LMCs: NHS England briefed against GPs

GP leaders have demanded that NHS England and NHS Improvement apologise and retract any communications that may have harmed their reputation or incited complaints by implying that practices had not been fully involved in care of patients throughout the covid-19 pandemic.

A motion passed at the annual conference of England’s local medical committees on 27 November said that much of NHSE/I’s communications with GPs, the press, and the public had been “abhorrent and insulting.” The conference called for NHSE/I to recognise general practice’s contribution to the management of the pandemic and the continuation of normal service, “particularly given the general practitioners who have died in the course of their duties to the public.”

The motion added that it “deplores the habit” of briefing journalists before communicating with the profession and its representatives. This refers to an episode where NHSE/I briefed journalists on a letter it had written to all practices reminding GPs that patients must be offered face-to-face appointments when they need them. GPs said this led to negative media coverage and a reported rise in complaints and abuse.

The incident led to Richard Vautrey, chair of the BMA’s General Practitioners Committee, writing to the NHS chief executive, Simon Stevens, asking for NHSE/I to “apologise to the profession and correct damage that has been done.” Vautrey wrote, “Implying within the press release that GPs are not providing patients with the appointments they need and ‘reminding’ them that they face ‘enforcement action’ if they do not has presented NHSE/I as antagonistic and completely out of touch with the profession. It also seems to many GPs that NHSE/I has, by using this tactic, intentionally sought to create negative media coverage of primary care services.

“The BMA is now hearing large numbers of reports from practices receiving complaints and many staff members being verbally abused by the public based on these unsupported and ill-informed media articles.

“This is clearly unacceptable, and NHSE/I must correct these inaccurate and damaging stories immediately.”

More than 400 GPs have since signed an open letter raising concerns about inaccurate and harmful media messages. Elisabeth Mahase, The BMJ
Cite this as: BMJ 2020;371:m4684

The BMAs Richard Vautrey said it seemed NHS England had “intentionally sought to create negative media coverage of primary care”
SEVEN DAYS IN

Fewer ethnic minority doctors report workplace improvements during pandemic

A GMC poll of 3693 doctors carried out in June and July has found that less than half (46%) of ethnic minority doctors said that the sharing of knowledge and experiences had been positively affected by the pandemic, whereas three fifths (61%) of white doctors reported positively.

The survey, published in the GMC’s annual State of Medical Education and Practice in the UK report, also showed that 68% of white doctors but 55% of ethnic minority doctors believed that teamwork between doctors had improved during the pandemic. And improvements in the speed of workplace changes were reported by 57% of white doctors but only 38% of ethnic minority doctors.

GMC chief executive Charlie Massey said the findings were a concern. “We know BAME [black, Asian, and minority ethnic] doctors too often lack the supportive and compassionate leadership that is required to thrive,” he said. “Doctors of all grades, and from all backgrounds, need and deserve the same levels of support if they are to provide the best possible care for patients, in what will continue to be difficult months ahead.”

Covid-19
Lighter restrictions didn’t work, study indicates
Tier 1 restrictions that applied to areas of England with lower rates of covid-19 before the most recent lockdown had “little impact” on transmission, a preprint study suggested. Researchers from the University of East Anglia found that tier 2 rules were effective in only around half of local authority areas, while stricter tier 3 restrictions seemed to be effective in most areas. But they said that regions were not allocated swiftly enough to the most appropriate tier and urged ministers toheed their findings as the tier system is reintroduced.

NHS will get £3bn “recovery” funding
The NHS will receive an extra £3bn next year to help services recover after the pandemic, the UK chancellor announced in his spending review. Rishi Sunak said that this would include £1bn to tackle the elective care backlog, around £1.5bn to help ease existing pressures in the NHS caused by covid-19, and around £500m to improve access to mental health services and invest in the NHS workforce. Andrew Goddard, president of the Royal College of Physicians, said the funding would not solve longer term problems such as workforce shortages.

Most of England is placed in toughest two tiers
Most of England would be placed under high or very high alert levels when the country’s national lockdown ended on 2 December, said the health secretary, Matt Hancock, on 26 November. Under the revised tier system, areas with the toughest restrictions (tier 3) include Greater Manchester, Bristol, the West Midlands, and Kent. Most areas in England have been placed in tier 2, including Liverpool and London. Only Cornwall, the Isle of Wight, and the Isles of Scilly are in tier 1.

Government failed to react to ventilator shortage
The NHS managed to provide care to all those patients with covid-19 who needed mechanical ventilators earlier this year despite the government being underprepared and slow in responding to hospitals’ needs, a report from the parliamentary Public Accounts Committee concluded. The MPs said that good luck rather than design had helped the NHS to care for patients with the disease.

Appraisals
Government pledges “streamlined” approach
England’s health secretary, Matt Hancock, pledged shorter appraisals for doctors as part of a drive to reduce bureaucracy in the NHS. A new appraisal format, which takes only 30 minutes to prepare and requires far less supporting evidence, has been in place since October 2020, after appraisals were suspended in March because of the covid-19 pandemic. Hancock said that the process would be retained subject to evaluation, alongside other measures such as making professional regulation proportionate, giving GPs more time to focus on clinical work, and greater digitisation of services.

Cancer
NHS pilots “liquid biopsy” blood tests
The NHS in England will pilot the use of an innovative blood test with the potential to spot more than 50 types of cancer. The Galleri blood test, a liquid biopsy developed by the US company GRAIL, can detect early stage cancers through a simple blood test. The pilot, which is due to start in mid-2021, will involve 140 000 people aged 50 to 79 years who have no symptoms but who will have annual blood tests for three years, together with 25 000 people with possible cancer symptoms who have been referred in the normal way.
MEDICINE

Period products
Scotland becomes first to legislate for free access
Period products will be obtainable free of charge in Scotland for every person who needs to use them, after the country became the first in the world to pass legislation on the issue. A bill passed unanimously in the Scottish parliament requires all local authorities in Scotland to ensure that period products are freely available. Schools, colleges, and universities must also make them available free of charge in their toilets, and the government has the power to make other public organisations do the same.

Obstetrics
Female doctors are less likely to support C sections
Female doctors were 25% less likely to perform caesarean sections than male doctors, said a review and meta-analysis of sections than male doctors, said a review and meta-analysis of obstetricians’ preferences for delivery mode. Studies conducted after 2000, but not before, showed that female physicians were 25% less likely to favour C sections and less likely to perform them, even when mothers requested them without medical indications.

