

Exiting the lockdown – a strategy for sustainably controlling the transmission of COVID-19 in England



Executive summary

When the lockdown ended back in June there was no coherent plan for keeping COVID-19 at bay. This was followed by rising infection rates, local lockdowns, a subsequent tiered approach to local infection rates and culminating in the current second national lockdown. As England prepares to exit its second lockdown we cannot make the same mistake and risk a rebound surge in infections, and the need for further national lockdowns. A sustainable strategy for reducing transmission of COVID-19 until a vaccine becomes available and is widely taken up is desperately needed. We must not squander the efforts of the many people who have followed the law, stayed at home, sacrificed freedoms and incurred financial loss in order to contain the virus.

This report sets out an exit strategy that the BMA believes must be put in place now to help towards near-elimination of COVID-19, enabling us to control the infection after lockdown ends and to prevent the need for further local or national lockdowns. The steps that are now required to control COVID-19 can be split into three phases, from ending lockdown through to mass vaccination.

Phase 1: Priorities before lockdown can be eased

Before we can exit lockdown two key things need to happen. Firstly, the **testing and contact tracing system needs to be reformed and revamped** so that it is fit for purpose to test, trace and isolate infected persons and contacts in a responsive, timely and effective manner.

Secondly a **coherent national prevention approach to keep the virus at bay needs to be set out to the public well in advance of exiting the lockdown**. This includes more stringent prevention control measures, support for vulnerable groups and making revisions to the current tiered system of local lockdowns should they be necessary.

Phase 2: Suppressing the virus as we exit lockdown

As England exits lockdown it needs to **have introduced national prevention measures to control infection** that can effectively keep the virus at bay. These include, among others:

- Reducing social mixing by replacing the ‘rule of six’ which allowed mixing of up to six households with a ‘two households’ rule
- The creation, monitoring and enforcement of COVID secure environments in public settings, hospitality and workplaces
- Consistent and widespread mask wearing, where people are less than two metres apart
- Continuing instructions to work from home where possible
- Clear measures to monitor, support and enforce compliance to infection control measures
- A fit for purpose one-stop NHS COVID-19 app that tracks contacts, provides local infection level data and public health information

Upon exiting lockdown should there be local outbreaks or surges of infection, there should be a **revised tiered system of local lockdowns**, with clear “triggers” for when areas move up or down a tier; greater clarity and guidance to the public and clinically extremely vulnerable groups what the different tiers mean for them; and, crucially, stricter rules within the system, including greater restrictions on social mixing and travel between tiers.

Greater **support is also required for vulnerable groups and action to address health inequalities**, including targeted action to support BAME communities, financial and practical support for vulnerable people and measures to reduce the mental health impacts of social isolation.

Phase 3: Planning and effective delivery of a vaccination programme

While waiting for the approval of a vaccine, we must plan for the delivery of an effective vaccination programme. GPs in England have already agreed an enhanced service with NHSEI to lead the delivery of the COVID-19 vaccination programme and stand ready for when a vaccine becomes available. They need **information and support** from Government, but also effective national local and public campaigns to provide **transparent information about the vaccine, address misinformation and build trust in it**.

The BMA has consistently called for a more comprehensive and robust approach to reducing transmission of COVID-19. With rising case numbers and hospital admissions, the Government's decision to introduce new national restrictions in England was necessary.

To avoid infections rising quickly again with the consequent risk of overwhelming the NHS and further lockdowns, it is vital that this second lockdown is now used to put in place coherent and robust measures that can sustainably control transmission of the virus over the longer term. The preventative measures we set out here must be put in place and adhered to, until a safe and effective vaccine is available and widely taken up by the public. Following this approach will have long term benefits to health and the economy – putting the NHS under less strain and averting further economically damaging lockdowns. The steps now required to control COVID-19 can be split into the three phases.

Phase 1: Priorities before lockdown can be eased:

- Reforming the testing and tracing system
- Setting what a national prevention approach will look like before lockdown ends



Phase 2: Suppressing the virus as we exit lockdown and until a vaccine is available and widely taken up:

- Introducing, monitoring and enforcing more comprehensive infection control measures
- Operating a revised tiered system in the event of local infection surges
- Greater support for vulnerable groups and action to address health inequalities



Phase 3: Planning and effective delivery of vaccination programme



Phase 1: Priorities before lockdown can be eased

Before the end of lockdown, it is crucial that the Government reforms the testing and contact tracing system, a key component of any government's strategy to limit transmission of COVID-19, and that it clearly sets out a national prevention approach. This must include the introduction of more stringent prevention control measures, support for vulnerable groups and revisions to the tiered system of local lockdowns.

