UK Health Security Agency

Public views on the acceptability of using institutions and other community venues to manage testing during a future pandemic

Final report

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Executive summary

Research aims and methodology

The UK Health Security Agency (UKHSA) commissioned Thinks Insight and Strategy (hereafter referred to as 'Thinks') to conduct research with the public to provide insight into the acceptability of using institutions, such as workplaces, schools and other community venues, as a way of managing testing during future pandemics.

Specifically, the research explored the following:

1. How does acceptability vary depending on the type of institution being used to deliver testing interventions?
2. How does acceptability vary depending on the pandemic scenario, from more to less severe, high to low transmission?
3. How does acceptability vary depending on how intrusive the intervention being delivered by the institution is, from more to less intrusive use cases?

To help answer these questions, UKHSA and Thinks developed 3 different use cases for how institutions could be used to manage testing in a future pandemic, ranging from more to less intrusive. Each use case was tested in the context of 3 pandemic scenarios. The scenarios differed along 2 measures: how transmissible the disease and the severity of symptoms. All scenarios were based on a respiratory infection.

The research approach included deliberative-style face-to-face workshops in 4 locations in England, and online mini-groups (small focus groups of up to 5 people). A total of 84 members of the public took part in the research, which was carried out between 6 and 21 March 2024.

The design of the research materials and the analysis of the data were informed by the Theoretical Framework of Acceptability (TFA).[1] The TFA is a model designed to assess the acceptability of health interventions by understanding which factors are most influential.

Key research findings

Expectations of testing in future pandemics

Experiences of the universal testing offer during the coronavirus (COVID-19) pandemic have set public expectations for how government will deliver testing during a future pandemic. These expectations are important to highlight, as they framed participants' views on the overall acceptability of the use of institutions in the pandemic scenarios explored in this research.

[1] Mandeep Sekhon, Martin Cartwright and Jill J. Francis (2012). 'Development of a theory-informed questionnaire to assess the acceptability of healthcare interventions'

Participants expect that, in a future pandemic, testing will be free of charge and easy for all to access. Most relevant for this research is the expectation that testing could be accessed locally via healthcare settings, such as pharmacies, and that other venues, such as community centres or schools, could be repurposed as test centres. Furthermore, the use of local institutions and community venues in delivering testing is felt to be convenient and aligned to expectations around ease of access.

This underlying expectation that institutions and community venues would be used in some way to deliver testing in a future pandemic, indicates a degree of latent support for the overall concept of using institutions to deliver testing, and underpins views around acceptability of the use cases and scenarios explored in this research.

How does acceptability vary depending on the type of institution being used to deliver testing?

This research found that, in general, the type of institution used to deliver testing is less important to acceptability than how that institution is being used and why.

Despite expressing some personal preferences about which venues they would use, most participants were ‘venue agnostic’. This is because delivering testing via a range of different venues was felt to be beneficial in terms of increasing access to testing for all, amplifying the overall effectiveness of testing as a public health intervention, even if individuals are not personally a user of a specific venue.

That said, 2 factors of the TFA - intervention coherence and feasibility - can be important for increasing acceptability in relation to the type of venue used. Venues are more likely to be considered acceptable if it is clear to the public who its regular users are, and that this includes a large proportion of the population, thereby increasing access. The use of schools (teachers, students, parents) and the workplace (employers, employees) felt most coherent in this respect, compared to the other venues explored in this research. Alongside this however, it is important that the public feels it is feasible for venue staff to play a role in delivering testing. If it is perceived as placing additional burden on staff, for example, teachers in schools, or if there is doubt about whether staff have the necessary skills and / or motivation, such as casual or temporary staff, the use of venues to deliver testing can be perceived as less feasible and therefore likely to be less effective, which can impact views on acceptability.

A small number of, mostly older, participants felt it is not acceptable to use places of worship to deliver testing due to the role they play in communities. These participants wanted to see places of worship protected, so that they can continue to deliver their core function, and assumed that people who attend them will be able to access testing at an alternative venue. It is important to note that this research did not explore the use of specific places of worship and the views on acceptability of groups within the population who might be users of those venues. Further research is required to understand this fully.

How does acceptability vary depending on the pandemic scenario (more to less severe, high to low transmission)?

Findings from this research indicate that the higher the perceived threat posed to individuals by the pandemic, the greater the acceptance by the public of institutions and community venues being used to deliver more intrusive testing interventions.

For example, for the most serious pandemic scenario tested in this research, where both severity of symptoms and rate of transmission are high, participants were, in general, accepting of institutions being used to deliver the most intrusive intervention tested, that is: venues supplying tests, checking tests have been taken, collecting results, and supporting the implementation of sanctions.

At the other end of the spectrum, if the threat level is perceived as low (low severity of symptoms, even where transmission is high), participants felt it is acceptable that institutions be used in a lighter touch way, to supply tests only, enabling individuals who need to test, for example because they are at higher clinical risk or close contacts of people who are, to do so. Using institutions to implement more intrusive measures is less acceptable in this scenario, as these measures are not considered proportionate to the perceived threat posed by the pandemic to the majority of individuals.

Whilst participants accepted institutions playing a role in implementing sanctions in the most severe pandemic scenarios, some were considered more acceptable than others. This is due to their perceived effectiveness in encouraging compliance, which is in large part informed by participants' experiences and perceptions of the effectiveness of sanctions during the COVID-19 pandemic. Fines, for example, are generally seen as ineffective in managing behaviours and therefore the role of institutions in supporting the issuing of fines feels less acceptable, though this is more to do with fines per se being unacceptable, rather than being specific to the role of institutions. Restricting access to venues is seen as a role that institutions could effectively implement and is therefore considered more acceptable.

How does acceptability vary depending on how intrusive the intervention being delivered by the institution is (more to less intrusive)?

As above, it is important that the way in which institutions are being used aligns with public understanding of the threat and that it is clear how the intervention plays a role in overall pandemic management. Within this context, institutions are accepted as playing a more intrusive, or directive, role so long as the public understand the rationale for this and believe the approach is effective in managing the pandemic.

Of the use cases tested in this research, the one which received the greatest push back from participants was that which occupied the middle ground in terms of intrusion, that is: tests would be supplied via institutions, who would follow up with individuals to check tests had been taken but would not collect the results.

As it was presented and explored in this research, with no additional information to explain the rational for this approach and how it might fit into wider pandemic management approaches, this use case was perceived as lacking coherence and participants did not understand how it would be effective in managing the pandemic scenarios explored. Arguably, this use case did not go far enough for participants, who were generally accepting of institutions asking for test results, particularly in more severe pandemic scenarios, where this was considered an important part of effective pandemic management.

Learnings for designing future testing interventions and public communications

Overall, the use of institutions and other community venues will feel most acceptable to the public where the rationale for doing so is clear and the way in which the interventions are being implemented is considered proportionate and effective for dealing with the severity of the threat. The key findings of this research indicate that the following factors of the TFA are likely to have the greatest influence on maximising public acceptability and should be borne in mind when considering how institutions might be used to deliver testing in future pandemics:

1. Effectiveness – do the public believe the way in which the institution is being used to deliver testing will be effective in managing the threat posed by the pandemic?
2. Feasibility (linked to effectiveness) – do the public consider it feasible for the institution in question to deliver the testing intervention, based on perceptions of staff capability and capacity to deliver what is required?
3. Intervention coherence (linked to effectiveness) – do the public understand the rationale for the intervention; is it clear to them how it plays a role in pandemic management?
4. Affective attitude – does the way in which the institution is being used feel intuitively acceptable to the public? This will be influenced by existing expectations of how testing should be delivered, as well as whether the use of institutions feels proportionate to the severity of the pandemic.
5. Opportunity cost – does the way in which the institution is being used have an opportunity cost for individuals, for example, losing out on income if they test positive and are unable to work? This is of greatest relevance for people living in areas of greater deprivation and/or who have to work outside of the home.

The research also points to the following specific learnings for the development of communications and policy in relation to the use of institutions to deliver testing in future pandemics.

Clearly communicate the rationale for the intervention

Providing a clear rationale for using the institution to deliver the testing intervention will help ensure it is perceived as coherent and effective by the public. Communications should speak directly to how the intervention will help the government effectively manage the pandemic and

demonstrate how it sits alongside wider pandemic management approaches. As part of this, expectations on individuals need to be made clear. For example, if the intervention also requires people to self-report all test results, this needs to be explicit, and mechanisms need to be in place to facilitate this behaviour.

Reassure the public that the venue has the capacity and capability to deliver the intervention

Provide reassurance, for example via communications, that venue staff have the skills and experience to deliver the intervention and that they capacity to do so. This is particularly true in the case of schools, where participants feel teachers are already under strain due to a heavy workload, and venues such leisure centres, where participants can question the competency of staff. Parents will need additional reassurance that testing involving children will be managed appropriately at those venues.

Ensure wider pandemic management policies support public adherence to testing interventions

Remove barriers to participation in testing interventions and provide support to those likely to be adversely impacted, such as sick pay for those who test positive and are unable to go to work. This is especially important for maximising acceptability and legitimacy of interventions when venues are being used to implement more intrusive or extreme measures, such as restricting access.

Consider carefully the role of institutions in implementing sanctions

If sanctions are considered for non-participation, the restriction of access to a venue rather than playing a role in issuing fines will be more acceptable. Participants' perceptions of the ineffectiveness of fines in managing behaviours, based on their own experiences and media coverage during the COVID-19 pandemic, impact how acceptable they feel fines are within an institution's remit to manage testing. Restricting access feels a more credible role for institutions to have in public health management during future pandemic scenarios.

1. Background and objectives

The UK Health Security Agency (UKHSA) is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents, and other health threats.

UKHSA has a remit to provide high quality evidence to enable the government to identify, assess and mitigate the impact of future pandemics. As part of this, UKHSA's pandemic preparedness insights work identified several lessons from the coronavirus (COVID-19) pandemic. The research detailed below was one of a number of projects commissioned in response.

