COVID-19

Finding our way to the new normal

Whole Systems Partnership

Discussion paper v2.0 (10th May 2020)

1 Introduction

The 11th May 2020 marks the start of week eight since the lock-down of the 23rd March. Evidence from social interactions before and after the 23rd March shows that whilst people had already started to change their work and travel patterns before the 23rd it is likely that this was more than compensated for by the significant increase in shopping trips, leaving our overall levels of interaction broadly similar until that date.

In terms of the spread of the virus it is therefore likely that the 23rd March was something of a cliff edge, although the pent up infections that would subsequently emerge as symptomatic, progressing to severe reactions, hospitalisation and potentially death would take a number of weeks to work through. The peak in hospitalisation and deaths in mid-April reflect this, although with key workers and essential travel continuing and over 90% of the population still susceptible to the virus new cases continue to occur.

On our current trajectory, with R, the all important reproduction rate, below 1 it would be theoretically possible to get to a point where those with the virus could be identified through test, track and trace (3T) and a significant return to normal life could resume. The practicalities of this, however, are daunting and have significant leakage points over the short term. 3T is in its infancy in the UK and remaining pockets of unidentified infection would persist within the population for many months.

We are therefore highly susceptible as a population to a resurgence of the virus were the lock-down eased too quickly or if people's behaviours interpreted relaxation measures too leniently or inconsistently.

2 The next 3-6 months…

2.1 The risk of subsequent peaks

There are an almost infinite number of possible scenarios, but broadly you could categorise these into the following:

1. That the lockdown is eased gradually from the 11th May over the next 6-8 weeks, meaning reduced overall effectiveness of social distancing, whilst the impact of 3T begins to develop so that by early-mid July the effectiveness of social distancing is back to where we were over the first period of lock-down.
2. A modest one-step change in social distancing effectiveness from the 11th May that does not risk a significant second peak, with no subsequent alterations over the rest of the calender year – the new pre-vaccine normal.

3. A more significant one-step change from the 11th May that causes R to rise above 1, initiates a significant second peak and therefore further needs to lockdown again later in the year.
4. An easing of the lockdown on the 11th May with only slight reductions in the effectiveness of social distancing plus earlier impact form 3T than scenario 1

Our modelling suggests that scenarios 1 and 3 produce second peaks over the summer, although of different magnitudes and neither being likely to swamp the NHS. However, what is likely to be characteristic of any second peak is that the mix of severity of need will be less. This is because the peak during April was fuelled by fairly open transmission of the virus between all risk groups during March, whilst any relaxation now put in place would still retain a good level of protection for the more vulnerable groups. Subsequent peaks are therefore likely to put more pressure on General Practice in supporting larger numbers of people not requiring hospitalisation, less pressure on hospital beds and lower risk of death.

2.2 Non-COVID needs

It is becoming clear that a significant side-effect from the seven week lockdown has been the suppression of non-COVID needs. There are three types of non-presenting need that should be recognised:

1. Needs that will simply pass and may have been addressed through alternative means including self-help. Much of the reduction in A&E attendances is likely to be of this type and is in may cases likely to have been perfectly safe and even positive in improving people's ability to self care.
2. Needs that can wait for weeks or perhaps a few months with no or minimal risk to health. This may be the case for some types of health checks or general health concerns in low-risk groups within the population.
3. Needs that will deteriorate if not addressed and could therefore lead to significant harm and additional excess deaths. This is likely to apply to a wide range of physical and mental health needs and is already suspected from excess deaths data that cannot be explained by COVID-19, although it will only be in retrospect that the full extent of this will be understood.

There will be challenges in addressing the back-log in both type 2 and type 3 suppressed demand, with an obvious priority being given to progressive conditions. Whilst some of this backlog could be addressed through virtual means, many require physical attendance at hospitals where social distancing rules will contibue to apply, for example in the number of people who might be allowed to attend an outpatient clinic and the lengthened time that might be required for standard procedures due to heightened vigilance in relation to hygiene.