Drug pricing
Bipolar drug remains on market after deal
Priadel, a brand of lithium widely used to treat bipolar disorder, will remain on the market after a new deal was struck between its manufacturer, Essential Pharma, and the Department for Health and Social Care. The drug company previously said that it would withdraw Priadel in April 2021. This led the Competition and Markets Authority to launch an investigation into whether the company had “abused its dominant position” to get patients to switch to alternative, more expensive treatments such as the company’s other drug Camcolit.

Pandemic policies
Europe “must prepare better” for lockdown exit
Governments in Europe need to implement more effective testing, tracing, and isolation policies when reopening their economies to prevent covid cases from spiking again, warned the Organisation for Economic Co-operation and Development. It said some European countries, such as Norway and Finland, had been better able to contain the spread of the disease, partly because of their lower population density but also because of greater preparedness, a rapid and effective strategy for test, track, and trace, and stronger trust and compliance among the public.

SIXTY SECONDS ON...
NHS RESERVES

RUNNING ABOUT IN CAMOUFLAGE GEAR AT THE WEEKEND?
No, silly, that’s NHS army reservists. We’re talking about NHS reserves, a similar idea but for clinical and non-clinical volunteers to support the NHS.

CLINICAL VOLUNTEERS? BUT WE’RE UNDERSTAFFED
Well, yes, but the idea is that these volunteers will come from some of the 75 000 clinical staff who leave the NHS every year. So they’ll come back to work—but for free.

UH-HUH. WHOSE IDEA IS THIS?
It was proposed by Alan Mak (below), MP for Havant and vice chair of the Conservative Party. Speaking in the House of Commons on 24 November, he introduced the National Health Service Reserve Staff Bill. It was supported by England’s health secretary, Matt Hancock.

DON’T WE ALREADY HAVE NHS VOLUNTEERS?
Yes. Mak said that there are thought to be around 80 000 volunteers working across all acute care trusts in England, contributing more than 13 million hours of volunteering each year. The bill’s aim is to formalise this.

WITH A BADGE AND A UNIFORM?
While you might be joking, Mak isn’t. Drawing comparisons with the Police Special Constabulary, he said that every NHS reservist would “wear the same uniform and have the same equal status as their regular health service counterparts.”

WILL THEY BE TRAINED?
Mak said that NHS reservists would receive “appropriate training” and that anyone working in a clinical discipline would be vetted and have to maintain the same up-to-date qualifications as the full-time staff.

SO, THEY’D WORK WITH PATIENTS?
Mak’s vision is that they would take on a range of roles, such as vaccinators or telemedicine providers. “They could also provide general cover in non-specialist clinical roles if private sector staff supply agencies, locums, or staff banks were not available to help at short notice,” he said.

IT SOUNDS A LOT LIKE A JOB
No, no, no. Because you’re volunteering for a charity, remember. Oh, wait . . .

Abi Rimmer, The BMJ
Cite this as: BMJ 2020;371:m4680

Cite this as: BMJ 2020;371:m4681

VACCINES
Russia reached an agreement with the drug company Hetero to produce 100 million doses of the Sputnik V covid-19 vaccine in India. Russia claims that preliminary data showed its vaccine to have more than 95% efficacy [Al Jazeera]

Abi Rimmer, The BMJ
Cite this as: BMJ 2020;371:m4680
LMC conference

News roundup from the annual meeting of England’s local medical committees, held virtually on 27 November

More investment needed, say GPs

GPs called on the government to recognise it was currently “far from business as usual” in general practice and that “significantly more investment” was needed to provide the same levels of service as before the covid pandemic. In a motion passed at the conference GPs said that Rishi Sunak’s claim that the NHS would get whatever it needed was “completely out of step with reality.” The motion called for the BMA’s GP Committee to “push NHS England and NHS Improvement to ensure all income from item of service contracts” was protected until after the pandemic and to negotiate that no further requirements would be demanded until practices had recovered from the pandemic.

Call to renegotiate vaccine contract

GPs called on the BMA’s GP Committee to renegotiate the “funding and flexibility” of the covid-19 vaccine contract, now that more information had come to light. The motion said that the “conference deplores the pace and pressure” placed on the GP Committee during the negotiations with the government and rejected the mandatory 8 am to 8 pm, seven days a week proposal for the vaccine rollout. GPs said they were “best placed to decide when and how to conduct their business to ensure maximal population coverage” and said the public must be told faults in the vaccine programme lay with the government.

Pay partners same as salaried GPs

Delegates backed a motion saying any pay deal where employees received a pay rise with no additional funding for their employer was a failure. In July salaried GPs in England were told they would receive a 2.8% pay rise, but GP partners or trainees were excluded because they were in the second year of multi-year deals. BMA GP Committee deputy chair Mark Sanford-Wood said the BMA wrote to the health secretary to express disappointment that GP contractors were not being recognised for their work in the pandemic. It called for the government to fill the financial shortfall that GP partners faced in funding the pay increases for staff.

Elisabeth Mahase, Abi Rimmer, The BMJ

Specialist mesh removal centres set to open in April

A network of specialist surgical mesh removal centres is to be set up around England, with a launch planned for April 2021.

The move implements a recommendation of a review, chaired by the Conservative peer and former health minister Julia Cumberlege (above), into three treatments that caused avoidable harm. One of these was the use of transvaginal tape and pelvic mesh to treat pelvic organ prolapse and urinary incontinence.

The review heard “harrowing” accounts of women left with serious complications. The mesh is hard to remove, and only a few surgeons in the UK are able to carry out the procedure.

The use of surgical mesh for urinary incontinence was suspended in England in 2018 after years of campaigning by patient groups. The Cumberlege review recommended that mesh not be used again until six conditions were satisfied, including the identification and accreditation of specialist centres to deal

High Court rules on children’s ability to consent to taking puberty blockers

Children under 16 cannot consent to the use of puberty blockers for gender dysphoria unless they can understand the immediate and long term consequences of the treatment, which is unlikely, the High Court in London has ruled.

Even for teens over 16 clinicians might well want to seek court authorisation before administering puberty blockers, said three senior judges.

The legal challenge was brought against the Tavistock and Portman NHS Trust, which runs the UK’s only gender reassignment service for young people.

Keira Bell, 23, who was treated as a teenager, and “Mrs A,” the mother of a 15 year old with autism who was on the waiting list for treatment, challenged the service’s policy and practice on the use of puberty blockers. They argued that children were unable to give informed consent for the treatment.

Treatment “experimental”

Victoria Sharp, president of the Queen’s Bench Division, sitting with Lord Justice Lewis and Mrs Justice Lieven, said it was “highly unlikely” that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. She said that the judges were “very doubtful” that a child aged 14 or 15 could understand and weigh the long term risks and consequences of the administration of puberty blockers.