Reforming the testing and contact tracing system

Effective test, trace, isolate and support programmes are an essential component of any government's strategy to limit transmission of COVID-19. These systems must not only have enough testing capacity but also be accessible, with rapid results, timely and efficient tracing of contacts, ideally back to the location source and supporting those affected to isolate. In May SAGE (Scientific Advisory Group for Emergencies) advised the Government that in order for the programme to be effective, tests needed to be turned around within 24hrs and 80% of contacts needed to be traced.¹ The test and trace system in England has been falling consistently short of this, and in September, SAGE concluded that the NHS Test and Trace programme was only having a 'marginal impact' on reducing the spread of the virus.² Several weeks on, only 70.8% of in person tests were returned the next day and only 60.4% of contacts reached by the national Test and Trace Programme.³ Before lockdown is eased the Government must introduce reforms to this system.

- There needs to be much greater integration between the testing being delivered at scale by NHS Test and Trace and contact tracing locally led by public health in local authorities and PHE health protection teams. **There should be greater clarity about who is responsible for which activities, based on effectiveness and with resources to match expected activity.** These changes should include seamless data sharing and access between organisations, to make better use of local intelligence and to allow for more targeted action against local outbreaks. To support this, local public health – both local PHE Health Protection Teams and local authority Public Health – should receive a much greater share of the overall funding for contact tracing. In June the government granted a £300 million funding package to local authorities, to support services across England, while £12 billion has been allocated to the national NHS test and trace programme.
- Mass asymptomatic testing programmes – such as that currently being trialed in Liverpool – could form an important part of finding and rapidly isolating new asymptomatic cases, either at population level or at least in specific settings. Such **programmes need to be clear in their purpose and properly evaluated, public health-led and feasible both economically and logistically, with resources for contact tracing and consequence management.** It is also vital that data from the evaluation of such approaches and the validity of any tests used, is shared transparently, to support decisions about implementation in other areas and settings

¹ Minutes of the 32nd SAGE meeting, (May 2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888807/S0402_Thirty-second_SAGE_meeting_on_Covid-19_.pdf

² <https://www.gov.uk/government/publications/summary-of-the-effectiveness-and-harms-of-different-non-pharmaceutical-interventions-16-september-2020>

³ Weekly statistics for NHS Test and Trace (England) and coronavirus testing (UK): 29 October to 4 November

- It remains important that **health and social care workers** (both with symptoms and those that are asymptomatic) continue to have **priority access to testing**. Given concern about the asymptomatic spread of COVID-19 within health and care settings, regular testing of asymptomatic staff has been introduced in some areas. This may be increasingly feasible with expanded testing capacity and new testing technologies – and must be rolled out as soon as possible.
- Research suggests that a low proportion of people in the UK are fully adhering to rules on self-isolation.⁴ Therefore, alongside improvements in the Test and Trace system, **more practical and financial support is required for businesses and individuals, to ensure that those who need to isolate are actively encouraged and not disincentivised, from doing so**. The government’s current support package, while welcome, is likely to be insufficient and is not available to all, particularly those employed and self-employed on low wages and often with irregular work and those who are not eligible for, or not claiming benefits. Steps should be taken to ensure that people having to self-isolate are paid at least the real living wage. The cost of doing this to the Treasury will be more than offset by the savings resulting from reduced spread of infection and the adverse impact on the health service and economy. In addition, practical support is required for those isolating without local support networks, such as support with getting groceries or prescriptions.
- Steps are also required to improve public understanding of the role of testing. In particular, clearer communication is necessary **to ensure immediate isolation of those with symptoms and their contacts before taking a test and while awaiting test results, and for those with symptoms even with a negative test** and in the case of rapid testing, prior to a second test.

Setting out what a new national prevention approach will look like before lockdown ends

Alongside reforming the testing and contact tracing system, the current lockdown must be used to develop and specify a national prevention approach on exiting the lockdown that will contain spread of the virus. This will include more stringent prevention control measures, revisions to the current tiered system of local lockdowns and greater support for vulnerable groups, so that the virus can be kept at bay until a vaccine is available and widely taken up. What this should look like is set out in more detail in phase 2 below.

⁴ Smith LE et al (09.09.2020) Factors associated with adherence to self-isolation and lockdown measures in the UK: a cross-sectional survey.

