

## GENERAL SYNOD

## COVID-19

## General Synod Update

## Introduction

1. It is generally recognised that we have reached the end of the first phase of a three-stage process in the COVID-19 pandemic in the UK that is likely to last between two and five years.
  - Stage one is suppression of *the first wave* of infection
  - Stage two is co-existence with the virus
  - Stage three is eradication or neutralisation of the virus as a major health threat
2. In this first phase more than 55,000 people in the UK are believed to have died from COVID-19 so far, with an unknown number infected. 'Excess deaths' above the five-year average since mid-March now stand at over 65,000 some, though probably not the majority of the additional 10,000 deaths will have been unrecorded COVID-19 cases.
3. The UK mortality rate is among the worst in the world with England being significantly more affected than other nations in the UK. While all the factors that have contributed to this have not been identified, concerns have been raised that the UK went into 'lockdown' later than was optimal, that a lack of PPE contributed to infection in healthcare settings and that the Care Home sector suffered from systemic weaknesses that led to a large number of residents' deaths (around 29% of all deaths overall, peaking at 40% of weekly deaths at one point). Other possible factors are discussed in '*Social and Other Factors*' below.

## Scientific Knowledge

4. After six months of research and investigation into the novel coronavirus and the associated illness COVID-19, much remains uncertain. This is not unexpected as very many long-standing illnesses such as cancer, Alzheimer's and a variety of autoimmune diseases are still only partly understood after decades of research; a vaccine for HIV has still not been discovered while smallpox remains the only infectious disease that the human race has managed to eradicate through scientific intervention.

At this point there is still uncertainty with regard to:

- **The timing and origin of COVID-19** ('patient zero in China'): there are suggestions that the virus might have been in the community for some weeks prior to China formally notifying the WHO on 31<sup>st</sup> December 2019. Initially two strains of the virus were in circulation with one notably present outside Hubei Province. While the 'wet-market' in Wuhan was instrumental in the spread of the virus, it is not certain that this is where the virus first became transmissible to and by humans.

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- **It's first entry into the UK.:** there are indications that the virus might have been present in the UK earlier than had been originally thought and that there might have been as many as 1,300 'patient zeros' who brought it into the UK.
- **The transmission mechanisms and their relative importance:** droplet spread and associated contamination of surfaces are thought to be the main means of the virus being transmitted, though the role of aerosol transmission is still unclear.
- **The full range of symptoms:** while a persistent cough and high temperature remain the most common symptoms ,these have been supplemented by a loss of taste and smell with a longer list of possible symptoms also having been identified, many of which are common to other illnesses.
- **The number of cases in UK:** overall estimates of the percentage of the UK population that have had the virus vary widely with estimates ranging between 5% and 30. The ONS has estimated that an average of 1 in 2,200 individuals within the community population in England had COVID-19 at any given time between 14 June and 27 June 2020. That equates to an estimated average of 25,000 people (95% confidence interval: 12,000 to 44,000) within the community in England having COVID-19 between 14 June and 27 June 2020. This compares with an estimated 31,600 new COVID-19 infections per week in England (95% confidence interval: 22,200 to 43,500) between 26 April and 7 June 2020.
- **The percentage of asymptomatic and very mild cases:** Until an analysis of sufficient numbers of anti-body tests in the UK has been carried out we cannot accurately estimate the number of asymptomatic or mild cases. Estimates throughout the pandemic have varied so widely (5%-80%) that they are of little use to us.
- **A comprehensive understanding of the variety of ways COVID-19 affects the body:** while initially presenting as a respiratory illness, the virus can attack a variety of organs and systems either directly or indirectly as the immune system seeks to fight off infection.
- **An understanding of medium to long-term physical and mental effects of being seriously ill with COVID-19:** evidence from SARS-COV1 suggests that many of those who require ventilation will encounter physical and mental challenges during recovery, some in excess of a year. By their nature, medium to long-term physical effects of COVID-19 are unknown, but there are some early indications that a range of post-viral effects should be expected.

### What is the Potential for a Second Wave?

5. Reductions in the population prevalence of COVID-19 in recent weeks show that the measures adopted to control the transmission of the infection have been effective. There is concern that as these measures are progressively lifted, potential exists for there to be a 'second wave' of the epidemic.

