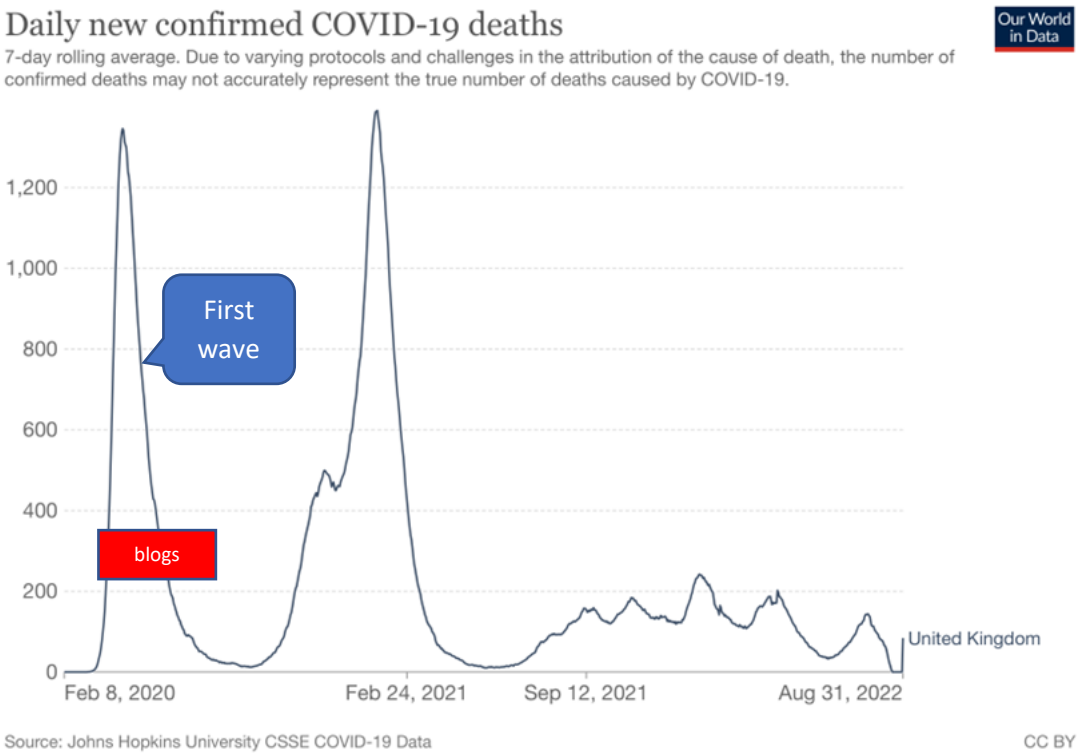
COVID-19
'THE FIRST WAVE'

20 Weekly Blogs tracking the first wave March - July 2020



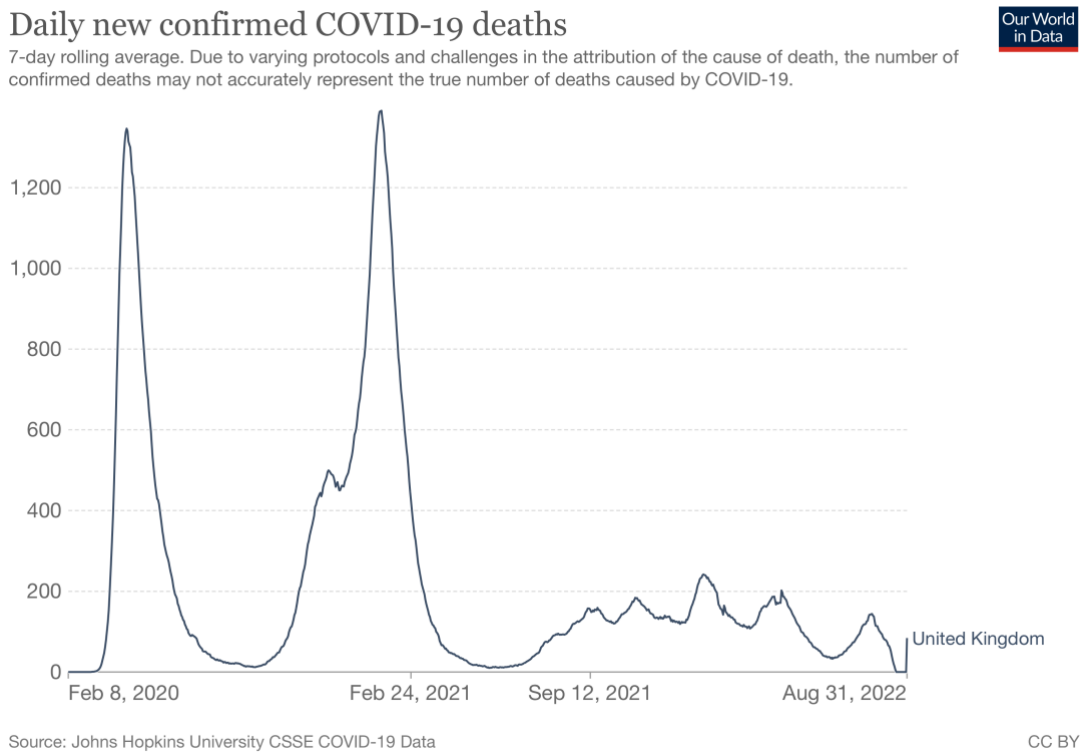
Socialist Health Association

CONTENTS

Introduction

The Socialist Health Association (SHA) is a policy and campaigning organisation which promotes health and well-being and the eradication of inequalities through the application of socialist principles to society and government. During the first wave of the pandemic one of its senior officers drafted a series of 20 weekly blogs which covered the period from mid-March 2020 to the end of July 2020 – effectively covering the first wave of the pandemic in the UK.

Fig 1. Waves of the Pandemic



The SHA blogs were drafted by a public health physician who had experience as an NHS inner city GP, a Director of Public Health (DPH) at District and Strategic Health Authority level, a UK CMO during the 2009 H1N1 flu pandemic and was working during the first 15 months of the pandemic within a Local Authority public health team. These draft blogs were edited and signed off by the Chair and other officers of the SHA, so the political content was supported and circulated via the SHA email list and posted on the SHA website and Facebook page. The 20 original blogs are accessible via the SHA website www.sochealth.co.uk

The SHA are pleased that the Independent Public Inquiry, Chaired by Baroness Hallett, has been established and started to examine the UK's response to and the

impact of the Covid-19 pandemic and learn lessons for the future. The way that the UK government approached the pandemic was defined during the early stages of the global pandemic and these blogs cover the period of the first wave during which time many of the problems of preparedness and in managing the ongoing pandemic became manifest. In many respects this snapshot of the early period can be seen to be the equivalent of assessing the first 100 days of a US President's term of office or a UK Prime Minister's tenure when ways of working are established. We believe that this series of blogs are helpful in setting out key issues that were clear even in the early days of the pandemic.

We note that there are already examples of people, closely involved in pandemic preparedness and the initial response to the pandemic who are providing their explanations for decisions made and, in some cases, seem to be using the metaphorical 'retro-spectroscope' and rewriting history. The SHA has pulled together the original blogs into an electronic book format and hardcopy to make it more accessible to the Inquiry team and wider public. To assist readers, we have added some data on hospitalisations and deaths for each week and the cumulative totals of both over this time at the beginning of each Blog. The data was obtained from the ONS data for England www.coronavirus.data.gov.uk

These blogs are published to ensure that many of the lessons learnt during the first wave should not be lost in the mass of information the team will have to assess. Their value lies in the fact that they were drafted by an experienced public health physician and are a contemporaneous weekly record from that time. No rewriting of history!

In the final blog on July 27th 2020 we noted seven main points for the All Party Parliamentary Group (APPG) investigation Chaired by Layla Moran MP as follows:

1. **Austerity (2010-2020**) - the public sector such as the NHS, Social Care, Local Government and the public health system had been weakened by 10 years of austerity.
2. **Emergency Planning but no preparedness –** the 2016 Operation Cygnus exercise looking at a future influenza pandemic exposed the lack of preparedness which led to problems such as PPE supplies, lack of much needed ventilators and poor ITU bed and staffing provision[1].
3. **Poor political leadership –** the very centralised decision making by the PM and SoS for Health excluded many players such as local Directors of Public Health and undermined the public health system by creating a privatised Test and Trace system, the creation of the Joint Biosecurity Unit, Ministers overpromising and misusing statistics.
4. **Social Care –** in the early data from China and in Europe it was clear that older people were at particularly high risk from Covid-19 and the social care system was already stressed in the UK with underinvestment and poor staffing levels. The 'Protect the NHS' mantra was laudable but as we saw 40% of care homes had outbreaks by the first wave and a third of the mortality was from that sector.

[1] *Subsequent to the blogs publication we have learned about another simulation – Exercise Alice in 2016 - that was based on SARS and MERS that was kept secret*.

5. **Inequalities –** it was said that the virus affected '*Prince and Pauper*' and while it is true that Prince Charles and the Prime Minister were early cases the evidence clearly shows that poorer people and especially those from BAME backgrounds have been particularly badly affected. This effect was highlighted by the disproportionate death rate in BAME doctors and nurses.
6. **Privatisation –** the contract agreed with Private Hospitals seemed to support that sector financially rather than the NHS. The private Lighthouse Laboratories did not invest in NHS and Public Health laboratories and Test and Trace did not integrate well with local public health or primary care services. PPE and other equipment supplies were not handled well with poor procurement systems, profiteering and a huge waste of resources to inexperienced suppliers.
7. **Recovery Planning –** there has been a wide range of positive lessons learnt during the first wave such as the reduction in air pollution due to reduced car use and many benefits from working from home and having access to green spaces. Access to fast broadband has exposed the digital divide and building new environments with a 'green deal' is an opportunity that should not be missed. The investment needed in the NHS and Social Care as well as a national public health system is clearly needed based on the pandemic experience of the first wave.

We hope that the insights obtained through linking these 20 weekly blogs written and distributed during the first wave will provide a useful resource to check that the Covid Inquiry is focusing on some of the fundamental lessons learnt by the end of the first wave.

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 1

Published: 17th March 2020

ONS England data:			
Hospitalisations on 19/3	**586**		
Deaths on 17/3	**51**	**Cumulative deaths**	**199**

COVID-19 Pandemic – The first 100 days.

The SHA wants to contribute to the tremendous national and international debate about controlling and mitigating the worst effects of the **COVID-19 pandemic**. We will base these thoughts through the lens of a socialist society, which advocated politically in the 1930s to create the NHS in the UK and for other socialist policies, which see the social determinants of health being as important as the provision of health and social care services as we strive for a healthier and fairer society.

This blog will be the first of a series and will cover

1. **A global crisis**
2. **The Public Health system**
3. **The NHS, Local Government and Social Care**
4. **Funding for staff and facilities**
5. **Staff training, welfare and support**
6. **Vulnerable populations**
7. **Assuring Universal Basic Income**

1. A global crisis

This COVID-19 pandemic has already been cited as the **greatest public health crisis for at least a generation**. The HIV/AIDS pandemic starting in the 1980s had a much slower spread between countries and is estimated to have caused an estimated 25-30m excess deaths so far. The potential scale of this type of respiratory viral infection pandemic with a faster spread means we should probably look back to the **1957 Asian flu** pandemic and indeed the 1918 post war '**Spanish flu'.** The 1918 pandemic led to an estimated 40-50m global deaths and was when there was also **no effective vaccine** or **treatment** for the new variant of flu. So basic public health hygiene (hand washing), identifying cases and quarantining (self-isolation) are still important. **We recognise this as a global challenge, which requires global solidarity and the sharing of knowledge/expertise and advice.**

The WHO, which is part of the United Nations, needs our support and is performing a very beneficial role. This will be especially important for those Low Middle-Income Countries (LMICs) who often have unstable political environments and weak public health and health systems. Remember the Democratic Republic of the Congo who have only just seen off their Ebola epidemic, war torn Syria and the Yemen.

The USA and other high-income countries should be unambiguous about recognising this as a fundamental global pandemic requiring collaboration between countries along the principles of mutual aid. The **UN and WHO need our support and funding and we look to international financial** organisations such as the IMF/World Bank to rally around in the way that the world banking system showed they could in their own self-inflicted 2008 financial crash. The WHO has recently referred to Europe as the epicentre of the pandemic and we **urge the Government to put aside their ideological objections and co-operate fully with the EU and our European partners.**

2. The public health system

The UK itself is in a relatively strong position with a national public health service, which has focus at a UK level (CMO/PHE), scientific advisory structures (SAGE), devolved governments, municipalities and local government. The NHS too still has national lines of control from NHSE to the NHS in England and the equivalents in devolved countries. The Tory 'Lansley' reforms in England destroyed the health authority structure below national levels (remember the former Strategic and District Health Authorities) but at least PHE has a regional organisation and Local Government have Directors of Public Health. We regret the fact that the 10 years of Tory austerity has depleted the resources in PHE and Local Government through not funding the PHE budget adequately and not honouring the public health grant for local authorities. We hope that the recent budget will mean that the public health service and local government does receive the financial and other resources required to help lead the pandemic response. Pandemics have always been high up in the UK risk register.

3. The NHS, Local Government and Social Care

We are grateful that, despite the privatisation of many parts of the NHS in England, we still have a recognisable system and a culture of service rather than profit within our one million or so staff and their NHS organisations. We were pleased to hear the **open-ended funding commitment from the Chancellor** at the last budget and urge that leaders within the NHS in England and the devolved countries use this opportunity to try to mitigate the underfunding over the last 10 years and implement the emergency plans that exist and calibrate them to deal most effectively with this particular viral threat. Any debates about further privatisation of the NHS needs to be taken off the agenda and let's not use the budget money to prop up the private sector but requisition capacity if that is what is needed and compensate usage on an NHS cost basis. We want to protect the NHS from the risk that the NHS Long Term Plan proposals for 44 Integrated Care Schemes opens up the risk of US styled private insurance schemes.

4. Funding for staff and facilities.

It will of course be difficult as a result of the staffing crisis that has been allowed to drift over the past 10 years with shortages of NHS workforce of 100,000 of which 40,000 are nurse vacancies but also includes doctors and other key staff. We and our Labour Party colleagues have been reminding Tory Ministers that it takes 10 years to train a medical specialist so you cannot whistle them up or poach them from other poorer countries. The government needs to abolish their proposed points-based immigration regime and indeed the compulsory NHS insurance of £650 per adult which is a huge disincentive to come here and work in the health and social care system.

Hospitals and other health facilities in the UK take time to plan, build and commission. We can of course learn from Wuhan in China where they built a 1000 bedded hospital in weeks! Our own war preparation in the late 1930s when industry shifted production rapidly from civilian to military supplies is another exemplar. **Despite the negative impact of 10 years of Tory austerity we urge the NHS to embrace this opportunity to invest in staff, supplies and facilities needed to manage the effects of the pandemic**. Creating strategic regional NHS bodies will ensure that capital and revenue resources committed from the centre are used optimally and equitable to meet population needs in collaboration with local authorities.

5. Staff training, welfare and support

Front line NHS and social care staff will need our support over this time. We must ensure that working practices protect staff as much as possible from the risks in the workplace. **Training and provision of Personal Protective Equipment (PPE)** is vital and employment practices will need to adapt to the changing situation. Let's not forget social care workers, dentists, optometrists and district nurses who are part of our front line. Staff will need retraining if doctors and nurses are to be diverted to unfamiliar roles as we will need A&E, pandemic pods and intensive care unit capacity to be enhanced. Sadly, we now have a significant workforce who work for private contractors as part of the Tory privatisation of the NHS. **We need to ensure that they have the same employment safeguards, minimum pay levels, sick pay and the health and safety entitlements as NHS staff.** This is the time to renationalise such services back into the fold.

Patients with existing long-term conditions remain in need of continuing care as will patients presenting with new life-threatening conditions such as cancers, diabetes and circulatory diseases. NHS managers will need support to organise these different services and decisions to postpone non-urgent elective surgery to free up resources. What also makes sense is testing novel ways of supporting people digitally and by teleconferencing to reduce attendance at NHS premises. This can be rolled out for Outpatient provision as well as GP surgeries. The NHS 111 service, and other online services and the equivalents in the devolved nations can easily be overwhelmed so pushing out good health information and advice is being done and needs to continue. **The public and patient engagement has always been at the heart of our policies and can be rolled out in this emergency utilising the third sector more imaginatively.**

6. Vulnerable populations.

In our assessment of what needs to be done we must not bypass the urgent needs of some of our most vulnerable populations. The homeless and rootless populations, many of whom have longstanding mental health conditions and/or substance dependency, are particularly at risk. They need urgent attention working closely with the extensive voluntary sector. Also, those populations with long term conditions who will feel at risk if services are withdrawn due to staff redeployment or staff sickness need planning for. Primary care needs to be the service we support to flag up those in need and ensure that their medications and personal care needs continue to be met even if we need to involve volunteers and good neighbours to help out with daily needs such as shopping/providing meals and other tasks.

Undocumented workers such as migrants and refugees are often frightened to use health services for fear of police intrusion. The government needs to make it clear that there will be no barriers to care for this population during this crisis and beyond.

Social care is in need of particular attention. It was virtually ignored in the budget. This sector is at risk in terms of problems with recruiting and retaining staff as well as the needs of the recipients of care and support. While business continuity plans may be in place there is no question that this sector needs investment and generous support at the time of such an emergency. They will be a vital cog in the wheel alongside home-based carers in supporting the NHS and wider social care system.

Those most at risk seem to be the most neglected. Disabled people with care needs have received little advice and no support. Already carers are going off sick and can be replaced only with great difficulty. Those paying for their own care with Direct Payments seem to get no support at all.

With the COVID-19 virus we are seeing that the older population and those with so called ‘underlying conditions’ are at particular risk. We must ensure that this large population do not feel stigmatised and become isolated. **Rapid assembly of local support groups should be encouraged which has been referred to as ‘local COBRA groups’**. Local government can play a key role in establishing local neighbourhood centres for information and advice on accessing support as we move toward increasing quarantining and isolated households. Again, wherever possible the use of IT and telephone connectivity to share information and provide remote support will make this more manageable.

7. **Assuring universal basic income.**

Finally, the SHA recognises that **the economy will be damaged** by the pandemic, organisations will go to the wall and staff will lose their jobs and income stream. We have always recognised that the fundamental inequalities arise from the lack of income, adequate housing, and the means to provide for everyday life. This pandemic will last for months, and we think that the Government needs to ensure that we have systems in place to ensure that every citizen has access to an adequate income through this crisis. We pay particular attention to the 2m part time workers and those on zero hours contracts as well as the 5m self-employed. There have been welcome changes in the timely access to the insufficient Statutory Sick

Pay, but this is not going to be the answer. People will be losing their jobs as different parts of the economy go under as we are already seeing with aviation, the retail sector, and café/restaurants. The government needs to reassure those fearful of losing their jobs that they will stand by them during the pandemic. It may be the time to test the Universal Basic Income concept to give all citizens a guarantee that they will have enough income for healthy living. We already have unacceptable health inequalities so we must not allow this to get worse.

8. **Conclusion**

The **SHA stands ready to support the national and international efforts to tackle this pandemic**. We assert our belief that a socialist approach sees universal health and social care as an essential part of society.

That these systems should be funded by all according to a progressive taxation system and meet people's needs being free at the point of use. We believe that a thriving state owned and operated NHS and a complimentary not for profit care sector is essential to achieve a situation where rich and poor, young and old and citizens in towns, cities and in rural areas have equal access to the best care.

We recognise that the social determinants of health underpin our health. We agree with Marmot who reminds us that health and wellbeing is reflected by 'the conditions that people are born, grow, live, work and age and by the inequities in power, money and resources that influence these conditions.

The pandemic is global and is a major threat to people's health and wellbeing. Universal health and public health services offer the best means of meeting this challenge nationally and globally. Populism and inward-looking nationalism needs to be challenged as we work to reduce the human suffering that is unfolding and direct resources to meet the needs of the people at this time.

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 2

Published: 24th March 2020

ONS England data for 24th March:			
Hospital admissions	**1,544**	**Total in hospital**	**3,598**
Deaths	**219**	**Cumulative deaths**	**1,095**

The Socialist Health Association (SHA) published its first Blog on the COVID-19 pandemic last week (Blog 1 – 17th March 2020). A lot has happened over the past week, and we will address some of these developments using the lens of **socialism and health**.

1. Global crisis

This is a pandemic, which first showed its potential in Wuhan in China in early December 2019. The Chinese government were reluctant to disclose the SARS-like virus to the WHO and wider world to start with and we heard about the courageous whistle blower Dr Li Wenliang, an ophthalmologist in Wuhan, who was denounced and subsequently died from the virus. The Chinese government recognised the risk of a new SARS like virus and called in the WHO and announced the situation to the wider world on the 31st December 2019.

The starter pistols went off in China and their neighbouring countries and the risk of a global pandemic was communicated worldwide. The WHO embedded expert staff in China to train staff, guide the control measures and validate findings. Dr Li Wenliang who had contracted the virus, sadly died in early February and has now been exonerated by the State. Thanks to the Chinese authorities and their clinical and public health staff we have been able to learn about their control measures and the clinical findings and outcomes in scientific publications. This is a major achievement for science and evidence for public health control measures but….

Countries in the Far East had been sensitised by the original SARS-CoV outbreak, which originated in China in November 2002. The Chinese government at that time had been defensive and had not involved the WHO early enough or with sufficient openness. The virus spread to Hong Kong and then to many countries showing the ease of transmission particularly via air travel. The SARS pandemic was thankfully relatively limited leading to global spread but 'only' 8,000 confirmed cases and 774 deaths. This new Coronavirus COVID-19 has been met by robust public health control measures in South Korea, Taiwan, Hong Kong, Japan and Singapore. They have all shown that with early and extensive controls on travel, testing, isolating, and quarantining that you can limit the spread and the subsequent toll on health services

and fatalities. You will notice the widespread use of checkpoints where people are asked about contact with cases, any symptoms e.g. dry cough and then testing their temperature at arm's length. All this is undertaken by non-healthcare staff. Likely cases are referred on to diagnostic pods. In the West we do not seem to have put much focus on this at a population level – identifying possible cases, testing them and isolating positives.

To look at the global data the WHO and the John Hopkins University websites are good. For a coherent analysis globally the Tomas Peoyu's review 'Coronavirus: The Hammer and the dance' is a good independent source as is the game changing Imperial College groups review paper for the UK Scientific Advisory Group for Emergencies (SAGE). This was published in full by the Observer newspaper on the 23rd March. **That China, with a population of 1.4bn people, have controlled the epidemic with 81,000 cases and 3,260 deaths is an extraordinary achievement. Deaths from COVID-19 in Italy now exceed this total.**

The take away message is that **we should have acted sooner** following the New Year's Eve news from Wuhan and **learned and acted on the lessons of the successful public health control measures** undertaken in China and the Far East countries, who are not all authoritarian communist countries! Public Health is global and instead of Trump referring to the 'Chinese' virus he and our government should have acted earlier and more systematically than we have seen.

Europe is the new epicentre of the spread and Italy, Spain and France particularly badly affected at this point in time. The health services in Italy have been better staffed than the NHS in terms of doctors/1000 population (Italy 4 v UK 2.8) as well as ITU hospital beds/100,000 (Italy 12.5 v UK 6.6). As we said in **Blog 1** governments cannot conjure up medical specialists and nurses at whim so we will suffer from historically low medical staffing. The limited investment in ITU capacity, despite the 2009 H1N1 pandemic which showed the weakness in our system, is going to harm us. It was great to see NHS Wales stopping elective surgical admissions early on and getting on with training staff and creating new high dependency beds in their hospitals. In England elective surgery is due to cease in mid-April! We need to ramp up our surge capacity as we have maybe 2 weeks at best before the big wave hits us. **The UK government must lift their heads from the computer model and take note of best practice from other countries and implement lockdown and ramp up HDU/ITU capacity.**

In Blog 1 we mentioned that global health inequalities will continue to manifest themselves as the pandemic plays out and spare a thought for the Syrian refugee camps, people in Gaza, war torn Yemen and Sub-Saharan Africa as the virus spreads down the African continent. Use gloves, wash your hands and self-isolate in a shanty town? So let us not forget the Low Middle-Income Countries (LMICs) with their weak health systems, low economic level, weak infrastructure, and poor governance. **International banking organisations, UNHCR, UNICEF, WHO and national government aid organisations such as DFID need to be resourced and activated to reach out to these countries and their people.**

2. The public health system

We are lucky to have an established public health system in the UK and it is responding well to this crisis. However, we can detect the impact of the last 10 years of Tory Party austerity which has underfunded the public health specialist services such as Public Health England (PHE) and the equivalents in the devolved nations, public health in local government and public health embedded in laboratories and the NHS. PHE has been a world leader in developing the PCR test on nasal and throat samples as well as developing/testing the novel antibody blood test to demonstrate an immune response to the virus. The jury is out as to what has led to the lack of capacity for testing for C-19 as the UK, while undertaking a moderate number of tests, has not been able to sustain community-based testing to help guide decisions about quarantining key workers and get intelligence about the level of community spread. Compare our rates of testing with South Korea!

We are lucky to have an infectious disease public health trained CMO leading the UK wide response who has had experience working in Africa. Decisions made at COBRA and announced by the Prime Minister are not simply based 'on the science' and no doubt there have been arguments on both sides. The CSO reports that SAGE has been subject to heated debate as you would expect but the message about herd immunity and stating to the Select Committee that 20,000 excess deaths was at this stage thought to be a good result was misjudged. The hand of Dominic Cummings is also emerging as an influencer on how Downing Street responds. **Remember at present China with its 1.4bn population has reported 3,260 deaths. They used classic public health methods of identifying cases and isolating them and stopping community transmission as much as possible. Herd immunity and precision timing of control measures has not been used.**

The public must remain focused on basic hygiene measures – self isolating, washing of hands, social distancing and not be misled about how fast a vaccine can be developed, clinically tested, and manufactured at scale. Similarly hopes/expectations should not be placed on novel treatments although research and trials do need supporting. The CSO, who comes from a background in Big Pharma research, must be seen to reflect the advice of SAGE in an objective way and resist the many difficult political and business pressures that surround the process. His experience with GSK should mean that he knows about the timescales for bringing a novel vaccine or new drugs safely to market.

3. Local government and social care

Local government (LAs) has been subject to year-on-year cuts and cost constraints since 2010, which have undermined their capability for the role now expected of them. The budget did not address this fundamental issue and we fully expect that in the crisis, central government will pass on the majority of local actions agreed at COBRA to them. During the national and international crisis LAs must be provided with the financial resources they need to build community hubs to support care in the community during this difficult time. The government need to support social care.

COVID-19 is particularly dangerous to our older population and those with underlying health conditions. This means that the government needs to work energetically with the social care sector to ensure that the public health control measures are applied effectively but sensitively to this vulnerable population. The health protection

measures which have been announced is an understandable attempt to protect vulnerable people, but it will require community mobilisation to support these folk.

Contingency plans need to be in place to support care and nursing homes when cases are identified and to ensure that they can call on medical and specialist nursing advice to manage cases who are judged not to require hospitalisation. They will also need to be prepared to take back people able to be discharged from acute hospital care to maintain capacity in the acute sector.

