CORONAVIRUS PANDEMIC: WESTMINSTER FAILURE

AN FBU RESPONSE

FIRE BRIGADES UNION

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INTRODUCTION

The coronavirus pandemic is an unprecedented emergency that has devastated communities across the globe. The first wave of the Covid-19 virus has so far infected more than eight million and killed at least half a million people worldwide. The virus has set a new reality for the immediate future.

In the UK more than 50,000 people have died because of Covid-19 in the first three months. At present, the UK has one of the worst death rates across the globe. At its peak, 20,000 people were hospitalised across the UK, while the virus has raged through care homes. It is a public health tragedy that has still not gone away.

Pandemic risks have been well known for decades and highlighted in the National Risk Register. Westminster governments failed to prepare for pandemics since 2010. Ministers failed to learn the lessons from other health crises. Austerity weakened NHS resilience to pandemics. The Health and Social Care Act damaged the NHS and opened further encroachment from private firms.

The Westminster government has failed to provide the necessary leadership faced with Covid-19. Track and trace ceased on 12 March because capacity for testing was insufficient. Lockdown on 23 March was too late and cost lives. Ministers and scientists flirted with herd immunity. Care homes were not shielded; instead they had to take patients from hospitals. Personal protective equipment (PPE) ran perilously low, affecting both hospitals, GPs and care homes. The Westminster government has put private firms at the centre of its response to Covid-19.

The fire and rescue service response to the Covid-19 pandemic has been managed through a unique UK-wide tripartite agreement between the FBU, fire employers and the chief fire officers. Firefighters have undertaken 14 additional activities to assist vulnerable communities and the NHS. Firefighters have delivered packages of food, medicines and other essentials to vulnerable persons, driven ambulances, delivered PPE, assisted at Nightingale hospitals, care homes and mortuaries.

Firefighters have continued to provide a 24/7 emergency service throughout the pandemic. This has included responses to domestic fires, fires at businesses, as well as wildfires. Thanks to the professionalism of firefighters, all fire and rescue services continued to function during the lockdown.

However fire and rescue services have still been affected by the pandemic. Many reported problems with supplies of equipment and PPE early on. Some have experienced significant levels of staff absence. Firefighters should have been tested earlier and more frequently for Covid-19.

Ministers, fire authorities and chief fire officers (despite known risks) failed to adequately prepare the fire and rescue service for the Covid-19 pandemic. 'Modernisation' reforms and austerity have weakened resilience: one-in-five (20%) firefighters were cut over the last decade.

The virus has not gone away. Fire authorities face the threat of cuts, when investment is needed to build resilience. Public services need to prepare for the new reality and further waves. Firefighters will always go the extra mile to help. But central government needs to make sure firefighters have the resources necessary to tackle current and future risks.

Matt Wrack
FBU general secretary

EARLY EVENTS

30 January	WHO: “public health emergency of international concern”
10 February	Hancock: “serious and imminent threat to public health”
13 February	Johnson starts a 12 day holiday at his Chevening residence
27 February	SAGE reasonable worst case scenario: 80% infection, 1% fatality, 500,000 deaths
02 March	SAGE sub-committee: 8% fatality rate in the over 80s; 12% of people hospitalised
03 March	Launch of the Westminster government’s Coronavirus action plan
11 March	WHO: Covid-19 defined as a pandemic
12 March	Chris Whitty, chief medical adviser for England announced that initial effort to contain the disease by testing and tracing abandoned
13 March	Patrick Vallance, chief science adviser speaks of “herd immunity”
16 March	WHO: “test, test, test”
18 March	UK school closures announced
20 March	UK pubs, gyms and other public places closed
23 March	UK lockdown announced

