



The All Party Parliamentary Group on
Coronavirus

*INTERIM REPORT
DECEMBER 2020*



Summary

The All-Party Parliamentary Group on Coronavirus (APPG) was set up in July 2020 to conduct a rapid inquiry into the UK government's handling of the Covid-19 pandemic. Its purpose is to ensure that lessons are learned from the UK Government's handling of the Coronavirus outbreak to date, and to issue recommendations to the UK Government so that its preparedness and response may be improved in future.

The group is chaired by Layla Moran MP. Dr Dan Poulter MP, Caroline Lucas MP, Clive Lewis MP, Dr Philippa Whitford MP, Liz Saville-Roberts MP, Munira Wilson MP, Barbara Keeley MP and Debbie Abrahams MP serve as vice chairs. From the House of Lords, Baroness Masham, Baroness Finlay, Lord Strasburger and Lord Russell are regular members of the group.

The scope of the APPG is to assess the impacts of the UK government's Coronavirus response on the NHS and social care systems in England, as well as on the health outcomes of the population and distributional effects across the population to date.

The scope of the inquiry includes:

- Testing
- Contact Tracing
- Personal Protective Equipment
- Exercise Cygnus
- Impact on the social care sector
- Impact on the National Health Service
- Impact on groups with protected characteristics
- The interaction of Coronavirus and Influenza
- Non pharmaceutical interventions
- Overall UK government strategy
- Scientific and health advice
- Pharmaceutical Availability
- Local and national response coordination

Methodology

For this report, the APPG used primary and secondary data, as well as information collected from expert witnesses and stakeholder groups who provided written and oral evidence to the APPG.

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All-Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. The views expressed in this report are those of the group.



Foreword from Layla Moran MP

The coronavirus crisis has touched every aspect of our lives. While it was not something we were expecting, it is now clear that we should have been much better prepared. I formed the All-Party Parliamentary Group (APPG) on Coronavirus, with members from all political parties and both Houses, because this pandemic has had a devastating impact on our country. An independent public inquiry had been spoken about but not started, and our concern was that there seemed to be no vehicle to provide constructive criticism and learn the lessons from the first wave to avoid the second. This report covers the work of our rapid inquiry from July to October 2020. It is published at the zenith of the second wave we were all hoping to avoid.

The central objective of the APPG on Coronavirus is to save lives but, as is laid bare in this report, to save lives is to save livelihoods. To do that, the Government must listen and adapt. We write this report with the sincere hope that, by working cross-party with scientists, civil society and individuals, we can help the Government to do what we need it to do at this time of national crisis: succeed.

It was also becoming apparent that the voices of ordinary people, especially those suffering with Long Covid, frontline workers and the bereaved were not being heard loudly enough. We hope this serves to amplify their contributions and remind policy makers of the real human consequences of their decisions.

The report contains 71 key findings, which inform 44 recommendations. This is especially important now, as the UK government is gambling with the UK's future by relaxing restrictions over the Christmas period and returning to a tier system which we know has not worked before. The recommendations range from the very specific (on Long Covid recognition and support) to the operational (highlighting the need for the Isolate part of Test, Trace, Isolate to be financially compensated more generously) and the strategic (the lack of a coherent exit strategy).

Our topmost recommendation is that we urgently need a UK-wide exit strategy that acknowledges that by saving people's lives, we in turn safeguard their jobs and the economy. We challenge the UK Government's core argument that there is a 'balance' to be found between the health and wealth of the UK, and instead advocate an approach closer to those nations that have successfully 'beaten' the virus. This includes strong initial restrictions to get case numbers extremely low everywhere, a TTI system that is locally led and nationally resourced that pays people to stay at home if they need to and aggressive testing at the borders, turning our island geography into a powerful advantage. We are concerned that the Government's approach so far has not worked and has left the UK mourning among the highest number of lives lost to the pandemic, while at the same time bracing for one of the deepest recessions in its aftermath. The vaccine may be around the corner, and that is brilliant news, but the logistical challenges and uncertainty make it almost certain that we have months, if not years, of aftermath to contend with.

I would like to thank all officers and members of the APPG on Coronavirus for their tireless work and input in numerous oral evidence sessions held since the summer, and for their work behind the scenes too. They have put party politics aside and worked with colleagues from across Parliament's political spectrum.

But most of all, I would like to thank everyone who has submitted evidence orally or in writing, especially those who have shared their personal stories. We have all been touched by their bravery and passion. This report is for them.



Layla Moran MP

Chair of the APPG on Coronavirus

Member of Parliament for Oxford West and Abingdon

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Introduction

This is an interim report into the APPG's findings, based on the first 10 oral hearings from July to October 2020.

The APPG heard from the following organisations and individuals at its oral evidence hearings:

- The British Medical Association
- Doctors in Unite
- The NHS Confederation
- The Long Covid Support Group
- Bereaved Families for Justice
- Relatives and Residents Association
- Age UK
- NHS Providers
- Independent Age
- The Royal College of Physicians
- The Royal College of Pathologists
- Community Integrated Care
- Mind
- University College London
- Beat
- The Mental Health Foundation
- Professor Martin McKee
- Dr Rachel Liebmann
- Dr Isobel Braithwaite
- Dr Alexander Allen
- Professor Sergio Bonini
- The Royal College of Nursing
- The GMB Union
- Doctors Association UK
- The Medical Protection Society
- The Centre for Mental Health
- Professor Brian Duerden CBE
- Sir Graham Thornicroft
- Dr Gabriel Scally
- Professor Deenan Pillay
- Cllr Ian Hudspeth
- Cllr Alex Crawford
- Sir Peter Soulsby
- Professor Luca Richeldi
- Professor Paolo Vineis
- Institute of Biomedical Science
- Professor Devi Sridhar
- Professor Stephen Reicher
- Dr David Nabarro CBE
- Dr Kevin Fong
- Alice Wiseman

The APPG is indebted to everyone who gave evidence to this rapid inquiry, both through written submissions and through oral evidence.

The APPG is continuing to receive evidence and to hold oral hearings.

The UK is currently experiencing a second wave of Covid-19. After listening to experts, frontline workers and organisations representing some of those most affected by Covid-19, the APPG believes that there are measures that the UK government can implement to reduce the impact of the pandemic. By providing better protection and support to those most affected, by empowering local authorities to assist in the management of the crisis, by recognising and mitigating against the unequal impact that Covid-19 has had on our society, we can reduce the scars of Covid-19, thereby helping us to come out of this period more united and more resilient.

The APPG urges the UK government to implement the APPG's recommendations.

Conclusions and recommendations

Exit Strategy

1. The UK government's approach to tackling the coronavirus pandemic has been based on the false choice between saving lives or saving jobs and the economy. **The APPG recommends that the UK government adopts the [Covid-Secure UK plan](#)¹ as the long-term exit strategy to protect both the health and the wealth of the UK until widespread immunity through vaccination is achieved.**

The Covid-Secure UK Plan consists of three steps:

1. **Control** - bring the reproduction rate below 1, reduce community transmission by implementing a locally led Find Test Trace Isolate and Support system.
2. **Suppress** - minimise transmission within the UK at large and stop imported infections at the UK borders.
3. **Eliminate** - obtain widespread immunity to coronavirus through vaccination. **The [Covid-Secure UK plan](#)² is set out more fully in chapter 1.**

[reference Key Findings from Chapter 2]

Find Test Trace Isolate and Support

2. The centralised and outsourced Test and Trace system operating in England is not working. It has consistently failed to meet the required target of 80% of contacts traced to be effective.

The UK government has prioritised arbitrary testing targets over a coordinated testing strategy. Mass testing needs to be backed up with adequate resources to ensure that tests are carried out by trained staff, supported by an information campaign which informs about the sensitivity and specificity of tests, and by an effective and comprehensive contact tracing service.

The UK government's outsourced tracing service has consistently traced only 60% of contacts, well below the required 80% target. Local contact tracing services have been much more successful, regularly tracing 90% of the contacts³. This is due to their understanding of the local areas, their ability to go directly to people's premises and their ability to foster trust and offer advice, explanation, and support.

Without adequate financial support and general assistance to isolate, the requirement to isolate is not being complied with by a significant proportion of cases. As a result, the chains of transmission are not being broken, and cases continue to rise. In areas where local teams are resourced to trace cases and to offer support for those required to isolate, including on

¹ As set out in Chapter 1.

² As set out in Chapter 1.

³ [Suggested steps for increased localisation of testing and tracing, 20 November 2020 | Local Government Association](#)

aspects such as shopping, financial advice and general support, compliance is much improved⁴.

Lockdowns have become the UK Government's only solution to bringing down the incidence of Covid-19 in England, because it does not have a locally led Find, Test, Trace, Isolate and Support system in place throughout the country.

The APPG recommends that the UK government empowers local authorities to deliver a Find, Test, Trace, Isolate and Support system, backed up with proper financial support and assistance for those isolating. [reference Key Findings from Chapters 2, 3, 6, 7 and 10]

Empowering Local Authorities

3. The inability for local authorities to access the precise real-time data has significantly impaired their ability to work effectively at a local level to contain outbreaks. **The APPG recommends that local authorities are provided with precise granular test and trace data in a timely fashion to enable local authorities to understand the incidence of Covid-19 in their areas and to trace contacts rapidly and effectively.** [reference Key Finding 7.1]
4. Local authorities need sufficient powers to enforce restrictions where necessary. **The APPG recommends that the UK government provides local authorities with the powers to take flexible and localised actions to enforce appropriate forms of non-pharmaceutical interventions, including lockdowns, where local action is necessary above national imposed restrictions.** [reference Key Finding 7.3]
5. Centralised identification of, and communication with, those shielding has not been consistent or clear. Moving to a new 'accounts based system' to manage the records of those identified as clinically vulnerable provides an opportunity for the UK government to work closely with local government to improve the current system, so in the future the support to those who might need to shield is delivered more effectively. **The APPG recommends that the UK government works closely with local councils on future shielding programmes to ensure effective communication and delivery of the shielding programme.** [reference Key Findings 5.3 and 7.3]
6. Local authorities need the powers to respond to local outbreaks. **The APPG recommends that the UK government delegates the powers to open and close schools and pre-schools, as contained in the Coronavirus Act 2020, to local authorities to enable them to respond quickly to local conditions.** [reference Key Finding 7.3]
7. Councils need clarification on the resumption of the policy of 'everyone in' (ensuring accommodation for all homeless people). **The APPG recommends that the policy requiring local authorities to ensure that homeless people are housed during the pandemic continues until widespread immunity to Covid-19 is achieved through vaccination.** [reference Key Finding 7.3]
8. **The APPG recommends that the No Recourse to Public Funds condition be lifted to enable the sheltering of homeless people and to prevent homelessness for households experiencing financial shocks.** [reference Key Finding 7.3]

⁴[COVID-19: local contact tracing case studies | Local Government Association](#)

Communication

9. UK government advice and guidance on shielding and on visiting those in residential care has been inconsistent and unclear. **The APPG recommends that the UK government works with the primary health care and social care sectors to ensure guidance and messaging on shielding is clear and precise.** [reference Key Finding 4.8]
10. **The APPG recommends that the UK government works more closely and collaboratively with the devolved administrations towards the shared objective of suppressing the virus on a UK wide basis. Each devolved administration should retain the ability and capacity to respond to its own needs where necessary, but within the framework of an agreed four nation strategy.** [reference Chapters 1 and 2]
11. UK government public health messaging has been inconsistent and unclear and the reasons for the application of NPIs are ill-defined. **The APPG recommends that the UK government reinstates the daily coronavirus briefings to keep the public informed for the duration of the pandemic.** [reference Key Finding 4.8]
12. **The APPG recommends that the UK government requests national broadcasters to report on the local level of infection present as part of each news and weather bulletin. This should occur across all news platforms, including broadcast, radio and online.** [reference Ch 1]

Testing

13. Access to testing for frontline NHS and social care staff has been unsatisfactory, resulting in staff being absent from their role while they or their family members wait for test results. This impacts on the ability of the NHS and social care sector to provide care. **The APPG recommends that testing is made available to frontline workers and their families as a priority, such that they are able to access a test at least once a week.** [reference Key Finding 6.8]
14. The international standard for the turnaround time of tests is 24 hours. **The APPG recommends that the UK government improves turnaround time for tests, such that all results are accessible within 24 hours.** [reference Key Finding 6.9]
15. Routine inspections of social care providers were suspended in March 2020. The APPG notes that testing has now been extended to all those in social care, including ‘support and specialist staff required to maintain the UK’s health and social care sector’⁵. **The APPG recommends that this definition applies to all those in managerial positions in the social care sector, including those in the Care Quality Commission, such that oversight of the social care sector can be fully reinstated.** [reference Key Finding 6.11]
16. The APPG finds that there has been inadequate coordination between Pillar 1 (NHS) and Pillar 2 (commercial) laboratories, which has detrimentally affected testing capacity, information flows and management decisions. **The APPG recommends that there is much greater coordination between Pillar 1 and Pillar 2 laboratories including at leadership and**

⁵ [Coronavirus \(COVID-19\): getting tested - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/coronavirus-covid-19-getting-tested)

management levels, and on data and information sharing. **Pillar 1 testing expertise should be represented on the national Test and Trace committees. The two Pillars must work together to ensure that testing capacity is maximised.** [reference Key Finding 6.4]

17. The coronavirus pandemic has exposed the capacity deficiencies in the UK's public health laboratory capability: existing public health laboratories did not have the capacity to meet the surge in demand posed by Covid-19. **The APPG recommends that the UK government invests in its public health laboratories to ensure that the UK can deal with the present coronavirus pandemic and be adequately equipped for any future epidemic.** [reference Key Findings 6.1 and 6.2]
18. The recently announced proposals for testing at airports are not sufficient. To minimise the number of imported cases of Coronavirus, **the APPG recommends that the UK government requires proof of a negative Covid-19 test 72 hours prior to travel, followed by mandatory testing 5 days after arrival in the UK. The APPG further recommends that there are post-travel requirements such as quarantine at regulated locations.** [reference Ch.1]

Personal Protection Equipment

19. The APPG finds that there was an insufficient supply of PPE for those in the social care sector and NHS. The APPG notes UK government guidance for the stockpiling, supply and distribution of PPE published in September 2020. The APPG notes the intention as stated in that guidance to move to a different model beyond March 2021. **The APPG recommends that the UK government continues to assume direct responsibility and oversight for the stockpiling, coordinated supply and distribution of PPE beyond March 2021, in order to ensure that there continues to be a sufficient supply of PPE for NHS and social care workers, which is fit for purpose and accounts for cultural, religious, ethnic, gender and disability considerations, to meet any future need.** [reference Key Findings 3.1, 3.2 and 3.3]

Public Health England

20. The reorganisation of Public Health England would be detrimental to UK's ability to respond to the coronavirus pandemic. Furthermore, institutional change as a means to address the challenges posed by Covid-19 pandemic fails to acknowledge the other key responsibilities of Public Health England. **The APPG recommends delaying any reorganisation of Public Health England until after widespread immunity to Covid-19 has been achieved by vaccination.** [reference Key Finding 7.4]
21. To command public trust, any future national public health body must provide transparent advice which is independent of government. **The APPG recommends that any reorganisation of Public Health England ensures that the body remains publicly funded, but independent of government, able to give independent and transparent advice, and with strong links with local and regional public health authorities.**[reference Key Finding 7.5]

Support for the NHS

22. **The APPG recommends that the UK government commits to at least repeating the emergency uplift in funding due to Covid-19 for 2021/22 and should commit to annual real terms increases in total health spending by at least 4.1% per year going forward.** [reference Key Findings 3.1 and 3.4, chapter 3 submission]
23. Before the coronavirus pandemic, NHS England had around 106,000 FTE vacancies including nearly 44,000 nurses and more than 9,000 doctors. Given the level and pace at which many staff on the frontline have been working, there is a need for significant ongoing support to manage the considerable impact the coronavirus pandemic has had on the mental health of NHS staff. **The APPG recommends that the UK government publishes a UK wide plan to improve the recruitment, retention, and support of NHS staff.** [reference Key Finding 3.2]
24. **The APPG recommends the NHS develops an effective system of risk assessment for all doctors, nurses and frontline NHS workers, including those from Black, Asian and Minority Ethnic (BAME) backgrounds, and those who are pregnant, to ensure that they can work in a way which minimises risk to themselves and patients.** [reference Key Finding 3.2]

Support for the Social Care Sector

25. The UK government guidance on visiting care homes in England is unclear and inconsistent compared to the equivalent advice and guidance issued for hospital visits. **The APPG recommends that the UK government issues much clearer guidance on visiting care homes, recognising the impact that isolation has on care home residents.** [reference Key Finding 5.3]
26. The social care sector did not receive sufficient support in terms of PPE, guidance, testing or quarantining provisions for those coming from the NHS into social care settings. **The APPG recommends that there is much greater coordination between the NHS and social care sector and that the UK government ensures equality of pay, training, career development and workforce planning between the social care sector and the NHS.** [reference Key Finding 5.1]
27. At the outbreak of the pandemic, there was a shortage of 100,000 social care staff. **The APPG recommends that the UK government publishes a national plan to improve the recruitment, retention, and support of social care staff.** [reference Key Finding 3.2]
28. Oversight of the social care sector was stopped in March 2020 due to a lack of testing availability for Care Quality Commission inspectors. **The APPG recommends that the UK government ensures that the full oversight of the social care sector by the Care Quality Commission is resumed as a matter of urgency by making testing available to inspectors.** [reference Key Finding 6.11]
29. Isolation is having a devastating impact on those in social care. All people living in care or supported living need to be safely reconnected with their support networks for the crucial emotional and practical support that friends and families provide. **The APPG recommends**

that the UK government ends isolation for all those supported or cared for in the social care sector, including all those in independent and supported living. Visits must not be restricted to a maximum of one or two family members or friends. The UK government must make clear that there is no requirement for staff supervision during visits. [reference Key Finding 6.12]

30. **For the visitors of residents in all social care settings, the APPG recommends that relatives and visitors be classed as key workers to enable them to access testing and PPE. The APPG further recommends that shorter turnaround tests be made available to facilitate an end to the isolation of all residents.** [reference Key Finding 6.12]
31. **The APPG recommends that there is an effective system of risk assessment for all social care workers, including those from Black, Asian and Minority Ethnic (BAME) backgrounds, and those who are pregnant, to ensure that they can work in a way which minimises risk to themselves and those they care for.**[reference Key Finding 3.2]

Inequalities

32. The Covid-19 pandemic has brought to the fore longstanding structural inequalities that persist within the UK and our public services. The APPG has found that NHS staff, and in particular those from BAME backgrounds, have experienced bullying and discrimination in the workplace when raising questions of workplace safety and lack of PPE. **The APPG recommends that the UK government ensures that the NHS continues to fulfil its Public Sector Equality Duty (PSED) obligations throughout the pandemic. Equality monitoring must continue throughout the crisis and steps must be taken to identify and mitigate health inequalities and disparities of experiences and outcomes as they arise.** [reference Key Finding 5.5]
33. The Covid-19 pandemic has brought to the fore longstanding inequalities that persist within the UK and our public services. The impact has been particularly detrimental on those living in areas of high deprivation, on people from BAME communities, on older people, men, those with a learning disability and others with protected characteristics. **The APPG recommends that the UK government renews its focus on health inequalities to strengthen future resilience.** [reference Key Findings 3.6 and 5.5]

Bereaved Families

34. **The APPG urges the Prime Minister to meet with the Bereaved Families for Justice group and commit to a judge-led public inquiry on the UK government handling of Covid-19.** [reference Key Finding 4.1]
35. The advice given by the NHS 111 service may have resulted in people experiencing severe symptoms being advised against seeking medical help. **The APPG recommends that there is an immediate review of the advice given by the NHS 111 service.** [reference Key Finding 4.6]
36. With Covid-19 restrictions in place, many lost loved ones to Covid-19 in isolated circumstances, where the normal support systems have not been accessible. **The APPG**

recommends that the UK government ensures that bereavement counselling and mental health support are available to those who have lost loved ones to Covid-19. [reference Key Finding 4.9]

Long Covid

37. As a medical condition, Long Covid has not yet received full recognition, sufficient research funding or adequate rehabilitation support. **The APPG recommends that the UK government formally recognises Long Covid, that it expands research on the long-term effects of Covid-19 on people's health to include those who were never hospitalised or tested, and the UK Government should launch a national registry to count the number of people living with Long Covid in the UK and spearhead global effort to research Long Covid.** [reference Key Finding 4.2]
38. There are insufficient guidelines for employers and GPs on recognising and managing Long Covid. **The APPG notes the work commenced by NICE and SIGN and recommends that the UK government expedites the work to develop new guidelines for GPs and ensures that there are also guidelines for employers. The APPG recommends that the UK government commits to a firm date by which these will be produced.** [reference Key Finding 4.3]
39. The UK government is not counting the number of individuals who are left with long-lasting effects of Covid-19 as a measure of the severity and impact of the pandemic. **The APPG recommends that the UK government collects and publishes regular figures on the number of people living with Long Covid, and those who have received support under the NHS England Covid Recovery service.** [reference Key Finding 4.1]

Mental Health

40. The APPG finds that Covid-19 has had severe impact on the mental health of a significant proportion of society. This may be because of isolation, loss of income, or loss of daily routine. The APPG notes that the UK government has committed to an additional £500 million spending pledge. **The APPG recommends that the UK government details how this funding will be spent and all respective success metrics.** [reference Ch 9]
41. The APPG finds that there has been an increase in demand for mental health support services, with many individuals seeking help for the first time. The APPG also finds that those suffering from mental health issues, including addictions, have seen their condition worsen over the course of the pandemic. **The APPG recommends that the government prioritises improving and strengthening both the availability of mental health services and the mental health estate. The condition of mental health wards must be improved. The UK government must also ensure that there is adequate sheltered housing for those suffering from a mental health condition to live with dignity in the community.** [reference Ch 9]
42. **For those living in mental health accommodation, the APPG recommends that the UK government ensures that relatives and visitors have access testing and PPE to facilitate an end to the isolation of all residents.** [reference Ch 9]

Charities

43. Throughout the duration of the coronavirus pandemic, the charitable sector has seen an unprecedented need for its support services. At the same time, charities have had to furlough frontline staff leading to a further reduction in charities' ability to deliver their services. **The APPG recommends that the rule preventing furloughed staff from volunteering with their employer is disapplied to the charitable sector.** [reference Key Finding 5.6]

International Comparisons

44. The UK government has failed to look to or learn from other countries in their handling of the pandemic. The APPG notes the experience of Norway and Finland, who built up their Find, Test, Trace, Isolate and Support systems over the Summer, as well as those countries who instigated testing and quarantine measures at airports early on, such as South Korea, Singapore, New Zealand and Hong Kong. **The APPG recommends that the UK government looks to other countries and implements the measures that have resulted in a much more successful handling of the pandemic.** [reference Key Findings 10.1 and 10.3]

Key Findings

Chapter 2: Lockdown and Exit Strategy

- 2.1 Lockdowns are a means of slowing down the incidence of the pandemic when all other means to control the virus have broken down.
- 2.2 The UK government's centralised test and trace system is not working.
- 2.3 The failure to provide sufficient financial support to those in self isolation is a barrier to compliance.
- 2.4 Public messaging is unclear, and the reasons for the application of NPIs are ill-defined.
- 2.5 There needs to be greater coordination between all stakeholders involved in the Coronavirus response.
- 2.6 Relaxing lockdown restrictions too early, without sufficient suppression, can cause more economic damage in the long term. 'Balancing health versus wealth' is a false dichotomy.
- 2.7 There is no such thing as Herd Immunity to Covid-19 in the absence of an effective vaccine.
- 2.8 A future vaccine should not be relied upon as a 'silver bullet' to solve the pandemic.
- 2.9 The UK government must remain focussed on NHS staff recruitment, retention and support.