Phase 2: Suppressing the virus as we exit lockdown and until a vaccine is available and widely taken up

Introducing more comprehensive infection control and preventative measures

On exiting lockdown, much more effective national measures are required to reduce infection rates and keep the virus at bay. We need to learn the lessons after the first lockdown, where rapid relaxation of infection control policies, inadequate monitoring and encouragement to socially mix in restaurants and bars and to return to work resulted in a surge of virus spread, leaving us unprepared to face autumn and winter. The exit from this lockdown must be more controlled and there should be greater steps taken to monitor, support and enforce compliance to infection control measures. While no single intervention is sufficient for preventing spread, multiple approaches combined will improve success. Below we set out a range of specific measures that collectively can have an impact on reducing transmission.

- **Greater focus on supporting the creation of COVID secure environments, as well as monitoring and enforcing compliance:**
 - More support is required to allow businesses and employers to put physical infection control measures in place for when lockdown is eased – including financial support for retrofitting screens and signage.
 - Clearer guidance is also required to implement infection control measures in hospitality settings, such as requiring a distance of two metres between tables in restaurants or pubs/bars as well as adequate ventilation. Crowded restaurants and pubs with little social distancing, as seen after the first lockdown, encouraged by the eat out to help out initiative, represent a danger to public health.
- **Continuing instructions on working from home where possible**, with support for employers to extend home working.
- **Consistent and widespread mask wearing – where people are less than two metres apart.** Masks are crucial when other interventions, like social distancing are not possible.
 - Masks must be worn in all indoor settings where social distancing is not possible and where there is poor ventilation.
 - They should also be worn outside where social distancing is not possible and there is direct communication between individuals facing each other.
 - Clear guidance on how to properly wear them is needed – this could be in the form of airline safety video-style content also available on the NHS COVID app.
 - Masks should also be worn in secondary schools and universities where social distancing is not possible and where there is poor ventilation.
- **Reducing social mixing to reduce transmission.** Social mixing is a major source of transmission of the virus, especially indoors. Upon exiting lockdown restrictions on household mixing must continue. The rule of six must be replaced with the ‘two households’ rule, meaning only two households can meet at any time, with exceptions for childcare and informal care. Mixing should be encouraged to take place outdoors.
- **Urgent action to reduce hospital acquired infections.** It has been suggested that up to a fifth of hospital patients with COVID-19 acquired the infection in hospital.⁵ Alongside asymptomatic staff testing (see above) increased focus is required on reducing nosocomial transmission. This should include the provision of adequate space to allow physical distancing in staff break areas and more widespread mask wearing to reduce spread between staff and to patients.

⁵ <https://www.cebm.net/covid-19/the-ongoing-problem-of-hospital-acquired-infections-across-the-uk/>

- **A more robust quarantine procedure.** This is necessary for travellers returning to the country to ensure that – once community transmission is low – reintroduction of the virus does not take place. This might include provision of transport for those returning home or to other locations in order to quarantine and could include facilities for quarantine close to ports of entry, similar to what has been done in Australia. Alongside this, objective criteria should be published for establishing and removing safe travel corridors. There must also be clearer rules regarding intra-regional travel once we see a return to the tiered system, as set out below.
- **Clear and consistent culturally-competent communication⁶** is required including in varied accessible and language formats on the steps we can all take to reduce spread and protect ourselves from infection. SAGE have identified that a lack of confidence and trust in government messaging requires co-creation and delivery of messages with local community leaders with content tailored to the perspective of Black, Asian and minority ethnic (BAME) populations. This should include a public information campaign centred around avoiding the [three C's](#) (crowded places, close-contact settings, confined and enclosed spaces).
- **A fit for purpose NHS COVID app.** The COVID app should be a one-stop shop where people can access easily digestible information on how to protect themselves from the virus, including clear information on mask wearing and other preventative measures. This could be in the form of pictures or airline safety video-style content. The public should also be provided with information on how the rate of infection is changing in their local areas to make informed decisions – making this as easy to look up local infection rates as the weather or pollen count. The COVID app should evolve to reflect this – with more granular level detail, including on the levels of infection not just in your home postcode, but also the area you are currently in and neighbouring areas.

Operating a revised tiered system

The Government has indicated that exiting the lockdown would involve a return to a tiered system of local restrictions if there are high levels of infection in specific geographical areas. However, the previous tiered system was inadequate and inconsistent in the way it was applied and did not contain spread of the virus. Therefore, to complement much more comprehensive national control measures, the tiered system must be urgently revised, with agreed “triggers” for moving up and down a tier – and so that it is clear, transparent and seen to be fair and equitable.

