Message

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on behalf of Michael Gove <michael.gove739@cabinetoffice.gov.uk> [michael.gove739@cabinetoffice.gov.uk]
Sent: 02/04/2020 10:51:27
To: Mark Sedwill [mark.sedwill@cabinetoffice.gov.uk]
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Dear Mark

I hope you won't mind me writing again. I thought it might be helpful to put down in one place some thoughts, suggestions, concerns and questions which I hope will help focus our efforts as effectively as possible.

There is as you will see quite a lot here - and I'm sure much, if not all of this, is simply a repetition of questions you have been asking, and activity is already well in train.

I'm therefore absolutely not expecting immediate answers to all these points, but I thought it was important to put as much down 'on paper' as possible, in the hope that it can reinforce and strengthen your hand and align us all in the right direction.

First, testing.

I appreciate that much of this may be covered off by announcements DHSC are making today, but my starting question, which I'm not sure we've answered perfectly is what is our overall strategy? At the moment we're caught on the hook of numbers, without, I think, having a clear explanation of why we're testing who we're testing in what way.

I appreciate that a lot of work has been going into different strands of effort, but a clear objective still eludes us. Not for media purposes but to direct activity across Government, the NHS, PHE etc.

Next, what are we acquiring, what do we actually need? What do we have coming by way of full kits? Can we be certain that the ThermoFisher kits we've ordered will make it out of the US? Are there other sources? What can we acquire by way of cassettes, chemicals, enzymes, other materials to increase test capacity here?

While the ventilator process has not been without its difficulties, we are now at least in a position to know what full ventilator capacity we're getting (or should be) from abroad, what domestic capacity can be ramped up, what new domestic production we have coming on line. Can we ensure we have something similar on test procurement?

And, just as we went public on what was required to make a ventilator, how publicly can we share the details of what we require?

Are we certain we have approached every possible domestic supplier/collaborator/in the private sector? What can the Chemical Industries Association offer? What has been the structured set of conversations with the wider Life Sciences/BioSciences sector?

Are we clear about how all offers of help are being triaged?

Where are we on the idea of stimulating competition?

Where are we on PM (or otherwise CHx) contact with major pharma/life science companies?

Are we certain that PHE (or whoever else) is validating the effectiveness of tests is operating quickly enough and has stripped out unnecessary bureaucracy from its processes?

I appreciate that testing is being centralised in sites in Milton Keynes and the North-West. It's great to have scaling up, but is all lab capacity across the NHS, other public bodies and universities (and indeed the private sector) being effectively utilised. Surely it should be the case that all research facilities are focused as far as possible on Covid?

I understand that the process in MK (mass production) requires automation of processes? Is that in place? Who has provided it?

Can we have the forward trajectory for the increase in testing capacity - one version of the truth however many versions of the test there may be?

Our focus, as I understand it, is on the testing of key NHS and social care workers first, although there are parallel processes that require explanation, and then the testing of a wider cohort of public sector key workers.

What support do DHSC need on the work to create the priority list of public sector (and other) workers? This is a strategic challenge which follows logically from clarity in our testing objective. When will the MIGs have the opportunity to review and discuss the public sector testing prioritisation list? The Prison Service has - understandably - sourced their own tests. Why wouldn't other sectors do this, in the absence of a coherent Government plan for testing?

If according to the latest DHSC papers, we are aiming to scale up testing to the wider public sector in 2 weeks, how are we going to ensure key workers remain in post in the interim?
We understand that CMO's office is working with counterparts in DAs - how can we make sure there is a consistent approach in prioritisation of public sector testing across the UK?
On the related question of *Antibody tests*
What is the plan for implementing Antibody tests and what will the scale-up be?
I was contacted by Toby Baxendale, who was encouraged personally by the PM and Matt Hancock to help, and who has sourced 1 million antibody tests from China (with a possible further 1 million in the pipeline). He claims to have received resistance from PHE in getting them green lighted. Have all the problems been unblocked?
Are we sure we are pursuing every angle on this simultaneously?
Next on my list is
Vaccines
Are we really sure we are riding every horse? I yield to few in my admiration of our scientists. But all professions have their cultures, practices and habits which it can sometimes be difficult fully to break free from. (see below on treatments as well)
Working internationally through CEPI is clearly important and right. But does it restrict us from finding more horses. Can we also fund research from other sources than those we currently are? As is always the case with this kind of effort, should we not widen the spectrum to focus on the less conventional sources too? To that end can we fund Professor Gus Dalgleish's work? If not, why not?
Can we also make sure the Harwell facility is engaged with properly. They are confident they can create a national manufacturing site - please can we check with them to ensure this is being secured. This was previously raised and dismissed, but on hearing from them myself, I think we should re-engage with their leadership and pursue.
That takes me to the next issue - treatments…
I understand that the trials for potential treatments such as hydroxychloroquine are only starting today and we may not get results for 8-10 weeks. That seems a dangerously long time. While that might seem rapid in normal circumstances, it seems painfully slow in our current crisis. Are we certain that we need to take so long? That might be best practice but what about just good enough practice? Why have Germany, France, Belgium and Italy included it in their treatment protocols?
I recognise that hydroxycholoroquine can be dangerous if taken in excess. But then so can paracetamol. What are the real medical risks of widespread prescription/dosage now? If the risks are low and the potential upside high isn't the moral case for widespread prescription powerful? Can't we manage (limited) trials alongside the prescription of this treatment (or others) for patients at a specific point in the progress of the disease? (ie not for everyone in the country but simply those presenting with symptoms whom we wish to avoid seeing deteriorate?)