Chapter 3: The Impact of Covid-19

- 3.1 The UK government did not adequately prepare in terms of stockpiling sufficient and adequate Personal Protection Equipment (PPE). The procurement, supply and distribution of PPE to the NHS and social care sector was delayed and poorly coordinated, with ineffective oversight.
- 3.2 There are significant staff shortages in both the NHS and social care sector. Covid-19 has had a considerable impact on the health, safety and well-being of the workforce.
- 3.3 The social care sector has been severely impacted by the pandemic. There was insufficient coordination of supply and distribution to the social care sector which led to significant problems with access to PPE. The quarantine arrangements for those coming into the social care sector from hospitals were inadequate.
- 3.4 In the first wave of the pandemic, there was a considerable resource shift in the NHS to managing patients with Covid-19. This has led to a considerable backlog of care.
- 3.5 The centralised Test and Trace system is not working.
- 3.6 Covid-19 has not impacted society equally.

- 3.7** Communication between the UK government and local systems of healthcare provision needs to be improved.

Chapter 4: Long Covid and Bereaved Families

Long Covid

- 4.1** The UK government is not counting the number of individuals who are left with long-lasting effects of Covid-19 as a measure of the severity and impact of the pandemic.
- 4.2** As a medical condition, Long Covid has not yet received full recognition, sufficient research funding or adequate rehabilitation support.
- 4.3** There are very few guidelines for employers or for GPs on recognising and managing Long Covid.

Bereaved Families

- 4.4** There must be a judge led inquiry into the UK government's handling of the pandemic.
- 4.5** UK government was too slow to lockdown during the first wave of the pandemic.
- 4.6** The advice given by the NHS 111 service may have resulted in people who were experiencing severe symptoms being advised against seeking medical advice.
- 4.7** Hospital admissions may have led to increased incidence of Covid-19 in the first wave.
- 4.8** Shielding guidance from the UK government was unclear.
- 4.9** There is a lack of support for bereaved families as the normal support systems (family, friends, mental health support) are not accessible while Covid-19 restrictions are in place.

Chapter 5: The Impact on Social Care

- 5.1** There has been a failure of those in social care⁶. The social care sector has been failed during this pandemic. This failure has brought into sharp relief the urgent reforms required for social care, with centralised oversight, funding and support.
- 5.2** The impact of complex bereavement, anxiety and depression on people in later life as exacerbated by the pandemic needs better recognition and support. Blanket lockdowns for long periods have had a severe impact on the mental health of residents and those who care for them.
- 5.3** The guidance on visiting care homes has been unclear.
- 5.4** The initial failure by UK government to include known mortality figures of those in the social care sector and reports of the use of blanket 'Do Not Resuscitate' Orders has created the impression that those in the social care sector are less valued.
- 5.5** Covid-19 has had a disproportionate impact on the health of those from Black, Asian and Minority Ethnic (BAME) backgrounds.

⁶ Social Care is addressed in chapters 3, 5, 6, 7, 8 and 9.

- 5.6 The charitable sector has seen an unprecedented need for its support services. At the same time, the financial viability of the charitable sector is at risk. Government financial support had not been distributed in a transparent or timely way.
- 5.7 Supermarkets need to increase the availability of slots for older and more vulnerable people and coordinate better with each other in their local communities.

Chapter 6: Test and Trace

- 6.1 Investment in the fields of virology and microbiology is needed urgently.
- 6.2 The UK government has not invested sufficiently in the UK's laboratory capability.
- 6.3 Arbitrary testing targets have been prioritised over a coordinated testing strategy.
- 6.4 There has been a lack of coordination between Pillar 1 and Pillar 2 laboratories.
- 6.5 Information flow between Pillar 2 laboratories and the NHS has not worked well.
- 6.6 The UK government's decision to abandon test and trace in March the virus to take hold in England and the UK unchecked.
- 6.7 The centralised test and trace system is not working.
- 6.8 Regular and accessible staff testing is critical to enable the NHS and social care sector to provide care.
- 6.9 Turnaround time of tests is not always meeting the required maximum 24-hour target.
- 6.10 For effective pandemic management, the NHS and Social Care sector responses need to be coordinated.
- 6.11 There has been no effective oversight of the social care sector since March.
- 6.12 Isolation is having a devastating impact on those in social care.
- 6.13 The cost of testing is a significant challenge for the social care sector.
- 6.14 Local authorities do not currently have a sufficient role in the organisation and oversight of testing for the social care sector.

Chapter 7: Local Authority Response and Reorganisation of Public Health England

- 7.1 The inability for local authorities to access the precise real-time data has significantly impaired their ability to work effectively at a local level to contain outbreaks.
- 7.2 The Covid-19 crisis has demonstrated the vital and reciprocal relationship between the NHS and social care.
- 7.3 Local authorities need enhanced powers and support.

- 7.4 Reorganisation of PHE should be delayed until after the pandemic.
- 7.5 Independent and trusted public health advice is critically important for a strong response to future threats.
- 7.6 Public health resilience has been impacted by reduced spending over the last decade.
- 7.7 In any reorganisation of PHE, all the functions of PHE should be read across and strengthened.
- 7.8 The public health system requires joined-up local, regional and national functions, that are responsive to the needs of local communities.

Chapter 8: The Impact on Frontline Workers

- 8.1 From the outset of the pandemic, frontline workers had inadequate access to personal protective equipment⁷.
- 8.2 The pandemic is having a clear impact on the mental health of frontline health and care workers. Many are experiencing stress, depression and burnout.
- 8.3 Access to testing for frontline workers has been unsatisfactory.
- 8.4 The social care workforce must have the same level of PPE and access to Statutory Sick Pay (SSP) as NHS staff. Greater guidance is needed for the sector.
- 8.5 Workers from Black, Asian and Minority Ethnic (BAME) backgrounds have been disproportionately impacted by the pandemic.
- 8.6 Doctors are particularly concerned about preparedness for winter and the ability of the NHS to face the elective backlog.

Chapter 9: The Impact on Mental Health

- 9.1 Covid-19 has had profound consequences for individuals' mental health.
- 9.2 Those with pre-existing mental health conditions have seen their mental health decline further throughout the pandemic.
- 9.3 Many individuals are experiencing mental health problems for the first time as a result of complex grief.
- 9.4 Throughout the pandemic there has been a reduced access to services and support as a result of Covid restrictions. The impact of this has meant more people are suffering without having access to support and thus causing their condition to worsen.
- 9.5 The reduction in normal activity and increased isolation has caused many to experience mental health problems for the first time.

⁷ PPE is addressed in Chapters 3, 5, 6 and 8.

- 9.6 There is specific concern for the mental health of key workers. Key workers urgently need support now and as we move into the next phase of the pandemic.
- 9.7 Those from BAME backgrounds have felt higher levels of depression and anxiety across the pandemic.

Chapter 10: International Comparisons

- 10.1 The UK government failed to learn from other countries in their handling of the pandemic.
- 10.2 Find Test Trace Isolate and Support is most effective when run at a local or regional level.
- 10.3 Countries with experience of tackling SARS and MERS have dealt with the virus most effectively such as South Korea, Taiwan and Singapore. Those that implemented widespread testing at an early stage with effective contact tracing, cancelling major public events early on, using masks and social distancing measures had better outcomes. Countries which imposed testing and quarantining measures at their ports of entry also had a better rate of success, such as New Zealand.
- 10.4 Communication, clarity, trust and risk perception are essential for compliance.

Chapter 1: Covid-Secure UK Exit Strategy

1.1 The Covid-Secure UK Plan

The Covid-Secure UK plan is the exit strategy that will protect both the health and wealth of the UK until widespread immunity through vaccination is achieved.

The Covid-Secure UK Plan consists of three steps:

4. **Control** - bring the reproduction rate below 1, reduce community transmission.
5. **Suppress** - minimise transmission within the UK at large and stop imported infections at the UK borders.
6. **Eliminate** - obtain widespread immunity to coronavirus through vaccination.

1.2 Control

Reduce the R number to below 1 for a sustained period, moving to a very low level of community transmission.

Measures that can be taken immediately to bring the virus under control include:

1. Urgently develop a locally led and coordinated, but nationally supported Find, Test, Trace, Isolate and Support (FTTIS) programme in England. All testing, including mass testing, needs to be properly supported at a local level with effective contact tracing provision. All testing and screening strategies must be supported by an information campaign which properly informs about the sensitivity and specificity of the tests. The existing mobile phone application should be fully utilised to assist in contact tracing. FTTIS is the most important weakness of the response in England so far.
2. Devolve public health outbreak control efforts such that the response to local flare-ups is led locally, rather than centrally. Provide local authorities with the data, powers, and resources to mobilise and scale-up operations as needed.
3. Introduce screening for coronavirus among groups beyond those already being tested in health and social care who are at particular risk. This includes groups in public facing roles in transport and similar settings. Face coverings and hand sanitiser should be made available free of charge in settings where they are required.
4. To gain entry to the UK at international ports, airports and railway stations, the UK government should require proof of a negative Covid-19 test obtained 72 hours prior to travel, followed by mandatory testing 5 days after arrival in the UK. Quarantine should be carried out at regulated locations. Such measures have proved successful for countries who had experience of SARS and MERS, such as Taiwan, Hong Kong and South Korea, as well as those who used their island geography to their advantage, such as Australia and New Zealand.
5. Effective public support and compliance with non-pharmaceutical interventions requires a full understanding of the severity and the risks associated with the virus incidence levels. High-quality real-time data of the disease spread must be available, with an understanding of the thresholds required for restrictions to be imposed. Public health messaging and advice must be clear, consistent and credible. Where instructions need to be given, these should be

specific. Measures must be communicated using clear, unambiguous, and simple messaging that is not open to misinterpretation, such as: '2 metres apart', not '1 metre plus'.

6. Ask national broadcasters to report on the local level of infection present as part of each news and weather bulletin, as with the pollen and UV rays. This should occur across all news platforms including broadcast, radio and online.
7. Reinstate the daily coronavirus briefings to update the public on progress made while following the Covid-Secure UK Plan.
8. Continue to actively encourage working from home. Where employees cannot work remotely, introduce mandatory face coverings for all employees working indoors and in close proximity with others.
9. Financially support those who need to self-isolate to ensure a high level of compliance with full salary compensation. Introduce a support package for businesses and the self-employed.

1.3 Suppress

Coronavirus is suppressed when community transmission is minimised, and outbreaks are identified and suppressed rapidly. This does not mean that there would be no cases, but that most new cases would be those brought into the UK via people coming through UK borders. Because of this, many of the measures necessary to bring the virus under control can be lifted – thus protecting the livelihoods of everyone in the UK and avoiding subsequent lockdowns and further economic harm.

Suppression is achieved when the number of new cases in the UK is no more than 10 new cases per million population per day, over a seven-day rolling average.

Measures that would be in place when coronavirus is suppressed in the UK include:

1. Proof of a negative Covid-19 test obtained 72 hours prior to travelling to the UK, followed by mandatory testing 5 days after arrival in the UK. Quarantine should be carried out at regulated locations.
2. Screening for groups at particular risk, including those in public facing roles in public transport and similar settings. Face coverings and hand sanitiser should be made available free of charge.
3. Where a case is detected, the fully functional Find, Test, Trace, Isolate and Support (FTTIS) programme and locally led response springs into action, rapidly tracing contacts and breaking transmission chains.
4. Financially support those who need to self-isolate to ensure a high level of compliance.
5. Under this plan the public health response will continue to be run by the devolved governments, while the UK government will be responsible for enforcement at the UK borders. This will require the UK government to work collaboratively with the devolved administrations towards this shared objective.

1.4 Eliminate

Implement a vaccination programme and achieve a high level of uptake.

When a vaccine is approved for use, the UK government should embark on mass-vaccination programme to protect the UK from coronavirus and establish systems to ensure continued surveillance to detect imported cases.

When thinking about the hugely encouraging announcements regarding successful vaccination trials, it is important not to forget that achieving immunity through vaccination is still a long way off. The virus is still not under control in England, let alone suppressed.

Chapter 2: Lockdowns and Exit Strategy

At the tenth⁸ Oral Evidence hearing⁹ the APPG heard from experts in public health¹⁰ on the efficacy of local/national lockdowns, and the path towards an exit strategy. The APPG heard from the following witnesses:

- **Professor Devi Sridhar**, Professor and Chair of Public Health, Edinburgh University.
- **Alice Wiseman**, Director of Public Health for Gateshead.
- **Professor Stephen Reicher**, Professor of Social Psychology at the University of St Andrews, member of the Sage subcommittee advising on behavioural science.
- **Dr David Nabarro CBE**, Special Envoy of the World Health Organisation Director General on Covid-19.
- **Dr Kevin Fong**, Consultant Anaesthetist, seconded to NHS England Covid-19 Emergency Preparedness Resilience and Response team.

Key Findings

- 2.1 Lockdowns are a means of slowing down the incidence of the pandemic when all other means to control the virus have broken down.**
- 2.2 The UK government’s centralised test and trace system is not working.**
- 2.3 The failure to provide sufficient financial support to those in self isolation is a barrier to compliance.**
- 2.4 Public messaging is unclear, and the reasons for the application of NPIs are ill-defined.**
- 2.5 There needs to be greater coordination between all stakeholders involved in the Coronavirus response.**
- 2.6 Relaxing lockdown restrictions too early, without sufficient suppression, can cause more economic damage in the long term. ‘Balancing health versus wealth’ is a false dichotomy.**
- 2.7 There is no such thing as Herd Immunity to Covid-19 in the absence of an effective vaccine.**
- 2.8 A future vaccine should not be relied upon as a ‘silver bullet’ to solve the pandemic.**
- 2.9 The UK government must remain focussed on NHS staff recruitment, retention and support.**

⁸ The ninth Oral Evidence hearing has been incorporated into Chapter 4, since both hearings dealt with the same topic.

⁹ 20th October 2020

¹⁰ Public health is addressed in chapters 2, 6 and 7.

2.1 Lockdowns are a means of slowing down the incidence of the pandemic when all other means to control the virus have broken down.

2.1.1 Lockdowns should be treated as a last resort measure¹¹: *'this is basically when your system is breaking down and you need to hit pause to figure out what you can sort before you can press play again'* (Devi Sridhar, Professor and Chair of Public Health, Edinburgh University).

'Lockdowns have a place where the virus is becoming out of control, but they should not be the solution that we use as a country' (Alice Wiseman, Director of Public Health, Gateshead).

2.1.2 Professor Devi Sridhar cited cases where local lockdowns worked as a strict interim measure to ensure that where there was a spike in cases, spread was prevented. This has worked in Aberdeen as well as in Finland and in Norway, where over the Summer they had a three-week lockdown, to reduce the incidence of the virus, and to build up local test and trace systems. Similarly, in Auckland, and in Victoria, strict lockdowns had worked, where the purpose was to prevent a spike in cases affecting low incidence areas¹².

2.1.3 Complete lockdowns become necessary when there is significantly high disease prevalence, to ensure that the prevalence of the virus reduces to a level low enough that enables the track and trace system to become an effective counter-measure.¹³ In such a scenario, it is important to act quickly and decisively, to avoid exponential increase in the virus spread, and to have very clear goals as to what level of incidence you are aiming for before restrictions can be relaxed.

2.2 The UK government's centralised test and trace system is not working.

2.2.1 The APPG heard that the most effective means to suppress the virus would be to have a functioning and locally led Find Test Trace Isolate and Support system¹⁴. The main aim of such a system is to identify local outbreaks and to break the chains of transmission. It is through breaking chains of transmission that the incidence of the virus will reduce, and it is on this that the UK government needs to focus attention, rather than on the numbers of cases or hospitalisations.

2.2.2 The witnesses were agreed that central government needed to work much more collaboratively with local authorities¹⁶, who have extensive knowledge of their communities, vital for tracing, compliance and for obtaining local trust. This needs to be backed up with powers for local authorities to act independently of central government, together with the resources to support isolation.

2.2.3 In her written evidence, Alice Wiseman submitted that *'whilst there had been a commitment for work to be made 'local by default', the overall programme for managing the pandemic continues to feel 'top down' and co-production doesn't appear to be influencing some of the fundamental changes which are felt as necessary at a local level. ... There must be a willingness*

¹¹https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/520/attachments/original/1604665190/201020_239237_APPG_on_Coronavirus_Session_10_18615_.pdf?1604665190

¹² *ibid*

¹³ *ibid*

¹⁴ Find Test, Trace, Isolate and Support is covered in chapters 2, 3, 6, 7, and 10.

¹⁵https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/520/attachments/original/1604665190/201020_239237_APPG_on_Coronavirus_Session_10_18615_.pdf?1604665190

¹⁶ Local authorities are addressed in chapters 2, 5, 6, and 7.

to hear and understand the issues that are being experienced by people on the ground so we can create a shared understanding of the problems we are trying to solve'. An example of this is the work that is being developed on a model for contact tracing. Much evidence has been provided to demonstrate the significant impact that local contact tracing has had on improving the reach and impact in local communities. Despite wide recognition of this evidence, and an expressed desire to build the local model, there remains a vast imbalance in the resources available to implement this between national and local partners'¹⁷.

2.2.4 Dr David Nabarro also confirmed that locally managed methods of Find, Test, Trace, Isolate and Support are the best way for the pandemic to be managed: *'I want to stress, it's no good talking about testing and isolation, it's no good talking about isolation without putting it into a system, it's having the whole system working particularly at the local level. That will lead us through it. And I'm still a bit stuck as to why this test, trace, isolate thing in the UK doesn't seem to be working properly because if we could crack that then a lot of these problems in my view might be a bit reduced compared with where they are now'.¹⁸*

2.2.5 Suppression measures require buy-in from all stakeholders involved in the Covid response at all levels. Dr David Nabarro reported¹⁹ on the measures taken in China to effectively suppress the virus:

- Full involvement of the people at all levels in responding to Covid.
- Building up a lattice-like public health capacity at the very local level in order to maintain as close as possible 'surveillance' over virus spread in the population, and in particular where there were people who needed support while they were asked to isolate.
- Repurposing hospitals to focus on Covid care to reduce mortality levels.
- Focussing the whole of government and society on support for dealing with Coronavirus immediately.

2.2.6 Similarly in Germany, the Find, Test, Trace, Isolate and Support systems were developed at the level of local authorities, and ensuring that test results are available to the local authorities, so that they can build epidemiological capacity in the communities where transmission is occurring. Equally, they ensured that people have the financial support to isolate, to ensure a high level of compliance.