For children of 16 and over there is a presumption that they have the ability to consent to medical treatment. But, “given the long term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where...
Asymptomatic covid may not be infectious, Wuhan study finds

A mass screening programme of more than 10 million residents of Wuhan, China, performed after SARS-CoV-2 was brought under control, has identified 300 asymptomatic cases of covid-19, none of which was infectious. The findings cannot be extrapolated to countries where outbreaks have not been brought under control successfully, said the authors of the report, published in Nature Communications.

The researchers used PCR testing to screen for viral RNA among 10 million participants aged between 10 and 89. Trained staff interviewed participants on their history of covid-19. Asymptomatic positive cases were defined as people who had a positive result on screening with neither a history of covid-19 diagnosis nor any clinical symptoms at the time of the nucleic acid testing. The researchers found no “viable virus” in cultures from asymptomatic samples.

Further swab tests of 1174 close contacts of the 300 asymptomatic positive cases were all negative.

The researchers said their findings did not show that the virus couldn’t be passed on by asymptomatic carriers, and they didn’t suggest that their findings were generalisable. They said that strict measures such as mask wearing, hand washing, social distancing, and lockdown helped to reduce the virulence of SARS-CoV-2 in Wuhan and that asymptomatic people there may have low viral loads.

Fujian Song, from Norwich Medical School, who collaborated with colleagues in Wuhan on the research, said, “The asymptomatic cases identified in the screening programme were truly asymptomatic, as none of them showed clinical symptoms before or during their follow-up isolation.” But he added, “There is plenty of evidence elsewhere showing that people infected with covid-19 may be temporarily asymptomatic and infectious, before going on to develop symptoms.”

Using antibody testing, the researchers found that almost two thirds of the asymptomatic cases had previously had covid-19. “With the centralised isolation and treatment of all covid-19 cases during the lockdown period in Wuhan, the risk of residents being infected in the community has been greatly reduced. When susceptible residents are exposed to a low dose of virus, they may tend to be asymptomatic as a result of their own immunity,” wrote the authors.

Shaun Griffin, London
Cite this as: BMJ 2020;371:m4695

with complications and removal. Centres will have to record all procedures on a national database, and all those involving implants will have to be entered on a national registry, along with organised follow-up and an audit of outcomes. Surgeons will have to demonstrate competence to perform complex vaginal mesh removal surgery, and only those with expertise in complex pelvic surgery will be allowed to perform the techniques.

Kath Sansom of the patients’ campaigning group Sling the Mesh called the centres a “step in the right direction,” but added, “Members of the group want to see a national mesh removal training scheme.” Sansom said some members had been waiting for removal for more than two years.

Agreed standards

Setting up the centres for complex surgery “doesn’t mean they have the correct skills to do it,” she said. “There is concern that these are the same surgeons who put the mesh in, the same surgeons who said mesh wasn’t a problem.”

Representatives from the seven centres—covering the North East and Yorkshire, the North West, the East of England, London, the Midlands, the South East, and the South West—met on 20 November to agree the standards all the centres will adopt. Clinicians from Scotland and Northern Ireland, which are establishing their own specialist centres, were also invited to the summit.

Cumberlege told The BMJ, “We want to make sure those who do these operations are not only skilled to do them but do them regularly. We thought it was important there was a consensus as to the best way of removing mesh.

“It’s an extremely difficult thing to try to achieve. In time, they will. Whether they can achieve it by April is another matter.”

Clare Dyer, The BMJ
Cite this as: BMJ 2020;371:m4589

The legal challenge was brought against the Tavistock and Portman NHS Trust, which runs the UK’s only gender reassignment service for young people

The trust, and other trusts to which it referred patients for treatment, had argued that taking hormone blockers and later cross sex hormones were entirely separate stages of treatment. Sharp concluded, “It is said therefore the child needs only to understand the implications of taking puberty blockers alone . . . in our view this does not reflect the reality. The evidence shows that the vast majority of children who take puberty blockers move on to take cross sex hormones, that stages 1 and 2 are two stages of one clinical pathway and, once on that pathway, it is extremely rare for a child to get off it.”

The judges emphasised that they were not deciding on the benefits or disbenefits of giving puberty blockers for gender dysphoria, whether in the short or long term, but only on the circumstances in which a child was competent to give valid consent to treatment.

Clare Dyer, The BMJ
Cite this as: BMJ 2020;371:m4699

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Asymptomatic covid may not be infectious, Wuhan study finds

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The researchers said their findings did not show that the virus couldn’t be passed on by asymptomatic carriers, and they didn’t suggest that their findings were generalisable. They said that strict measures such as mask wearing, hand washing, social distancing, and lockdown helped to reduce the virulence of SARS-CoV-2 in Wuhan and that asymptomatic people there may have low viral loads.

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Shaun Griffin, London
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Concerns persist about purpose, ethics, and effect of rapid testing in Liverpool

The government says the city’s pilot is a great success and plans to offer rapid lateral flow tests to other areas with high covid rates. But the scheme raises more questions than answers, finds Jacqui Wise.

Liverpool started its community testing pilot on 6 November, with all residents and workers offered repeat covid-19 testing, even if they have no covid symptoms, “to find more positive cases and break chains of transmission.” Whether the scheme has indeed contributed substantially to a fall in infection rates remains uncertain, and it has been criticised over the lack of transparency, the accuracy of the tests being used, and costs and potential harms.

This week Liverpool was moved out of the toughest tier 3 restrictions and into tier 2 at the end of the national lockdown. Boris Johnson and England’s health secretary, Matt Hancock, both claimed this was down to the success of the testing pilot, and they urged other tier 3 areas to use lateral flow tests to drive down infection rates.

“But we haven’t learnt anything from Liverpool, as nothing has been put in the public domain,” said Jon Deeks, professor of biostatistics at Birmingham University and leader of Cochrane’s covid test evaluation activities. “We only know the number of positive tests, and we don’t know the number of false positives or false negatives.” Deeks is particularly concerned about the sensitivity of the Innova lateral flow test, which can be as low as 58% when used by the public, meaning that as many as half of cases will be missed. He said, “Statements that these cases do not matter as they will not be infectious are not based on evidence. Infectious cases will be missed, and we need to know how many.”

What was the scheme’s purpose?

There has been confusion over the purpose of the testing in Liverpool and whether it is, in fact, screening. At first the term mass testing was widely used by the government and on Liverpool City Council’s website, although the scheme is now more often referred to as community testing.

Allyson Pollock, director of the Newcastle University Centre for Excellence in Regulatory Science, is among experts who have been calling for clarity about the purpose of the testing. She said that what is happening is population screening of asymptomatic people, which is not endorsed by the World Health Organization or the government’s SAGE committee. “There is very little evidence on asymptomatic transmission. And testing asymptomatic people is likely to be of only marginal benefit.”