Apart from older people in need there are also many people with long term conditions needing home-based support services, which will become stressed during this crisis. There will be nursing, and care staff sickness and already fragile support systems are at risk. As the retail sector starts to shut down and there is competition for scarce resources, we need to be building in supply pathways for community-based people with health and social care needs. Primary health care will need to find smart ways of providing medical and nursing support.

4. The NHS

In January and February when the gravity of the COVID pandemic was manifesting itself many of us were struck by the confident assertion that the NHS was well prepared. We know that the emergency plans will have been dusted down and the stockpile warehouses checked out. However, it now seems that there have not been the stress tests that you might have expected such as the supply and distribution of PPE equipment to both hospitals and community settings. The planning for COVID-19 testing also seems to have badly underestimated the need and we have been denied more accurate measures of community spread as well as the confirmation or otherwise of a definite case of COVID-19. This deficiency risks scarce NHS staff being quarantined at home for non-COVID-19 symptoms.

The 2009 H1N1 flu pandemic highlighted the need for critical care networks and more capacity in ITU provision with clear plans for surge capacity creating High Dependency Units (HDUs) including ability to use ventilators. The step-up and step-down facilities need bed capacity and adequate staffing. In addition, there is a need for clarity on referral pathways and ambulance transfer capability for those requiring even more specialised care such as Extracorporeal Membrane Oxygenation (ECMO). The short window we now have needs to be used to sort some of these systems out and sadly the supply of critical equipment such as ventilators has not been addressed over the past 2 months. The Prime Minister at this point calls on F1 manufacturers to step in – we wasted 2 months.

News of the private sector being drawn into the whole system is obviously good for adding beds, staff and equipment. The contracts need to be scrutinised in a more competent way than the Brexit cross channel ferries due diligence was, to ensure that the State and financially starved NHS is not disadvantaged. We prefer to see these changes as requisitioning private hospitals and contractors into the NHS.

5. Maintaining people’s standard of living

We consider that the Chancellor has made some major steps toward ensuring that workers have some guarantees of sufficient income to maintain their health and

wellbeing during this crisis. Clearly more work needs to be done to demonstrate that the self-employed and those on zero hours contracts are not more disadvantaged. The spotlight has shown that the levels of universal credit are quite inadequate to meet needs so now is the time to either introduce universal basic income or beef up the social security packages to provide a living wage. We also need to ensure that the homeless and rootless, those on the streets with chronic mental illness or substance misuse are catered for and we welcome the news that Sadiq Khan has requisitioned some hotels to provide hostel space. It has been good to see that the Trade Unions and TUC have been drawn into negotiations rather than ignored.

In political terms we saw in 2008 that the State could nationalise high street banks. Now we see that the State can go much further and take over the commanding heights of the economy! Imagine if these announcements had been made, not by Rishi Sunak, but by John McDonnell! The media would have been in meltdown about the socialist take over!

6. Conclusion

At this stage of the pandemic, we note with regret that the UK government did not act sooner to prepare for what is coming both in terms of public health measures as well as preparing the NHS and Local Government. It seems to the SHA that the government is playing catch up rather than being on the front foot. Many of the decisions have been rather late but we welcome the commitment to support the public health system, listen to independent voices in the scientific world through SAGE and to invest in the NHS. The country recognises the serious danger we are in and will help orchestrate the support and solidarity in the NHS and wider community. Perhaps a government of national unity should be created as we hear much of the WW2 experience. We need to have trust in the government to ensure that the people themselves benefit from these huge investment decisions.

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 3

Published: 31st March 2020

ONS England data for 31st March:	
Hospital admissions 2,477	**Total in hospital 11,154**
Deaths 604	**Cumulative deaths 4,078**

The Socialist Health Association (SHA) published its first two Blogs on the COVID-19 pandemic on the 17th March and 24th March 2020. A lot has happened over the past week, and we will address some of these developments from our political perspective.

1. A **global crisis**

The pandemic continues to spread around the world, and we are seeing that while Europe remains a global hotspot the epicentre is now shifting to North America. It remains to be seen how the Trump administration 'handles' the situation but global leadership and best practice will not emanate from the White House, and we will need to look to those progressive State and City level leaders in New York City and California for examples of political leadership in a crisis.

The astonishing successes in tackling the pandemic seen in the Far East should still be sources of practical evidence of good practice. Despite the concerns about transparency in the Chinese system it remains an extraordinary achievement to have controlled the spread from the centre of Wuhan (population 11m) to be contained within Hubei Province (population 58m). A bit like London and the rest of the UK! The 1.4bn population of China have so far been exposed to relatively minimal spread. Some of the urban populations in China are huge such as Shanghai's 24m people and the density and housing would be vulnerable to the spread of C-19. Our government talk of 'contain' and 'delay' and 'suppress' the coronavirus – well there is much to learn from Asia.

Whenever we see TV footage of the Chinese control measures, staff in public places are gowned, have masks and/or goggles and gloves. Clearly there is no shortage of PPE in China! Frequently you see officials challenging people in the streets and checking temperatures with the thermal imaging meters. Of course, these screening measures are imprecise and the scientific evidence to support them is thin but we were told in the UK that the two key questions were – have you got a fever or a dry cough? We know that many people are symptomless when they first contract the virus and can be infectious, **but** this does not rule out basic questions such as these delivered by lay workers to protect others in the streets/shops/surgeries/workplaces?

People who have symptoms of a cough or fever are referred to diagnostic pods for advice and further testing. This does seem to be good public health control and is also used at airports and seaports, which have been pretty absent in the UK.

Test, test, test was the refrain from WHO leader Dr Tedros A. G. and one of the countries that has shown success in controlling the spread of C-19 is **democratic capitalist** South Korea where the population of 52m has had 9,583 confirmed cases with only 152 deaths by the 29th March. They have led the world in **PCR testing for the presence of the virus** with an estimated 316,000 tests done by 20th March. Germany is close behind with 167,000 tests done and the UK trails behind at 64,000 by the 19th March. It is basic communicable disease control methodology to identify probable cases by the history (symptoms/signs) and then have a test to confirm the case. If positive, then there is contact tracing and cases are quarantined. It is still not clear why the PCR testing capacity was not scaled up in the UK during the time between the middle of January when the RNA code of COVID-19 was shared worldwide and March when demand for testing and containment accelerated. This is one of the key questions for the enquiry after the pandemic is over. The relative lack of testing capacity has made the control measures here more difficult. The cases recorded here have, since abandoning the contain phase, been those presenting to hospitals rather than measuring the incidence in the community.

Attention is now moving towards rolling out the second test – the '**have you had it?' antibody test**. This will not help in the early stages of the illness but will help confirm that people have actually had C-19 and will in most cases have immunity to the virus. This will give more confidence for NHS and Social Care and other essential workers to return confidently to their workplaces. This is in the evaluation stage but should be available soon and hopefully will not be held up. Getting scarce NHS and Social care workers, and other essential workers back to work is extremely important as is protecting them at work from contracting infections.

The pandemic is gradually spreading to **India and down the African continent** too. This will expose more at-risk populations living on the edge economically, often in poor and unsanitary housing. We know that infection control measures will be difficult to undertake, and the health services remain relatively weak in LMICs. As ever, social determinants of health and wellbeing will emerge as factors and the mortality will reflect the global inequalities we already know about.

So it was good to learn on the 25th March that the **G7 countries have stated their support for the UN and WHO** and committed some resources to help tackle the pandemic. The UK has offered £240m which if mirrored by other G7 countries will not get very far towards the WHO target of £71 billion for the immediate public health response and priority research. Let's hope that sufficient resources will flow but sadly the richest country in the world (USA) has had a recent track record of disinvesting from global organisations such as the UN and WHO.

As in the previous Blogs we support the research into novel treatments and the development of a vaccine but **not to let that divert us** from trying to delay the spread of the virus across our country by enforcing the stay at home and lockdown measures. We should continue to apply basic public health control measures, even within households, of isolating symptomatic people, strengthening hand washing and hygiene measures.

We also welcome the action that has been taken by some Local Authorities to provide accommodation for the homeless and rootless and also providing them with food and places to stay during the day, which reduces spread amongst this very vulnerable population. Let's make some of these initiatives set the pattern for tackling this issue in the post pandemic age.

2. The NHS and Social Care

The NHS has been ramping up their preparedness and we welcome the use of private facilities as part of the national response although we prefer that this is seen as **requisitioning** and not a favourable commercial contract for the private sector. We also welcome the creation of the emergency Nightingale Hospitals built in Conference centres and sports stadia in London, Birmingham, Manchester, Glasgow, Belfast and Cardiff. These new beds will be purpose built for COVID-19 caseloads, but we note that they will need to be staffed by trained nurses and doctors. These new beds must be seen alongside the closure of an estimated 33,000 beds since 2008/9, which has weakened the NHS resilience and made the UK one of the European countries with the lowest beds/1000 population. For example, Eurostat data for 2017 identifies 'curative beds/100K population' and shows that Germany had 601, France 309, Italy 262, Spain 242 and the UK 211. It is no surprise then that we see intensive care patients being airlifted from Italy and France to Germany. Germany's testing control measures and its hospital bed capacity is part of the explanation for them appearing more in control of the situation with currently a comparatively low death rate.

We have seen a massive shift in the way that GP services are provided and how GPs and patients are adapting to telephone and videoconferencing. GPs are also playing a vital role in advising and supporting those receiving community care and have long term conditions. These vulnerable patients will be well known to their primary care teams and reliant on being able to get advice. It goes without saying that **out of hospital care** will be vital during the time when local acute hospitals are stressed with redesigning services to deal with acutely ill COVID-19 patients.

In terms of overall preparedness, one does **wonder whether the NHS was more prepared for Brexit than a pandemic!**

The **social and residential care sector** in the UK will be a vital player as the pandemic rolls out with its particular risk for older people. The dynamic between social care and the NHS will be important as the NHS struggles and the transfer/admitting/discharge criteria change. Already the NICE guidance on criteria for intensive care has identified frailty explicitly as an issue to assess suitability to admit a patient.

As with other key services social and residential care staffing will be a challenge as recruitment and retention issues increase and staff stay off work to self-isolate. The guidance on personal protective equipment (PPE) is being actively reviewed and both **NHS and Social Care staff in the Community must be provided with appropriate protective equipment** to match the cases that they are assessing in the community or actually caring for. This will become more important for primary care clinicians as well as social care staff asked to look after acute COVID-19 patients or those discharged for hospitals.

2. **Jobs and income**

Clearly the pandemic has driven a coach and horses through the economy. The Chancellor's proposals have been helpful and the proposals for the self -employed has moved a long way toward providing some security for this sector. The gig economy however is more difficult, and the benefit system has been shown to be inadequate as a place to go for this group of workers. The SHA still feels that there is an opportunity to trial universal basic income as a mechanism to provide all citizens with assurance of having enough income for their health and wellbeing.

There are also concerns that without close Parliamentary scrutiny there are risks that the Tory government will award contracts to their people and the State revenues will be subject to fraudulent claims from offshore companies and global players who have been able over the years to duck paying tax. The SHA has always viewed a progressive tax system to be the route to funding necessary services and that tax dodging should be rooted out.

There may be a case now for a form of Parliamentary scrutiny, so Labour Shadow Ministers have sight of the details around awarding such huge amounts of public money to companies run by the Bransons and Dysons of this world. There is a positive movement underway shown by the selfless work of health and social care services and other essential workers. It is also exhibited by the clapping applause last Thursday and the 750,000 volunteers.

There should be an opportunity, as we come out of this crisis, to lay the foundations for a different type of society in the same way that after WW2 the incoming Labour Party brought in such great reforms as creating the NHS and introducing State Education.

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 4

Published: 6th April 2020

ONS England data for 6th April:	
Hospital admissions 2,679	**Total in hospital 17,154**
Deaths 806	**Cumulative deaths 8,723**

The Socialist Health Association (SHA) published its first three Blogs on the COVID-19 pandemic weekly since the 17thMarch 2020. A lot has happened over the past week, and we will address some of these developments from our 'politics and health' perspective.

1. The global crisis

The pandemic continues to spread around the world and we are seeing that while Europe remains a global hotspot the new epicentre has now shifted to North America.

New York Governor Cuomo is showing some visible leadership and filling some of the space that the President should be in. It was always the case that the private health system in the USA would not be able to present a joined-up emergency response and primary care has never been strong either in the States. The CDC in Atlanta has, like the UK public health system, been starved of funds during Trump's Presidency but more alarmingly their advice has been ridiculed and ignored. Compare this to when the USA public health system, under President Obama, supported the international effort to control the Ebola outbreak in West Africa?

President Trumps best friend Mr Modi has declared a 3-week lockdown across India and in the process condemned millions of migrant workers to walk without adequate food or water hundreds of kilometres back to their rural villages. These dreadful scenes include police spraying them with disinfectant and stories of pushing wheelchair bound people 25 miles each day. Such news reports are matched only by the sealing off of ghettos areas in big cities such as Mumbai and Kolkata. Looking at how these people in dire poverty live without adequate housing, drinking water, food and sanitation is heartrending. Consider our government's guidance on staying at home, washing hands and social distancing makes the prospect of widespread community spread, illness and death in these slums an absolute certainty. Let us hope that Modi's BNP party do not further fuel anti Muslim feeling in these poor and excluded communities.

So, Africa will be next and looking at Lagos with a population of 21 million with a large shanty town and Kinshasa in DRC at 11 million there will be vulnerable populations with inadequate sanitation and housing for the virus to spread exponentially. African economies are characterised by local markets which like India are very crowded, in narrow streets where people struggle against various motor and animal vehicles as well as packed buses and taxis. The WHO and UN as well as the IMF/World Bank need to urgently do what they can to help African governments mitigate the worst consequences of the pandemic, which includes harmful long-term economic impacts. Many African countries remember have over the last 5-10 years enjoyed solid growth in their GDPs.

The pandemic will harm the poor more than the rich and although as Michael Marmot noted recently – **at the beginning of a pandemic both prince and pauper are infected** but over time the social conditions that the poorer populations are living and working in will mean that they suffer most. Securing income to live on for the many and somewhere to shelter for the homeless will be an urgent part of our pandemic response.

2. The European picture

So, what can we learn about how the pandemic is affecting Europe? The first thing to note is of course that Italy and Spain are and have been suffering badly with high numbers of confirmed cases and deaths reported. In parts of the country both their hospital systems have been overwhelmed with health care staff succumbing to the infections and overall death rates being high. The pictures of patients on corridor floors and overcrowded trolleys are distressing as are the reports of nursing homes left to their own devices exposing staff and residents to mortal danger. We do need to ensure that mutual aid is respected in the UK to avoid NHS hospitals becoming overwhelmed as this is dangerous and hugely demoralising.

Why is Germany apparently riding the storm better than their southern neighbours? The simple answer seems to be that they were better prepared than we are and have sufficient testing capability across the country, have a sound public health system at a national and federal level, sufficient numbers of hospital beds and ITU capacity, and supplies of PPE/ventilators to handle the load. There seems to be a better link between the national government and the federal institutions able to undertake public health action locally. There have been criticisms in the UK of the lack of coherent leadership at regional public health in England who are linked into the NHS and local authorities. The devolved system of national governments gets more coherence via the CMO roles at UK level and their links to First Ministers of devolved government.

Recent reports show that Germany with 97,000 confirmed cases has had 1,478 deaths compared to the UK's 48,000 confirmed cases and 4,932 deaths (18 deaths/million population compared to the UK 65 deaths/million at this point in the pandemic). Compare these rates to Italy and Spain who have been ahead of us in terms of epidemic spread at 259 deaths/million and France at 117 deaths per million.

We have raised questions in earlier Blogs about the preparedness of the UK for a pandemic and the constraints on testing capacity, the shortage of adequate PPE for frontline staff and the inadequate supply of acute hospital beds (Germany 601

beds/100,000 and UK 211 beds/100,000) never mind ITU staffing and beds. We obviously commend the rapid building of the Nightingale Hospitals, which will be able to receive ventilated patients thus relieving local hospitals. We are pleased to hear too that the Abu Dhabi based owners of the Excel centre are withdrawing their charge of £2-3m per month for the venue, which would have been empty during the pandemic. We also commend the NHS for its preparation by increasing ITU capacity and redirecting staff usually working in other specialties. Let us investigate how the private hospitals are charging the NHS for access to their beds and facilities – our position has always been – requisitioned in a national emergency.

The **private hospital sector** in the UK will be protected through the pandemic unlike other businesses. Large players such as Circle Health and BMI have been making a loss in 2018/9 amounting to £12m for BMI and Circle's £14m. During the pandemic they faced economic disaster as their Middle East customers and the NHS elective care referrals ceased. These private health care companies are controlled by US health insurance companies and private equity funds. Another large group, Spire hospitals, lost £24m in 2018. Spire's share price jumped 15% on Matt Hancock's announcement! The Wellington and Portland Hospital, owned by US group HCA, lost £74m last year and will also be pleased to have access to taxpayers' money. It remains to be seen under 'open book accounting' how the expenditure will be audited. Note that the best paid executives at Circle, BMI, Spire, and HCA earned £377,000, £452,000, £615,000 and £711,000 respectively according to Private Eye sources!

3. **The UK**

The NHS has been making huge efforts to be as prepared as possible for the potential tsunami of COVID-19 cases. With the lockdown A&E departments have been relatively quiet and with elective care suspended and no visiting for inpatients many hospitals outside of London/Birmingham/Newport have been eerily quiet. Healthcare staff have been trained up to undertake different roles in anticipation of patients being admitted who require respiratory support – this seems to be the main serious impact of Covid-19. Let's not forget however that heart attacks, strokes and childbirth will continue to occur, as will the treatment requirements of cancer patients.

In previous blogs we have referred to the care sector and how important they are in managing the pandemic. The recent guidance on PPE has clarified some of the queries and enabled more staff to feel more protected than before. However, the supply of PPE to front line staff remains patchy and with the death toll rising of healthcare workers the government must ensure that supplies are readily available for community nurses and care workers as well as social care staff in the residential and care home sector.

While it is absolutely necessary to be transparent about the evidence of benefit from ventilation, we do not think it humane or ethical to have strict age-based criteria for decisions to admit to acute hospitals for assessment. Frailty criteria published by NICE, for suitability for ventilation are of course necessary but the **reports of people being coerced to sign Do Not Resuscitate (DNR) advanced directives is very dangerous** and will lead to the perception that older and disabled people are being denied hospital treatment. Residential and Nursing Homes will also feel that they are being left to manage very ill residents who are on an end-of-life pathway without

adequate resources and safeguards for staff. The same feeling will apply if domiciliary patients are transferred to nursing homes with a Covid diagnosis in large numbers. This is a very sensitive policy area, which needs careful consideration and an investment in resources to mirror that provided to NHS hospitals and the new Nightingales. There have already been examples of nursing homes having to deal with a relatively large number of residents with Covid-19.

4. Looking forward

The pandemic will sadly spread across the UK from its hot spots in London, the West Midlands and Gwent. The government is being held to account for its failures in preparation – perhaps more attention to Brexit than Pandemic planning! The slow response has been noted, the lack of scaling up of testing and the poor logistics on PPE stand out in the story so far.

We still sense a racial/culture hostility to widespread use of masks yet many Asian countries that have controlled the spread have used them widely. We look forward to the WHO reviewing the evidence. The virus is transmitted from and to the nose and throat, so it does seem that there is a case that face masks have a role to play. However, facemasks have not been available in the UK for weeks and have in a sense been rationed to health and social care staff!

As we have pointed out even without the widespread use of facemasks Germany has shown us the benefit of sound preparation, supplies and capacity in their health system and we need to learn that lesson from our European partner. Austria is already planning its exit from lockdown. There has also been **clear political leadership** in Germany without chopping and changing with promises announced almost daily as we have seen here.

The **exit plan** needs to be addressed and in the same way that we have not treated London as our Wuhan we do need to nuance our policies to match regional/metropolitan differences in where the pandemic has occurred and the readiness to relax the lockdown based on testing evidence of community immunity, protected populations and overall resilience.

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 5

Published: 13th April 2020

ONS England data 13th April:	
Hospital admissions 1912	**Total in hospital 18,621**
Deaths 811	**Cumulative deaths 14,859**

The Socialist Health Association (SHA) has published its weekly Blogs on the COVID-19 pandemic since the 17thMarch 2020. This provides a narrative of political and health issues over the past 5 weeks.

A lot has happened over the past week, and we will address some of these developments from our socialist health perspective.

1. Situation update

So far in our Blogs we have drawn attention to how the UK has been to slow to respond to the pandemic threat since the warnings from Wuhan started at the end of December 2019 and were confirmed in mid-January 2020. This was despite the fact that an **infectious disease pandemic ranks No 1 in the UK government risk register** and we knew that this was a **SARS like virus**.

The Tory government had not paid attention to the various simulation exercises that have been done over the past few years most notably Exercise Cygnus in 2016, during Jeremy Hunt's time as SoS for Health. The exercise simulated **'swan flu'** and showed that there was a serious risk that the NHS would be overwhelmed with lack of PPE and insufficient ITU beds. Recommendations to increase stockpiles were ignored in a time of austerity and PPE equipment such as face visors were evidently deemed too difficult to store. It is interesting to note that many of the facemasks have a use by date from before that time. Even as far back as the Swine flu pandemic in 2009 the relatively small number of ITU beds has not been addressed and we have seen how relatively low the NHS acute bed numbers, as well as the ITU beds/1000 population are comparatively. The government have it seems been **more interested in preparing for Brexit at the end of January than for a real pandemic threat.** Instead of building up stockpiles of ventilators and other equipment the government have had to turn in emergency to their friends such as Dyson and JCB but it is no surprise that delivery takes time as medical equipment needs testing and tough quality assurance.

We have also pointed to the ***laisser faire approach*** to this pandemic even after it became a global threat. The scientific advisory group 'modellers' had by late February warned the government that the country faced the possibility of suffering 500,000 deaths from Covid-19. So, at this time we knew that this was a virulent virus that was easily transmitted person to person and if not suppressed would spread

within communities rapidly and seek to move out to new areas. The religious community in South Korea was a clear case of transmission from Wuhan and rapid spread within a religious community in Daegu. In mid-February this was traced back to **Patient 31** by their **effective contact tracing and testing protocol**. South Korea, to their credit, stamped on the virus and did not allow it to spread and has only had just over 200 deaths within its population of 52m who continue to enjoy freedoms outside lockdown.

As the virus began to spread, we saw countries closing their borders and screening people arriving from air or sea. New Zealand and Australia are examples of this tough policy and they have managed to keep the virus from penetrating the country at scale. New Zealand has had four deaths and Australia 60 by 12th April. The UK note is also surrounded by sea and with Ireland is a separate landmass from Europe, but **we have not introduced any significant border health checks at any time.**

In Europe we all watched with mouths open when health services in Lombardy were overwhelmed and people who had been on skiing holidays had already returned to the UK and started to spread the virus here. **What actions did the Border Forces take?** How actively did we follow up reports of fever and cough in returning travellers? Do we even now check peoples travel history and report symptoms on return to the UK? Our death rates now are moving to exceed Italian and Spanish rates and compete to be the worse in Europe.

Some of the success of countries such as Germany and Denmark have been closing their borders and undertaking health checks, testing and advising quarantining/isolation if needed. **Denmark closed the border on 13th March (final day of the UK Cheltenham Gold Cup meeting in the UK)** and a few days later closed schools, universities and banned gatherings of more than 10 people. Denmark which, is a small country of only 5.6m, has had 273 deaths by the 11th April. Scotland in comparison with a population of 5.5m has already had 566 deaths. Denmark is now considering loosening the lockdown requirements whereas Scotland still fears new spread.

However frightening Covid-19 virus is in terms of its effects on people it is a virus, susceptible to soap and water and unable to spread between human beings unless spread by aerosol or droplets by coughs and sneezes or hand to face contamination. Basic communicable disease methodologies work – **hence the WHO advice to test, trace and treat by isolation**. No need to rely exclusively on mathematical models but tried and tested methods of infectious disease control measures. We hear very little of the most basic ‘tests’ namely asking people about their contact history and what symptoms they have. In the early days of this pandemic, we had all heard about the cardinal symptoms and signs of **Dry Cough and Fever**.

In the current situation that is enough for classification as a possible if not probable case. This then needs follow up with an antigen PCR test to confirm. Tracing other contacts and testing them and all contacts need to be isolated/quarantined. We realise that we have missed the boat now but should acknowledge that this is basic public health methodology in use for decades but not used here even at the start of the epidemic spread in the UK. Public Health trainees were often told – **use more shoe leather than computer software when involved in outbreak management**. The UK seems to be bemused by other countries testing temperatures with thermal

imaging meters or checking if people have stayed in isolation as advised. God forbid people wearing face masks either!

In earlier blogs we have also referred to the reluctance to learn from policies in countries that have been successful in suppressing the pandemic. Take facemasks, which are used widely in Asian countries, who have had success in controlling spread. It just seems to make sense (have face validity) that a virus transmitted from nose and throat to others would be hindered in **person to person** spread if everyone was wearing a face mask. A recent review by the respected evidence-based group in Oxford recommends the precautionary principle in a time like this. The CDC in the US is recommending the use of facemask too especially as we look to reducing lockdown rules. Rather than say we need a randomised control trial – just do it! Of course, in the UK it is almost impossible to buy quality facemasks, hand sanitiser gel or often latex gloves!

The situation we find ourselves in is that **PPE seems to be rationed** and sadly there remain reports from NHS and social care clinical staff that they cannot get proper PPE supplies. Again, we see TV reports of other countries in the world where many essential workers –non health care providers have access to PPE equipment which reassures them and is symbolic to others about the risk of cross contamination. Our bus drivers and other public facing non-NHS public servants have been exposed to risk.

The government has struggled with scaling up the logistics and thanks to the Armed Forces supplies are getting through. However Public Health England (PHE) who were fast off the blocks once the Chinese Government shared the genome of Covid-19 have been **unable to seriously scale up** the PCR testing capacity. It remains to be seen whether the 100,000 tests by the end of April will be delivered. It is said by management consultants – '**Never promise more than you can deliver'. It is also** recommended; **'don't stretch the truth'**. We have sadly seen this transgressed by Matt Hancock promising the ramping up of testing, supply of PPE. His boast of purchasing 3.5m antibody tests before they have been shown to be valid is embarrassing. Reminds us of the Brexit Ferry contract from a company that had never managed a Cross Channel Ferry service.

The vaccine is of course much more important than the antibody test and we applaud the progress that researchers have made but do caution that we should not promise more than can be delivered. A safe and effective vaccine requires safety and effectiveness trials and this all takes time.

2. Inequalities and risk factors

One of the striking findings of this pandemic is the susceptibility of Black and Minority Ethnic (BAME) groups to the virus. It has been striking that the first group of doctors who have given their lives to the virus have been Black or South Asian heritage.

Some of the areas where the NHS has had pressures are also areas with relatively high Asian populations (Brent, Luton, West Midlands). This risk factor will of course have social, economic and cultural determinants alongside some biological factors such as a higher risk of diabetes and cardiovascular disease. There are very few health conditions where socio-economic factors do not affect incidence and prevalence. The two hospital porters from Oxford who died recently of Covid-19, were outsourced workers, both of Filipino heritage and like doctors and nurses exposed to risk at work. Their NHS fellow workers allegedly offered to share PPE in the early stages of the pandemic!