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6. Whether this will happen or not is necessarily speculative. However, the following factors should be borne in mind:
  - The whole country is actively on the alert for cases of COVID-19
  - Many factors which were not present at the outset of the epidemic are now in place (track and trace, provision of PPE, widespread testing etc)
  - Behaviours to prevent transmission of the virus are now well understood and established within the population.
7. Thus, while a second wave cannot be ruled out, the preparedness to meet any increased transmission far exceeds that which existed early in 2020 and should act significantly to reduce the potential for a further outbreak.
8. Much more probable is the occurrence of a sequence of localised secondary outbreaks which are likely to need the application of local control measures. Currently, the government has in place a three-tier

### **Anti-viral Drugs, Treatments and Vaccines**

9. At present there are no confirmed effective anti-viral drugs. Nonetheless, research into finding such drugs continue because of their potential usefulness in countering the virus. Although scientists have not been able to develop a vaccine against the retrovirus which causes Acquired Immunodeficiency Syndrome (HIV/Aids), antiviral drugs have transformed treatment. Novel antiviral drugs may become the principal pathway to suppressing Covid-19 in the absence of a vaccine.
10. In the meantime, dexamethasone has successfully passed clinical trials and has begun to be used as a treatment in patients with acute respiratory inflammation. Research indicates that this can cut deaths of those on ventilators by 35% and those receiving oxygen therapy by 20%. Remdesivir, while not reducing mortality rates, has shown promise in shortening length of illness.
11. According to the World Health Organisation, as of 9 June 2020, there were 136 candidate vaccines currently being evaluated. Ten of these had moved from preclinical to clinical evaluation. In the first instance this means careful testing for harmful effects before moving on to potential efficacy. or vaccine and these might take a considerable time to discover.
12. An extraordinarily wide variety of approaches are being taken in constructing a potential vaccine. Some work with proteins, or smaller elements of proteins known as peptides. Others use nucleotides DNA or RNA, the coding strands which are used by cells to assemble proteins.
13. How the proteins or the nucleotides are delivered to potentially raise an immune response are also extremely varied. The range of different carriers, including different viral carriers which are not able to replicate, and various kinds of immune stimulants (adjuvants). It seems there are almost as many different approaches, and choices of what to use as the key target, as laboratories.
14. It is possible that a vaccine which is universally effective may not be possible or it may not provide long-lasting immunity. It may not work in all places, or for all people. Making sufficient vaccine to immunise everyone on the planet will be a great challenge. There are different forms of vaccine being worked on,

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including those which would be delivered nasally. Those which require careful preservation before administration will be that much harder to use in some parts of the world.

15. The huge number of laboratories engaged across the globe to find a vaccine, and the variety of different approaches, is something to be thankful for. One hopes that this extraordinary effort will work for the good of humanity and meet with success but this cannot be guaranteed.
16. Recent reports that the USA has purchased around 90% of the world's three month stock of remdesivir have fuelled concerns with regard to equitable access to further anti-viral drugs or to a vaccine if one were to be produced.

**Medical factors**

17. The NHS has identified two groups of people for whom COVID-19 poses added risk of serious illness or death.
18. Those who are '*Clinically Extremely Vulnerable*' are advised to have very limited contact with people outside their households while leaving their homes for exercise only. Those who are '*Clinically Vulnerable*' are advised to work from home if possible and to take extra care when outside their homes. Further details can be found in '*COVID-19 Personal Risk Factors for Clergy, Church Workers and Volunteers*'.  
<https://www.churchofengland.org/sites/default/files/2020-06/Personal%20Risk%20Factors%20for%20Clergy%2C%20Church%20Workers%20and%20Volunteers%20v1.pdf>

**Social and Other Factors**

19. Public Health England has identified a number of risk factors for serious illness and death as a result of contracting COVID-19. The main risk factors include:
  - **Age:** approximately 89% of deaths have occurred in over 65s, 65% in over 75s, 36% in over 85s, 1% in under 45s. A person over 80yrs with COVID-19 is seventy times more likely to than someone under 40 with the illness. Residents of Care Homes have been at particular risk from COVID-19 with 29.6% of all deaths occurring in Care Homes. The ONS estimates that there have been some 20,000 'excess deaths' among Care Home residents during the first wave of the pandemic.
  - **Sex:** men make up 71% of critical care admissions and are 1.78 times as likely to die as women with COVID-19
  - **Disability:** The ONS estimates that two-thirds of deaths have occurred among people with a known disability. Women with disabilities of 'working age' are 11 times as likely to die from COVID-19, men 6.5 times as likely as people living without disabilities..
  - **Deprivation:** the mortality rate among those from the most deprived areas was double that from the least deprived areas. This is a greater disparity than pre-COVID-19, indicating that there are features distinctive to this pandemic

