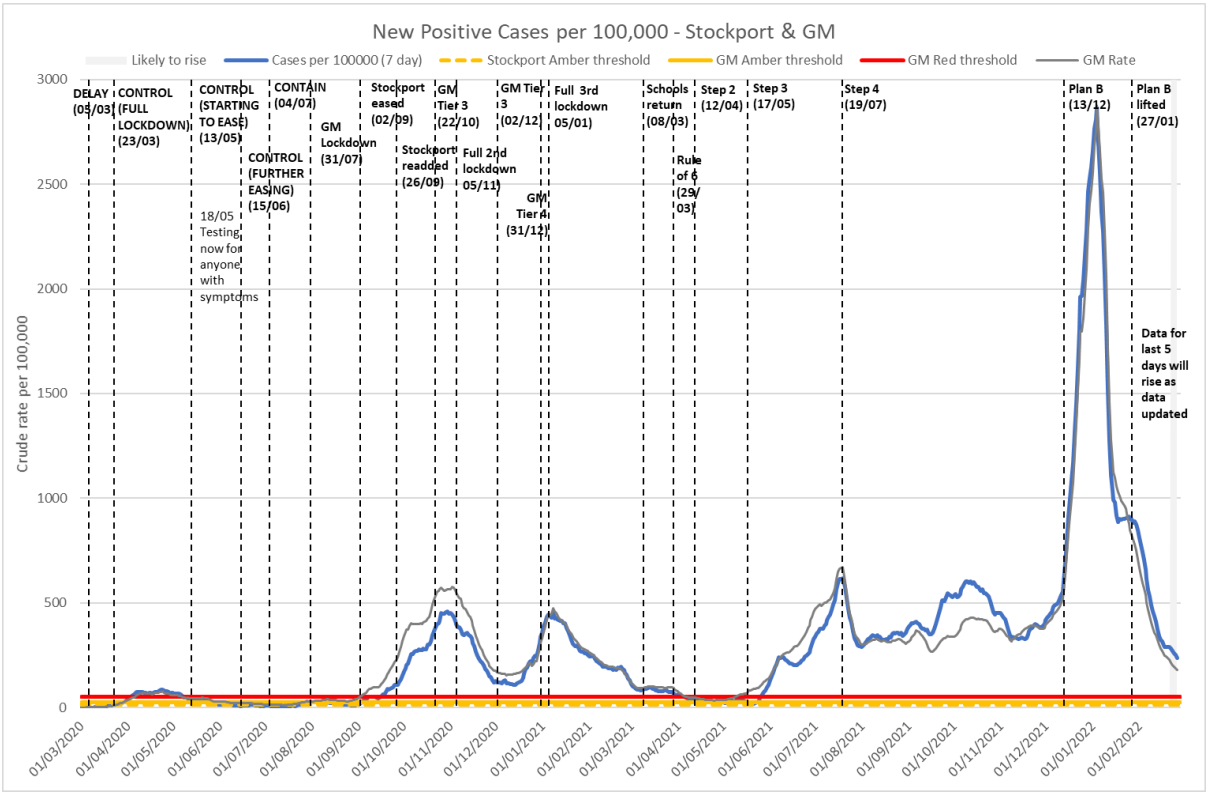
COVID-19 Update for Adults Care and Health Scrutiny Committee 03/03/2021

