

## **Government meeting 20th Sep: COVID Control strategy**

*Interchangeable terms of control, elimination and eradication are often used but poorly understood. [The WHO](#): 'control is a reduction in the incidence, prevalence, morbidity or mortality of an infectious disease to a locally acceptable level; elimination as a reduction to zero of the incidence of disease or infection in a defined geographical area; and eradication as permanent reduction to zero of the worldwide incidence of infection.'*

The current strategy requires acknowledging the virus is endemic and the need to learn to live with COVID. Recent responses are out of proportion to the threat. They are underpinned by a lack of understanding of the data, the role of community pathogens and an overreliance on predictive modelling. Thinking has been distorted by three decades of 'influenza preparedness as if there were no other pathogens with pandemic potential.

- Spain provinces appear well past local peak by date of symptoms. ([see here](#)); greater number of cases are asymptomatic ([see here](#)); if the rate of growth maintained exponential rise, the daily level would be above 200,000 by now.
- In reply to a 2017 [parliamentary question](#) – Children's admissions double/treble from Aug to Sept
- RCGP surveillance shows cases of acute respiratory infection increased by >50% in a week to 67 per 100k. Current COVID cases are increasing somewhat in line with this (seasonal effect)
- Symptomatic consultations will increase 4 to 8-fold into winter
- Roughly one in thirteen (7.8%) deaths with COVID-19 on the certificate did not have COVID as underlying cause of death; this proportion has risen to 29% for the last eight weeks of reporting.

## **COVID control strategy (targeted measures that protect the most vulnerable from COVID)**

A strategy built around control (scenarios of elimination and eradication not viable).

### **Aim: To control the spread of acute respiratory illness while minimising societal disruption**

#### **COVID control strategy (8-month plan) back to near normal by May 2020**

- Care Homes plan - urgently needed - signal already in the data (82% of the outbreak occurred within 8 weeks in Spring). Actions: new minister care homes; 20% increase in staffing (no moving between homes ([evidence](#) for this); intensive clinical care home team in the community (keep in home at all costs). Germany's CFR same in the elderly, fewer cases, explains lower death counts.
- Enhanced hospital infection control – requires transparency around nosocomial infections.
- 50% work at home strategy (intervention on social distancing with low impact on productivity)
- Young people - simplify the message, too confusing, losing their trust
- Seeking to increase the personal threat perception of COVID should now be reconsidered
- Testing- switch of testing in primary schools ([evidence](#) children to adults transmission is limited).
- Universities set up their own testing facilities.
- Abandonment of the binary test result Y/N, creation of management protocols at all levels which require more information but allow focus on what is important - Cycle threshold (Ct) to direct tracing strategy to those most likely to be infectious (Ct<30).
- Xmas break - 5000 more deaths a week will occur at the height of the seasonal ILI effect. Xmas can be extended for schools by 2 weeks with minimal disruption because of planning lead-in time. Could act as a breakwater at the height of viral respiratory illness "season".
- The road ahead will be bumpy, and there will be more deaths but there needs to be context. The public is fed the daily diet of Covid - deaths are lower than influenza/pneumonia.

## **Intelligence Unit**

There is an enormous amount of data becoming available every week. The general quality is improving but overall, still poor. A systematic approach to gather and sort these to separate facts from opinions is required.

- Current interventions poorly thought through and not having the desired effect-. We are working with WHO to provide two weekly updates on transmission. Understanding what makes a difference to transmission crucial
- Better use of data - how many asymptomatic, use of cycle thresholds, improved (for all ILI)-local hospital trust data on the impact of disease (small group of trusts and rapidly upscale)
- Robust testing of interventions - no need to rush headlong in - we are none the wiser if we do this
- A wider group of healthcare expertise required to inform next steps (primary care not represented)