She added, “The whole thing seems extraordinarily rushed and poorly thought through. It appears they are making it up as they go along, and they have marginalised experts who could have offered help, such as the National Screening Committee.”

However, Iain Buchan, dean of the Institute of Population Health at the University of Liverpool, who is one of the senior clinicians involved in analysing the data, said the pilot scheme has been misrepresented. “The city was clear with the government from the start that we sought community open access testing to underpin a targeted approach and not untargeted mass testing,” he told The BMJ. He says that what the scheme is doing is not screening but an urgent public health intervention.

Buchan said that Liverpool was pursuing “SMART” testing: systematic, meaningful asymptomatic repeated testing. This has three components: test to protect (where testing is accessible to the whole community but can focus on people at highest risk, such as care home visitors), test to release (to enable people to exit quarantine earlier), and test to enable (to allow a return to activities).

Buchan said the pilot was just completing its first phase, which was about making testing accessible to all members of the community. It was about to enter phase 2, which is about targeting areas of high need, such as care home visiting, and release from lockdown.

Lack of transparency

Much of the criticism has focused on the general lack of information about the pilot. “Why haven’t they published their protocol, what information sheets were given to the public, and was proper informed consent obtained?” Pollock asked. “They have torn up the rulebook on research governance and ethics.”

In response, Buchan said that they have evaluation plans for each sub-project, shared with the Department of Health and Social Care and reviewed weekly. He points out that academic input was requested for service evaluation and not for research but that researchers have sought ethical approvals for fieldwork.

He notes that economic evaluation was less relevant, because test kits had already been purchased and his team was carrying out “after-action research”—evaluating a complex heath intervention. Live dashboards are updated every 30 minutes and emailed in reports twice daily. Public reports will be made soon.

Has the testing reduced covid?

There is no doubt that the prevalence of covid-19 has come down rapidly, from almost 700 per 100 000 population in mid-October to 137.7 per 100 000 on 26 November. However, Liverpool was the first area to go into tier 3 restrictions on 14 October. “Boris Johnson’s claim that rates are coming down in Liverpool due to the testing is not good science,” said Deeks. “Liverpool was ahead of other areas of the country on their wave, and their figures had...
already started to come down.”

The latest figures show that between 6 and 26 November 108,304 people in Liverpool were tested with lateral flow tests and that 703 tested positive. In the same period 65,050 were tested with PCR tests, of whom 2158 tested positive. But Pollock points out that it is impossible to know the true picture because we don’t know whether people going for the lateral flow tests were truly asymptomatic or were pre-symptomatic, or whether they did have symptoms and just wanted a quick test. Another unknown is how many of those testing positive on the lateral flow test actually went on to have a confirmatory PCR test.

**Potential harms**

Pollock believes that the harms of testing have not been adequately considered. “Some people are getting false reassurance, as the tests are not very accurate,” she said. “People were being told on the radio that if they got a negative test they could go about their business.” She added that, since she raised concerns, the FAQ page on the Liverpool council website has been updated to include information on false negatives, and it now says that a negative lateral flow test result does not constitute a “green pass.”

Another issue is the cost. It is not known how much has been spent on the pilot in Liverpool, which has involved 2000 army personnel. But the government recently advertised a contract for £912m to deliver rapid testing across the country. “This is costing huge amounts of money and resources,” says Pollock. “It could have been better used for tracing contacts and supporting those who are isolating.”

The government has said that local authorities in tier 3 “will be offered support from NHS Test and Trace and the armed forces to deliver a 6 week rapid community testing programme.” But it is not clear how much support local areas will be given, and from 3 December there will be 23 million people under tier 3 restrictions.

Maggie Rae, president of the Faculty of Public Health, said that local areas would need much support. “We are going to be overwhelmed and will need to prioritise our actions and resources.” She expressed the view that, with the promising news on vaccines, resources should be put into rolling out vaccination rather than used for mass testing.

Rae did welcome the government’s announcement on 26 November that local authorities will be able to decide how to use the lateral flow test kits. “We have been pushing for more local determination and more targeted testing, otherwise it has the potential to widen inequalities,” she said.

**IT IS NOT KNOWN** how much has been spent on the pilot in Liverpool, which has involved 2000 army personnel. But the government recently advertised a contract for £912m to deliver rapid testing across the country.

**Is it reaching those most at risk?**

An advocate of mass testing, Julian Peto, professor of epidemiology at the London School of Hygiene and Tropical Medicine, told The BMJ, “The pilot scheme in Liverpool has been ridiculous and an absurd way to go about mass testing. It’s missing those in the areas that are most affected.” He added, “They have been inundated with the worried well, and those in the most deprived areas are not coming forward.”

A report on BBC’s Newsnight programme on 23 November said that the testing pilot was failing to reach the poorest communities in the city and that in some parts only 4% of residents had turned up to be tested.

But Buchan dismissed the 4% figure as “unfounded.” He said, “Uptake of lateral flow testing has been much higher than PCR testing in deprived areas, and more so as test site deployments were adapted to the signals from the data.”

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But Buchan dismissed the 4% figure as “unfounded.” He said, “Uptake of lateral flow testing has been much higher than PCR testing in deprived areas, and more so as test site deployments were adapted to the signals from the data.”

**Potential harms**

Pollock believes that the harms of testing have not been adequately considered. “Some people are getting false reassurance, as the tests are not very accurate,” she said. “People were being told on the radio that if they got a negative test they could go about their business.” She added that, since she raised concerns, the FAQ page on the Liverpool council website has been updated to include information on false negatives, and it now says that a negative lateral flow test result does not constitute a “green pass.”

Another issue is the cost. It is not known how much has been spent on the pilot in Liverpool, which has involved 2000 army personnel. But the government recently advertised a contract for £912m to deliver rapid testing across the country. “This is costing huge amounts of money and resources,” says Pollock. “It could have been better used for tracing contacts and supporting those who are isolating.”

The government has said that local authorities in tier 3 “will be offered support from NHS Test and Trace and the armed forces to deliver a 6 week rapid community testing programme.” But it is not clear how much support local areas will be given, and from 3 December there will be 23 million people under tier 3 restrictions.

Maggie Rae, president of the Faculty of Public Health, said that local areas would need much support. “We are going to be overwhelmed and will need to prioritise our actions and resources.” She expressed the view that, with the promising news on vaccines, resources should be put into rolling out vaccination rather than used for mass testing.