UKHSA commissioned Thinks Insight and Strategy (hereafter referred to as 'Thinks') to provide insight into the acceptability of using institutions, such as the workplace, schools and other community venues as a way of managing testing during future pandemic scenarios.

The specific research questions were as follows:

1. How does acceptability vary depending on the type of institution being used to deliver testing interventions?
2. How does acceptability vary depending on the pandemic scenario, from more to less severe, high to low transmission?
3. How does acceptability vary depending on how intrusive the intervention being delivered by the institution is, from more to less intrusive use cases?

It is important to note that this research was not commissioned to deliver insight into how to drive behaviour change in relation to testing nor the specific behavioural impacts of the different use cases explored. Rather, it was designed to understand public attitudes towards the use of institutions to deliver testing, on the assumption that acceptability is a key motivational element to achieve desired testing behaviours in future pandemics. Further research is required to explore how routes to improving acceptability would have an impact on behaviour (intentionally and unintentionally)

The findings from this research will contribute to the wider evidence base used to inform UKHSA's pandemic preparedness work.

2. Methodology

2.1 Overview

Given the expansive and complex nature of the research objectives, a qualitative approach was used to meet the requirements of the study. Qualitative research addresses ‘how’ and ‘why’ questions, which enables us to explore perceptions, motivations and barriers. It does not answer questions about ‘how many’ or ‘how much’. For example, it does not measure the prevalence of sentiment within the sample, but can provide insight into the nature and strength of sentiment.

The research was conducted between 6 and 21 March 2024 and included the following:

1. An online pre-task which participants completed before the workshops or mini-groups. This pre-task included a mix of qualitative and quantitative style questions and tasks, designed to gather baseline views on the acceptability of using the workplace, schools and other community venues to deliver public health interventions.
2. 3 x 3-hour face-to-face deliberative workshops (21 to 22 participants per workshop), in London, Sutton Coldfield and Blackpool.
3. 4 x 90-minute online mini-groups (small focus groups of 5 participants per group), with participants from ethnic minority backgrounds. Participants were recruited from locations across England.

A face-to-face deliberative style approach was used because:

- the extended (3-hour) sessions enabled coverage of all the dimensions of the research questions, including pandemic severity and how the institutions may be used to deliver interventions. This ensured confidence in understanding the bounds of public acceptability. Face-to-face sessions also help maintain engagement over a longer workshop
- it allows for a greater number of people to engage in a group which exposes participants to different views and perspectives. This is particularly important in this context given views on using the workplace, schools and other community venues are likely to be socially mediated
- it gives opportunity for a greater range of tools and techniques to guide conversations and maintain engagement – for example, immersive scenarios and workbooks to record individual perceptions

Participants from ethnic minority backgrounds were engaged via mini-groups because they are amongst those groups within society who are more likely to experience health inequalities and

who were disproportionately impacted during the COVID-19 pandemic.[2] It is important that their views are represented in research to inform the design of future policy and interventions, to ensure these do not inadvertently widen the equality gap. The views of participants from these mini-groups were analysed alongside those of the workshop participants, so that any areas where they differed or aligned, and the reasons for this, could be identified.

2.2 Research design and stimulus

All research materials were designed and developed in collaboration with the UKHSA Behavioural Science and Insights Unit, with input from UKHSA pandemic preparedness and public health leads. These materials, which were designed to facilitate discussion of the research questions, are detailed below.

2.2.1 Stimulus: testing use cases

Three use cases detailing how institutions could be used to manage testing during a pandemic were tested. The use cases ranged from less to more intrusive. The testing use cases presented to participants are detailed in the table below.

Table 1. Testing use cases

Use case A Supply tests	**Use case B** Supply tests and check	**Use case C** Supply tests and share your result
Workplaces, schools and other community venues will supply tests to people who regularly go to those places. People can take the test either at the venue or at home. They do not have to share their test result with the venue.	Workplaces, schools and other community venues will supply tests to people who regularly go to these places. They will then contact those people to confirm if they have taken the test but will not ask for their test result. The venue will keep track of people who have and have not taken tests.	Workplaces, schools and other community venues will supply tests to people who regularly go to these places. The venue will then contact those people to confirm if they have taken the test and ask for their test result. The venue will keep track of the test results. If people do not follow the rules, the venue may notify the relevant body to issue a fine or stop people from entering the venue.

2.2.2 Stimulus: pandemic scenarios

Three hypothetical pandemic scenarios were developed. These scenarios were designed across 2 axes: severity of symptoms and how transmissible the disease. Descriptions of each scenario are included in Annexe B.

[2] Ethnicity Health (NHS)

To ensure consistency, all scenarios described a respiratory disease. The scenarios were built out to include additional information beyond the nature of the symptoms and rate of transmission, for example, the impact on society and the NHS, as well as more vulnerable groups.

A low symptom severity and low transmission pandemic scenario was not included. This was due to an assumption that supplying testing via the workplace, school and other community venues is unlikely to be necessary in that scenario.

2.2.3 Stimulus: institutions

The following institutions or venues were in scope for this research:

- workplaces
- schools and other education institutions such as universities
- libraries
- leisure centres
- government buildings
- places of worship

2.2.4 Discussion guide

The discussion guide covered the following topics:

- initial reactions to each pandemic scenario
- perceptions of each use case in each scenario – we used certain dimensions (described in the analysis section below) to structure this conversation
- recommendations for the use of institutions in interventions

The discussion guides used at the workshops and online focus groups are included in Annexe B.

2.2.5 Participant workbook

Participants were given a workbook to record individual reflections of the overall acceptability of each use case. Participants rated each use case in each pandemic scenario after a group discussion. The aim of the rating was to give a summary of acceptability which takes into account all factors. Practically, participants gave each use case an acceptability score out of 10 for each pandemic scenario. These have been reported in the detailed sections.

2.3 Sample

In total, 84 members of the public took part in the research. All participants regularly engaged with at least one institution in scope of the research, for example a workplace, school, or library.

Participants were recruited to include an even gender split, a spread of different ages and for ethnicity and socioeconomic group to be reflective of the local area where workshops were taking place.

Sample quotas were set to ensure representation from audiences of interest, including:

- parents
- people with long-term health conditions (LTHCs)
- people living in more deprived areas
- people from ethnic minority backgrounds

These groups were chosen to give consideration to those who are likely to be disproportionately impacted by public health threats (except for parents, who were included to give a view on the use of schools as a venue).

The workshop participants were recruited from 3 broad areas: London, Sutton Coldfield and Blackpool. The mini group participants were recruited from: Birmingham, Manchester, Liverpool, Nottingham, Bradford, Northampton and Sussex.

Blackpool was specifically selected as an area of higher deprivation and the majority of participants in this workshop were living in the 20% most deprived areas in England, according to the index of multiple deprivation.[3]

The total number of participants in each audience group were as follows:

- parents: 51
- people living with long-term health conditions: 30
- people living in more deprived areas: 34
- people from ethnic minority backgrounds: 37

Thinks' network of freelance qualitative recruiters was used to identify and recruit participants for the research, via recruiters based in the chosen locations. All profiles were reviewed by a Thinks team member before participants were confirmed.

2.4 Analysis

2.4.1 The Theoretical Framework of Acceptability

Following consultation with members of the UKHSA Behavioural Science and Insights Unit, the Theoretical Framework of Acceptability (TFA)[4] was used to inform the discussion guide and analysis of the data.

[3] English indices of deprivation 2019
[4] Mandeep Sekhon, Martin Cartwright and Jill J. Francis (2012). 'Development of a theory-informed questionnaire to assess the acceptability of healthcare interventions'

The TFA is a model designed to assess the acceptability of health interventions, by understanding which factors are most influential. It is comprised of 7 dimensions:

1. Affective attitude: how an individual feels about the intervention.
2. Burden: the amount of perceived effort required to participate in the intervention.
3. Ethicality: the extent to which the intervention is morally acceptable from the perspective of the individual.
4. Perceived effectiveness: the extent to which the intervention has achieved its intended purpose.
5. Intervention coherence: how well the individual understands the intervention and how it works.
6. Self-efficacy: the individual's confidence that they can perform the behaviours required to engage in the intervention.
7. Opportunity cost: the benefits or values given up to engage in the intervention.

2.4.2 Approach to analysis

The analysis approach reviewed each testing use case in detail, based on responses to the different dimensions of the TFA, exploring:

- overall perceptions, as rated by participants, who gave each testing use case a score out of 10 after the discussion of the dimensions of acceptability
- how perceptions shift (if at all) by the severity and rate of transmission of the pandemic scenario
- how perceptions differ (if at all) by audiences of interest
- how each factor within the TFA influences perceptions of acceptability

Discussions from the workshops and mini-groups were recorded and transcribed, then analysed using a thematic grid. The grid was structured according to the key research questions and dimensions of the TFA, providing insight into how perceptions of acceptability differ between audiences and locations.

Individual responses to the pre-task and the workbooks used during the workshops were reviewed to understand how perceptions of acceptability changed over the course of participating in the workshops.

Throughout the fieldwork period, emerging findings were reviewed by the Thinks research team, to draw together insights and identify any areas to explore further in later workshops.

2.5 Limitations of the research

There are some limitations to this research, which should be borne in mind when reviewing the findings. These are outlined below.

Firstly, memories of the relatively recent COVID-19 pandemic heavily influenced participants' views on this topic. On one hand, this means participants may have a strong point of view on pandemic management. However, these views are shaped primarily by their experiences of that pandemic. This includes how testing was delivered, with policies such as local venues being used as test centres and twice weekly testing both playing into overall perceptions. These views have been included as points of analysis within this report, where relevant.

