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those who live in single households and might benefit from company and provision of food should be prioritised.

Appropriate communication and awareness need to be enhanced for better community acceptance of facility-based isolation. If populations are made aware of the public health benefit of institutional isolation, appreciate the fact that such isolation will lead to better protection of their loved ones, and is associated with better clinical care for themselves, including easy access to food and practical support, maybe public acceptance will increase.

We declare no competing interests.

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Unnecessary obstacles to COVID-19 mass testing

Whether an effective COVID-19 vaccine will be universally available in the UK within a year is unclear. The UK Government has now accepted that in the interim, the only way to restore the normal life that COVID-19 has overturned for so many people is whole-population testing about once per week with integrated contact tracing.¹ However, while profitable for consultants and contractors, Operation Moonshot mass testing plans² might fail as badly as their current testing and tracing systems.

Public health specialists working at the local level have more experience than Deloitte, Serco, or G4S in population screening and contact tracing, and the best (and cheapest) tests for rapid roll-out might well be non-proprietary PCR and loop-mediated isothermal amplification (LAMP) protocols. No approved commercial tests were available when the pandemic emerged, so the government has decided “to provide first-generation in-house assays for public health laboratories as an interim measure and for gradual migration to a commercial alternative.”³

We urge the government to reconsider this commitment to unspecified commercial contracts that cannot supply the 10 million tests per day needed for weekly testing in the UK. Rapid tests administered by a trained person, although essential in airports and various other public venues, are not suitable for weekly whole-population screening. Self-collected samples analysed in a laboratory can provide reliable same-day results entered online, triggering household isolation and immediate contact tracing.¹ Whether sample testing takes 5 min or 3 h is less important than the proportion of results that are reported both personally and centrally within a day or less. Both RT-PCR and RT-LAMP can be almost as sensitive as quantitative PCR, the gold standard test, and false positives can be virtually eliminated by a confirmatory

test. Cost-benefit evaluation of RT-PCR and RT-LAMP tests on self-taken saliva samples compared with rapid point-of-care nasal swab tests and other systems can be carried out during roll-out of organised population screening, which should expand as rapidly as the supply of kits, equipment, and reagents permits. As population screening expands, this ongoing comparison of RT-PCR and RT-LAMP against commercial alternatives will identify the best tests for screening and for other purposes.

Large university and independent labs will contribute to the roll-out and evaluation of population screening in their city or district, supplementing the capacity of the lighthouse labs while local RT-LAMP testing facilities are being established. They can provide expertise, a trained workforce (including volunteers), and, in many cases, the extra PCR machines.

We declare no competing interests.

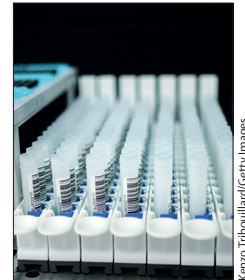
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Influenza control during the COVID-19 pandemic

As the northern hemisphere influenza season begins, challenges loom for health systems bracing to manage a simultaneous rise in cases of COVID-19 and influenza. Successive winters have taught us that the burden of influenza is high in ordinary times, and a



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