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- **Ethnicity and related inequalities:** after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity have around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity have between 10 and 50% higher risk of death when compared to White British. This is the reverse of pre-pandemic mortality statistics where White British people had the highest mortality rate, suggesting, again, that there are features distinctive to COVID-19.

While there might be some genetic factors contributing to these disparities, PHE reports suggest that COVID-19 has highlighted existing inequalities that have contributed to disproportionate deaths within BAME communities.

Inequalities highlighted in the report include:

- *Increased risk of exposure to the virus due to occupation, use of public transport and housing;*
  - *Increased risk of medical complications due to existing co-morbidities and higher rates of obesity linked to economic and social deprivation;*
  - *Racism, discrimination, stigma, fear and mistrust within or about state and societal institutions that make effective access to information, engagement and treatment more difficult than for the White population.*
  - **Occupation:** those with 'public-facing' jobs are at increased risk, particularly if coming into contact with large numbers of people.
  - **Presence of comorbidities:** Cardiovascular disease, dementia, diabetes, hypertensive disease, chronic obstructive pulmonary disease, chronic kidney disease, obesity.
20. A detailed analysis of the ways in which these (often over-lapping) risk factors have combined to provide morbidity and mortality outcomes is not yet available; caution needs to be exercised in interpreting them.

### Government complexity

21. There are a number of Government Departments whose policy and advice has an impact on the Church of England. The key departments are:
- The Department of Health and Social Care (DHSC) which provides health advice. Two of the bodies that it oversees are NHS England (NHSE) and Public Health England (PHE)
  - The Ministry of Housing Communities and Local Government (MHCLG) which has responsibility for faith, and runs the recently established Places of Worship Taskforce
  - The Department for Digital, Culture, Media and Sport (DCMS)
  - The Department for Education
22. In addition "Number 10" has a significant role and influence in ensuring policies are in keeping with the Prime Ministers intent, and is made up of a policy unit and special advisers.
23. Government is designed more for 'peacetime' than the sort of emergency situation we are experiencing now. It tends to work in silos, with each

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department responsible for its own policy making. It is therefore not surprising that we are seeing examples of inconsistency in policies and advice as officials and Ministers work at pace, inevitably having to interpret and apply advice that is outside their own expertise. Endeavours to co-ordinate are, however, taking place. For example COBR is the Government's emergency committee that brings together senior Ministers and officials from relevant Departments.

24. Government policy, while informed by science (SAGE, CMO etc), is rarely entirely based on it, as other considerations come into play. Officials offer advice, Ministers decide the policy. At the beginning of the pandemic, the medical science very heavily influenced policy. Now we are seeing a move away from this, with medical science increasingly becoming only one factor in the decisions being made.

### Test and Trace

25. People who have been in close contact with someone with coronavirus are now being traced. At present this will be done using an entirely manual system, though an app to assist is being researched.
26. NHS Test and Trace includes dedicated contact tracing staff working at national level under the supervision of Public Health England (PHE) and local public health experts who manage more complex cases. Local public health experts include both PHE health protection teams and local authority public health staff.
27. In line with other government guidance for other venues, religious bodies have been asked to assist this service by keeping an accurate temporary record of visitors for 21 days, in a way that is manageable for places of worship, and to assist NHS Test and Trace with requests for that data if needed for contact tracing and the investigation of local outbreaks.
28. A template for doing this in a way that is both manageable and in keeping with data protection and other laws is currently being prepared and will be made available on the Church of England website

### Children and COVID-19

29. Children and adolescents are half as likely to catch coronavirus according to recent findings by UCL and the London School of Hygiene and Tropical Medicine who reviewed a number of studies. Children were 56% less likely to catch the virus when exposed to an infected person than an adult. In terms of deaths, of those registered by 8<sup>th</sup> May 3 were under 15 years of age.
30. The evidence is less clear about how easily children can spread the virus. One study reviewed suggested 10% of 31 clusters of infections were started by a child (compared to 54% of influenza clusters).