Secondly, the stimulus only covered one type of disease, that is, a respiratory infection. This was to reduce the variation between scenarios and as such allowed for a cleaner comparison by severity and transmission, the 2 most important factors to consider for this brief. However, it meant other factors were not explored. For example, some participants expressed that they may feel differently about reporting results for a different type of disease, for example, a sexually transmitted infection. This may have implications for the acceptability of using venues to manage a future pandemic and is an area warranting further research.

Thirdly, the descriptions of the use cases explored in the research were short and simple, so they were easy for participants to understand as stimulus for discussion within the research settings. The descriptions focussed on the role of institutions and did not provide detail on how this would sit alongside wider pandemic management policies. Further research is therefore needed to understand how public acceptability of the use of institutions to deliver testing might be vary depending on the nature of wider pandemic management policies.

Finally, to deliver depth of insight it was necessary to trade-off the breadth of issues covered in the research. As a result, the scope of discussions was limited to testing, rather than other interventions and, when considering the impact on groups who might be at greatest risk, on people with weakened immune systems, rather than other groups, such as children.

2.6 Terminology in this report

This report uses the terms 'institutions' and 'venues' to describe the settings in scope for the research, that is, the workplace, schools and other community venues listed above.

The term 'venue' is used mostly when we are reporting findings from participants as this was the language used in stimulus materials and the discussion guide.

If views are in relation to a specific institution, this is noted.

3. Detailed findings

This section includes detailed findings from the research. It looks first at participants' expectations of testing in a future pandemic, then explores reactions to each use case in relation to the 3 different pandemic scenarios. The final section includes overarching findings on how responses differed by the different groups represented in this research: people living in areas of greater deprivation, people with long term health conditions, parents, and people from ethnic minority backgrounds.

3.1 Expectations of testing in future pandemics

Participants' expectations of testing in a future pandemic were explored via a pre-task, in advance of them taking part in the workshops. This exercise showed that experiences of the universal testing offer during the COVID-19 pandemic have set public expectations for how government will deliver testing during a future pandemic.

These expectations are important to highlight, as they framed participants' views on the overall acceptability of the use of institutions in the pandemic scenarios explored in this research.

1. Across all audiences and locations, there is a strong expectation that government will provide testing in a future pandemic. Participants expect that tests will be provided free of charge to anyone who wants to test. However, priority is expected to be given to vulnerable groups, who may be more adversely affected by the virus, and key workers. Participants assume key workers may be interacting with vulnerable people, for example in healthcare settings, and are more likely to be working out of home, increasing their potential exposure to disease.
2. Participants expect to access tests locally in healthcare settings, such as pharmacies, and other venues, including schools and community centres. For the latter, the assumption is these venues would be closed and used as test centres in a pandemic, rather than fulfilling their core purpose.
3. Alongside this, there is an expectation that people would be also able to order tests (online or via telephone) to be delivered to their home.
4. Finally, participants expect that testing would be accompanied by social contact restrictions. Participants say they would want advice from 'experts' in this regard (though they did not specify which) but generally assume that if someone receives a positive test, they should self-isolate to slow disease transmission.
5. Notably absent were any expectations regarding reporting test results. In line with findings from other research exploring barriers to reporting test results during the COVID-19 pandemic, carried out by Thinks for UKHSA, this suggests that the reporting of results was not an ingrained behaviour and was therefore less memorable. Instead, behaviours that might be required following a test result, for example, self-insolation, were much more salient.

Of particular relevance for this research is the underlying expectation that institutions and community venues would be used in some way to deliver testing in a future pandemic. This indicates a degree of latent support for the broad concept of using institutions to deliver testing and underpins views around acceptability of the use cases and scenarios explored in this research.

3.2 Perceptions of testing use case A: supply tests

In use case A, venues will supply tests to people who regularly go to those places. People can take the test either at the venue or at home. They do not have to share their test result with the venue.

3.2.1 Overall perceptions

Overall, using institutions to supply tests alone was felt to be most acceptable in pandemic scenarios where either the transmission or severity of the disease is high (and the other factor is low). Most participants felt strongly that there will be a need for mass testing during a pandemic, and using workplaces, schools and other venues explored in this research to supply tests felt appropriate in this context. This was seen as a way of increasing access to testing for the population.

After discussion of each use case within each of the 3 scenarios, participants were asked to give an overall acceptability score out of 10, taking into account all the factors discussed. A mean acceptability score was then derived from all scores given. These scores give a general indication, across all participants, of the overall acceptability of each use case in the different scenarios. Scores are based on participants' reflections after qualitative exploration of the issues and are indicative only.

Table 2. Overall mean acceptability scores out of 10 for use case A, derived from scores given by 84 participants

Workshop acceptability score	Scenario 1: High transmission / low severity	Scenario 2: Low transmission / high severity	Scenario 3: High transmission / high severity
Use case A Supply tests	6.2	6.8	4.2

3.2.2 Key factors influencing acceptability

Two factors from the TFA (perceived effectiveness and affective attitude) are most important in influencing acceptability in this use case.

Perceived effectiveness

Broadly, participants felt that use case A is an effective way to make testing accessible to the public and quickly distribute tests.

However, there was doubt about how effective this use case will be in helping the government to manage a pandemic and control the spread of disease. This was for 2 main reasons:

1. It does not collect any testing data. Participants felt that data about the prevalence of disease would be essential for government in managing a pandemic. In more severe scenarios, like scenario 3, it was seen as a waste of resource to distribute tests without collecting any data.
2. It relies on a sense of personal responsibility. It works on the assumption that the public will behave appropriately, for example stay home if they are positive. Although most felt that they personally will comply, there was scepticism about the behaviour of others.

This intervention was therefore felt to be most effective in scenarios 1 and 2, where symptoms are less severe or fewer people are catching the virus. Notably, participants almost always referred to managing the spread in terms of themselves or their loved ones getting ill, as opposed to managing the societal or economic impact.

In the high severity, high transmission scenario (scenario 3), testing use case A felt less acceptable. There was a strong feeling that the severity of this scenario warrants more intrusive interventions for the government to effectively manage the spread of the pandemic.

> “I would be uncomfortable if they didn't share results with who it needed to be shared with. There'd be no tracking. It should not be private." (London workshop participant)
>
> “The more serious the symptoms and the spread…the more control you need there to be.” (Blackpool workshop participant)
>
> “Hypothetically someone tests positive, there is no plan from that point onwards. It’s up to the individual testing positive. If they are truthful and abide by rules then they will share that and will put in appropriate measures to protect others. But there is a minority who might not be that bothered and will continue as normal. It depends on a lot of honesty.” (Online mini-group participant from an ethnic minority background)

The exception to this was that some participants in Blackpool felt strongly that trust should be placed in the public to act in a responsible way, to avoid removing personal freedom. They were less likely to be concerned about the behaviours of others influencing effectiveness.

Affective attitude

Participants' initial reactions to the use case in each scenario strongly influenced feelings of acceptability. Participants felt more positively about this intervention when it felt proportionate to the severity of the pandemic, with participants making a cost-benefit decision. As a result, there was consensus that this intervention felt most acceptable for lower risk scenarios.

If individuals are at low risk, then participants felt there was less need to do more than supply tests. They felt the additional 'cost' of collecting and sharing data would bring a smaller benefit. However, there was a group (often those who feel at higher risk themselves) who felt that any pandemic warrants testing, collecting and sharing data. This was both because of the impact on the health of vulnerable people and because of the pressure that a pandemic places on health services. As a result, they felt more positive about testing use case C than use case A.

> "I appreciate what this is trying to do, but there should be a framework. You can't just test. You need to have a way of reporting back the results otherwise there is no point." (London workshop participant)

3.2.3 Additional factors influencing acceptability

Beyond the perceived effectiveness and affective attitude, there were 3 other factors that influenced acceptability of the use of intuitions in testing use case A.

Perceived risk

Views on whether institutions solely distributing tests is acceptable varies according to perceptions of the severity of the disease. Participants felt this role is more appropriate when the risk to the public is lower. In this context, individuals can use tests to determine how to behave, for example whether they should go and see a vulnerable relative.

On the other hand, if the risk to the public was perceived as greater, this intervention was considered less appropriate, with participants favouring use case C instead. In more severe scenarios, such as scenario 3, participants assumed that the need for data from testing is more important to inform other government decisions.

Intervention coherence

Generally, testing use case A felt coherent and straightforward to participants. It is clear that the venues would hand out the tests and have no further involvement regarding the result.
It is clear to most how testing helps manage a pandemic, namely that it enables people to know if they are positive and can take appropriate action. However, it can feel unclear how further government action could be taken if no data is collected.

Burden and self-efficacy

Participants felt testing use case A was the easiest intervention for individuals to engage with. It is convenient and requires little effort from the individual, as people would be able to pick up a test while accessing venues as part of their daily routine.

Participants felt confident they could access venues to receive and take a test themselves. Most felt they would be going about their daily lives in scenarios 1 and 2. In scenario 3, they envisaged people would be required to stay at home to contain the spread of the virus, and under these circumstances would expect venues to be operating like test centres, as per the COVID-19 pandemic.

"It'd save everyone time, wouldn't it? You go to Church on a Sunday, you take the kids to school every day… you were scraping around anywhere to get a test, last time." (Sutton Coldfield workshop participant)

"I wouldn't want to be going anywhere and have a chance of getting it. I don't want to be there if everyone is going to pick up the test." (Online mini-group participant from an ethnic minority background)

3.3 Perceptions of testing use case B: supply tests and check

In use case B, workplaces, schools, and other community venues will supply tests to the people who regularly go to these places. They will then contact those people to confirm if they have taken the test but will not ask for their test result. The venue will keep track of people who have and have not taken tests.

3.3.1 Overall perceptions

Participants across audiences and locations perceived use case B as likely to be the least effective of all use cases, impacting views on acceptability of using institutions in this way. Whilst they agreed testing should be widely accessible in pandemics of all severities, there was a strong feeling that monitoring testing levels will not be any more effective at controlling a pandemic than only supplying tests (use case A). In this context, the additional investment of time and resource to monitor testing levels was criticised as an unnecessary extra step, the benefit of which to managing the pandemic was not well understood.