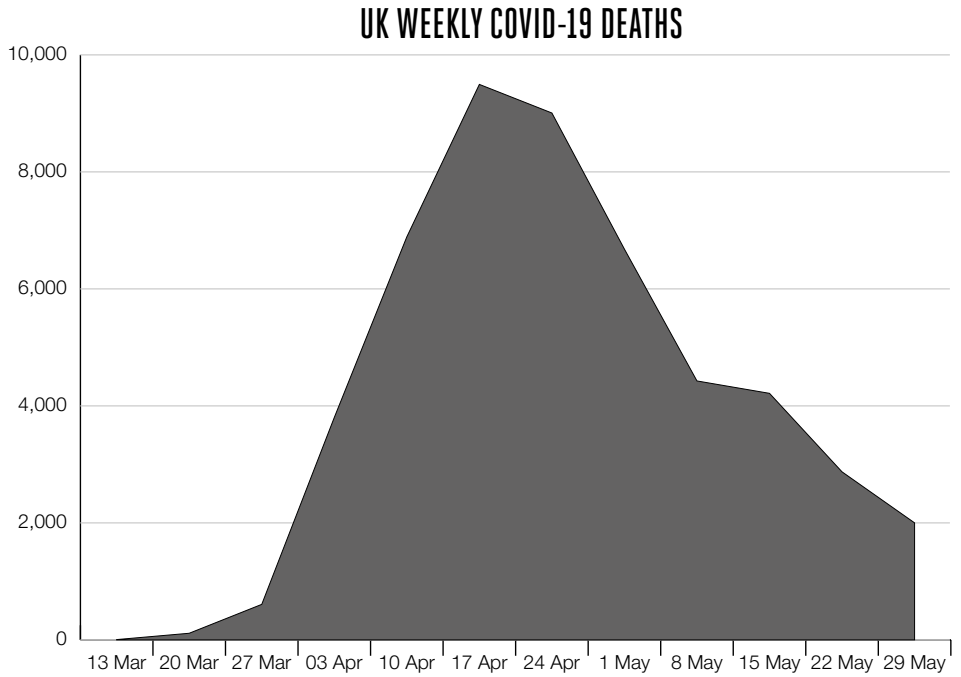
The FBU took a range of initiatives during the height of the pandemic:

21 February	First NJC circular on Covid-19
15 March	Shutting down non-essential outside activities
20 March	Letter to ministers on priority Covid-19 testing for firefighters
23 March	Letter to ministers about the lack of preparedness.
23 March	The UK-wide tripartite agreement was signed
25 March	Additional shifts, variations to working patterns and additional work activities
4 April	NJC circular on leave during coronavirus outbreak
8 April	Covid-19 and compensation for firefighters
9 April	The tripartite agreement was extended
15 April	Letter to national employers on retained firefighters’ pay
16 April	The agreement was further extended
23 April	Further additions to the agreement
21 May	Two further areas of work added to the agreement
3 June	The agreement was renewed

1 DEATH TOLL – A DAMNING PICTURE

Just over 50,000 people in the UK died from Covid-19 between March and May 2020. ONS figures show more than 63,000 excess deaths have been recorded across the UK.

Total UK Covid-19 deaths reported by ONS, 29 May	50,107
Deaths in hospital	62%
Deaths in care homes	31%
Worst single week for deaths 17 April	9,495



At the end of May, the UK had the second-highest rate of excess deaths per million from the pandemic after Spain. It had the second highest absolute number of excess deaths behind the US. The UK had the second worst excess deaths compared to historical averages (FT 28 May).

ONS data on daily deaths (12 June) revealed some grim statistics from the height of the pandemic:

Worst recorded day for deaths 8 April	1,431
Days with more than 1,000 deaths per day	21

Department for Health and Social Care figures show that the peak number of people in hospital with Covid-19 (12 April) was 20,677. By 31 May there were still 7,539 people in hospital with Covid-19.

PROFILE OF DEATHS

A Public Health England analysis of Covid-19 deaths (2 June) found that:

- People 80 or older were seventy times more likely to die than those under 40
- Working age males diagnosed with COVID-19 were twice as likely to die as females
- People of Bangladeshi ethnicity had around twice the risk of death compared to people of White British ethnicity. People of other Black ethnicity had between 10% and 50% higher risk of death compared to White British
- People living in the most deprived areas of the country were almost twice as likely to die than those living in the least deprived.

Men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19. Nursing auxiliaries and assistants have seen an increase in all cause deaths.

2 LACK OF PREPAREDNESS

The Westminster government failed to prepare for pandemics in the long term.

