Covid-19: A personal analysis by Lord David Owen

first posted on 29 June 2020 but occasionally updated to show a running commentary

Despite the Prime Minister previously saying it would not be "a good use of official time", he has now agreed to hold an independent inquiry into the UK's response to Covid-19. But given the dismal history of recent inquiries, the length of time they take, the role of successive Cabinet Secretaries in withholding evidence and protection of the civil service and Prime Ministers, we should not be too hopeful of its comprehensiveness or its speed to report. Meanwhile, the House of Commons Select Committees are showing every sign of being far more effective under the new chairmanship selection process. On Health and Social Care, the current chairman, Jeremy Hunt, who was Secretary of State for Health from 2012-2018, is somewhat compromised on the serious lack of preparedness during his period in office but against that he knows the subject inside out and this is useful for what exactly did happen in 2020. The powerful Public Accounts Committee whose chairman always comes from the Official Opposition, currently Meg Hillier, should investigate the priority and spending given to Preventive Health as a percentage of the overall NHS budget for the years 2000-2020. The Business Committee, chaired by Labour MP, Darren Jones, who has worked in the health service, is doing a good job too on aspects of Covid-19. As to scientific investigation, apart from Greg Clark, Conservative chair of the Science and Technology Committee, I hope the much respected Royal Society, which embraces all science, will conduct an inquiry that has the potential for making a lasting contribution and perhaps ending the disputed areas of Covid-19 science and modelling.

The more general debate should focus on what was said in December 2016 by the then Chief Medical Officer, Sally Davies, at an international conference, that as a result of the Cygnus simulation exercise of a H2N2 influenza pandemic a couple of months earlier "it became clear that we could not cope with the excess bodies" and faced the threat of "inadequate ventilation." The real NHS – the one we had from 1948-2013 – would have acted on her concerns. Did Sally Davies appeal directly to the then Secretary of State, Jeremy Hunt, or not? We need to know in detail what steps were taken as a result of that simulation and why the full results of the exercise remain classified. This was the fundamental moment when the CMO feared the UK was not prepared for any pandemic, whether influenza or another coronavirus. Complacency followed buttressed by the self-congratulatory belief that the UK was one of the best prepared countries in the world. What nonsense that has proved to be.

The underlying reason for our unpreparedness stems from 20 years of structural vandalism to the NHS. Hospitals no longer serving geographical areas, the incoherence and fragmentation of an unrecognisable NHS. It had come about through four legislative Acts - 2002, 2006, 2008 and above all the Health & Social Care Act of 2012. It was overseen by Prime Ministers Blair, Brown and Cameron. [A detailed description of this period is described in my book *'The Health of the Nation - NHS in Peril'* published in 2014 and now available in pdf format on this website]. It was coupled with

insufficient money for the NHS made worse by the hidden huge extra cost to the NHS from PFI started in John Major's government and embraced by Gordon Brown as Chancellor whereby the NHS instead of paying to build hospitals by borrowing from the Treasury at traditionally low levels of around 4% interest, instead had to borrow from venture capitalists at over 20% interest. These were ludicrously high rates for a low risk investment, presumably undertaken to manipulate the lowering of the Public Sector Borrowing Requirement, PSBR. A reminder of the folly of Treasury budgetary control of the NHS on an annual basis.

Putting aside all partisan politics, let there be no doubt that it has been the low priority given to Preventive Health which has bedevilled our response to Covid-19. The excellent charitable think tank, Centre for Health and the Public Interest, questioned in December 2013 whether the very different NHS to emerge from the 2012 H & SC Act was ready for pandemic flu.[1] An indication of priorities was the public health grant in 2019-20 which was £850m lower in real terms than initial allocations in 2015-16. The roots of the NHS testing deficiency in 2020 lies in the abolition of the Public Health Laboratory Service first established in 1940 as an Emergency Public Health Service as a response to the threat of biological warfare and continued as the PHLS which by 1955 had 1,000 staff with an epidemiological focus. In 2003 it became the new non-departmental body, Health Protection Agency, HPA, with the decision to retain only central laboratories and regional centres, but no network of local laboratories and then in 2013 it became part of PHE.

