of hospitality settings and working from home, but schools open) are required to suppress transmission. This is especially important considering more transmissible variants, and at least until effective vaccination is widespread or much greater population immunity has amassed.
- Estimates of the impact of different NPIs on hospitalisations per se is limited, but it is reasonable to assume that a reduction in Rt would also bring about a reduction in hospitalisations. However, this association will be weaker as a result of the ratio of cases to hospitalisations being lower with the combination of high booster uptake, high cumulative infections, and Omicron being less severe on average than Delta. The early indications the growing Omicron sublineage BA.2 evades immunity to a lesser extent than the currently dominant BA.1 should also be considered.
- Below is brief advice on the current protective measures at Alert level 0. Note previous advice is not repeated here.

⁶ Early evidence searches to inform “Modelling studies used to evaluate the effect of population-level non-pharmaceutical interventions (NPIs) on the Reproduction number of COVID-19: Rapid Evidence Summary”, Health Technology Wales, January 2022, full report to be published here: [Wales COVID-19 Evidence Centre | Health Care Research Wales \(healthandcareresearchwales.org\)](https://healthandcareresearchwales.org/)

Risk assessments for businesses, employers and other organisations

- As discussed previously by SAGE, baseline measures should aim to do the following:
 - Reduce the likelihood that people who are infectious are mixing with others in the population.
 - For those potentially infectious people who are not isolated, reduce the likelihood that they enter higher risk settings or situations.
 - Decrease the transmission risk from an infectious person in any given environment.
- Risk Assessments by themselves will not reduce the risk of transmission. This is because their effectiveness depends on whether or not appropriate actions are taken as result of assessing the risk.
- In terms of reducing the risk of transmission, physical distancing remains beneficial, with short range inhalation of infected aerosols likely to be the highest risk for exposure in many settings. However, distancing on its own may not be not enough, particularly in poorly ventilated spaces⁷.

Self-isolation

- Self-isolation for the general population is a balance between risk from the release and thereby mixing of infectious individuals, versus socio-economic risks from exclusion of individuals from society. Isolation, particularly on the basis of symptoms or following a positive test, but also when identified as a contact, is an important way to reduce onwards transmission. The benefits of providing financial and other support for isolation are substantial. However, the balance of harms has shifted with the rise of Omicron, for which there is considerable evidence of reduced risk of hospitalisation or death compared to previous waves.
- One study estimating the effectiveness of the implementation of different NPIs in 190 countries (note first wave only), found mandatory isolation to be associated with a reduction of 11.40% (95% confidence interval, 13.66% to 9.07%) in the Rt of Covid-19, when compared to sites without implementation⁸. Note this study had a number of limitations such as not being able to account for the intensity of enforcement and people's adherence, which varied between countries
- Another study from September 2021 suggested switching from isolation at home to daily contact testing, at least in the school setting studied, kept rates of symptomatic COVID-19 in students and staff at similar levels. Daily contact testing may therefore be a safe alternative to home isolation and could be

⁷ [EMG and SPI-B: Non-Pharmaceutical Interventions \(NPIs\) in the context of Omicron, 15 December 2021 - GOV.UK \(www.gov.uk\)](#)

⁸ [Effectiveness of non-pharmaceutical interventions on COVID-19 transmission in 190 countries from 23 January to 13 April 2020 - International Journal of Infectious Diseases \(ijidonline.com\)](#)

considered an alternative to routine isolation of close contacts following school-based exposures.⁹