"The evidence has shown that people are much more likely to comply when they hear a local voice who understands the nuances of a local area, who understands the places that somebody may have gone or may need to go, and who is also able to say actually we're asking you to do this but this is the support we can offer you at the same time, and those things need to be absolutely hand in hand because telling somebody to do something without the necessary support is never going to reach the conclusion that we all want."
Alice Wiseman, Director of Public Health Gateshead.

¹⁷https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/503/attachments/original/1603740534/Alice_Wiseman_Evidence_Summary_17905_.pdf?1603740534

¹⁸https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/520/attachments/original/1604665190/201020_239237_APPG_on_Coronavirus_Session_10_18615_.pdf?1604665190

¹⁹ *ibid*

2.3 The failure to provide sufficient financial support to those in self isolation is a barrier to compliance.

- 2.3.1 As highlighted in Alice Wiseman’s written submission²⁰, the virus has not impacted on society equally. The Non-Pharmaceutical Interventions (NPIs) that are used to control the virus spread have not affected people equally. Restrictive measures, such as lockdowns, impact society unequally. The UK government needs to ensure that there is sufficient support in place to mitigate the inequality and enable people to comply with the restrictions without impacting their own health and well-being. Otherwise, health, adherence and trust in the UK government approach and restrictive measures could be harmed.

“All these interventions (NPI’S) have associated costs in terms of health and wellbeing and many interventions will affect the poorest members of society to a greater extent. Measures will be needed urgently to mitigate these effects and to achieve social justice We also know that people in our most deprived communities are more likely to work in low paid, front-line occupations where there is a greater risk of exposure to COVID-19. Furthermore, people from the poorest backgrounds are most likely to be working in the sectors that will bear the brunt of local restrictions. Current packages of support do not sufficiently take account of the different way that restrictions will be felt between regions and across communities” Alice Wiseman, Director of Public Health, Gateshead.

- 2.3.2 Local authorities need the powers to enable their communities to isolate. As stated by Dr David Nabarro: *‘There should be no question that local is the only way and I’ve talked to business people in places like Telford, they’re running quite tricky high exposure industries and they’ve been talking about how they’ve been able to work with the local mosque, the local synagogue, the local churches, the local sports clubs and actually building an integrated approach because you just don’t do it simply by one particular avenue. And lastly, the national has to support this, it’s no good having national in conflict with local. We saw how the Italian thing got bad at the beginning earlier this year, very, very clear that that was a breakdown between national and Local Authority and everywhere you get that the virus finds a way through, it’s got to be consistent’.*

2.4 Public messaging²¹ is unclear and the reasons for the application of NPIs are ill-defined.

- 2.4.1 Communication is key to ensuring compliance, but the UK government communication has been a continual problem²². Too often key decisions and announcements are made without notice and without consultation with local authorities or local communities: *‘Too often*

²⁰https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/503/attachments/original/1603740534/Alice_Wiseman_Evidence_Summary_17905_.pdf?1603740534

²¹ Communication and messaging are addressed in Chapters 2, 3, 4, 5, 7 and 10.

²²https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/503/attachments/original/1603740534/Alice_Wiseman_Evidence_Summary_17905_.pdf?1603740534

decisions and announcements are still made without much, if any, notice. This often results in Local Authorities and Directors of Public Health being very much on the back foot, trying to respond to the understandable queries from residents but without the necessary detail. SAGE highlights the importance in building and maintaining community trust and this is undermined if local leaders can't explain what is going on'.

- 2.4.2 As UK government messaging has not been clear and consistent, this has negatively impacted compliance. As Stephen Reicher pointed out, compliance with the rules at the beginning of the first lockdown was high, but the sudden ease of restrictions, without real evidence to support the decision to ease restrictions, has undermined adherence²³.

"If I had to say one moment where my heart fell it was when it was decided to reopen pubs and hospitality on July the 4th, leading to headlines of Independence Day and of freedom Saturday and I think by opening up too fast and in far too unregulated a way we instead of suppressing the virus, which we had the opportunity to do, we allowed it to continue, it was already endemic in certain areas in the North-West and that's why when conditions began to get worse, when the summer ends, when people begin to be indoors, when schools go back, when universities go back, it was bound to increase again. So, if you relax too quickly I think you pay the cost in the long-term."
Professor Stephen Reicher, Professor of Social Psychology.

- 2.4.3 Stephen Reicher submitted that instrumental compliance is not effective²⁴. Far more effective is for authority to be seen as part of the community and working for the community, by listening and being seen to listen, by showing respect and trust and by admitting fallibility. *'There needs to be a lot more humility, we don't need world-beating this or that, we need functional this and that. We need to be able to admit our mistakes and we got things wrong and how we're going to improve them, and we need to move away also from punishment.'* (Stephen Reicher, Professor of Social Psychology.)
- 2.4.4 Compliance will be achieved if the goals are clear and well-defined, such that the public understand the purpose of compliance: *'there would be greater compliance if we were clearer and we were more systematic'* (Stephen Reicher, Professor of Social Psychology).
- 2.4.5 Further, restrictive measures need to be backed up with powers for local authorities to enforce them. Local authorities need robust immediate powers to shut down the few businesses who do not comply with restrictions²⁵.
- 2.4.6 Finally, restrictive measures such as lockdowns, need to be used for two purposes. The first is to reduce the incidence of transmission. The second is to implement measures so that the need for repeated lockdowns is avoided. The time that a lockdown provides should be used to create a locally based test, trace, isolate and support system.²⁶

²³https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/520/attachments/original/1604665190/201020_239237_APPG_on_Coronavirus_Session_10_18615_.pdf?1604665190

²⁴ *ibid*

²⁵ *ibid*

²⁶ *ibid*

2.5 There needs to be greater coordination between all stakeholders involved in the Coronavirus response.

- 2.5.1 Alice Wiseman submitted in her written evidence²⁷ that management of the pandemic requires interventions at all levels of society. However, as the strategic aims of pandemic management have not been defined, there has been confusion on the part of the different stakeholders. To improve management processes, a broad and comprehensive strategy to define the aims and responsibilities of all stakeholders should be agreed.
- 2.5.2 The Association of the Directors of Public Health (ADPH) publication ‘Protecting our Communities’²⁸, sets out the principles which could be used as a starting point for improving the strategy for central, regional, local government and communities to work together, thereby ensuring greater effectiveness and compliance.

1. Collaborative leadership.

This is the time for people of all political persuasions to work together in the interests of public health and wellbeing. Decision makers should seek to put personal views and party politics aside.

2. With, not to.

Action should be taken with, and through, local people with their local representatives being a key part of the solution, as well as national leaders. The system needs to work together: not national or local but national and local.

3. Partnership.

A strong three-way contract between the people, local systems and national government is essential to creating a clear and consistent public narrative.

4. Communication.

A commitment to explaining a rationale for decisions, timeframes for implementing measures, why measures are being selected and how they are being developed.

5. Subsidiarity.

Consensus about subsidiarity should be sought i.e. the choice of which geographical footprint is best for interventions and actions.

6. Avoiding false choices.

Promoting and protecting health and creating a vibrant economy is not a binary choice, both must be viewed as complimentary aspirations.

²⁷https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/503/attachments/original/1603740534/Alice_Wiseman_Evidence_Summary_17905_.pdf?1603740534

²⁸ https://www.adph.org.uk/wp-content/uploads/2020/10/Protecting-our-communities_ADPH_final.pdf

7. Sustainability.

Agreeing timeframes and balancing the trade-offs between health, social and economic factors is a key consideration when implementing measures that could be in place for a short period of a few weeks, or for a much longer period of several months.

8. Consistency.

It is important to provide enough time for the impact of measures to be observed and understood and realistic about how long interventions might take to reduce transmission rates whilst acknowledging certain circumstances will require rapid decision making.

9. Agility.

There will remain a need for an agile response to the use of measures with local areas flexing their approaches to meet the changing circumstances as the pandemic progresses.

10. Evidence-informed.

Application of measures should be informed by existing evidence where we have it but not limited to what is evidence-based now when there is a clear rationale for acting. We need to acknowledge that the evidence base is being developed through practice i.e. this will be iterative. Consequently, flexibility at all levels will be required to respond to the emerging data, epidemiology, evidence on effectiveness and outcomes and make the best possible decisions with the information available at the time.

2.6 Relaxing lockdown restrictions too early, without sufficient suppression, can cause more economic damage in the long term. ‘Balancing health versus wealth’ is a false dichotomy.

- 2.6.1 Professor Sridhar referred to a paper²⁹ for the Royal Society on the economic aspects of the Covid-19 crisis on the UK economy, which concluded that a tight lockdown which is released too quickly or too fully would probably lead to adverse outcomes in terms of both lives and livelihoods. Where restrictions are lifted, there can be more economic damage and unemployment because of the uncertainty and changes in consumer behaviour. The countries who have been the most successful in managing the pandemic from a public health perspective (for example Taiwan, China, South Korea, New Zealand amongst others) are now seeing economic growth, because they have suppressed the virus successfully³⁰.
- 2.6.2 Witnesses were critical of the ‘Eat out to Help out’ scheme and the sudden release of restrictions ahead of July 4th when it was clear that the pandemic had not been suppressed enough. The boost to the hospitality industry has now been entirely removed because of the need for tighter restrictions³¹. The result has been that if restrictions are released too soon, the cost to the economy is worse in the long term.
- 2.6.3 As stated in the ADPH publication ‘Protecting our Communities’³² *‘Promoting and protecting health and creating a vibrant economy is not a binary choice, both must be viewed as complementary aspirations’*.

2.7 There is no such thing as Herd Immunity to Covid-19 in the absence of an effective vaccine.

- 2.7.1 Dr David Nabarro was clear³³ that Covid-19 is a virus that we are going to have to live with. Living with the virus means holding it at bay. The virus is much broader than a respiratory illness: it is damaging to particular epithelial cells, particularly in the respiratory tract but also to the cells that are part of the lining of blood vessels, as well as to the cells that are around the brain. A significant proportion go on to suffer from Long Covid. A herd immunity strategy is not viable or ethical.
- 2.7.2 Living with the virus means changing our behaviours. It means physical distancing and it means wearing face coverings. If everyone complied with these measures, then top down restrictions become less necessary.

2.8 A future vaccine should not be relied upon as a ‘silver bullet’.

- 2.8.1 While the prospect of a vaccine or other medical developments are compelling, they should not be relied upon as the solution to this virus, partly because we do not know of their efficacy,

²⁹ <https://rs-delve.github.io/reports/2020/08/14/economic-aspects-of-the-covid19-crisis-in-the-uk.html#key-conclusions>

³⁰ https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/520/attachments/original/1604665190/201020_239237_APPG_on_Corona_virus_Session_10_18615_.pdf?1604665190

³¹ *ibid*

³² https://www.adph.org.uk/wp-content/uploads/2020/10/Protecting-our-communities_ADPH_final.pdf

³³ https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/520/attachments/original/1604665190/201020_239237_APPG_on_Corona_virus_Session_10_18615_.pdf?1604665190

or how long they will take to approve and roll out, and partly because we do not know how long immunity will last, even with a vaccine.

2.9 The UK government must remain focussed on NHS staff recruitment, retention and support.

2.9.1 As submitted by Kevin Fong, not enough consideration has been given to looking after the NHS staff in the pandemic, in terms of recruitment, retention and support:

'The NHS will long cease to be able to deliver intensive care for its population of patients, whatever their conditions, long, long before we run out of our last ventilator or our last bed. The staff have not been enough of a factor in our thinking here, they need to be as we go forwards, they are part of the equation, a factor, an important factor in the equation for the sustainability of Covid going into the next few months.'

'The most important thing we've discovered is that if you bring people together as a community, if you get them to think in terms of 'we' rather than 'I' then they can support each other and they can be incredibly resilient and the most important thing then is for Government not to see the public as weak and as a problem which they have to manage but as a resource and as a partner that they need to work with. And if they do that, then I think we have a remarkable asset which can take us through the pandemic and allow us to live with and come out successfully from this experience.'

Professor Stephen Reicher, Professor of Behavioural Psychology.

Chapter 3: The impact of Covid-19

In the first Oral Evidence hearing³⁴, the APPG heard from organisations representing those working directly at the frontline of the pandemic: the BMA, National Health Service Confederation, and Doctors Unite.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Doctors in Unite is the UK's oldest medical trade union representing junior doctors, general practitioners, and hospital consultants.

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. The NHS Confederation represents hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

Key Findings

- 3.1 The UK government did not adequately prepare in terms of stockpiling sufficient and adequate Personal Protection Equipment (PPE). The procurement, supply and distribution of PPE to the NHS and social care sector was delayed and poorly coordinated, with ineffective oversight.**
- 3.2 There are significant staff shortages in both the NHS and social care sector. Covid-19 has had a considerable impact on the health, safety and well-being of the workforce.**
- 3.3 The social care sector has been severely impacted by the pandemic. There was insufficient coordination of supply and distribution to the social care sector which led to significant problems with access to PPE. The quarantine arrangements for those coming into the social care sector from hospitals were inadequate.**
- 3.4 In the first wave of the pandemic, there was a considerable resource shift in the NHS to managing patients with Covid-19. This has led to a considerable backlog of care.**
- 3.5 The centralised Test and Trace system is not working.**
- 3.6 Covid-19 has not impacted society equally.**
- 3.7 Communication between the UK government and local systems of healthcare provision needs to be improved.**

³⁴ 29th July 2020

3.1 The UK government did not adequately prepare in terms of stockpiling sufficient and adequate Personal Protection Equipment (PPE). The procurement, supply, and distribution of PPE to the NHS and social care sector was delayed and poorly coordinated, with ineffective oversight.³⁵

- 3.1.1 The UK experienced the pandemic later than some other countries³⁶. With time on our side and an ability to learn from other countries that had experienced the pandemic in advance the UK, the witnesses submitted that the UK government did not adequately prepare in terms of stockpiling sufficient and adequate PPE.
- 3.1.2 Initially there were widespread shortages of PPE across the health and social care sectors. The lack of appropriate PPE for doctors was demonstrated by a BMA survey, April 2020³⁷, of over 6,000 doctors which demonstrated that around half of doctors working in high-risk areas said there were shortages or no supply at all of long-sleeved disposable gowns and disposable goggles, while 56% said the same for full-face visors. In general practice, more than a third of GPs said they had no eye protection, with a further third saying there were shortages generally.
- 3.1.3 This was further exacerbated through significant delays to procuring additional PPE, with reports of some batches being sent to the NHS being either faulty or past their expiry date.
- 3.1.4 The UK government asserted³⁸ that some of the problems were logistical, rather than due to lack of supply. The UK government also suggested that PPE was being '*wasted by frontline staff*'. This lack of transparency and attribution of blame by UK government led to a lack of trust by many frontline workers³⁹.
- 3.1.5 Given the fragmentation of the NHS supply chain, there needs to be accountable and coordinated leadership instead of a disconnected web of private providers who have acted independently and with ineffective oversight.
- 3.1.6 While over £15 billion worth of investment⁴⁰ has seen the situation improve significantly, concerns remain as more patient services resume across the country, while the NHS also maintains capacity for a second wave of the disease this winter.
- 3.1.7 Equalities considerations were not considered when commissioning and supplying PPE, with doctors who wear beards for religious reasons being told there were no alternatives to FFP3 masks. As a result, they were told they must abandon their religious practice and shave their beards, even though the HSE recognises that suitable alternatives like PAPR hoods should be provided. There were also instances of women and those of different ethnicities struggling to find face masks that fit. Additionally, doctors who are deaf and reliant on lip-reading have highlighted the need for transparent face masks to be developed.

³⁵ PPE is addressed in Chapters 3, 5, 6 and 8

³⁶https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/296/attachments/original/1596126241/APPG_on_Coronavirus.pdf?1596126241

³⁷ BMA survey, April 2020, <https://www.bma.org.uk/news-and-opinion/doctors-still-without-adequate-supplies-of-ppe-major-bma-survey-finds>

³⁸ <https://www.bbc.co.uk/news/av/health-52253732>

³⁹https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/328/attachments/original/1597774552/239117_All_Party_Group_on_Coronavirus_Oral_Evidence_Session_1_%281%29.pdf?1597774552

⁴⁰ <https://nhsconfed.org/resources/2020/07/summerstatement>

3.2 There are significant staff shortages in both the NHS and social care sector. Covid-19 has had a considerable impact on the health, safety and well-being of the workforce.⁴¹

- 3.2.1 Before the pandemic, the NHS in England had around 106,000 FTE vacancies, including nearly 44,000 nurses and more than 9,000 doctors⁴². There were more than 100,000 vacancies in social care⁴³. Even without the demands of the pandemic, there was (and remains) an urgent need to expand the health and social care workforce.
- 3.2.2 In response to the pandemic, the NHS diverted staff, stopped activity and increased its workforce, creating enough capacity to manage the demands from patients with Covid-19.
- 3.2.3 Given the level and pace at which many staff on the front line have been working, there is a need for significant ongoing support to manage the considerable impact this intense period will have had on their mental health⁴⁴. This will also be important if we are to support staff to cope with local outbreaks and a second wave.
- 3.2.4 Further, much greater action is also required to protect the health, safety, and wellbeing of the workforce. BMA survey data indicates that, as recently as July 2020, 30% of doctors had still not had a risk assessment to determine if they are likely to be at increased risk from Coronavirus. There needs to be an effective system of risk assessment for all doctors, including those from Black, Asian and Minority Ethnic (BAME) backgrounds, and those who are pregnant, to ensure that doctors can work in a way that minimises risk to themselves and patients.

3.3 The social care sector has been severely impacted by the pandemic. There was insufficient coordination of supply and distribution to the social care sector which led to significant problems with access to PPE. The quarantine arrangements for those coming into the social care sector from hospitals were inadequate.

- 3.3.1 Care homes were severely affected by the Covid-19 pandemic in many countries across the world. In the UK an excess of 20,000 deaths of individuals in care homes was reported during March and April 2020⁴⁵. Many care homes are privately owned, and therefore oversight is challenging and there is little central coordination or planning. In addition, there were 100,000 vacancies in social care at the outbreak of the pandemic⁴⁶.
- 3.3.2 Access to and distribution of PPE to social care settings were even more difficult for those working in social care settings than in the NHS. This was partly attributed to the fragmentation of the social care sector.

⁴¹ Social Care is addressed in chapters 3, 5, 6, 7, 8, and 9

⁴² <https://fullfact.org/election-2019/12k-fullfact-nhs-vacancies/>

⁴³ <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>

⁴⁴ Mental health is addressed more fully in Chapter 9, and also in chapters 4, 5, and 8

⁴⁵ [Academy of Medical Science: Preparing for a challenging Winter 2020/21](https://www.academyofmedicalsciences.org.uk/Preparing-for-a-challenging-Winter-2020/21)

⁴⁶ <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>

- 3.3.3 Going forward, there needs to be much greater coordination of planning of the NHS and social care sectors. It is vital that the social care sector receives the appropriate level of support and expertise to prevent outbreaks. The UK government needs to adopt transitional and quarantine provisions between NHS and social care, and within social care.
- 3.3.4 There needs to be central oversight of the procurement and delivery of PPE to the social care sector.
- 3.3.5 There is a lot of movement of staff between the NHS and social care. Because pay is better in the NHS, most of the movement is towards the NHS⁴⁷. Support and pay for staff need to be equalised between the two settings.

3.4 In the first wave of the pandemic, there was a considerable resource shift in the NHS to managing patients with Covid-19.

- 3.4.1 In a report commissioned by the UK government, the Academy of Medical Sciences recently warned⁴⁸ that the NHS faces a number of potential challenges this winter, including the risk of a second wave of Covid-19 cases, a significant flu outbreak and a growing backlog of work (for example, it has been estimated that waiting lists for elective care could rise as high as 10 million by the end of the year).
- 3.4.2 The unprecedented resource shift towards critical care to prepare for the Covid-19 outbreak came at the expense of other parts of the NHS. This included postponing all non-urgent elective operations, urgently discharging hospital inpatients medically fit to leave, and block-buying capacity in independent hospitals⁴⁹. There was also a large shift in workforce and technical capacity from other clinical areas towards critical care. This has had far-reaching effects on both patients and the health and social care workforce. In a recent BMA survey, 40% of respondents said that the longer-term impact of Covid-19 on patient clinical demand was their top concern⁵⁰.
- 3.4.3 As we emerge from the worst aspects of the first wave of the pandemic, workload intensity will increase above pre-Covid levels as the NHS resumes all services and deals with the backlog of non-Covid patient need. As such, the UK government is urged to commit to increased resources for the NHS to ensure all patients can receive the care they need in a timely and safe fashion, both for themselves and the NHS staff who care for them.