This was all compounded by running down the number of people involved in local tracing and tracking new virus infections. Public Health England diverted money into epidemiological modelling, much of poor quality. An inspector of microbiology and infection control at the Department of Health from 2003-10 highlighted all this in a letter to the *Guardian* saying how his remit became increasingly difficult because of the so-called " "modernisation" of pathology services, with microbiology/virology laboratories centralised in main hospitals or on non-hospital sites. Some remain managed by NHS trusts but others are run by private companies, and trusts only funded the testing they required for their patients and those of local GPs – public health did not feature."[2] The Chief Executive of Public Health England, Duncan Selbie, confirmed this in a letter written in defence of his organisation "PHE operates specialist reference laboratories for novel and dangerous pathogens, not large scale pathology services." But who then was responsible for building the capacity to quickly scale up for large scale production of testing equipment if it was not PHE? We need to know. He also claims "PHE had sufficient capacity to contact trace throughout the containment phase. We believe that this delayed the peak of the pandemic by around a month and enabled the NHS to prepare more fully." He goes on to add, "All symptomatic people coming into the country at this point were tested and asked to isolate." A claim that needs to be

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[1] CHPI, 'Getting behind the Curve? Is the new NHS ready for Pandemic Flu?', December 2013

[2] 'Public Health England is not fit for purpose' by Professor Brian I Duerden and three others, *Guardian* letter column, 18 June 2020.

challenged. As well as his further claim “The change to targeted tracing came when there was sustained transmission within the community, not because of a lack of capacity. The Scientific Advisory Group for Emergencies [SAGE] agreed with this at the time.”

Whilst there has been a lot of criticism of the NHS England and PHE response not sufficient critical attention, I believe, has been directed in this global crisis at the total failure of the three leading commercial global players, Apple, Google and Facebook, who have not combined resources and technology to formulate and develop an app or method for track and trace which they could offer to the world in a standard format that can be used by any country. If anyone for all their expensive PR and communication expertise should have stepped up to the plate and combine it is those three highly profitable rich conglomerates.

On 11 March 2020 testing was limited to hospitals. That death laden decision failed to be accompanied by a major commitment to care homes, a huge mistake. Still on 13 March the Chief Scientific Adviser, Patrick Vallance said the aim was “to build up some degree of herd immunity”, confirming later that night that herd immunity would require 60% of the population to contract the virus – a questionably high figure for Covid given the number of symptomless carriers and would have needed, as had been argued in SAGE, a vaccination programme. Greatly exaggerated though the modelling figures were of predicted deaths from Covid-19, they were to be a wake-up call to a very rapid acceleration sufficient to overwhelm the NHS. Overwhelming was the inevitable consequence of NHS England constantly pushing up bed occupancy, sometimes as high as 98%, as if they were running a series of hotels rather than hospitals. It was always a very dangerous policy that NHS hospitals had no spare capacity. And although the rapid building of the Nightingale hospitals was impressive, the first one in London was not ready until 3 April and probably contributed to the decision to transfer patients to care homes.

The UK Government guidance up until 12 March said it was “very unlikely that people in care homes will become infected by Covid-19” even though SAGE minutes recorded scientists’ unease on this unlikelihood.[3]

On 17 March Sir Simon Stevens, the Chief Executive of NHS England and Amanda Pritchard, NHS Chief Operating Officer, issued an eight-page emergency instruction, which has been widely criticised for having the effect of ‘dumping’ untested Covid patients from NHS hospitals into ill-equipped Care Homes without any notice while others were to stay at home without planned diagnostic tests and operations.

[3] Alistair Haimes, *The Critic*, July/August 2020 issue 9.

The Government was right to use the military in the crisis and the army played a huge role in the rapid building of Nightingale hospitals as an insurance policy. Fortunately, the NHS was not overwhelmed but this was only achieved at a horrendous cost in that non Covid-19 NHS patients suffering serious illnesses were pushed aside and operating theatres pre-empted for Covid patients. We will never fully know the price we paid in loss of life elsewhere in the NHS.