- The Technical Advisory Group recently published a summary of evidence to support a reduction in the self-isolation period for positive cases in Wales to a minimum of five full days, with cases strongly advised to take two consecutive lateral flow tests on days 5 and 6 to check that they are not still infectious. This drew on analyses from PHW, UKHSA and NERVTAG¹⁰, concluding the risks from release of infectious individuals on day 6, supported by consecutive use of LFTs, is similar or reduced when compared to isolation for 10 days.
- These analyses had a number of caveats, in particular that a shorter isolation period would result in a greater risk of individuals being released to infect others (higher if consecutive LFTs are not undertaken properly, resulting in potentially infectious individuals ending isolation prematurely). As a result, some caution is recommended in the period immediately following release from isolation and a gradual return to mixing behaviours following release from isolation would be considered sensible.
- The acceptability of this approach was also strongly linked with the observed reduction in severity of Omicron, and the balance of harms may change if there is a negative step-change in the severity of COVID-19 or reduction in vaccine effectiveness against severe outcomes. This clear rationale for the policy change should continue to be communicated to the public, with a focus on the balance of harms and a move to the population taking more control over their decisions, with system-level support. Preliminary evidence around the Omicron sublineage BA.2 to date suggests that it is no more likely to cause severe illness than BA.1, although it may be 50% more transmissible. This could still mean an increase in hospitalisations due to a higher number of total cases, although this may be offset by BA.2's reduced vaccine escape compared to BA.1. More data will be required until this can be stated with confidence.

Face Coverings

- Previous advice remains unchanged, with evidence reviews continuing to find evidence for the effectiveness of face coverings in reducing transmission in community settings (e.g. [UKHSA review](#), [CEC review](#)).
- There is some evidence on the effectiveness of face coverings on Rt. According to one modelling study¹¹, the introduction of policies requiring mask-wearing in most or all shared/public spaces reduced transmission by 12% [95% CI: 7–17%]. However, it is worth noting before the start of the second infection wave, countries in the examined dataset had less stringent

⁹ [Daily testing for contacts of individuals with SARS-CoV-2 infection and attendance and SARS-CoV-2 transmission in English secondary schools and colleges: an open-label, cluster-randomised trial - The Lancet](#)

¹⁰ [technical-advisory-group-reduction-in-isolation-period-supported-by-LFT-for-cases-of-COVID-19.pdf \(gov.wales\)](#)

¹¹ [On secondary atomization and blockage of surrogate cough droplets in single- and multilayer face masks \(science.org\)](#)

policies that required mask-wearing only in select public spaces. Therefore, the estimated effectiveness of this NPI is the additional benefit of a stricter policy. In addition, when estimating the effectiveness of the implementation of different NPIs in 190 countries (note first wave only), the mandatory wearing of face masks was found to be associated with a change of -15.14% (from -21.79% to -7.93%) in the Rt of COVID-19, when compared to sites without implementation. However, it is important to note neither of these estimates are relevant to the Omicron context.

- Correctly worn surgical masks can reduce the emission of viral particles from an infected individual (source control)^{12,13} but there is little evidence about the efficacy of face masks in different settings¹⁴ such as hospitality, public transport or education.
- As noted in earlier advice¹⁵ (13 January 2022), recent research (not yet independently reviewed) indicates that the infectivity of the virus in an aerosol declines after 20 minutes, and the greatest risk of infection is in small and medium-sized groups of 10 to 50 individuals (such as in a classroom, bus, small restaurant or small shop). Some indoor activities occur around outdoor events, such as travelling by public transport or congregating in pubs.
- The CMO recommends retaining mandatory face coverings on public transport and in retail settings until the arrival of spring weather and the possibility of a late flu or respiratory syncytial virus (RSV) season recedes. The risk of infection on public transport comes from exposure to exhaled infectious breath rather than contaminated surfaces, highlighting the role of face coverings¹⁶. Social distancing and ventilation in higher-risk indoor environments provide more benefit than wearing a face mask¹⁷ but it can be difficult for passengers and shoppers to maintain social distancing or ensure adequate ventilation in their surroundings. It is important to note the definition and implementation of NPIs differs across studies and it is difficult to identify nuance around whether implementation was a legal requirement or guidance.