⁴⁷https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/328/attachments/original/1597774552/239117_All_Party_Group_on_Coronavirus_Oral_Evidence_Session_1_%281%29.pdf?1597774552

⁴⁸ <https://acmedsci.ac.uk/more/news/prepare-now-for-a-winter-covid-19-peak-warns-academy-of-medical-sciences>

⁴⁹ Letter from Sir Simon Stevens and Amanda Pritchard, 17 March 2020, <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf>

⁵⁰ BMA, 03 May 2020, <https://www.bma.org.uk/news-and-opinion/bma-survey-reveals-almost-half-of-doctors-have-relied-upon-donated-or-self-bought-ppe-and-two-thirds-still-don-t-feel-fully-protected>

3.5 The centralised Test and Trace system is not working.⁵¹

- 3.5.1 In the absence of an efficient drug treatment or a vaccine, the control of Covid-19 relies on the traditional infection control measures of find, test, trace, isolate and support.
- 3.5.2 The witnesses submitted to the APPG that the UK government's decision to favour a nationwide privatised test and trace approach over the locally established primary health care system of find, test, trace, isolate and support, has impacted our ability to control the spread of the pandemic from the start, with test results taking too long, being lost, not being available to local GPs, or to local hospitals⁵².
- 3.5.3 According to a Treasury report⁵³, £10bn was spent on the UK government's test and trace strategy. The DHSC also documented that local public health⁵⁴ teams traced eight times more contacts compared to the national call centre run by Serco and Sitel⁵⁵. Rather than outsourcing the contract tracing service to private firms, it was submitted that local public health teams would have been better placed to lead this initiative had they been better resourced and sufficiently funded.
- 3.5.4 Further, concern was raised by witnesses as to the misleading reporting by UK government on the number of tests being carried out for Covid-19, as reported by the UK Statistics Authority (UKSA). The UKSA highlighted a lack of clarity and transparency over the number of tests carried out and the number of testing kits sent out by post⁵⁶. Concerns were raised as to the UK government's assertions that testing centres and mobile units were turning around test results within 24 hours, with recently published data seeming to contradict these claims⁵⁷.
- 3.5.5 Concerns were also raised as to the accessibility of privately run testing centres, as well as to the accessibility of results, many of which have gone missing and are not accessible to GPs⁵⁸.
- 3.5.6 The witnesses submitted that to be effective contract tracing needs to be locally based and carried out by people based in the community, who know the community, who can go out and talk to people, explain why they need testing and why they need to isolate.
- 3.5.7 Communities unable to self-isolate due to financial reasons or as a result of their housing environment need to be supported financially or via the provision of alternative accommodation to enable compliance.

⁵¹ Find Test, Trace, Isolate and Support is addressed in chapters 2, 3, 6.7, 7 and 10

⁵²https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/296/attachments/original/1596126242/BMA_submission_Coronavirus_APPG_inquiry_170720.pdf?1596126242

⁵³ HM Treasury, A plan for jobs (July 2020): <https://www.gov.uk/government/publications/a-plan-for-jobs-documents/a-plan-for-jobs-2020>

⁵⁴ Public health is also addressed in chapters 2, 6 and 7.

⁵⁵ BMJ, Covid-19: Local health teams trace eight times more contacts than national service (June 2020), <https://www.bmj.com/content/369/bmj.m2486>

⁵⁶ Sir David Norgrove response to Matt Hancock regarding the Government's COVID-19 testing data (June 2020): <https://uksa.statisticsauthority.gov.uk/correspondence/sir-david-norgrove-response-to-matt-hancock-regarding-the-governments-covid-19-testing-data/>

⁵⁷ <https://fullfact.org/blog/2020/jul/inaccurate-testing-data/>

⁵⁸https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/296/attachments/original/1596126241/APPG_on_Coronavirus.pdf?1596126241

- 3.5.8 A community-based approach to find, test, trace, isolate and support can achieve successful tracing and isolation levels. This is the model used in Germany: central coordination and support, but locally driven.

3.6 Covid-19 has not impacted society equally.⁵⁹

- 3.6.1 Covid-19 has shone a harsh light on the health and wider inequalities in our society⁶⁰. The impact has been particularly detrimental to those living in areas of high deprivation, to people from BAME⁶¹ communities, on older people, men, those with a learning disability and others with protected characteristics⁶². There is a need for a much stronger focus on the impact of health inequalities on the resilience of communities and individuals to the virus.
- 3.6.2 As has been acknowledged in PHE's recent paper Beyond the Data: Understanding the Impact of Covid-19 on BAME groups⁶³, lessons need to be learnt from this initial phase of the pandemic, to mitigate the risk that future waves could again have severe and disproportionate impacts.
- 3.6.3 Additionally, more support must be given to those on precarious contracts who are financially compelled to work: for those who are unsure of their eligibility for NHS care, there needs to be clear messaging from UK government that all are eligible for treatment. Without supporting the most vulnerable in our society, we risk increasing the spread of the pandemic.
- 3.6.4 Further, while it was noted that a move by GPs to online consultations had worked reasonably well, and had been beneficial to many patients who would otherwise struggle to attend GP surgeries, caution must be noted for the following areas: face-to-face contact is still important for some consultations, and the UK government must ensure that moving to digital consultations does not exacerbate existing health inequalities.
- 3.6.5 The Covid-19 pandemic has brought to the fore longstanding structural inequalities that persist within the UK and our public services. However, it has also exposed where action is needed to address these. Recommendations within PHE's report⁶⁴ on the impact of Covid-19 on BAME communities must be urgently implemented and an action plan published that clearly sets out roles and responsibilities for taking these recommendations forward.
- 3.6.6 Public bodies must be clear that the Public Sector Equality Duty (PSED) remains in force throughout the current crisis and must continue to gather data and assess the impact on equality of their policy and practices. Equality monitoring must continue throughout the pandemic and steps taken to identify and mitigate health inequalities and disparities of experiences and outcomes as they arise.

⁵⁹ Inequalities is addressed in chapters 3, 7 and 9.

⁶⁰ <https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/>

⁶¹ The impact on BAME communities is addressed in Chapters 3, 4, 5, 8 and 9.

⁶² <https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/>

⁶³ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

⁶⁴ <https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/>

3.7 Communication between the UK government and local systems of healthcare provision needs to be improved.⁶⁵

- 3.7.1 Witnesses to the APPG were united in their view that the response to the pandemic worked best when partnerships of public sector leaders developed local solutions, informed by the differing needs of their communities. National responses, in areas such as PPE and Testing (as described above) were markedly weaker.
- 3.7.2 Similarly, information flow for shielding programmes between national and local systems did not operate effectively. Communication to shielding patients should be done through GPs rather than by a centralised system.
- 3.7.3 In terms of staff support, failure by UK government to listen to frontline workers and their concerns over matters such as provision of PPE had undermined trust and morale.

⁶⁵ Communication and messaging are addressed in Chapters 2, 3, 4, 5, 7 and 10.

Chapter 4: Long Covid and Bereaved Families

In the second Oral Evidence hearing⁶⁶, the APPG heard from members of the Bereaved Families for Justice group and Long Covid Support Group.

Long Covid Support Group is a group which was started on Facebook. At the time of writing, the group now had over 22,000 members. Members of the group, along with other groups such as Long Covid SOS are campaigning for ‘recognition, research and rehabilitation’.

Bereaved Families for Justice is a group of bereaved family members who have come together to seek justice for their loved ones who have died from Covid-19.

At the time of writing, the APPG had received over 1200 individual submissions via the APPG evidence portal. Over 50% of submission came from those suffering from Long Covid. Over 200 submissions were received from bereaved family members or friends.

Key Findings

Long Covid

- 4.1 The UK government is not counting the number of individuals who are left with long-lasting effects of Covid-19 as a measure of the severity and impact of the pandemic.
- 4.2 As a medical condition, Long Covid has not yet received full recognition, sufficient research funding or adequate rehabilitation support.
- 4.3 There are very few guidelines for employers or for GPs on recognising and managing Long Covid.

Bereaved Families

- 4.4 There must be a judge led inquiry into the UK government’s handling of the pandemic.
- 4.5 UK government was too slow to lockdown during the first wave of the pandemic.
- 4.6 The advice given by the NHS 111 service may have resulted in people who were experiencing severe symptoms being advised against seeking medical advice.
- 4.7 Hospital admissions may have led to increased incidence of Covid-19 in the first wave.
- 4.8 Shielding guidance from the UK government was unclear.
- 4.9 There is a lack of support for bereaved families as the normal support systems (family, friends, mental health support) are not accessible while Covid-19 restrictions are in place.

⁶⁶ 5th August 2020

4.1 The UK government is not counting the number of individuals who are left with long-lasting effects of Covid-19 as a measure of the severity and impact of the pandemic.

4.1.1 ‘Long Covid’, also known as ‘Long Haul Covid’, is the term being used to describe the lasting effects of having Covid-19. There is currently no medical definition or definitive list of symptoms of Long Covid. What is clear from the evidence submitted to the APPG is that there is a wide range of symptoms which can vary from individual to individual. The most common symptoms are akin to that of existing conditions such as ME or chronic fatigue, though the APPG heard that those living with Long Covid do not want the condition to be caught under the umbrella of existing illness. The APPG was pointed to an article in the British Medical Journal by Dr Nisreen Alwan. Dr Alwan suffers from Long Covid. The article states *‘death is not the only thing to count in this pandemic, we must count the lives changed’*.⁶⁷ Witness Dr Jake Suett referred to this during the oral evidence hearing. Given that there is little known about Long Covid, we need to conduct more research: *‘we cannot fight what we do not measure’*⁶⁸ (Dr Jake Suett).

4.1.2 The APPG received evidence as to the wide-ranging symptoms of Long Covid. These include, but are not limited to:

- Fatigue
- Dyspnea
- Headache
- Tight chest
- Cough
- Muscle pain
- Sore throat
- Increased temperature
- Pain between shoulder blades
- Pain/burning feeling in lungs
- Heart palpitations
- Increased resting heart rate
- Dizziness, nose cold
- Burning feeling in the trachea
- Fever
- Ageusia
- Diarrhoea
- Joint pain
- Nausea
- Mucus, sneezing
- Heat flushes
- Eye problems
- Ear pain
- Weight loss
- Vomiting
- Red spots on toes/feet, purple toes

“I have had symptoms since 7th March, ongoing chest tightness and breathing problems 6 months on” (Written submission to APPG portal).

“I’ve been using a wheelchair for a month now, I had been bedridden for several weeks at the beginning, only able to shuffle to the toilet and possibly downstairs for one meal a day.” Claire Hastie, Long Covid Support Group and witness to APPG hearing.

⁶⁷ <https://blogs.bmj.com/bmj/2020/07/28/nisreen-a-alwan-what-exactly-is-mild-covid-19/>

⁶⁸ APPG Transcript, accessible at:

https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/340/attachments/original/1597225304/239122_All_Party_Parliamentary_Group_on_Coronavirus_Session_2.pdf?1597225304

4.2 As a medical condition, Long Covid has not yet received full recognition, sufficient research funding or adequate rehabilitation support.

- 4.2.1 Evidence received to the APPG makes clear that there is an urgent need for recognition, research and rehabilitation.
- 4.2.2 There is a need for employers to recognise Long Covid. Witnesses testified that they felt *'pressured back to work by employers who do not understand Long Covid'*, particularly since it was understood that those with mild cases of Covid-19 would recover after two weeks.
- 4.2.3 Long Covid must not be 'compartmentalised' into an existing category of illness. A written submission to the APPG portal states: that *'compartmentalising Long Covid into an existing category is a route to dismissal'*.
- 4.2.4 It must be recognised that Covid-19 is not 'binary'. The discourse surrounding Covid-19 must communicate that there is not a binary between young persons in good health and those who are elderly or had pre-existing health conditions. Witnesses to the APPG oral evidence hearing state that those who are young and in good health may suffer long term from Covid-19.
- 4.2.5 At present, there is inadequate research and understanding as to the condition. The first UK study to assess the long term health impacts of Covid-19 is the PHOSP-Covid Study, from the Leicester Biomedical Research Centre.⁶⁹ While an important study, the APPG was told that there is an urgent need to study not only those who were hospitalised but also those who did not receive hospital treatment. The APPG was also directed to a Dutch study by the Lung Foundation⁷⁰, which states that the severity of symptoms is no different from those who are hospitalised and those who are not.
- 4.2.6 Greater research and more research funding are required. The officially recognised list of Covid-19 symptoms (fever, cough, loss of taste) does not reflect the range of symptoms that may be experienced by those suffering from Long Covid.

4.3 There are very few guidelines for employers or for GPs on recognising and managing Long Covid.

- 4.3.1 There is a need for greater medical support and treatment for those living with Long Covid, particularly for those who were not among the hospitalised cohort.
- 4.3.2 Those living with Long Covid express frustration at GPs misdiagnosing Long Covid as ME or chronic fatigue or post-viral fatigue. Moreover, the APPG has learned that patients have been ignored by GPs who have suggested that *"it's caused by anxiety and is all in [our] heads"*⁷¹.
- 4.3.3 There must be greater advice on the treatment and management of Long Covid for GPs.

⁶⁹<https://www.leicesterbrc.nihr.ac.uk/themes/respiratory/research/phosp-covid/>

⁷⁰<https://www.longfonds.nl/nieuws/wetenschappelijk-tijdschrift-publiceert-over-longfonds-onderzoek>

⁷¹ APPG Transcript, accessible at:

https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/340/attachments/original/1597225304/239122_All_Party_Parliamentary_Group_on_Coronavirus_Session_2.pdf?1597225304

“I am extremely concerned about the lack of support and treatment for the thousands of people suffering from ‘Long Covid’ symptoms who were not hospitalised. My daughter has suffered for four months. She has anxiety due to the lack of information, help, support or medical advice.” APPG Portal Submission.

Bereaved Families

At the time of writing, there have been over 44,000 deaths from Covid-19 in the UK. With each of these deaths families and friends are left grieving, often alone or without support.

4.4 There must be a judge led inquiry into the UK government’s handling of the pandemic.

- 4.4.1 The Bereaved Families for Justice Group alongside many bereaved individuals are calling for an urgent judge-led inquiry into the UK government handling of deaths caused by the virus.
- 4.4.2 The inquiry must be urgent so that lessons can be learnt, and more families will not have to suffer the loss of a loved one.
- 4.4.3 The APPG has written to the Prime Minister, Boris Johnson, requesting that he meets the bereaved families who have lost loved ones to Covid-19. At the time of writing, he declined to meet members of the Covid-19 Bereaved Families for Justice group, despite promising to do so.⁷²

4.5 UK government was too slow to lockdown during the first wave of the pandemic.

- 4.5.1 The APPG heard that bereaved families believe that, had lockdown occurred earlier with workplaces being required to close and travel to broadly cease, their loved ones may not have died as a result of Covid-19.
- 4.5.2 Of the written submissions provided to the APPG, a large proportion of them note that lockdown ‘should have been earlier’.

“I begged him to stop going to work during the weeks before official lockdown, but without government support, people had no choice but to continue going to work Lockdown should have been implemented earlier, if they had my dad might still be alive.” APPG Portal Submission.

⁷² <https://www.theguardian.com/politics/2020/sep/01/boris-johnson-backtracks-on-meeting-group-for-covid-19-bereaved>

“Dad had a lot of reasons to live, his daughters, his family, his community, his charity work, but he only needed one reason to die, the Government’s sluggish response to the threat of Covid-19 to our country. If our Government had taken heed of the WHO declaring Covid-19 a global pandemic emergency on the 13th of March, a lockdown even one week sooner than the 23rd of March, Covid would have been far less prevalent in our society and our NHS staff and key workers like my Dad would have been sent to work without it costing so many of them their lives. We should also have quarantined all those returning to the UK from abroad when it became clear in early March what Spain, Italy, France, Portugal and Germany were experiencing, the warnings were there we just didn’t listen. My only aim in telling my Dad’s story is to better highlight the failures of the government’s response to the first wave of this pandemic so that lives can be saved in the coming second winter wave” Hannah Brady, witness to APPG.

4.6 The advice given by the NHS 111 service may have resulted in people who were experiencing severe symptoms being advised against seeking medical advice.

- 4.6.1 Both written and oral evidence highlighted the need for an urgent review of the NHS 111 service. The advice from this service has been deemed ‘insufficient’ in many written submissions, however, the APPG heard during the evidence hearing that the *“111 service [is] responsible for many, many deaths”*⁷³ (Charlie Williams, witness to the APPG).
- 4.6.2 Guidance for 111 responders was insufficient. Written submissions from bereaved individuals state that when contacting the service, they were told that the patients breathing difficulties were ‘not Covid related’, for them to later die from the virus. Many submission state similar experiences.
- 4.6.3 Those who likely required hospital treatment were advised to stay at home by the 111 service. Jo Goodman of the Bereaved Families for Justice group testified that many were told to stay at home despite their symptoms being *“clearly extremely severe”*⁷⁴ (Jo Goodman, witness to the APPG).
- 4.6.4 There must be an urgent review into the advice given to and provided by the 111 service to Black, Asian and minority ethnic individuals.

“With a black person, you cannot tell if their lips are blue, that one question alone is responsible for several deaths within the BAME community and the wider community as well” Charlie Williams, witness to APPG.

⁷³ ibid

⁷⁴ ibid

4.7 Hospital admissions may have led to increased incidence of Covid-19 in the first wave.

- 4.7.1 The issue of hospital admissions was detailed across written and oral evidence.
- 4.7.2 There must be a review of hospital admissions. Many patients receiving treatment for non-Covid-related illnesses may have caught Covid-19 whilst in hospital care. Written evidence stated that their mother had gone into hospital initially with a suspected kidney infection but later died of Covid-19 having contracted it whilst there. Another stated that their *“Mum went to hospital because she had a fall. She caught Covid in hospital. She has been let down in the worst possible way.”* (APPG portal submission).
- 4.7.3 Families were unable to say goodbye to loved ones who died from Covid-19 in hospital. There was inadequate provision to do so. Many patients died ‘scared and alone’. Written evidence stated that they were only able to say goodbye over video call by using a nurse’s personal phone.

“Family members have watched their loved ones die slow agonising deaths, some have said goodbye on phone calls, video calls, while others like us weren’t able to say goodbye at all.” Kathryn de Prudhoe, witness to APPG.

- 4.7.4 Concerns were raised as to the reports of Covid-19 patients being placed on ‘Do Not Resuscitate’ orders without consent⁷⁵.

4.8 Shielding guidance from the UK government was unclear.

- 4.8.1 Guidance surrounding those who should be shielding was *‘too slow’*, and *‘complicated’* and the level of risk to many individuals was not effectively communicated.
- 4.8.2 There may have been millions of people who ought to have been shielding before lockdown.
- 4.8.3 A witness to the APPG reported how her father received his shielding letter in April, nine days after he had died⁷⁶.

⁷⁵https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/296/attachments/original/1596126241/APPG_on_Coronavirus.pdf?1596126241

⁷⁶https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/340/attachments/original/1597225304/239122_All_Party_Parliamentary_Group_on_Coronavirus_Session_2.pdf?1597225304

4.9 There is a lack of support for bereaved families as the normal support systems (family, friends, mental health support) are not accessible while Covid-19 restrictions are in place.

- 4.9.1 Many families are suffering from complex grief. Families have been deprived of the normal grieving process. Their normal support networks of friends and family have been cut off due to Covid restrictions. Witnesses to the APPG reported that there has been inadequate provision of mental health⁷⁷ and bereavement support for families.

“Mum self-isolated immediately after being bereaved and most people haven’t been able to access their usual support networks of family and friends. Funeral restrictions have deprived us of the basic fundamental part of the grieving process” Kathryn de Prudhoe, witness to APPG.

⁷⁷ Mental health impact is addressed in Chapter 9, and also in chapters 4, 6, and 8

Chapter 5: The Impact on Social Care

In the 3rd Oral Evidence hearing⁷⁸, the APPG heard from Independent Age, Age UK, NHS Providers, Relatives and Residents Association.

The Relatives & Residents Association champions the rights of older people needing care in England, providing information, advice and support to empower older people and their families/friends, and use their unique perspective to raise awareness and to influence policy and practice.

Age UK is a national charity that works with a network of partners, including Age Scotland, Age Cymru, Age NI and over 130 local Age UK charities across England. Its work focuses on ensuring that older people have enough money; enjoy life and feel well; receive high quality health and care; are comfortable, safe and secure at home; and feel valued and able to participate.

NHS Providers is the membership organisation for the NHS hospital, mental health, community, and ambulance services that treat patients and service users in the NHS. NHS Providers help those trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

Independent Age is a national charity who listens to, and amplifies the voices of, people in later life.

Key Findings

- 5.1 **There has been a failure of those in social care⁷⁹. The social care sector has been failed during this pandemic. This failure has brought into sharp relief the urgent reforms required for social care, with centralised oversight, funding and support.**
- 5.2 **The impact of complex bereavement, anxiety and depression on people in later life as exacerbated by the pandemic needs better recognition and support. Blanket lockdowns for long periods have had a severe impact on the mental health of residents and those who care for them.**
- 5.3 **The guidance on visiting care homes has been unclear.**
- 5.4 **The initial failure by UK government to include known mortality figures of those in the social care sector and reports of the use of blanket 'Do Not Resuscitate' Orders has created the impression that those in the social care sector are less valued.**
- 5.5 **Covid-19 has had a disproportionate impact on the health of those from Black, Asian and Minority Ethnic (BAME) backgrounds.**

⁷⁸ 12th August 2020

⁷⁹ Social Care is addressed in chapters 3, 5, 6, 7, 8 and 9.

- 5.6 The charitable sector has seen an unprecedented need for its support services. At the same time, the financial viability of the charitable sector is at risk. Government financial support had not been distributed in a transparent or timely way.**
- 5.7 Supermarkets need to increase the availability of slots for older and more vulnerable people and coordinate better with each other in their local communities.**

“The pandemic has shone a light on the need for reform and sustainable funding of our social care sector. Although emergency funding has helped in the short term, it is not enough to undo years of underinvestment in the sector.” NHS Providers.