As a consequence, bed occupancy will have to be reassessed soon before the future hospital building programme is settled and the all powerful voice of the 'bed manager' will be diminished. The bed occupancy percentage will vary between hospitals but is likely to lie between 10-20% reserve capacity for quite apart from future pandemics, the NHS has to be able to cope with other unpredictable events.

When all the new modelling predictions on death rates had been absorbed the lockdown was announced on 23 March. According to Sir Patrick Vallance, however, addressing the House of Commons Science and Technology Committee on 15 July, SAGE's advice had been to urge a full lockdown "on 18 March or 16 March". Perhaps we will learn in due course whether the lockdown was delayed by that crucial week because they had hoped the first Nightingale Hospital would be up and running and Covid patients could be directed there, easing the pressure on other hospitals. Because they weren't was that the critical factor which lead to the 'dumping' of patients into care homes as ordered by the NHS England CEO and COO on 17 March. Were there differences of opinion at this time between Matt Hancock and Simon Stevens?

The national lockdown was never a policy. It was a defeat for the UK's state of readiness and that of some other countries. It must not become an accepted wisdom that it will ever be used again. It was a huge price for our unpreparedness for a virus like Covid-19. The tragedy was there were other alternatives to adopt and open to us from December 2016. There will be other virulent viruses and if we face a second wave of Covid-19 local lockdowns should be considered first, not another nationwide one. Indeed, I would rule it out now. The economic cost of another national lockdown is a burden too costly to bear.

We may have to face again a rise in death rates but this time much better equipped and far more knowledgeable in our ability to treat Covid-19 so a similar high death rate is very unlikely.

Staggered hours and days for work to prevent the cheek-by-jowl inner city transport system are urgent and essential, not just now but also for the future. It was a public health scandal that such overcrowding was ever tolerated. Similarly, we must not tolerate any longer the low priority of the past for public health and that is why the present design of separation within the NHS has been proven not to work. Health is a seamless robe, fragmentation menaces health provision.

There is one treatment option which the Government has still to decide on. That is to manufacture and trial as an immunoglobulin concentrated Covid-19 antibodies for injection. A well-known manufacturing process of proven medical worth exists and has been used for many earlier viruses prior to successful vaccination programmes. A more detailed background note on this is made available in the accompanying Annex.

Much political and scientific energy has been spent in examining the complex decision making of those critical days in March 2020. Too much blame has been handed out and some of it may prove premature. What is now necessary to examine urgently, are the historic reasons why we found ourselves in this dreadful place of being so ill-prepared and what urgent provisions have to be taken in the next few months to prepare for another wave. Highly complex choices in a crisis deserve scrutiny but not constant sniping. We need to retain our national unity and purpose during the now very dangerous period of easing the lockdown and prepare ourselves. For example, the Nightingale hospitals must be kept ready for use even though they are less likely to be used though some NHS hospitals surely must now be designated for Covid patients and other hospitals closed as far as possible for Covid patients. A quick catch-up in diagnosis and treatment is urgently needed for non-Covid patients deliberately delayed. But rather than as initially proposed to the Treasury for private hospitals and clinics repeating the emergency arrangements, who not unreasonably asked they be re-examined, the NHS should return to using, though for many more cases, the arrangements long in place for temporarily relieving NHS loads in certain areas. More generally the NHS itself has developed or bought new technologies whether by GPs or in hospitals to speed up diagnosis and treatments.

The deepest lesson to learn from the crisis, however, is that no amount of dedication from NHS staff can correct historic neglect and that the current marketised NHS has been a disaster for preventive health. Not surprisingly, either, it has been no friend of resilience or sustainability. Nor of mental health. Marketisation has also proven to be in procurement inefficient and hugely costly. Shortages of Personal Protection Equipment in hospitals and care homes was an avoidable disaster and stocks must never be allowed ever again to deteriorate in situ beyond use. The NHS must never again be forced to join a ruthless global auction for both PPE and tests. This has been addressed to a certain extent as we are told 2 billion pieces of equipment are ready for any future use. But the reason behind this huge error was also the fragmentation of responsibility.