Rae did welcome the government’s announcement on 26 November that local authorities will be able to decide how to use the lateral flow test kits. “We have been pushing for more local determination and more targeted testing, otherwise it has the potential to widen inequalities,” she said.
Major structural change should not be part of the plan for recovery

New legislation for the NHS in England seems to be back on the agenda. Media stories emerged in the summer that the prime minister was considering proposals for a major NHS reorganisation—including changes to bring national NHS bodies under closer political control. NHS commentators are calling for legislation to give greater power to local leaders to reorganise care as the NHS recovers from the pandemic. And changes to the English public health system currently being considered by government—set in motion by the poorly timed decision to abolish Public Health England back in August—include returning some public health responsibilities to the NHS.

The rationale for legislation depends on whom you ask—and involves a mix of policy and politics. For NHS leaders, the argument is that the rules governing the NHS make it harder to deliver the improvements promised in the long term plan—including better integration between health and social care and a greater focus on disease prevention.

Analysts of institutions often focus on the interaction between the “rules in form”—the formal rules that govern how systems work on paper—and the “rules in use”—the way things actually work in practice. The Health and Social Care Act 2012 introduced rules to encourage competition within the health system. In reality, NHS leaders embraced collaboration instead, establishing sustainability and transformation partnerships and integrated care systems to lead local service changes. But these partnerships have no formal powers, and rules on competitive tendering can hold back collaboration.

For politicians, the motivation for new NHS legislation may be different. Like NHS England, the health secretary seems convinced of the benefits of collaboration. But the government may also see legislation as a route to gain tighter control over the day-to-day workings of the NHS—something the 2012 act sought to loosen. NHS England has become the de facto headquarters for NHS strategy under Simon Stevens (photo), its chief executive. The previous health secretary, Jeremy Hunt, has said he never felt he “lacked a power to give direction” to the NHS under the 2012 act. But perhaps the incumbent feels less powerful.

Reform to bring NHS England under closer political control may also help build a narrative, ahead of any covid-19 public inquiry, that arm’s length bodies—not government—are to blame for England’s pandemic performance.

Politics over evidence

NHS reorganisations happen frequently but appear to deliver little benefit. They can also bring additional costs, destabilise services and relationships, and divert resources away from patient care. NHS England has called for targeted legislation rather than wholesale reorganisation of the NHS. This pragmatic approach makes sense—though even the NHS’s more limited proposals risk unintended disruption and may replace one set of workarounds with another.

It is unclear how seriously government is considering more widespread reform, or what the reorganisation of public health agencies may mean for NHS responsibilities. It is much clearer, however, that any moves to bring NHS England under closer ministerial control would be rooted in politics rather than evidence.

The NHS has faced the most difficult year in its history and is heading into what is likely to be its bleakest winter. The challenges facing the NHS when it emerges from the pandemic are enormous. The backlog of unmet healthcare need is substantial. NHS staffing shortages stand at over 100 000—and could double over the next five years. Public services also face the challenge of reducing the gaping health inequalities exacerbated by covid-19. Major structural reorganisation of the NHS would not be the answer to these problems—and would probably make them harder to fix.

If the government is interested in structural reform, a better place to look would be adult social care. For politicians, the motivation for new NHS legislation may be different. Like NHS England, the health secretary seems convinced of the benefits of collaboration. But the government may also see legislation as a route to gain tighter control over the day-to-day workings of the NHS—something the 2012 act sought to loosen. NHS England has become the de facto headquarters for NHS strategy under Simon Stevens (photo), its chief executive. The previous health secretary, Jeremy Hunt, has said he never felt he “lacked a power to give direction” to the NHS under the 2012 act. But perhaps the incumbent feels less powerful.

Reform to bring NHS England under closer political control may also help build a narrative, ahead of any covid-19 public inquiry, that arm’s length bodies—not government—are to blame for England’s pandemic performance.

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Well before covid-19, the world already faced an emergent threat of antimicrobial resistance, and many have sounded the alarm over further escalation during the pandemic. 1 A study from the US, for example, showed that 71% of covid-19 patients received antibiotics while only 4% had true bacterial co-infection. 2 This overuse of antibiotics may have contributed to the observed 10% increase in resistance against several classes of antibiotics (compared with 2019) at the same institution.

Spread of misinformation during epidemics has been documented before, 3 but covid-19 has brought with it a global deluge of misinformation. Politicisation of the pandemic in many countries led to politicians being a leading source of misinformation, 4 while initial underestimation of the pandemic by key public health stakeholders led to inconsistent messaging and widespread public confusion. 5 A survey of online news articles identified incorrect reports published in 25 languages in 87 countries, roughly a fifth of which were on cure and treatment. 6 In low and middle income countries, many of which already have a high burden of multidrug resistant organisms, misinformation includes overemphasis on the role of antimicrobials. This includes the use of azithromycin, which has been shown repeatedly to have no efficacy against covid-19. 7

Lack of basic knowledge on infections and their treatment has resulted in poor understanding of this viral pandemic and its aetiology by general populations worldwide and, in some settings, medical professionals. 8 In Australia, 44% of respondents to a population survey incorrectly thought antibiotics could treat or prevent covid-19. 9

Misinformation affects clinicians and health policy makers as well as the public—partly fuelled by management controversies triggered by the early release of poorly reported and preliminary research findings. Early posting of preprints has allowed rapid dissemination of important research but also raised concerns over the public release of poorly conducted studies and the premature or inaccurate media reporting of unsubstantiated findings that often follows. 10 Both policy makers and frontline clinicians struggle to keep up with rapidly evolving evidence on the management of covid-19, particularly clinicians in low and middle income countries with limited access to timely, verified sources of information.

Digital solutions
Strategies must be developed now to counter the detrimental effect of misinformation on the use of antimicrobials and prevent further deterioration in the global crisis in antimicrobial resistance. Since roughly half the adults in emerging economies 11 and almost all adults in higher income countries have access to a digital device, and more than half the world’s population uses social media, 14 these strategies must include creative, regulated online media campaigns to combat misinformation.

Some organisations, such as the World Health Organization and Nigeria Centre for Disease Control, 15,16 already use their digital platforms to correct antimicrobial misinformation by discussing the ineffectiveness of antimicrobials as a primary treatment for covid-19. Others, including the Africa Centres for Disease Control and Prevention and the US National Institutes of Health and Centers for Disease Control and Prevention, 17,18,19 provide general information on public health measures, disease symptoms, associated myths, and stigma but do not discuss antimicrobial use specifically. They should be encouraged to correct this serious omission.