5.1 There has been a failure of those in social care.

5.1.1 The witnesses testified that the following factors all contributed to a tragic loss of life within social care:

- inability for those working in social care to access PPE.
- failure to provide adequate testing to staff or residents.
- discharging patients from hospital into care homes without testing.
- inadequate guidance provided to those in social care.
- limited access to clinical support.
- high levels of staff sickness within an already depleted workforce.

Between the 7th March and 22nd May, there have been more than 16,000 deaths of care home residents attributable to Covid-19.⁸⁰

5.1.2 Reports suggest that by the end of March an average of 25% of frontline social care staff were unable to work⁸¹ and the sector experienced a 170% increase in the numbers of days providers lost staff to sickness. This equates to 2.3 million extra days lost to sickness in March and April than is usually expected⁸².

5.1.3 One of the causes for such high levels of staff absence was the failure to access tests. Challenges remain to access regular, rapid and reliable tests, to ensure the proper functioning of the NHS and the social care sector⁸³.

5.1.4 Testing for Covid-19 needs to be much more accessible, regular and with rapid turnaround times. As stated by the witnesses to this hearing, there is no use attaching value simply to a high number of tests nationally, when it is the regularity and the turnaround time between test and result that are of crucial importance.

5.1.5 There were reports that Pillar 2 test results did not get reported to GPs and were difficult to access, especially for those without an email address⁸⁴.

⁸⁰ ONS. (2020) Deaths involving Covid-19 in the care sector, England and Wales. Accessed via <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19inthecaresectorenglandandwales>

And

ONS. (2020). Deaths registered weekly in England and Wales, provisional.

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales>

⁸¹ Skills for Care. (2020). Covid-19 Workforce Survey. Accessed via <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/COVID-19/COVID-19-survey.aspx>

⁸² Skills for Care. (2020). ASC-WDS Tracking. Accessed via <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/COVID-19/ASC-WDS-Monthly-Tracking.aspx>

⁸³ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/344/attachments/original/1597776197/239125_APPG_on_Coronavirus_Session_3_TSC.pdf?1597776197

⁸⁴ *ibid*

- 5.1.6 As regards PPE⁸⁵, it was noted that provision to 55,000 social care providers was logistically more complicated than to 217 NHS Trusts. In this regard, NHS Providers noted that in order to ensure adequate supply across all sectors, there needed to be a national stockpile of PPE for the NHS trusts, and regional stockpiles for the care sector.
- 5.1.7 To maintain safe staffing levels, care homes were dependent on agency staff. There was a lack of guidance on reducing staff movement between and within care homes as well as in domiciliary care, which led to care staff spreading the virus within and between different settings.
- 5.1.8 Early on in the pandemic in March 2020, the Care Quality Commission (CQC) suspended its routine inspections of care homes. This lack of oversight and scrutiny was compounded by emergency legislation allowing for the ‘easement of local authorities’ duties under the Care Act, the suspension of complaints investigation by the Local Government Ombudsman and the discharge of Covid -19 patients from hospital to care homes⁸⁶.
- 5.1.9 With lack of appropriate oversight and of a viable, central complaints mechanism, the social care sector has been left with few routes and little power to challenge poor practice. There has also been little centralised dissemination of good practice to encourage individualised approaches and to allow care providers to learn from each other (Relatives and Residents Association).

5.2 The impact of complex bereavement, anxiety, and depression on people in later life as exacerbated by the pandemic needs better recognition and support⁸⁷.

- 5.2.1 During lockdown, many families were unable to maintain contact via other means (such as phone/video) either due to lack of support to facilitate contact, communication difficulties, or dementia/other conditions making such contact impracticable.
- 5.2.2 Some residents remained isolated within care homes (confined to their rooms, as communal areas were closed), with staff interaction minimised.
- 5.2.3 Isolation has had a devastating impact on the mental well-being of care users. The Relatives and Residents Association reported of people becoming increasingly depressed and withdrawn.

⁸⁵ PPE is addressed in Chapters 3, 5, 6 and 8.

⁸⁶ The issues facing local authorities are addressed in chapters 2, 5, 6 and 7.

⁸⁷ Mental health is addressed in Chapter 9, and also in chapters 4, 5 and 8.

“We hear daily from our helpline callers about how their relatives in care are deteriorating, not just their mental health but also the knock-on impact on their physical health of older people losing weight, losing speech, losing their memory, no longer being able to recognise their family members and there’s one relative put it to us that they’re losing the will to live, so we really need to find a safe way to manage the virus going forwards in care settings to achieve a better balance between protecting life and protecting wellbeing.” Helen Wildbore, Director Relatives and Residents Association.

“People with dementia in residential care have been disproportionately affected by the pandemic due to lack of testing and access to personal protective equipment (PPE) and the impact of restrictions on family visits. Since the early stages of the outbreak, Dementia UK has urgently called for improved access to PPE and regular testing for care home residents, staff – and family carers so they can visit residents. Family carers provide an essential part of a person’s care. We remain concerned that these fundamental measures are still not consistently in place, even after assurances from the government.” Dementia UK.

5.2.4 Independent Age also highlighted the need for mental health support. The experience of partner bereavement, resulting in complex grief: they estimate that since the start of Covid-19 until August 2020, up to 85,000 people over the age of 65 may have suffered the death of a partner. This is almost one and a half times as many as in the same period during each of the previous five years.

5.3 The guidance on visiting care homes has been unclear⁸⁸.

5.3.1 The UK government guidance advised against visiting care homes in England except in end of life situations. This was out of line both with the advice on hospital visiting as well as that provided by the Scottish government for care homes, which permitted visits for those with a mental health issue where a visitor not being present would cause the person to be distressed.

5.3.2 On July 28, the UK government produced guidance on visiting care homes in England. The Relatives and Residents Association reported that the guidance was still unclear, provided ‘scant practical advice on future management of the virus and is difficult to follow’.

5.3.3 Witnesses reported that the UK government guidance for vulnerable groups and people in later life was unclear. The Relatives and Residents Association polled adults over 65 and found that 43% incorrectly believed that the UK government had instructed over-70s with no underlying health conditions to shield by not leaving the house. This raises the concern that

⁸⁸Communication and messaging are addressed in Chapters 2, 3, 4, 5, 7 and 10.

many healthy over 70s shielded unnecessarily, which could have resulted in increased isolation and loneliness.

“There was no advice given to those who advise patients, so medical professionals and care professionals were put in an impossible position where they were being rung up by people who’d seen something on the news and had only just received the advice themselves.” Chris Hopson, NHS Providers.

5.4 The initial failure by UK government to include known mortality figures of those in the social care sector and reports of the use of blanket ‘Do Not Resuscitate’ orders have created the impression that those in social care are less valued.

- 5.4.1 The UK government’s initial failure to include known mortality figures of care users in the daily count created a feeling that the lives of people using care services were less valued.
- 5.4.2 There were also reports of deeply concerning ‘blanket’ policies being applied to older people living in care homes. These have included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders for care home residents as well as policies around hospital transfer and admission of individuals.
- 5.4.3 Helpline callers reported relatives not being sent to hospitals for treatment or being asked to agree end of life plans that excluded hospitalisation, raising fears that the process of prioritising health services was being based on non-clinical factors such as age or disability. Callers have also reported problems with inaccurate death certification, including terminology like ‘frailty’.

“Older people in receipt of care, in care homes especially, have been catastrophically let down and many have died before their time as a result.” Age UK.

5.5 Covid-19 has had a disproportionate impact on the health of those from BAME backgrounds⁸⁹.

- 5.5.1 NHS Providers noted the disproportionate impact that Covid-19 has had on people from BAME backgrounds, with approximately 20% of nursing and support staff and 44% of medical staff coming from BAME backgrounds. Analysis suggests individuals from BAME backgrounds account for 63% of all NHS staff deaths from COVID-19, including 64% of deaths of nursing and support staff and 95% of deaths of medical staff⁹⁰.

⁸⁹ The impact on BAME communities is addressed in Chapters 3, 4, 5, 8 and 9.

⁹⁰ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/343/attachments/original/1597772144/NHS_Providers_Submission-APPG-Coronavirus.pdf?1597772144

- 5.5.2 NHS Providers noted the report from Public Health England (PHE)⁹¹ on 16 June, which found that individuals from BAME backgrounds are more likely to work in occupations with a higher risk of Covid-19 exposure. In addition, historic racism and poorer experiences of healthcare may mean that individuals from BAME backgrounds are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about PPE or risk.
- 5.5.3 NHS Providers highlighted the urgent need to take action to transform the culture of all our public institutions from top to bottom and urged the APPG on Coronavirus to look into this as a matter of priority.

5.6 The charitable sector has seen an unprecedented need for its support services.

- 5.6.1 The pandemic has created an unprecedented need for support from the charitable sector and has increased vulnerability in service users. By way of example, since the outbreak of coronavirus, Age UK, locally and nationally, has seen a huge increase in enquiries and requests for support. Nationally, between 11th March to 21st April visits to the Age UK website were more than 80% higher than in the same period the previous year, rising from 1.2 million to 2.1 million.
- 5.6.2 At the same time, the immediate financial viability and long-term future of the charitable sector are both at risk as income streams, such as shops, clubs, and services, have been shut due to the pandemic. Age UK testified that if local Age UK shops close for good it will be at a time when they are needed more than ever. While the UK government financial support announced on 8 April 2020 was welcome, Age UK submitted that the funds were not distributed in a transparent or timely way.

“With charity shops shut and fundraising events cancelled, we estimate charities stand to lose around £4bn in 12 weeks as a result of the crisis.” Age UK.

- 5.6.3 Further, the rule preventing furloughed staff from volunteering with their charity employer has been frustrating for charities - they cannot afford not to furlough staff, but at the same time are seeing high demand for their services.
- 5.6.4 On the other hand, the job retention scheme has been very welcome and used widely across the Age UK network of charities. The scheme has broadly been easy to access and efficiently implemented.

⁹¹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

5.7 Supermarkets need to increase the availability of slots for older and more vulnerable customers.

5.7.1 Age UK submitted that shopping and access to food were major concerns for people in later life, especially in the more vulnerable categories. These people need to easier access to supermarket delivery slots, with priority over those less vulnerable members of society. Additionally, it would be helpful if there were greater cooperation between supermarkets as to their ability to help more vulnerable members of society. Many older people do not have access to the internet, and as such, information on which local supermarkets offer a telephone service would be helpful.

5.7.2 Older people are more likely to rely on cash as their means of payment. While Banks and Building Societies offered online consultations for those seeking their help, this largely ignored the needs of older customers.

Chapter 6: Test and Trace

At the fourth Oral Evidence hearing⁹², the focus of the hearing was on test and trace. This subject was repeated and updated at the ninth Oral Evidence hearing⁹³. For ease of reference, the two hearings have been combined in this chapter.

At the fourth Oral Evidence hearing, the APPG heard from:

- **Professor Andrew Goddard**, Consultant in Gastroenterology at Royal Derby Hospital, and the current President of the Royal College of Physicians.
- **Professor Jo Martin**, Professor of Pathology at Queen Mary University, Director of Academic Health Sciences and an Honorary Consultant at Barts Health NHS Trust. She is the current President of the Royal Society of Pathology.
- **Mark Adams** of CEO of Community Integrated Care, one of the UK's largest social care charities.
- **Professor Duerden CBE**, Emeritus Professor of Microbiology at Cardiff University and former Director of Public Health Laboratories in Cardiff.
- **Dr Gabriel Scally**, Public health physician, Visiting Professor of Public health at the University of Bristol and member of Independent SAGE.

In the ninth Oral Evidence hearing, the APPG heard from:

- **Mark Adams**, CEO of Community Integrated Care, one of the UK's largest social care charities.
- **Judy Downey**, Chair of the Relatives and Residents Association, an organisation which champions the rights of older people needing care in England, providing information, advice and support to empower older people and their families/friends, and use their unique perspective to raise awareness and to influence policy and practice.
- **Professor Andrew Goddard**, Consultant in Gastroenterology at Royal Derby Hospital, and the current President of the Royal College of Physicians.
- **Dr Rachael Liebmann**, Vice President of The Royal College of Pathologists and Group Medical Director of The Doctors Laboratory and Health Services Laboratories.
- **Allan Wilson**, President of the Institute of Biomedical Sciences.

⁹² 19th August 2020

⁹³ 6th October 2020

Key Findings

- 6.1 Investment in the fields of virology and microbiology is needed urgently.
- 6.2 The UK government has not invested sufficiently in the UK's laboratory capability.
- 6.3 Arbitrary testing targets have been prioritised over a coordinated testing strategy.
- 6.4 There has been a lack of coordination between Pillar 1 and Pillar 2 laboratories.
- 6.5 Information flow between Pillar 2 laboratories and the NHS has not worked well.
- 6.6 The UK government's decision to abandon test and trace in March the virus to take hold in England and the UK unchecked.
- 6.7 The centralised test and trace system is not working.
- 6.8 Regular and accessible staff testing is critical to enable the NHS and social care sector to provide care.
- 6.9 Turnaround time of tests is not always meeting the required maximum 24-hour target.
- 6.10 For effective pandemic management, the NHS and Social Care sector responses need to be coordinated.
- 6.11 There has been no effective oversight of the social care sector since March.
- 6.12 Isolation is having a devastating impact on those in social care.
- 6.13 The cost of testing is a significant challenge for the social care sector.
- 6.14 Local authorities do not currently have a sufficient role in the organisation and oversight of testing for the social care sector.

6.1 Investment in the fields of virology and microbiology is needed urgently.

- 6.1.1 Testing must be carried out for a particular purpose, which must be clear, with the test appropriate to that purpose.
- 6.1.2 Any problem with the analysis and handling of test results can have a significant impact on disease spread, risk assessment, morbidity, mortality and population health. These problems arise from a range of issues, including poor specimen taking, poor labelling and poor transcription of details, slow turnaround of results, poor quality control, ineffective communication of the result, inappropriate application of the results, and lack of clinical input or oversight. Experienced staff are crucial to the process.
- 6.1.3 There is currently a staff shortage of around 25% in those able to report test results⁹⁴. Much more needs to be done to train and recruit staff. Many local general hospitals have been unable to fill microbiology posts. Investment in the scientific and medical workforce across these specialties must occur as a matter of urgency. Professor Duerden submitted that more emphasis needed to be placed on training microbiologists in order for them to have adequate virology and molecular experience. Covid-19 is likely to be one of many new viruses that we will have to deal with.

6.2 The UK government has not invested sufficiently in the UK's laboratory capability.

- 6.2.1 Professor Duerden submitted⁹⁵ that in terms of biosecurity, the pandemic exposed the impact of the long term hollowing out of the service: existing public health laboratories did not have the capacity to meet the surge in demand posed by Covid-19⁹⁶.
- 6.2.2 In order to scale up the capacity to test, the UK government chose not to increase the existing NHS capacity, but instead purchased capacity from the commercial sector and from universities, neither of which have sufficient experience of large-scale diagnostic testing.
- 6.2.3 It was noted by both Professor Scally and Professor Duerden that the UK government had no virology/microbiology experts on SAGE with appropriate expertise in delivering large scale diagnostic testing services and had precluded SAGE from operational considerations for testing. Both advised that there was a need for the UK government to be advised by people who deliver public health microbiology to support the translation of scientific suggestions into action.
- 6.2.4 At the ninth oral hearing, Allan Wilson, President of the Institute of Biomedical Sciences (IBMS) submitted to the APPG⁹⁷ that, in order to assist in the scaling up of capacity, the IBMS twice offered assistance to the Secretary of State for Health, Matt Hancock MP, in April, and to Dido Harding in May. Neither offer was taken up.

⁹⁴ <https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/376/attachments/original/1598542982/RCPATH-COVID-19-testing-a-national-strategy.pdf?1598542982>

⁹⁵ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/376/attachments/original/1598999721/consolidated_Covid_submission_Final_version.pdf?1598999721

⁹⁶ Public health is addressed in chapters 2, 6 and 7.

⁹⁷ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/502/attachments/original/1603739823/IBMS_All-Party_Parliamentary_Group_on_Coronavirus_Evidence_Submission_Final.pdf?1603739823

- 6.2.5 The complexity of scaling up laboratory capability involved different testing platforms. Procurement of supplies and allocations of tests were done centrally. There were initial concerns raised regarding this centralisation, but it was noted that a multiplicity of platforms and reagents could ensure security of supply.

6.3 Arbitrary testing targets have been prioritised over a coordinated testing strategy.

- 6.3.1 When scaling up capacity, the UK government chose to focus on numerical targets for tests (e.g. 100,000 tests a day) rather than the strategic deployment of tests. In this mass scaling up, testing was much increased, but the labs did not have the United Kingdom Accreditation Service (UKAS) and their quality assurance programme for tests was uncertain.
- 6.3.2 The IBMS submitted⁹⁸ that the arbitrary testing targets have been a distraction and have had the effect of putting Pillar 2 in competition for staff, equipment, and consumables with Pillar 1 laboratories. This has encouraged stockpiling of resources in Pillar 2 laboratories, which could have been more effectively used by Pillar 1 laboratories.

6.4 There has been a lack of coordination between Pillar 1 and Pillar 2 laboratories

- 6.4.1 Allan Wilson of the IBMS and Dr Rachel Liebmann of the Royal College of Pathology, submitted that there is a lack of collaboration between Pillar 1 and Pillar 2 laboratories⁹⁹, which has impacted upon the success of the testing regime. The lack of collaboration extends to resources, staff, decision making and data sharing.
- 6.4.2 The diagnostic expertise and experience in the Pillar 1 laboratories should have meant that Pillar 1 controlled Pillar 2 laboratories, who have little or no expertise or experience in this area.
- 6.4.3 Testing would work better if the competitive barriers were broken down between Pillar 1 and Pillar 2 laboratories. Collaboration would mean that there would be an efficient use of resources – both intellectual (scientists and technicians) and physical (reagents and equipment) as this would enable the ability to react to changes in operational needs: if there were robust modelling of daily demand for testing versus daily capacity across all providers, with a road map detailing how and where capacity would be created, together with detailed plans for delivery of all aspects of testing, including processing capacity, access to supplies and to staff, this would minimise testing capacity issues. Further, there needs to be clear communication with the public where demand outstrips supply¹⁰⁰.
- 6.4.4 In the same submission, the IBMS urged UK government to ensure that appropriately qualified and UKAS accredited staff be available across both Pillar 1 and Pillar 2 laboratories, for example through secondment, to ensure robust and accurate testing. This should be achieved collaboratively, and not by poaching staff.

⁹⁸ *ibid*

⁹⁹ https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/489/attachments/original/1603982431/Test_and_Trace_transcript.pdf?1603982431

¹⁰⁰ https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/502/attachments/original/1603739823/IBMS_All-Party_Parliamentary_Group_on_Coronavirus_Evidence_Submission_Final.pdf?1603739823

- 6.4.5 The APPG heard how the lack of cooperation between the Pillar 1 and Pillar 2 laboratories has created a lack of trust: those who work in the Pillar 1 laboratories are not on any of the committees set up to deal with the UK’s test and trace service. They are not involved in any of the decisions made as regards UK testing decisions or capability¹⁰¹. The APPG learnt that there is no one with any testing experience involved in any of the committees set up to manage the UK’s test and trace capability¹⁰².

“What we need is real working together and combined management and leadership structures to make sure that we make the very best use of what capacity we’ve got.”
Dr Rachel Liebmann, Royal College of Pathologists.

6.5 Information flow between Pillar 2 laboratories and the NHS has not worked well.

- 6.5.1 The information from Pillar 2 laboratories was initially not readily available to organisations such as the NHS and local authorities¹⁰³. Existing capabilities were bypassed, including the link into the existing NHS system, the PHE health protection teams, individual health records as well as to GPs, all of which would have supported a localised Find, Test, Trace, Isolate and Support (FTTIS) model (see below).
- 6.5.2 This kind of flow is important for a local understanding of where outbreaks are occurring. While it was noted that the situation has improved as regards data flow, concern was raised that any future provision of laboratory testing needed to include integration with existing clinical systems as part of the service specification¹⁰⁴.

“I think it’s a frustration right from the beginning of this pandemic [...] the scientists working in pillar one labs have been doing this for decades, running diagnostic labs, connecting the whole specimen pathway from when the sample was taken to the final report goes out, so we have decades of experience within our memberships of connecting, of IT connecting systems [...] We should be looking at that, we should be working together to produce one flexible testing pathway where we could move work around where there are pockets of problems and we can work together to solve those issues that we’re currently seeing coming out [....] the Lighthouse Labs do not have decades of experience and breadth of experience that we have within the membership of the College and Institute to help with that [...] and I think that’s been more clearly highlighted in the IT issues that we’ve seen recently and over the last six months. We’ve got that experience of connecting systems because that’s what we do.” Allan Wilson, President of the Institute of Biomedical Sciences.

¹⁰¹https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/489/attachments/original/1603982431/Test_and_Trace_transcript.pdf?1603982431

¹⁰² *ibid*

¹⁰³ The issues facing local authorities are addressed in chapters 2, 5, 6 and 7.

