

## OFFICIAL SENSITIVE

**RWCS Clinical Alignment Planning meeting**  
**Friday 14<sup>th</sup> Feb**  
**16.30**

### Attendees

#### DHSC:

- CMO

Personal Data

- Name Redacted

Personal Data

#### NHSE

- Name Redacted
- Name Redacted
- Steve Powis (SP)
- Name Redacted

#### PHE

- Sharon Peacock

#### Dialled in

- Patrick Vallance (GCSA)
- JVT (DCMO)
- Keith Willett (NHSE)
- Jenny Harries (DCMO)

### Actions:

- **JVT to work with KW** – list out every question we need to model out. Are they a static model to which we know the answer e.g beds, or dynamic requiring new info. And which of the modelling groups own this problem? Once this is worked up check the modellers agree
- **JVT** will need to co-chair SPI-M on behalf of government (CMO as alternate) from to give it clinical focus. Needs a practical output.
- **KW:** Develop scenarios to gauge that we don't want to take out more than x amount of GP surgeries in a certain area (because at that point you increase clinical risk rather than minimise it). Let's have some of these conversations prospectively.
- **DHSC policy/NHSE:** Buy some O2 concentrators.

### Meeting:

**NR** said there were two questions:

1. what is the agreed point of view on clinical treatment protocols for different groups and the supply chains.
2. What are the constraints – o2 etc? so we can do as much as possible we get to the second turning phase.

CMO sees three phases:

1. Realistic chance this can be contained in China in which case we need to get on top of every case
  2. Has escaped China and going around world – can slow (but cannot stop) ideally to summer, and some degree of isolation is likely to be helpful.
  3. Becomes ordinary HCA airborne infection – view as per flu
- CMO: Working out times is useful, but we don't know when we will shift from phase 1 (if we do). But when we move into phase 2 the models can help us work out how long we have got until it hits NHS in large enough numbers to be noticeable. There will probably be several weeks between transmission becoming established in the UK and substantial impact on NHS services.
  - PV stated we should use SAGE numbers. These will change when we get new data; currently many of the assumptions are based in 'flu.
  - PV said the duration would probably be 2-3 months. The detail will be clear after we have sustained transmission in the UK. The key is that we need to pick it up as early as possible.
  - In a reasonable worst-case scenario, based on the pandemic flu plan, the total proportion expect infected 80%, 50% proportion symptomatic, 4-5% require hospitalisation, ¼ of these will require respiratory support. If we bring it together with the bed numbers, we should be able to get an accurate picture.
  - PV said the length of stay should be modelled at 14 days (the longest one is 43). JVT: It is 7 days in Singapore but there is no strain on their system. Based on 67 pts, 8 of which are in ITU. This is 20% of those admitted with pneumonia. JVT feels it's about 25%. Ventilation practice is different between SE Asia and the UK.
  - SP asked how solid the 80% figure was. PV said there is lots of uncertainty around it.
  - KW talked through the NHSE modelling: We built a simulation model looking at three cohorts:
    - 1) biggest one a home care cohort;
    - 2) second group is hospitalised but not mechanical ventilation;
    - 3) third group is those in critical care supported by mechanical ventilation.
  - For each of these cohorts have been passed to clinicians in the field so they can use in the currency of a patient day, look at bed occupancy, nursing complement required to nurse one patient in a bed day for that illness, also recorded all consumables used in one bed day, all the medicines and medical devices, PPE consumption in one day, also investigations required on that currency base.
  - KW: NHSE then feed back into supply chain where we know lots from EU Exit work. Can look at resource requirement but also stockpile exhaustion rate based on how these cohorts change. Can update every time SAGE updates core assumptions. It would help to look at numbers – high at peak time but as you broaden the distribution what matters is what we do at the start of the incline. We have set up two steps ahead group to:
    - 1) Identify across GP in England all patients in vulnerable category at high risk of hospitalisation / infection – as we hit that slope we can self-isolate them for as long as possible and home support them. Behavioural science important.