SURREY LOCAL OUTBREAK ENGAGEMENT BOARD – 18 FEBRUARY 2021

PROCEDURAL MATTERS – QUESTIONS AND RESPONSES

1. Question submitted by John Gardner

The cost to society of significantly reduced access to NHS services during lockdown means there will be considerable numbers of people whose conditions/diseases have progressed to an irretrievable point, meaning many could die prematurely of undiagnosed: cancers, untreated strokes, heart attacks and diabetes – all of whom have effectively been denied treatment. The costs and impact on the local economy could be considerable.

If COVID-19 becomes endemic, and lasts much longer than anticipated, what contingency measures and resources does the Council envisage will be required to achieve its long-term objectives for the future wellbeing of its population?

RESPONSE:

The analysis of mortality data suggests a strong link between heightened vulnerability to COVID-19 and pre-existing health inequalities. Failure to reduce health inequalities is likely to further exacerbate the future impacts of the pandemic.

The nature of health inequalities is often complex and require strategies that are multifaceted to bring Health, Local Government and Voluntary, Community and Faith Sector (VCFS) organisations to work together.

In September 2020, a multi-agency Equality and Health Inequalities workstream as part of the Recovery Board was set up. This workstream oversees the current interventions targeted against the key COVID-19 health inequalities. The urgent priorities for this workstream have been informed by considering the key local COVID-19 vulnerabilities (e.g. age, pre-existing physical/mental health conditions, people with learning/physical disabilities, living in the most deprived areas, BAME and homeless population) and the findings of Surrey COVID-19 Community Impact Assessment. However, as we go into recovery, appropriate interventions though partnership working will need to be implemented to increase the well-being of the local population for benefits to be realised in short, medium and long terms as listed below:

Short/immediate term: Reducing and managing the clinical risk factors; early diagnosis (e.g. cancer, stroke, dementia and cardiovascular conditions), better management of long-term conditions (e.g. mental health, high blood pressure, diabetes, respiratory conditions) and addressing geographical variation in delivery of health care services.
Medium term: Building a healthy population by promotion of the prevention agenda to increase the uptake of healthy life interventions, such as nutrition, physical activity, smoking secession, alcohol and substance misuse reduction.
Long-term: addressing the wider determinants of health, such as economic, environmental and social factors. There is an urgent need to do things differently and build a society based on the principles of social justice in order to reduce income and wealth inequalities. Our strategy in rebuilding the economy needs to be based on the achievement of health and wellbeing outcomes, not just narrow economic goals. We also need to build a society that can respond to the climate crisis as well as achieving greater health equity.

Doing things differently will require engagement with the local population to empower, rebuild resilience and strengthen community cohesions. Joint outcomes will need to be set to

bring Health, Local Government and VCFS organisations together to maximise benefit. Bringing these facets together effectively, requires strong engagement of the system leadership, partnership working to deliver integrated processes.

There has been a lot of learning from the pandemic which can be expanded and built on. For example, initiation of great initiatives such as community champions, closer engagement with community faith leaders and local/regional collaboration across organisations between Primary/Secondary care, Local Government (including Public Health and Adult Social Care), statutory/non-statutory and community services. Additionally, established workstreams such as the Equality and Health Inequalities and Surrey Health and Wellbeing Strategy will help provide the delivery vehicles for making our vision to tackle inequalities in Surrey a reality.

2. Question submitted by Renos Costi

What is the model being used and what is the expected trend of the virus as we leave winter accounting for seasonality, accounting for new vaccines, and new strains which maybe resistant to these?

What level of community infection is the Council willing to tolerate given that this must be weighed against the deaths directly caused by lockdowns?

RESPONSE:

- **What is the model being used and what is the expected trend of the virus as we leave winter accounting for seasonality, accounting for new vaccines, and new strains which maybe resistant to these?**

There are many factors that would need quantifying, with appropriate ranges for sensitivity analyses, including:

Seasonal effect – There have been published papers suggesting less impact over Summer months when compared to the Winter. This is observed in all respiratory viruses and a similar impact would be expected with COVID-19. However, the evidence is variable when comparing southern hemisphere experiences against the northern hemisphere. Therefore, the impact of seasonality is difficult to predict.

Strength and length of immunity from infection – The most up to date data shows good levels of antibodies in those infected 6 months after infection. With SARS CoV, antibodies were sustained well for 18 months, but tailed off after that. This is unlikely to have a major impact on assumptions for the next 6 months, but it is not known definitively for SARS-CoV-2.

The impacts of any new significant variants – At the moment, there have emerged a number of variants of concern. Increases in transmissibility and the ability to evade the immune system (from natural immunity and current immunisations) are under investigation. The likely impact also depends on our border policies and how quickly emerging variants can be identified and ring protections put in place. None of these components can be accurately quantified at this stage.