We are familiar with the social gradient of disease and death. So, it is no surprise that in the USA we are also seeing African American citizens are losing their lives disproportionately. For example, in Michigan 15% of the population is black, but account for 40% of the deaths. Chicago has a 30% African American population and this group account for 70% of deaths. These ratios are also reflected in Louisiana in the deep south, especially New Orleans, where the Mardi Gras celebrations continued regardless of the pandemic.

These global health inequalities will also be mirrored in Africa when the virus moves down that continent. Think of our discourse about the dearth of PPE and medical equipment such as ventilators. In the Central African Republic of the Congo (CARC) with its 5m population it is estimated that they have 3 ventilators. On the international market prices have responded to demand. Costs of a ventilator on the market have jumped from $9000 to $20,000 over the past few weeks. The CARC‘s GDP/capita is $1.3 per day with very poor health infrastructure.

It is good to hear that the British Government has donated Aid to the UN and WHO to support Low- and Middle-Income Countries combat the pandemic. It is in all our interest that these countries and their people weather the storm. One World and Planetary Health – we are all mutually dependent.

3. **Political Leadership**

One of the issues that has emerged through the experience so far with this public health emergency is the **quality of political leaders**. We have already drawn attention to Denmark with Mette Frederiksen who is a woman and the country’s youngest–ever PM. Last week we referred to Angele Merkel’s clear leadership in Germany, which is doing extremely well so far in controlling Covid-19. Think too of Jacinda Ardern the Labour Prime Minister in New Zealand who in her short time as PM has had to deal with three different emergencies – the Mosque massacre, the Whakaari/White Island volcanic eruption and now the Covid-19 pandemic. She has provided exemplary leadership by **going hard and going early**. She placed the country in total lockdown on the 25th March and softened the blow by using a slogan – ‘**be kind’**.

Epidemiologists have praised her ‘**brilliant, decisive and humane leadership** which has seen New Zealand achieve a remarkably efficient implementation of the elimination strategy. Of course, the country will still be susceptible to Covid-19 but the health protection measures have worked so far and unlike the UK will not have such high death rates/population.

4. **A great science policy failure?**

Richard Horton, Editor of the Lancet, has said that the global response to Sars-CoV-2 is the **greatest scientific policy failure in a generation**. The signals were clear. Hendra in 1994, Nipah in 1998, Sars in 2003, Mers in 2012 and Ebola in 2014; were all caused by viruses that originated in animal hosts and crossed over into humans. Covid-19 is caused by a variant of the same coronavirus that caused Sars. The US Institute of Medicine (IOM) in 2004 concluded that; "the rapid containment of Sars is a success in public health, but also a warning. **If Sars recurs health systems worldwide will be put under extreme pressure and continued vigilance is vital"**

The IOM report quoted Goethe:

"**Knowing is not enough; we must apply.**

Willing is not enough; we must do"

Sadly, we have known about this threat since Sars emerged in 2003 and we have undertaken simulation/emergency planning exercises as recently as 2016 which tested resilience for 'swan flu'. However, it looks like **we did know but we did not act.**

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 6

Published: 20th April 2020

ONS England data 20th April:	
Hospital admissions 1522	**Total in hospital 16,654**
Deaths 685	**Cumulative deaths 19,986**

The SHA started to publish its Covid-19 Blogs on the 17th March and since then have issued weekly blogs. It is extraordinary to reflect on this being our sixth commentary on the socialist health view of the unfolding global pandemic.

In earlier Blogs we have covered many different topics and each Blog reflects on particular issues that have sprung up over the past week and identified as emerging issues. In this week's Blog we will look at social care, testing, and possible steps out of lockdown.

1. Social Care

This has rightly hit the headlines over the past week as the plight of our care services and their residents have been under the media spotlight. We knew from the early data from China mid-January that the C-19 virus seemed to particularly harm older people and particularly adults with underlying conditions such as obesity, diabetes, heart and lung disease. Mortality rates in these at-risk groups is comparatively high and 90% of deaths in the UK have been in the over 60-year-olds with half of these deaths being in people over 80 years old. This has led the UK government to define vulnerable groups and those 'very vulnerable' people who need to be 'shielded' from exposure to the virus. The very vulnerable shielded groups are estimated to number 1.5m and are self-isolating indoors for 12 weeks. Many but not all these very vulnerable people will be in residential or nursing homes.

Having identified these at-risk populations, attention needed to be directed towards those sub populations of older or vulnerable people who were living in residential or nursing homes. These institutions are high risk as 'closed communities' accommodating a group of high-risk individuals who would be at risk of an outbreak of C-19 within that setting. Decisions have had to be made by the management of these residential and nursing homes to, in many cases, exclude relatives from visiting. Some brave and extremely committed care staff have decided to move themselves into the nursing or residential homes to reduce the risk of them bringing C-19 in from their own homes and local community. It cannot be a surprise to hear now about outbreaks in these establishments causing disease and death to workers and their residents. Again, like other aspects of this pandemic response – we had

early warnings from Italy and Spain about the isolation and risks that this sector faced. Did we do enough quick enough?

SHA President Prof Allyson Pollock published an Editorial in the BMJ on the 14th April, which identified that social services in the UK are amongst the most privatised and fragmented in the world, and have been underfunded for decades. Between 2010 and 2018 local authority spending on social care in England fell by 49% in real terms. The UK has 5500 providers operating 11,300 care homes for older people and 83% of these care home beds are provided by the for-profit sector, it is more privatised than the US.

She also reports that care services employ 1.6m care staff (1.1m full time equivalent) of which 78% are employed by the independent sector. Pay is low; 24% of people working in adult social care are on zero hours contracts, and in March 2019 around a quarter were being paid the national living wage of £7.83 an hour or less. The sector is 120,000 workers short, and agency staff, are commonly employed and move from care home to care home. Social care has been a low priority for PPE supplies despite the high risks for residents and staff.

Valiant efforts have been made by the sector with heroism shown by these low paid workers as well as stoicism by residents, many of whom may well be bemused and depressed as to why they no longer have visitors as well as the unusual PPE equipment being used by staff. It will have been difficult to plan for the various contingencies when cases emerged in homes, to access testing of staff and residents, to successfully isolate cases and discuss whether residents should be moved to hospital to obtain extra levels of care. Such admissions to more resourced NHS facilities should be an option even if cases would not meet eligibility for ITU care or wishing to be subject to that level of intrusive care. There should be options available, rather than simply assuming appropriate care will be delivered in that setting by stretched staff with relatively few registered nurses, no medical presence on site and few resources of PPE and other equipment such as oxygen supplies, oxygen delivery equipment and monitors such as oximeters.

The SHA has been concerned about the social care sector for years and has developed policies to transform the sector under the banner '**rescuing social care'**. At the 2019 Labour Party Conference the SHA called on a future Labour Government to legislate for a duty to provide a universal system of social care and support based on a universal right to independent living. This should be **based on need and offering choice; be free at the point of use, universally provided and fully funded through progressive taxation**. This new National Care Service (NCS) should ensure that there are nationally agreed qualifications for staff, a career structure and enhanced pay and conditions of service. Recognition of informal carers is needed too with clarity about rights and support. The policy proposal has many other facets and stops short of integrating the NCS with the NHS. However close working would be built in and integrating data and information into a common system would be expected.

As for many of the issues that have arisen so far with the pandemic the social care sector has not been in a strong position to push back C-19.

The underpaid staff, the high vacancies and the often unsuitable, adapted accommodation is rarely fit for modern care needs. The fragmentation of the sector

with ‘for profit operators’ finding it hard with constrained funding has led to vulnerability in the sector as well as the residents. Maybe this will be the time that showed how, rather than a **shiny green badge**, the social care service should be taken into a publicly funded national care service.

2. Tracking, Tracing, **Testing, and Treating (isolating)**

One of the criticisms we have made of the Government’s pandemic response has been the decision on the 12th March to pull back from testing for cases in the community and contact tracing. It may turn out that this was a policy decision **driven by the lack of availability of tests** rather than a decision made not to control community spread. On the 24th February there had been 9 confirmed cases of C-19 in the UK and the WHO had announced that countries should ‘prioritize ***active, exhaustive case finding and immediate testing and isolation, painstaking contact tracing and rigorous quarantining of close contacts***”

By the 22nd March there were 5683 confirmed cases and yet even then the WHO advice was ‘find ***those who are sick, those who have the virus and isolate them. Find their contacts and isolate them’.*** In outbreaks you do not always have confirmatory tests available but can make public health decisions based on the history and observation in the context of the unfolding epidemic. We seem to have forgotten the cardinal symptoms of continuous cough and fever.

We have pointed out in earlier Blogs that countries that have been successful so far in controlling C-19 such as South Korea and Taiwan have been ones that have used widespread testing, tracing contacts and quarantining them. Germany has also been an example of a Western European country that has used this traditional communicable disease control methodology to save lives and protect their health service. Such a public health approach is most important in epidemics like this where there is **no vaccine and no effective therapeutics** other than sophisticated intensive supportive care.

It is symbolic that the data that is presented at the daily press briefings has in the main used hospital testing data, hospital admissions and until recently exclusively hospital deaths. TV crews have been crawling over ITUs to get extraordinary footage of these wonderful NHS teams doing outstanding and stressful work. The incredible success of building Nightingale Hospitals in record time has been a reminder of the extraordinary efforts made in Wuhan to meet urgent need.

However outside hospitals we have had the social care sector relatively unprepared, people self-isolating in their homes and having to gauge the seriousness of their symptoms with intermittent telephone calls to NHS111. The disease has been spreading across the country from London to other metropolitan centres and then into smaller towns and rural areas. We could and should have shutdown London earlier as this has been our Wuhan. Local surveillance is limited and active contact tracing thought to be irrelevant even when many areas across England, Wales and Scotland had few cases. **Environmental Health Officers in Local Government have not been mobilised. An opportunity missed**.

We have also seemed content to keep our airports and seaports open with little if no border health security. Again other countries who have managed to control this pandemic stopped and controlled air traffic, quarantining arrivals from high risk areas

and making basic investigation on history (?cough) and taking travellers temperatures. Not difficult to do and look at Australia and New Zealand for actions on this source of new infections of a virus with high levels of transmissibility. **In the UK it is estimated that over 190,000 people flew into the UK from China between January and March with no testing/quarantining.**

3. Evidence of unpreparedness

The UK seems set to be one of the countries in Western Europe with the worst outcome regarding mortality rates from C-19 despite the effectiveness of the NHS, which has withstood the pressure. We are often said to have an exemplar emergency planning system, the government had a pandemic as No. 1 risk on the national risk register, kept stockpiles and has computer modellers of world class.

Yet we do not seem to have acted on the emergency planning exercises such as the 2016 Operation Cygnus ('swan' flu). We are now aware that in Sept 2017 the National Risk Register of Civil Emergencies reported that "***There is a high probability of a flu pandemic occurring with up to 50% of the UK population experiencing symptoms, potentially leading to between 20,000 and 750,000 fatalities and high levels of absence from work'.***

There have been disclosures recently that are worth referring to that set out the timelines which showed the Prime Minister distracted and absent from COBRA meetings in January/February (A comprehensive countdown to how Britain came to have one of the highest COVID-19 per capita death rates – http://www.bylines.com). Also there has been an Insight team report for the Sunday Times on the 19th April 2020 (**Coronavirus: 38 days when Britain sleepwalked into disaster**). The current Secretary of State is an actor in this drama and the former Secretary of State for Health Jeremy Hunt who has been a critic of some aspects of the Governments response was of course in power during this time. We are told that '**pandemic planning became a casualty of the austerity years when there were more pressing needs' and 'preparations for a no-deal Brexit sucked all the blood out of pandemic planning'**

4. Getting out of lockdown

There are various scenarios that are being set out about how to get out of lockdown once the number of new cases decline and the first wave is thought to be 'over'. This is likely to take time as the curve is flat and the proportion of the population with resistance is thought to be quite low. The government are hesitating about setting out the scenario and talking too much about the delivery of an effective, safe and tested vaccine. This usually takes 12-18 months and can never be guaranteed. They

also are talking up the possibility of an effective drug therapy, but we all know that viral illnesses do not lend themselves to highly effective drug treatments as we know with the Tamiflu debate after the 2009 H1N1 pandemic. So really, we should again consider more immediate and classic public health control measures that have been shown to work in this pandemic.

This will need health scrutiny and effective border controls that New Zealand and Australia have used successfully. There will, within the country, need to be effective systems of testing, contact tracing and quarantining with everyday life respecting physical distancing and the use of facemasks. South Korea has shown the way that this can be enhanced and made more bearable by using mobile phones loaded with new technologies. These will warn people if at risk and disclose red, amber or green status. This will allow the economy to restart and people begin to get out and about again. The very vulnerable will in the early phases of this need to be protected.

Prof. Pollock in a recent BMJ editorial (**Covid-19: why is the UK government ignoring WHO's advice**) states that 'this means instituting a massive, centrally co-ordinated, locally based programme of case finding, tracing, clinical observation, and testing. It requires large teams of people, including volunteers, using tried and tested methods updated with social media and mobile phones and adapting the guidance published from China' and other countries who are implementing such systems.

This will require a change of mindset in government and from their medical and scientific advisers but as **J.M.Keynes** said:

"**When the facts change, I change my mind. What do you do?"**

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 7

Published: 27th April 2020

ONS England data 27th April:	
Hospital admissions 1344	**Total in hospital 14,255**
Deaths 506	**Cumulative deaths 24,097**

This is the 7th week that the SHA has published a Blog tracing the progress of the Coronavirus pandemic globally but more specifically across the UK. Over this time, we have drawn attention to the slow response in the UK; the lack of preparedness for PPE supply and distribution; the delay in scaling up the testing capacity and system of contact tracing; a too early move away from trying to control the epidemic and poor anticipation of the needs of the social care sector.

However, we need to start to look at how we can reverse the situation we find ourselves in being **one of the worst affected countries in the world**. Our deaths in the UK now exceed 20,000 and we have been following Italy and Spain's trajectory. It is true that while the lockdown came too late – London should have gone first – it has had an impact on suppressing the first wave and the NHS has stood proud and able to cope thanks to the unflagging commitment from all staff. It is good that Parliament has been reconvened so proper scrutiny can be given to government decisions on public health as well as the economy. We look to the new Shadow Team to pursue this energetically.

It is no surprise that Trump's USA is a lesson of the damage disinvesting in the Centers for Disease Control and Prevention (CDC) has had. It has led to poor emergency preparation and poor leadership at handling the pandemic at a federal level. From a SHA perspective an example of the superiority too of a nationalised health system as compared with a private health care model in the USA. Compare how it looked in New York City during their peak and the relative calm in London on the 8th April. From his rehabilitation home at Chequers, it was concerning that **one of the first phone calls PM Boris Johnson allegedly made was to Mr Trump.** They share many characteristics but let's hope that we do not end up second only to the USA in the international table of deaths/100,000 population and tie ourselves too closely with the 'Make America Great Again' nationalist neo-conservative movement.

1. **Scientific advice**

One of the characteristics of this pandemic has been the UK Government Ministers repeated claim that they have been making decisions on the **best scientific advice**. This claim has mystified some commentators who feel that the decisions being made by Ministers has not been in line with WHO advice (test, test, test) and not consistent with comparable EU countries who seem to have managed the pandemic more successfully (**Germany** and **Denmark**). We have never said that we cannot compare data published in Germany and Denmark before now!

Sometimes Governments make bad calls during an emergency and wanting to keep the membership of SAGE secret was one such.

There has been mounting concern about the provenance of some of the advice leading to Ministerial decisions. For example, the early misunderstandings about 'herd immunity' and the fear that the nudge behavioural psychologists were having undue influence leading to the crucial delay in lockdown. Some of these scientists work in government units, which is not good for an independent perspective.

The mixed messages about the modellers and their estimates of the likely deaths (20,000 to 500,000) which also surfaced before one modeller was allegedly responsible for pushing (thankfully) the belated decision on the lockdown.

Many public health trained people have begun to wonder who on SAGE had any **practical public health experience in communicable disease control?** These concerns were prompted by the sudden abandonment of testing and contact tracing, the lack of airport or seaport health regulations used by other countries such as Australia and New Zealand (Australian deaths so far 80 for a population of 25m and NZ 18 for a population of 5m).

Recently we have also been bemused by the inability to recognise how **homemade cloth facemasks** might play a part in easing lockdown. While there might be a relative lack of 'gold standard' evidence there is 'face validity' that a mask will stop most droplets, and this will be important as we are finding so many people are infected for days before showing the classic symptoms and signs of fever and cough. Homemade cloth masks would not compete with NHS and Social Care supplies, and these do seem to have been part of the strategy that countries that have been more successful at containment than the UK. We suspect that in time the recommendation to wear a cloth mask when going outside your home will become a recommendation!

After the initial planeload of British nationals from Wuhan, who had been appropriately quarantined, there are no measures in place at all at our airports. The explanation about incubation period does not hold if people are quarantined for 14 days. The precision of temperature measurements should be seen as part of a screening regime, which would include risk assessment of country of origin, symptoms reported on a questionnaire or observed as well as temperature measurement. It is obvious that if passenger causes concern the less accurate thermal imaging technique can be augmented by other more reliable ways of taking a temperature! It does not seem right that such measures are discounted for the UK and we are one of the worst performers while other countries with competent public health professionals take it seriously. It is estimated that nearly 200,000 people arrived from China in the UK between January and March 2020 with no checks at all apart from general Covid advice. Empty hotels would have been suitable for quarantining people at risk of having the virus.

This matters as it is a very contagious virus and can spread before symptoms appear. Such symptoms can also be minimal and hard to detect.

Now that the membership of SAGE has been leaked, we can see that one of the Deputy CMOs is the only person who has had any 'on the ground' experience of communicable disease control in communities. This is important when we start to consider how we can get out of lockdown by using the new testing capacity optimally, contact trace effectively and introduce control measures locally. This will require Public Health England (PHE) to begin to strengthen its relationship with local **Directors of Public Health (DsPH) located in Local Government.** These DsPH can provide local leadership and work with Environmental Health Officers (EHOs) who to date have not been drawn into the pandemic management system.

The presence of **Dom C** in SAGE meetings raises concerns. Of course, civil servant officials have always attended the meetings to ensure that they are properly organised, agendas circulated and minutes recorded. It is quite a different thing to have an influential Prime Ministerial adviser like **Dom C** attend the meeting and no doubt interject during discussions and help shape the advice. That should be the Chief Scientific adviser's (Prof Vallance) job and his role to brief the PM. The trust in SAGE has been damaged by the delayed disclosure of membership, the lack of jobbing public health input as well as the presence and influence of these special advisers (SPADs).

2. Easing lockdown

One of the problems in the management of the pandemic in the UK has been the **centralised London perspective**, which has dominated the options and led to a one-size fits all approach. We have said before in these Blogs that **Greater London was our Wuhan** (similar population sizes). We should have shut London down much earlier and stopped the nonsense of those crowded tube trains and buses. We have seen from the Ministerial briefings that London has had an almost classic epidemic curve – rising steeply and then levelling off and declining. The devolved nations and English regions have lagged behind. Scotland and Wales got their first cases about 4 weeks after London and the South East. Regions such as the SW region in England, Northern Scotland and the Islands, rural Wales and parts of the North of England have been slow to have cases and even now have had few cases and few deaths. **These areas did not need to be locked down at the same time as London and the South East** and could have instituted regional testing and contact tracing which would have helped flatten the curve and protect the NHS. Such a strategy would have built up experience of doing this which we now have realised we need to do to get out of lockdown. However, we have an asymmetric situation with the regions showing gradual and flat epidemic curves, which will be prolonged and frustrate a UK alone approach.

The **challenge of easing lockdown will be quite different in metropolitan urban areas** with heavily used public transport and metro trains and a more dense housing with fewer green spaces. The picture in more rural areas and small towns is quite different. There is a serious need to engage with local government more appropriately, pull back from central control and set out a framework as has been started in Scotland and Wales which local government partners can start to address via their Local Resilience Fora (LRFs) and emergency control structures.

There does **still need to be a UK wide COBR** approach, but the strategy needs to be more nuanced to set out the UK framework and allow devolved nations who are a similar size to New Zealand and Denmark and English regions to plan locally sensitive approaches drawing on expert advice from Public Health organisations such as Public Health Wales, Scotland and PHE. Metropolitan areas such as London, Birmingham and Manchester will also want to be able to adapt measures to fit their local complexities. This will be particularly important as we start a system of community testing, contact tracing and control measures. National testing standards and quality will apply and any mobile apps that are developed will need to be agreed at a national level with all the safeguards on privacy and information governance.

Children have been remarkably resilient to this virus and it seems that back to school is something worth considering as an early venture as long as schoolteacher's health is safeguarded, by not exposing 'vulnerable' teachers, and implementing systems to make physical distancing more feasible. It is urgent to look at international best practice and be flexible in our approach.

Pubs and restaurants will be further down the list as will mass sporting events but widening the retail sector and getting some workplaces back should be planned. Again, travel to work should only be necessary for some workplaces and physical distancing, masks and health and safety regulations will need to be updated to suit each work environment before permission to reopen is given. **All these steps require enhanced local public health capacity.**

3. Recovery planning

An important part of emergency planning frameworks is the need immediately an emergency is recognised to begin the '**recovery planning'**. This will depend on the characteristics of each emergency. In the case of Covid-19 we will need to look at the build-up of elective care, especially surgical waiting lists. It will also need to urgently review those people with long-term non-Covid conditions who may have had their continuing medical care disrupted. There will also be those casualties of the pandemic who have been traumatised by the pandemic and have mental health issues, burnout, faced economic hardship and PTSD. People who have had Covid-19 and survived a period in ICU and ventilation will also need weeks and sometimes months to recover. So, all this adds up to a load for the NHS and associated services to address.

As we have seen the economy has taken a big hit and many businesses have found themselves having to close down or reduce their workforce/suspend manufacturing output. It is unclear how we measure what has happened to our economic base, but we have seen the growth in unemployment, the rise in welfare applications and the stories of those caught out with a sudden loss of employment and income. We know that 12 years after the 2008 financial crash that the legacy remains. This is far bigger so we need to begin to agree how the economy can be rebooted safely while protecting those vulnerable populations and safeguarding the children returning to school or workers to the factory floor. Trade Unions must be key partners of this economic recovery planning challenge.

The other aspect of a recovery plan is to **take advantage of good things** we have experienced such as the reduction of air pollution with a reduction of car use and

aviation and other transport. The global satellite pictures of Beijing, Delhi and Milan tell the story that life can be better if we reduce our carbon footprint. Working from home, the benefit of fast broadband should all lead to a reappraisal of environmental and other life changes. The growth in cycling and physical activity in green spaces should also be built on.

Finally, the pandemic has once again thrown a light on **inequalities** with the risks of occupational exposure (bus drivers), risks in hospital environments (porters, receptionists to nurses and doctors) and retail shops (shop assistants/cashiers). Many manual workers have had to go out to work still and in the process through travel and the work environment been at higher risk. Those who live in overcrowded households have been at greater risk with fewer opportunities to self-isolate. Many of those in poorer urban housing estates have also been exposed to risk and found safely going to shops, medical centres, or exercise much more difficult. We know about the health inequalities gradient and when this pandemic is analysed fully these social economic and environmental determinants will show through. It is clear that BAME communities have been more susceptible to the virus and while this may have some biological features such as cardiovascular/metabolic risks it will also be socioeconomic, cultural and reflect occupational exposure.

So recovery plans need to be set out to ensure that **we do not revert to business as usual** but grasp the opportunities that there are to build a better future after the C-19 pandemic.

The Beveridge Committee was established relatively early during WW2 and the report was published in 1942 setting out the vision of an NHS and State Education for example. We have an opportunity to push for similar progressive changes after Covid-19.

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 8

Published: 4th May 2020

ONS England data 4th May:	
Hospital admissions 1063	**Total in hospital 12,020**
Deaths 412	**Cumulative deaths 27,277**

This is now the 8th weekly Blog published by the Socialist Health Association (SHA) commenting on how the Coronavirus pandemic is progressing both locally and globally. The lens we use is a socialist worldview where we aspire to **One World and Planetary Health** and are as concerned to reduce global as well as local health inequalities. The Covid-19 pandemic has shone a light on local inequalities within the UK as well as stark global inequalities where people find themselves exposed and unable to follow the advice we receive in the UK and other rich countries to social distance and pursue rigorous hand hygiene.

1. Health inequalities in the UK

Last week the Office of National Statistics (ONS) published a report on Covid-19 deaths by local area and by socioeconomic deprivation (www.ons.gov.uk). This covered the period from the 1st March to the 17th April. During this period there were 90,232 deaths in E&W and of these deaths 20,283 involved Covid-19.

Unsurprisingly London had the highest age-standardised mortality rate with 85.7 deaths/100,000 people involving Covid-19. This is significantly higher than any other region and almost double the next highest rate. In these SHA Blogs, one of our observations has been that London was the early hotspot and should have been shutdown much sooner and been our 'Wuhan'. Remember all the press reports of bars and restaurants remaining open and people packed into London underground trains and buses?

In London Covid-19 deaths were 4,950 amounting to 42% of deaths since the beginning of March compared to 1,051 deaths in the South West region of England, which was only 13% of total deaths there. The eleven Local Authorities with the highest mortality rates were all London boroughs with Newham, Brent and Hackney suffering the highest rates. Outside London rates are high in Liverpool, Birmingham and Manchester.

Newham has the highest age standardised death rate with 144.3 deaths /100,000 population followed by Brent with 141.5 and Hackney with 127.4. In **Newham 78% of its population are in BAME groups and 48% live in poverty** after rent and household income are taken account of. The three London boroughs are in the most

deprived group and across England the most deprived areas have a death rate of 55.1/100,000 compared with 25.3 in the least deprived (**118% difference**).

The Index of Multiple Deprivation (IMD) is an overall measure based on income, employment, health, education, crime, the living environment and access to housing within an area. Each area of England is grouped into one of ten deciles and the most deprived is in d1 and least deprived in d10.

As we know from **work over the last 40 years since the Black report in 1980** – there is a social gradient for mortality and many other indicators of health and wellbeing. Covid-19 has magnified the difference especially for those in the three most deprived deciles which shows a stark difference between Covid-19 deaths and all deaths. In the least deprived decile, the mortality rate for all deaths was 122 deaths/100,000 population, whereas in the most deprived it was 229. The difference between all deaths (classic social gradient) was 88% whereas between **Covid-19 deaths the difference was 118%,** which is 30% higher.

A similar picture emerges in Wales where they present the data as differently. The most deprived fifth of areas have a rate of 44.6 deaths per 100,000 involving Covid-19; this was **almost twice as high** as the least deprived area with 23.2 deaths/100,000.

The other key finding from the ONS report was on **urban versus rural areas**. Major urban conurbations had a death rate of 64.3/100,000, which is statistically significantly higher than other categories including urban minor conurbations. The lowest rates unsurprisingly are in rural settings with rates as low as 9/100,000 population. There is a category ONS use called 'major towns and cities' in E&W which are built up areas excluding London. Of the 111 major towns and cities the highest mortality rate was in **Salford with a rate of 112.6 deaths compared to Norwich with 4.9/100,00**. One interesting prosperous market town that was hard hit is Cheltenham with a death rate of 49/100,00, which is significantly higher than the English average!

