Message

From: Michael Gove [michael.gove739@cabinetoffice.gov.uk]
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]
CC: Jessica Glover [jessica.glover@cabinetoffice.gov.uk]; Simon Ridley [simon.ridley@cabinetoffice.gov.uk]; mreynolds@no10.gov.uk; tshinner@no10.gov.uk; Mark Sweeney [mark.sweeney@cabinetoffice.gov.uk]

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?)

I know we are exploring other treatment options, but why aren't we considering Professor Gus Dalgleish's proposal to use IMM-101 as an "immunity boost"?

I'm also worried that there is too little advice online about what to do if you have Covid other than stay home. Should you take ibuprofen? How do you know when your shortness of breath is dangerous? How long should you expect the symptoms to last? We know you shouldn't call 111 but should you notify your GP? What advice are they giving? If we don't know when people first come down with symptoms, how are we testing different drug therapies?

Should we set up mobile X-ray vans - this is something they have done in Italy - to diagnose pneumonia without requiring a hospital visit?

On treatments overall, I understand the SRO is Alex Jones from BEIS. Who else is working on this in WH and what is the governance/structure?
That takes me to the next set of questions - on Whitehall structures.
Are we confident that we have the right governance structures in place to coordinate the right activities across DHSC, PHE and NHS England, and provide sufficient assurance to the centre?
I am not clear to whom these organisations are accountable in our current processes.
The 915 is an important meeting but it can only cover a limited section of the waterfront. It primarily serves as an update and an opportunity for the PM to provide overall steers.
Given that so many questions - on testing, on PPE procurement and distribution, on treatments, on vaccines, on workforce, have such far reaching implications for the public sector, our economy and wider society is the current structure allowing ministers and officials the clarity over delivery to reassure and inform the PM properly?
It also seems that we have lost the power and gravity of a COBRA through their replacement with the MIGs which while powerful don't quite have the same portent, pressure or status.
When it comes to issues such as testing, are we confident we have the appropriate team leading this work? The SRO Kathy Hall is a Director who is, entirely understandably, self-isolating at home because her husband is asthmatic. Is she experienced in industrial scale delivery programmes? Does she have the right support and oversight?
More broadly, how many people are working on all these questions XWH? Have we fully mobilised people with the right skills and experience to support this work? Are there strong officials with DHSC experience in other departments we should draft in? Or other strong delivery figures we should deploy? Mike Green from DFE on hospital capacity?
I particularly worry about PHE. An organisation which has been as much about warning us off sugar as preparing for pandemics may not, still, be organised, as it should be. Do both PHE and DHSC need more senior support and if so can we find more officials with relevant experience to help?
Next, PPE
I know that a lot of work has been going on here. And some amazing efforts by both officials and others in the private sector generating equipment through innovative 3-D printing etc.

But when can we see a total demand projection, including all government and private sector priority requirements, properly sequenced?

If Steve Oldfield is the PPE SRO, is that all he's doing so he can dedicate sufficient time to it (and if not, can more commercial DGs be surged into DH?)

Why are we not yet turning whole domestic factories into producing PPE?

When will we have clarity on the precise nature of the materials required for gowns, and the ability of UK producers to generate that material?

Are we certain (as above in other areas) that all PPE offers are being triaged properly.

Getting PPE right is critical to giving staff at the frontline confidence.

Considering staffing next, absence rates are concerning but we're only seeing the national picture.

When will we have hospital-by-hospital breakdown of absences so we can understand hotspots, and plan ahead for the non-London hospitals most likely to fall (e.g. by Simon S' three types: V staff able to ventilate; G staff fully trained; J staff able to work under supervision)?

How can we get better visibility over the DA hospitals?

Additionally, how can we be certain we're asking the DAs for the right MI?

Next, I wanted to touch on an area that I know you have been giving a huge amount of thought to - Government resilience.

A huge amount is resting on Emily Lawson and Steve Oldfield; who are their reserves if one or both become ill?

Can we bring back (even temporarily) other good officials currently on loan or leave?

Finally, there are some basic communications and organisation questions.

What thought has been given to changing/reviewing the guidance we have issued?

For example, when will we review guidance on school attendance (given that far from being overwhelmed school attendance is running at around 2% and many vulnerable children are neither in school nor being supported by social workers and local authorities?)
Can we be clear over who is in charge of all guidance?

Can we also be clear over who is in charge of ensuring that services which are now facing hugely ramped up demand (eg Verify) are being properly managed?

Can we produce a new organogram showing just who is responsible for what and how to contact them?

And, are we thinking now about how - whenever it is possible - about how we can start easing the restrictions and doing so in a way that does the least possible damage to our economy.

Finally, I wanted to emphasise that I know that many in the Civil Service and wider public sector are going to extraordinary efforts in recent weeks. None of these questions are intended to detract from that or the many and significant achievements which the Government's efforts so far have delivered.

Yours

Michael