One of the key issues with this use case is that using institutions to deliver testing in this way, as described in the research stimulus, did not feel proportionate to participants – it was perceived as too resource intensive in lower threat pandemic scenarios yet does not go far enough in higher threat scenarios.

Overall, this use case, as it was presented and explored in this research, with no additional information to explain the rational for this approach and how it might fit into wider pandemic management approaches, was perceived as lacking coherence and participants did not understand how it would be effective in managing the pandemic scenarios explored.

This use case demonstrates the importance of explaining clearly to the public the rationale for the use of institutions to deliver testing and how it will help the government effectively manage the pandemic. As part of this, expectations on individuals need to be made clear, for example, if the intervention also requires people to self-report all test results.

After discussion of each use case within each of the 3 scenarios, participants were asked to give an overall acceptability score out of 10, taking into account all the factors discussed. A mean acceptability score was then derived from all scores given. These scores give a general indication, across all participants, of the overall acceptability of each use case in the different scenarios. Scores are based on participants' reflections after qualitative exploration of the issues and are indicative only.

Table 3. Overall mean acceptability scores out of 10 for use case B, derived from scores given by 84 participants.

Workshop acceptability score	Scenario 1: High transmission / low severity	Scenario 2: Low transmission / high severity	Scenario 3: High transmission / high severity
Use case B supply tests and check	3.2	3.2	2.2

3.3.2 Key factors influencing acceptability

Three factors from the TFA – intervention coherence, perceived effectiveness and affective attitude – are most important in influencing acceptability of using institutions in use case B.

Intervention coherence

Understanding of how this intervention works was low. As previously outlined, participants struggled to understand how collecting testing data without recording the result could help the government manage a pandemic. They therefore did not feel that this intervention would help manage disease transmission any more effectively than use case A. This perception heavily influenced how acceptable they considered this use case, as the resource needed to monitor testing levels was not seen to provide any benefit.

> "This is more expensive and more time consuming but you get the same result [as use case A]." (London workshop participant)

Perceived effectiveness

As described above, based on their understanding of how use case B would work, participants felt it would be no more effective at controlling a pandemic than use case A. However, the additional resources that participants envisaged would be needed to deliver use case B and the burden it would place on venue staff, meant that, in comparison to use case A, this intervention felt much less acceptable.

A small number of participants felt there could be some additional benefits to collecting testing data only, including:

- knowing where testing levels are lower and higher across the country
- deterring people from 'hoarding' tests, which these participants feel occurred during the COVID-19 pandemic
- reminding people to take the test

These participants tended to have some experience of work or study in healthcare or biology-related fields. On balance, however, for these participants the benefits were still not felt to warrant the additional investment and resource required by this intervention.

Participants felt that an intervention of this kind would be more effective in some workplaces, for example those where people work with vulnerable groups such as children and the elderly. They felt that these contexts warrant closer monitoring of testing. However, they still doubted how effective this intervention would be at stopping the spread of disease to vulnerable groups if the test result is not being shared.

The perceived effectiveness of this intervention, whilst always the lowest of the 3, decreased as the pandemic scenario becomes more severe. It was therefore considered particularly ineffective in scenario 3.

"It only makes sense if you're actually tracking how many have got the virus." (Sutton Coldfield workshop participant)

"It's way worse than [use case A]…they won't know how the disease is spreading around the area." (Blackpool workshop participant with long term health condition)

Affective attitude

Most participants responded negatively to this scenario, as intuitively it does not feel like a proportionate response to the pandemic scenarios explored. The extra step of collecting testing behaviour but not results was seen as a poor use of money and resource. Compared to the other use cases, use case B was perceived as too resource intensive in lower threat pandemic scenarios yet does not go far enough in higher threat scenarios.

"That's useless to me, it serves no purpose. You can't monitor the spread." (Online mini-group participant from an ethnic minority background)

3.3.3 Additional factors influencing acceptability

Feasibility

Feasibility was a key factor influencing acceptability of this use case as it had an impact on how effective participants believed the intervention would be. Participants from all locations and across audiences felt that the use case is not feasible due to perceptions of how challenging it would be for venues to contact regular users to ask about their testing behaviour.

In particular, this was discussed in the context of schools, with participants generally assuming a member of the school staff would be responsible for making calls. They felt staff members would have neither the time nor the capacity to do this. They therefore struggled to understand how this intervention could operate in practice and did not feel it is a good use of venue resource. This resulted in the intervention feeling less acceptable.

"I worry about the workload that puts onto workplaces or teachers, who are having to take that role on. Are they going to be trained to do it? I'm worried about that." (Blackpool workshop participant with long term health condition)

Trust in others

The effectiveness of this intervention was felt to depend on individuals around the country displaying high levels of personal responsibility and answering truthfully should they be contacted by a venue and asked if they have taken a test.

Participants felt they would personally be honest in all pandemic scenarios. However, there was a strong sense amongst the majority of participants that other people may lie about whether they had taken a test, should a venue follow up with them. There are no sanctions in place should the individual lie, so there is a feeling that people may not tell the truth simply as a way of easily ending the conversation.

In the high transmission, high severity scenario, there was greater trust that people will be honest about testing, particularly with schools and workplaces.

"If no one is following up to record the result then there's no point. I think you have to give more information for it to be useful. I think it's easy to lie and people will be selfish and won't care about it at all." (Blackpool workshop participant with long term health condition)

Concerns over 'scam' calls

A number of participants said they tend to ignore calls from unknown or withheld numbers in case these are scam or nuisance calls. Many therefore felt they would be unlikely to answer

calls from venues calling to check whether they had tested, if they did not recognise the number. This was particularly a concern of participants in Blackpool.

It is less of an issue in relation to schools, as parents tended to have the phone number of their children's school saved, so would recognise the call and report whether they have tested, if asked.

Though this concern is not directly a driver of acceptability, it is worth noting because it impacts perceptions of the likely effectiveness of the intervention and therefore acceptability of the use of institutions to deliver it.

"I wouldn't answer the phone. Even if I knew it was them. Right at the beginning when we got COVID the nurses rang me lots about what I was doing. If you were ill why would you want someone ringing you?" (Blackpool workshop participant)

3.4 Perceptions of testing use case C: supply tests and share results

In use case C, workplaces, schools and other community venues would supply tests and contact people to confirm that they have taken the tests, as well as asking for their result. The venue will record the result and can issue fines or stop people from entering the venue should they not follow rules.

3.4.1 Overall perceptions

There was a consensus that use case C was the most worthwhile intervention, particularly in more severe scenarios. This was due to collecting and monitoring test results which participants felt would be important for effective pandemic management.

As with the other use cases, participants viewed this intervention in light of their experiences during the COVID-19 pandemic, noting the importance of testing and tracing at that time.

After discussion of each use case within each of the 3 scenarios, participants were asked to give an overall acceptability score out of 10, taking into account all the factors discussed. A mean acceptability score was then derived from all scores given. These scores give a general indication, across all participants, of the overall acceptability of each use case in the different scenarios. Scores are based on participants' reflections after qualitative exploration of the issues and are indicative only.

Table 4. Overall mean acceptability scores out of 10 for use case C, derived from scores given by 84 participants

Workshop acceptability score	Scenario 1: High transmission / low severity	Scenario 2: Low transmission / high severity	Scenario 3: High transmission / high severity
Use case C supply tests and share your result	5.2	6.7	7.7

3.4.2 Key factors influencing acceptability

Four factors from the TFA (perceived effectiveness, affective attitude, ethicality and opportunity cost) are most important in influencing acceptability of this use case.

Perceived effectiveness

Participants felt use case C was the most effective intervention. A key element of this intervention is that it collects test results and there was a consensus amongst participants that this is vital information to enable effective management of a pandemic. Most participants felt this was true regardless of the severity of the pandemic.

> "I think collecting the test result is the most beneficial part of the process, both for tracking for yourself, but also for the government…being able to monitor that and give more knowledge to the public about what's happening where." (Online mini group participant from an ethnic minority background)

However, a minority felt that collecting test results may not be necessary in less severe scenarios. This group tended to be more sceptical of politicians and government intervention in general, and often included those living in more deprived areas.

For most participants, restricting access to venues for those who do not participate in testing was perceived as an effective way of reducing the spread of disease. The role institutions play in this respect in this use case was therefore generally acceptable to participants. Conversely, fines were perceived by many as an ineffective pandemic management tool. In Blackpool, for example, some participants said that they had been fined during the COVID-19 pandemic but this did not change their ongoing behaviour. This element of the role of institutions is therefore perceived as less acceptable due to lack of perceived effectiveness.

> "Telling people they will be fined will just means they won't test…or they will tell you lies about their results." (Blackpool workshop participant)

Affective attitude

Overall, most participants' top of mind reaction to this use case was positive, particularly in severe scenarios. For example, under scenario 3, this more intrusive use case feels proportionate to the severity of the wider context. This additional step of collecting test results feels absolutely necessary in this situation.

Most participants' top of mind response was also positive in less severe scenarios. This is because they saw no harm in collecting data to help manage the pandemic.

> "I'd rather be on the safe side than the risky side of people getting really ill. The more information you know, the more knowledge you have, the more informed decisions you can make. So, I don't mind about tests and sharing results." (Sutton Coldfield workshop participant with long term health condition)

However, a minority reacted less positively to this use case in scenarios where symptoms are less severe or transmission is lower. This group tended to include participants from Blackpool, who were more cautious about government intervention overall. In these situations, this intervention felt 'too much' and there was pushback against authorities for introducing it.

Ethicality: sanctions

Most participants were not opposed to restricting access to venues for users who do not participate in testing. They saw restricting access as a sensible step to control the spread of disease in public spaces. In a similar vein, participants also expected venues would restrict access to anyone who tests positive.