¹⁰⁴https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/502/attachments/original/1603739823/IBMS_All-Party_Parliamentary_Group_on_Coronavirus_Evidence_Submission_Final.pdf?1603739823

6.6 The UK government's decision to abandon test and trace in March wasted time and allowed the virus to take hold in England and the UK unchecked.

- 6.6.1 As described by Dr Scally, the effect of stopping test and trace in early March was that two months were wasted during which we could have been scaling up the locally based Find Test Trace Isolate and Support (FTTIS) system¹⁰⁵. The UK government's decision to abandon test and trace in early March in order to focus on testing within the NHS and manage the clinical and organisational challenge facing the NHS led to outbreaks throughout the England and the UK, but unidentified, with contacts untraced.
- 6.6.2 Professor Duerden referred to evidence¹⁰⁶ which suggested that if the UK government had persisted in targeted test, track and trace for recently arrived travellers, the disease could have probably been contained¹⁰⁷. Instead, the UK government switched its focus to concentrate on providing mass laboratory services.

6.7 The centralised test and trace system is not working.

- 6.7.1 Doctor Scally¹⁰⁸ and Professor Duerden submitted¹⁰⁹ that the most effective method to manage an epidemic is the Find, Test Trace, Isolate and Support (FTTIS) method. A test and trace system without the other elements will not be as effective: finding the contact of cases, explaining the requirement to isolate, and providing the element of support - in terms of providing access to essentials including food - are all necessary requirements to suppress outbreaks.
- 6.7.2 It was further submitted that the most effective method of FTTIS is one carried out a local level, embedded as much as possible within existing health and social care networks, utilising Local Authority and NHS actors such as the health commissioner, primary care, local hospital laboratories, school nurses and environmental health officers. This will ensure a robust system in place for future upsurges in infection, and for decision making. Effective community engagement is essential to discuss implementation, problems and solutions, working in partnership with local and national groups.
- 6.7.3 Outsourced testing contracts have contributed to the inability to turn tests around within 24 hours, and increased concerns about the quality of samples taken at home or in drive-through centres. Other countries have addressed these by widespread availability of tests in pharmacies, local health centres and other community settings.
- 6.7.4 The outsourced tracing system is not connected with existing networks of communication, coordination, and support. The net effect of this is a much lower level of success in the tracing of contacts and a much lower level of buy-in by the public. Unless at least 80% of close contacts are traced and isolated for 14 days, suppression of the virus is impossible. At the time of submission, over a 9-week, period Serco tracers had traced 56% of contacts.

¹⁰⁵ Find Test, Trace, Isolate and Support is addressed in chapters 2, 3, 6, 7, and 10.

¹⁰⁶https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/376/attachments/original/1598999721/consolidated_Covid_submission_Final_version.pdf?1598999721

¹⁰⁷ <https://www.bbc.co.uk/news/health-52993734>

¹⁰⁸ <https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/376/attachments/original/1598999415/IndependentSAGE-report-4.pdf?1598999415>

¹⁰⁹https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/376/attachments/original/1598999721/consolidated_Covid_submission_Final_version.pdf?1598999721

6.7.5 The UK government needs to learn from countries who are managing the pandemic more successfully.

6.7.6 Dr Scally on behalf of Independent Sage submitted that these failures made it highly unlikely that the SERCO contract is cost-effective. In order to control the pandemic, Independent Sage advise¹¹⁰:

- The Serco tracing contract should be ended. Budgets should be shifted so contact tracers are recruited and trained by local authority public health teams.
- The Deloitte testing contract for community tests in car parks should be ended. In the most recent week's statistics, only 72% of home test results were received within 48 hours of the test being sent out.
- Home testing should be ended and every person in England should have access to a test within a short distance from where they live.
- Local public health and primary care doctors should get real time information about test results and patient details.
- A national framework should be agreed whereby local authorities can make their own decisions about new community restrictions and set up community centres for quarantine and support of mild cases who cannot isolate effectively at home.
- UK government should focus on a) strategic guidance based on evidence, b) financial support to local authorities, and c) financial support guaranteed to all cases and contacts (not just those employed on PAYE) to offset wage losses.

'If we don't take isolation seriously, our economy will spiral downwards. We should have had an effective isolation policy in February, with better pandemic planning. Not to have one six months later is nothing short of public health malpractice.' Dr Gabriel Scally, Public Health physician.

6.8 Regular and accessible staff testing is critical to enable the NHS and social care sector to provide care.

6.8.1 Professor Andrew Goddard submitted on behalf of the Royal College of Physicians that in a survey¹¹¹ of doctors carried out on 21/22 September, 6.5% of doctors were off work. Of these 40% were self-isolating because a family member was waiting for a test or the results of a test.

6.8.2 The implication of 6.5% of doctors not being in post is that hundreds of doctors are unavailable to provide care. *'As the infection rates rise, the need for tests will rise and a large proportion of the workforce could be out of a job for want of a test'*¹¹².

¹¹⁰ <https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/376/attachments/original/1598999415/IndependentSAGE-report-4.pdf?1598999415>

¹¹¹ <https://www.rcplondon.ac.uk/news/covid-19-and-workforce-ready-and-waiting>

¹¹² *ibid*

- 6.8.3 Any absence of frontline workers will impact on the NHS’s ability to provide care. While in April all elective care was cancelled, the aim going forward must be to keep normal NHS services open for as long as possible. Given the need to provide both Covid and non-Covid care, there is inevitably much less flexibility in the workforce. Additionally, medical students who were able to act as Foundation Year 1 Medics in April are, at this point in their training, too inexperienced to carry out this role. Finally, there is the additional concern over normal winter pressures, including flu.
- 6.8.4 Social care¹¹³ is similarly affected by a lack of access to tests or a delay in turnaround times of tests.
- 6.8.5 Further, Mark Adams, CEO of Community Integrated Care highlighted how the UK government guidance on testing only applies to those aged 65 or over and in registered care homes¹¹⁴. The guidance was silent on the provision of testing to those who do not live in registered care homes and their carers. This is arguably discriminatory against the many (c850,000) who access other forms of social care support – for example, those in supported living, extra care and domiciliary care. Testing needs to be available to all those receiving social care support.

‘It is important to keep in mind that to have any real value, testing in care homes needs to be timely and complete. There is a two-day window in which the insight of testing is most valuable – test results returned in 48 hours are invaluable in halting the spread of an outbreak from the outset. Test results that return late obviously present an extended risk that an asymptomatic carrier has brought Covid-19 into the service and at a certain point late results become so retrospective that they are useless. We also need to see results for testing returned collectively – a piecemeal delivery of small batches of test results over days does not provide meaningful intelligence.’

Mark Adams, CEO Community Integrated Care.

6.9 Turnaround time of tests is not always meeting the required maximum 24 hours target.

- 6.9.1 In order to be as effective a control as possible, and consistent with the international standard for testing, the turnaround time of tests should be no more than 24 hours¹¹⁵.
- 6.9.2 The IBMS submitted that to be effective, turnaround time targets need to be established, and performance against these targets needs to be equitable, well defined, and clear across all testing streams¹¹⁶. This would allow for accurate comparison, early identification of ‘hot spots’ and targeted support at both national and local levels.

¹¹³ Social Care is addressed in chapters 3, 5, 6, 7, 8 and 9.

¹¹⁴https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/502/attachments/original/1603739824/Community_Integrated_Care_%282%29_-_APPG_on_Coronavirus_submission_Sept_2020.pdf?1603739824

¹¹⁵ https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/502/attachments/original/1603739823/IBMS_All-Party_Parliamentary_Group_on_Coronavirus_Evidence_Submission_Final.pdf?1603739823

¹¹⁶ *ibid*

6.10 For effective pandemic management, the NHS and Social Care sector responses need to be coordinated¹¹⁷.

- 6.10.1 Professor Andrew Goddard of the Royal College of Physicians submitted that the UK government needed to recognise the inextricable link between the NHS and social care, with decisions in one affecting the other. Local plans needed to be developed for future waves and based on national guidance.
- 6.10.2 Each local system should develop plans for future waves, to aid good communication between providers, escalation plans and a clearer understanding of the roles and responsibilities of the different stakeholders.
- 6.10.3 Social care must be given the resources it needs to effectively manage during future Covid-19 outbreaks and waves: from PPE to testing, staffing and funding, it is key that social care is placed on a sustainable footing.

6.11 There has been no effective oversight of the social care sector since March.

- 6.11.1 Regular inspections of care homes were suspended in March¹¹⁸. Testing has not been compulsory for those in managerial positions in the social care sector, nor for those in the Care Quality Commission. This has meant that there is little scrutiny and oversight of this sector¹¹⁹: unable to prove their covid status, inspectors have not been allowed access to care homes.

6.12 Isolation is having a devastating impact on those in social care.

- 6.12.1 The continued isolation of those in care homes is having a devastating impact on residents and their families. This situation could be alleviated by the availability of tests with short turnaround times, such as are available in Germany, Italy, and at various international airports¹²⁰.

“Regardless of age or disability, people must have a right to the dignity of being with family and friends in private. It seems an extraordinary measure and speaks volumes about how families and residents are viewed. We fervently hope that the Government will realise this and amend their guidance accordingly.” Judy Downey, Relatives and Residents Association submission.

- 6.12.2 The APPG was told how the UK government guidance on ending isolation required that each resident must be allowed no more than two visitors, but normally only one. The Relatives and

¹¹⁷ Social Care is addressed in chapters 3, 5, 6, 7, 8 and 9.

¹¹⁸ <https://www.cqc.org.uk/news/stories/routine-inspections-suspended-response-coronavirus-outbreak>

¹¹⁹ https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/489/attachments/original/1603982431/Test_and_Trace_transcript.pdf?1603982431

¹²⁰ *ibid*

Residents Association submitted that this restriction was inhumane, often with devastating consequences for families¹²¹.

- 6.12.3 Further, the Relatives and Residents Association submitted that the requirement for each visitor to be accompanied by a member of staff was demeaning and in breach of the Mental Capacity, Human Rights Acts and Equality Act, as well as other legislation¹²². They urged the UK government to better support care homes to ensure that decisions are made on a humane and individual basis as required by law, so that visits can go ahead as safely as possible.

“The effects of not having tests are not simply mechanistic, they are having real effects on real people at the end of their lives, people are actually losing hope, the effect of the drag as it were between testing and results not only does it mean that staff are anxious and that places are under-staffed but it also means that there’s greater reliance on agency workers and on ad-hoc replacements and the people who are ringing our helpline in utter despair and who we used to think we could help, we now can offer very little because the guidance is so rigid and unhelpful, there’s no scrutiny, particularly of those places where there are serious concerns about standards frankly, so it’s not just people aren’t being tested what a pity, it’s the impact on day-to-day life, on relationships, on staffing.”

Judy Downey, Relatives and Residents Association.

6.13 The cost of testing is a significant challenge for the social care sector.

- 6.13.1 The cost of testing is a significant challenge for those in the social care sector. Mark Adams of Community Integrated Care expressed concern about the financial challenges facing many care providers when the Infection Control Fund ends: *‘We hope that the government is not only looking at supporting social care through these worrying winter months, but has the appetite for long-term strategy, reform and investment in the sector’*¹²³.

6.14 Local authorities do not currently have a sufficient role in the organisation and oversight of testing for the social care sector.

- 6.14.1 Mark Adams, CEO of Community Integrated Care submitted to the APPG that the future of health and social care should be delivered locally, using local authorities to ensure that there is local capacity for testing to meet the needs of the community¹²⁴. It would also be beneficial if batches of tests were returned together, to enable meaningful intelligence on where outbreaks were occurring¹²⁵.

¹²¹https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/502/attachments/original/1603739821/R_RA_Winter_Plan_comment_230920_FINAL_14907_.pdf?1603739821

¹²² ibid

¹²³https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/502/attachments/original/1603739824/Community_Integrated_Care_%282%29_-_APPG_on_Coronavirus_submission_Sept_2020.pdf?1603739824

¹²⁴https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/489/attachments/original/1603982431/Test_and_Trace_transcript.pdf?1603982431

¹²⁵https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/502/attachments/original/1603739824/Community_Integrated_Care_%282%29_-_APPG_on_Coronavirus_submission_Sept_2020.pdf?1603739824

- 6.14.2 Allan Wilson of IBMS submitted that testing should be locally led and linked to Pillar 1 laboratories to enable the rapid identification of local hotspots and to deliver the ability to respond to local needs effectively¹²⁶.
- 6.14.3 It was noted at both hearings that data connectivity is a key aspect of improving the quality of testing. To maximise the public health efficacy, links between primary and secondary care and public health bodies need to be strengthened to ensure all results are available to clinicians when required, form a part of an individual's public health record and can be used, in an appropriate and legal framework, for public health purposes.

¹²⁶ *ibid*

Chapter 7: Local Authority response and the Reorganisation of Public Health England

The 5th Oral Evidence Hearing¹²⁷ was divided into two hearings: in the first the APPG heard from representatives from local government. In the second the APPG heard from experts in public health¹²⁸. It should be noted that the second session was relevant particularly to England, since it concerned the proposed restructure of Public Health England. However, the recommendations made are relevant to the organisation of public health generally.

In the first session, the APPG on Coronavirus heard from representatives from local authorities:

- **Cllr Ian Hudspeth**, Leader of Oxfordshire County Council, and representing the Local Government Authority.
- **Cllr Alex Crawford**, Rushmoor Borough Council.
- **Sir Peter Soulsby**, Leicester City Mayor.

Local Authority response

Key Findings

- 7.1 The inability for local authorities to access the precise real-time data has significantly impaired their ability to work effectively at a local level to contain outbreaks.**
- 7.2 The Covid-19 crisis has demonstrated the vital and reciprocal relationship between the NHS and social care.**
- 7.3 Local authorities need enhanced powers and support.**

¹²⁷ 26th August 2020

¹²⁸Public health is addressed in chapters 2, 6 and 7.

7.1 The inability for local authorities to access the precise real-time data has significantly impaired their ability to work effectively at a local level to contain outbreaks.

- 7.1.1 Local authorities¹²⁹ have not been given the data that they need from central government which would enable them to use their local knowledge, people and skills effectively¹³⁰. The inability for local authorities to access the precise real-time data has significantly impaired their ability to work at a local level to avoid outbreaks and lockdowns.
- 7.1.2 When centralised data was forthcoming, for many local authorities, it was neither timely, nor did it contain sufficient information: access to information such as address, contact details, ethnicity and, where relevant, workplace, would have enabled a much more focused tracing strategy. Access to this level of granular data has previously been the cornerstone of every local Public Health Track and Trace service. The data should not relate to the city as a whole, but to communities, neighbourhoods, streets, even the households in the city where outbreaks were occurring.
- 7.1.3 In response to this failure by central government to provide timely and localised information on outbreaks, local authorities, such as Leicester, developed their own data, looking at deaths and hospital admissions and where they came from in the community, in order to have an idea where local outbreaks were occurring.
- 7.1.4 Sir Peter Soulsby described how¹³¹, in June, the Director of Public Health for Leicester had identified an apparent spike in the data for Leicester and asked a number of questions of government and of PHE about what that might indicate. He was unable to get direct access to the data that lay behind the city-wide figures in a way that would have enabled him to have predicted and perhaps pre-empted the local lockdown that was eventually applied to Leicester.
- 7.1.5 In terms of information flows between central and local governments, local authorities noted that they had little influence over the actions taken by central government. They also submitted that the UK government was neither listening nor responding to their feedback.

“We’ve found out most of what’s been going on from news releases.” Sir Peter Soulsby.

“I’ve been getting daily announcements from the Government, but there’s no sense that the Government is listening to feedback... there’s no listening and responding backwards.” Cllr Alex Crawford.

¹²⁹ The issues facing Local authorities are addressed in chapters 2, 5, 6 and 7.

¹³⁰ Find Test, Trace, Isolate and Support is addressed in chapters 2, 3, 6, 7 and 10.

¹³¹ https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/378/attachments/original/1603193137/239135_APPG_on_Coronavirus_Session_5_13489_260820.pdf?1603193137

7.2 The Covid-19 crisis has demonstrated the vital and reciprocal relationship between the NHS and social care.

- 7.2.1 Social care¹³² is still a front line of the battle against Covid-19.
- 7.2.2 Covid-19 has thrown into high relief the long-standing challenges facing social care and the precariousness of a sector that has been under-valued and under-funded for too long. It also revealed the lack of coordinated planning for that sector.
- 7.2.3 Response to the pandemic has also demonstrated that effective care and support is rooted in strong local communities. This recognition together with wide public support means we have the basis for addressing these challenges and building a consensus around both the funding
- 7.2.4 The newly established Joint Health and Social Care Taskforce needs a clear plan, which involves shared leadership with councils to ensure effective support for the social care sector and to address the issues relating to sustainable social care in the longer term.
- 7.2.5 The Covid-19 crisis has highlighted the vital and reciprocal relationship between social care and the NHS, and this needs to be built on in the future.

7.3 Local Authorities need enhanced powers and support.

Supporting the Shielded

- 7.3.1 The UK government must work with councils to improve the current system in identifying clinically vulnerable patients who should shield. This should be a locally led system, subject to proper funding for delivery of it from UK government.
- 7.3.2 An important element of support to the shielded cohort and to the non-shielded vulnerable has been the ability to provide them with access to supermarket delivery/click and collect slots. Consideration still needs to be given to support of those who are also digitally excluded.

Children and Young People

- 7.3.3 Powers to open and close schools and pre-schools, as contained in the Coronavirus Act, need to be delegated to councils, to allow them to quickly respond to local conditions. Councils must have access to test, track and trace data as soon as it is available to give greater confidence to teachers and parents around school openings, and allow councils to manage outbreaks in schools if new Covid-19 clusters emerge.
- 7.3.4 Additional concerns were raised regarding the impact that the pandemic will continue to have on Council's service, including:
 - The delivery of socially distanced home-school transport services
 - Anticipated increased referrals to social care
 - Increased disadvantage gap
 - Early years settings – where take up of places is anticipated to be slow for some time

¹³²Social Care is addressed in chapters 3, 5, 6, 7, 8 and 9.

Homelessness

7.3.5 Councils need clarification on the continuation of the policy of ‘everyone in’ (ensuring accommodation for all homeless people). Will this policy continue or is that a matter for each Council? Also, consideration needs to be given to:

- moving those in emergency accommodation to longer term solutions
- ensuring homeless people can properly self-isolate when required to do so.

7.3.6 A significant proportion of rough sleepers are thought to have no recourse to public funds, which means they can’t access statutory services or welfare benefits. Councils are calling for the NRPF condition to be universally and temporarily lifted to enable move-on for rough sleepers as well as homelessness prevention for households experiencing financial shocks.

Transport

7.3.7 There continues to be ongoing concern about the commercial viability of local bus networks. The UK government needs to review and reset the relationship between local government and local bus services, with much greater local oversight and control to ensure that services and public subsidy is targeted to where it is needed the most.

“I have two fundamental messages: one is to say to Government to trust local Government. We know our local communities. We know our people and we can be very helpful to the mission of central Government if we are trusted. The other thing I would say is: trust us with the data, let us know what is happening in our communities in a timely, in an effective way and in a way that gives us the complete picture of what’s happening at a local level, because when you give us that with the trust we can actually do something very useful. But I’m afraid during most of the time of the pandemic, we have been very much hampered in trying to do it effectively.”

Sir Peter Soulsby, Mayor of Leicester.

Reorganisation of Public Health England

In this second part of the 5th Oral Evidence hearing, the APPG on Coronavirus heard from experts in public health¹³³. On August 18th 2020, the UK government announced that Public Health England (PHE) would be replaced with the National Institute for Health Protection. The new agency will combine the activities of PHE with the National Health Service (NHS) Test and Trace service for Covid-19.

The APPG heard from the following experts in Public Health:

- **Professor Martin McKee**, Professor of European Public Health and Director of Research Policy at the European Observatory.
- **Dr Isobel Braithwaite**, Public Health Registrar in Local Authority, Local Health Protection, National PHE, Academic clinical fellow at UCL.
- **Dr Alexander Allen**, Public Health registrar. For the last 8 months he has been at Field Services at PHE, working on the COVID-19 pandemic, both from the front line (case finding and contact tracing) and from a higher level (outbreak data analysis, guideline and protocol writing).

Key Findings

- 7.4 Reorganisation of PHE should be delayed until after the pandemic.**
- 7.5 Independent and trusted public health advice is critically important for a strong response to future threats.**
- 7.6 Public health resilience has been impacted by reduced spending over the last decade.**
- 7.7 In any reorganisation of PHE, all the functions of PHE should be read across and strengthened.**
- 7.8 The public health system requires joined-up local, regional and national functions, that are responsive to the needs of local communities.**

¹³³ Public health is addressed in chapters 2, 6 and 7.

7.4 Reorganisation of PHE should be delayed until after the pandemic.

- 7.4.1 To conduct an institutional reorganisation at this time is considered to be ill-conceived when the country is both in the middle of a pandemic and at the same time approaching the winter flu season: it risks damaging morale, and consequentially staff, thereby losing capacity and expertise, and reducing productivity.
- 7.4.2 Reorganisation of the public health system should be carried out in a well-planned, careful and strategic manner, in consultation with public health professionals and the wider public health system. Any restructuring should be delayed until after the pandemic to avoid weakening England's pandemic response over winter.