2. Austerity and the slow burning injustice

In his 2020 report of '**Health Equity in England: the Marmot Review 10 years on'** Marmot found that the **improvement of life expectancy which had been a consistent finding since the turn of the 19th century stalled in 2010** and years spent in ill health increased. He also showed that the social gradient in health became steeper and regional differences increased.

The two features of Tory government policy during this period was to roll back the State – **public expenditure went from 45% of GDP in 2010 to 35% in 2018** – and to be **regressive**. This meant that the poorer you were the more likely you would be to be disadvantaged by these changes.

The excuse for the policies enacted from 2010 was **the 2008 global financial crisis, which led to a decline in the global economy of 0.1% in 2009**. The IMF has predicted that the global economy will decline by **3% in 2020** on account of the pandemic. Already we have seen Universal Credit claims in the UK rise from 150,000 before the pandemic to 1.4m by the 13th April and rising daily. Marmot points out the risk that it would be a calamity if we face a new era of austerity after

the pandemic. We need on the contrary to argue for a better society with less inequality and built by **reducing child poverty, improving child health and education, improved working conditions ensuring that everyone has the minimum income to lead a healthy life and creating a sustainable environment in which to live and work creating the conditions for people to pursue healthy living.**

3. Places affected by conflict and humanitarian crises

Inequalities are manifest globally as well as locally in the UK. For instance, many of the estimated **70m forcibly displaced people worldwide** live in insanitary and inhospitable conditions sometimes up to six families living in one tent in a 3sqm area. In these camps people share few latrines and washing facilities and have to queue for food each day. The Covid-19 mantra has been hand washing, social distancing and lockdown. People in conflict zones or refugee camps simply cannot follow this guidance and have access to very rudimentary healthcare facilities.

There is an urgent need to put international pressure on **warring parties in Syria and Yemen** to end restrictions on access to health care and humanitarian assistance. Public health support is needed to provide the conditions that do not allow the virus to spread and substantial financial support to overhaul the present conditions. This is more important and practical than supplying ventilators. The Covid-19 pandemic requires a global response for the most vulnerable populations globally as well as locally in the UK (see David Nott Lancet 1st May 2020)

Another globally vulnerable group are **prisoners**. In all countries including the UK prisons are a risk being closed communities with people living in crowded and in some countries squalid conditions. Conditions are worse in countries led by leaders like Duterte and Bolsonaro. In the Philippines for example there are an estimated 215,000 prisoners in prisons built for a capacity of 40,000 and in Brazil 773,000 prisoners are crammed into prisons built for 461,000.

Whether it's parts of the world with conflict and humanitarian crises or populations suffering from repressive governments there is an urgent need for rich countries to invest in **international organisations such as the UN, WHO, UNHCR, UNICEF and AID organisations to try to mitigate the risks that Covid-19 poses** on top of already stressed social conditions. It is possible to act locally on health inequalities as well as show solidarity globally.

4. So what?

In our earlier blogs we have been critical of some aspects of the pandemic response in the UK. It is sad to note that the **UK is heading to have the worst outcome in Europe** with us starting our epidemic behind Italy, Spain and France when Covid-19

hit Europe. **The Government have been too slow** to take measures such as locking down London and the South East rapidly and should have continued **testing, tracking and isolating** across the country – especially where the number of cases has been low and well within the capacity of local resources. This would have built practical experience and we would have learnt valuable lessons.

Now that we have more testing capacity, we need to build the programme from the bottom up. **Local public health teams in Local Government** stand ready to provide local leadership teaming up with professional Environmental Health Officers (EHOs) who have the skills and local knowledge to provide local leadership. **Resources need to be targeted at areas of greatest need** as we have illustrated through the excellent ONS report. Certainly, smart apps will play a part as well as national leadership from COBR on the key features of the test, trace and isolate programme. However there has arguably been too centralised and London based approach to pandemic management. The time is ripe to allow local authority public health, supported by specialist PH resources, to work with their Local Resilience Forum (LRF) using their local skills and knowledge to bring the pandemic to heel **using classic communicable disease control** methods. This will help eliminate the virus, protect the NHS allowing it to reopen for normal business and enable the economy to start up again as soon as practicable.

Pandemics kill in three ways says Jonathan Quick of the Rockefeller Foundation:

‘**The Disease kills,**

Disruption of the health service kills

and the

Disruption to the economy kills’.

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 9

Published: 11th May 2020

ONS England data 11th May:	
Hospital admissions 866	**Total in hospital 10,109**
Deaths 290	**Cumulative deaths 29,681**

Introduction

The SHA has produced a weekly Blog on the Covid-19 pandemic for the past 2 months. In these Blogs we have looked at many issues, but the overriding finding is that the **UK Government has been much too slow** in responding to the pandemic, which has cost lives, stressed the NHS and severely damaged the economy. We are now one of the countries in Western Europe with the worst outcome in terms of reported deaths and deaths/million population.

This is a scandal, and as we have learned more about the background to the response, we learnt about the emergency scenario planning exercise in 2016 **- Operation Cygnus (Swan flu)**. This exercise, which involved the devolved nations and over 900 participants, made recommendations on the need for more PPE to be stored, more ITU ventilators to be procured for an enhanced ITU provision and robust planning for the social care sector which was at risk of being overwhelmed. The recommendations seem to have been largely ignored by the Tory government during its declared policy of disinvesting in the public sector and the policies of economic austerity. At that time Boris Johnson was a senior Cabinet Minister as Foreign Secretary and Jeremy Hunt, now Chair of the Health Select Committee, was Secretary of State for Health and Social Care. **Who will take responsibility for not acting on the advice?**

The other issue that has become even more obvious is that public services such as the **NHS have been starved of resources over the 10 years** of austerity and while the service has made an extraordinary response to the pandemic it is against the background of poor capital investment and major staffing pressures such as medical and nurse staff vacancy levels. Similarly, the **Local Government sector has been pared down** during the Tory years with massive disinvestment, floating State Education to unaccountable Academies and Free Schools, and running down many of its former functions including environmental health and trading standards. Local Authorities who have been driven to cut services and their budgets year on year are now being asked to stand up and take responsibility in an emergency while also trying to cope with the social care scandal. **It sticks in the throat to hear government Ministers speak appreciatively about public sector workers, often**

in low paid jobs, who they have in the past criticised as a burden on the taxpayer.

In this week's blog we want to raise the issues about **re-building the public health system so it can run the test, trace and isolate campaign** from neighbourhood, local authority population, region, nation, and central government. We are also concerned about the evidence of **further privatisation using the Covid Trojan Horses** and the excellent examples from other countries about how they have handled the pandemic successfully and published coherent plans to get out of their lockdowns.

1. Test, track and trace, and isolate

Since the beginning of the pandemic, we have been calling for Covid-19 to be contained by using **tried and tested public health measures of communicable disease control**. Even without access to swab testing of suspected cases local public health workers would be able to establish whether someone was a suspected or probable case from taking the history of their illness. With swab testing this would convert the suspected/probable case to become a confirmed case and the local public health team would build their information base and start to map out the spread of the infection in their locality. Notifiable disease works in this way and at the start of the pandemic this could have been done in all areas. Contact tracing and recording demographic details as well as presenting symptoms would have built up a local picture of the manifestations of the infection, the demographic details and travel histories involved.

A history of fever and continuous dry cough would have been sufficient to be a suspected case. It was a serious error to not start contact tracing and local notification in all areas to build up the knowledge and skills of local PH teams. Obviously when community spread became overwhelming such detailed work on contact tracing might reduce but a local record of test positive cases should have continued to be built up. Laboratory test results are still collected but this should have fed into the local teams' databases. The variation in new cases and deaths across the UK has been very marked and in some areas this task would have been comparatively easy to sustain and in the process train new people under the watchful eye of experienced Environmental Health Officers (EHOs) supported by their Local Authority based public health colleagues. Expert advice obtained from Laboratories and Public Health England would support the local teams under the leadership of Directors of Public Health (DsPH). Similar networks exist in Wales, Scotland and Northern Ireland.

The reason for spelling this out at this stage of the pandemic is that at long last the government have rumbled that **testing, tracing and isolating is part of the strategy to get out of the blunt tool of total societal lockdown**. South Korea's success was wholly dependent on rigorous testing including basic approaches being supplemented by mobile phone data and other digital systems. They have shown how they can monitor community infections and step in quickly to contain new cases as they arise. They did not have to resort to society lockdown and their economy has continued to function – as well as coping with voting in a general election during this time.

To get testing scaled-up from its hospital base, the government has defaulted to their prior preferences and have turned to their friends in the private sector: Deloittes, Serco, G4S and Sodexo. Rather than building local public health teams in Local Government and enhancing PHE reach from their regional organisations, **we now have a mix of inexperienced private contractors**. So rather than start the process of using the pandemic to re-establish public health capacity locally and regionally we see short-term contracts with the private sector. These private contractors are advertising for contact tracers at £8.72/hr. Sodexo, which is running many of the Covid-19 drive-through testing centres with minimal staff with clinical experience, are paying testers £13.50 /hr and trainers £17.50 /hr and all jobs are offered on a casual basis.

These political decisions have already led to communication problems with poor reporting back to primary care and PHE, and who knows how, or whether, the data will be integrated into the system in a consistent and reliable way? To everyone's astonishment, pop-up testing pods appear in local areas without anyone knowing that they were planned, and samples then have to be **sent to the USA (yes, the USA)** to be tested when really results should be back quickly, and within 2 days to be useful. **This is a huge lost opportunity to try and re-establish public sector public health services from local to regional levels and so build system resilience and independence rather than inexperienced private sector for profit organisations.**

2. Privatisation – the Trojan Horses

The privatisation of the testing services is also being matched by the opening of NHS data and information systems. NHS England and NHS Improvement (NHSE & I) (now merged in practice, though without the necessary legislation) is creating a data store to bring multiple data sources together including data from NHS111 calls, NHS digital and Covid-19 test results, and NHS and Social Care data. We are told that NHS data will remain under NHS England and NHS Improvement's control!

This data is very operational looks at occupancy levels in hospitals, capacity in A&E departments and statistics about length of stay of Covid-19 patients. The dashboard will provide a public health overview and supply operational data across the NHS. The partners in this include private sector multinationals Microsoft, Palantir Technologies UK, Amazon Web Services (AWS), Faculty (an AI company), and Google. We are told that data and information governance will be strictly controlled.

Apart from the **private sector "entryism"** into NHS data and information, we have seen **KPMG being commissioned to build the Nightingale warehouse hospitals**, which are having to be redesigned or mothballed. The NHS was only able to stand up to the extreme pressure **through the dedication, commitment of health workers and their administrative and management staff embued with public service ethos**. Another private sector stablemate, Deloittes, was handed the contract to provide PPE and to commission vaccine development. **All this without the need for tendering**.

The risk that derives from the 2012 Lansley Act, the 2015 NHS guidance in England and the more recent Coronavirus Act 2020, is that it eases privatisation of our NHS. Privatisation with even more stealth than that recommended by Nicholas Ridley's Tory Research Dept proposals to Margaret Thatcher in 1977, before she even

became Prime Minister. Much commissioning of NHS services now takes place at national levels with very little if any scrutiny from publicly accountable local Boards. All these changes, brought in by the Tory Government before the pandemic, are now being used to privatise services and potentially set up the NHS for deeper intrusions into its role as a publicly funded and delivered health service.

3. Exit out of lockdown

Although some countries such as Korea and Sweden have avoided lockdown, many others have had to use this blunt but too often necessary strategy. We are now seeing that countries that acted early and fast with containment measures, are planning the steps needed to safely reduce the constraints on everyday life and the economy.

We have seen an excellent visual map of the five stages to be taken between May-August in the Irish Republic, which has so far been doing extraordinarily well in containing the infection with relatively few cases or deaths. New Zealand, which has been a beacon to other countries, seems to have succeeded with their policy of eliminating the virus. Under the excellent leadership of Jacinda Ardern, they too have set out their plan for freeing up movement of people and the economy. Neighbouring Australia have also done well with their policy on restricting air travel and quarantining arrivals, closing State borders, and undertaking lockdown. They have only had 92 recorded deaths in their 25 million population and now have their staged plan published. No doubt we will be able to watch international sporting contests between NZ and Australia inside their Anzac bubble!

On the European mainland Italy and Spain are taking their first cautious steps out of lockdown, which in their cases have pulled back the out-of-control spread. France has colour coded their regions and the red areas will remain under tougher conditions, but the South and West will see greater relaxation of controls. All these countries have published clear plans with criteria in easily understood diagrams of each phase and steps clearly laid out.

The UK government has so far failed to set out the plan clearly and is at risk of confusing people by changing the message from “Stay at Home” to “Stay Alert”! They risk division across the devolved nations of the UK and misunderstandings about any new freedoms. Workers will need proper risk assessments of their workplaces before returning safely to work. This must include considerations about their journey to work, canteen and welfare facilities in the workplace, and that they that meet the standards of social/physical distancing and PPE provision where required. This will take time and many partners such as Trade Unions will need to be involved in aspects of the risk assessment in the workplace as well as facilitating transport to work.

4. Conclusion

We are at a critical point in the pandemic where we are still suffering from a comparatively high level of new cases being identified, with the social care sector suffering from particularly serious epidemic spread, risking the lives of thousands of very vulnerable residents. The government has rather belatedly recognised the WHO advice to test, test, test, and has successfully increased testing capacity but has

failed to invest either in rebuilding the capacity of local public health teams in Local Government or in more local Public Health England teams.

In its struggle to get on with the response it is choosing to invest in private companies who have over the past decade already profited from NHS contracts in support services and laboratories, but now seem to have been also given access to NHS data. **There is a serious risk of even further and deeper privatisation of NHS provision while publicly extolling the virtues of the NHS.** The opportunity of using the data to try and sell private health insurance directly to individuals or advertise private services in many more areas currently covered by the NHS?

Finally, exiting lockdown will not be easy to achieve, as the epidemic has not declined in a persuasive manner, with the first wave suppressed and therefore prolonged. What people need is a clear staged plan for the steps to be taken and the data that will monitor progress rather than a statement of intent.

As cardiologist Dr Banerjee notes in the Observer newspaper:

“**We were not humble enough to look at other countries and learn a lesson from them and lock down quickly – it is as simple as that. We were arrogant and thought that we had nothing to learn from other countries and thought that we were an exceptional case. In fact, we had a lot to learn but didn’t take the opportunity”**

SOCIALIST HEALTH ASSOCIATION COVID-19 BLOG 10

Published: 18th May 2020

ONS England data 18th May:	
Hospital admissions 733	**Total in hospital 8,668**
Deaths 253	**Cumulative deaths 31,501**

Introduction

This is the tenth SHA weekly blog on the COVID-19 pandemic. We are at an interesting phase of the pandemic when we are moving from **Response to Recovery** and uncertain how to navigate the tricky waters without the charts and the data dashboard to guide us.

We have a government that was ill prepared for the pandemic and has been playing catch up from the early days of **denial,** then **delay** and a too early **departure** from building local systems of **community testing, tracing and isolating**. We are beginning to hear of possible COVID-19 cases in the UK and neighbouring European countries emerging before Xmas so the virus could have been around longer than we have thought. Even so we wasted precious weeks in February and then had the damaging delay between the 10th March to the 20th March, when lockdown proper started during which time the viral spread had been exponential. We now note that England has one of the highest rates of excess deaths of the 24 European countries analysed by EuroMOMO.

1. Game changers

The government have, in the turmoil, grasped at '**game changers'** such as the so-called home-based **antibody blood spot test** which was scientifically unproven and nevertheless succeeded in getting the Government to buy 3.5m on 'spec'. We need to know how much Taxpayers money was wasted on that contract and demand a greater scrutiny on such wild contracts without basic safeguards.

The next 'game changers' were the treatments such as **chloroquine**, which Trump was allegedly pushing on the NHS to treat Prime Minister Johnson. Again, these drugs have been shown to be ineffective and potentially harmful treatments. The US Federal Drug Administration (FDA) issued a caution against its use in COVID-19 on the 30th April! There are other drugs being trialled such as remdesivir and favipiravir and some show promise but need properly conducted clinical trials and not be pushed out too soon by politicians anxious to grab a **game changer**. Remember the risk of Thalidomide, which was used in early pregnancies with disastrous consequences. We have seen with HIV/AIDS that therapies can be successful in

controlling a viral disease, but the process takes time and effectiveness trials and safety are paramount.

The other ‘game changer’ is the **vaccine** which has always been a long shot because there have never been vaccines developed for Coronaviruses such as SARS or MERS. Other viruses such as HIV have also proved impossible to develop a vaccine for and remember each year the Influenza virus ‘flu jab’ immunisation contains three variants which experts assess are the most likely to be circulating during the coming winter months. The effectiveness of the Influenza vaccine is much less than others such as measles in the highly effective MMR vaccine. Furthermore, while there are hopeful signs of successful vaccines being developed and some moving into human trials very early on there needs to be clarity about the time these trials take and the manufacturing process as well as mounting an effective vaccination programme. It is not part of the immediate pandemic control measures and with preventive vaccines you need to be very sure of safety as well as effectiveness. We know how the **anti vaxxers** mislead the public about risks of vaccination and do not want to damage the high uptake of vaccines across world populations.

Matt Hancock has during his time as SoS for Health and Social Care promoted **digital solutions** to many NHS issues including promoting companies who in effect were competing as privateers with NHS primary care (Babylon Health). His latest ‘**game changer’ application** will be the apps being trialled in the Isle of Wight and others elsewhere to assist in contact tracing. Big players Apple/Google stand ready with their apps to step in! Of course, countries like South Korea, Taiwan and Singapore have been using such apps for months and have shown the benefit they confer in the process of Test, Trace and Isolate which the UK government abandoned on March 12th.

It does seem unbelievable that South Korea has not been subject to lockdown and using testing, tracing and isolation has only had 262 deaths from COVID-19 by the 17th May with a population of 51m people. Their epidemic started several weeks before ours, and it is not clear what attempts the UK government has made to properly understand their system and learn from it.

2. Local Authorities and Public Health

Local Authority public health capacity has been reduced over the 10 years of Tory austerity and the public health grants reduced in the period leading up to the pandemic. While the Directors of Public Health, through their national body the Association of Directors of Public Health (ADPH), have been involved with the CMO’s office and Public Health England (PHE) they have not been placed at the centre of the **Test, Track and Isolate** planning. Again, the Government’s default position is to ask their consultancy mates to help design a system from scratch which we have seen with the national testing centres and the Lighthouse laboratories by Deloittes. This is a top-down approach rather than a collaborative bottom-up development.

Further work now under a **Joint Biosecurity Centre (JBC)** is again focused on the digital app and how the information provided can be analysed and communicated. This has all the tenor of a security service GCHQ venture rather than a public health pandemic response!

If the testing roll out is anything to go by there will be major glitches in communications with organisations at the heart of it not receiving information and the people themselves left waiting.

It seems to us that local public health teams under the **DPH leadership** should have been involved from the beginning working with Public Health England/Wales/Scotland, and Environmental Health departments to help facilitate test, track and isolate policies locally. They have not been closely involved since containment was abandoned prematurely across the UK despite wide variations in the spread of the virus at that time.

The government announced that 18,000 staff will be taken on to work on the national test, trace and track initiative run by SERCO but Local Public Health departments were not asked to build local teams as part of the local response but prepare to help implement the national response. Primary care has also not been part of the model, which is another wasted opportunity of bottom-up working, using local knowledge effectively. The GP surveillance system has shown its worth over many years with respiratory viruses like Influenza and patients know their GP practice as a trusted point of contact.

We have seen that COVID-19 has spread across the UK unevenly and a UK wide response designed in Westminster has not been appropriate elsewhere where case numbers may have been very low with risks quite different from metropolitan London, Birmingham, and Manchester. Of course, there needs to be national leadership in the design and procurement of such an app and Public Health England with their counterparts in the devolved nations be part of the design team. However, for it to be an effective system there needs to be local leadership and engagement which builds links between partners and particularly with local primary care teams to use test results and develop the capability of mapping clusters and initiating further local investigations within national case definitions to ensure testing is done, contacts traced, and people are isolated swiftly as there is a risk that the virus will persist for weeks to come. There are signs that devolved governments such as in Wales may be approaching this in a more joined up way.

3. Social Care

In earlier blogs we have talked about the vital role that the social care sector plays, how their staff often work in difficult conditions on low pay. The impact of the pandemic now has shifted to this sector, which has 17,000 homes and look after 400,000 elderly or disabled people in need of care. This sector is where many of the excess deaths have been occurring and thanks to statisticians outside government who have signposted the excess deaths measure, we know that they have accounted for 20,000 deaths so far. Weekly deaths in care homes have tripled in the past month. In Scotland recently it is estimated that 57% of deaths from COVID now come from deaths in nursing or residential homes.

We have heard case after case of social care providers not having the PPE they require, having to accept hospital discharges who may have been infectious, not being supported in the way you might expect from external agencies. They have had to introduce infection control policies, which seem inhumane when considering the resident’s end of life experience and the memories of their survivor families. We should have a quick look at the risk assessments/processes to allow named next of

kin to visit their relatives and be there at the end of life. It does feel that this is the time to grasp the nettle and create a new **National Care Service** which is publicly run, and which does not require rental payments to 'off shore' bodies, who have invested in the land and properties rather than the commitment to care. Not all care homes are owned and run by business interests of course but all suffer from chronic underfunding, staff shortages and service gaps between the NHS and their own provision. The CQC is unable to bridge the gap.

4. Moving out of Lockdown

We are all getting tired of having our lives constrained by lockdown while at the same time pleased at the social solidarity shown by most of the population. The trade unions are quite right to ensure that the workforce is not endangered by a hasty return to work without rounded risk assessments.

Take the school debate for example. It is relatively easy to look at children themselves and declare that they as an age group have been relatively spared the harms of COVID-19. However, we know that they do seem to get the infection and harbour the virus in their noses and throats too. We don't know how contagious they are but there is obviously a risk and scientific studies are understandably scarce. European countries such as Norway and Denmark have had far less cases and deaths than the UK and have got down to very low levels. For example, Norway has had 8,244 cases with 232 deaths and Denmark 10,927 cases with 547 deaths. Their schools have had to implement big changes in the way they mix outdoors and indoors classes and have had to physically distance children in classrooms and for school meals. Halving class sizes seems the likely way we would need to go in the UK which might mean two-day sessions which would have huge implications for schools.

But it's not just children! Teachers and school staff are at risk and there needs to be proper occupational health assessments to assess individual risks in the staff. Then there are parents and grandparents who may be involved in bringing children to school and mingling with others at drop off. Children may in turn bring back the virus to the home where there may be vulnerable others living there. So rather than the hurried declaration made to reopen fully on the 1st June there needs to be proper discussion and agreement with trade unions and parents and staff/school Governors on the risk assessment and plans. Remember too that schools have been open during this time for children of essential workers and vulnerable children many of whom have not attended. Oh, by the way, Eton pupils will return to school in September, and they already have small class sizes!

5. Scrutiny of Public Expenditure

It is estimated that the Government has now built up £300 billion national debt through its Pandemic investments. The furloughing scheme has been widely welcomed, as has the cancellation of NHS (England) historic debt. However there have been some decisions made by harried Ministers that have been misplaced (such as the home-based antibody test) as well as some of the spend on ventilators and Nightingale hospitals when it was already apparent that the NHS was coping

somehow with the huge demand on ITU capacity. The decisions to contract out some of the tasks on testing, track and trace have been questionable and the investments in the pharmaceutical industry for vaccine production/drug development need to be scrutinised. Contracts worth more than £1bn have been awarded to 115 private companies dealing with the pandemic, without allowing others to bid for the contract. This has been under fast-track rules which suspend normal procedures and include contracts to provide PPE, food parcels, COVID-19 testing and to run operations rooms with civil servants. This latter group includes Deloitte, PWC and Ernst & Young!

The last thing we want is to be plunged back into austerity at the end of the pandemic. Already we hear of withdrawal from the rough sleepers investment in accommodation before alternative plans are in place and indeed before realistic resurgence in tourism happens. The **new normal** needs to preserve the advances that have been made. Similarly simple calls for people to drive to work risks the modal shift that is possible towards walking, cycling to work if public transport is deemed too crowded for social distancing. Electric cycles can be promoted for those with further to travel or in hilly areas. The reduction in air pollution while helping the carbon load is still not at levels this year required if we want to meet the goals of the Paris Accord and keep global temperature rise to 1.5 degrees.

The Chancellor and his advisers will be wondering how to get more money into the Treasury. Now is the time to look at a proper wealth tax and to deal with offshore tax avoidance. Dyson tops the Sunday Times Wealth list and remember Sir James moved his head office out of the UK to Malaysia during the Brexit debates. He is sitting on £16.2 billion wealth. The Duke of Westminster has had 300 years in the top spot of property wealth (£10.3 billion) built on their portfolio of 300 acres of Mayfair and Belgravia (remember the Monopoly Board!). Others in the top 10 include the Coates family who have accrued £7.17 billion through gambling business such as Bet365 and we know the damage to public health that gambling does. Finally let's call out Richard Branson who sought a government subsidy of £500m for his furloughed staff in Virgin Atlantic with his £3.63 billion. He has apparently not paid any personal tax in the UK for 14 years. These super rich need to be taxed on their annual earnings as well on inheritance transfers, which by using Family Trusts subvert the process.

Finally

As we think of US billionaire David Geffen on his $590m yacht, who posted on Instagram that he was isolated in the Grenadines avoiding the virus – let's consider a better fairer future.

The pandemic can be an **opportunity for progressive change to reduce inequalities,** but we know that there are entrenched and powerful interests. The rich are often supporters of entrenched interests as they benefit from the status quo. In

the light of the pandemic, they should reflect on **how sustainable the status quo really is. We also need to clear set out a new road map for a fairer future.**

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 11

Published: 25th May 2020

ONS England data 25th May:	
Hospital admissions 498	**Total in hospital 7,448**
Deaths 175	**Cumulative deaths 32,910**

The SHA has been publishing its COVID-19 Blogs weekly since the 17th March. A number of themes have cropped up consistently throughout as actual events have occurred.

1. Too slow to act

The slow and dithering response by the government has been one such theme. This has been exposed with embarrassing clarity by media investigative teams which this weekend includes the **Insight team**. Their detailed report on the dither and delay leading up to lockdown showed that when Italy and Spain locked down on the 10th and 13th March respectively each had over a million estimated infections in their countries. In the UK we had looked aghast at the footage from Lombardy and Madrid as their health and care system was visibly overwhelmed but the government failed to heed their strictly enforced lockdown policies in the 2 weeks warning we had. During this time from the 8th March the Johnson administration allowed the Five Nations rugby matches to go ahead in Twickenham and Edinburgh, the Cheltenham races, the Liverpool/Atletico Madrid football match on the 11th March and two Stereophonics pop concerts in Cardiff held on the 14th and 15th March. All this was apparently following the science…..

France locked down on the 16th March with an estimated 800,000 infections and Germany locked down on the 21st March with only 270,000. The Johnson government had resisted calls to lockdown at the same time as France on the 16th March. They waited until the 23rd March by which time the estimated number of infections in the community had almost doubled to 1.5m.

This dither and delay lies at the heart of our comparatively poor outcome with the COVID-19 confirmed deaths of 37,000 (an underestimate of all excess deaths). This list includes at least 300 NHS and care workers.