### Face-Coverings

31. Face coverings on public transport and for hospital staff, outpatients and visitors are now compulsory in England. Face masks are for use in a medical setting only. Coronavirus is spread largely by droplets and it is thought that face coverings can help reduce the spread of the virus from an infected person.

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- Scientists in Singapore concluded that the contagion risk from the virus is especially high in the 24 – 48 hours before an infected person is aware they have symptoms. In addition some people who have the virus are asymptomatic.
32. However the evidence for the effectiveness of face coverings is not strong as only a small number of studies have been undertaken. WHO guidance on 5th June recommended that those over 60 or with health issues should wear medical grade face masks, and other people face coverings, when they are out and cannot socially distance. This is on the basis of protecting others from the wearer spreading the virus. It is still not known if wearing face coverings affords any benefit to the wearer, whilst face masks can contribute in this way.
33. A recent (May 2020) report from Delve, a multidisciplinary group convened by the Royal Society reviewed the evidence and came out in favour of the public wearing face masks, including face coverings. They considered 3 things:- the incidence of asymptomatic and pre-symptomatic transmission; the role of respiratory droplets in transmission, which can travel as far as 1-2 metres; and studies of homemade and surgical masks to reduce droplet spread. They concluded that face masks including coverings can reduce spread from the wearer in situations where social distancing is not possible, whilst face masks can protect the wearer also. However these findings are not supported by all scientists and the debate continues and will do so until better studies are available.
34. Currently, the government advises people attending places of worship to consider wearing face-coverings, particularly in those situations where 2m physical distancing cannot be maintained.

**The Effects of COVID-19 on the Treatment of Other Conditions**

35. In England, 60% fewer people suspected to have cancer were urgently referred to a specialist in April compared to the same month in 2019 and the number of first treatments for cancer fell by 21%. In total, during the first wave of the pandemic, referrals were down by 45% compared with last year. A recent study by DATA-CAN, the Health Care Research Hub (HDR UK) for Cancer, suggests that somewhere between 7,00 and 35,000 excess cancer deaths might result from delayed cancer referral, diagnosis and treatment.
36. Overall, 63% of people with serious long-term conditions had their planned treatment cancelled during March and April.
37. From March to May, A&E visits and emergency admissions through A&E were lower than in the same period last year. Ambulance crews also transported fewer patients to A&E with more patients treated at the scene.
38. Visits to major A&E departments were down 26% in March and 33% in May. In minor A&E departments visits in May were 58% lower than in 2019 although some patients who might have visited a minor A&E department accessed care through NHS 111.
39. Emergency admissions were down 22% in March and 24% down in May compared to 2019.

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40. Fewer GP appointments took place, especially during the early weeks of the pandemic (down 30% from first to last week in March) and have not been fully compensated by video/tele consultation. A number of routine checks, for example for over 75s have been suspended and are only now being re-instated in some places.

**Domestic Abuse and Safeguarding**

41. Emerging evidence from statutory and voluntary agencies across the UK has emphasised the increased risks of domestic abuse, with Refuge reporting a 25 per cent increase in calls and online requests since the lockdown began in March 2020. The risks are not unique to the UK and are reported to be affecting society worldwide, including China, Italy and Spain.
42. Domestic abuse organisations have observed increased household tension and domestic violence due to forced coexistence, economic stress, and fears about the virus. Increased isolation could create an escalation in abuse, where those who are living with an abusive partner or family member, may be less likely to ask for help. Fewer visitors to the household may mean that evidence of physical abuse goes unnoticed.
43. The COVID-19 outbreak has also curtailed access to support services for survivors, particularly in the health, social care, police and justice sectors. Emergency services are experiencing an overstretched workforce concentrated on tackling the pandemic.
44. Safeguarding and child protection are as important now as they ever have been. But with many children spending less time in schools and social distancing measures in place across the UK, we all need to think about the way we keep children safe during the coronavirus pandemic (COVID-19).

**Mental Health**

45. A range of mental health and wellbeing issues has affected large numbers of people during the first wave of the pandemic, some linked to anxiety about the virus, some to experiences of 'lockdown', some to caring for those who have been ill and some to the particularly trying circumstances surrounding death and bereavement.
46. As the first wave recedes, these are likely to be the tip of the iceberg with ongoing mental health issues affecting the bereaved, NHS and Social Care staff (including chaplains) many of whom have faced unparalleled and sustained stress and those who are recovering from severe illness including protracted periods in intensive care.
47. Experience from past epidemics and pandemics suggest that there will be increased levels of depression, anxiety and PTSD-type symptoms within the community for years to come.