All of these semi-autonomous bodies need to be brought back under the overall control of the Secretary of State and answerable to Parliament. To date the Government has made nine coronavirus related Statutory Instruments, seven of them using powers under the Public Health (Control of Diseases) Act 1984. Two have since been revoked, five are still operative. The Health & Social Care Act 2012 has not been changed. Yet no one watching the present Secretary of State, Matt Hancock, can be under any

doubt that wisely he has had little regard for the very considerable limitation on his powers in relation to NHS England or PHE in the 2012 legislation. In many areas he is, in effect, acting *ultra vires* and that was also happening under his predecessor, Jeremy Hunt. David Cameron admitted publicly the 2012 legislation was his greatest mistake. Let Boris Johnson's first major piece of post-Covid legislation be to reverse the Lansley mistakes and to coin a phrase take back control of NHS England to the Secretary of State. As for PHE it is under ministerial control, legally – but it has no statutory basis. There is a framework agreement in place between the Department of Health and Social Care and PHE which operates as an executive agency with operational autonomy.

We urgently need, therefore, a short Bill to restore the Secretary of State for Health's powers as in the 1948 Act and in doing so abolish the largest QUANGO in the world and the post of Chief Executive of NHS England and Chief Executive, Public Health England. Other lessons can come after careful analysis but it will have to embrace changes in community care inextricably linked to NHS care and the time has come for involving the large City Mayors in this process.

Ahead of us now lies a very serious economic threat that has to be given the highest priority. A second spike in Covid cases is more than likely because in part that is the historic experience of pandemics. It may well start not just because of relaxing the most economically damaging measures of our lockdown to stem the spread. Why Covid-19 behaves as it does, we do not yet fully understand nor the associated issues of immunity. Antibody finger print tests are unreliable still and one in ten are missing Covid-19 cases. Preventive science has to embrace open questions on the choices ahead.

Genuine consultation over Covid with the Official Opposition, Scottish, Welsh and Northern Irish leaders was established and worked tolerably well. It must be built on soon with legislation on our Constitution. The involvement of the elected leaders of our big cities in England was, however, far from satisfactory and cooperation there has to become mandatory. Hospital Trusts can no longer be isolated, even divorced in some cases, from the communities they serve geographically.

The Chancellor of the Exchequer and the CBI and TUC worked very well together over the introduction of the generous furlough scheme and that cooperative mood will hopefully continue. Sadly, on education in England we failed to reach a satisfactory solution, whereas in Wales the decision to split the summer weeks into three for pupils was innovative. Over time we must ask why primary and secondary education in England is so centralised. Local educational authorities during the crisis had to be advised by central government on the risks but the decision to open particular schools should have been theirs to determine and be answerable to parents. Now in the new school year the decision should be taken nationally to release social distancing rules for schools well before September.

The UK post Brexit was meant to introduce constitutional reform. Covid-19 has shown deficiencies and opportunities in all our democratic structures. In areas as important as the environment, we have had our eyes during lockdown opened up to new vistas. A post Covid-led economic revival can be a better one. There are fundamental lessons to be learnt and opportunities to be seized, particularly in applying the new technologies. Old patterns of behaviour should not be set in concrete. In every area of our lives change can now be introduced to improve the quality of life. Public money will have to be used to rescue business but unlike in 2008 this time in 2020 conditions must be attached on pressing environmental and social priorities.

The older generation have been correctly shielded during this stage of the pandemic. Those of us who participated week by week with the clapping in the street for the NHS will not easily forget that spirit. The political class will forget that at their peril. It is no good returning to normal. The mood for change is deep. Whitehall and Westminster have ignored that growing mood for too long. The older generation, many of whom were well shielded, have a particular responsibility. Now it is our turn to repay that by taking less in state pension increases and a greater share of the personal tax burden than hitherto.

