Message

From: Theodore Agnew [Personal Data]
on behalf of Theodore Agnew [Personal Data]
Sent: 11/04/2020 1:13:07 PM
To: Gareth Rhys Williams [gareth.rhyswilliams@cabinetoffice.gov.uk]
CC: PS Lord Agnew Mailbox [pslordagnew@cabinetoffice.gov.uk]
Subject: RE: Volumes - progress today - decisions needed

Gareth,

Many thanks for your note.

I pretty much agree with all of it. By killing off the 'no hope' designs you free up resource to really concentrate on getting the viable ones through regulatory testing and onto the battle field.

A couple of points

a. I'm v keen that we try to salvage some of the financial cost for HMG. One possible way to do that is keep giving support to the machines for which HMG has the IP (as below I think). I intend to persist with my idea that DFID buy the best of what we have designed and built. They can then use them for humanitarian purposes. In tandem they can be an export product in their own right for more affluent countries who might want them.

- Sagentia (Mosquito) - although we have licenced them to release it abroad
- Team (Jarrehead/EVA) - although there is significant background IP from Diamedica in this (it is a cut down Helix)
- TTP - CoVent
- CCL - Apollo13

b. I agree that any that can get MHRA approval should get it. But I'd like us to consider the HMG IP ones are put in for clinical trials too if we can find hospitals that accept these are second tier solutions, but may have a place in the oxygen treatment hierarchy. I would accept Duncan's view on which of these might have a role. (see also point f below)
c. We are going to have to handle Dyson carefully. I accept that contractually we can walk away as he hasn't delivered by the due date. I also accept that we have an indemnity battle ahead. But just killing off his design (assuming it gets through MHRA) won't be an option. I suspect we'll have to buy a few machines, get them into hospitals so that he can then market internationally being able to say they are being used in UK hospitals. I also probably have more faith than you that he will be able somehow upgrade his machines to get higher up your graph of functionality. We should not underestimate his enormous design firepower even if new to the medical devices industry. I fully accept that you are likely to disagree with me but we both need to accept it will be a bigger decision than we can both make. Remember he got a personal call from the PM. This can't be ignored.
d. Now that we have clarity on ventilator demand from DH we can respond accordingly, cut back the numbers but probably for prudence operate on a 25% overage to their figures to cover the inevitable geographic mismatches that we have discussed. I also agree that having far fewer models in circulation will be make life easier for clinicians. I do though think we need formal sign off on the new manufactured numbers from DH SoS to avoid any confusion. (A dreaded sub will probably be needed !)
e. I have been trying for a week to get some data out of DH on what type of machines they are ordering from abroad and when they're due to arrive. I have been unsuccessful. I will try again in my E Argar meeting next week.
f. The last point that we need to remain alert to is that clinical practice could change. Ie there is a very active debate about CPAP/ less invasive etc. If we or others are able to come up with designs that reduce oxygen consumption on CPAP that could alter demand. Or indeed any of our lower end devices that could operate with a mask rather than intubation might become a more popular strand of treatment.

g. In the meantime the focus has to be on procuring parts for the machines that the NHS wants and getting the new quantities built and into their warehouse.

With many thanks for all your hard work.

TA

From: Gareth Rhys Williams <gareth.rhyswilliams@cabinetoffice.gov.uk>
Sent: 10 April 2020 19:02
To: PS Lord Agnew Mailbox <pslordagnew@cabinetoffice.gov.uk>; Theodore Agnew [Personal Data]
Cc [NR] cabinetoffice.gov.uk>; CCO Office <cco@cabinetoffice.gov.uk>; Clare Gibbs <clare.gibbs@cabinetoffice.gov.uk>; Barbara Bradley <Barbara.Bradley@paconsulting.com>
Subject: Volumes - progress today - decisions needed

Dear Lord Agnew,

Apologies for the lack of a formal sub but there are couple of things to get in front of you reasonably urgently. Hope fully we can discuss on today's call after we go through the component availability.

It's becoming clear in the last couple of days that the volume requirement for this program is changing dramatically. You recall we previously have been working to a short-term V target of some 15,000, plus normal ICU occupancy of some 2,000, but also a estimate of some 75,000 V patients in week 42. Today's CRIP shows a short-term target of some 6,000 - far below the previous 17,000. It also shows a much flatter curve for the next few weeks.

Until Wednesday evening you were encouraging us to make as much as possible, recognising that many of the 40,000 firm orders plus the LOI's were not going to actually be achievable due to product or manufacturing failure, et cetera, but we now recommend that we throttle back considerably.

Following on from the meeting last night we have as requested already stopped buying components for the Remora and OxVent and Helix. (We've also had a discussion with the Helix management team, the owner of Diamedica and the MHRA test house in Birmingham to see what might be salvageable from the Helix product. There are some options but it's not looking that optimistic.)

We have also had a meeting today with DH colleagues which has given some further clarity. Their SOS is still pushing them for a total of 18,000 viable ventilators in the short term (which we are interpreting as the end of April). The Prime Minister's target was 30,000, and that, In the absence of any recent long-term projection from the NHS, seems to be a reasonable medium-term target (say end of June) to put us in a good position for any potential second peak.

We have asked NHS colleagues to review their list of likely purchases, so we can see which of that list are likely to arrive and which of those meet the new higher spec related to suction and supported breathing. The difference gives us the target we need to be manufacturing.

We've also had a technical design authority (TDA) meeting today with our clinician panel and Duncan. We have reviewed the product portfolio and come to a number of conclusions;

The only likely candidates we have to meet the new spec are Breas, Penlon and the OES products, with possibly the Babcock, Vyaire and Apollo 13 products.

The implication is that:
- we should kill off the Remora
- we should kill off the Helix unless they're within a day of resolving the residual pressure issue

- we should allow those products going to the test house this weekend to continue, but we should come to you on Monday evening with a list of which of those we should also kill off. The list of likely candidates to be struck off are the:
- OxVent
- Florence
- Dyson
- Mosquito
- Jarrehead and
- Apollo 13
in that order

We will give you the condensed output of the TDA so you can see how we've arrived at those recommendations.

Early next week we can then put together a list of those products that have passed test, that will be needed to hit the 18,000 target, that we may nonetheless rotate out as more of the better (Penlon) products come on stream or are bought, such that over time we end up with 18,000 'Penlon or better' products, and by the end of June with 30,000 'Penlon or better' products.

I appreciate this is quite a lot to take in so I wanted to flag this to you as soon as possible so we could discuss on Monday.

The key decisions we will need from you and other ministers, are whether you feel those 18,000 and 30,000 targets are appropriate, and if you want us to manufacture (how many more) for export or DFID use. We can then trim the previous volume asks to match. I hope that makes sense!

Yours

Gareth

Sent from my iPhone

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