2.3 Building the intelligence base

The COVID-19 epidemic has highlighted the relatively poor state of our intelligence about patient flow through a system of care. The effective modelling and forecasting of the impact of the pandemic in a local system relies on knowing more about flow, but such intelligence is rare. Relatively simple questions such as '*where do COVID patients go after discharge?*' or '*how many people are dying in care homes and the community?'* are proving difficult to ascertain leaving us reliant on assumption building that is either based on a mixture of sparse but useful data points, professional judgement, guess work and triangulation.

The relaxing of data sharing arrangements should be used to accelerate our proficiency in the use of linked data with a particular focus on learning about the progress of the pandemic – tracking people with a COVID-flag from first symptoms through to recovery or

death should be a priority in our building of the intelligence necessary to manage any subsequent peaks, and the transition to a new normal.

In addition, it is clear that there will be a 'COVID-shadow' in the population, and therefore in our data for a significant period to come, potentially for several years. The risk of harm from COVID-19 such as lung or kidney damage, or through non-COVID needs not being met, could extend the period of Excess deaths well beyond the point when the pandemic is declared over. At some point, however, the presence of excess deaths in one period will reduce the numbers of people who would have died at a later point, but who's death was effectively brought forward by the pandemic and its effects. Recognising this COVID-shadow in our population health management programmes will therefore be necessary for several years.

3 The transition

There will be no sudden end to the COVID-19 epidemic before the development of a vaccine. Even for those who can say positively that they have had the virus and perhaps then return to work will need to continue to practice social distancing for the safety of others. For those who remain in the high-risk category and are still susceptible the need to be shielded is likely to continue well into 2021. The transition period will therefore be staggered for different groups and for different reasons.

However, during this transition we should also be ready to recognise behaviours and responses to the epidemic that are to be valued and if at all possible sustained. These might, for example, include:

- People's reluctance to go to ***A&E*** does harbour risk, but equally fulfils much that has been attempted by health systems over many years in the art of self-care – striking the balance and encouraging people to learn from their willingness to self-care should be explored;
- Equally the significant reduction in unscheduled hospital admissions might in part be a reflection of the choice that some people have struggled to make in the past at the ***end of life***, that is to support people to die at home, and this relates to COVID and non-COVID patients – learning from this could contribute significantly to the ongoing policy direction to encourage and support people's wishes at the end of life;
- The development of Community Support Groups for COVID-19 represents an opportunity to explore the effectiveness of ***community organising***; the contribution and partnerships necessary in and with the charitable and voluntary sector; and the extent to which strength based v's 'traditional' voluntary sector support is able to respond, meet needs and improve outcomes – these groups have the potential to continue their vital role through the transition and beyond, with support for the shielded and their ability to respond in ways that have the potential to address low-level mental health related needs such as anxiety;
- Our reliance on simple and accessible ***technology*** during the epidemic has mushroomed and needs to be seen as an opportunity to embed new ways of working – exploring the contribution that technology has made to meeting people's needs during the epidemic and retaining what works well should therefore be a priority, although any excessive use of technology where the physical presence with a professional adds value to the encounter and improves outcomtes should be identified and avoided.

4 The new normal

The new normal should not therefore be about returning to the past. A care system that has learned how to respond as a system rather than as individual organisations takes us a giant step forward. An epidemic also highlights the importance of population health approaches to understanding and addressing people's needs, albeit on a drastically reduced timescale. We should therefore look to a future in which:

- The needs of any given local population will have been reshaped by the passing of the epidemic – recognising and responding to this through the emergent population health management programmes will be critical;
- The COVID-shadow will remain a factor in meeting health needs for several years to come – adequately reflecting this in our health and care planning will be an ongoing task;
- People's ability to self-care and to rely on local support networks will have been enhanced and needs to be reinforced alongside which new strength-based approaches to community organising will have been demonstrated and should be seen as a contribution to addressing some of the wider determinants of health including low-level mental health needs, loneliness and social isolation or other vulnerabilities;
- Primary, community health and social care services will have had an opportunity to work more closely together as people choose not to go to hospital for non-COVID needs, something to be harnessed and refined in the context of local needs;
- Our reliance on A&E and admission to hospital will perhaps have been sufficiently challenged to enable us to return to a new normal in which the balance between hospital and community services will have made a stepped change.

Your thoughts and contributions to enhance these insights would be very welcome.

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