7.5 Independent and trusted public health advice is critically important for a strong response to future threats.

- 7.5.1 A core part of outbreak control is effective public health risk communication¹³⁴¹³⁵. Concern was raised that public health communications have been developed and approved without the close involvement of public health professionals who have expertise in health risk communication. This has impacted on the ability of public health experts to deliver the public health response effectively.
- 7.5.2 In any restructuring the UK government must ensure that the independence of public health professionals and advisory bodies is enhanced, so that they can give critical, independent, and expert advice to governments. This will improve transparency and accountability and help to maintain public trust in public health advice.

7.6 Public health resilience has been impacted by reduced spending over the last decade.

- 7.6.1 Public health funding has seen substantial real-term reductions over the last decade, from an already low baseline of 4% NHS spending in 2009¹³⁶ to under 3% now¹³⁷. PHE's total annual budget from 2019-20 was less than £300 million. By contrast, the total budget for the Test, Trace, Contain and Enable programme is £10 billion¹³⁸.
- 7.6.2 In real terms, the local authority public health grant was cut by 23.5% between 2013-14 and 2018-19. Although technically ring-fenced, due to local authorities' budgets falling by nearly

¹³⁴ Communication and messaging are addressed in Chapters 2, 3, 4, 5, 7 and 10.

¹³⁵ World Health Organisation (16 March 2020) Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-10 Preparedness and Response

¹³⁶ Butterfield R, Henderson J and Scott R (2009) Public Health and Prevention Expenditure in England. Report No. 4.

<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.372.1840&rep=rep1&type=pdf>

¹³⁷ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872798/DHSC_allocations_circular_2020_to_2021.pdf

¹³⁸ <https://www.gov.uk/government/publications/a-plan-for-jobs-documents/a-plan-for-jobs-2020#covid-19-response>

half in real terms from 2010 to 2018¹³⁹, this money is having to go much further to fulfil statutory functions¹⁴⁰.

7.7 In any reorganisation of PHE, all the functions of PHE should be read across and strengthened.

7.7.1 The public health system works to prevent disease, improve health, prolong lives and reduce inequalities¹⁴¹ at global, national and local level. This includes the following three domains:

- Health protection: limiting exposure to infectious diseases and environmental hazards
- Health improvement: preventing illness and keeping people healthy
- Healthcare public health: maximising the population benefits of healthcare.

7.7.2 PHE's role since 2013 is to act across the domains of public health.

7.7.3 The goals of any national public health organisation must be to improve health, create resilience to health threats and reduce health inequalities. These goals cut across all sectors: housing, education, transport, planning, the economy, welfare, social care. The reorganisation of PHE threatens to diminish the roles of health improvement and that of reducing health inequalities within the new organisation.

7.7.4 In order to improve not only the ability to respond to and recover from the wider effects of the pandemic, but also to strengthen the role of public health more generally, the new organisation must be able to operate effectively as a whole system, with health protection able to work closely with these other health domains.

7.8 The public health system requires joined up functions responsive to the needs of local communities.

7.8.1 The current public health system exists at a local level (primarily through Directors of Public Health and Public Health teams in local authorities) and a regional and national level (including PHE regional teams and the national PHE offices). Effective public health action requires a continued presence at each of these three levels, plus clear and constructive partnership, clarity on accountability and roles and responsibilities, and communication between each level.

- Local public health teams have detailed and a nuanced understanding of the needs, assets and priorities of their local communities.
- Regional teams cover a number of local authorities and are well-placed to identify and respond to outbreaks that often spread across local authority boundaries.

¹³⁹ The Health Foundation (2018) 'Taking our Health for Granted' <https://reader.health.org.uk/taking-ourhealth-for-granted>

¹⁴⁰ <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health>

¹⁴¹ Inequalities are addressed in chapters 3, 7, and 9.

- National teams are able to synthesise evidence, combine learning, gather and compare data and input into policy, and provide a resource of expert specialists.

7.8.2 The following issues were raised as examples of where a more joined up, consultative approach would have significantly improved outcomes:

- The division of testing into multiple pillars run by different organisations has created confusion and a lack of clear accountability.
- Major policy changes affecting multiple parts of the system have been announced with little or no prior consultation with local health protection teams or local authorities¹⁴² and frontline staff.
- The existing divide between health and social care has had harmful consequences for residents in care settings.

7.8.3 Good communication between all stakeholders is vital to the success of a future public health system and this must include listening to and learning from members of the public, health and social care professionals and communities.

¹⁴² <https://www.bmj.content/369/bmj.m1934>

Chapter 8: Impact on Frontline Workers

In the sixth Oral Evidence Hearing¹⁴³, the APPG heard evidence from the Royal College of Nursing, GMB Union, Medical Protection Society, and Doctors' Association UK.

The Royal College of Nursing (RCN) is the largest trade union and professional body in the world, representing 450,000 members of the UK. Its members have been at the fore of the response to Covid-19, leading treatment and care. The RCN was represented at the hearing by Susan Masters, the Director of Nursing Policy and Practice.

GMB Union is a trade union representing all workers. They have over 620,000 members. GMB Union was represented by Rehana Azam from the Public National Services Team; Zoe Smith who is a front-line residential care worker; and Chika Reuben who is also a front-line care worker.

Doctors Association UK (DAUK) is a doctor-led trade association for doctors. DAUK is grassroots lobbying and campaigning group advocating for the medical profession and patients. They were represented at the hearing by Dr Samantha Batt-Rawden, the president of DAUK, as well as Dr Dolin Bhagawati and Dr Vinesh Patel.

The Medical Protection Society (MPS) is a not-for-profit protection organisation for doctors, dentists, and healthcare professionals. MPS supports over 300,000 healthcare workers around the world, including over 121,000 active members in the UK. Rob Hendry, the MPS Medical Director represented the organisation.

Key Findings

- 8.1 From the outset of the pandemic, frontline workers had inadequate access to personal protective equipment¹⁴⁴.
- 8.2 The pandemic is having a clear impact on the mental health of frontline health and care workers. Many are experiencing stress, depression and burnout.
- 8.3 Access to testing for frontline workers has been unsatisfactory.
- 8.4 The social care workforce must have the same level of PPE and access to Statutory Sick Pay (SSP) as NHS staff. Greater guidance is needed for the sector.
- 8.5 Workers from Black, Asian and Minority Ethnic (BAME) backgrounds have been disproportionately impacted by the pandemic.
- 8.6 Doctors are particularly concerned about preparedness for winter and the ability of the NHS to face the elective backlog.

¹⁴³ 9th September 2020

¹⁴⁴ PPE is addressed in Chapters 3, 5, 6 and 8.

8.1 From the outset of the pandemic, frontline workers had inadequate access to personal protective equipment.

- 8.1.1 The provision and procurement of PPE was the most frequently cited issue across submissions.
- 8.1.2 At the beginning of the pandemic, across all settings, the procurement of PPE was a significant problem. This remained an issue at the time of the oral evidence hearing (9 September 2020). Rehana Azam of GMB Union told the APPG that PPE *'is still very much a live concern'*. Within weeks of UK case numbers accelerating and admissions climbing in UK hospitals, *'doctors started to tell of PPE shortages'*.
- 8.1.3 Despite WHO, European CDC and US CDC clinical guidelines and standards being published outlining minimum standards of full-length disposable gowns, PHE released guidance which differed from the international consensus¹⁴⁵.
- 8.1.4 The written submission from DAUK notes that the organisation was told of doctors having to *'source their PPE from hardware shops and nurses who were told to "hold their breath" to save PPE'*¹⁴⁶.
- 8.1.5 Furthermore, the written submission from DAUK details the results of their survey conducted in conjunction with Messly¹⁴⁷. Through this, frontline doctors could report real-time shortages of PPE. In total, they received 1396 distinct reports from 269 practices and hospital settings. It found:
- 38% of respondents reported no access to any eye protection.
 - 23% of respondents reported no access to eye protection during the most high-risk aerosol-generating procedures (AGPs).
 - 70% of doctors had no access to FFP3 respirator masks. This was at a time when the UK Resuscitation Council deemed Cardiopulmonary Resuscitation to be an AGP.
 - 38% of respondents reported no access to FFP3 respirator masks whilst doing aerosol-generating procedures (AGPs).
 - 75% of respondents reported no access to long-sleeve gowns.
 - 47% of respondents reported no access to long-sleeve gowns whilst performing an aerosol-generating procedure.
 - 60% of respondents reported that they had not had mask fit testing, as recommended by the Health and Safety Executive (HSE).
- 8.1.6 Guidance on the use of PPE was *'unclear', 'confusing'* and a *'one size fits all approach'*¹⁴⁸ (Rehana Azam, GMB Union). Susan Masters of the RCN stated that *'only 28% of our members felt confident that they were protected from Covid-19 in the workplace because of the changing guidance partway through the pandemic'*¹⁴⁹. GMB Union stressed the need for UK government guidance to be issued *'in partnership with trade unions and key stakeholders'*.

¹⁴⁵ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/499/attachments/original/1603737274/GMB_Union_-_APPG_Coronavirus_Written_Evidence.pdf?1603737274

¹⁴⁶ *ibid*
¹⁴⁷ *ibid*

¹⁴⁸ https://appgcoronavirus.marchforchange.uk/publications_appg

¹⁴⁹ *ibid*

Moreover, social care workers were initially excluded from PPE guidance. GMB told the APPG that '*only after pressure from GMB union and other unions that guidance was issued on the use of PPE*'.¹⁵⁰

8.2 The pandemic is having a clear impact on the mental health of frontline health and care workers. Many are experiencing stress, depression and burnout.¹⁵¹

8.2.1 The pandemic is having a clear impact on the mental health of frontline health and care workers. Many are experiencing stress, depression and burnout.

8.2.2 The risk to frontline workers must be acknowledged and measures must be put in place to protect their mental health. Additionally, where doctors and frontline workers are working outside their usual areas of expertise because of the redeployment to respond to the pandemic, they must be protected/indemnified if they have acted in good faith¹⁵². The Medical Protection Society noted the considerable additional stress that this concern was causing to frontline workers.

8.2.3 DAUK state in their written evidence that the impact of mental health on frontline healthcare workers '*must not be underestimated and [it will] lead to significant morbidity in the months and years to come*'¹⁵³. Frontline healthcare workers are experiencing higher rates of mental illness including '*anxiety, depression, substance misuse and burnout*'.¹⁵⁴

8.2.4 A DAUK snapshot survey¹⁵⁵ with 1431 respondents revealed that 57% were most worried about a second wave of Covid-19 as we head into the winter. 40% stated that they were most worried about secondary harm to patients because of delays in diagnosis and treatment due to Covid-19. The remainder were concerned about the impact of Covid-19 on the mental health of patients¹⁵⁶.

8.2.5 An extensive survey conducted by GMB¹⁵⁷ found that 71.25% of those respondents that work in the NHS felt that '*work is causing them stress and impacting on their mental health*'. When asked the cause of this stress 60.95% attributed it to fear of taking home, and 50.95% attributed it to fear of catching the virus.¹⁵⁸

8.2.6 In the oral evidence session, Susan Masters of the Royal College of Nursing told the APPG that there has been almost a 30% increase in calls where staff are exhibiting psychological distress. Moreover, Susan Masters pointed to a members' survey in which 91% expressed concern about the wellbeing of their nursing colleagues.¹⁵⁹

¹⁵⁰ *ibid*

¹⁵¹ Mental health is addressed more fully in Chapter 9, and also in chapters 4,5 and 8.

¹⁵² https://d3n8a8pro7vvhmx.cloudfront.net/marchforchange/pages/499/attachments/original/1603737275/MPS_Submission_19623_.pdf?1603737275

¹⁵³ https://d3n8a8pro7vvhmx.cloudfront.net/marchforchange/pages/499/attachments/original/1604355126/Doctors'_Association_APPG_Coronavirus_Submission.pdf?1604355126

¹⁵⁴ *ibid*

¹⁵⁵ *ibid*

¹⁵⁶ *ibid*

¹⁵⁷ <https://www.gmb.org.uk/news/4-5-care-workers-expect-colleagues-quit-amid-coronavirus-danger>

¹⁵⁸ https://d3n8a8pro7vvhmx.cloudfront.net/marchforchange/pages/499/attachments/original/1603737274/GMB_Union_-_APPG_Coronavirus_Written_Evidence.pdf?1603737274

¹⁵⁹ https://d3n8a8pro7vvhmx.cloudfront.net/marchforchange/pages/486/attachments/original/1603982667/239147_APPG_on_Coronavirus_Session_6_TSC_%284%29.pdf?1603982667

8.3 Access to testing for frontline workers has been unsatisfactory.

- 8.3.1 The testing of health and social care staff was raised across submissions and by witnesses to the APPG evidence hearing.
- 8.3.2 Although the availability of tests has improved, at the time of submission many frontline workers submitted that they had to travel many miles to access a test. Many of these workers do not have access to cars thus had to risk using public transport to be tested.
- 8.3.3 Testing systems, particularly in care settings, took too long to implement. The Royal College of Nursing note in their written submission that it *'too long to roll-out across acute Trusts and the wider health and care system. This meant that nursing staff took the precaution of self-isolating when presenting with symptoms, unable to access a test. As a result, in early April, some Directors of Nursing in London were reporting staff sickness rates of over 20%. This presented a significant staffing challenge and placed additional pressure on already overburdened staff'*.¹⁶⁰
- 8.3.4 Testing must be accessible to permanent staff, agency staff and bank staff.
- 8.3.5 Testing must be improved to identify health and care professionals symptomatic and asymptomatic with possible Covid-19.
- 8.3.6 GMB Union were particularly critical of the test, track and trace strategy. The biggest problem, they note, is the time that it takes for test results to be returned. Rehana Azam told the APPG that testing was still *'not widely available. It's very difficult to access. Government strategy on that is very poor'*.
- 8.3.7 Rapid testing of staff and patients must be available as the elective functions of the NHS begin to reopen.
- 8.3.8 GMB Union state that there must be regular and mandatory testing of all staff, available at home or the workplace.¹⁶¹

8.4 The social care workforce must have the same level of PPE and access to Statutory Sick Pay (SSP) as NHS staff. Greater guidance is needed for the sector.

- 8.4.1 The social care workforce must have the same level of PPE and access to Statutory Sick Pay (SSP) as NHS staff. Greater guidance is needed for the sector.
- 8.4.2 The written submission from GMB Union makes clear that the social care workforce was excluded from PPE guidance. It was only after pressure from GMB union and other unions that guidance was issued on the use of PPE. However, access to PPE remained a real issue for most social care workers for many weeks after the guidance was published.

¹⁶⁰https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/499/attachments/original/1603737278/RCN_submission_August_2020_19432_%281%29.pdf?1603737278

¹⁶¹https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/499/attachments/original/1603737274/GMB_Union_-_APPG_Coronavirus_Written_Evidence.pdf?1603737274

8.4.3 The social care workforce has largely been denied access to full pay when on sick leave, meaning that many were placed in the untenable position of having to choose between having a liveable income or ignoring UK government self-isolation advice and attend work. At the time of writing, GMB is conducting an extensive survey¹⁶² of its members in social care to better understand the effects of not receiving full sick pay. The interim findings from respondents are particularly concerning, they note:

- 76.64% of respondents were on Statutory Sick Pay (SSP) with only 8.63% receiving full sick pay. The remainder did not know.
- 80.56% of those surveyed said that living off SSP would mean having to borrow money from friends or family or getting into debt.
- 50.59% of respondents had taken time off for sickness unrelated to Covid-19 in the last 12 months. 41.69% had taken sick leave as a result of Covid-19.
- Of those that responded, reducing their pay to SSP whilst unwell would make them more inclined to return to work before they are ready.

8.5 Workers from BAME¹⁶³ backgrounds have been disproportionately impacted by the pandemic.

8.5.1 The impact COVID-19 crisis is not uniform across ethnic groups. Health and social care workers from BAME backgrounds have been particularly affected by Covid-19.

8.5.2 Those of South Asian descent are more likely to have higher disease severity on admission to hospital and more likely to need ICU support.¹⁶⁴ DAUK note in their written evidence that the Public Health England report, 'Disparities in the risk and outcomes of COVID-19'¹⁶⁵ identified that individuals of Black African or Black Caribbean ethnicity are of highest increased risk. The same report also found that the mixed and Indian, Pakistani, and Bangladeshi ethnic groups are also at significantly increased risk of death from COVID-19. According to this report, all-cause mortality from Covid-19 compared to the general population is 4 times higher for Black males and 3 times higher for Asian males.

8.5.3 Dr Dolin Bhagawati told the APPG that '*those from an Indian background are 310% more likely to be in health and social care compared to a white British male*'. At the same time, however, they are also more likely to be exposed to disciplinary action (DAUK). Indeed, Dr Bhagawati stated that '*we have members still saying that they were worried about the threat of deportation.*'

'There is a toxic culture of bullying, especially if you say something about the lack of PPE. There is a shortage of almost everything, as an IMG doctor, I'm worried that I'll speak up and get deported' DAUK member.

¹⁶² *ibid*

¹⁶³ The impact on BAME communities is addressed in Chapters 3, 4, 5, 8, and 9.

¹⁶⁴ Sapey E, Gallier S, Mainey C, Nightingale P, McNulty D, Crothers H, et al. Ethnicity and risk of death in patients hospitalised for COVID-19 infection: an observational cohort study in an urban catchment area. medRxiv

¹⁶⁵ Public Health England 'Disparities in the risk and outcomes of COVID-19'

8.6 Doctors are particularly concerned about preparedness for winter and the ability of the NHS to cope with the elective backlog.

- 8.6.1 Alongside the usual pressures of winter, NHS and care staff will have to deal not only with Coronavirus but also the elective backlog caused by lockdown and Covid-19 restrictions.
- 8.6.2 There must be sufficient stockpiles of PPE.
- 8.6.3 UK government support is needed to ensure that those that have to take time off work for Covid-19 related reasons, as well as for those identified as high risk and in need of working from home options or redeployment into Covid-19 secure areas.
- 8.6.4 In their written evidence¹⁶⁶, DAUK notes that the pandemic has had a marked impact on the provision of NHS services. Emergency attendances and admissions fell dramatically during the lockdown, but also, the number of patients waiting under Referral to Treatment (RTT) for consultant-led care and those waiting for elective procedures has markedly increased.
- 8.6.5 To maximise capacity, hospitals were instructed by NHS England on 17th March 2020 to cease elective working and re-structure from at least April 15th for a minimum three-month period. As Covid-19 caseloads and admissions continue to fall, and the three-month window draws to a close, the numbers are beginning to reveal the extent of the elective backlog that would require clearing.
- 8.6.6 Statistics in England, comparing May 2019 to May 2020¹⁶⁷:
- RTT waiting list figures have fallen during the pandemic, from 4.4 million to 3.8 million patients.
 - Routine testing (such as for suspected cancer and heart function) has dropped by 37.5% from 1.2 million to 870,000
 - Elective operations in England fell by 80% from 296,000 to 55,000.

¹⁶⁶ Ibid

¹⁶⁷ <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/07/May20-RTT-SPN-publication-version.pdf>

Chapter 9: Impact on Mental Health

In the 7th Oral Evidence hearing¹⁶⁸, the APPG heard from the Centre for Mental Health, Mind, University College London, Beat, the Mental Health Foundation and Sir Graham Thornicroft.

The Centre for Mental Health is a charity with over 30 years' experience in providing life-changing research, economic analysis and policy influence in mental health. Chief Executive of the organisation, Andy Bell, represented the organisation in the oral evidence hearing.

Mind provides advice and support to empower those experiencing a mental health problem. As an organisation, Mind campaigns to improve services, raise awareness and promote understanding of mental health issues. Louise Rubin, their parliamentary and campaigns manager gave spoken evidence to the APPG. Mind published a report in June 2020 on the impact of the pandemic on mental health, based on a study of over 16,000 participants.

University College London has been running a study to understand the psychological and social impact of the pandemic. Daisy Fancourt, Associate Professor of Psychobiology and Epidemiology, leads the Covid-19 Social Study. The study is an investigation looking at the social experiences of adults in the UK during the pandemic. At the end of April, the study had over 70,000 participants.

Beat is the UK's eating disorder charity. Tom Quinn, director of external affairs gave evidence to the APPG. Demand for Beat's support services increased by 97.8% during March-August 2020, compared to the same period in 2019.

The Mental Health Foundation is the UK's leading charity for mental health prevention. Dr Antonis Kousoulis, who gave oral evidence to the APPG has previously occupied several prestigious posts including chief executive of Mental Health Media, former board member and vice-chair for the Commission for Patient and Public Involvement in Health, a founding member of National Survivor User Network (NSUN), and former chair and treasurer of Survivors Speak Out.

Sir Graham Thornicroft is a British psychiatrist, researcher and professor of community psychiatry at the Centre for Global Mental Health and Centre for Implementation Science at King's College London.