Covid passes

¹² [Wales COVID-19 Evidence Centre Rapid Review, Face coverings to reduce transmission of SARS-CoV- 2, July 2021](#)

¹³ [Infrared-based visualization of exhalation flows while wearing protective face mask, Physics of Fluids \(scitation.org\)](#)

¹⁴ [Wales COVID-19 Evidence Centre Rapid Evidence Summary, Barriers and facilitators to the uptake of personal protective behaviours in public settings, Jan 2022](#)

¹⁵ [Advice from the Technical Advisory Cell and Chief Scientific Advisor for Health: 21 day review: 13 January 2022 | GOV.WALES](#)

¹⁶ [Tracing surface and airborne SARS-CoV-2 RNA inside public buses and subway trains - ScienceDirect](#)

¹⁷ [Speech air flow with and without face masks | Scientific Reports \(nature.com\)](#)

- As advised previously^{18,19}, there remains a high degree of uncertainty around the effectiveness of the COVID Pass in reducing infections given the absence of robust evaluation of these interventions. This will remain a challenge when attempting to attribute change to a single intervention operating alongside several other measures. In general, wherever people mix and are close to each other for a period of time, there is a risk of transmission. This risk is increased in closed, confined and crowded environments.
- While applying COVID Passes alongside other protective measures has the potential to reduce the number of infectious people in the relevant settings, there remains limited peer-reviewed published evidence to demonstrate this. There are some studies²⁰ to suggest an impact on vaccine uptake; however this is closely correlated with countries' levels of vaccine uptake prior to the intervention being implemented, with the greatest impact in those with lower vaccine uptake and limited impact where uptake is already high. However, several reviews suggest that COVID Passes have the potential for harm as well as benefit.
- Even if formal certification is not required, testing before attending any gathering or event (including at workplaces and schools) would be beneficial for reducing transmission, with isolation to follow if the test is positive. Attending multiple separate work or social events one after another may pose additional risk from the linking of otherwise separate networks.

7. Behavioural Considerations

- Recent evidence for Wales suggests a high degree of (self-reported) adherence to a range of protective measures. For example, [Ipsos MORI survey data](#) suggest three in four (76%) continue to report wearing a face covering, more than half (53%) report keeping their distance and seven in ten (68%) report regular hand washing. Furthermore, one in three (36%) report the use of lateral flow tests before meeting other people and of those in work, three in ten (28%) report working from home where feasible. As previously noted, trust in government is an important predictor of adherence to protective measures and two in three (66%) continue to report Welsh Government doing a good job in its handling of the pandemic. While these proportions may have declined slightly since the festive period in some instances, in line with the move back to alert level 0, the levels remain broadly consistent when compared with previous waves of data collection since autumn 2021.
- Recent data from Public Health Wales²¹ appear to support this narrative, with substantial proportions reporting to mostly adhere to protective measures in place (85%), that measures in place were about right (67%) and supporting the continued wearing of face coverings in shops and other indoor places

¹⁸ [Updated advice from the Technical Advisory Group and Chief Scientific Advisor for Health on the evidence for the use of COVID Passes | GOV.WALES](#)

¹⁹ [Technical Advisory Group: advice on vaccine passports | GOV.WALES](#)

²⁰ [technical-advisory-cell-summary-of-advice-21-january-2022.pdf \(gov.wales\)](#)

²¹ [How are you doing? - Public Health Wales Public Engagement Survey on Health and Wellbeing during Coronavirus Measures, Jan 22 \(nhs.wales\)](#)

(85%). [CoMix data](#) are also available, the most recent summary covering the period to the end of January 2022, suggesting the mean number of contacts reported by adults in the UK remained stable during December and January at just below three contacts per day, while use of face coverings remained high.

- Despite the phased return to alert level 0 in recent weeks in Wales and the signalling by UK Government that 'Plan B' protective measures would be relaxed in England on 27 January, the available data would not suggest a significant waning in adherence to protective measures. Furthermore, support for the current approach would appear to be at a consistent level. These indicators will be closely monitored in the coming weeks.
- Led by the Risk Communication and Behavioural insights sub-group, TAG is currently developing advice on the transition out of the pandemic. Previous advice on sustaining COVID safe behaviours remains highly relevant, including that [published by TAG](#) last summer to support the move to Alert Level 0. This advice will attempt to reflect the current level of uncertainty and be underpinned by an assumption that the transition towards endemicity is unlikely to be quick, predictable or harmless²².

²² [COVID-19: endemic doesn't mean harmless \(nature.com\)](#)