2. Protect the NHS

Germany's earlier decision has reaped benefits alongside their border closure, effective test, trace and isolate (TTI) policies, with sufficient testing capacity, and led by regional public health organisations. They also have sufficient ITU/hospital bed capacity without the need to build new Nightingale Hospitals. Our government did not close borders or introduce quarantining on entry and turned out not to have used February to build our testing capacity either.

The strategic attention in the UK has been to '**Protect the NHS'** but not in the same way Care Homes. Because of the shortage of testing capacity, we had to stop the community-based test, track and isolate (TTI) programme. The NHS has stood up well through the dedication of its staff and demonstrated the superiority of a nationalised health system. However, from a public health policy perspective the **COBR meetings should have been thinking about the whole population and what populations were at high risk such as those in residential and care homes.**

The data in Wuhan had been published quickly and had shown that it was older people who are most at risk of disease and death. We knew all this; the Chinese data has been replicated in Europe but the Government failed to follow through.

3. The Privately owned Social Care sector

Unlike the NHS hospital sector, the care sector, of residential and nursing homes, are a patchwork of large 'private for profit' owners, smaller privately owned and run homes and the charitable sector. There is a registration system and some quality assurance through the Care Quality Commission (CQC). The fact that we do not have a National Care Service along the lines of the NHS has led to operational problems during the pandemic between commissioners, regulators, owners, and the staff who run the homes. As privately run establishments there were varied expectations about procuring PPE for the staff in the early phase of the pandemic response. There was also a lack of clarity about whether satisfactory infection prevention and control procedures were in place and able to deal with COVID-19. How had residential and care homes undertaken risk assessments, working out how to cohort residents with symptoms and manage their care? What about staffing problems, agency staff and policies for symptomatic staff to self-isolate? It was important early on to consider in what respect COVID-19 is the same as or different from influenza or a norovirus outbreak.

It seems that the Secretary of State for Health and his staff have been too slow in aligning Public Health England (PHE), GPs and primary care infection control nurses alongside the homes to provide more expert advice and support on infection prevention and control. It seems also that some nursing homes took patients discharged from the NHS who were still infected with COVID-19, when on the 19th March the Department of Health announced that 15,000 people should be discharged to free up NHS beds. There was no mandatory testing or period of quarantining before these patients were discharged. In this way hospital-based infections were transferred to nursing homes.

The scarcity of PPE (caused by the Government's failure to heed the results of Exercise Cygnus) meant that professionals felt nervous about entering homes to assess sick residents and sadly to be able to certify death and certificate the cause of death. Rationing of PPE in this sector has contributed to the risk of infection in

care staff, which would cause transmission in the care home. Most homes had to lockdown too, stopping visiting and in some cases having staff move into the home themselves at personal risk and disruption to their lives. It became clear that transmission from the community to care home residents was occurring through staff. This has been very hard on these undervalued and low paid staff, who began to realise that they were transmitting infection between residents or from themselves.

Some of the stories of care staff's heroism and dedication to their residents is extraordinary. It is reminiscent of **Camus's** book **The Plague,** which recounts heroism undertaken by ordinary people doing extraordinary things. Tellingly Camus also suggests that **the hardest part of a crisis is not working out the right thing to do, but rather having the guts to get on and do it**. Many care home managers and staff had to do just that.

4. Follow the money

A recent report looked at **HC-One**, which is Britain's largest care home group with 328 homes, 17,000 residents and so far, 700 COVID related deaths. The operating profits of the company are of the order of £57m but, through the financial arrangements with offshore related companies, the profits 'disappear' in £50m 'interest payments'. While global interest rates have been at historically low levels HC-One have apparently been paying 9% interest on a Cayman Island loan of £11.4m and 15-18% interest on another Cayman company for a £89m loan. Apparently, HC-One paid only £1m in tax to the HMRC last year (Source: Private Eye 22nd May) through this transaction with offshore interests off-setting their profit. This is not however inhibiting them from seeking government support at this time.

A better future would be to rescue social care by nationalising the social care sector, bring the staff into more secure terms and conditions of service and sort out the property compensation over time through transparent district valuations.

5. Test, trace and isolate (TTI)

At long last the government has signalled that it wishes to reactivate the community-based test, trace and isolate programme that it stood down over 10 weeks ago. Of course, once the virus had been allowed to spread widely within communities, the TTI programme would have had to modify their objectives from the outbreak control of the early stages. However, they could have continued to build the local surveillance picture within their communities, help PHE to control residential and nursing home outbreaks with their community-based contacts and prepare for the next phase of continuing control measures during the recovery phase.

They seem to have at last realised **the potential of local Directors of Public Health (DsPH)** who are embedded in local government and who, after all, lead Local Resilience Fora as part of the framework of a national emergency plan. The DsPH have links to the Environmental Health Officers (EHOs) who survived the austerity cuts. EHOs are experienced contact tracers well able to recruit and train new staff locally to do the job. This is in sharp contrast to the inexperienced staff now being recruited and used by the private sector.

The local public health teams also work closely with PHE and NHS partners and so can fulfil the complex multiagency leadership required in such a public health emergency. Building on these strengths is far better than drawing on private sector consultants such as Deloittes, or companies such as SERCO, Sodexo, Compass or Mitie. All these private sector groups have an interest in hiving off parts of the public sector. In addition, unsurprisingly, they have close ties to the government and Conservative Party. Baroness Harding, who has been brought in to Chair the TTI programme, is a Tory peer married to a Tory MP who was CEO of Talk Talk. She was in charge at the time of the 2015 data breach leading to 4m customers having their bank and account details hacked. No surprises, then, that she is asked to undertake this role as a safe pair of hands in much the same way that Tory peer Lord Deighton has been asked to lead the PPE work.

6. Game changers – and what is the game?

In last week's Blog we mentioned that Government Ministers seem to be fixated on **game changers** whether novel tests, treatments, vaccines, or digital apps. We mentioned last week that treatments like Chloroquine need proper evaluation to see if they are safe and effective. A report in the Lancet on the 22nd May found that there was no benefit. Indeed, the study found that the treatments reduced in-hospital survival and an increase in heart arrhythmias was observed when used for treating COVID-19

Vaccines need to be researched, as they may well be important in the future but remember that a 2013 review from the Netherlands found that they take – on average – 10.71 years to develop and had a 6% success rate from start to finish.

The mobile apps trial in the Isle of Wight seems not to have delivered a reliable platform, and of course the Government has probably ignored the apps working splendidly in South Korea and Singapore. Meanwhile Microsoft, Google, Facebook, Faculty and Amazon stand ready to move in. There are major risks with getting into bed with some of these players including the data mining company **Palantir**.

7. Palantir

This company was initially funded by the CIA but has secured lucrative public sector contracts in the USA covering predictive policing, migrant surveillance and battlefield software. These IT and data companies have been drawn into the UK COVID-19 'data store'. While working alongside NHSX and its digital transformation unit wanting to assess and predict demand there are concerns over data privacy, accountability and the possible impact on the NHS.

Palantir has been of interest to **Dominic Cummings (DC)** since 2015, according to the New Statesman, when he reportedly told the Cambridge Analytica whistle-blower, that he wanted to build the '**Palantir of politics**. The other company **Faculty** had close ties too with the **Vote Leave** campaign. Cummings is said to want to remould the state in the image of Silicon Valley.

8. Conclusion

So, in the turmoil of the COVID-19 response the government has looked to multiple game changers while ignoring straightforward tried and tested communicable disease control measures. It has succeeded in 'Protecting the NHS' (though not against the incursion of the private sector) but allowed the residential and care home sector to be exposed to infection. We welcome the belated return to supporting DsPH and local public health leadership, which has been left out for too long. Let us hope – and demand – that there is also more investment in public health services and not allow Government spokespeople to start to blame organisations such as Public Health England (PHE).

We worry that they are **not being alert** to safeguard public services by inviting some dubious partners to the top table. On the contrary they are **VERY alert** – to the opportunity of inserting private capital (and profit) in the NHS and other public sector organisations.

One such company new to many of us is the data mining company **Palantir – a company named after an all-seeing crystal ball in JRR Tolkien's The Lord of the Rings**. Lurking in the background is of course the Prime Minister's senior political adviser DC.

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 12

Published: 1st June 2020

ONS England data 1st June:	
Hospital admissions 522	**Total in hospital 5,954**
Deaths 121	**Cumulative deaths 34,409**

This is the twelfth week of the SHA COVID-19 blog in which we have responded to emerging issues in the pandemic response, from a politics and health perspective. As it stands the UK has performed **"like lions led by donkeys**". The NHS and care home staff, plus all the other essential workers in shops, delivering mail and answering phones have been heroic, risking their lives, working long hours, and generally going well above and beyond the call of duty. They have been supported by armies of volunteers, delivering food to neighbours, sewing protective clothing, organising suitably distanced entertainment, and generally rising to the occasion. While the Tory Government, led by Johnson "advised" by Cummings, on the other hand, has done very badly in comparison to the governments of some of our European neighbours as well as many countries further away in Asia and Australia/New Zealand.

1. Germany and Greece

UK government advisers have told us that the UK could not easily be compared with Germany. This was a surprise to most people as Germany, France and the UK have over many years had comparable levels of social and economic development. We have drawn attention in earlier Blogs to Germany's quick response to lockdown, how it closed its borders and uses test and trace widely with leadership in regional Public Health departments. The latest data shows that Germany, with a population of 83m people, has had 8,500 deaths which is a crude death rate of 10/100,000 population. This compares very favourably to the UK, with a population of 68m, which has had 38,400 deaths with a crude death rate of 58/100,000. The UK was slow to lockdown, has not closed its borders but promises to introduce quarantining in a week's time and is struggling to introduce test, track and isolate having not developed its local public health capacity.

So, if we don't compare well to Germany – **what about relatively poor Greece** which has in recent years been ridden with national debt? Greece locked down in early March, before many cases were identified and ahead of any COVID-19 related deaths. They enforced lockdown vigorously, closed schools and for their population of 11m, they have had 175 deaths at a population crude death rate of

1.6/100,000. They have now been opening-up in comparative safety with shops on May 4th and shopping malls on the 18th May along with archaeological sites. They are now advertising for summer tourists to come from countries like Germany and Eastern Europe: but from the UK only if we get COVID under control!

2. Test, Trace and Isolate

The COVID-19 SARS virus has many troubling characteristics, such as its infectivity while people are not showing symptoms and its ability to cause serious systemic illness in adults and particularly older people. However, it behaves much like other respiratory viruses; transmission can be blocked by isolating infected people, hand washing, cleaning surfaces and maintaining physical distance from others to prevent droplet/aerosol spread. Facemasks have also been shown to reduce spread from individuals hosting the virus in their nose and throat. **These control measures are not 'modern' or technically complex – they are basic public health interventions** to prevent infectious diseases spreading and they have been shown to work over many years. The government's belated control measures, such as stay at home, isolate and maintain social distancing, use these infection control measures. They have worked as infection rates have reduced but are in danger of now being undermined.

The testing process has been problematic, as we have said before, not least in the slow pace of increasing capacity. In order **to try and catch-up** politicians have plucked large round numbers out of the sky, announced them at the Downing Street briefings without any explanation as to why that number and how it all fits together strategically. They then commission inexperienced private sector consultancies and contractors to try and build a new system of testing de novo, which has also involved Army 'squaddies' to deliver. This has led to serious organisational and quality problems, results taking too long to be useful, and not being fed back to the people who need to know other than the patient, namely GPs, local Public Health England teams and local Directors of Public Health. **The big question has always been why did they not invest in the PHE system to scale up and at the same time invest in local NHS laboratories to tool up?**

Local NHS laboratories could have worked with university research labs and local private sector laboratories in the area to utilise machinery and skilled staff. This new capacity would have built on established NHS and Public Health systems and avoided the confusion and dysfunction. **The answer is they decided to save the money! They chose to ignore the findings of Cygnus, which foretold all this, because they were intent on cutting the funding of the NHS to the bone and privatising everything that could be turned into a profit-making enterprise.**

Tracing contacts is a long-standing public health function often done from sexual health and other NHS clinics but also in local authority-based Environmental Health departments, which are used to visiting premises where food is handled and following up outbreaks of food poisoning and infectious diseases. GPs are also used to being part of the infectious disease control procedures with Sentinel Practices, set up to provide early warning of infectious diseases such as meningococcal meningitis and helping to track e.g. influenza incidence in the community.

It should NOT have been left until LAST WEEK to start seriously engaging with local public health departments and their local microbiology laboratories and

primary care! These local leaders and partners should have, as in Germany, been what the community control of the pandemic was built on. This did not need to wait for SERCO to set up a telephone answering service and train people on You Tube videos with a malfunctioning (and in some areas totally non-functioning) IT system.

Typically, the Government made an announcement that Tracing was going to start before arrangements were in place, and local Directors of Public Health were left to make bids for investment after the starting gun had been fired! To this day the data that 'comes down' to local level is from the Office of National Statistics (ONS) and Public Health England (PHE) and is on a **Local Authority population level.** There is no postcode or other data that would help local surveillance and understanding where infected people live or indeed where deaths have already taken place.

The NHS has data by GP practice and hospital, but again there remain issues about identifying where those individual patients reside, who have been hospitalised or, sadly, died. These data could be analysed but that job has not been undertaken and so Directors of Public Health do not have the "**Information Dashboard**" (or data visualisation software) they need to be credible local leaders in the testing, tracing and isolating work that needs to be done to monitor the local situation and intervene with control measures. Hopefully we are on the road to getting a more balanced approach with national standards and the introduction of a mobile app to support contact tracing. Why did the government not learn lessons from South Korea, Singapore and Germany where they have been successful?

3. Independent SAGE

SAGE is the Scientific Advisory Group on Emergencies which is supposed to be independent. The SHA is delighted that Sir David King has taken the initiative and established a credible **Independent SAGE** group. We are pleased to see that SHA President Professor Allyson Pollock has been invited to contribute as well as others known to be supportive of our approach such as Professor Gabriel Scally, a former regional Director of Public Health and public health adviser to Andy Burnham.

The way that the Chief Medical Officer (CMO) and Chief Scientific Adviser (CSA) have been played into the Downing Street briefings has been problematic and the secrecy behind who was giving the government scientific and public health advice and what specifically that advice was, has been exposed as unacceptable. The CSA has belatedly started to share the membership and minutes (suitably redacted of course) but this has only come about because of political pressure. The SHA were not alone in expressing horror that Dominic Cummings (Johnson's senior special advisor or SPAD) and his sidekick Ben Warner were allowed to attend these meetings and in fact intervene in the debates! It is the job of the CSA to Chair the meetings of SAGE and discuss the advice for Government, and then summarise the advice for the politicians.

The Independent SAGE group has a very different outlook, and its aims are to:

1. *Provide clear and transparent reasons for government policy*
2. *Remove ambiguity – messages should be very precise about what behaviours are needed, how they should be carried out and in what circumstances.*
3. *Develop detailed, personalised advice that can be tailored to specific groups of people and specific situations depending on their risk from infection.*

4. *Messaging should emphasise collective action, promoting community cohesion and emphasising a sense of civic duty and a responsibility to protect others.*
5. *Avoid any appearance of unfairness or inconsistency. Any easing from lockdown must be clearly communicated and explained to prevent loss of trust in the Government.*

By adopting this SAGE Scientific Pandemic Influenza Group on Behaviour (SPI-B) terms of reference it is hard for government to be critical! In response to recent government decisions on easing lockdown and opening primary schools further the independent SAGE group finds that:

"We have already been critical of the recent change in the content of the messages from Government, from the clarity of 'Stay at Home' to the vagueness of 'Stay Alert' (breaching recommendations 1-3). Now there is a clear risk that the gain delivered from the long period of lockdown will be lost as a result of recent events, further breaching recommendations 4 and 5, with the potential that many take less seriously current and further public health messages from the Government. The recommendation about collective action is especially important in rebuilding trust that has been eroded. Working in close and respectful partnership with organisations across society including those representing disadvantaged communities and working people will be vital in this process".

The new group will also work in a more transparent way by engaging in:

"an open debate on the topics on the agenda. This evidence session was live streamed on YouTube *so the public can see the evidence presented and understand the debate within the scientific community on the most appropriate course of action for the UK government".*

We will "*provide a series of evidence-based recommendations for the UK government based on global best practice*".

When should a School Reopen?

The Independent SAGE group have published their report on school reopening after their public hearing:

"We all found hearing directly from the public incredibly valuable, and have updated our report accordingly by:

- *Developing a risk assessment tool to help schools and families work together to make return as safe as possible.*
- *Emphasising further the importance of providing a full educational experience for children as soon as possible – including the many children who will not be returning to school soon. This should include educational opportunities for children over the summer holidays, through a combination of online learning, summer camps and open-air activities. Teachers cannot be the primary workforce for such activities and other options such as scout leaders, sport coaches and other roles should be explored.*

- *Explaining further the risks of reopening for children, staff and communities based on our modelling and taking into account SAGE modelling released on 22nd May*
- *Emphasising the need to support black and minority ethnic (BAME) and disadvantaged communities, whose members are at higher risk of severe illness and death from COVID19.*

The group went on to say that the decisions to reopen schools should be done on a case-by-case basis in partnership with local communities. They pointed out the risks of going too early while recognising the needs of children who remain at home and their right to education.

4. What is the strategy, the science and where are we going?

There is increasing concern that the government have lost the plot and are now making sudden decisions based on the Prime Minister's wish to move the debate on from the appalling behaviour of Dominic Cummings his adviser. We have lost the step-by-step changes undertaken with care, built on the published science, and giving time for organisations to adapt and respond to the new requirements. There is a pattern of behaviour – **policy announcement incontinence** – amongst Ministers asked to attend the Downing Street briefings. Announce on Sunday evening, flanked by advisers, and expect delivery to start on Monday morning!

The English CMO seems locked into this format, which has disabled him from establishing a rapport with the public. His advice and the advice of other CMOs across the UK is meant to be independent professional advice on public health and health care. Similarly, the CSA should be there to report on the SAGE findings and recommendations. There is no reason for them to both attend as sentinels at these briefings. Indeed, it would be welcome for the CMO to illustrate his independence to have regular slots with the media to explain some of the findings and the rationale for his recommendations. He should have become a trusted adviser – **the Nation's Doctor** – and steer clear of the shady political manoeuvring.

There is increasing evidence too that SAGE scientists are getting restless that the finger of blame will be pointed at them – to become scapegoats when the blame game truly starts. That is why the secrecy around SAGE should not have been permitted and the role of the CSA should have been clearer – to transmit the advice to the government. The Independent SAGE group has shown how this can be done and how you can also engage the wider professional community and public voice in the discourse. The SHA has always advocated for co-production of health and wellbeing.

The Prime Minister's newspaper the Sunday Telegraph has today (31st May) applauded him for not sacking his adviser, admits that mistakes have been made but points the finger of blame quite unfairly on Public Health England (PHE). They declare that the 'system needs structural change' after the pandemic. The last period we had such changes were during austerity which cut back the NHS and Local Government and the implementation of the disastrous **Andrew Lansley NHS disorganisation**.

Scientists need also to beware as the government casts around to blame someone else and we have long been concerned about the claims that they have been

‘**following the science’**. Several senior SAGE advisers have had to break ranks to say that in their view the government is relaxing the lockdown in England too early. As we have said repeatedly the UK has not performed well in controlling the pandemic and we have had a terrible death toll. It will be shameful if politicians point to scientists, PHE and their own professional advisers as the cause of **the dither and delay at the start and the poor decision making since on ‘game changers and digital apps.** The chaotic introduction of private consultancies and contractors have hindered a joined up public health partnership response and wasted resources which could have been invested in re-building capacity in local government, PHE and the NHS.

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 13

Published: 8th June 2020

ONS England data 8th June:	
Hospital admissions 348	**Total in hospital 4,830**
Deaths 98	**Cumulative deaths 34,842**

This is now our 13th weekly Socialist Health Association Blog about the COVID-19 pandemic. Many of our observations and predictions have sadly come true. **The leadership group of the UK Tory government remains extremely weak, without a clear strategy or plan of action.** Policy announcements at the Downing Street briefings are aimed at achieving media headlines. The Prime Minister (PM) has declared that he is taking charge but on questioning in Parliament was unclear who had been in charge up to this point!

In this Blog we look at the poor political and scientific leadership and lack of a credible strategy; the faltering start of Test Trace and Isolate (TTI); the demands for an urgent independent inquiry of the pandemic and financial audit of government investments in the private sector; and solidarity with Black Lives Matter.

1. Lonely Ministers

The last Downing Street briefing on Friday the 5th June found Matt Hancock (the Secretary of State in charge of the nation's health) on his own, reading out the slides and reporting on the continuing high number of new cases and relentless roll call of COVID-19 related deaths. The PMs **'sombrero' epidemic curve' has been suppressed but not flattened** as it has in other countries in Europe. Deaths remain stubbornly high here as care home outbreaks continue to spread with 50% now affected and there is belated recognition that hospitals and care homes are places of work where transmission occurs. Transmission occurs between staff, patients/residents, within households and the local community.

The UK Statistics Authority (UKSA) has challenged the way that statistics are presented at these briefings and are arguably MISLEADING the public. Remember the international evidence presented on deaths, which was fine when we were on the nursery slopes of the epidemic but became embarrassing when we overtook Italy, France, and Spain? **World beating in terms of total deaths** was probably not what the PM had in mind. Last week the total number of deaths in the UK exceeded that of all the EU(27) countries put together. We are now flying

alongside Trump (USA), Bolsanaro (Brazil), Modi (India) and will shortly be joined I expect by Putin (Russia) as a group of the world's worst performers.

One of the areas of misrepresenting statistics that has exercised the UKSA has been reporting the number of daily tests. We have drawn attention in earlier blogs to how ridiculous it is to snatch a large round number out of the air and declare it as a target. And so, it was with the 100,000 tests per day target and more recently the PMs 200,000 target. The challenge of meeting the Government targets meant that officials and private contractors started to count tests sent out in the post to households rather than completed tests. This was rephrased as test capacity. A similar change in data definition happened when we approached the end of May grasping for the 200,000 target. Suddenly antibody tests and the swabbing antigen tests were both included in the total figure. Ministers did not mention that that these tests have different applications, and many thousands are used as part of epidemiological surveys rather than diagnostic tests on individuals as part of track and trace.

2. What is the strategy?

There are calls from politicians and in the media for there to be an urgent and time limited independent inquiry into what has gone wrong here. This is not to punish individuals but to help us learn lessons urgently and maybe make changes to the way we are conducting ourselves ahead of a possible second wave. One thing that is missing is a clear strategy that government sticks to and criteria that are adhered to in decision making. The Cummings affair has been a disgraceful example of double standards but the acceleration of changes in 'opening up' the economy, increasing lockdown freedoms and reopening schools are examples where the scientific advice and the published 5 stage criteria are being disregarded. **Wuhan eased their lockdown when RO was 0.2.** (RO or R zero, where R is the reproductive value, the measure used to track how many people, on average, will be infected for every one person who has the disease).

3. Led by the science?

The other noticeable change has been the change of mood amongst the scientists advising government through the SAGE committees. Many of them now seem willing to speak directly to the mainstream media and engage in social media interactions. The Independent SAGE group that we referred to last week has become the preferred source of scientific advice for many people. It has been interesting to see how many Local Authorities and their Directors of Public Health (DsPH) have not been urging schools to open if not ready and the local RO is near or at 1.0. The Chief Scientific Adviser (CSA) has lost control and must be reflecting nostalgically back to when he was at GSK earning his £780,000 pa salary (Source: Private Eye). But he has managed to shovel a shedload of resources to old colleagues and friends in the industry involved in the endeavour to develop a safe and effective vaccine 'game changer'.

The CSA was absent from duty last Friday and so too the CMO and his two deputies. One wonders whether this is a short-lived change but maybe they too realise that that they are being set up with the SAGE advisers to take the blame for the UK's dismal record. The CMO needs urgently to catch up with his public profile and **face the media on his own and build some trust with the population,** now

anxious to be able to believe in someone at the centre of government decision making. Finally, there is the NHSE Medical Director who could not be there – no doubt to be the one to remain standing when the SoS announced at 5pm on a Friday evening that all staff in the NHS should wear surgical face masks and all visitors to wear face coverings! An impossible logistical and supply issue for an organisation which employs over a million workers in many different settings of care. And there was no consultation with the leaders of the NHS or Professional bodies such as the RCN and Medical Royal Colleges or Trade Unions like the BMA/Unite. **What a shambolic way to run things – you couldn't make it up!**

4. Test, Trace and Isolate (TTI)

Test, Trace and Isolate (TTI) continues to have a difficult 'rebirth' from when it was put down in mid-March with a comment from a deputy CMO as a ***public health approach more suited to third world countries*****.** Baroness Dido Harding (past Talk Talk CEO and wife of Tory MP John Penrose) is meant to be leading this. She had an uncomfortable time at the Health Select Committee when she had to admit that she had no idea how many contacts had been traced by the 25,000 tracers who had been fiddling on their home computers for days after having self-administered their online training. Typically, Ministers had announced the launch of TTI to the usual fanfare and she had to admit that the end of June was a more likely date for an operational launch.

It is extraordinary that **the programme is being run by private contractors, who have had no prior relevant experience**. We are already witnessing the dysfunction in passing timely, quality assured information to Public Health England and local DsPH. Local public health contact tracing teams need information on names, addresses, ages and test results to get started on mapping the spatial location of cases, exploring their occupations and contact history. Local contact tracers may need to actually **visit these people to encourage compliance after the Cummings affair**. They should really get this information straight from local laboratories and be resourced to employ local contact tracers familiar with the local area. Local DsPH would then look for support from the regional PHE team and not be dependent on the PHE or the GCHQ- sounding Joint Biosecurity Centre.

This is what happened in Germany, where local health offices (Gesundheitsamter) were mobilised, and local furloughed staff and students were employed to form local teams. We have positive examples of local government being proactive too such as in Ceredigion in Wales where rates have been kept extremely low. In the post-Cummings era local teams will get drawn into discussions about the **civic duty** to disclose contacts and of adhering to isolation/quarantining. Difficult for an anonymous call handler to undertake against the background sounds of Vivaldi.

5. Auditing misuse of public funds

One aspect that an independent inquiry will need to look at is the investment of public funds into private companies without due diligence, proper contracting and insider dealing. We have already referred to the **vaccine development** and governments and philanthropic organisations have provided over $4.4bn to pharmaceutical organisations for R&D for COVID-19 vaccines. No information is

available about the access to vaccine supplies and affordability as a precondition of the funding. The deal with the Jenner Institute at Oxford and AstraZeneca has received £84m from the UK government. Apparently, AstraZeneca owns the intellectual property rights and can dictate the price (Source: Just Treatment). We gather that the company has refused to share the trial data with a WHO initiative to pool COVID-19 knowledge! National governments cannot manage alone **this longstanding problem with global pharmaceutical companies who are often unwilling to invest in needed but unprofitable disease treatments, even though they often receive public funds and benefit from close links with University Researchers and Health Service patients and their data.** There need to be global frameworks to govern such investment decisions.