**Schools**

48. Schools in England have remained open throughout the COVID-19 pandemic, initially for children of keyworkers and for vulnerable children (e.g. those with



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Educational Health Care Plans or under the care of a social worker), however the take-up of places has been low. Schools have responded rapidly to move lessons and teaching online, with many schools using their own digital resources or signposting to the newly established Oak National Academy which was launched on 20 April by the and has since been accessed by over 2 million users 10 million times. The Church of England has become the delivery partner for the Oak for weekly collective worship, producing 2 x 10 minute films for Primary and Secondary audiences, co-released through Oak and the Church of England's new Faith at Home webpages:

<https://www.churchofengland.org/faith-action/faith-home>

49. Since the beginning of June, schools have opened more widely to years R,1,6,10,12 and Church of England schools have played a full and proactive part in opening up as quickly as possible. By the end of June over 270,000 pupils were attending Church of England schools which is proportionally higher than those attending non-church schools. Schools are now planning for the full opening of schools to all pupils in all year groups from September. The Church of England has supported this development nationally as we consider it vitally important for children's mental health and wellbeing, as well as for their educational development, that they are back in school as soon as possible.
50. The main hierarchy of controls will remain in place (increased cleaning and handwashing) and children will now be in bubbles of whole year groups to make arranging the timetable and curriculum manageable, with teachers being able to move across different bubbles. Movement around the school will be carefully managed to avoid large gatherings, and assemblies and collective worship will be in class or year groups rather than any larger gathering.
51. Diocesan education teams will be supporting school leaders as they plan for this wider opening in September. Mindful of the need to focus on staff and pupil wellbeing the Education Office has produced materials on grief, bereavement and trauma and will also be adopting a different approach to denominational inspection for the coming academic year in order that dioceses can best support schools in this recovery phase.

### **Singing and Music in Church Buildings**

52. While there have been instances of localised outbreaks of COVID-19 associated with choir practices and church services during which congregational singing took place, the available scientific evidence on risks associated with singing and playing brass and woodwind musical instruments is not particularly robust.
53. Public Health England is currently undertaking a literature review of the topic as well as conducting specific research with singers and musicians.
54. Until PHE issues its report (expected by the end of July), government guidance advises that singing and playing brass and woodwind musical instruments in church buildings should be avoided (other than for organ practice).
55. PHE is also in the process of advising the Central Council of Church Bell Ringers to enable the safe ringing of church tower bells to recommence.

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**International Concerns – Children are paying the price**

56. Responses to the pandemic in the global South have mirrored those in the global North. This has happened despite the very different demographics in different parts of the world. In the UK, the median age of the population is 40.5 years. In Niger the median age is 15 years. Given that the impact of COVID-19 is much greater in older than younger age groups, this may suggest that a different response might have been needed in the South. In the whole of Africa as of 16th June it has been estimated that there have been 242,969 cases of COVID-19 and 6,524 deaths. The deaths caused by COVID will be dwarfed by the deaths caused by measures designed to control the disease which are leading to the widescale and damaging disruption of education and immunisation programmes and increasing children's susceptibility to child labour, trafficking and exploitation.
57. As a result of the policies that have been pursued, 192 countries have closed schools, 1.5 billion children no longer have access to education in schools, 370 million children are no longer being fed in schools. Children appear to have few direct health consequences from COVID-19, and appear to play little role in transmission of the virus; they are not the beneficiaries of school closure. The longer marginalized children are out of school, the less likely they are to return, particularly girls. Being out of school is associated with increased risk of:
- In girls: early marriage, early pregnancy, abuse
  - Inappropriate child labour
  - Poor educational attainment
  - Lower future earnings and career prospects
58. The World Bank estimates that COVID-19 is likely to cause the first increase in global poverty since 1998, pushing an estimated 49 million people into extreme poverty (living on less than \$1.90/day) in 2020. Though sub Saharan Africa has been hit relatively less by the virus from a health perspective, projections suggest that it will be the region hardest hit in terms of extreme poverty.