NATIONAL RISK REGISTER

The Cabinet Office publishes the National Risk Register, setting out the "assessment of the likelihood and potential impact of a range of different risks that may directly affect the UK". The first National Risk Register (2008) stated that "there is a high probability of another influenza pandemic occurring", half the UK population could become infected, resulting in "between 50,000 and 750,000 additional deaths". The UK was likely to face "wider social and economic disruption, significant threats to the continuity of essential services, lower production levels, shortages and distribution difficulties".

The National Risk Register 2008 also highlighted the risks from new diseases. It stated:

> *Over the past 25 years, more than 30 new, or newly-recognised, infections have been identified around the world. The pattern of known infections also changes constantly, as the areas where disease is constantly present expand beyond traditional limits. Most of these cases are zoonotic infections, in other words, they are naturally transmissible, directly or indirectly, between vertebrate animals and humans.*

These warnings have been repeated, often verbatim, in subsequent editions of the National Risk Register. The latest (2017) edition has a substantial section devoted to human diseases. It stated that "the emergence of new infectious diseases is unpredictable but evidence indicates it may become more frequent". The risks of a pandemic were foreseeable.

PANDEMIC PREPAREDNESS

The UK government published *The National Framework for Responding to an Influenza Pandemic* in November 2007. *The Scottish National Framework for responding to an Influenza Pandemic* was published in March of the same year. These frameworks provide guidance to assist organisations across all sectors to make appropriate preparations. UK guidance was updated in 2011.

Exercise Cygnus, a pandemic planning drill took place in October 2016. It involved major government departments, the NHS and local authorities. The exercise simulated a pandemic of the H2N2 influenza virus. It showed gaping holes in Britain's emergency preparedness, resilience and response plan, including a shortage of ICU beds and PPE. The report was not published, apparently because its findings were considered too terrifying. In March 2018, the Scottish government carried out Exercise Iris, to assess the readiness of Scotland to respond to an outbreak of MERS-CoV. The report highlighted problems with sourcing PPE and with contact tracing.

AUSTERITY

Since 2010, NHS funding has been consistently below historic levels. Budgets rose by just 1.5% each year on average over the last ten years, compared to the 3.7% average since 1948. Over the last decade, the NHS has begun to miss hospital waiting targets for the first time, suffered staff shortages and saw more delays in people accessing GPs. Social care and public health (covering sexual health, smoking cessation, drug and alcohol support and other key interventions at local level) also suffered funding cuts.

NHS BEDS

The total number of NHS hospital beds in England has more than halved over the past 30 years, from around 299,000 in 1987-88 to 141,000 in 2018-19, while the number of patients treated has increased significantly. Between 2012-13 and 2018-19 beds fell by 5%. The UK has fewer hospital beds per 1,000 inhabitants than many other comparable health systems. The UK maintains one of the lowest number of critical care beds relative to the population

Before the Covid-19 pandemic, there were signs of a growing shortage of beds. In 2018-19, overnight general and acute bed occupancy averaged 90% and regularly exceeded 95% in winter, well above safe levels.

HEALTH AND SOCIAL CARE ACT

The Health and Social Care Act 2012, piloted by former health secretary Andrew Lansley, introduced further structural weaknesses into the NHS. The Act abolished primary care trusts and created new clinical commissioning groups (CCGs). The Health Protection Agency, whose functions included protecting the public from infectious disease epidemics, was replaced with Public Health England.

The 2012 Act promoted market competition and expanded the role of private companies in the health system. The NHS became a loose, fragmented collection of public and private enterprises that would compete for funding. David McColl, a professor of global public health at Queen Mary University of London argues that "the drive towards commodifying healthcare and enforcing market competition has weakened the NHS by diverting funds to pay for the administrative costs of running a market in a sector that is particularly prone to market failures".

Private business damages the health and social care system in other ways. An estimated £1.5bn leaks out of the care home industry every year to private companies and financiers. Over the next five years, almost £1bn of taxpayer funds (£973m) will go to PFI companies.

In 2011, during the passage of the Health and Social Care Act, nearly 400 public health experts warned it would "undermine the ability of the health system to respond effectively to communicable disease outbreaks and other public health emergencies".

3 WESTMINSTER GOVERNMENT FAILURE

The Westminster government failed to tackle the pandemic at multiple levels. First was complacency. Boris Johnson took a 12 day holiday between 13 and 25 February, shortly after the Westminster parliament defined Covid-19 as a "serious and imminent threat to public health".