- Equity and fairness are key to ensuring compliance with restrictions. It is therefore crucial that Government better communicates and explains the rationale for local restrictions. This would be aided by more transparency in the decision-making process around why areas are moved into different tiers with criteria for step down and step up being clearly set out in advance. **The BMA has been calling since July for the introduction of metric ‘trigger points’ at which restrictions would consistently be applied across local areas.** Alongside this consideration should be given to whether more tiers are required to ensure they sufficiently cover the whole range of prevalence across the country.
- Greater clarity is required on the advice being given to those that are clinically extremely vulnerable and to those previously shielding. **This should include the development of guidance tailored to each tier.**
- With any reintroduction of the tiered system, the Government must clarify the rules on travel between different tiers. **To prevent spread of infection, non-essential travel particularly between higher and lower prevalence areas should be restricted,** with exemptions for work, care, life events and essential shopping, exercise and access to green space.

Greater support for vulnerable groups and action to address health inequalities

While necessary, extended measures to control the spread of COVID-19 can lead to mental ill- health as a result of social isolation and have already widened pre-existing health inequalities. It is important therefore, that steps are taken to mitigate these direct and indirect negative impacts of the pandemic. The pandemic has also impacted disproportionately on more deprived groups and on BAME people, disabled people, and some faith communities. In England, the mortality rate for deaths involving COVID-19 in the most deprived areas in July 2020 was more than double the mortality rate in the least deprived areas.⁷ Meanwhile, those of Black and South Asian ethnic background are shown to have increased risks of death from the virus compared with those of White ethnic background.⁸

⁶ SAGE (22 July 2020) Public Health Messaging for Communities from Different Cultural Backgrounds

⁷ ONS (2020) Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020.

⁸ ONS (2020) Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020

It is therefore of the utmost importance that the government take a much more proactive approach to addressing widening health inequalities, as well as putting in place targeted support to better protect BAME communities.

- Given the impact that measures to control the pandemic can have on people’s mental health as a result of social isolation **it is important that people are able to continue to form exclusive support bubbles and that formal and informal caring arrangements can continue.** Eligibility to form support bubbles should be extended beyond single-person households – so long as this is done on an exclusive basis. This would allow two elderly grandparents needing support to form a bubble with their children’s family (at the moment two elderly grandparents who need support are not allowed to form a bubble, while a single younger person is), or to allow those who are pregnant or new parents to have family support.
- Alongside this, specific steps are required to support public mental health during the pandemic and beyond. To help inform this, further research is required to establish which groups are at a higher risk of developing mental illness, or seeing their mental health deteriorate. **Local authorities should also be given the funds to double spending on public mental health over the winter months, so that vulnerable groups can be supported, to prevent the onset or worsening of mental illness.**
- **Measures must be taken now to ensure we are able to address health inequalities as we exit lockdown.** While the focus to date has rightly been on health protection, ensuring health improvement and healthcare public health functions have enough resources and staffing to address health inequalities, and are well integrated with health protection functions both nationally and locally, is equally important as the UK exits lockdown.
- The government must also put in place measures to reduce the impact of restrictions on vulnerable people such as prioritising initiatives to eliminate food and in-work poverty, addressing inadequate and overcrowded housing and tackling domestic violence. There should be a specific focus on preparing for school closures should they be necessary, to ensure any impact on educational inequality is minimised. Local authorities are often best-placed to implement these measures and should be enabled to do so through additional Public Health ringfenced funding, evidence-based guidance and toolkits and greater access to data, including from health services.
- **Targeted support is required to better protect BAME communities immediately, complemented by long-term interventions to reduce deprivation and to address systemic racism.**
 - Such support should include more culturally tailored public health messaging which is understood and trusted by those from a BAME background, as recommended by SAGE,⁹ and closer working with local community groups and trusted leaders. Alongside this there should be more widely accessible and culturally tailored advice for clinically extremely vulnerable people.
 - It is crucial that BAME workers have access to occupational risk assessments followed by action to protect those at high risk from the virus, including protective equipment for keyworkers. There needs to be increased guidance and support for self-employed and casual workers.¹⁰
 - The BMA continues to call for an action plan detailing how and when the government will implement the recommendations set out in both the second [PHE report](#) and the Equality Minister’s first report on government progress to reduce Covid-19 health inequalities.
 - Efforts to improve the reach of health services to BAME communities must also be strengthened.
- **The Government must ensure that care homes and hospices are supported to allow safe visiting by family and friends.** While new visiting guidance has been published, there are concerns that some visiting methods are restrictive and not appropriate for all care home residents.
 - The BMA supports calls by the National Care Forum and others for regular testing of care home visitors, support for care homes to create safe visiting spaces and the provision of training and PPE for visitors, rather than simply face coverings, to reduce the risk of infection.
 - Specific steps are also required so that insurance policies do not prevent visiting, through provision of government indemnity for the care sector.