However, participants saw this as essentially making participation mandatory due to the importance of attending work or school. This felt appropriate in scenario 3 where they felt the greatest sense of personal risk. It felt less appropriate to some in scenarios 1 and 2, due to the perceived risk being lower.

Participants who would lose income from missing work were especially hesitant. Many said they would only participate in testing if they were symptomatic to avoid a potential 'false positive'. If testing were made mandatory they said they would comply but emphasised the importance of support if they were unable to go to work.

The inclusion of fines was seen by many as a step too far. Across all groups there was pushback on fines, due to:

1. Low trust in government: media coverage and investigations into the government's handling of the COVID-19 pandemic and the actions of some members of the government during that time has weakened public trust. This has negatively impacted the credibility of future governments to impose this kind of sanction.

2. A sense that the wider situation will be unpleasant enough: there was a strong feeling that coping with the health, social and economic costs of a pandemic will be difficult enough for people, especially those who are clinically vulnerable and / or struggling financially. This made it seem inappropriate to issue fines to those not complying with rules. Instead, participants saw refusing entry to venues as sufficient and acceptable as a sanction.

"No fines. It's too controlling, and peoples' circumstances are different. We're in a recession, I can't afford to put the heating on." (Blackpool workshop participant)

Ethicality: data sharing

Participants did not see any ethical risks to sharing their test result with the venue. The experience of regularly reporting results to authorities during the COVID-19 pandemic means this behaviour feels familiar and is largely normalised. That said, participants did want reassurance about the data sharing process, namely:

- who from the venue would have access to information: some participants reported feeling reluctant to share their test result with an unknown person from the community venue. To counter these privacy concerns, people would prefer sharing their data directly with a government portal or app, similar to logging a test result on the NHS app
- staff training: participants believed that extra training of staff would be necessary to deliver use case C to a high standard in line with GDPR

"I would do it if it felt like it was for the greater good and I understood why they were using my data, but I do have concerns." (Sutton Coldfield workshop participant)

Opportunity costs

Despite not seeing any ethical risks to sharing test results, some participants did question the opportunity cost. This was particularly true for those who work out of home and could lose income as a result of not being able to going to work, and who tended to be living in areas of greater deprivation. For this group, loss of income was a serious concern, particularly if they were already struggling financially.

Most of this group were still accepting of sanctions in the most severe pandemic scenario, that is, scenario 3. This is because loss of income is a smaller risk than catching a serious illness. However, there was a strong feeling that use case C is only acceptable if there is additional support in place. For example, suitable sick pay to support people if they are unable to go to work.

Providing appropriate support was also seen to increase the likelihood of people ‘doing the right thing’ and participating in the intervention, as well as isolating if they test positive. Conversely, it was felt that people are more likely to break the rules if there is no support available.

“If it's at my work, then yeah [I’d lie]. Telling them my result means I can't work." (Blackpool workshop participant)

"When the government said they'd furlough and pay you, that's when people accept these measures." (Sutton Coldfield workshop, parent participant)

3.4.3 Additional factors influencing acceptability

Intervention coherence

Participants had a good understanding of the rationale for use case C. This was largely based on their experiences of the COVID-19 pandemic. Whilst not an important factor influencing acceptability in and of itself, it meant participants were able to better judge the effectiveness of this intervention.

That said, there was some confusion about data sharing and how sanctions would be issued. For example, whilst this would not be the case, some participants assumed the venues themselves would issue fines directly, which does not necessarily align with existing perceptions and experiences of those venues.

“People don’t view these as places of authority, like libraries. No one pays library fines.” (Sutton Coldfield workshop, parent participant)

Trust in others

Participants stated that they would comply with testing regulations and report their test results. However, there were concerns that not everyone would do so. This was due to:

- uncertainty about whether individuals who cannot access a venue due to a positive test result will receive compensation
- the belief that there will always be people who would not comply. Indeed, some participants in Blackpool said they would not comply with this intervention, even if sanctions were imposed

This led some participants to doubt the effectiveness of the intervention and to calls for additional measures, such as submitting a photograph of the test result.

Feasibility

As with use case B, there was a strong sense that providing tests and recording results may put additional burden on already overworked staff. This raised questions for participant about how feasible this intervention would be in practice. As with use case B, this concern was most prominent with regards to schools and teachers.

Participants believed that use case C would require extra resources, that is, staff appointed to each venue to manage the intervention, for implementation to succeed.

3.5 Responses from specific groups of interest

Across all use cases and scenarios explored, there were some differences in responses amongst participants from the specific groups of interest represented in this research, that is: people living in areas of greater deprivation, people with long term health conditions, parents, and people from ethnic minority communities.

3.5.1 People living in areas of greater deprivation

Participants living in areas of greater deprivation lived under social contact restrictions for longer than other areas of the country, and many work in industries which were disproportionately affected by COVID-19 policies, such as tourism and hospitality. This research indicates that this experience can impact perceptions of acceptability particularly in relation to more intrusive interventions, which are less likely to be considered acceptable by this group, especially in less severe pandemic scenarios. In general, participants living in areas of greater deprivation were more likely to favour placing a greater emphasis on personal responsibility and would require more convincing of the need for stronger intervention.

As participants from this group are more likely to be working outside of the home, often in the tourism industry for those from Blackpool, or in roles with caring responsibilities, they were more likely to highlight the opportunity cost of participation and want to see a supportive wider policy context, for example sick pay. Without other measures in place, they were less likely to feel the use of institutions to deliver testing interventions, particularly where these include sanctions, are acceptable.

Finally, participants within this group were more likely to admit to non-compliance with testing and social contact restrictions during the COVID-19 pandemic. Many felt they would behave similarly in a future pandemic, depending on their perceived level of risk. Fines are unlikely to drive adherence: some said they were fined during the COVID-19 pandemic and either did not pay or did not change their behaviour as a result. Other sanctions, such as restricting access to venues, and demonstrating compliance by other means, for example via social norms focussed communications, are more likely to be perceived as acceptable.

3.5.2 People with long term health conditions

Those with long-term health conditions were more likely to feel at greater risk during a pandemic, compared to those without a long-term health condition. This is particularly true for those with weakened immune systems or respiratory conditions who were required to shield during the COVID-19 pandemic. As a result, participants within this group were more likely to feel more intrusive interventions would be acceptable in all pandemic scenarios, regardless of severity. That said, their perceived sense of risk also means many would avoid public institutions in the event of a pandemic. Therefore, whilst perceiving the interventions as acceptable, they felt they would be unlikely to participate.

3.5.3 Parents

Whilst parents' perceptions of acceptability were mostly in line with the wider public, they did voice additional concerns about using schools to manage testing. In particular, they worried about the impact that using primary schools to manage testing could have on young children's mental health. Some were concerned, for example, that children may find it scary to be tested in school without their parents present. To increase acceptability, they wanted more detailed information about how interventions would be delivered in schools and to be reassured that interventions that could impact children would be managed appropriately.

3.5.4 Ethnic minority communities

Views on the acceptability of using institutions to manage testing, in the specific testing use cases and scenarios explored in this research, did not differ significantly for participants from ethnic minority backgrounds, compared to those who are not from ethnic minority backgrounds. It should be noted that the research sample was designed to ensure a broad mix of people from across different ethnic minority communities, to give a sense of whether, at a total population level, there are any notable differences in responses from across ethnic minority communities, compared to those not from ethnic minority communities. It was not possible within the scope of this research to include participants in robust enough numbers to allow for exploration of views by specific ethnic minority communities. This is a limitation of this research, which is acknowledged, and which should be prioritised for future investigation.

4. Learnings for designing future testing interventions and public communications

Overall, the use of institutions and other community venues will feel most acceptable to the public where the rationale for doing so is clear and the way in which the interventions are being implemented is considered proportionate and effective for dealing with the severity of the threat.

The key findings of this research indicate that the following factors of the TFA are likely to have the greatest influence on maximising public acceptability and should be borne in mind when considering how institutions might be used to deliver testing in future pandemics:

1. **Effectiveness** – do the public believe the way in which the institution is being used to deliver testing will be effective in managing the threat posed by the pandemic?
2. **Feasibility** (linked to effectiveness) – do the public consider it feasible for the institution in question to deliver the testing intervention, based on perceptions of staff capability and capacity to deliver what is required?
3. Intervention coherence (linked to effectiveness) – do the public understand the rationale for the intervention; is it clear to them how it plays a role in pandemic management?
4. **Affective attitude** – does the way in which the institution is being used feel intuitively acceptable to the public? This will be influenced by existing expectations of how testing should be delivered, as well as whether the use of institutions feels proportionate to the severity of the pandemic.
5. **Opportunity cost** – does the way in which the institution is being used have an opportunity cost for individuals, for example, losing out on income if they test positive and are unable to work? This is of greatest relevance for people living in areas of greater deprivation and/or who have to work outside of the home.

This research also points to the following specific learnings for the development of communications and policies in relation to the use of institutions to deliver testing in future pandemics:

Clearly communicate the rationale for the intervention

Clearly communicate the rationale behind the intervention and use of the institution to deliver it, to ensure it is perceived as coherent and effective by the public. Communications should speak directly to how the intervention will help the government effectively manage the pandemic and demonstrate how it sits alongside wider pandemic management approaches. As part of this, expectations on individuals need to be made clear. For example, if the intervention also requires people to self-report all test results, this needs to be explicit, and mechanisms need to be in place to facilitate this behaviour.

Reassure the public that the venue has the capacity and capability to deliver the intervention

Provide the public with reassurance, for example, via communications, that the venue in question has the capacity and capability to deliver the intervention. This is particularly true in the case of schools, where participants feel teachers are already under strain due to a heavy workload, and venues such leisure centres, where participants can question the competency of staff. Parents will need additional reassurance that testing involving children will be managed appropriately at those venues.

