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Minutes

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COVID-19 OPERATIONS COMMITTEE

Minutes of a Meeting of the Covid-19 Operations Committee
held in Conference Room A and by video conference on

THURSDAY 29th October 2020
At 0910 AM

P R E S E N T

The Rt Hon Michael Gove MP
Chancellor of the Duchy of Lancaster, Minister for the Cabinet Office

The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

ALSO PRESENT

The Rt Hon Robert Jenrick MP
Secretary of State for Housing, Communities and Local Government

The Rt Hon Baroness Evans of Bowes Park
Leader of the House of Lords and Lord Privy Seal

The Rt Hon Jacob Rees-Mogg MP
Lord President of the Council and Leader of the House of Commons

The Rt Hon Mark Spencer MP
Parliamentary Secretary to the Treasury (Chief Whip)

Chris Heaton-Harris MP
Minister of State, Department for Transport

The Rt Hon John Whittingdale OBE MP
Minister of State (Minister for Media and Data)

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Baroness Williams of Trafford
Lords Minister, Home Office

Nadhim Zahawi
Parliamentary Under Secretary of State (Minister for Business and Industry)

John Glen MP
Economic Secretary to the Treasury

Professor Jonathan Van-Tam
Deputy Chief Medical Officer

Dr Thomas Waite
Director, Joint Biosecurity Centre

NR
Chief of Staff, NHS Test and Trace

NR
National Director, NHS Test and Trace

Kathy Hall
Director General, COVID-19 Taskforce

Will Green
Deputy Director, COVID-19 Taskforce

Secretariat

J Parry
NR

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Situation Report

THE DIRECTOR FOR EPIDEMIOLOGY AT THE JOINT BIOSECURITY CENTRE said that the epidemiological data was going in the wrong direction across the board. The weekly case rate for over 60s had increased by over 50 per cent in a week and had reached 224 per 100,000, up from 168 in the previous week. There had been a pronounced down-turn in new case rates for the 17-21 age group, down 50 per cent. However, all other age groups continued to rise quickly and the evidence had shown that the spike in the younger age range had spread to older age groups. An increase in case rates for the over 60 bracket could be seen across the country, with the spread in this group most notable in East and West Midlands, the North East, and the North West. Cases were also rising in this group faster than any other age range, particularly in the North West.

Continuing, THE DIRECTOR FOR EPIDEMIOLOGY AT THE JOINT BIOSECURITY CENTRE said that the upwards curve in the epidemiological data was broadly consistent across the four nations of the United Kingdom. Test and Trace data showed that the most affected areas of the country were the North West, which had increased to 493 cases per 100,000, and Yorkshire and the Humber which had seen 440 cases per 100,000 in the past week. The data had shown that high incidence in one area was slowly spreading into the surrounding areas and this was most obvious in the North West. All areas in the country now had a higher case rate per 100,000 than Leicester did when restrictions were first introduced there in July.

Continuing, THE DIRECTOR FOR EPIDEMIOLOGY AT THE JOINT BIOSECURITY CENTRE said that surveillance data from REACT and the Office for National Statistics (ONS) had both shown large increases in prevalence from all parts of the country and there was a high level of consistency between the two separate sources. Test positivity was extremely high, which meant that predictions were likely underreporting the true case rate. In the North West, the National Health Service (NHS) had already reached the same level of peak occupancy as seen in the first wave with many areas close behind. Hospital admissions were fast increasing and yesterday had seen over 1,000 admissions to hospital for Covid-19 (coronavirus)-related causes.

Concluding, THE DIRECTOR FOR EPIDEMIOLOGY AT THE JOINT BIOSECURITY CENTRE said that there was less headroom in NHS capacity than there had been during the first wave, as much of the capacity was beginning to be used for other hospital activity related to winter. Looking forward, it could be expected that NHS capacity would be exceeded by at least 10 per cent in the next four to five weeks. It was likely that hospital occupancy would exceed the peak of the first wave by approximately 11 November. The death rate had also begun

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to increase. There had been a further 300 deaths the previous day and 1186 deaths within 28 days of a coronavirus diagnosis had been reported in the last week. This was double the amount of deaths in July.

Responding, THE DEPUTY CHIEF MEDICAL OFFICER said that it was clear England was now in a very bad place and would be in an extremely bad place by the end of November. The best case scenario reading of the current situation was that England would be entering winter with a very high coronavirus case burden. Any slip up in terms of maintenance of non-pharmaceutical interventions would cause us to lose control of the virus from a very high starting point. The worst case reading was that control of the virus had already been lost. Two weeks ago, it had seemed inappropriate to take action in a low prevalence area such as the South West. This was no longer the case. The Government had to do more.

In discussion, the following points were made:

a) the hospital fatality rate appeared lower than in the first wave. This might be driven by the fact that so far in this wave, a younger age profile had been affected, but it could be expected that the number of elderly patients would increase and, therefore, so would the death rate. Fewer people dying also did not mean less strain on the NHS as elderly patients typically had a long stay before discharge and would therefore use more capacity. He said that even if mortality rates were lower this might not mean they had a shorter hospital stay, especially where the age profile was higher;

b) there had been very little evidence yet that the Local Covid Alert Level (LCAL) three measures had been working to suppress the virus sufficiently. If this evidence did not emerge in the coming weeks, more action would be needed;

c) there had been some evidence in Liverpool that the case rate amongst over 60s was stabilising, however due to the incubation period and data lag for the virus, this would only include infections that occurred in the first few days of the local restrictions. This data should not create a false sense of security, as there had been international examples, such as Belgium, of cases initially appearing to stabilise only to later skyrocket. It would be safer to comment on Liverpool in a week or so; and stabilisation in the number of new cases would not be sufficient to warrant a relaxation in measures; and

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d) Stabilising in some areas would mean resting at a new weekly case rate of 400 per 100,000, quadruple the level at which initial intervention had taken place in Leicester.

Summarising, THE CHANCELLOR OF THE DUCHY OF LANCASTER said that the data was clearly showing that there was no part of the country where the virus was not increasing. Cases were growing faster amongst the older age brackets whilst diminishing amongst the youngest. Hospital admissions were increasing across the country and the steepness of the increase of the gradient of admission was fast approaching that of the first wave. The number of deaths had begun to double every few days. The data seemed to show that we had become proportionately better at dealing with those hospitalised and the risk of mortality was lower.

The Committee:

— took note.

Local Covid Alert Levels

THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE said that the coming weeks were the final opportunity to prevent the overflow of the NHS using the regional approach, but that we were very close to that approach failing. A regional approach was better for many reasons: it was more proportionate, caused less economic damage, and secured more buy-in from the local area. However, because of failings in the last few months, namely that the necessary action had not been taken to tackle incidence in the highest tiers in line with public health advice, more stringent action was now needed. These failings and the impact of the delay to act should be noted and guide the government's approach going forwards.

Continuing, THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE said the following areas should move as soon as possible to LCAL three, preferably with the support of local leaders: West Yorkshire, noting that negotiations were in late stages and close to being finalised; Teesside. Rapid engagement should take place with local leaders in the following areas over the following week to prepare them for the move to LCAL three: Tyneside, The West Midlands, Staffordshire, Leicester and Leicestershire.

Continuing, THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE said the following areas should move to LCAL two: Carlisle, noting that this meant almost all of the North West would be in LCAL three with the exception of a very small pocket of geography;

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