6. BAME communities and COVID-19

We have referred in previous Blogs to the higher risks of developing severe illness and death in Black, Asian and Minority Ethnic (BAME) groups. The Professor Fenton report **was finally published** this week as a Public Health England report. The report is a useful digest of some key data on COVID-19 and BAME populations and **confirms the higher relative risks of severe illness and death in these populations.** The report steps back from emphasising the extremely high risks of death by accounting for other factors such as age, sex, deprivation, and region. Even taking these factors into account they find that **people of Bangladeshi ethnicity had twice the risk than people of White ethnicity. Other South Asian groups such as those of Indian, Pakistani, or Afro-Caribbean descent had between 10-50% higher risk of death.**

There has been some controversy about whether this report was edited heavily by Ministers, and whether sections that might discuss structural issues of racism had been cut. Certainly, by **taking 'account of' deprivation and place of residence or region it is possible to choose not to see racism as part of health inequality**. Many people will remember the early evidence from Intensive Care Units, which showed that while BAME communities make up 14% of the overall population they accounted for 35% of the ITU patients. How can we forget in the early stages of the pandemic, seeing the faces of NHS workers who had died from COVID-19? You did not have to be a statistician to notice that the majority of the faces seemed to be BAME people. The BMA have pointed out that BAME doctors make up 44% of NHS doctors but have accounted for 90% of deaths of doctors.

To be fair, the NHS was quick to send a message out across the health system asking that risk assessments be done taking account of individual risks such as ethnicity, co-morbidities such as obesity/diabetes as well as occupational exposure to risk of transmission. Adequate supply of PPE and good practice does work as very few if any ITU staff have succumbed. As ever it is likely to be the nursing assistants, cleaners, porters, or reception staff who get forgotten.

The recent demonstrations of solidarity with the **Black Lives Matter** campaign in the light of the dreadful murder of George Floyd under the knees of US policemen is a reminder that **there is a global and long-standing issue of racism.** The government and all organisations including the NHS need to reflect on the findings of the McPherson report (1999) following the death of Stephen Lawrence that defined institutional racism as:

‘**The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people’.**

We must work to rid our country of racism in individuals, communities, organisations and government. It will only be achieved through commitment throughout the life course and by stamping out racism and inequalities to achieve a fairer society for all our people.

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 14

Published: 15th June 2020

ONS England data 15th June:		
Hospital admissions	**365**	**Total in hospital 3,920**
Deaths	**62**	**Cumulative deaths 35,360**

So, we are into our 14th weekly blog tracking our way through the COVID-19 pandemic. There are many issues which we have raised before which remain relevant over the past week. The most notable are the **continuing blunders by the Johnson government,** intent on appearing to have a strategy and being in control. The **podium politics** continue with **premature announcements blurted out as intent, without having checked out their feasibility** with professional advisers. The school's debacle was always couched in terms of recalcitrant Trade Unions rather than the fact that our school buildings have **lacked investment over decades**, class sizes are high and teacher staffing relatively low. This means that you cannot reduce class sizes to enable social distancing in the buildings you have available! A simple estimate of size of buildings, number of children and staffing levels would have demonstrated that this was always going to be a challenge before taking account of the risks of transmission to teachers and back via children and staff to people's homes. **The embarrassing retreat could have been avoided and the stress on schools reduced by consulting those that know how the system runs.** Meanwhile schools are open to vulnerable children and greater efforts can be made to get them back in the school setting.

A similar fiasco has emerged in health when, suddenly and belatedly worried about outbreaks in hospitals and nursing homes, the government decides to direct all NHS staff in patient/public facing roles to wear **surgical facemasks** and all visitors to wear facemasks. Imagine the planning this requires and the supplies that will be needed to sustain it! PPE and the scarcity of medical facemasks has been a story throughout the pandemic. **But there was no consultation with the NHS before the announcement on a Friday evening**.

As for **Test, Trace and Isolate (TTI)** this has had a 'wobbly' start, as rather than trusting in local Directors of Public Health (DsPH) to build local teams that local laboratories can report to quickly, they have sidestepped the service and asked **private contractors, with no prior experience**, to set up a telephone answering/contact tracer service. Training has been very basic, and it is not delivering the timely communication needed to ensure cases isolate themselves and their contacts traced urgently by local staff. In the '**post-Cummings stay alert era'** it is already emerging that people may have less commitment to listen to government

guidance, and when the lockdown is easing will be reluctant to stay off work and name their contacts who may be in a similar position.

1. BAME and Inequalities

Two issues, which we have raised before, are **the need to address racism in our society and its link to general inequalities**. The Black Lives Matter movement is trying to ensure that the government does not whitewash this issue and hide behind statistical methods which try to discount the fact that BAME communities are overrepresented in disadvantaged groups and have additional pressures on them that **arise from racism in society, in key organisations and in the individuals, they interact with**.

We have seen an **extraordinary example of institutional racism** over the process of publication of the Public Health England (PHE) report on Disparities in risks and outcomes of COVID-19.

This report was commissioned by the government, 'from the podium' in Downing Street, when confronted by the announcements of deaths related to COVID-19 where BAME people have been heavily overrepresented. The NHS employs many BAME staff but did not expect to hear that while **44% of NHS doctors are from BAME groups they accounted for 90% of deaths of doctors**. **BAME nurses are 20% of the workforce but account for 75% of deaths.** So, Ministers appointed Professor Fenton, a senior Public Health Director in PHE, to lead the review. This provided some comfort to the BAME communities, as Fenton is an articulate and experienced black health professional able to access the views of BAME communities to deepen our understanding of what was happening to lead to these extraordinary outcomes.

In the event publication of the report, which had been delivered by Fenton and PHE as promised by the end of May, had been delayed. Professor Fenton had been booked to lead a webinar for the Local Government Association (LGA) on Tuesday 2nd June fully expecting to be able to refer to his report. He seemed unaware that the report would not be published by the Government, without it being clear that this was the Fenton Report, until a couple of hours later, and even then, without it being clear that the publication was the Fenton Report. What has subsequently emerged is that the section of his report that starts to address the pathways that lead to these huge differences in health outcome **had been taken out of the report without consultation.** This was hugely disappointing to the many hundreds of individuals and organisations who had contacted him and the review team during their rapid review process. The LGA webinar had been hosted by colleagues in Birmingham, and both the local Director of Public Health for Birmingham and the Chair of the Health and Wellbeing Board, Cllr Hamilton, were clearly engaged in providing insight and proposals as to how to start to address the challenges.

Of course, we do not yet fully understand the **shenanigans** that have gone on but suspect that someone else was asked to edit the report **and effectively take out all the challenging political bits** and resort to a dry re-publication of some of the statistics which we knew about, and which had led to the inquiry itself! This new epidemiological input seemed determined to try and account for as much as possible of the higher mortality by **apparently neutral factors** such as co-morbidities, occupational risk, living in cities and relative deprivation. Such findings had been

submitted by a SAGE report at the end of April, which had not been peer reviewed or published. **This attempt to explain away the disparities seriously misses the point about racism and how it works through cumulative lifetime risks.** Treating Professor Fenton in this way exhibits a form of institutional racism that no doubt the Ministers, and the experts drawn into stripping the report of its insights into how racism works, do not grasp.

Despite taking account of sex, age, deprivation, and region in England people of Bangladeshi ethnicity had twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean, and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. By stripping out other factors an attempt has been made to soften the data impact and bin the feedback from local communities based on their life experience and the specific experience with COVID-19.

Other countries have shown that there is an overrepresentation of black people amongst hospitalised patients. The US Center for Disease Control and Prevention (CDC) report, for example, that: in New York City death rates from COVID-19 among Black/African American people was, 92/100,000 and Hispanic/Latino people 74/100,000. These rates are substantially higher than the 45/100,000 for the White population and 34/100,000 for Asians.

Back in the UK, if you look outside the health sphere you see similar data in the criminal justice system. **The BAME population make up 14% of the population yet 51% of inmates of the youth justice system**. Stop and search records show that black people have 38 searches /1000 population compared to 4/1000 for the White population. They are also more likely to be arrested with 35/1000 for the Black population compared to 10 for the White population. The Black population are five times more likely to be restrained and twice as likely to die in custody. Looking specifically at the Black population rather than BAME groups as a whole they account for 3.3% of the population and 12% of the prison population. Black people make up 1.2% of police officers while 93% are of white ethnicity (Sunday Times, 14th June).

This information has been well known to the black populations of most of our cities since well before the 1981 riots in Brixton, Toxteth, Moss Side, Handsworth and Chapeltown, let alone the Black Lives Matter protests of 2000.

2. Inequalities

The Office of National Statistics (ONS) still manage to produce reports that have **not been politically edited** in the way that Fenton's was, and they have published a review on inequalities and COVID-19. This shows that the most deprived areas of England have more than twice the rate of death from COVID-19 than the least deprived. In the period from the 1st March until the 31st May the death rates were 128/100,000 for the most deprived compared to 58.8/100,000 for the least deprived. This inequality continues to be proportionately high and is mirrored in Wales too where they measure multiple deprivation differently (WIMD) yet still show a contrast between 109/100,000 for the more deprived populations compared to 57.5/100,000 in the least deprived. **Both nations show a gradient across the groups**, which is the important point that Marmot and others have made that inequality is not just something that influences the socially excluded groups but adversely affects the whole society from top to bottom.

The SHA has consistently argued that we need to seriously address the social determinants of health and wellbeing. We also recognise the work that Marmot has done globally with the message that **where we live, learn, work and play affect our health. The conditions in which people live, learn, work, and play contribute to their health.** These conditions over time lead to different levels of health risks, needs and outcomes among people in certain racial and ethnic minority groups.

The Centers for Disease Control and Prevention (CDC) in America use this approach to set out how these determinants might be tackled despite the fact that the Trump administration is deaf and blind to their advice!

The international response to the George Floyd murder on the street in Minneapolis must be built on to turn these daily injustices around. The Black Lives Matter (BLM) campaign needs support.

As Labour's David Lammy MP says:

'**We can't just look back in 5 years and remember George Floyd as a hashtag. We have to find a way to transform this righteous anger into meaningful reform'.**

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 15

Published: 22nd June 2020

ONS England data 22nd June:	
Hospital admissions 318	**Total in hospital 3,417**
Deaths 58	**Cumulative deaths 35,747**

We are now into the 15th weekly blog during the pandemic and confidence in the government is plummeting as the weeks roll on. The UK stands out as the **sick man of Europe** according to the Economist with the highest excess deaths per million population and with the OECD forecasting the UK as having the highest % decrease in GDP for 2020 compared to a year ago

Channel 4 broadcast a speech by Prince Charles on Monday (June 22nd), saying how grateful the Nation was to the Windrush Generation who came to staff the NHS and other public services after WW2. Viewers have been horrified by the programmes on TV showing how badly they had been treated under the Hostile Environment policy of Theresa May, and how disproportionately they are currently suffering from COVID-19.

In this week's blog we will touch on familiar themes such as the slow rebirth of local test and trace/outbreak control plans, the failure of the world beating NHSX app on the Isle of Wight, the scandal of government contracts for PPE purchases and the revelation that there was indeed a Fenton report on BAME deaths that was withheld.

1. BAME

As protests about Black Lives Matter continue across the country and the world, our Ministers are on a learning curve about the historic slavery/civil rights context of '**taking the knee',** and that Marcus Rashford is a famous black Man United footballer and English international. The PM and his Cabinet Ministers continually display how out of touch they are.

Having looked at the Fenton Part 2 report '**Beyond the data: Understanding the impact of COVID-19 on BAME groups**' most people will nod quietly at the eminently sensible recommendations he made which were based on a rapid review of the literature, his group engaging with 4,000 people across the country with direct experience of racism and suggestions about what is to be done.

These **stakeholders expressed deep dismay, anger, loss and fear in their communities** about the emerging findings that BAME groups are being harder hit by COVID-19 than others. This exacerbates existing social, economic and health inequalities.

Professor Fenton's report recommends that there be improved ethnicity data collection, more participatory community research, improved access to services, **culturally competent risk assessments, education, and prevention campaigns.** He calls for pandemic recovery plans that are designed to reduce health inequalities caused by the wider determinants of health to create long term sustainable change. The SHA heartily supports these recommendations and, along with David Lammy MP, demand that the government implements findings from previous BAME related reviews that date as far back as the Stephen Lawrence inquiry in 1999.

We know that inequalities reflect racism and structural factors in society outside health. The **Runneymede Trust looked at Pensioners' Income** for the Financial Years 2017-18 and found that Black pensioner families receive almost **£200 less a week** than White British pensioner families. Black households were the least likely to receive personal pensions. They also found that **Black African and Bangladeshi households have approximately 10p for every £1 of white British savings and assets**. The figures show that for every £1 a white British family has, Black Caribbean households have about 20p and Black African and Bangladeshi households about 10p. **It's not just COVID!**

2. Test and Trace

Remember that **the Government called a halt to the local test and contact tracing** that was happening in early March, claiming that there was too much community transmission for it to have an impact and there were not sufficient local resources to manage the surge? The real reason it has emerged was that there was insufficient test capacity to sustain both NHS hospital testing and testing in care homes and the community. That fateful decision meant that local test and trace schemes were stood down and did not follow the pandemic by analysing local surveillance and build-local systems. A few weeks ago, quite suddenly, the government recognised the role that such local test and trace schemes might have as the pandemic continued and demanded that local Directors of Public Health prepare new Local Outbreak Control Plans by the end of June. Thankfully they appointed a CEO from Leeds Council to advise them and quite properly he has been working with the **Local Government Association** (LGA) and the **Association of Directors of Public Health** (ADPH). At long last local plans are emerging and demands increasing for timely access to test results. Some government investment has been extracted from Deloittes and other consultants and safely invested in local government teams.

As we have touched on before, the government has been **too centralised** in its approach and the national testing sites have been 'outsourced' to firms in the private sector, such as SERCO, with Deloittes hovering, and also creaming off profit while mismanaging things. This means that there is undue delay in getting test results back to local teams and the initial contact tracing is being handled by inexperienced call handlers at a distance from the person involved. Remember that COVID-19 has shown us that it affects **older people, people in care homes, people of BAME heritage and those from the most disadvantaged communities in the UK,** disproportionately badly. I wonder what advice scientists might have given about the most effective way of reaching the most at risk people? Surely by now we know that, despite apps and complicated ventilators, health care is still a people

business. Skilled and empathetic care workers' matter. Meanwhile GPs and primary care are bystanders to this world beating system and local public health teams are frustrated at step one of outbreak control, namely information about who has relevant symptoms and whether they have tested positive.

3. The app!

'**The app the app my kingdom for an app!'** It is alleged that people have heard the scream from the SoS who has a boyish interest and naïve faith in apps and other digital technologies. The 'world beating' app being developed in the exceptionally clever UK and tested on the Isle of Wight has bitten the dust. Stories are now emerging about the errors and misjudgements that there have been on the way. Developers of successful apps, such as that of Prof Tim Spector of Kings College London which now has 3.5m users, tells us that the NHSX treated his research teams as the enemy. They told him that far from collaborating, their world beating **all singing and dancing app** would make his redundant. In case we think this is just Tim Spector we hear that Ian Gass of Agitate tried to tell the NHSX in March that its app design, which tried to use Bluetooth signals, was flawed. He describes this **weird almost paranoid state, where the government says publicly that they're asking for help, but then rejects it when it is offered.**

4. PPE contracts

With the PPE supplies debacle, we also heard the refrain that the government was inviting local UK companies to help produce PPE for the NHS and Social Care**.** Company boss after company boss reported trying and failing to make contact with government commissioners**.** It seems that it is only the insiders who get the contracts. **Some previously small companies like PestFix are under scrutiny having won contracts with a value of £110m**. This amount is nearly a third of the £342m public sector contracts signed for COVID-related PPE.

We are pleased that **Meg Hillier MP**, Chair of the Public Accounts Committee is taking evidence on these contracts. MPs have said rightly that the pandemic crisis should not be an excuse for failing to achieve value for money.

And finally - We started this blog with a reference to a report in the right-wing leaning Economist magazine. It is extraordinary that their leader in the June 20th-26th edition under the banner heading '**Not Britain's finest hour**' should say:

"The *painful conclusion is that Britain has the wrong sort of government for a pandemic – and **in Boris Johnson, the wrong sort of prime minister….beating the coronavirus calls for attention to detail, consistency and implementation…..The pandemic has many lessons for the government, which the inevitable public inquiry will surely clarify.** Here is one for voters: when choosing a person or party to vote for, **do not under-estimate the importance of ordinary, decent competence**.***"

Hear hear!

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 16

Published: 29th June 2020

ONS England data 29th June:	
Hospital admissions 172	**Total in hospital 3,024**
Deaths 34	**Cumulative deaths 36,089**

So here we are in Week 16 of our SHA Blog about how the Johnson government is mishandling and mismanaging – except where it comes to the interests of the profit-making private sector – the COVID-19 pandemic; and why the UK is "world beating" – in terms of the **highest death rate from COVID** in Europe!

1. Test and Trace

The "teething problems" with the **centrally designed, and privately contracted, NHS Test and Trace** scheme, continues. It is a privatised system organised through the likes of Deloitte, which is one of the Big Four accounting organisations in the world, whose business is in financial consultancy. These private firms put the NHS logo in their own "branding" to try to build public trust and confidence, that what they are doing is part of the NHS and in the public's interest. In fact, it is a private system making lots of money for private investors: in the way that suits them best, rather than the most efficient way it could be done.

It has had a huge investment of taxpayers' money to employ 20,000 under-used telephone operators who are poorly trained in the complex field of contact tracing. The Independent SAGE group reports that one contact tracer told them that '**out of 200 tracers at my agency we have only had 4 contacts to call over the past 4 weeks'**. Speaking to worried people and trying to elicit information about their contacts within a system which has not been able to build trust is a genuine challenge. The familiar GP practice or the local hospital and local authority – in which people really do have confidence – have in this "NHS Test and Trace scheme" **had to take a back seat.** Readers will recall from previous blogs that the Independent SAGE group was set up in May to provide scientific advice independent of political pressure, after it was reported that Johnson's "special advisor" Dominic Cummings had attended, and was believed to have influenced, the Government's "official" Scientific Advisory Group on Emergencies.

Early problems have been identified in the initial design of diagnostic testing. **No NHS number for instance, no occupation or place of work recorded, no ethnicity data and test results not being shared with the GP**. The Lighthouse

labs set up in Milton Keynes, Alderley Park Cheshire, Cambridge, and Glasgow are collaborations between pharmaceutical industries (GlaxoSmithKline (GSK) and AstraZeneca), Universities in Cambridge and Glasgow, Boots, Amazon and the Royal Mail alongside the Wellcome Trust. AstraZeneca owns Alderley Park.

They were set up to meet the escalating government targets to get testing up to 100K (Hancock) and then to 200K (Johnson) without Ministers being clear about the strategy for testing and ensuring that results got back quickly to people and local players such as GPs and the local Public Health teams who could act. If the objective was just to get tests sent out in the mail or undertaken by Army 'squaddies' in car parks across the country, to get the numbers up for the Downing Street briefings, then there was no need to worry about useful information about workplace/occupation? It is not the consortium of laboratories' fault, as they are contributing to a national emergency, **but the political leadership, which has not taken enough notice of public health professionals** who have provided laboratory services and integrated themselves with NHS and local public health teams over decades. Public Health England are faced with the nightmare of quality assuring data sent to them from these private laboratories.

2. Workplaces

One reason to worry is that **incomplete information can lead to a delay in identifying a workplace outbreak**. Returning the test result information started at Local Authority level which is not enough information on which to act. After some pressure the local teams have started to get postcode data. However, noting a rise in individual cases scattered across West Yorkshire did not help public health officials pin down the common link: which was that they all worked at the **Kober Meat Factory in Cleckheaton**! These public health systems need to be designed by people who know about public health surveillance, outbreak management and contact tracing. It works best if the tests are undertaken locally, results go back to GPs and local Public Health teams with sufficient information to associate cases with industries, schools, places of worship, community events or food/drink outlets. **This is the level of data that would help the public health team in Leicester** who are under scrutiny with 'knowledgeable' politicians such as Home Secretary Priti Patel declaring the need for a local lockdown in the city. Speed is of the essence, too, as we know that COVID-19 is being transmitted when people do not have symptoms and is most contagious in the first few days of the illness.

We have known from international data that **meat-processing plants** are high risk environments for transmission. This is clearly something to do with the damp, cool working environment, which is noisy and so workers have to shout to each other and are often in close proximity. Toilet facilities and rest areas are likely to be cramped and how often they are being cleaned an issue. Furthermore – as we have learnt from Hospital and Care Home outbreaks – how staff get to work will be important to know, too: for example, if they are bussed in together or car sharing, both of those involve being with other people in enclosed spaces.

As in abattoirs here in the UK and in other parts of the world, jobs like this are usually undertaken by migrant workers. These workers usually live in cramped dormitory type multi-occupation residences. Low paid often migrant workers, who are poorly unionised, are particularly vulnerable to the COVID-19 contagion whether they work in US meat packing factories or in Germany or indeed in Anglesey (Wales).

The 2 Sisters plant in Llangefni for instance has had over 200 workers with positive test results.

The Tonnies meat processing factory in Germany has had more than 1500 of its workers infected and 7000 people have had to be quarantined because of the outbreak. This has had a ripple out effect with schools and kindergartens, which had only recently reopened, having to close again. Unsurprisingly there are stories of the factory being reluctant to share details of the staff, many of whom are Romanian or Bulgarian and speak little German.

3. Contact tracing

The importance of testing and rapid reporting of cases to local agencies was highlighted in a recent South Korean example, where a previously well -controlled situation was threatened by the finding that a series of nightclubs had been linked through one very energetic person. Tracers had to follow up 1700 contacts and be able to control the on-going chain of transmission! While South Korea, unlike the UK, has had a mobile phone app to assist contact tracing, they still depend on the local tracers to use **shoe leather** rather than **computer software** to really understand the local patch and the complex community relationships.

The Independent SAGE group is producing useful analyses and information for us all and has been promulgating the WHO Five elements to test and trace, namely:

FTTIS – Find**, T**est**, T**race**, I**solate and **S**upport.

All of these are important and the recent example in Beijing shows again how a rapid local lockdown response was used to implement **FTTIS** and they appear to have managed to contain the outbreak to one part of this megacity of over 20m people.

4. Social distancing

The Independent SAGE has also recently taken a line critical of the government position on social distancing. They say that the **risk of transmission in the UK remains too high to reduce the social distancing guidance**. They oppose the move from a 2m guidance to 1m plus and say that it risks multiple local outbreaks, or in the worst case a second wave. The pattern of continuing waves of infection has been seen in the USA, where social distancing has been poorly enforced, and in other countries where a significant second wave has occurred such as Iran.

The Government is rightly worried about the economic impact of the lockdown and pandemic, but they are sending out mixed messages on social distancing which has led to chaotic scenes on Bournemouth beach, urban celebrations in Liverpool and street parties in many cities. In the USA it has identified the 20-44 year olds as being a group who are testing positive more frequently and we need to send the message out loud and clear that although they may not die from COVID-19 at the rate older people and those with underlying conditions, they are at risk of long term damage to their health and will transmit the virus to other more at-risk people in their families or local communities.

The Prime Minister always wants to be communicating good news and needs to beware that the call for more ‘**bustle**’ on the high streets and **ramping up/turbo charging the economy** carries big risks of new local outbreaks that will ensure that

the Sombrero curve of infection is not flattened, but that we are condemned to live with on-going flare ups across the country.

Ex Chancellor Kenneth Clarke tweeted recently, in the light of the situation in the UK and the flip-flopping on air travel restrictions, that:

‘**The UK government’s public health policy now seems to be ‘go abroad on holiday, you’ll be safer there!’**

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 17

Published: 6th July 2020

ONS England data 6th July:	
Hospital admissions 150	**Total in hospital 2,099**
Deaths 35	**Cumulative deaths 36,311**

In this week's Blog we will have a look at the lessons learnt so far with the first City lockdown in Leicester and see what this tells us about the UK Government's handling of the COVID-19 pandemic, raise issues again about their competence, outline why the social determinants of heath matter and assess the risks involved in privatisation of the NHS testing centres and public health functions.

1. Local lockdown

Leicester has been directed by central government (Hancock in the House of Commons on the 30th June) to remain in lockdown this weekend when other parts of England were being urged by the Prime Minister to **be brave, to bustle** in the High Streets to help **ramp up an economy** which is waiting **to be turbo charged**. The government announced in Westminster on June 18th that there was a local outbreak causing concern in Leicester. This news broadcast in the media saw the local Mayor of Leicester and their local Director of Public Health (DPH) in a bemused state. They had been left in the dark because the central government and their privatised drive through/hometesting service led by Deloittes/SERCO had not shared the so-called Pillar 2 data with them. They did not receive Pillar 2 test data for the next 10 days!

2. Outbreak plans

Local Directors of Public Health (DsPH) across England had been required by central government a month earlier to produce Local Outbreak Control Plans by the 30th June. According to the PM they were meant to be in the lead to '**Whack the Moles'** in his typically colourful and inappropriate language. Whacking moles apparently means manage local outbreaks of COVID-19. Anybody who has tried to **Whack a Mole** on their lawn or at a seaside arcade will know that this is almost impossible and usually the mole hole appears again nearby the following day.

Local DsPH have been receiving from Public Health England (PHE) regular daily data about local NHS hospital laboratory testing from the Pillar 1 sources. In Leicester this was no cause for concern as there had been a decline since the peak

in positive cases in April. **That explains why the Mayor and DPH were bemused**. Each week there are now summary bundles of data incorporating both sources sent by PHE but not in a way that local teams can analyse for information of interest such as workplace/occupation/household information. Belatedly, postcode data is now shared which had been hidden before! One of the first requirements in outbreak management is to collect information about possible and confirmed cases with an infection in time, place and person. This information needs to include demographic information such as age and gender, address, GP practice and other data pertinent to the outbreak such as place of work/occupation and travel history. Lack of workplace data has made identifying meat packing plants in outbreaks such as near Kirklees more difficult and another example where the local DPH and the Local Authority were wrong footed by the Minister.

3. Public Health England review

On the 29th June PHE published a review '**COVID-19: exceedances in Leicester'**. This excellent review showed that the cumulative number of tests in Leicester from Pillar 1 was 1028 tests whereas the number of Pillar 2 was 2188 which is twice as many! The rate per 10,000 people in the Pillar 1 samples was a relatively low rate of 29 while Pillar 2 showed a rate of 62/10,000. The combined positive rate of 90/10,000 is more than twice the rate in the East Midlands and England as a whole. **It was on the basis of this Pillar 2 data that the government became alarmed.**

It is just incredible that the government have contracted Deloittes/SERCO to undertake something that they had no prior experience in and to allow a situation to develop when the test results from home testing and drive through centres was not being shared with those charged with controlling local outbreaks.

The **political incompetence** was manifest to an extraordinary level when Nadine Dorries, Minister for Mental Health, confirmed to a Parliamentary enquiry that "**the contract with Deloittes does not require the company to report positive cases to Public Health England and Local Authorities**'.

It seems as if the point of counting numbers of tests undertaken each day was to simply verify that home tests had been posted and swabs had been taken in the drive-through sites so that Matt Hancock could boast at the Downing Street briefings that the number of tests was increasing. But we are trying to control COVID-19 and Save Lives. Sharing test results with those charged with controlling local outbreaks must be a fundamental requirement.

4. Deprivation and health

In earlier BLOGs we have highlighted that COVID-19 has disproportionately affected those who live in more deprived areas and additionally has impacted even more on BAME people. Studies have shown that relative poverty, poor and cramped housing, multigenerational households, and homes with multi-occupants are all at higher risk of getting the infection and being severely ill. Other factors have been occupation, people on zero hours contracts, low pay and in jobs where you are unable to work from home and indeed need to travel to work on public transport. Many of these essential but low paid jobs are public- or client-facing which confers a higher risk of acquiring the infection.