ANNEX

COVID-19 CONVALESCENT PLASMA

OUR ONLY HOPE UNTIL A VACCINE IS READY

Since the beginning of March, I have been waiting for Governments worldwide to announce that they would order the manufacture of Covid-19 Hyperimmune Immunoglobulin from convalescent plasma by the Cohn fractionation process. The product would be used in its intravenous form to give immediate passive immunity to treat seriously ill patients with Covid-19 and to give in its intramuscular form to Front line health workers, Care Home Staff and residents, the BAME community, the immunocompromised and all other vulnerable groups to be used in a prophylactic manner. From the experience of using other viral immunoglobulins, in this latter form, passive immunity can last for several months or more. During the second world war, Edwin J Cohn, an American Harvard University Scientist, was asked to develop a process that would separate albumin from human plasma to be used to treat soldiers suffering from shock and burns. The process that he developed was not only successful in separating albumin but a whole range of plasma proteins including immunoglobulin. The Cohn fractionation process is still used today in plasma fractionation facilities around the world. The one of most importance for todays' coronavirus covid-19 pandemic is called specific hyperimmune immunoglobulin. It is called specific because plasma is collected from blood donors that have recovered from a specific viral infection, examples being Hepatitis, Measles, Varicella-Zoster, Rabies etc. The plasma, known as convalescent plasma, is high in antibody (hyperimmune) to the viral infection from which they have recovered. Specific immunoglobulins have been manufactured from convalescent plasma for more than 50 years and this very safe and efficacious product has saved thousands of lives.

It is the same product that a vaccine stimulates our immune systems to produce when we are infected by a live virus. To be clear, a vaccine is a virus that has been neutralised in such a way that its antigenic properties activate our immune system without being infectious. Our immune systems produce antibody and memory cells to the vaccine and so when we are infected by the live virus our memory cells immediately produce antibody to destroy the live virus. If we take convalescent plasma from patients having recovered from covid-19 then it will have high levels of antibody to the virus that we can separate and on injection can be used to help save the lives of those whose immune systems are not so robust.

From the end of March, The US Department of Health and Human Services announced that they, in cooperation with the FDA, were approving the use of convalescent plasma for direct infusion into patients suffering with covid-19. This would continue until their plasma fractionators had enough convalescent plasma to pool and manufacture the specific covid-19 hyperimmune immunoglobulin to treat patients. One plasma fractionator, Grifols, was given an upfront payment of $14.5 million to make the product. It takes approximately 5 weeks from pooling the convalescent plasma to having a batch ready for release.

The US are moving quickly. The country's first convalescent plasma transfusion trial results have been published and show 19 out of 25 patients improved with the treatment, and 11 were discharged from hospital. With no adverse side effects caused by the plasma transfusion, the study concluded that convalescent plasma is a safe treatment option for patients with severe COVID-19 disease. Patients were first treated under emergency use guidelines (eIND) from the FDA and then received approval on April 3 from the FDA to open the trial to more patients as an investigational new drug (IND). This extraordinarily rapid approval granted by the FDA gave access to convalescent plasma treatment for COVID-19 patients. Not all plasma recipients transfused were part of this first trial. Since late March, when the first patients were infused with convalescent plasma, of 74 critically ill COVID-19 patients, 50 have been discharged from the hospital and are recovering.

The UK do not seem to be going so fast. A paper written by NHSBT - Understanding the convalescent plasma trials for COVID-19 published on 21 May 2020 has the last sentence "We hope to have results from these trials by Spring 2021".

The French fractionator is working with the alliance of plasma fractionators from around the world and their first clinical trial is expected in summer 2020.

The US clinical trial results are not a surprise. Studies of the use of convalescent plasma and hyperimmune immunoglobulin in previous SARS outbreaks have been reported as reducing the Case Fatality Rate.

Until a vaccine is ready and this could be a long way off, there are tens of thousands of people that have recovered from Covid-19 across countries in Europe and who are ready to donate their blood plasma to save lives. Furthermore, there is always the concern of a second wave. If all plasma fractionators are prepared to manufacture the specific covid-19 hyperimmune immunoglobulin now then not only could covid-19 infected patients be treated and the "at risk groups" be given prophylactic passive immunity but stocks of the product could be built up to save us from a potential second wave.

I simply do not understand why our European Governments are not forcing the manufacture of this product to save lives.

David C Donald- retired

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