- The first group would be comprised of very high risk people who may be immunosuppressed. This group is thought to be between 1 and 2 million people [DN. Assume this is across the whole population, not just those of working age? I ask as BEIS and CO were very focused on this question earlier] and could be identified between clinical reference groups and cancer registries.
- Individuals in this group would be asked to follow something close to the current PHE advice for those self-isolating for a period of up to 13 weeks – they would not, for example, be able to go to work or to go food shopping.
- A second, larger group (probably compromised of individuals who are 70+) would be advised to reduce social mixing to reduce their number of social contacts over a 13 week period. This group would also include some individuals with chronic health conditions, some of who would be of working age.
- This group would be advised to reduce unnecessary contacts, but would follow a more liberal approach. For example, whilst where possible they would be advised to work from home, if that was not possible then in general they would be able to go to work. However, we might need to advise a small number of individuals with increased risk, such as healthcare workers or social care workers, or for example bus drivers with cardiovascular disease, to take further steps to protect themselves.
- We would not seek to identify individuals in this wider group but would communicate through the usual channels to the public for them to self-identify; however, we may consider actively identifying individuals in the first, higher risk group and proactively contacting them.

James Harrison
Coronavirus RWCS Strategy
Department of Health and Social Care
M: **Irrelevant & Sensitive**

From: Mehta, Nisha <Nisha.Mehta@dhsc.gov.uk>
Sent: 07 March 2020 14:19
To: Harrison, James <James.Harrison@dhsc.gov.uk>; **Name Redacted** @dhsc.gov.uk>
Cc: Harries, Jenny <Jenny.Harries@dhsc.gov.uk>; Dodds, Kevin <Kevin.Dodds@dhsc.gov.uk>
Subject: FW: Readout: Definition of at risk groups

Kevin – something must have come up as we are on the call without you. I have refined the summary bullets further – James will craft for CCS and circulate to all on the call.
Thanks
Nisha
Dear all
Summary of the section of the call relating to definition of at risk groups
Full readout including an initial broader discussion relating to operationalising the self isolation / home quarantine interventions (NPI 1 and 2) - below
Please circulate to anyone on the call whose names I missed (? Jonathan Marron)

- Between clinical reference groups and cancer registries we will identify a cohort around very high risk people who may be immunosuppressed. We think that population is about 2m. they can be identified through CRGs, cancer centres, cancer centre data and other means.
- This should follow something close to current self isolation model for 13wk including not going to work / out for groceries –this is for their own protection
- For a larger group (probably 70+) to reduce social mixing to reduce number of contacts (as per modelling) but this tier will be a more liberal approach eg so should wfh adapted work process, can work if need be
- This also would apply to those not covered by age cutoff who are wider – chronic conditions, some working age.
- If any individuals such as HCW, care workers in those groups we need to specifically protect at work, also consider other particular groups eg bus drivers with CVD
- We do not plan to identify individuals in the wider group rather give clear messages to the public
- May consider actively identifying the 1.2m group via HRGs and working backwards to GP surgeries asking them to proactively contact
- In this way we are not taking everybody out of the workforce except the particularly vulnerable 1-2 m so easier for OGDs
- OGDs do need to understand specific groups eg 1-2m, specific groups in working age population 40-60yrs (eg bus drivers with CVD)

Bw
Nisha
Vulnerable individuals – clinical call 7 Mar readout
Jenny Harries chairing
Keith Willet
Aidan Fowler
Susan Hopkins
Kevin Dodds
Name Redacted
NR
Jonathan ? Marron
- Outlined current three proposed NPIs based on modelling
- Focus of this call is identifying vulnerable groups
- Cocoon – isolate in a positive sense to prevent getting into contact with disease
- What are risk factors we would look for in a contact chain and apply in reverse to this group

KD
- Asked whether first two groups already appropriately covered? – yes these are covered

KW
- Can we take offline – whatever the agreed case definition is go to KW as they are building protocols for those reporting symptoms who we assume people are infected
- Assessment process will determine disease severity

JH
- How will you watch people with underlying conditions who are presenting symptoms?

KW
- Algorithm will ideally scale to the size of the problem
- Bear in mind that therapies available are limited
- When numbers get bigger we will have to rely on people to contact us if they need assessment
- In the end the only assessment we will need is whether you need oxygen
- If coronavirus – how sick are you? Do you need oxygen?
- More subtlety inc bacterial infection
- But module will collect risk factors – these are relevant but in the end all that is necessary is do you need oxygen therapy
- The thing that stops us building algorithms is we can't get the clinical definitions
- Once agreed this can be built into the algorithm within 24h

Susan
- When are we going to ask population to self isolate without testing
- Currently PTP is narrow – but still not highlighting a large number in community
- When we move to sustained CT – symptoms of cough/cold/flu are wide ranging
- Need to understand pragmatism of how many people in that scenario we keep at home
- If we take ILI (fever/myalgia/headache) vs URTI (cough/cold/runny nose). ILI 1/100,000
- Cough and cold the baseline rate is 20/100,000 up to 60/100,000
- The volumes of people we keep off work will be challenging esp in early stages when we have a large amounts of population at home vs how many actually have disease
- Reason we pick fever – marker of illness and clearly need medical attention
- SOB is marker of potential oxygen
- Cough – good barometer of people who can spread the virus easily.
- This was the pragmatism behind why we picked those three
- Therefore when are we changing home quarantine without testing and how
- When do we start measures therefore?

JVT
- Helpful – ideally what we need is to switch off all other URTIs because it is still winter
- If we had managed to delay for another month this would have been much easier
- May need graduated testing