All these factors seem to be in play in Leicester. The wards with the highest number of cases have a high % of BAME residents (70% in some wards). One local cultural group are Gujeratis with English as a second language. Another factor that is emerging is the small-scale garment producing factories. It is estimated that up to **80% of the city's garment output goes to internet suppliers such as Boohoo.**

5. The garment industry

Two years ago, a Financial Times reporter, Sarah O'Connor, investigated Leicester's clothing industry. She described a bizarre micro-economy where £4-£4.50 an hour was the going rate for sewing machinists and £3 an hour for packers. These tiny sweatshops are crammed into crumbling old buildings and undercut the legally compliant factories using more expensive machines and paying fairer wages. As she points out (Financial Times 5th July) this Victorian sector is embedded into the 21st century economy and the workforce is largely un-unionised. The big buyers are the online 'fast fashion' retailers, which have thrived thanks to the speed and adaptability of their UK suppliers. Boohoo sources 40% of its clothing in the UK and has prospered during lockdown by switching to leisurewear for the housebound while rivals have shipments left in containers.

Mahmud Kamani with Kane founded Boohoo in 2006 and it has made him a billionaire. It is said that other competitors such as Missguided and Asos have been put off by concerns about some of Leicester's factories – including claims over conditions of modern slavery, illegally low wages, VAT fraud and inadequate safety measures. A researcher went into the garment factories earlier this year and is quoted as saying

'**I've been inside garment factories in Bangladesh, China and Sri Lanka and I can honestly say that what I saw in the middle of the UK was worse than anything I've witnessed overseas'**.

Occupational risks, overcrowded housing and poverty have been shown to be risks to contract the virus and become severely ill with it. BAME communities have additional risks over and above these as we have discussed before in relation to the Fenton Disparities report, which was blocked by Ministers who were not keen on the findings of racism in our society and institutions.

6. Health and Safety

In Leicester the **Health and Safety Executive** has contacted 17 textile businesses, is actively investigating three and taking legal enforcement action against one. In business terms the UK's low paid sector are an estimated 30% less productive on average than the same sectors in Europe. **As unemployment rises in the months ahead it will be vital to focus on jobs as the Labour leadership have stated**. However, quality should be paramount, and the government apparently wants 'to close the yawning gap between the best and the rest'.

The Prime Minister has recently promised '**a government that is powerful and determined and that puts its arms around people**'. These arms did not do much for care homes during the first wave of COVID-19 and looking to the future of jobs and economic development the fate of Leicester's clothing workers will be another test of whether he and his government meant it.

7. **Incompetent government**.

The pandemic has exposed the UK but particularly people in England to staggering levels of government incompetence. There are other countries too that have this burden and Trump in the USA and Bolsonaro in Brazil spring to mind. They seem confident that the virus won't hit their citizens and it certainly won't hit **the chosen ones**.

Psychologists say that people like this appear confident because as leaders they know nothing about the complexity of governing. They refer to this as the Dunning-Kruger effect:

'**Incompetent people don't realise their incompetence'**.

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 18

Published: 13th July 2020

ONS England data 13th July:	
Hospital admissions 137	**Total in hospital 1,612**
Deaths 24	**Cumulative deaths 36,475**

In this week's blog we urge the government to stop dithering and clarify the guidance on face masks; to get on with sharing all test results with local Directors of Public Health; and to stop shifting the blame for our **world-beating COVID death rate** onto Public Health England (PHE) and the NHS.

1. Facemasks

The important point to note with facemasks, which gets lost in translation, is that **face coverings help prevent the wearer from transmitting the virus to others**. Remember in the COVID-19 pandemic we have learnt that people without symptoms can pass on the virus to others – by coughing, sneezing, shouting, singing or even talking loudly. As the prestigious Royal Society report puts it: "**My facemask protects you, your facemask protects me"**

The value of the public's wearing facemasks has been slow to gain scientific support from the World Health Organisation (WHO) as well as within wealthy Western Countries such as the UK and USA. The WHO have, however, changed their tune now and recommend the use of non-medical masks for the public when out and about and where maintaining social distance is difficult. The advice is clear that **medical masks are for health care workers as they reduce the risk of the health care worker getting the virus from their patients**. It also prevents a healthcare worker who has the virus but doesn't have symptoms from transmitting the virus.

For the public there are two groups of people who should wear medical quality masks according to the WHO – **people over the age of 60yrs and those with underlying conditions such as diabetes**. The point here is that high quality fluid resistant facemasks help protect the wearer from the virus when treating patients and similarly protects older people at risk and those younger people at higher risk due to underlying conditions. This becomes even more important as vulnerable people and those in the shielded groups emerge from their lockdown.

The rest of the population are advised to wear **non-medical face coverings** that can be homemade and made of cloth. There are plenty of websites (including UK government ones) showing how to make them from old socks, tee shirts, tea towels,

coffee strainers and the like. The benefit of this advice is that while there is a worldwide shortage of medical grade masks the **use of cloth face coverings does not risk depleting supplies for health care staff.**

Remember**: My facemask protects you: Your facemask protects me!**

Mutual benefit is something that socialists have little difficulty understanding and accepting but it does require a high uptake, which is where political leadership comes in. We saw the UK Prime Minister wearing a blue Tory facemask on the 10th July alongside a hint that he is considering making it a requirement to wear them in shops. This has of course already been introduced in Scotland, which is having a comparatively successful campaign to stop the spread of COVID-19 and going for elimination of the virus like New Zealand. Sunday's BBC News reported that the US President had finally agreed to wear a face mask because someone told him he looked like the Lone Ranger!

In the middle of June, it was made a requirement in England to wear a face covering, if travelling on public transport such as buses and trains, where maintaining a 2m distance was impossible. So, the government typically is inching its way towards making a decision – **a slow adopter,** in the terminology of the Economics of Innovation.

The UK is starting from a low base with estimates of 25% of the public wearing masks in public places but so too were other countries in Europe like Italy and Spain who now report adherence of up to 80% which is moving them towards the levels achieved in countries which have been successful in containing COVID-19 in East Asia. What it needs is **political leadership: for example, politicians like the Chancellor should be wearing a face covering when serving food in Wagamama.**

We know that failed leaders like Trump find it counter to his macho self-image to wear a sissy mask but meanwhile thousands of his citizens are going down with the virus. Our PM, who shares many of the Trump traits, has also been slow to show leadership, and **he missed the opportunity when they changed the social distancing recommendation from 2m to 1m+.** That was the opportunity to require that people going into shops and other enclosed public spaces must wear a face covering.

As far as the underlying science is concerned there have been research groups in Oxford who have reviewed the literature and state that '**the evidence is clear that people should wear masks to reduce viral transmission and protect themselves'**. On the light blue side of the debate a Cambridge group of disease-modellers have stated that population-wide use of facemasks helps reduce the R rate (the number of people that one infected person can pass the virus on to) to less than 1 and prevents further waves when combined with lockdown. This benefit remained even when wearers ignored best advice, contaminating themselves by touching their faces and adjusting their masks! In answer to critics these researchers have pointed out that **there have been no clinical trials of the advice to cough into your elbow, to social distance or to quarantine**.

It comes down to political leadership and we note that Nicola Sturgeon has made the move, successful countries in Europe have too, and London Mayor Sadiq Khan has

called on the Government to get on with it. Surely, we have learnt enough about COVID-19 being spread before symptoms arise – by the so call **silent spreaders**?

2. Sharing Test Results

In previous Blogs we have talked about the hugely expensive and unsatisfactory '**NHS" test and trace initiative**. Imagine a Director of Public Health (DPH) within a local patch who has colleagues in Public Health and the local NHS/PH laboratories. Under normal circumstances they have a strong professional relationship and get test results emailed back very fast from the Laboratory with information that is useful for contact tracing – name and address, GP, date of birth and the history leading up to the test being taken. They can act quickly and ensure good liaison with Public Health experts and the local NHS. Logically the government should in England, like they have in Wales, have invested in a greater capacity of local testing. **The so-called Pillar 1 tests have been this sort, and results have been supplied to local Directors of Public Health (DsPH) in a timely way**.

Enter stage left Matt Hancock and his buddies. Establish something completely new – the so-called **NHS Test and Trace initiative**– at a great cost and run by an accountancy firm Deloitte and a private contract company SERCO neither with any prior experience. They establish some Lighthouse Laboratories with Big Pharma, who may be geographically close to the local NHS labs but are contracted privately as a parallel service. They establish contracts with Amazon/Royal Mail/the British Army and others to take the swabs and transport them. Result – a mess where huge numbers of tests are lost, the results delayed and poor-quality information is belatedly supplied to bemused DsPH. That is what we have seen in Kirklees, Leicester and now some other districts which have not had the benefit of the so-called Pillar 2 tests done by Test and Trace.

The latest data published by the government shows that there are more than a million tests that were 'sent out' but not completed. This all helped Matt Hancock show at the Downing Street press conferences that he had the testing capacity and had posted the swabs out! No wonder that the UK Statistical Authority have been concerned about how the information on testing has been presented!

One of the excuses offered by the government has been about personal data being shared with DsPH. They forget that this is a **PUBLIC HEALTH EMERGENCY,** that COVID-19 is a **notifiable disease** and there is a statutory duty to report on cases. Again, we see dither and delay……

June 24th PHE starts to share postcode, age and ethnicity with DsPH.

July 3rd NHS Digital releases Pillar 1 and 2 results.

July 6th Positive test results reported at below Local Authority level

July 15th Postcode level dashboard to be supplied including contact tracing at LA level.

July 16th Test results at smaller population areas (down to a 6000 households level)

The message here is that the data from NHS Test and Trace is **being very slowly shared** with local DsPH and their teams who have been charged with managing local outbreaks like the one in Leicester. **The key issue is – why did the**

Government encourage the design of the system from the top down rather than bottom up?

3. Don't blame PHE and the NHS.

The PM and Matt Hancock have become a bit nervous about the '**blame game'** as the demand for an urgent and time limited inquiry increases. Their performance has been poor compared to others within the UK like Scotland and across the Irish Sea and the English Channel. So, who can they point the finger at?

The Daily Telegraph is of course the PM's previous employer and vehicle for his thoughts. It was in this newspaper on the 30th June that we first heard about Public Health England shouldering the blame. The newspaper headline was '**Heat on PHE as the Prime Minister admits Coronavirus response was sluggish**'.

The performance of PHE has not been faultless, but we know why they were not able to scale up their testing capability when they had the opportunity. During the pandemic they have provided expert public health guidance to the system and supported local Health Protection teams, but those teams have been "slimmed down" to anorexic levels during the austerity years, along with Local Authority departments.

Public Health England was created in 2013 when it replaced the Health Protection Agency. **It is an executive agency accountable to Ministers** and the Department of Health and Social Care. It has many specialist research laboratories vital to national security – as used when Novichok was used in the attempted assassination of Sergei and Yulia Skripal in Salisbury in 2018. Remember the local DPH leading the local response, and then being supported by Porton Down and Public Health England?

Public Health England employs 5500 staff with a budget of £287m per annum.

The infectious diseases element of PHE has a budget of £90m per annum so it surprised everyone to learn that the Government has set aside **£10 billion** for spending on the NHS Test and Trace system. This money will be going to private firms such as SECO and G4S and dwarfs the entire PHE budget 110-fold **because it is paying not just the cost – as it would if it were being done in the public sector – but the cost plus the high profits they demand!**

Remember too that on July10th G4S settled its Serious Fraud Office (SFO) case in which it was accused of overcharging the Ministry of Justice for electronic tagging of offenders. The Serious Fraud Office said that **G4S had accepted responsibility for three counts of fraud** that were carried out in an effort to 'dishonestly mislead' the government, in order to boost its profits.

As the Guardian reports on the G4S case: **"The £44.4m in fines and costs takes the total paid out by outsourcing firms involved in the prisoner tagging scandal to more than £250m. SERCO reached its own £22.9m agreement with the SFO last year, six years after repaying £68m to the Ministry of Justice**".

So, what is our government doing? It is pointing the finger of blame at Public Health England, which is an executive agency accountable to Ministers, and handing out generous contracts to G4S and SERCO who only recently have been found guilty of fraud.

The one success in the pandemic has been the way that the NHS coped with the surge of cases – yes: hard to believe, but the PM is also pointing his finger at the NHS, too, and is threatening another round of Tory disorganisation.

Clap Clap!

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 19

Published: 20th July 2020

ONS England data 20th July:	
Hospital admissions 86	**Total in hospital 1,278**
Deaths 12	**Cumulative deaths 36,586**

In this week's blog we will look again at the emerging **Blame Game** which is attempting to divert attention away from the PM and Health Secretary, raise again the unbelievable issue of the national **Test and Trace scheme** not sharing information on test results with local Directors of Public Health, salute the letter to the **National Audit Office** about PPE procurement and applaud the **Vaccine Research** group at Imperial College for creating a Social Enterprise company committed to sharing the vaccine globally.

1. Blame Game

The Prime Minister's innate self-interest is exercising his mind at present and with the support of his political adviser Dominic Cummings is casting around to identify who he can blame for the very poor outcome of the pandemic in the UK, particularly in England. Commentators have pointed out that if a man/woman from Mars dropped in they would struggle to work out whether Cummings or Johnson was the Prime Minister (PM). Dom will do whatever it takes to insulate the PM from criticism says a senior civil servant.

2. Local Authorities and their Public Health teams

Once the PM and Secretary of State, Hancock realised that the COVID-19 first wave 'sombrero' had not been flattened, we have not eliminated the virus and the population are likely to continue to suffer from local upsurges of COVID-19 cases. They want to shift the blame onto others. The Local Authority based public health teams had been left out of the loop from the start of the pandemic and their role has been as a local megaphone for central guidance or to help out regional Public Health England with local outbreaks.

The Department of Health started to get involved in Local Outbreaks and twiddled their thumbs when they noticed increasing positive test results in Leicester. Rather than share the data and engage local leaders they wondered what actions they could take from their Whitehall village and became alarmed and made an emergency announcement in the evening to Parliament declaring a local lockdown. At the same time, they passed the buck to the surprise of the local Director of Public Health (DPH) and Local Authority leaders.

With more test result data ‘passed down’ to the local team things have started to settle and local tracing and community engagement has blossomed. The local DPH and Mayor of Leicester have stood up and accepted the challenge and are dealing with it with the support of Public Health England and local communities.

3. Local data

The whole pandemic response has been top-down and now that has been shown to be ineffective and expensive, they are shifting the responsibility onto local teams, who welcome the recognition that they should always have been the place for an effective population response. However there remain issues to do with sharing fully and quickly all the necessary information for local teams to plan their prevention campaigns specific to the at-risk populations. The **national test and trace scheme has been shown to be very expensive and has poor outcomes in terms of speed of test results and their contact tracing efforts.** Despite that there seems to be reluctance still in proper sharing of test result details on the basis of information security, which the government in England have failed to comply with.

Public Health specialists have worked with person identifiable data for decades and the system is compliant with data security. Just get on with it and don’t put the spotlight onto Leicester, Kirklees, Blackburn, and Pendle without sharing the data that is available from the testing sites.

It is estimated that in June a quarter of the 31,000 people who had their case transferred to the Test and Trace scheme were not reached. Almost a third of those who were did not provide any contacts. Compare this to **the success rate of local so-called Pillar 1 NHS hospital testing system where nearly 100% contacts are traced**. It is time that the Test and Trace budget be devolved and that local DsPH manage the testing arrangements they require and ensure that the most useful information is obtained when samples are taken and ensure that the local public health department gets the results as well as the GPs who need to be drawn into the campaign. In Wales and other devolved nations much better systems are in place.

Remember the hype about the Isle of Wight phone app? Lord Bethell, the Health Minister responsible for the Google and Apple technology, is now quoted as saying: “**We are seeking to get something going for the winter, but it isn’t a priority for us at the moment**”.

If this wasn’t enough the government have had to recall thousands of **Randox test kits as a health and safety risk**. These were contracted by the Baroness Harding Deloitte’s Test and Trace outfit and used in Care Homes and for home testing. Another embarrassment to add to all the rest!

Why didn’t they invest in local NHS laboratories linked to local GPs and Public Health teams, who would have got the results back quickly with the information required for effective locally based contact tracing? **Centralisation and Privatisation have not worked and have cost the taxpayer billions**.

4. Workers and Employers

The Chancellor has been enjoying himself when announcing hand-outs of government resources (in Tory language tax-payers money). Public sector borrowing stands at its highest peacetime level in 300 years. **Four million people could be**

unemployed by next year which according to the Office of Budget Responsibility will be the worst jobs crisis in a generation. The furlough scheme, which is helping pay wages for 9.4m people will end in October. The annual deficit is set to rise to £350bn and economic contraction of 25% in the last 2 months. So, it is not surprising that the PM wants to get the economy going again. However, his call to open up the offices again and get people spending money in town centre shops by 1st August carries with it huge risk to public health and a burden on employers to make the workplace COVID secure.

John Phillips of the GMB union has stated: "The PM has once again shown a failure of leadership in the face of this pandemic. **Passing the responsibility of keeping people safe to employers and local authorities is confusing and dangerous**." Frances O'Grady of the TUC said that: "The return to work needs to be handled in a phased and safe way. **The government is passing the buck on this big decision to employers**. Getting back to work safely requires a functioning test and trace system and the government is refusing to support workers who must self-isolate by raising statutory sick pay from £95 per week to a rate people can live on."

5. Civil servants

The third group of people who have a finger pointing at them are civil servants. The sacking of Mark Sedwill, head of the civil service, is one '***top of the tree'*** example. His generous departure settlement is the same amount as he would have been entitled to if he had been made compulsorily redundant. **In his letter to Mr Sedwill the PM stated that Sedwill was 'instrumental in drawing up the country's plan to deal with coronavirus'**.

The PM has reluctantly agreed to have **an inquiry into the handling of the pandemic but has lobbed the date into the long grass**. He said that: "There are plenty of things that people will say that we got wrong, and we owe that discussion and that honesty to the tens of thousands who have died before their time". **We all know that when the blame is distributed it will be civil servants, scientists, public health officials, and some Ministers who will be scapegoated** for the outcome that has seen more than 45,000 deaths and left the British economy facing the biggest recession of any European nation. In addition, the recent Academy of Medical Sciences report estimates that the risk of a second wave mid-winter is of the order of 120,000 excess deaths.

6. National Audit Office

In earlier Blogs we have drawn attention to the potentially fraudulent way that millions of pound contracts have been awarded, sometimes to shell companies or companies that have no history of having undertaken such roles such as PPE suppliers. We are delighted that Rachel Reeves MP and Justin Madders MP of the Labour Shadow team have written to the National Audit Office (NAO) requesting investigation into waste and fraud with especial focus on the PPE procurement, which amounts to £1.5bn. The letter draws attention to many concerns such as awarding the contract to Deloitte without competition. In emergencies governments are entitled to use something called a '**single bidder emergency procurement process'** to avoid delays that arise with competitive tendering.

It won't surprise SHA members to learn that this, EU based measure, has been used by the UK government more than 60 times during the pandemic compared to twice in Spain, 11 times by Italy and 17 times by Germany. The sloppy allocation of contracts to best buddies in the commercial world and Tory Party supporters must be called out and let's hope that the NAO accepts the request and does a speedy audit on some of these contracts.

7. Vaccines and global health

We have already, in previous blogs, pointed out how Trump's 'Make America Great Again' and 'America First' is illustrated in examples such as Remdesivir. This antiviral drug, which shortens hospital stays in patients with COVID, was basically bought up by the USA. It was reported at the end of June that the US had **bought up virtually all stocks for the next three months leaving none for the UK, Europe or most of the rest of the world**. The Trump administration has shown that it is prepared to outbid and outmanoeuvre all other countries to secure the medical supplies it needs. This has implications for the vaccines being actively developed across the world.

Geopolitics is already at work with reports of Russian cyber-crime attacks on the UK based vaccine researchers in Oxford. It was therefore great news to hear that the Imperial College based researchers with Philanthropic and UK government funding have formed a social enterprise. **This not-for-profit arrangement aims to ensure fair distribution by waiving royalties for low-income countries so that the poorest get it for free and the richest pay a bit more**. Human trials of their vaccine start in October and Imperial are looking for volunteers.

This group are a reminder that it doesn't need to be profiteering and greed and stands alongside others who have come through the pandemic with gold stars such as **Tim Spector's C-19 symptoms app group** in Kings College London who are using an app that actually works!

8. Gramsci

Finally, Michael Gove caused a stir when he recently quoted from Antonio Gramsci, the Italian Marxist intellectual:

"**The crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of morbid symptoms appear".**

This quote is from Prison Notebooks, written by Gramsci during his imprisonment in the time of Mussolini. You could look at this quotation in a completely different perspective to those like Michael Gove and Mr Cummings.

SOCIALIST HEALTH ASSOCIATION (SHA) COVID-19

BLOG 20

Published: 27th July 2020

ONS England data 27th July:		
Hospital admissions	**82**	**Total admissions 945**
		Cumulative admissions 111,861
Deaths	**12**	**Cumulative deaths 36,686**

This is our twentieth weekly blog the series where we have commented on the course of the pandemic and the political context and implications from its impact on our country. The SHA has submitted our series of blogs to the **All-Party Parliamentary Group (APPG),** Chaired by Layla Moran MP (LD, Oxford West and Abingdon), who are taking evidence to learn lessons from our handling of COVID-19 in time for the high-risk winter 'flu season'. The Labour MP Clive Lewis is on the group.

This is an edited version of the seven main points we have submitted:

1. ***Austerity (2010-2020)***

This pandemic arrived when the public sector – NHS, Social Care, Local Government and the Public Health system had been weakened by disinvestment over 10 years. This was manifest by cuts to the Public Health England budgets, to the Local Authority public health grants and lack of capital and revenue into the NHS. In workforce terms there was staff shortages in Health and Social Care staffing exceeding 100,000.

2. ***Emergency Planning but no investment in stocks***

The publication of the 2016 Operation Cygnus exercise has exposed the lack of follow-on investment by the Conservative government which led to problems of PPE supplies, essential equipment such as ventilators and in NHS ITU capacity. The 2016 exercise was a large-scale event with over 900 participants and occurred during Jeremy Hunt's tenure as Secretary of State. There needed to be better preparation too on issues such as border controls as we note 190,000 people from China travelled through Heathrow between January-March 2020.

Pandemics have been at the top of the UK risk register for years and the question is why preparations were not undertaken and stockpiles shown to be insufficient and sometimes time expired.

3. ***Poor political leadership (PM and SoS Health)***

During the pandemic there has been a lack of clarity on what the overall strategy is and inconsistency in decision-making. The New Zealand government for example went for elimination, locked down early, controlled their borders and took the public with them successfully. We have had an over centralised approach from the Prime Minister and SoS for Health such as the NHS Test and Trace scheme and creating the Joint Biosecurity Unit. Contact tracing and engaging the Local Directors of Public Health was stopped on the 12th March and only in the past few weeks have their vital role been acknowledged. Ministers have been overpromising such as the digital apps, the antibody tests, the vaccine trials and novel drug treatments. Each time the phrases such as 'World Beating' and 'Game Changers' have been used prematurely. The Ministerial promises on numbers of tests has been shown to have become a target without an accompanying strategy and the statistics open to question from the UKSA.

4. ***Social care***

From the early scientific reports from Wuhan (China) it was clear that COVID-19 was particularly dangerous to older people who have a high mortality rate. A public health perspective would raise this risk factor and plan to protect institutions where older people live. Because of the distressing TV footage from Lombardy (Italy) the government's main aim was to ***Protect the NHS****. This was laudable and indeed the NHS stood up and had no call on the Nightingale Hospitals, which had a huge investment. The negative side of this mantra was that social care was ignored. As we have seen 40% of care homes have had outbreaks and about a third of COVID related mortality is from this sector. There have been serious ethical questions about policies in Care Homes as well as discharge procedures from the NHS that need teasing out. The private social care sector with 5,500 providers and 11,300 homes is in bad need of reform. Some of the financial transactions of the bigger groups such as HC-One need investigation, especially the use of offshore investors who charge high interest on their loans. The SHA believes that the time is right to 'rescue social care' taking steps such as employing staff and moving towards a National Care Service.*

5. ***Inequalities***

It was said at the beginning of the pandemic in the UK that the virus did not respect social class as it affected Prince and Pauper. Prince Charles certainly got infected as did the Prime Minister. However, we have seen that COVID-19 has exploited the inequalities in our society by differentially killing people who live in our more deprived communities as shown by ONS data. In addition to deprivation, we have seen the additional risk in people of BAME background. The combination of deprivation and BAME populations put local authorities such as Newham, Hackney and Brent in London at high risk and been affected badly. The ONS have also shown that BAME has an additional risk to the extent of being double for people of BAME heritage even taking statistical account for deprivation scores. Occupational risk has also been highlighted in the context of BAME status with the NHS having 40% of doctors of BAME heritage who accounted for 90% of NHS medical deaths. The equivalent proportions are 20% NHS nurses and BAME accounting for 75% deaths. The

government tried to bury the Fenton Disparities report and we believe that this is further evidence of institutional racism.

6. ***Privatisation***

The SHA is strongly committed to a publicly funded and provided NHS and are concerned about the Privatisation that we have witnessed over the last 10 years. We are concerned about the risks in the arrangement with Private Hospitals, the development of the Lighthouse Laboratories running parallel to NHS ones and the use of digital providers. In addition, we feel that there needs to be a review of how contracts were given to private providers in the areas of Testing & Tracing, PPE supplies, vaccine development and the digital applications. There are concerns about fraud and we note that some companies in the recent past have been convicted of fraud, following investigations by the Serious Fraud Office yet still received large contracts during the pandemic.

7. ***Recovery Planning***

During the pandemic many of us have noticed the benefit of reduced traffic in terms of reduced noise and air pollution. Different work patterns such as working from home has also had some benefits. The risk of overcrowded and poor housing has been manifest as well as how migrant workers are treated and housed. Green spaces and more active travel have been welcomed and the need for universal access to fast broadband noting the digital divide between social class families. With the government having run up a £300bn deficit and who continue to mismanage the pandemic we worry about future jobs and economic prosperity. There is an opportunity to build a different society and having a green deal as part of that. The outcome of the APPG review should on the one hand be critical of the political leadership we have endured but also point to a new way forward that has elements of building a fairer society, creating a National Care Service, funding the NHS and Public Health system in the context of the global climate emergency and the opportunities for a green deal.

Let's hope that the APPG can do a rapid review so we can learn lessons and not have to wait for years. **The Grenfell Tower Inquiry remember was launched by Theresa May in June 2017**, and we still await its key findings and justice for those whose lives were destroyed by the fire. The Prime Minister has been pointing the fingers of blame on others for our poor performance with COVID-19 but has accepted that mistakes were made and that an inquiry will be held in the future.

However often these are mechanisms to kick an issue into the long grass (Bloody Sunday Inquiry) and even when completed can be delayed or not published in full such as the inquiry into Russian interference in our democratic processes. So, let's support the APPG inquiry and the Independent SAGE group who provide balance to the discredited way that scientific advice has been presented. As one commentator has pointed out there are similarities to the John Gummer MP moment when in 1990, he fed his 4yr old daughter a burger on camera during the BSE crisis. **The public inquiry into the BSE scandal called for greater transparency in the production and use of scientific advice.** During this crisis we have seen policy

confusion whether on herd immunity, timing of lockdown, test and trace, border and travel controls and the use of facemasks.