9 SAGE (22 July 2020) Public Health Messaging for Communities from Different Cultural Backgrounds

10 Evidence from the Institute for Financial Studies shows that BAME people are disproportionately in key worker roles and Pakistani and Bangladeshi men are 70% more likely to be self-employed than the White British majority. Institute for Financial Studies (May 2020) [Are some ethnic groups more vulnerable to Covid-19 than others?](#)

- In line with [WHO guidance](#), **steps should be taken to ensure medical grade masks (fluid resistant surgical face masks) are available to vulnerable people** (aged 60 and over and those with comorbidities). This is important since medical masks protect the wearer from the virus (in addition to reducing transmission from the wearer), given they are more at risk of adverse health outcomes. This will also reduce pressure on the NHS.

It is also important to **consider the impact of mask wearing on disabled and deaf people and to put in place appropriate support** – this may include greater access to clear face masks and public messaging about valid exemptions. Schemes such as the hidden disabilities sunflower should also be more widely promoted.

- While it is welcome that the furlough scheme has been extended until March, it is important that **clinically extremely vulnerable people are able to automatically access the furlough scheme, or equivalent support, if their job remains viable/active and they are unable to work from home**. Practical support is also required for clinically extremely vulnerable people so that so that they can access essential supplies, maintain wellbeing and reduce social isolation.

Phase 3: Planning and delivery of effective vaccination programme

Widespread uptake of a safe and effective vaccine is the most effective way of tackling COVID-19, protecting vulnerable people and easing economic and societal restrictions. The government must use this time to plan for the delivery of an effective vaccine programme, so that a vaccine can be rolled out as soon as feasible. To support this:

- The BMA's GP committee and NHSEI have agreed an [enhanced service](#) for general practice in England to lead the delivery of the COVID-19 vaccination programme. **The BMA, GPs and their teams must be provided with immediate information and support from NHSEI and Government** so that they are fully prepared to deliver as soon as a safe and effective vaccine is available for use. It will also be important to ensure systems are in place that allow for mass notification of patients and recording of vaccination status in the GP record.
- GP practices will deliver the COVID vaccination programme alongside the flu programme, while maintaining care for patients who need it. **NHSEI and Government must therefore provide support for practices** to ensure they can prioritise the vaccination programme, recognising the impact this might have on other services.
- The MHRA (Medicines and Healthcare Products Regulatory Agency) and JCVI (Joint Committee on Vaccination and Immunisation) both have key roles in ensuring the safety and efficacy of any proposed vaccine. JCVI have already published [interim advice](#) on priority groups for COVID-19 vaccination, which may be revised depending on the clinical characteristics of any final vaccine. **Ensuring these approval and licencing processes are robust and transparent will be crucial to ensuring both public and healthcare professionals have confidence in a safe vaccine and help maximise uptake.**
- As more vaccines become available, and more of the population is able to access them, **national and local public campaigns** must ensure everyone knows who can access a vaccination, when and how.
- Maintaining public trust in immunisation is vital. It will therefore be **important to ensure that authoritative information on any COVID-19 vaccine is widely available, as well as culturally tailored.** We are aware that some faith groups have concerns about the contents of possible vaccines. The government should do an equality impact assessment on the distribution of a vaccine and engage with faith groups about it.
- There are valid concerns about the spread of misinformation about vaccination. The BMA has previously called for the Government to **devise and implement binding standards that compel social media companies to actively prevent dispersal of false or misleading vaccine information online.** This will become even more important as we move toward a COVID-19 vaccine.
- There needs to be clear and consistent messaging about what the public and healthcare professionals are expected to do during, and after, the rollout of any vaccine. This is particularly important to ensure infection control measures are not stepped down prematurely. In healthcare settings, clear advice is required on the continued use of PPE and segregated care pathways. **The government needs to plan now for how this will be managed and communicated.**