Concerted effort is also required to make sure medical providers have rapid, timely access to evidence updates on the management of all aspects of covid-19. Online teaching, webinars on management algorithms, systematic reviews, and living guidelines such as The BMJ’s Rapid Recommendations, 20 should be developed by regional and global agencies, and made available free to healthcare workers, allowing the rapid dissemination of trustworthy evidence.

Fragile healthcare systems in many parts of the world may not withstand the covid-19 pandemic if also faced with a substantial increase in antimicrobial resistance. We must tackle the twin pandemics of covid-19 and misinformation simultaneously.

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Covid-19: What now for remdesivir?

The spectre of past pandemics looms large over remdesivir, one of the first purported treatments for covid-19. With a WHO trial finding little benefit, Jeremy Hsu asks if the expensive drug is just another Tamiflu.

It’s a cautionary tale worth remembering amid the coronavirus pandemic. Starting in the early 2000s, governments spent billions of dollars stockpiling the antiviral drug oseltamivir (Tamiflu) in anticipation of flu pandemics. Years later, independent researchers gained access to unpublished clinical studies that showed the drug had only a modest effect on reducing the duration of symptoms, had many side effects, and displayed insufficient data to conclude whether it could prevent influenza’s most serious complications.

Fast forward to 2020 and we have remdesivir, an expensive, experimental antiviral and one of the first, and hence hyped, treatments to emerge for covid-19. It comes from a collaboration between Gilead Sciences, the US Centers for Disease Control and Prevention (CDC), and the US Army Medical Research Institute of Infectious Diseases that sought to find treatments for RNA based viruses with the potential to spark pandemics. After disappointing results treating Ebola in 2014, remdesivir was tested in the early stages of the covid-19 pandemic. Initial trial evidence suggested that it can shorten recovery times for severely ill hospitalised patients, giving it global attention.

The results were lauded by the National Institutes of Health (NIH) and an emergency use authorisation (EUA) was swiftly made by the US Food and Drug Administration (FDA) in May. It is soon to be more widely available in the UK and Europe.

None of the randomised controlled trials published so far, however, have shown that remdesivir saves significantly more lives than standard medical care. There is conflicting evidence about whether a five or 10 day treatment cycle leads to any clinical improvement. And the World Health Organization’s Solidarity trial—a huge international study involving thousands of patients—has published interim results showing that the drug has no significant impact on mortality, length of hospital stay, or need for ventilation among hospitalised patients. This represents some of the strongest evidence yet that remdesivir is unlikely to be the lifesaving drug for the masses that many have hoped for.

Instead, researchers are now focusing on moderately ill patients who could still benefit from the drug if it’s given early. But considering the high price, limited stock, and now arguably limited benefits, what now for remdesivir and doctors considering using it?

A high price to pay

“Paying a high price for remdesivir without good evidence of mortality benefit is a gamble,” says Robin Ferner, a physician and professor of clinical pharmacology at the University of Birmingham.

Even before the Solidarity trial results came out, many doctors questioned remdesivir’s effectiveness, particularly considering its cost can quickly add up to millions for a single...
Limited Supplies

Supplies of remdesivir remain variable across the world. Shortages and high prices have affected the US and much of Europe. Gilead has moved to boost remdesivir production, but WHO has taken a cue from its Solidarity trial in excluding remdesivir from the list of priority drugs it’s looking to supply to poor countries.27,28

Still, Gilead has signed licensing agreements with manufacturers in Egypt, India, and Pakistan that permit the sale of generic versions of the drug across low and middle income countries including Bangladesh and the Philippines.29,1031

Gilead’s Bahar Turkoglu told The BMJ, “Currently, our licensees have made generic remdesivir available to patients in need in more than 40 countries, and we expect this number will continue to grow over the coming months.”

Many hospitals have also faced difficult decisions about which patients would benefit from taking remdesivir—a challenge further complicated by supply problems, changing regulatory advice, and lingering questions about clinical effectiveness and safety.

Steven Pearson, a physician and president of the Institute for Clinical and Economic Review, a Boston based non-profit organisation focused on cost effectiveness analyses of medical treatments and tests, has said that Gilead’s pricing of remdesivir is cost effective only if two key assumptions hold true. “The current price would meet a key cost effectiveness threshold only if it were used solely to treat patients hospitalised with moderate-to-severe disease and—importantly—only if one still assumes that remdesivir saves lives,” Pearson said in a statement in November.29

The first assumption is undermined by the fact that US regulators have expanded possible use of remdesivir to patients with milder cases of the disease. The second assumption also remains unproven given that the Solidarity trial and other clinical trials have shown no significant mortality benefit. As a result, the Institute for Clinical and Economic Review’s pricing model “suggests that remdesivir’s current US price is too high to align reasonably with its demonstrated benefits to patients,” Pearson said.

Compounding matters, none of the preclinical studies that tested remdesivir on animals infected with SARS-CoV-2 have yet established a record of robust safety and efficacy, according to Rokuro Hama, a physician and director of the non-profit Japan Institute of Pharmacovigilance in Osaka, who has also extensively studied Tamiflu. The FDA’s prescribing information for remdesivir currently includes cautionary notes about the need to monitor kidney and liver function in human patients.31

Unlike some researchers who are pushing for more human clinical trials, Hama prefers to first see evidence of efficacy in the preclinical studies that tested remdesivir on animals infected with SARS-CoV-2, which was sponsored by the NIH. ACTT-1 found no evidence of benefit from remdesivir. Instead, the FDA’s drug approval announcement cites just one placebo controlled trial: ACTT-1 which was sponsored by the NIH. ACTT-1 showed a five day course of remdesivir improved patients’ time to clinical improvement, but this study also made the controversial decision to end the placebo treatment arm early.32 That limited the capability to collect more data on the effects of remdesivir and possibly see if the drug can reduce mortality rates.
Solidarity

WHO’s Solidarity trial is an open label study that does not include a control group receiving placebo. A Gilead statement attempted to cast doubt on the Solidarity trial because of its open label design that allows physicians and patients to know who is taking remdesivir, despite the fact that the pharmaceutical company has touted results from other open label studies that it sponsored.\textsuperscript{11,14}

Solidarity was designed to look at harder, more objective health endpoints that open label clinical trials would be unlikely to influence, such as mortality, ventilation requirements, and length of hospitalisation.

Srinivas Murthy, an intensive care and infectious diseases physician at the British Columbia Children’s Hospital in Vancouver and principal investigator for the Canadian portion of Solidarity, says, “Mortality should not be affected by whether a study is open label or closed or placebo blinded for obvious reasons: you or your doctors can’t will yourself into staying alive by knowing you had the drug.”