8. NHS and NIHR

For the SHA we have been pleased with how the **NHS has stood up to the challenge** and not fallen over despite the huge strain that has been put under. Despite the expenditure on the Nightingale Hospitals and generous contracts with Private Hospitals these have not made a significant difference. These arrangements certainly helped to provide security in case the NHS intensive care facilities became overwhelmed and allowed some elective diagnostics and cancer care to be undertaken in cold hospital sites. However, the lesson from this is the **superiority of a national health system with mutual aid and a coherent public service approach to the challenge** compared to those countries with privatised health care. The social care sector on the other hand, despite some examples of excellence, is a fragmented and broken system. The pandemic has shown the urgent need to ensure staff have adequate training, are paid against nationally agreed terms and conditions and we create an adequately resourced National Care Service as outlined in the SHA policy of '**Rescuing Social Care**'.

Another area where a national approach has paid off is the leadership provided by the **National Institute of Health Research (NIHR)** which helps to integrate National R&D funding priorities and work alongside the Research Councils (MRC/ESRC) and Charitable Research funding such as from the Wellcome Trust and heart/cancer research funders. These strategic research networks use university researchers and NHS services to enable clinical trials to be undertaken and engage with patients and the public. It is through this mechanism that the UK has been able to contribute disproportionately to our knowledge about treatment for COVID-19 and in developing and testing novel vaccines.

For example, the Recovery trial programme has used these mechanisms to enlist patients across the UK in clinical trials. The dexamethasone (steroid) trial showed a reduction in deaths by a third in severely ill patients and is now used worldwide. On the other hand, **Donald Trump and Brazil's Jair Bolsanaro's hydroxychloroquine has been shown to be ineffective** and this evidence will have saved unnecessary treatment and expense across the world. Such randomised controlled trials are difficult to undertake at scale in fragmented and privatised health systems. The vaccine development and trials have also been built on pre-existing research groups linked to our Universities and Medical Schools. Finally, while Hancock's phone app hit the dust in the Isle of Wight, Professor Tim Spector's COVID-19 symptom app has managed to enlist 4m users across the country providing useful data about symptoms and incidence of positive tests in real time. This is all from his Kings College London research base reaching out to collaborators in Europe. Ireland has launched the Apple and Google app created with the Irish software company NearForm successfully and it is thought that Northern Ireland is on the way to a similar launch within weeks too!

9. A wealth tax?

In earlier blogs we have drawn attention to the huge debt that the government have run up and we are already seeing the emerging economic damage to the economy and people's livelihoods when the furloughing scheme is withdrawn in October.

Already people are talking about up to 4m unemployed this winter and what this will mean in terms of the economy and funding public services like local government, education and health. The **UK's public finances are on an 'unsustainable path**' says the Office for Budget Responsibility.

There is a lot of chatter about the value of a **wealth tax** and there are some variations to the theme. It is estimated that there is £5.1 trillion of wealth linked to home equity. It is also said that the unearned gains on property are a better target for new taxes than workers earned income. Following this through a think tank has proposed – a property tax paid when a property is sold or an estate if the owner has died. A calculation could be made by taxing at 10% on the difference between the price paid for the property and the price at which it was sold. The % tax could be progressive and increase when the sum exceeds £1m for example. Assuming property rise in value by only 1% per annum this tax would raise £421bn over 25 years. If this sounds like an inheritance tax – that is true but for years now **such taxes have become a voluntary tax** for those with access to offshore funds and savvy accountants. In the USA, inheritances account for about 40% of household wealth. Fewer than 2 in 1000 estates paid the Federal estate tax even before Trump cut it in 2018. Trusts and other tax havens abound. Apparently, **Trump's own Treasury Secretary has placed assets worth $32.9m into his 'Dynasty Trust 1'**

Inherited wealth has been referred to in earlier blogs in relation to the Duke of Westminster family wealth. Another study which shows how this type of wealth transfer passes down the generations comes from Italy where in 2011 a study of high earners found many of the same families appeared as in the Florence of 1427!

10. Populism and COVID

In our blogs we have pointed to the fact that those countries, in different continents, which have had a bad pandemic experience are ones such as the UK, USA, Brazil, India and Russia. What unites them is a leadership of right-wing populists.

A recent study has started to analyse why this occurs and what the shared characteristics are:

1. The leaders **blame others** – the Chinese virus/immigrants
2. **Deny scientific evidence** – use ineffective drugs/resist face masks
3. **Denigrate organisations** that promote evidence – CDC/PHE/WHO
4. **Claim to stand for the common people** against an out of touch elite.

What the authors found was that these leaders were successfully undermining an effective response to the pandemic. Sadly, there is a risk that populist leaders perversely benefit from suffering and ill health.

Taking lessons from history and the contemporary global situation we need to continue **to speak out against these political forces and advocate for a better fairer recovery**.

Acknowledgements

These blogs were drafted each weekend during the first wave of the pandemic during an intense time for public health, NHS workers, patients and others involved with managing the pandemic. Sources to inform the blogs were drawn widely from the authors experience working for a local Director of Public Health in England during this phase, daily newspapers such as the Guardian/FT, Twitter, Bylines and international sources of news such as the New York Times. Magazines also proved helpful and include the Economist, New Statesman and Private Eye's MD columns. The Independent SAGE group outputs (individuals and the group) were also of help as were some of the 'think tank' reports such as the Kings Fund and Health Foundation. The author also used the NHS, PHE, ONS and government websites which commendably were good sources of data.

The decision to produce and circulate this collection was prompted by noticing an increasing number of attempts to influence the Hallett Independent Public Inquiry by 'pre-emptive strikes' some of which are not based on what happened or on any evidence. An example is the recent political statement from some MPs that lockdowns don't work!

This collection reproduces the blogs produced and published on the Socialist Health Association website as a contemporaneous commentary on the first wave of the pandemic in the UK. Its production was influenced by the example of the Private Eye publication 'Dr Hammond's Covid Casebook' which is a collection of the MD columns running from 16th March 2020 - 24th May 2021 (Private Eye productions Ltd 2021). Like this publication we have also provided some data for each blog showing the hospitalisations and deaths at that time.

We have added an Introduction and an Appendix with a Glossary, Chronology and data charts drawn from the excellent Office of National Statistics (ONS) and One World Data (Johns Hopkins University).

Finally, I would like to acknowledge the support of the previous Chair and Secretary of the SHA, Dr Brian Fisher and Jean Hardiman Smith, as well as the other Officers who added helpful comments to the drafts.

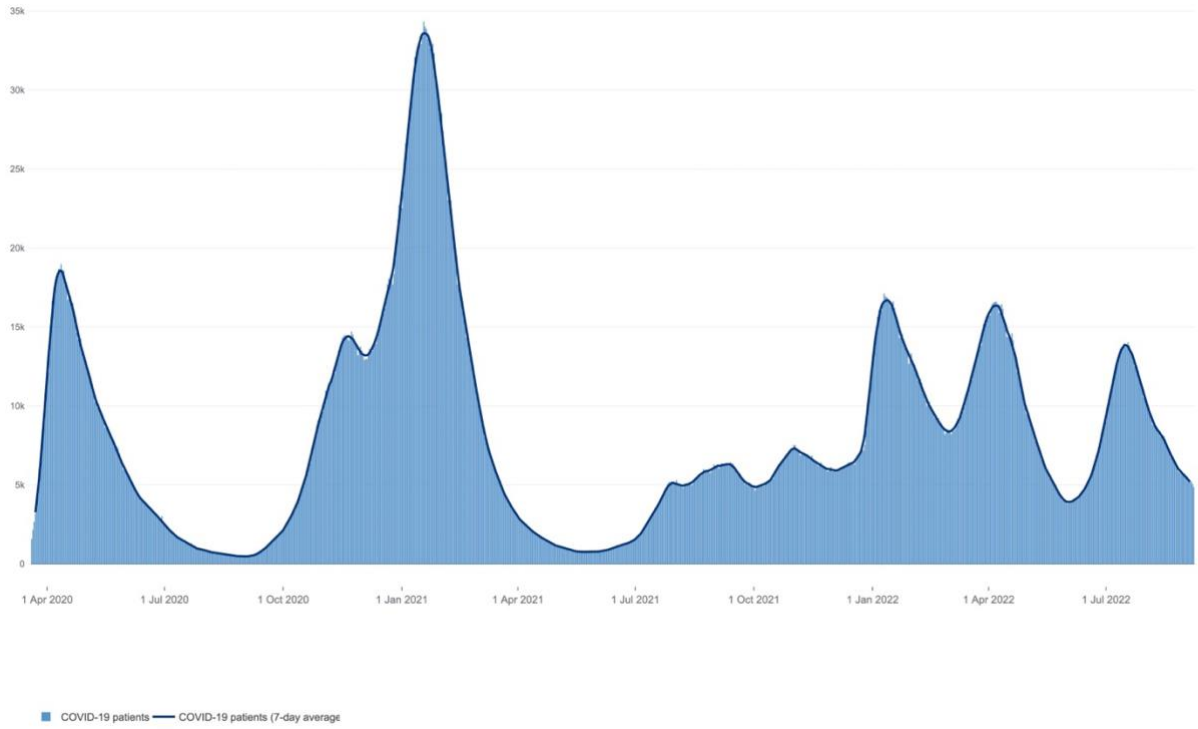
Dr Tony Jewell

Glossary

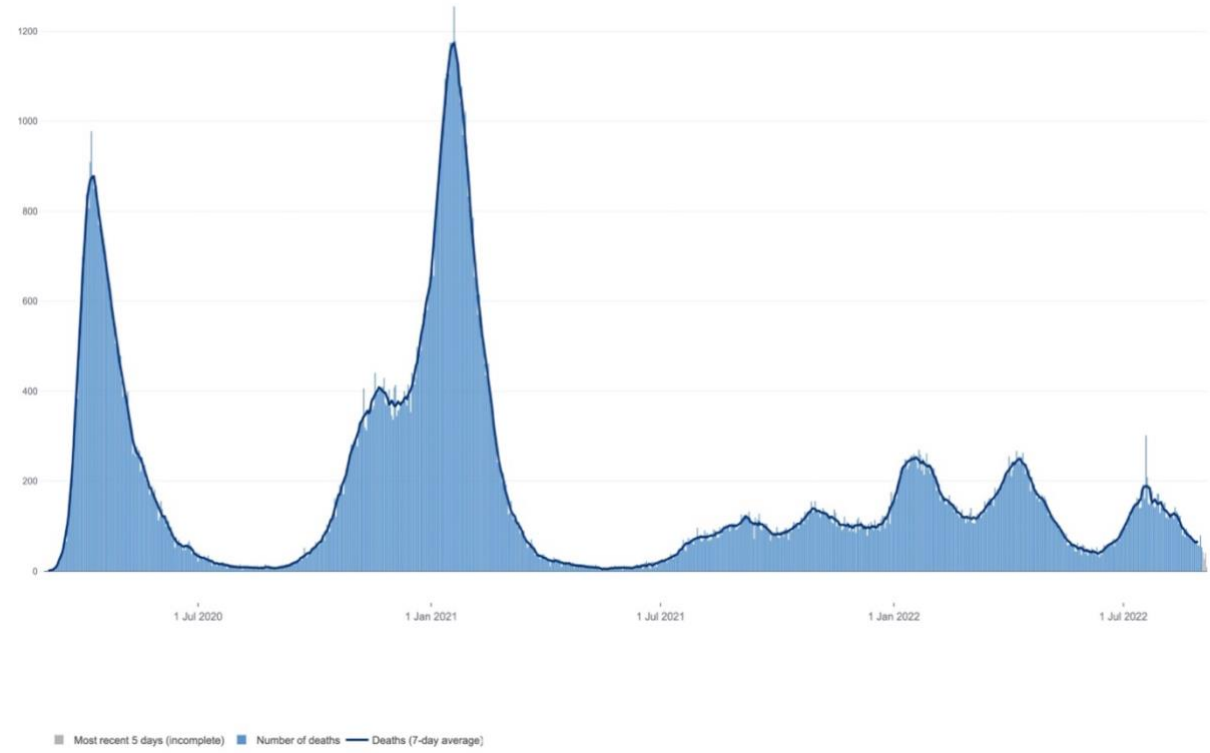
BAME	Black, Asian and Minority Ethnic groups which is no longer used as an aggregate term
CMO	Chief Medical Officer
CSA	Chief Scientific Adviser
COBRA	Cabinet Office Briefing Rooms (COBR) for civil contingencies – room A originally
COVID-19	Coronavirus disease 2019, caused by SARS-CoV-2
DRC	Democratic Republic of Congo
Excess death	Number of extra deaths, over a given period of time, than would be normally expected
FTTIS	Find, Test, Trace, Isolate and Support
GSK	formerly GlaxoSmithKline plc now GSKplc
H1N1	2009 Swine flu, influenza A pandemic virus
Herd Imm.	When enough immune people to stop/reduce transmission. Usually through vaccination
ICU/ITU	Intensive Care Unit / Intensive Therapy Unit
JBC	Joint Biosecurity Centre
Lansley	Lansley reforms of the NHS Health and Social Care Act (2012) set up GP Commissioning Groups.
Lighthouse	A high throughput laboratory dedicated to C-19 testing and managed via academic, commercial and NHS Trusts. Not part of PHE
MERS	Middle East Respiratory Syndrome

NERVTAG	New and Emerging Respiratory Virus Threats Advisory Group
NHS111	A free to call non-emergency number to call and an online service
Nightingales	Seven temporary hospitals set up in England at a cost of more than £530m and mostly unused
PCR	Polymerase Chain Reaction testing to detect RNA in samples that contain SARS-CoV-2 virus
PHE	Public Health England
Pillar tests	Pillar 1 swab testing in PHE and NHS hospitals. Pillar 2 swab testing for the wider population
	Pillar 3 serology antibody testing
	Pillar 4 blood and swab testing for ONS/PHE
PPE	Personal Protective Equipment
SAGE	Scientific Advisory Group for Emergencies
SARS	Severe Acute Respiratory Syndrome, caused by SARS-CoV-1
SPI-M-O	Scientific Pandemic Influenza Group on Modelling, Operational sub-group.
SoS	Secretary of State
Test & Trace	A government funded service to test and trace Covid-19 cases. It was never run by the NHS and now part of UK Health Security Agency
UKHSA	UK Health Security Agency
WHO	World Health Organisation

COVID-19 data – 1. Patients in hospital (England)

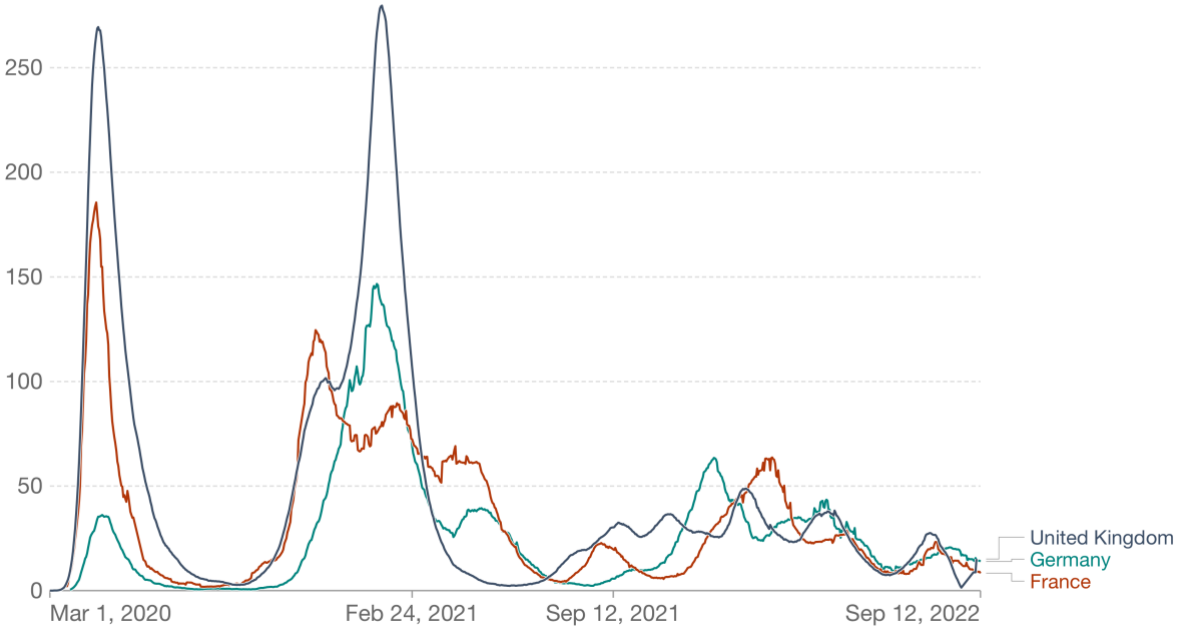


2 Deaths within 28 days of positive test by date of death (England) Source: ONS



Biweekly confirmed COVID-19 deaths per million people

Biweekly confirmed deaths refer to the cumulative number of confirmed deaths over the previous two weeks. Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the true number of deaths caused by COVID-19.

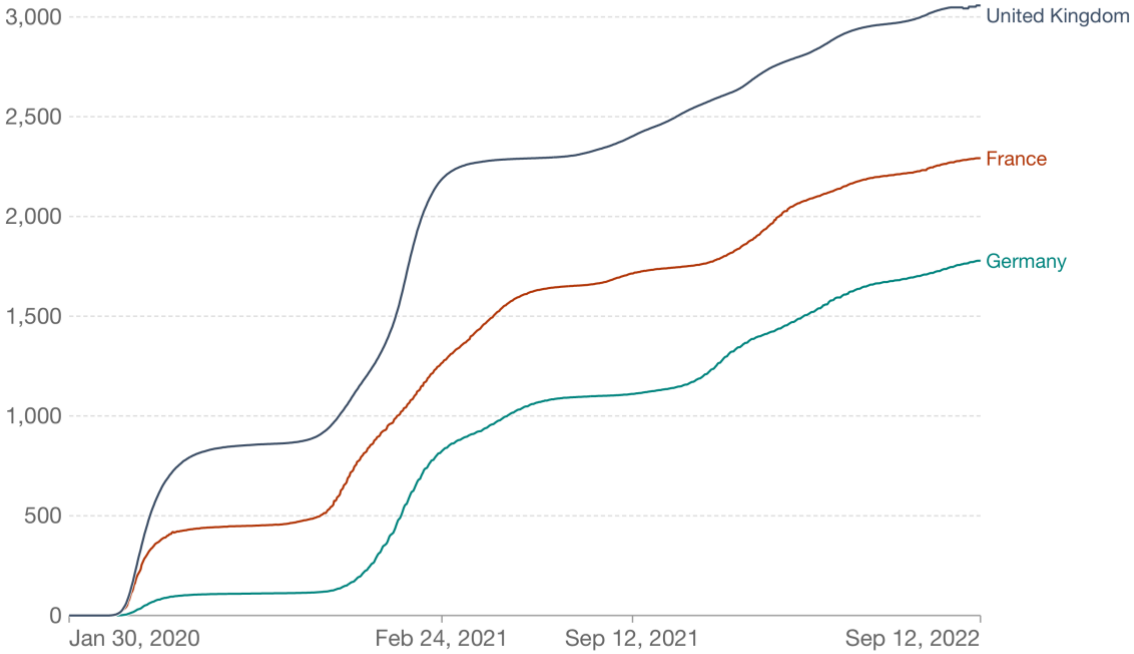


Source: Johns Hopkins University CSSE COVID-19 Data

OurWorldInData.org/coronavirus • CC BY

Cumulative confirmed COVID-19 deaths per million people

Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the true number of deaths caused by COVID-19.



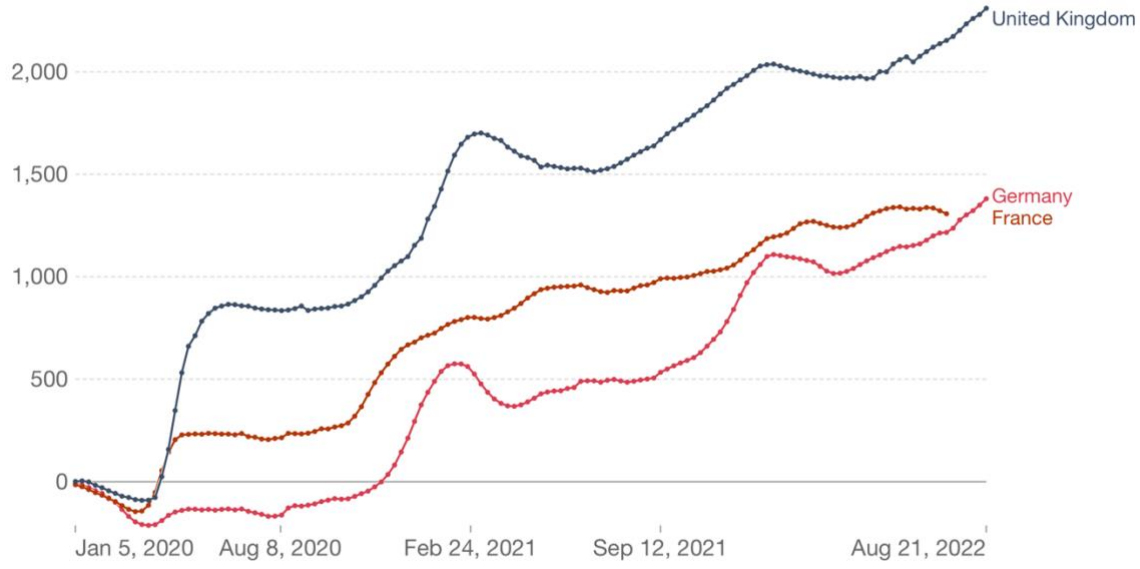
Source: Johns Hopkins University CSSE COVID-19 Data

CC BY

Excess mortality: Cumulative number of deaths from all causes compared to projection based on previous years, per million people

Our World in Data

The cumulative difference between the reported number of deaths since 1 January 2020 and the projected number of deaths for the same period based on previous years. The reported number might not count all deaths that occurred due to incomplete coverage and delays in reporting.



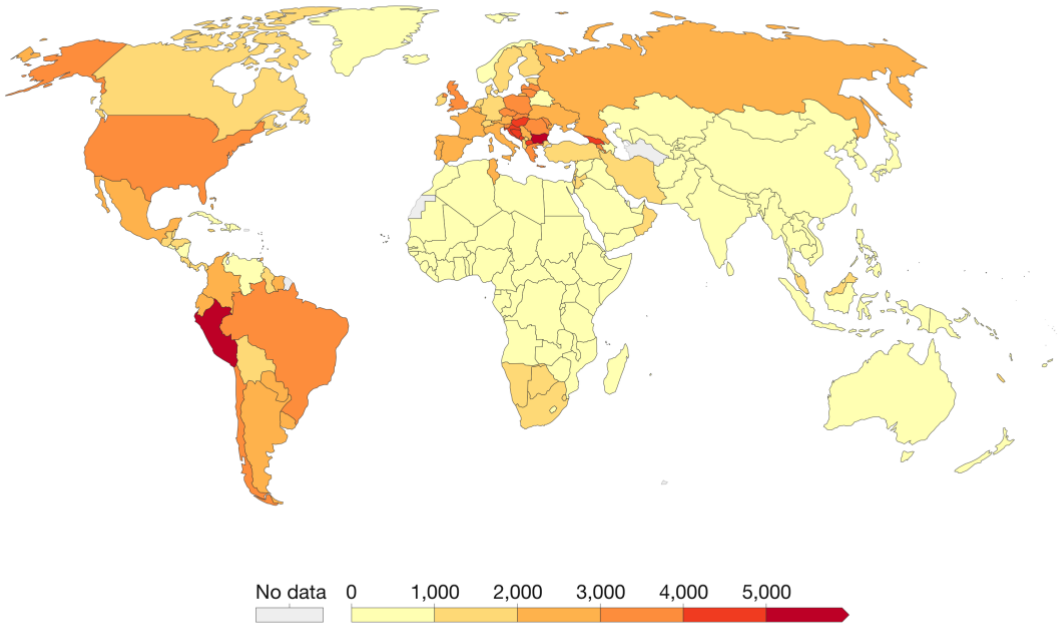
Source: Human Mortality Database (2022), World Mortality Dataset (2022) OurWorldInData.org/coronavirus • CC BY

Note: Comparisons across countries are affected by differences in the completeness of death reporting. Details can be found at our Excess Mortality page.

Cumulative confirmed COVID-19 deaths per million people, Sep 12, 2022

Our World in Data

Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the true number of deaths caused by COVID-19.



Source: Johns Hopkins University CSSE COVID-19 Data CC BY

Chronology for the First Wave of COVID-19 March 2020 - May 2020

December 2019	Emergence of the new Coronavirus (SARS-CoV-2) in Wuhan, China with three people hospitalised on 10th December
31st Dec 2019	New Coronavirus reported to WHO
12th January 2020	WHO confirms new Coronavirus is transmissible and the cause of the respiratory illness. China shares the genetic sequence
13th January 2020	First case of C-19 outside China in Thailand and first case reported in Japan on 15th Jan. PHE says no need to change travel plans to Wuhan as risk is low
January 2020	Likely to be spreading in the UK via travellers from China and from Spain, Italy, and France towards the end of January 2020
21st January 2020	NERVTAG and SAGE (22ndJan) say border screening would be ineffective. WHO (23rdJan) says travel bans cause more harm than good. PHE moves risk level from 'very low' to 'low'
29th January 2020	First 2 patients test positive in York – Chinese nationals in hotel
4th February 2020	SAGE - it will not be possible to halt the spread of the virus
11th February 2020	SPI-M-O recommends mass gatherings should not be cancelled
26th February 2020	SAGE - suppressing C-19 as in China would result in a large second wave and the preferred way is to allow the disease to spread while reducing the peak
4th March 2020	PHE say facemasks ineffective, and government says cancelling events is ineffective. First confirmed death in UK
10th – 13th March	Cheltenham Festival and on 11th March, Atletico Madrid play Liverpool with an estimated 3,000 Spanish fans travelling to UK
23rd March 2020	Stay at Home lockdown
25th March 2020	Coronavirus Act 2020 passed on 25th March
End March 2020	First wave peaked at end of March/early April
13th May – 4th July	Restrictions gradually lifted

Sept 2020 - April 2021 – Second wave of pandemic in UK

December 2020	Covid-19 vaccination programme started

What is the Socialist Health Association?

The Socialist Health Association is a campaigning membership organisation. We promote health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We believe that these objectives can best be achieved through collective rather than individual action.

We stand for:

- Universal publicly provided healthcare meeting patients' needs, free at the point of use, funded by taxation
- Democracy based on freedom of information, election not selection and local decision making
- Equality based on true equality of opportunity and progressive taxation

We campaign for an integrated healthcare system which reduces inequalities in health and is accountable to the communities it serves. We are affiliated to the Labour Party. Until 1980 we were called the Socialist Medical Association.

Contact details

Website: https://www.sochealth.co.uk

Twitter and Facebook: @SocialistHealth

Address: c/o Harry Stratton

One Essex Court

Temple

London EC4Y 9AR