Johnson held a press conference on 3 March with Patrick Vallance and Chris Whitty to launch the Westminster government's Coronavirus Action Plan. Johnson joked that: "I was at a hospital the other night, where I think there were actually a few coronavirus patients, and I shook hands with everybody, you'll be pleased to know, and I continue to shake hands."

LOCKDOWN

Professor John Edmunds, a key advisor on SAGE said on the Andrew Marr Show on 7 June:
"We should have gone into lockdown earlier. I think it would have been hard to do it, I think the data that we were dealing with in the early part of March and our situational awareness was really quite poor. So I think it would've been very hard to pull the trigger at that point, but I wish we had. I wish we had gone into lockdown earlier. I think that has cost a lot of lives unfortunately."

Professor Neil Ferguson told the Westminster Science and Technology Committee on 10 June that "the epidemic was doubling every three to four days before lockdown interventions were introduced... so, had we introduced lockdown measures a week earlier, we would have reduced the final toll by at least a half".

TESTING

On 12 March, Chris Whitty announced then that the initial effort to contain the disease by testing and tracing had been abandoned. This was due to insufficient capacity. At the time of lockdown, fewer than 6,000 tests were carried out daily across the UK.

On 25 March Professor Sharon Peacock from Public Health England told the House of Commons Science and Technology Committee that antibody tests were likely

to be approved within days. In fact antibody tests were only approved in late May. On 25 March Boris Johnson told the daily press conference that testing was being ramped up. He said: “We are going up from 5,000 to 10,000 tests per day, to 25,000, hopefully very soon up to 250,000 per day.”

On 4 April, Matt Hancock unveiled the Westminster plans to scale up its coronavirus testing. His headline pledge was 100,000 tests a day by end of April. At the time, just over 14,000 tests a day were carried out across the UK. The target was only met on 30 April because 40,000 tests were posted to people and counted in the total tests.

HERD IMMUNITY

On 13 March, Patrick Vallance said on BBC Radio 4’s Today programme: “Our aim is to try and reduce the peak, broaden the peak, not suppress it completely… Also, because the vast majority of people get a mild illness, to build up some kind of herd immunity, so more people are immune to this disease, and we reduce the transmission. At the same time, we protect those who are most vulnerable to it. Those are the key things we need to do.”

Later the same day Vallance told Sky News herd immunity meant 60% of the population. On 15 March, Hancock wrote in the *Sunday Telegraph*: “Herd immunity is not a goal or a strategy.”

CARE HOMES

On 25 February, Public Health England issued guidance stating that it was “very unlikely” care homes would become infected. The guidance was not withdrawn until 12 March. Government advice from 2 to 15 April was: “Negative tests are not required prior to transfers/ admissions into care homes.”

The Westminster government’s Covid-19 Action Plan for Social Care is still to send confirmed-positive coronavirus sufferers back to care homes:
1.32 A small number of people may be discharged from the NHS within the 14-day period from the onset of Covid-19 symptoms needing ongoing social care. They will have been Covid-19 tested and have confirmed Covid-positive status. Some care providers will be able to accommodate these individuals through effective isolation strategies or cohorting policies.

On 28 April, officials at Public Health England submitted an 11-point plan proposing "a further lockdown of care homes", but this was rejected by ministers. Almost 16,000 care home residents were confirmed or suspected to have died from Covid-19, according to official UK figures at the end of May, amid outbreaks in 38% of homes in England and 59% of those in Scotland.

NHS PPE

On 31 March, the British Medical Association (BMA) warned that the health of doctors and patients was at considerable risk as many hospitals and GP practices faced life-threatening shortages of PPE, despite assurances from the Westminster government that enough would be delivered.

On 2 April, the BMA said it had received concerns from doctors in over 30 hospital trusts about PPE shortages. GPs across England reported grossly inadequate supplies and had not received essential eye protection. Public Health England revised its guidance on what health workers should do in the event of PPE shortages. On 3 April, the BMA, RCN, Unite and UNISON called for the mass manufacture of PPE to meet the crisis in healthcare settings.