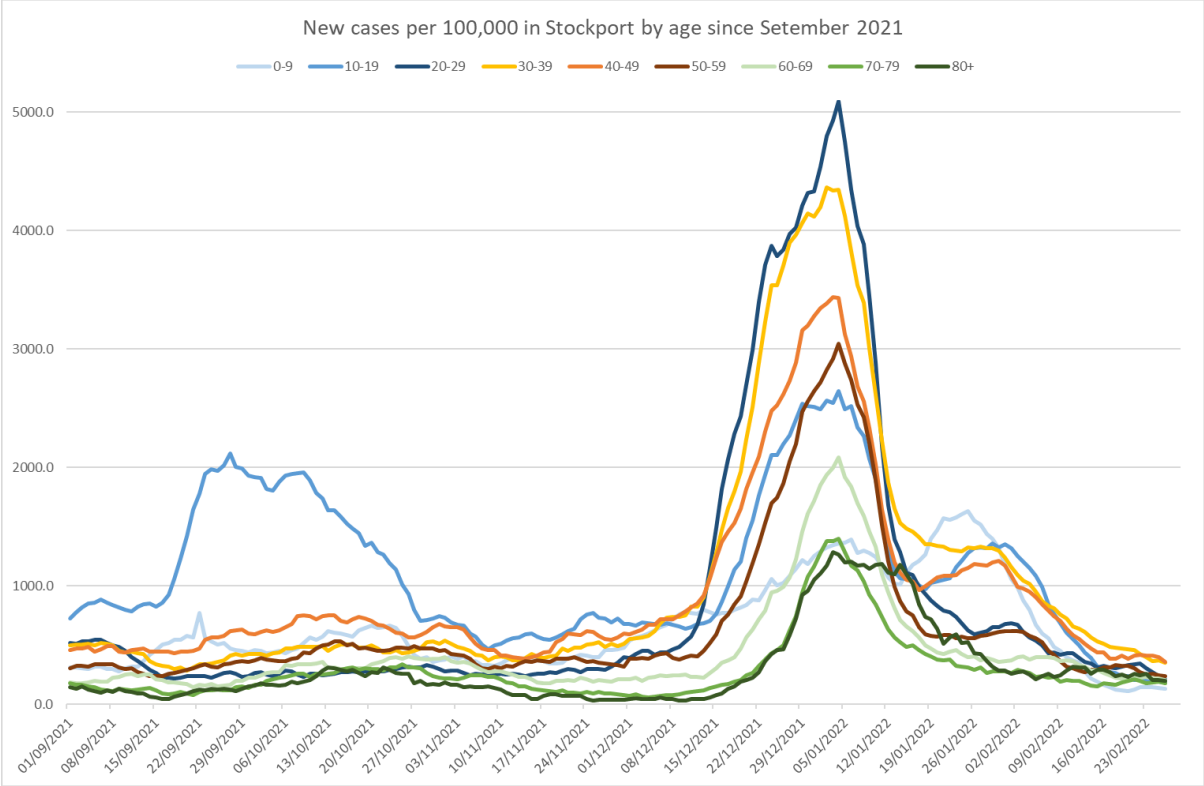
1. Assessment of current situation

1.1 Latest data shows that in Stockport we have had an average of 98 new cases per day over the last week. This gives us a rate of 235 per 100,000 population. This is above the Greater Manchester average of 178 per 100,000 but below the England average of 394 per 100,000. This rate has fallen dramatically from the Omicron wave in December and January, but remains above the rates seen during the last two summers.



1.2 The rate for those aged 0-17 is 150 per 100,000. This rate had an additional peak in February 2020 driven by infections in unvaccinated younger children when schools returned after Christmas, but has now fallen below the wider population rate. The rate for those aged 18-29 is 213 per 100,000. The rate for those aged 30-59 is 314 per 100,000. The rate per 100,000 for those age 60+ (green) is a lower, at 193. There is a falling trend for all adult age groups.

The graph below shows the rate in 10 year age bands.