The impact of the vaccination programme – Without doubt, the immunisation programme will have a significant impact on the risk of an individual contracting COVID-19 and the severity of disease. Quantifying the overall impact is challenging. Modelling can take the published vaccine effectiveness data, the roll out schedule and likely uptake to project impacts forward. However, the impact on transmissibility is unclear, although likely to be

positive, and as mentioned in the variant section, we cannot be sure that mutations have not emerged that affect the effectiveness of the current vaccines. The potential impact of being vaccinated on behaviours, means predicting overall impact on transmission is impossible; this will also be influenced by the potential impact of infection prevention and control measures easing in places where everyone has been vaccinated.

Political impact – Decisions on foreign travel, border control, how we exit from lockdown and any re-escalation will all have significant impacts on subsequent waves. Making any predictions of future political decisions is not viable at this stage. When escalation points and the measures for easing are clearer this can be reconsidered.

Population behaviours – Population behaviours are very difficult to predict. The impact of weather, the length of restrictions, media reporting, political announcements and being vaccinated will all have impacts.

These are all challenging considerations and any thorough sensitivity analysis will lead us to two scenarios - minimal subsequent wave and the original pandemic reasonable worst case scenario. At the moment, we await further guidance and views from SAGE that considers all of the expert modelling from SPI-M (Scientific Pandemic Influenza Group on Modelling). Work is underway at PHE and NHS to provide insight to future modelling and assumptions.

- **What level of community infection is the Council willing to tolerate given that this must be weighed against the deaths directly caused by lockdowns?**

Decisions regarding lockdowns and release are made at a national level.

3. Question submitted by Philip Walker

In the UK Influenza Pandemic Preparedness Strategy 2011, point 2.20 recommends preparing for a case fatality rate of 2.5%, with severe burdens on healthcare capacity, and yet point 3.1.ii stresses the importance as an objective of minimising societal disruption and returning to normal at the earliest opportunity. Points 4.1, 4.2 and 7.4 all assume and recommend that the government will not restrict the normal daily lives and gatherings of the healthy population.

The accompanying ethical framework emphasises respect for the public and the personal choices they make with regard for all aspects of their health, minimising the harm brought by disruption to society and that any restrictions be justified by cost benefit analyses.
Current statistics show that across the vast majority of the population the lethality of COVID-19 is a tiny fraction of the assumed 2.5% case fatality rate yet the local and national response to the virus has taken choice away from the whole population, prioritised the virus over other life and quality of life threatening concerns, and has no end point that has been committed to.

Does the local authority consider the 2011 Strategy relevant and if not, why not?

What action is the local authority taking as the vaccines are rolled out to pressure central government to commit to fulfilling their ethical duty to allow healthy people to choose to go back to normal at the earliest possible opportunity?

RESPONSE:

There are elements of the UK Influenza Pandemic Preparedness Strategy 2011 that would be relevant to any disease pandemic. For example, similar factors will influence the impact of the pandemic, such as; disease characteristics (number of cases, severity of disease, transmission, clinical groups affected); service capacity (number of patients presenting to primary care, hospital or intensive care facilities); and the behavioural response (levels of concern and compliance with control measures). The key elements of a pandemic response will also be similar, such as detection and assessment; reducing the risk of transmission and infection; minimising serious illness and deaths; and vaccination.

Although influenza and COVID-19 are both respiratory diseases, they are caused by different viruses, therefore not all of the measures set out in the UK Influenza Pandemic Preparedness Strategy 2011 are relevant for this current pandemic. For example, we have antiviral drugs available to treat influenza, however for COVID-19 we have had to explore possible treatment options during the pandemic and our understanding of how to treatment COVID-19 is still developing. We also have effective influenza vaccinations, which could be adapted for a new strain of influenza, however COVID-19 vaccines have had to be developed during the pandemic. Therefore, with limitations to the some of the measures we have to protect the population from COVID-19, the strategy has had to be adapted.

National lockdowns are only one part of the national COVID-19 response strategy. Without such measures when community transmission is very high, there is the potential for COVID-19 to cause significant morbidity and mortality within the general population, and the potential for the healthcare system to be overwhelmed by this burden. As the level of community transmission falls and more people are vaccinated, the burden of morbidity and mortality from COVID-19 is likely to fall and it will be possible for the level of restrictions to be reduced. The health and wellbeing of our residents is our primary concern, and we are implementing support measures to ensure that residents are supported during this period. The Surrey Local Outbreak Control Plan is our key vehicle for ensuring appropriate action takes place in response to the pandemic.