Message

From: Whitty, Chris [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0B3EE62E0CA04E978730B14F9B416A1E-WHITTY, CHR]
Sent: 09/10/2020 15:31:10
To: Simon Case - Cabinet Office - (OFFICIAL) [simon.case@cabinetoffice.gov.uk]
CC: Ridley, Simon - CO (OFF-SEN) [Simon.ridley@cabinetoffice.gov.uk]; Kate Josephs [kate.josephs@cabinetoffice.gov.uk]; P.Vallance1@go-science.gov.uk
Subject: Tier 3

Dear Simon

I have had a chance to read the Tier 3 proposals, and have also discussed with Patrick (ccd), who agrees with this analysis (he may reply separately). In Tier 3 areas by definition COVID incidence rates are high, and rising fast and exponentially. The implications of this as it moves into older populations are widely accepted and do not need restating.

There were two options we thought had a reasonable chance of success of meeting the strategic goals set out by the PM, based on SAGE advice, in some combination:

1) A package of interventions sufficient to get areas with rapidly rising transmission back to around R≤1, stabilising the situation but not decreasing incidence below current rates. These would, by definition have to be maintained over the entire major period of risk, which probably for practical purposes means to the end of winter (ie 5-6 months). Incidence would not drop below what it is now but track along even if the package were sufficient. R may naturally rise over the respiratory virus season requiring additional measures to retain status quo.
2) A firebreak period of very strong measures for a defined period of a few (2-4) weeks that have a high chance of pushing R below 1 so cases fall, resetting the clock on transmission. It should be possible to get away with fewer NPIs over the long run than 1) above if this approach is taken but some would still be needed.

The current minimum package, which at its core is pretty limited, for only 4 weeks is likely to be neither significant enough to achieve a time limited firebreak, nor prolonged enough to maintain control albeit at a higher level. Only if Local Authorities chose to go to the top of the possible range of options which are defined as 'subject to engagement' across multiple domains would it be likely to have an effect in a short period, and even this is not certain. Longer periods of significant NPIs are likely to be needed in these high incidence areas.

Both 1) and 2) above need buy in from the population, and from LAs; local consent is essential.

I worry that this current approach will fall between two stools, unless all the affected LAs choose to go to the top of their licence, which is likely to be the advice of their Directors of Public Health who are faced with the stark realities of where the current exponential growth will leave their populations and local NHS, in the face of exponential growth in cases.

I am happy to support in any way that would be helpful.

Best wishes

Chris

Department of Health & Social Care

Prof Chris Whitty CB FMedSci
Chief Medical Officer for England and
Chief Scientific Adviser
Department of Health and Social Care, 7th Floor, 39 Victoria Street, London, SW1H 0EU

E: chris.whitty@dhsc.gov.uk