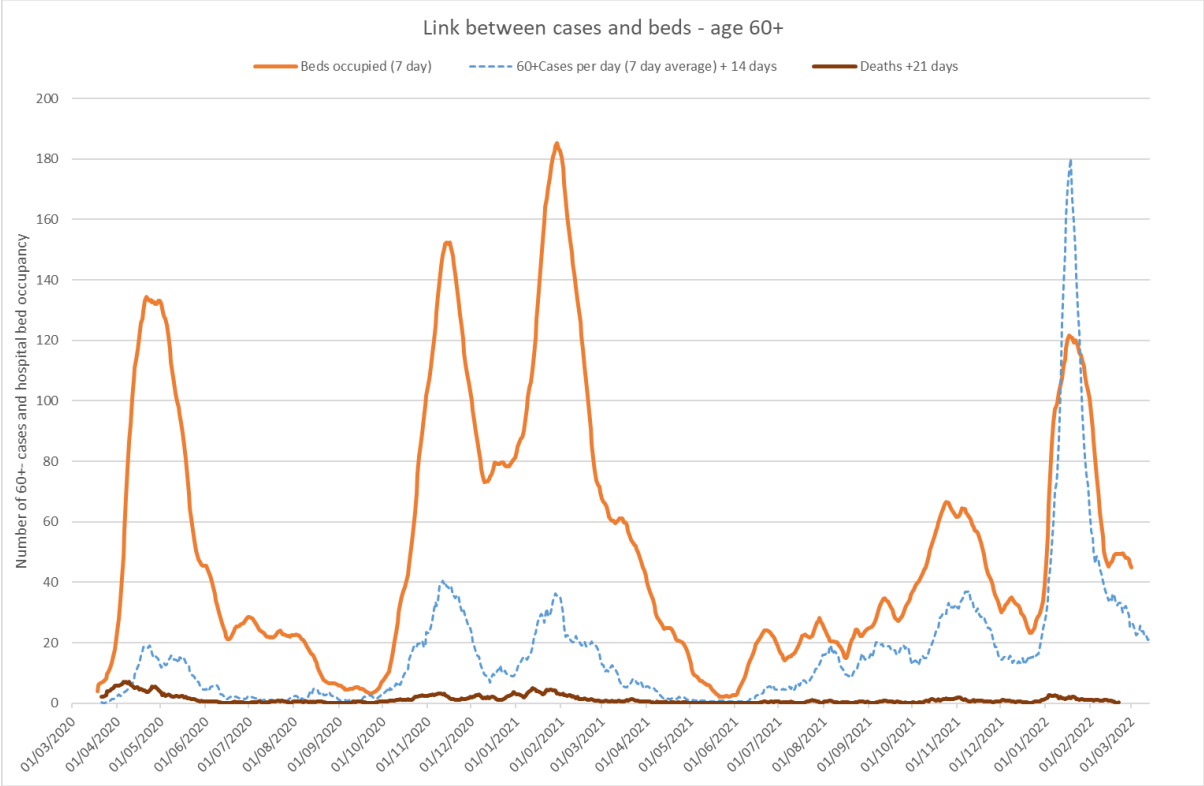


1.3 Geographically across Stockport, there continues to be regular movement in which MSOA area has highest rates, with no singular 'hotspot' or cluster on a geographical basis (Interactive map of cases | Coronavirus in the UK (data.gov.uk).

1.4 The Omicron variant resulted in the large wave of transmission around the turn of the year, and remains the dominant variant. We expect to see other variants continue to emerge in the coming months and years, but we are not seeing cases linked to new variants increasing locally at the current time.

1.5 The number of beds occupied due to COVID-19 at Stockport NHS Foundation Trust reached its winter peak in January at just over 210 beds, and has since declined to a level between 45 and 50 beds over the last week.

1.6 The chart below shows the link between diagnosed cases (all age / 60+) offset by 14 days and bed occupancy. This demonstrates the weakened link between cases and hospitalisations and deaths, also demonstrating that this link is not entirely broken by vaccination and available treatments.



2. Vaccine uptake

2.1 Stockport has the highest overall uptake of first and second doses for all over 12s in Greater Manchester and is above the GM average for all age groups. Stockport has also achieved a higher uptake of booster doses than the GM average in all age groups and is second only to Trafford in the overall proportion of residents who have received a booster.

2.2 To end of 28th February:

- 236,243 Stockport patients have received their first dose, 87.3% of 18+
    - 72.2% of those aged 16-17 and 62.8% of 12-15 year olds.
    - 129 first doses given in the last week
- 224,159 Stockport patients have received the second dose, 85.0% of 18+
    - 53.5% of those aged 16-17 and 35.5% of 12-15 year olds
    - 397 second doses given in the last week
- 180,212 Stockport patients have received the booster dose, 70.9% of those age 18+, 88.1% of those eligible aged 50+ (94.2% of all 70+)
    - 641 booster doses give in the last week

Overall, there are 32,140 adults in Stockport who have not been vaccinated yet, and a further 1,912 aged 16-17 and 5,641 aged 12-15. For those over 50 years, 94.1% of people have had the first dose. 7,365 people remain unvaccinated.