What Solidarity does to an impressive extent is to evaluate remdesivir’s impact in a patient population on a far bigger scale than any previously published studies—2750 patients who received a 10 day course of remdesivir came from a total study population of 11,266 hospitalised adult patients. The number of Solidarity study participants dwarfs the number involved in the ACTT-1 study that has been touted by Gilead and US regulators. “The number of participants in the Solidarity trial is almost five times that of ACTT-1,” Hama says.

The Solidarity trial also draws upon a diverse group of patients in 405 hospitals spread across 30 countries. Gilead questioned the Solidarity results because the study “prioritised broad access, resulting in significant heterogeneity in trial adoption, implementation, controls, and patient populations.” But both the Solidarity team and independent experts say that this actually represents the strength of the study—a global test of how remdesivir performs in complex real world environments beyond the controlled settings of the smaller clinical trials that came before.

“We have patients with COVID-19 who newly qualify under the updated EUA when we can provide them with remdesivir.”

“With a disease that has infected over 45 million people in nearly 200 countries and caused over one million deaths, we need trials with heterogeneous populations,” says Erin McCreary, an infectious diseases clinical pharmacist at the University of Pittsburgh Medical Center, who was not involved in the WHO study. “Solidarity was an impressively massive trial that is pretty much as good as it gets in a global pandemic to determine which therapies are effective and which populations optimally benefit.”

Before the Solidarity results were announced, McCreary had co-authored an editorial for \textit{JAMA} summarising the conflicting evidence from the remdesivir studies and detailing the study design differences, including the recruitment of patients with varying severities of illness.\textsuperscript{15} Earlier studies had already consistently shown that certain subgroups of patients did not derive benefit from remdesivir: the more severely ill patients who require high flow supplemental oxygen through nose tubes, non-invasive ventilation through face masks, or invasive ventilation through a tube down the throat. Solidarity continues to recruit patients to its ongoing study. McCreary told \textit{The BMJ}, “We now have over 5000 patients in the remdesivir arm of the Solidarity trial that still show no benefit.”

That leaves clinicians to conclude that remdesivir only benefits a small subset of moderately ill patients. McCreary says the drug needs to be studied in randomised trials in this subset of patients who may benefit. “We don’t have conclusive evidence to say what the ideal patient population is for this drug, and it’s still a globally scarce resource (see box).”

The Solidarity trial is continuing to study if remdesivir can help such moderately ill patients who seem the most likely to benefit from the drug (those requiring low flow oxygen but who are not on ventilators). There may still be a chance of remdesivir delivering a mortality benefit for such patients. “If there is an effect, it’s an exceedingly small one,” Murthy says, “But any effect on mortality is still show no benefit.”

Regulation and revelations

The public health emergency compelled regulators to speed up regulatory processes and allow hospitals to make some conditional uses of remdesivir before completion of the usual approval process.

The EUA enabled the drug to skip all that and be used in clinics for emergencies. Remdesivir has also sometimes been provided on a “compassionate use” basis at cost price under FDA rules that permit the use of experimental drugs outside of clinical trials if a doctor applies.\textsuperscript{16} But there are no restrictions on how much a pharmaceutical company can charge once it receives either an EUA or gets formal approval for a new drug application. Gilead stated the compassionate use programme in the US was winding down following the EUA.\textsuperscript{17}

“There is always a tension between withholding a drug from general use when it is beneficial, and protecting the public from a drug that doesn’t work or is unacceptably harmful,” Ferner says.

One controversial regulatory decision came on 28 August, when the FDA expanded the EUA to allow use of remdesivir in all patients hospitalised with covid-19, not just severe cases. For some physicians and medical researchers, that was a step beyond what the available clinical trial evidence can support. Alyssa Letourneau, an infectious disease physician and director of the antimicrobial stewardship programme at Massachusetts General Hospital in Boston, told \textit{The BMJ} on 6 October, “At this price point it’s more difficult to give it to patients who newly qualify under the updated EUA when the data aren’t clear that they will benefit.”

Similar concerns were raised in an open letter by Eric Topol, director and founder of the Scripps Research Translational Center in La Jolla, California, which questioned the credibility of the FDA commissioner, citing the expanded remdesivir EUA among other decisions.\textsuperscript{18} “There are insufficient data to support this approval, as it is based on small, open label studies with subjective endpoints,” Topol wrote. “Remdesivir is an expensive drug, costing around $3000 per treatment, in short supply, and even its approval for severe covid-19 was based on time to recovery in a relatively small trial of just over 1000 patients.”
The European Medicines Agency had already granted conditional approval similar to the FDA’s EUA for remdesivir back in July. On 8 October, the European Commission followed up by signing a joint procurement framework contract with Gilead for a six month supply of up to 500 000 treatment courses of remdesivir worth $1.2bn. But what the European Commission didn’t know was that Gilead had already received a draft manuscript of the Solidarity findings in September. The commission only learnt about remdesivir’s lacklustre performance in Solidarity the day after it signed the contract with Gilead.

To the surprise of many, on 22 October—a week after the Solidarity results became public—the FDA officially approved the drug as a covid-19 treatment for all hospitalised patients over 12 years of age. FDA reviewers were aware of the Solidarity trial data, says Chanapa Tantibanchachai, a press officer at the FDA. But she added that the agency’s approval of remdesivir was largely based on the NIH’s ACTT-1 trial along with two Gilead sponsored trials.

It is possible for the FDA to withdraw approval of drugs for reasons of safety or effectiveness. But some researchers worry that the FDA approval will make it harder to carry out additional studies, especially if some physicians are reluctant to withhold remdesivir from patients. “The FDA does not believe that the approval of remdesivir will negatively impact the clinical development of remdesivir,” Tantibanchachai told The BMJ.

But Derek Angus, an intensive care physician and chief healthcare innovation officer at the University of Pittsburgh Medical Center, who co-authored the JAMA editorial on remdesivir with McCreary, says a potential side effect of the FDA approval is that it will thwart or stymie the conduct of further randomised controlled trials that would otherwise be able to help delineate exactly in whom, and at what point in the course of disease, remdesivir should be used. “The lack of benefit in the Solidarity trial only reinforces the need to better understand remdesivir’s effects,” he says.

A Gilead representative noted that there are multiple international clinical trials ongoing to evaluate the safety and efficacy of remdesivir for different patient populations, formulations, and in combinations with other therapies. But the company also suggested that testing remdesivir against placebo would no longer be warranted.

Bahar Turkoglu, senior director of public affairs at Gilead Sciences UK and Ireland, told The BMJ, “Now that the safety and efficacy of remdesivir has been assessed across multiple randomised controlled clinical trials and it is considered a standard of care, it would not be ethical to conduct a placebo controlled trial in patients who would otherwise be eligible to receive this treatment.”