Ensure wider pandemic management policies support public adherence to testing interventions

Ensure wider pandemic management policies remove barriers to participation in testing interventions and provide support to those likely to be adversely impacted, for example, sick pay for those who test positive and are unable to go to work. This is especially important for maximising acceptability and legitimacy of interventions when venues are being used to implement more intrusive or extreme measures, such as restricting access.

Consider carefully the role of institutions in implementing sanctions

If sanctions are considered for non-participation, the restriction of access to a venue rather than playing a role in issuing fines will be more acceptable. Participants' perceptions of the ineffectiveness of fines in managing behaviours, based on their own experiences and media coverage during the COVID-19 pandemic, impact how acceptable they feel fines are within an institution's remit to manage testing. Restricting access feels a more credible role for institutions to have in public health management during future pandemic scenarios.

5. Areas for further research

Other pandemic scenarios

This research only covered one type of disease, an airborne respiratory disease. Some participants said that their views of acceptability of interventions, and the use of institutions to deliver them, may differ if the disease was different. Some said they might not be comfortable reporting their test results if the disease was a sexually transmitted one, for example. Further research is needed, therefore, to understand the impact of different types of infection and routes of transmission on the acceptability of using venues to manage testing in future pandemics.

Alternative interventions

This research briefly explored the acceptability of distributing other public health interventions, for example, antiviral medication. The research found that distributing antivirals via institutions was not felt to be appropriate in the scenarios explored in this research. Most participants felt the distribution of medication requires the oversight of a healthcare professional and they would not feel comfortable picking medication up without this. However, this was a very small part of the research and further exploration is needed to understand how other pandemic interventions may or may not be acceptable.

Ethnic minority communities

The findings of this research did not indicate any differing views on the acceptability of using institutions to manage testing, in relation to the testing use cases and scenarios explored, amongst participants from ethnic minority communities. It should be noted that the research sample was designed to ensure a broad mix of people from across different ethnic minority communities, to give a sense of whether, at a total population level, there are any notable differences in responses from across ethnic minority communities, compared to those who are not from ethnic minority communities. Further research is needed to fully understand how acceptability differs by different ethnic minority communities and the factors which influence this.

People living in areas of greater deprivation

The scope of this research was limited to participants living in one area of greater deprivation only (Blackpool and surrounds). Whilst people living in Blackpool had nuanced views on acceptability, which are influenced by the impact on their local area of COVID-19 pandemic management policies, further research is needed to understand how perceptions of acceptability might differ in different areas of deprivation across the country.

Other vulnerable groups

This research focussed on pandemic scenarios that disproportionately impacted people with weakened immune systems. We did not explore pandemics that seriously impact other potentially vulnerable groups, such as children or the elderly. The research found that the vulnerability of children was front-of-mind for many, however further research is needed to understand acceptability in scenarios where different population groups are at greater risk.

Communications approaches

Communicating clearly to the public the rationale for the use of institutions in delivering testing, and providing reassurance around concerns, for example about venue capacity and staff capability, have been identified as important for maximising public acceptability. However, further research is required to understand what the most effective approaches would be for communicating these messages to the public in a future pandemic. Research on this topic should also consider how communications should be tailored for groups within the population (such as those listed in section 3.5 above) who may have heightened or specific concerns or barriers in relation to the use of institutions in delivering testing.

Annexe A. Additional insights from this research

Participants' experiences of the COVID 19 pandemic undoubtedly framed their responses to the questions explored in this research. Whilst they do not directly answer the specific research questions of this project, the following emerged as important contextual factors for shaping responses to the use cases discussed. These factors are captured here, as they are likely to frame public views on pandemic policy interventions in future, for those who experienced the COVID-19 pandemic.

The duration and experience of lockdown restrictions

Participants in Blackpool lived under social contact restrictions during the COVID-19 pandemic for considerably longer than those from the other research locations. As a result, people from this area tended to be more cautious about the implementation of more intrusive pandemic management interventions.

The type of job role and workplace

Those who were able to work from home tended to feel less at risk from pandemics than those who had to work out of home. This was due to having the option to maintain their income whilst self-isolating if they needed to. For those who had to test regularly to come to work, for example through twice weekly testing, testing in workplaces felt normal and therefore more acceptable. Additionally, participants who had lost income due to having to stay home when they tested positive, even if they had no symptoms, felt more hesitant about potentially being excluded from venues.

The sense of personal risk from disease

In all scenarios, those who felt at higher risk tended to be older and/or have a health condition that meant they had to shield during the COVID-19 pandemic[5]. This group tended to find all interventions – including those which are more intrusive - more acceptable than other groups.

[5] Shielded Patient List (NHS)

Perceptions of other people's behaviour in response to government interventions

Participants in all locations shared experiences of other people 'flouting' the rules during the COVID-19 pandemic. This led to scepticism about the efficacy of government interventions. Whilst most participants did not expect that they would be influenced by others' behaviour, research during the COVID-19 pandemic demonstrated that normalisation of rule breaking can contribute to an overall drop in compliance.[6]

Perceptions of government management of the pandemic

Overall, participants felt that the government did not act quickly enough to tackle the COVID-19 pandemic and wanted to see that lessons have been learnt from this experience. To demonstrate this, participants felt that government should act swiftly and decisively – taking stronger action sooner was seen as preferrable to a slower, more cautious approach.

Experiences of how well children handled the pandemic restrictions

Some parents felt their children struggled with social contact restrictions during the COVID-19 pandemic and are still feeling the impact today, for example, in terms of anxiety about illness and socialising. Consequently, some parents felt hesitant about using schools to deliver testing, borne out of a concern for how this could impact their children's mental health longer term.

[6] Majority feel they comply with COVID-19 rules better than others

Annexe B. Research materials

Pandemic scenarios

Scenario 1

Symptoms

- fatigue or tiredness
- body aches
- cough
- high temperature (only for the most severely affected)
- difficulty breathing (only for the most severely affected)

Spread

- highly infectious – lots of people are catching the disease.
- most people who catch it only experience mild cold-like symptoms.
- certain groups experience more severe symptoms

Vulnerable groups

- those with weakened immune systems and underlying health conditions are more likely to experience severe symptoms

Impact

- hospitals are becoming overwhelmed – even though only a minority experience severe symptoms, this adds up to a lot of people as the disease is infecting so many
- GPs, pharmacies and NHS 111 see a big rise in demand from people experiencing mild symptoms

Scenario 2

Symptoms

- fatigue or tiredness
- body aches
- cough
- high temperature
- difficulty breathing

Spread

- the disease is not very infectious, so not many people are catching it
- however, those who do catch it are likely to experience severe symptoms

Vulnerable groups

- those with weakened immune systems and underlying health conditions are likely to be hospitalised

Impact

- lots of people go to A&E, their GP or call 111 thinking they have the disease, putting a strain on these services
- many people are frightened and start to reduce their social contact, for example going to the shops less, avoiding crowded places

Scenario 3

Symptoms

- fatigue or tiredness
- body aches
- cough
- high temperature
- difficulty breathing

Spread

- highly infectious – lots of people are catching the disease
- most people who catch it experience severe symptoms

Vulnerable groups

- most of those who catch it will experience severe symptoms
- people with weakened immune systems and underlying health conditions will experience the most severe symptoms

Impact

- demand on GPs, NHS 111 and the ambulance service is high
- hospitals are overwhelmed
- lots of people cannot work as they're unwell; some businesses have closed and public services are struggling to keep going
- most people are reducing their social contact

Workshop agenda

The agenda below was used to guide discussions during the deliberative workshops. Three workshops were held in total, in London, Sutton Coldfield and Blackpool. Each workshop lasted 3 hours and involved 21 to 22 participants.

Table 5. Agenda for deliberative workshops

Section and aim	Key questions and probes
Arrival and set up	Participants will be asked to arrive up to 20 minutes before the start of the workshop. Workshop facilitators will welcome and sign in participants as they arrive, and show them to the main workshop room and their allocated table. Refreshments will be available in the main room and moderators will ensure facilities are clearly signposted. Facilitators will ask participants to write their name on a name tag. Each table will have access to the following printed stimulus and materials: • books and pens • stimulus pack
Introduction and warm-up Whole group Running slides	Lead facilitator to start the workshop: Thank participants for attending. Run through venue housekeeping (toilets, fire alarms) and so on. Lead facilitator to introduce the topic of the research and requirements of their participation: Tonight we are interested in speaking to you about how workplaces, schools, and other community venues could be used in the future to help deal with a public health problem. For example, an infectious disease outbreak which is sometimes known as ‘a pandemic’. In your warm-up task we asked you a couple of questions about this. Today’s conversations will build on some of the answers you gave. We understand that everyone had different experiences of the COVID-19 pandemic and this topic may raise some memories which might be uncomfortable. Please be reassured that when answering the questions you can give as much detail as you want. You can of course also decide not to answer a question if you don’t want to.