For those who are clinically vulnerable

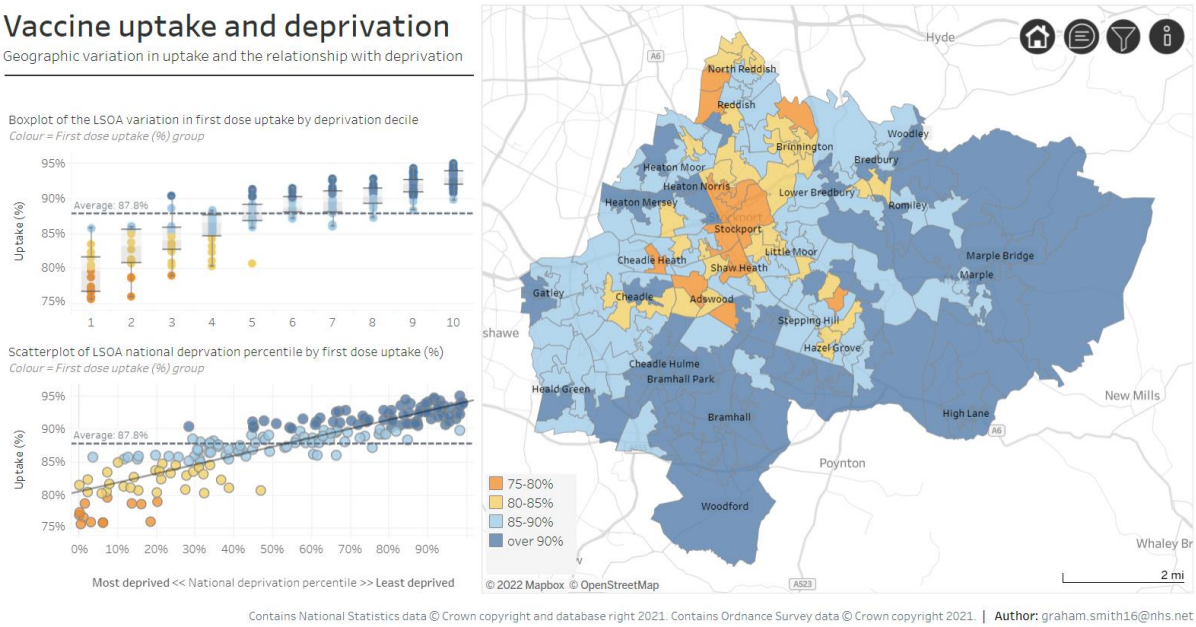
- 95.3% of those who are extremely vulnerable have been vaccinated
- 90.7% of those who have other priority conditions have been vaccinated

4,838 clinically vulnerable people remain unvaccinated, 3,202 aged <50.

Taken together this means there are 10,567 eligible people who are aged 50+ or clinically vulnerable who have not yet had their first vaccine.

