SAGE UPDATE (INFORMAL NOTE)
23RD APRIL
TOPICS DISCUSSED
1. Introduction

- • UKRI – funding longitudinal studies on immunity
- • **Previous principles of SPI-M social distancing paper** was very well received by policy makers – foundation of how things are designed and how strategic objectives for longer term
- • **Mask advice to Ministers** accepted – moving on
- • Care homes remain major concern -exponential increase in number of care homes affected
- • Nosocomial appears to be at a plateau

Personal note: bring SAGE paper back to group – discuss at CMO Advisory Group on 27th April – consider how it will support recommendations to CMO and Ministers. Nicola Steedman was pursuing correspondence on masks
2. Situation Update

- • Unchanged - slight downturn
- • Deaths are more– reporting issue nursing home
- • Important ICNARIC data - **average time in ITU 10 is days** – average of **6 days before ITU** admission

Personal note: ITU data important for modelling
3. Understanding Covid-19

- • **Health data research prioritisation paper** approved by SAGE (co-ordinated by HDR UK – I have a personal conflict)
- • 44 projects
- • Prioritisation funnel to rapidly develop new evidence relevant to patients, policy makers, system leaders and NHS
- • UKRI supportive
- • Will embed SAGE research priorities
- • SAGE members to comment on projects – any gaps, any need a push

Personal note: Need to articulate to the publics the need and benefits of better data for active surveillance and evidence generation – d/w Caroline Lamb
4. Testing strategy and immunity

- • Calculations from SPI-M
- • **Care homes:** Important to know number we would need to test in care homes
- • Mark Woolhouse – excellent work – if not infected – ?testing every day – with option for hotel stays
- • Every care home worker every day would be a lot of testing – needs a discussion – a lot of care home workers and itinerant population – mobility of staff also an issue
- • Need to define "care home" – what about elderly resident community

- • **Hospitals:** Any patient admitted for any reason will be tested from Monday; at weekend four trusts will be testing 500 asymptomatic members of staff; need to test all discharged patients
- • **Cycle closure time is critical** – how soon to make decision – ideally needs to be hours
- • **Note in Korea they performed 200 tests per case** – 3+ for each index case – one confirmatory and two negatives to release from quarantine

Each contact has two tests as well – suggests 100 contacts per case

Personal note: Policy in development – we need to support PHS and Testing Group who are doing a great job to model "with book-ends" of upper and lower ranges
All numbers of NHS admissions per day
Implications for all Staff
All care home residents – need to define "care home"
All care home staff
How often to test and who to test
For each test – cycle closure time
Also need to consider prisons

Testing Phase	Testing group	Estimated population size	Cumulative population	Estimated daily testing requirement
Current scope of testing	**Hospital Patients** (incl. emergency and elective admissions)	-	-	12,000
	Care home residents	-	-	12,000[1]
	Priority 1 Key Workers (NHS and Social Care workers)	2,687,000	-	10,211
	Priority 2 Key Workers	3,067,016	**5,754,016**	11,655
Expanded key worker scope (planned 23 April)	**Priority 3 Key Workers**	5,023,860	**10,777,876**	19,091
Total demand numbers				**64,957**

- ***Modelling of tests and contact tracing in the community (excludes hospitals etc)*** ○ If 30 contacts per case – divide contact tracing capacity by 30 then that gives you incidence rate that is tractable
  - ○ Singapore - Police and military doing contact tracing
  - ○ How long will it take to get to that incidence that is TTI amenable?
  - ○ Peak 130K 30th March
  - ○ Seven days halfing rate
  - ○ 4th May 4000 - there would need to be 120K
  - ○ 18th May 1000 - there would need to be 30K
  - ○ Key Issue is contact tracing - depend on web based connections with telephone follow – several thousand people will need to be trained
  - ○ **The APP won't do it alone**
  - ○ **Socio-economic status** – there appears to be an obvious gradientsby SE status – x2 number of contacts during lockdown

- Risk is of differences in disease risk across different SE strata

Personal note: Refer testing group to matrix of testing options produced by SPI-M

5. Reducing transmission/ lifting measures

- • **Behavioural issues around testing** – sensitivity and specificity of test
- • False positive – saying they are immune – social distancing
- • Experiment on going to how to refer to Immune certificates
- • Mistaken self- diagnosis of people who think they have had COVID

Public order

- • Big issue
- • How to lift lock down without seeing civil disorder
- • Public order difficulties – how will it be policed
- • Equity, trust and inequality are important – key drivers are structural issues around policies around lock down and legitimacy – of the decision making process
- • A lot of polling is going on re: legitimacy of different policy options with dash boards – high volume polling
- • Adapt questionnaires to give much higher volumes of data
- • Anything on polling
- • SPI- B looking at this

Personal note: flag across SG – are they linked in? Stephen Reicher's SPI-B paper excellent

6. Vaccines and therapeutics

- • Recovery Trial 7000 participants
- • Plasma arm and IL-6 arm, then synthetic antibodies
- • But only 10% of eligible patients

7. Review and next steps

- • CO-CIN John Reid – Nosocomial – need to feed rates of transmission back to Trusts as they know the highest

Personal note: Chase CO-CIN for Scottish hospitals