Section and aim	Key questions and probes
	Introduce the Thinks team. Introduce UKHSA. Set the 'ground rules: • we're an independent research agency so we're here to listen to your honest views and opinions. There are no right or wrong answers • please share as much information as you feel comfortable sharing. If there are questions you don't feel comfortable answering then you don't have to provide an answer • please be kind and respectful. It's ok to disagree with others, but please do so politely • if you're not sure about something, please just ask. We're very happy to help! • help us keep to time – We are here to guide you through the workshop discussions. Sometimes we may need to move the conversation, to make sure everyone can go home on time Recap terms of participation: • we will be recording our discussions tonight • everything you say this evening will be anonymised. This means you won't be personally identified. Instead, you will be known as "participants from Sutton Coldfield, Blackpool or London" • we will be transcribing the recordings from our discussions tonight and sharing an anonymised version with UKHSA. These will be used for research purposes only and will be available only to the people working on this project at Thinks and UKHSA • we will also be writing up a report based on all 3 locations. This will be shared with UKHSA and may be published on GOV.UK. Just to remind you everything will be reported anonymously and no one taking part in the research will be identified in the report Cover the agenda for the evening. Define the terms: • what is a pandemic? • institutions in scope – workplaces, schools, universities and other community venues

Section and aim	Key questions and probes
	• ways the venues may be used
Pre-task and introduction to scenario 1 Whole Group Running slides	Lead facilitator to run through the findings from the pre-task. [Share slides] How people were feeling during the early days of COVID-19 pandemic: 3 words. Expectations for how testing should look like in a future scenario. How acceptable or otherwise it is to use community venues to deliver public health interventions. Lead facilitator to briefly ask the whole room: • is there anything in there that surprised anyone? • does anyone want to tell the room a little more about their answer? Lead facilitator to introduce scenario 1: We are now going to be talking about those 3 uses for the workplace, schools and other community venues in more detail. As a reminder, here they are again: [Share slide x] Lead facilitator to present the uses to the room. We are going to be doing this by imagining 3 future pandemics and thinking about what you would do and how you would feel in those circumstances. These pandemics are not real. They have been created by the research team solely to prompt discussion. Lead facilitator to read out the description for scenario 1 before moving into breakout tables. [Scenarios to be rotated across workshops – guide to be amended to reflect rotation for each workshop.]
Scenario 1 - discussion Breakout groups Stimulus pack	Table facilitator press record Table moderator to welcome participants to the table and to introduce themselves to the group. Moderator to then ask participants to introduce themselves: • what is your name? • what do you like to do in your spare time? • does anyone have any questions before we get started? Table facilitator to share the stimulus related to scenario 1, for example, headlines, WhatsApp messages. In your book, please can you write down 3 words to describe how you would be feeling in this scenario?

Section and aim	Key questions and probes
	Table facilitator to then lead a discussion: • how do you think you would be feeling in this scenario? • what makes you say that? • how worried or otherwise would you be? Let's start with the testing use case 1. How would you feel if this were happening in this scenario? • what sounds good about it, if anything? • what concerns would you have, if any? • to what extent, if at all, is there a need for this in response to the scenario? • how do you think it will help manage the pandemic? • how well, if at all, do you think it will be at doing so? • how appropriate or otherwise do you think it is to use workplaces, schools and other community venues in this way? • how fair, if at all, does it feel? (Facilitator to probe for you, for other people) • what makes it feel more appropriate? Why? (Facilitator to encourage participants to think about the scenario) • what makes it feel less appropriate? Why? (Facilitator to encourage participants to think about the scenario) • what would you personally do in this scenario? • how easy or difficult would you find this? • what would make you more likely to 'follow the rules' and access testing in this way? • what, if anything, would make it more challenging for you to follow the rules? Why is that?

Section and aim	Key questions and probes
	• what do you think other people will do? (Facilitator to probe on who they are talking about and how factors differ for others) I'd now like you to fill in the tasks in your book: Please mark on the scale in your book how happy or otherwise you feel about using the workplace, schools and other community venues in this way. Please circle the venues you would be happy to be used. Now let's move on to use case 2. How would you feel if this were happening in this scenario? • what sounds good about it, if anything? • what concerns would you have, if any? (Facilitator to probe on the additional contact from the venue) • to what extent, if at all, is there a need for this in response to the scenario? • how do you think it will help manage the pandemic? • how well, if at all, do you think it will be at doing so? • how appropriate or otherwise do you think it is to use workplaces, schools and other community venues in this way? (Facilitator to probe on the differences between use case 1 and 2 and the reasons for this) • how fair, if at all, does it feel? • what makes it feel more appropriate? Why? • what makes it feel less appropriate? Why? • what would you personally do in this scenario? (Facilitator to probe on the differences in claimed behaviours between use case 1 and 2 and the reasons for this.)

Section and aim	Key questions and probes
	• how easy or difficult would you find this? • what would make you more likely to 'follow the rules'? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do? I'd now like you to fill in the tasks in your book: Please mark on the scale in your book how happy or otherwise you feel about using the workplace, schools and other community venues in this way. Please circle the venues you would be happy to be used. Finally, let's look at use case 3. How would you feel if this were happening in this scenario? • what sounds good about it, if anything? • what concerns would you have, if any? • how would you feel about your employer or school knowing your test results? • how would you feel about your employer or school issuing sanctions? • how do you think other people might feel? To what extent, if at all, is there a need for this in response to the scenario? • how do you think it will help manage the pandemic? • how well, if at all, do you think it will be at doing so? • how appropriate or otherwise do you think it is to use workplaces, schools and other community venues in this way? (Facilitator to probe on the differences in claimed behaviours between use case 1, 2 and 3 and the reasons for this.)

Section and aim	Key questions and probes
	• what makes it feel more appropriate? Why? • what makes it feel less appropriate? Why? • what would you personally do in this scenario? • how easy or difficult would you find this? • what would make you more likely to 'follow the rules'? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do? I'd now like you to fill in the tasks in your book: Please mark on the scale in your book how happy or otherwise you feel about using the workplace, schools and other community venues in this way. Please circle the venues you would be happy to be used. Table facilitator to zoom back out: Thinking about all of these uses of venues. What difference, if any, does the actual venue make? For example, if it were your workplace or a school and so on. • are there some venues where it feels more acceptable for them to be doing this? • are there some venues where it feels less acceptable for them to be doing this? We've talked about testing. But how would you feel if venues were distributing medication to control the disease? • when, if at all, is this acceptable? • when, if at all, is this not acceptable?

Section and aim	Key questions and probes
	It says those with weakened immune systems and underlying health conditions are most affected. How, if at all, would your views change if… • …babies and young children were most affected? • …teenagers were most affected? • …the elderly were most affected? Lead facilitator to lead a brief plenary session where table facilitators report back a summary of the discussions.
Break	Lead facilitator to introduce break and catering.
Scenario 2 Whole group, then breakouts Stimulus pack	Lead facilitator to introduce scenario 2 before moving into breakout groups. Table facilitators to start recording. Throughout this section probe on perceived differences between the scenarios. Table facilitator to share the stimulus related to scenario 2, for example headlines, WhatsApp messages. In your book, please can you write down 3 words to describe how you would be feeling in this scenario? Table facilitator to then lead a discussion: • how do you think you would be feeling in this scenario? • what is similar or different to the previous scenario? • what makes you say that? • how worried or otherwise would you be? Table facilitator to return to how workplaces, schools and community venues may be used. Let's start again with use case 1. You said before you would feel [XX] if this were happening. What's similar or different about doing the same in this new scenario? • what sounds good about it, if anything? • what concerns would you have, if any?

Section and aim	Key questions and probes
	Before you said there [was or was not] a clear need to do this. How have things changed, if at all, in this scenario? And before you said it was/was not appropriate to do this. What's similar and what's changed, if anything, under this scenario? • how fair, if at all, does it feel? • what makes it feel more appropriate? Why? • what makes it feel less appropriate? Why? • what would you personally do in this scenario? • what would make you more likely to "follow the rules"? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do? Facilitator to probe on who they are talking about and how they may behave differently. I'd now like you to fill in the tasks in your book: Please mark on the scale in your book how happy or otherwise you feel about using the workplace, schools and other community venues in this way. Please circle the venues you would be happy to be used. Repeat for uses 2 and 3 filling out the relevant tasks in the book each time after the discussion.
Scenario 3 Whole group, then breakouts Stimulus pack	Lead facilitator to introduce scenario 3 before moving into breakout groups. Table facilitators to start recording. Table facilitator to then lead a discussion: • how do you think you would be feeling in this scenario? • what is similar or different to the previous scenarios?

Section and aim	Key questions and probes
	• what makes you say that? • how worried or otherwise would you be? Table facilitator to share the stimulus related to scenario 2, for example headlines, WhatsApp messages. In your book, please can you write down 3 words to describe how you would be feeling in this scenario? Table facilitator to return to how workplaces, schools and community venues may be used. Let's look at all 3 uses again. How would you feel about each of these in this scenario? • what sounds good about it, if anything? • what concerns would you have, if any? • in this scenario, is there a clear need to use venues in this way? (Facilitator to probe on which ones and how they see using venues in this way will help manage the pandemic.) And under this scenario, which of them feel more and less appropriate? • how fair do they feel, if at all? • what makes some feel more appropriate? Why? • what makes some feel less appropriate? Why? • what would you personally do in this scenario? (Facilitator to probe on if they would adhere to some use cases and not others.) • how easy or difficult would you find doing so? • what would make you more likely to 'follow the rules'? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do?

Section and aim	Key questions and probes
	I'd now like you to fill in the tasks in your book after each use case is discussed: Please mark on the scale in your book how happy or otherwise you feel about using the workplace, schools and other community venues in this way. Please circle the venues you would be happy to be used.
Reflections Breakout groups, then whole group	Thank you for all your answers so far. Now I'd like you to reflect on everything that we've spoken about today. Table facilitator to show a summary card of each pandemic and then cards for each use case As we mentioned at the start, the purpose of this workshop is to understand how you might feel about using workplaces, schools, places of worship and other community venues, for example sports centres and libraries as testing venues in a future pandemic. We'd like to know about how happy or unhappy you would feel. First, we'd like you to ask you to complete a short task in the book. Reflection activity Next, I'd like us to work together to develop some recommendations: What are your recommendations to make sure using workplaces, schools and community venues to give out testing…. • is fair? • feels appropriate for the scenario? Throughout the discussion the facilitator should probe on the different types of venue, pandemic and how the venue is being used. [IF TIME] Moderator to select a participant from each group to playback the key recommendations to the whole group and lead moderator to collate a master list. Is there anything missing?
Final wrap-up	Lead facilitator to thank.

Online focus group discussion guide

The discussion guide below was used for online mini-groups, which were small focus groups of 5 participants per group. A total of 4 mini-groups were held with participants from ethnic minority backgrounds, recruited from locations across England.