Age group ^	Eligible	Dose 1 by end 27th Feb	Dose 2 by end 27th Feb	Booster by end 27th Feb	% dose 1 by end 27th Feb	% dose 2 by end 27th Feb	% booster total by end 27th Feb
80+	16,785	16,263	16,208	15,875	96.9%	96.6%	94.6%
75-79	12,428	12,046	12,003	11,755	96.9%	96.6%	94.6%
70-74	15,590	14,954	14,890	14,553	95.9%	95.5%	93.3%
70+	**44,803**	**43,263**	**43,101**	**42,183**	**96.6%**	**96.2%**	**94.2%**
65-69	16,062	15,225	15,122	14,560	94.8%	94.1%	90.6%
60-64	19,004	17,752	17,597	16,533	93.4%	92.6%	87.0%
55-59	22,129	20,442	20,199	18,497	92.4%	91.3%	83.6%
50-54	22,303	20,254	19,949	17,782	90.8%	89.4%	79.7%
50 +	**124,301**	**116,936**	**115,968**	**109,555**	**94.1%**	**93.3%**	**88.1%**
40-49	42,829	36,688	35,801	29,308	85.7%	83.6%	68.4%
30-39	46,711	37,167	35,463	25,036	79.6%	75.9%	53.6%
18-29	39,811	30,721	28,293	15,941	77.2%	71.1%	40.0%
TOTAL 18+	**253,652**	**221,512**	**215,525**	**179,840**	**87.3%**	**85.0%**	**70.9%**
16-17	7,009	5,097	3,749	597	72.7%	53.5%	8.5%
12-15	15,148	9,507	5,385	18	62.8%	35.5%	

2.2 The table above demonstrates the inequity of uptake by age group. Additional inequity of uptake is seen by ethnicity and deprivation, shown in the map and charts below. It should be noted that whilst some areas fall below the Stockport average, we have now achieved our objective to ensure that first dose uptake is at least 75% among adults in every LSOA within Stockport, as demonstrated by the removal of all red areas from the map below. The information below relates to adults. For children, the uptake shows a much greater inequality. This data is available on request.



Contains National Statistics data © Crown copyright and database right 2021. Contains Ordnance Survey data © Crown copyright 2021. | **Author:** graham.smith16@nhs.net

3. Modelling future scenarios (extracted from SAGE minutes, February 2022)

3.1. There are a range of possible futures for the course of the pandemic. SAGE considered 4 scenarios describing plausible outcomes in the next 12 to 18 months and in the longer term (with the 2 central scenarios considered the most likely).

3.2. These scenarios describe a range of evolutionary trajectories and possible impacts, although scenarios outside of this range are possible. Each scenario assumes that a relatively stable pattern is reached over several years. However, it is likely that the transition to a stable pattern is highly dynamic and unstable, with shifts between scenarios possible. A constant in each scenario is the possibility of continued disproportionate impacts on certain groups, for example communities with lower vaccination rates (high confidence).

3.3. The interaction of future SARS-CoV-2 waves with other respiratory infections, such as influenza, will be important. Co-circulation over a season is possible, as is displacement (where different waves of infection peak at different times), which could lead to a longer period of pressure on healthcare services. There is further evidence from ISARIC that co-infection with SARS-CoV-2 and influenza is more likely to require ventilation or lead to death, compared to SARS-CoV-2 infection alone.

3.4. The emergence of new variants and a resultant wave of infections can occur very quickly, potentially within just several weeks. The ability to rapidly detect and characterise new variants and to scale up necessary responses (such as TTI and vaccinations) quickly will be very important. Considerations for future response preparedness and surveillance infrastructure should take this into account.

3.5. SAGE reiterated the ongoing importance of the ONS Coronavirus infection survey as a critical tool for understanding the state of the epidemic. Lead indicators are required, and this might need additional surveillance mechanisms. Scenarios modelled for the coming winter and into 2022 suggest COVID-19 hospital admissions above the level seen in January 2021 are increasingly unlikely, but there are uncertainties around behaviour change and waning immunity.

4. Living with COVID

4.1 .The government's 'living with covid' plan aims to :

- enable society and the economy to open up more quickly and enable the country to manage Covid-19 like other respiratory illnesses while minimising mortality.
- Ensure resilience, maintaining contingency capabilities to deal with a range of possible scenarios including waning immunity and new variants that could put NHS under unsustainable pressure.

4.2. The plan is structured around 4 principles:

- Living with Covid-19 : removing domestic restrictions, promoting safer behaviours through public health advice
- Protecting people most vulnerable to Covid-19: through accination, treatment and targeted testing
- Maintaining Resilience: ongoing surveillance, managing and responding through routine public health interventions, management of healthcare demand surges, contingency planning and the ability to reintroduce key capabilities such as mass vaccination and testing in an emergency
- Securing innovations and opportunities from the COVID-19 response: Investment in life sciences, health & care integration, UKHSA, cooperation on border & travel policies

4.3. The plan identifies vaccination and medical treatments as the principle ways of addressing the risks we continue to face from COVID-19, and removes the remaining non-pharmaceutical measures that have been used to manage these risks since March 2020. The response to any resurgence of COVID-19 is likely to involve additional vaccination and testing. Detail of these contingency plans is currently awaited.