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The next Tamiflu?

The full story of remdesivir will not be known until Gilead releases the full clinical study reports, as the pharmaceutical company Roche finally did with Tamiflu in 2013. “It was only once we looked at the whole thing that we found the benefits of Tamiflu were the shortening of the duration of illness by a few hours,” says Tom Jefferson, an epidemiologist and Cochrane reviewer who is currently suing Roche under the US False Claims Act. “There was nothing credible on deaths, transmission, or hospitalisation.”

There is a chance to avoid similar uncertainty hanging over remdesivir, especially with so many patients who can be enrolled in large scale clinical trials during the pandemic. Much will depend on whether future studies are designed to test remdesivir’s potential effectiveness. All this remains in the middle of a still raging pandemic, with alternative treatments now impacting discussions about remdesivir’s cost effectiveness. The well known, cheap, and widely available corticosteroid dexamethasone, for example, has been proved to reduce mortality among severely ill covid-19 patients who were either on ventilators or receiving oxygen. Given the apparent benefit to reducing mortality in some cases at a cost of less than $1 per day, many experts want to see studies testing remdesivir’s effectiveness when given in conjunction with corticosteroids.

And then there is remdesivir’s relative. In late August, the NIH began investigating the potential of GS-441524, another compound owned by Gilead that is the parent nucleoside of remdesivir. Compared with remdesivir, GS-441524 could be easier to synthesise and manufacture—and could cost much less. It could also be produced as an oral formulation—remdesivir must be given intravenously—that can be administered outside hospitals earlier following diagnosis when antiviral drugs typically show the most benefit. Preclinical animal studies suggest it may also prove less toxic to many organs of the body than remdesivir and therefore could be given at higher doses with possibly improved therapeutic effect.

“Gilead has done a considerable amount of safety and toxicity work on GS-441524, and they have data on file with the FDA,” says Victoria Yan, chemist at the University of Texas MD Anderson Cancer Center, who has been pushing for a phase I trial to explore GS-441524 as a covid-19 treatment. Gilead told The BMJ that it chose to prioritise development of remdesivir over GS-441524 as a covid-19 treatment because of available evidence at the time from animal studies and because the company already had some safety data on remdesivir in humans from prior clinical trials focused on Ebola. But the company is currently investigating GS-441524 through animal studies.

“We have initiated additional preclinical studies to further compare remdesivir and GS-441524,” Turkoglu says. “We will publish the data as soon as they become available.”
The sight of a parent or guardian “standing on the doorstep with tears in their eyes, and the young person so happy that they seem to have food at last” is an everyday experience for Alexandra McMillan.

In June 2020, McMillan, who used to work as a personal trainer, set up the Legendary Community Club in Lewisham, a London borough where 37% of school children experience food insecurity. Since then, she has coordinated the distribution of more than 7500 lunches and 2200 food parcels to prevent children going hungry.

“I was volunteering at the local food bank while on furlough,” she recalls. “Someone mentioned that teachers at nearby schools were dipping into their own pockets to make sure their pupils didn’t go hungry. I saw there was a need and that I could do something.”

What helped, she says, was that, once established, the club became eligible for free membership of the Independent Food Aid Network (IFAN), the charity being supported by The BMJ Appeal 2020-21. The network has come into its own during the covid-19 pandemic.
pandemic, supporting a growing number of independent food banks and other community meal providers.

The medical profession has long recognised that this is major public health issue, causing “the heartbreak and pain of suffering hunger for so many children, as well as higher rates of obesity, rickets, and depression, while also a ticking time bomb for premature death from heart disease and diabetes in the future,” says Guddi Singh, a paediatric doctor at the Mary Sheridan Centre for Child Health at the Guy’s and St Thomas’ NHS Foundation Trust in London.

Singh says that food poverty remains a largely misunderstood problem, despite a campaign led by Marcus Rashford forcing government U-turns on free school meals. In June, Rashford sent a passionate letter to all members of parliament asking for them to reconsider their decision to end free school dinner vouchers. “Political affiliations aside, can we not all agree that no child should be going to bed hungry? Food poverty in England is a pandemic that could span generations if we don’t course correct now.”

Despite its role as a network to support food aid providers and ensure that people who are unable to afford or access food are able to eat, IFAN’s vision is an end to the need for food banks. “They’re seen as sticking plasters, and members want to work together to bring about changes so they are no longer needed,” explains Helen Crawley, registered nutritionist and director of First Steps Nutrition Trust. “In the meantime, though, IFAN does an excellent job of supporting and representing anyone who is out to help. Through its members, its work is varied, diverse, and sustainable.”

Membership of the network has more than doubled since March and now includes more than 400 independent food banks and other community meal providers tackling child hunger in the UK on a daily basis. Data from May 2020 show that there has been a 177% increase in the number of three day emergency food parcels distributed this year, compared with the same period last year. Independent food banks in Scotland reported at least twice the need for emergency food parcels in April to July compared with last year.

“We’ve seen at least twice the demand due to covid-19,” says Paul O’Brien of Micah Liverpool, a social justice charity based at Liverpool Cathedral and a longstanding member of IFAN. “While we used to mainly cater for refugees and homeless people, it’s now mostly working families who aren’t earning enough to be able to feed their children throughout the month.”

O’Brien says that IFAN provided support when panic buying resulted in supply shortages and when older volunteers were no longer able to turn up to help. “With IFAN’s brilliant help,” he says, “it’s very straightforward. If people are hungry, we feed them.”

At another member group—Dads House Charity in Earls Court, London—Billy Granaghan says that “a big increase in need is from the gig economy, manual workers, and bar staff, including men and women, many of them single parents who have lost their jobs and don’t have savings for emergencies—we’ve got young people who first volunteered and now use our food bank.”

Rather than spending funds on infrastructure, IFAN only supports food aid workers who are already established. It deliberately avoids contractual agreements with national supermarkets, though the network’s coordinator, Sabine Goodwin, is quick to intervene when local supermarket branch managers are “uncooperative.”

“Since the onset of covid-19, IFAN has distributed over 500 small, emergency grants to its frontline member organisations ranging from £50 to £100 to enable them to respond to increased need for their services,” she explains.

That kind of funding may seem a drop in the ocean, but “it was enough to buy stock to provide packed lunches for local youth clubs before we crowdfunded for the rest,” says McMillan.

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Support the Independent Food Aid Network’s frontline and advocacy work

Please return to: Independent Food Aid Network, 58 Standen Road, London SW18 5TQ
Title ___________ Forename ___________________ Surname ___________________
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Start date (if shown on card) ____________________________
Signature ____________________________ Date ____________________________