Table 6. Discussion guide for online mini-groups

Section and aim	Key questions and probes
Introduction and warm-up Running slides	Welcome participants and thank them for attending. Introduce moderator and Thinks. • I'm [NAME]. I work for Thinks Insight and Strategy. We're an independent research agency so we're here to listen to your honest views and opinions. There are no right or wrong answers. Introduce topic of the research: Tonight, we are interested in speaking to you about how workplaces, schools, and other community venues could be used in the future to help deal with a public health problem. For example, an infectious disease outbreak which is sometimes known as 'a pandemic'. In your warm-up task we asked you a couple of questions about this. Today's conversations will build on some of the answers you gave. We understand that everyone had different experiences of the COVID-19 pandemic and this topic may raise some memories which might be uncomfortable. Please be reassured that when answering the questions you can give as much detail as you want. You can of course also decide not to answer a question if you don't want to. Introduce UKHSA.

	Introduce participant terms: • please share as much information as you feel comfortable sharing. If there are questions you don't feel comfortable answering then you don't have to provide an answer • please be kind and respectful. It's ok to disagree with others, but please do so politely • if you're not sure about something, please just ask. I'm very happy to help! • help me keep to time. I am here to guide you through the discussions. Sometimes I may need to move the conversation on to make sure we finish on time Recap terms of participation: • I will be recording our discussions • everything you say this evening will be anonymised. This means you won't be personally identified • we will be transcribing the recordings from our discussions today and sharing an anonymised version with UKHSA. These will be used for research purposes only and will be available only to the people working on this project at Thinks and UKHSA • we will also be writing up a report based on what comes out of these focus groups. This will be shared with UKHSA and may be published on GOV.UK. Just to remind you everything will be reported anonymously and no one taking part in the research will be identified in the report We will be talking for 90 minutes, finishing up at [TIME] Define the terms we'll be using this evening: • what is a pandemic? • institutions in scope - workplaces, schools, universities and other community venues • ways the venues may be used Start recording.

Section and aim	Key questions and probes
Scenario 1	First of all, let's do some introductions. Please could you introduce yourself by letting me know: • your name • whereabouts you live • what you would usually be doing on a Wednesday or Thursday evening Moderator to introduce scenarios: • we are now going to be talking about those 3 uses for the workplace, schools and other community venues in more detail. As a reminder, here they are again [Moderator to present use cases] • we are going to be doing this by imagining 3 future pandemics and thinking about what you would do and how you would feel in those circumstances • these pandemics are not real. They have been created by the research team solely to prompt discussion Moderator to read out the narrative for scenario 1. Moderator to share screen with the stimulus related to scenario 1, for example headlines, WhatsApp messages. Moderator to leave summary for scenario 1 on screen. In the chat, please can you write down 3 words to describe how you would be feeling in this scenario? Moderator to pick out a few responses and ask participants to explain why they've chosen these words. Let's start with the testing use case A. How would you feel if this were happening in this scenario? Moderator to re-share testing cases on screen if needed. • what sounds good about it, if anything? • what concerns would you have, if any? • to what extent, if at all, is there a need for this in response to the scenario? • how do you think it will help manage the pandemic?

Section and aim	Key questions and probes
	• how well, if at all, do you think it will be at doing so? Moderator to listen out for and probe on being able to keep venues open. • how appropriate or otherwise do you think it is to use workplaces, schools and other community venues in this way? • how fair, if at all, does it feel? (Moderator to probe for you, for other people) • what makes it feel more appropriate? Why? (Moderator to encourage participants to think about the scenario) • what makes it feel less appropriate? Why? (Moderator to encourage participants to think about the scenario) • what would you personally do in this scenario? • how easy or difficult would you find this? • what would make you more likely to 'follow the rules' and access testing in this way? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do? (Moderator to probe on who they are talking about and how factors differ for others) Moderator to share screen with scale of 1 to 10. Please type in the chat, on a scale of 1 to 10, with 1 being not happy at all, and 10 being completely happy, how you feel about using the workplace, schools and other community venues in this way. Now let's move on to use case B. How would you feel if this were happening in this scenario? Moderator to re-share testing cases on screen if needed. • what sounds good about it, if anything? • what concerns would you have, if any? Moderator to probe on the additional contact from the venue.

Section and aim	Key questions and probes
	• to what extent, if at all, is there a need for this in response to the scenario? • how do you think it will help manage the pandemic? • how well, if at all, do you think it will be at doing so? • how appropriate or otherwise do you think it is to use workplaces, schools and other community venues in this way? Moderator to probe on the differences between use case A and B and the reasons for this. • how fair, if at all, does it feel? • what makes it feel more appropriate? Why? • what makes it feel less appropriate? Why? • what would you personally do in this scenario? Moderator to probe on the differences in claimed behaviours between use case A and B and the reasons for this. • how easy or difficult would you find this? • what would make you more likely to 'follow the rules'? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do? Moderator to share screen with scale of 1 to 10. Please type in the chat, on a scale of 1 to 10, with 1 being not happy at all, and 10 being completely happy, how you feel about using the workplace, schools and other community venues in this way. Finally, let's look at use case C. How would you feel if this were happening in this scenario? Moderator to re-share testing cases on screen if needed. • what sounds good about it, if anything?

Section and aim	Key questions and probes
	• what concerns would you have, if any? • how would you feel about your employer or school knowing your test results? • how would you feel about your employer or school issuing sanctions? • how do you think other people might feel? • to what extent, if at all, is there a need for this in response to the scenario? • how do you think it will help manage the pandemic? • how well, if at all, do you think it will be at doing so? • how appropriate or otherwise do you think it is to use workplaces, schools and other community venues in this way? Moderator to probe on the differences in claimed behaviours between use case A, B and C and the reasons for this. • what makes it feel more appropriate? Why? • what makes it feel less appropriate? Why? • what would you personally do in this scenario? • how easy or difficult would you find this? • what would make you more likely to 'follow the rules'? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do? Moderator to share screen with scale of 1 to 10. Please type in the chat, on a scale of 1 to 10, with 1 being not happy at all, and 10 being completely happy, how you feel about using the workplace, schools and other community venues in this way.

Scenario 2	I'd now like to discuss using venues in these ways in a different scenario. Moderator to read out the description for scenario 2. Moderator to share screen with the stimulus related to scenario 2. Moderator to leave the summary on screen. In the chat, please can you write down 3 words to describe how you would be feeling in this scenario? Moderator to pick out a few responses and ask participants to explain why they've chosen these words. Moderator to return to how workplaces, schools and community venues may be used. Let's look at all 3 uses of venues again. How would you feel about each of these in this scenario? Moderator to probe on any differences. • what sounds good about it, if anything? • what concerns would you have, if any? • in this scenario, is there a clear need to use venues in this way? Moderator to probe on which ones and how they see using venues in this way will help manage the pandemic. • under this scenario, which of them feel more and less appropriate? • how fair do they feel, if at all? • what makes some feel more appropriate? Why? • what makes some feel less appropriate? Why? • what would you personally do in this scenario? (Moderator to probe on if they would adhere to some use cases and not others) • how easy or difficult would you find doing so? • what would make you more likely to 'follow the rules'? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do?

Section and aim	Key questions and probes
	To sum up, I'd like us to rate each of the ways of using these venues in the chat. Moderator to bring up a slide with all the use cases on and participants share their scores in the chat, for example A = 10, B = 7, C = 1.
Scenario 3	Finally, I'd like to look at our third scenario. Moderator to read out the description for scenario 3. Moderator to share screen with the stimulus related to scenario 3. Moderator to leave the summary on screen. In the chat, please can you write down 3 words to describe how you would be feeling in this scenario? Moderator to pick out a few responses and ask participants to explain why they've chosen these words. Moderator to return to how workplaces, schools and community venues may be used. Let's look at all 3 uses of venues again. How would you feel about each of these in this scenario? Moderator to probe on any differences. • what sounds good about it, if anything? • what concerns would you have, if any? • in this scenario, is there a clear need to use venues in this way? Moderator to probe on which ones and how they see using venues in this way will help manage the pandemic. • and under this scenario, which of them feel more and less appropriate? • how fair do they feel, if at all? • what makes some feel more appropriate? Why? • what makes some feel less appropriate? Why? • what would you personally do in this scenario? (Moderator to probe on if they would adhere to some use cases and not others) • how easy or difficult would you find doing so?

Section and aim	Key questions and probes
	• what would make you more likely to “follow the rules”? • what, if anything, would make it more challenging for you to follow the rules? Why is that? • what do you think other people will do? To sum up, I’d like us to rate each of the ways of using these venues in the chat. Moderator to bring up a slide with all the use cases on and participants share their scores in the chat, for example A = 10, B = 7, C = 1.
Reflection	Thank you for all your answers so far. Now I’d like you to reflect on everything that we’ve spoken about today. Thinking about all of these uses of venues. What difference, if any, does the actual venue make? For example, if it were your workplace or a school and so on. • are there some venues where it feels more appropriate for them to be doing this? • are there some venues where it feels less appropriate for them to be doing this? We’ve talked about testing. But how would you feel if venues were distributing medication to control the disease? • when, if at all, is this acceptable? • when, if at all, is this not acceptable? In these scenarios those with weakened immune systems and underlying health conditions are most vulnerable. How, if at all, would your views change if: • babies and young children were most affected? • teenagers were most affected? • the elderly were most affected?
Wrap up	Thank you all so much for your time this evening. Before you go, I’d like you to imagine you are talking to the person in charge of testing. What one piece of advice would you give them about using workplaces, schools and other community venues to deliver testing?

About the UK Health Security Agency

UK Health Security Agency (UKHSA) prevents, prepares for and responds to infectious diseases, and environmental hazards, to keep all our communities safe, save lives and protect livelihoods. We provide scientific and operational leadership, working with local, national and international partners to protect the public's health and build the nation's health security capability.

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