4.4. Specific policy changes within the plan take effect in stages. From 21st February, guidance for staff and students in mainstream educational settings to test regularly was rescinded but remains in place as previously in SEND settings. From 24th February, the legal requirement for cases and contacts to self isolate, the contact tracing service and the availability of self-isolation suport payments has ceased. Cases are still advised to self-isolate as previously, but this is no longer a legal requirement. From 24 March, statutory sick pay regulations revert to the pre-pandemic arrangements. From 1st April, free testing will not be universally available for the public with or without symptoms, and will be offered for specific groups or purposes only. As a result, a large amount of guidance that is built around the universal availability of testing will be further revised at this point.

5. Our response

5.1 Our response to COVID-19 has continued to evolve to reflect both the epidemiology and the developing policies from the government. As we implement the changes in the national plan, we are mindful of the inequalities in our community that have been exacerbated by the pandemic, as well as of the need to retain preparedness to respond to future waves of COVID-19 infection.

5.2. We will continue to monitor COVID-19 in our community via the ONS infection survey, but will not have access to timely data on infections when testing ceases. Our daily COVID-19 situation reports have moved to weekly reports this month, and will cease at the end of the month.

5.3. Vaccination remains at the core of the ongoing covid19 response. Our programme will continue to work to improve vaccine uptake as much as possible, with a particular focus on equity of uptake. This work is being led by the vaccine inclusion group and works thorough our networks of community champions and VCSE partners to reach the communities with lower uptake. Over the coming months, we will work with our NHS partners to provide a 4th dose for people aged over 75 and a 5th dose for people with a suppressed immune system. Vaccinations will also be offered to children aged 5 to 11 from April. Wherever possible, vaccine will be offered in multiple locations across the borough and through an 'all age' offer that enables entire families to attend for vaccination. A comprehensive set of frequently asked questions, including where to access your vaccine, are available on Stockport CCG website: Stockport Clinical Commissioning Group Frequently Asked Questions (FAQs) about the COVID-19 Vaccination programme (stockportccg.nhs.uk).

5.4. Our testing and contact tracing services will end in line with government announcements. Our contact tracing service ended on 23rd February, and our testing sites will close at the end of March. Our pandemic-specific staff teams, who work on testing, contact tracing, PPE and vaccination services, will reduce in scale from around 50 FTE to around 20 FTE this summer, and will broaden the scope of their work to offer a wider range of interventions to support health in our communities as they recover from COVID-19 alongside maintaining preparedness for future waves of infection. To enhance this preparedness, we will train further employees in essential health protection skills, including vaccination. We will continue to retain a small local stock of PPE and COVID-19 tests.

5.4 Our messaging remains in line with national government messaging. The key messages for the public support basic public health measures including staying at home if you're unwell and regular hand washing, as well as continuing to emphasise the need to get your vaccine if you haven't already done so. We are also continuing to highlight the support that's available for those suffering from long COVID.

5.5. We are continuing to work in partnership, but evolving our approach to reflect the changes within the living with covid plan, for example:

- Schools – the use of face masks and regular testing has ended in mainstream settings, and we no longer expect schools to report all cases to us, but we continue to provide a helpline and support to schools as they adjust to the latest policy changes
- Adult social care – continuing to manage outbreaks and continuing to reinforce that use of personal protective equipment and ongoing use of testing are vitally important measures to protect residents, staff and visitors in care homes

5.6 The governance of our response remains through the Health Protection and Response Board reporting through to our Outbreak Management Board, but over the coming months we will seek to reduce the frequency of meetings, and align the COVID-19 response governance more closely with the governance of our wider Health Protection work.