Key Findings:

- 9.1 **Covid-19 has had profound consequences for individuals' mental health.**
- 9.2 **Those with pre-existing mental health conditions have seen their mental health decline further throughout the pandemic.**
- 9.3 **Many individuals are experiencing mental health problems for the first time as a result of complex grief.**

¹⁶⁸ 16th September 2020

- 9.4 Throughout the pandemic there has been a reduced access to services and support as a result of Covid restrictions. The impact of this has meant more people are suffering without having access to support and thus causing their condition to worsen.**
- 9.5 The reduction in normal activity and increased isolation has caused many to experience mental health problems for the first time.**
- 9.6 There is specific concern for the mental health of key workers. Key workers urgently need support now and as we move into the next phase of the pandemic.**
- 9.7 Those from BAME backgrounds have felt higher levels of depression and anxiety across the pandemic.**

9.1 Covid-19 has had profound consequences for individuals' mental health.

- 9.1.1 Covid-19 has had profound consequences for individuals' mental health¹⁶⁹. ONS data shows that almost one in five adults (19.2%) were likely to be experiencing some form of depression during the coronavirus pandemic in June 2020. This is almost double the figure (9.7%) before the pandemic¹⁷⁰ (July 2019 to March 2020).

"As we're heading into the winter it's not just going to be about a second wave potentially being bad for mental health, it's also going to be about a recession and Brexit and we know that these two activities are also going to have detrimental psychological effects so we could be looking at a kind of double/triple jeopardy type scenario"
Daisy Fancourt, UCL, witness to APPG.

- 9.1.2 Covid-19 has brought despair to individuals, families, and communities, leaving many people feeling unsafe and disconnected. Moreover, *'it has taken the lives of those already exposed to health inequalities¹⁷¹ at a disturbing rate¹⁷²*. The UK alone has seen tens of thousands of tragic deaths, as well as the profound economic shock of the Covid-19 response.¹⁷³
- 9.1.3 The fallout of the pandemic has resulted in fractured relationships, isolation, debt, unemployment, and grief (Mind). On top of this, access to services or support has been limited or completely unavailable. Beat told the APPG that further restrictions or cancellations to services will have a significant impact on mental health both now and as we move out of restrictions.
- 9.1.4 Andy Bell from the Centre for Mental Health, a research organisation and witness to the APPG stated that *'overall, the surveys that have been produced and some of the academic evidence points to a sharp deterioration in mental health¹⁷⁴*.
- 9.1.5 At the time of the oral evidence hearing, Mind told the APPG *'that though 'the peak of the pandemic may have passed; we are already experiencing a knock-on mental health emergency'*. Now, as we approach winter and are already experiencing further restrictions, the situation will likely get worse.¹⁷⁵
- 9.1.6 Throughout lockdown there has been an increase in demand for mental health support services. Beat, the UK's eating disorder charity, told the APPG that they saw an increase of 97.8% between March and August 2020. This represents an increase of 46, 625 individuals.¹⁷⁶

¹⁶⁹ Hotopf, M., Bullmore, E., O'Connor, R., & Holmes, E. (2020). The scope of mental health research during the COVID-19 pandemic and its aftermath. *The British Journal of Psychiatry*, 1-3. doi:10.1192/bjp.2020.125

¹⁷⁰ <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/june2020>

¹⁷¹ Inequalities is addressed in chapters 3, 7, and 9.

¹⁷² https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/500/attachments/original/1603738731/MIND_minds-five-tests-for-mental-health-final-090720.pdf?1603738731

¹⁷³ *Ibid*

¹⁷⁴ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/487/attachments/original/1604665018/160920239168_APPG_on_Coronavirus_Session_7_TSC_%289%29.pdf?1604665018

¹⁷⁵ *Ibid*

¹⁷⁶ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/500/attachments/original/1603738736/BEAT_Inquiry_to_the_APPG_on_Coronavirus_into_the_Impact_of_the_Pandemic_on_Mental_Health_20218_.pdf?1603738736

9.2 Those with pre-existing mental health conditions have seen their mental health decline further throughout the pandemic.

- 9.2.1 There is a need to understand and tackle the significant impact the pandemic has had on those who already suffer from poor mental health. Written evidence from the Mental Health Foundation states that *'those who entered the pandemic with prior experience of mental health problems have been more likely to experience anxiety, panic, and hopelessness. Much of the support for people with mental health problems such as one-to-one therapy, training courses, volunteering and supported employment opportunities, were curtailed or stopped'*.¹⁷⁷ Their 'Mental Health in the Pandemic' study shows that those with a pre-existing mental health problem have been the most likely to experience stress and inability to cope. Very worryingly, they have reported suicidal thoughts and feelings at a rate almost triple those in the general population.
- 9.2.2 Louise Rubin from Mind told the APPG that the results from a survey conducted by Mind in April and May found that of the 16,000 responses, two-thirds of people with existing mental health problems felt their mental health had deteriorated further. Louise Rubin *'The evidence we have received is that one in five people who had not experienced a mental health problem before, are now saying that their mental health is poor'*¹⁷⁸.
- 9.2.3 In the evidence hearing, Professor Sir Graham Thornicroft told the APPG that those with pre-existing conditions do not have adequate access to services, and even where they do, they may be reluctant to come to appointments: *'previously it was because of stigma, now it's stigma plus avoidance of possible infection, therefore we've seen people more often waiting to a crisis point and then going to casualty and then being subject to the Mental Health Act'*.
- 9.2.4 Those with severe illness face double jeopardy. They are usually without employment or UK government support, and now their caregivers will be without income. With inpatient care disrupted, those who are unable to afford medications, without specialist or community-based care, and in households with relatives without employment risk becoming homeless.

9.3 Many individuals are experiencing mental health problems for the first time as a result of complex grief.

- 9.3.1 Complex grief', or 'complicated grief' is where individuals are unable to recover from the grief of losing a loved one. For some people, feelings of loss are debilitating and do not improve over time. In complicated grief, painful emotions are so long-lasting and severe that you have trouble recovering from the loss and resuming your own life.¹⁷⁹
- 9.3.2 The Centre for Mental Health notes *'in normal circumstances, when people suffer loss and bereavement, around 7% will have a more complex reaction, with more severe and prolonged grief symptoms associated with depression and PTSD. However, there are circumstances associated with this crisis which may add to the difficulty of those mourning the loss of a loved one'*. These include restrictions placed on visits to hospitals, care homes and even in the community and then further restrictions placed on funerals. We should therefore expect that a greater number of people will have a greater struggle over the loss of loved ones and may

¹⁷⁷https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/500/attachments/original/1603738733/mental_health_foundation_Coronavirus_-_The_divergence_of_mental_health_experiences_Updated_%281%29.pdf?1603738733

¹⁷⁸https://d3n8a8pro7vnm.cloudfront.net/marchforchange/pages/487/attachments/original/1604665018/160920239168_APPG_on_Coronavirus_Session_7_TSC_%289%29.pdf?1604665018

¹⁷⁹ <https://www.mayoclinic.org/diseases-conditions/complicated-grief/symptoms-causes/syc-20360374>

require some intervention. This may affect tens of thousands of people as a result of both Covid-19 and other causes of death during this time.

- 9.3.3 Kathryn de Prudhoe, a witness to one of the APPG evidence hearings, spoke of the psychological impact of Covid-19 bereavement. As well as having lost her father to Covid-19, Kathryn is also a psychotherapist. She told the APPG that she has *'grave concerns about the psychological impact of Covid-19 bereavement on many of the members of our group. Covid-19 bereavements are really traumatic, both in the nature of the death and the complex circumstances surrounding them caused by lockdown and the social distancing measures that were in place, and as a result of that the grief is very complex too. There was already a huge funding gap in mental health services before Covid-19 with really long NHS waiting lists, many third sector counselling services relying on trainees and volunteers to meet demand'*.¹⁸⁰
- 9.3.4 Morgan Vine of Age UK also spoke of complex grief when giving evidence to the APPG. She said *'we estimate that about 98,000 people have lost a partner during Covid and that is one and a half times as many as the last five years for this period, so there are going to be many people in later life who are experiencing complex grief...[individuals] might have experienced multiple bereavements in one go, [they] didn't know they were coming, [they] couldn't be there with the person, [they] don't know if they had a good end of life and all of that can combine to create a situation where people experience PTSD symptoms and would need professional support'*.¹⁸¹

9.4 Throughout the pandemic there has been a reduced access to services and support as a result of Covid-19 restrictions. The impact of this has meant more people are suffering without having access to support and thus causing their condition to worsen.

- 9.4.1 Over the course of the pandemic there has been a reduced access to services and support as a result of Covid-19 restrictions. The impact of this has meant more people are suffering without having access to support and thus causing their condition to worsen. The Centre for Mental Health notes that although NHS services have officially remained open throughout the pandemic, at the height of lockdown those who use mental health services or those who were experiencing mental health problems reported that support decreased or was harder to access: *'Maintaining referrals and access to mental health services at the same level as before the pandemic (at a level which already did not meet demand) has not been achieved. Fewer people have been able to access support for their mental health, risking the deterioration of their mental health and increasing the likelihood of more acute mental health need as things worsen'*.¹⁸²
- 9.4.2 Beat, in their written submission, note that the usual routes of referral have been impacted by Covid: *'usual referral routes not being accessed, such as children and young people not being in school, limited face to face visits with GPs, families concerned about using NHS*

¹⁸⁰https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/342/attachments/original/1597776353/CBF4J_Submission_to_APPG_Coronavirus_July_2020_%281%29.pdf?1597776353

¹⁸¹https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/296/attachments/original/1596126241/APPG_on_Coronavirus.pdf?1596126241

¹⁸²https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/500/attachments/original/1604355412/CentreforMentalHealth_COVID_MH_Forecasting3_Oct20.pdf?1604355412

services due to concerns on getting Covid-19¹⁸³. Beat is concerned that once referral routes start being accessed again, services will not be able to cope with the demand.

9.5 The reduction in normal activity and increased isolation has caused many to experience mental health problems for the first time.

9.5.1 The reduction in normal activity and increased isolation has caused many to experience mental health problems for the first time.

9.5.2 Rethink Mental Illness, in their survey conducted in April and May found that the most common reasons that people gave for their mental health getting worse included not being able to do normal activities, not being able to see family or friends and worrying that their loved ones would catch the virus. Though these are difficulties that everyone can relate to at this time, Rethink note that *'the impact will be very different for those who are already experiencing severe mental illness. For some, regular visits from friends or family, the ability to exercise or access to outdoor space can be the difference between staying well and becoming seriously ill. The way that people are affected by the changes to daily life depends a lot on their condition and their circumstances'*.¹⁸⁴

9.5.3 Beat highlighted that during lockdown people with eating disorders, for example, struggled to find 'safe' foods'. They note that *'people were unable to access safe foods and that was contributing to the development of their eating disorder behaviours'*¹⁸⁵.

9.6 There is specific concern for the mental health of key workers. Key workers urgently need support now and as we move into the next phase of the pandemic.

9.6.1 The Centre for Mental Health stated that there is international evidence that *'working in frontline health care during a crisis can increase the level of distress by as much as 50%, with post-traumatic stress and burnout much more likely amongst these workers over a 1-2 year period'*.¹⁸⁶

9.6.2 The study from University College London found that key workers are reporting more daily stressors. Key workers are substantially more worried about work than non-key workers.¹⁸⁷ Sir Graham Thornicroft submitted a number of papers as written evidence¹⁸⁸. Through this, the APPG has learned of the significant impact Covid-19 has had on health and care workers. Working in distressing situations is made worse due to increased stigma, social isolation and quarantine.¹⁸⁹

¹⁸³https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/500/attachments/original/1603738736/BEAT_Inquiry_to_the_APPG_on_Coronavirus_into_the_Impact_of_the_Pandemic_on_Mental_Health_20218_.pdf?1603738736

¹⁸⁴https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/500/attachments/original/1603738726/RethinkMentalIllness_APPG_on_Coronavirus_evidence_submission_Sep_20_-_FINAL.pdf?1603738726

¹⁸⁵https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/487/attachments/original/1604665018/160920239168_APPG_on_Coronavirus_Session_7_TSC_%289%29.pdf?1604665018

¹⁸⁶ British Medical Association (2020) Stress and burnout warning over COVID-19 [Online] Available from: <https://www.bma.org.uk/news-and-opinion/stress-and-burnout-warning-over-covid-19> [accessed October 2020]

¹⁸⁷ <https://www.covidsocialstudy.org/results>

¹⁸⁸https://d3n8a8pro7vhm.cloudfront.net/marchforchange/pages/500/attachments/original/1603738729/Sir_Graham_Thornicroft_covid_briefing_notes_160920_4_13026_.pdf?1603738729

¹⁸⁹ Maulik, P.K., Thornicroft, G. & Saxena, S. Roadmap to strengthen global mental health systems to tackle the impact of the COVID-19 pandemic. *Int J Ment Health Syst* **14**, 57 (2020)

9.6.3 In addition, the direct impact of Covid-19 on mental illness of those infected or health workers involved in care of those infected is also significant, and is often precipitated due to increased stigma, social isolation and quarantine.¹⁹⁰

9.7 Those from BAME backgrounds have felt higher levels of depression and anxiety across the pandemic.

9.7.1 UCL's study significant evidence concerning those from BAME¹⁹¹ backgrounds: over 45,000 individuals from such backgrounds took part in the study. The study found that those from BAME backgrounds have higher levels of depression and anxiety across the pandemic, and lower levels of happiness and life satisfaction.¹⁹²

9.7.2 Further, whilst 17% of people from white backgrounds have reported being often lonely during lockdown, this figure has been 23% amongst those from BAME backgrounds. Although thoughts of death have affected fewer than 15% of people, the number of people reporting having these thoughts have been a third higher from these groups. Similarly, the report from UCL states that *'although fewer than 5% of people have reported self-harming, these experiences have been around 70% higher amongst BAME groups. Although on average fewer than 1 in 10 people have experienced psychological or physical bullying or abuse during lockdown, reports have been around 80% higher amongst Black, Asian and minority ethnic groups.*

9.7.3 Andy Bell from the Centre for Mental health told the APPG *'what is very clear is that many groups who are experiencing adversity anyway and social and economic adversity is really at the heart of inequality and mental health across society... there's a really important lesson here about the links between physical and mental health and social adversity'*.¹⁹³

¹⁹⁰ Maulik, P.K., Thornicroft, G. & Saxena, S. Roadmap to strengthen global mental health systems to tackle the impact of the COVID-19 pandemic. *Int J Ment Health Syst* **14**, 57 (2020) – Submitted to the APPG by Sir Graham Thornicroft

¹⁹¹ The impact on BAME communities is addressed in Chapters 3, 4, 5, 8 and 9.

¹⁹² <https://www.covidsocialstudy.org/results>

¹⁹³ https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/487/attachments/original/1604665018/160920239168_APPG_on_Coronavirus_Session_7_TSC_%289%29.pdf?1604665018

Chapter 10: International Comparisons

At the eighth Oral Evidence hearing¹⁹⁴, the APPG heard evidence on international comparisons to the UK Government's handling of the Coronavirus pandemic. The APPG heard from Professor Martin McKee, Professor Paolo Vineis, Professor Luca Richeldi, Professor Sergio Bonini, and Professor Deenan Pillay.

Professor Martin McKee is Co-Director of the Core Management Team of the European Observatory on Health Systems and Policies. He is also professor of European Public Health at the London School of Hygiene and Tropical Medicine. He spoke to the heterogeneity of national responses to Covid-19

Professor Paolo Vineis is Chair of Environmental Epidemiology at Imperial College, London and he leads the Exposome and Health theme of the MRC-PHE Centre for Environment and Health at Imperial College. He is also Head of the Unit of Genetic and Molecular Epidemiology at the Italian Institute for Genomic Medicine (IIGM), Torino, Italy.

Professor Luca Richeldi is a professor of respiratory medicine and honorary consultant at Southampton, Luca maintains strong links with medical colleagues in Modena where he founded and leads the Centre for Rare Lung Diseases and is an Associate Professor of Respiratory Medicine at the University of Modena and Reggio Emilia. Luca is a member of international scientific societies, including the European Respiratory Society, the American Thoracic Society and the Fleischner Society.

Professor Sergio Bonini is Professor of Internal Medicine and Research Associate at the Italian National Research Council (CNR), Institute of Translational Pharmacology, Rome. From 2013 to 2017 he was Expert-on-Secondment at the European Medicines Agency. He is a Member of the Scientific committee of the Italian Embassy in London.

Professor Deenan Pillay is a Professor of Virology at UCL. His work at UCL focusses on clinical, population and laboratory-based studies to limit the spread of HIV.

Key Findings

- 10.1 The UK government failed to learn from other countries in their handling of the pandemic.**
- 10.2 Find Test Trace Isolate and Support is most effective when run at a local or regional level.**
- 10.3 Countries with experience in tackling SARS and MERS have dealt with the virus most effectively.**
- 10.4 Communication, clarity, trust and risk perception are essential for compliance.**

¹⁹⁴ 23rd September 2020

10.1 The UK government failed to learn from other countries in their handling of the pandemic.

- 10.1.1 Professor Luca Richeldi told the APPG that he was ‘shocked’ by the pandemic response in the UK. Despite the situation in Italy being portrayed by *‘images that usually you see in wars’*, the UK had *‘very little or no reaction... what was happening in Italy was not perceived as something that could happen in the UK’*.
- 10.1.2 Professor Deenan Pillay testified as to the ‘English exceptionalism’ in the UK’s approach. He notes that while *‘twenty-thirty years ago...the UK and the US were leaders of science in the world’*, this should not have precluded the urgent need from seeking advice from and learning from the example of other countries. Professor Deenan Pillay told the APPG *‘there’s no doubt there was a delay in seeking advice from those countries, including Italy, where this experience had already happened’*.
- 10.1.3 The response of other countries, such as Italy, was deemed to be ‘exaggerated’. Professor Paolo Vineis told the APPG that the response in Italy was *‘considered to be exaggerated and we are too focused on the family, we are too emotional and we shouldn’t react like that, but in fact perhaps we had the right reaction’*. Had the UK taken action on the basis of the situation in Italy, it is likely that many lives could have been saved.
- 10.1.4 The APPG heard that the main driver of cases during the first wave was movement and mobility. Professor Paolo Vineis told the APPG that as mobility was reduced through lockdown the *‘R rate went down dramatically’*. Limiting movement and travel in the early stages of the pandemic prior to national lockdown in the UK may have prevented cases of Covid-19.

10.2 Find Test Trace Isolate and Support is most effective when run at a local or regional level.¹⁹⁵

- 10.2.1 Professor Paolo Vineis stated that the lower number of cases of Covid-19 in Italy at the time of the hearing was due to their effective contact tracing system, set up at a regional level.
- 10.2.2 Professor Martin McKee highlighted the need for a *‘joined up strategy’* on find, test, trace, isolate and support, with each element needing a clear. He told the APPG: *‘we need a joined-up strategy where there’s clear lines of accountability, clear lines of data flow and we haven’t had that’*.
- 10.2.3 Moreover, he stated that countries such as Germany and Italy as well as other central European countries that had a local approach to testing and tracing have achieved greater success.
- 10.2.4 Countries entering the pandemic from a SARS and MERS perspective have dealt with the virus most effectively
- 10.2.5 Professor Martin McKee stated *‘countries who came into this with their frame of reference being SARS and MERS had a lot of preparation and that was how they looked at it, but compared to the influenza countries which had a different view’*, this *‘narrative, that paradigm,*

¹⁹⁵ Find Test, Trace, Isolate and Support is addressed in chapters 2, 3, 6, 7, and 10..

that frame of thinking was quite important and just the ability to work across different bits of government’.

10.3 Countries with experience in tackling SARS and MERS have dealt with the virus most effectively.¹⁹⁶

- 10.3.1 Professor Sergio Bonini spoke of the issue of ‘risk perception’. In Italy, both politicians and scientist presented the risk of Covid-19 to the public from the outset¹⁹⁷. In doing so there was greater confidence in the Prime Minister and Minister of Health.
- 10.3.2 Professor Luca Richeldi told the APPG that in Italy, *‘the public trust was enhanced by the fact that the situation was really perceived as a dramatic situation, as something which was life or death. And there was no complaining because the people [were] believing and trusting in what they [were] trying to do’.*
- 10.3.3 Professor Sergio Bonini further spoke of the need for widespread support for measures. He stated *‘it is extremely important that there is a partisan support for the actions and measures which are being presented. Because if there is a political fight this creates confusion in the people and compliance will be reduced’.*
- 10.3.4 Discussions of the concept of ‘herd immunity’ ‘created some confusion’ (Professor Sergio Bonini).

10.4 Communication, clarity, trust and risk perception are essential for compliance.

- 10.4.1 There is *‘dysfunction between politics and science’* in the United Kingdom and its approach. Professor Deenan Pillay stated: *‘it comes down to a dysfunctional relationship between what is called science and our political class, our political, our Civil Service infrastructure...exemplified by the sort of the speed with which right at the beginning politicians talked about ‘we are following the science’, with little understanding of what that means’.*

¹⁹⁶https://d3n8a8pro7vhmx.cloudfront.net/marchforchange/pages/488/attachments/original/1604355625/Transcript_239203_All_Party_Parliamentary_Group_on_Coronavirus_Session_8.pdf?1604355625

¹⁹⁷ Communication and messaging are addressed in Chapters 2, 3, 4, 5, 7, and 10.



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