DRAFT LETTER TO PM

Dear Prime Minister,

We are making huge progress in our fight against COVID-19: case rates are falling and vaccines have been rolled out to over 12 million people in England. However, we are all agreed that businesses and the British people need some certainty after almost a year of sacrifice. In setting out the plans for easing restrictions in the week commencing 22 February, as you have committed, we need to be clear about what actions are most likely to be sustainable and help us prepare for the Winter, therefore achieving a much better outcome for both the NHS and the economy.

In time, COVID-19 will reach a more settled, endemic phase, with surges likely in winter. We are unlikely to eradicate the virus, but we should aim to contain cases, much as we do with the flu, which society has shown we can tolerate alongside a vaccination programme and an open economy. We need to plan ahead for that likely and brighter future, both in terms of setting ourselves up on the right path in the way we exit this lockdown and putting in place the healthcare and other responses needed to manage the 'new normal'.

At this moment, we have a very high caseload of a virus which is aggressive and highly transmissible. Although vaccination of the adult population should, in time, ~~achieve around 50% immunity~~protect a large proportion of the population from severe disease over ~~in~~ the course of 2021, if we release other interventions too quickly, cases will surge among those who are not protected by either vaccination or previous infection. The impact will be evident in serious illness, hospitalisations and deaths.

Commented [VTJ1]: I don't recognise that concept. Given variants I would not overplay this

While mortality rates overall, are likely to drop as a result of the vaccine programme, there will still be a significant number of deaths if we release NPIs when we do not have control of the virus. Serious illness will still occur along with 'long-Covid', and hospitalisation rates – which are longer for those less vulnerable than those likely to die – will outstrip capacity and overwhelm the NHS. Moreover, high caseloads are a breeding ground for new variants and a variant that escapes the vaccine is potentially the start of a whole new epidemic.

We need to bring cases down as much as possible alongside the vaccination programme, release the controls cautiously, and come down very hard on new variants. Even so, SPI-M has concurred that "a further wave of the epidemic is almost certain": it is how we mitigate against this which is important. This wave might be within manageable tolerances if the upsurge begins later rather than sooner, and from a low starting point of cases. The modelling clearly shows that the higher the starting point, the higher the resulting peak.

To ensure we are in the best position achievable when this upsurge begins, strategic patience in releasing restrictions, measured in weeks between stages, and maximising the use of testing, is imperative and will enable us to avoid significant harm caused by the reinsertion of strict controls, with loss of business and public confidence. Both health and economic impacts will be mitigated if we delay the release of non-pharmaceutical interventions (NPIs) so that we can build up immunity in the population and reduce overall prevalence in the likely further wave. This will need to be carefully explained to the public to justify measures and secure continued compliance with restrictions.

To achieve our objectives and keep the public's confidence, our approach should continue to be data-led to determine how and when restrictions are eased. We should avoid committing to specific dates or timeframes as there are simply too many unknowns about the epidemic: the effect that vaccines will

have, the possibility and severity of new variants, and how the number of cases, hospitalisations and deaths will change in response to each de-escalation. Instead, there should be a commitment to review the restrictions in light of the data, which may result in maintaining restrictions, de-escalation or even re-escalation. We must provide the public and businesses with as much certainty as we can, but we must also be clear that it is imperative we retain the flexibility to respond to the epidemiological situation in real-time.

I have just written to the Chancellor ahead of his Budget Statement setting out my latest assessment of the financial requirements of the health and social care system in fighting Covid. That assessment is based on the slow and phased reduction in NPIs, and retention of significant baseline NPIs, that is most consistent with our objectives. But even in this scenario and even assuming non-covid demand continues to be suppressed at 80%, indicative DHSC analysis suggests we could see 52+ week waiter growing beyond 500,000 and the waiting list beyond 5 million by the end of 2021. So the case for building on the non-recurrent £1bn for elective recovery we have allocated so far and through the NERT agreeing a sustained multi-year elective recovery plan ahead of the next election, including through an increase in the permanent bed base will be strong.

The same analysis suggests that under a quicker reduction in NPIs we could see the number of people waiting more than 52 weeks increase beyond 600,000, and the waiting list beyond 6 million by the of 2021. Increasing the scale of the challenge by around 20% in this way, will add more than 20% to the cost of tackling it given the increasing marginal cost of buying the physical and workforce capacity we would need.

Commented [HC2]: sounds very colloquial - those waiting 52+ weeks?

And these are far from the only financial implications of a quicker reduction in NPIs. Further to the assessment set out in my Budget letter to the Chancellor, we would need to provide for the following:

- The scale of the peak in hospitalisations would further delay the return to normal financial planning in the NHS; each quarter of lost efficiency creates around £900m of recurrent pressure against SR20 assumptions.
- It would require us to take additional capacity-enhancing interventions to avoid the NHS being overwhelmed.
- It would create an impossible backdrop against which to deliver the 1% pay award provided for at the SR – each 1% above that creates c 540m of cost pressure.
- It would mean we would need hundreds of millions more to cover the costs of therapeutics and PPE.
- It would increase the incidence and long-term costs of treating Long Covid.
- The fact that the peak would arrive prior to the vaccination programme taking full effect, would increase the impact on workforce availability across the economy. It would mean we would definitely need to extend the three funds we have established to reduce transmission and bolster workforce capacity at an additional cost of over £500m.
- Average prevalence would be [x%] higher increasing demand for and costs of PCR testing, and increasing the chance of vaccine escape variants which may mean further waves and increased costs across our Covid response.

Finally, I want to draw to your attention that across our Covid response, there are a range of options we are considering which can maximise the chance of us making a reality or even 'outperforming' the

assumptions built into the SPI-M modelling and so limiting the implications for deaths, hospitalisation, NHS performance and costs.

- Investing heavily in newer Testing use cases such as targeted testing surges, workplace testing, and Test to enable
- Maximising compliance with self-isolation by substantial increasing the size and eligibility thresholds for financial support
- Further investment to boost vaccine take-up, potentially including financial incentives.
- Radically scaling up our support for the development of anti-virals and other potential treatments with an aggressive commercial approach on the model of the Vaccine Taskforce Force, and investment in the low £billions.
- Revaccination, possibly in Autumn 2021

Formatted: Font: (Default) +Body (Calibri)