On 7 April, a BMA survey revealed that more than half of doctors working in high-risk environments said there were either shortages or no supply at all of adequate face masks, while 65% said they did not have access to eye protection. More than half (55%) said they felt pressurised to work in a high-risk area despite not having adequate PPE. Almost 90% of GPs in contact with Covid-19 patients reported either shortages or no access at all to eye protection and 62% reported problems with supply of face masks. On 10 April, the BMA warned that PPE supplies in London and Yorkshire were not sufficient to deal with the Covid-19 outbreak.

On 18 April, a BMA survey of more than 6,000 doctors found that around half working in high risk areas said there were shortages or no supply at all of long-sleeved disposable gowns and disposable goggles, while 56% said the same for full-face visors in other hospital settings, around half of doctors said that there were shortages or no supply at all of scrubs and eye protection. On 22 April, ministers told health care staff to use aprons in the place of gowns, in contravention of PHE and WHO guidance. Ministers promised that 40,000 gowns from Turkey would be flown in by RAF. In May it emerged that this PPE from Turkey was sub-standard.

On 3 May, a third BMA survey involving over 16,000 UK doctors found that nearly half of doctors said they had sourced their own PPE for personal or departmental use, or they have relied upon donations. Many confirmed they were pressured to work without the right PPE and pressured to stay silent for fear of repercussions.

USE OF PRIVATE COMPANIES

The Westminster government has provided profitable opportunities for private companies during the pandemic, having run down previous public provision for such services. The consultancy firm Deloitte was put in charge of the Covid-19 testing programme, including the Amazon Web Services platform that the test tracking system sits on. Sodexo, G4S, Serco, Mitie and Compass are running the drive through centres. Call centre contact tracers are provided by Serco.

Early in the pandemic, ministers agreed an arrangement by NHS England with private hospital operators such as Circle Health, Spire Healthcare and HCA to reimburse them all of their costs in return for the use of facilities such as acute beds.

4 LACK OF FIRE AND RESCUE PREPAREDNESS

Ministers, fire employers and chief fire officers failed to prepare properly for pandemics since 2010, despite the known risks. They have weakened fire and rescue service resilience with austerity cuts and 'modernisation' reforms.

At the turn of the century 'modernisation reforms' fragmented the fire and rescue service. The Fire and Rescue Services Act 2004 in England and Wales, with similar devolved legislation in Northern Ireland and Scotland replaced the previous statutory framework. This scrapped the Central Fire Brigades Advisory Council (CFBAC) and the fire inspectorate in England. It introduced Integrated Risk Management Plans (IRMPs). The Civil Contingencies Act 2004 made the fire and rescue service a category 1 responder, with statutory responsibility to assess the risk of an emergency occurring, to publish plans to respond to an emergency and put in place business continuity management arrangements.

The first National Risk Register (2008) stated that during an influenza pandemic, the UK was likely to face "wider social and economic disruption, significant threats to the continuity of essential services, lower production levels, shortages and distribution difficulties". The latest (2017) edition states under strategies listed to respond to such a pandemic:

- *Personal protective equipment - emergency responders have personal protective equipment for severe pandemics and infectious diseases. There are also protocols in place for infection control both before and during an incident.*

Between 2007 and 2011, the FBU participated in the Fire and Rescue Service Health and Safety Group. The group also included the Chief Fire Officers Association (CFOA), Local Government Association (LGA), Welsh LGA, Scottish Executive, Institution of Fire Engineers, Unison, Health and Safety Executive and the Fire Service College. It discussed pandemic flu as a priority during this period.

In 2008 the Department of Health and Health Protection Agency published *Pandemic Flu: Guidance for the Fire and Rescue Service*, in collaboration with DCLG and CFOA. The guidance warned of the high risk of pandemic flu and the likely risks faced by operational firefighters. It included advice on the use of PPE by firefighters and highlighted the impact of staff shortages. It did not address the difficult question of what firefighters should do if PPE or other equipment was not provided in sufficient quantities (and/or to the right standard) during a pandemic.

The union is not aware of any further, more detailed guidance for fire and rescue services since this publication. The guidance was not refreshed in light of international experience of swine flu in 2009-10 or other significant global health guidance. This represents a failure of leadership to plan and prepare for a pandemic like Covid-19.

CUTS

The fire and rescue service has been decimated since the Fire and Rescue Services Act and Civil Contingences Act were imposed in 2004.

JOB CUTS IN ENGLAND

	Wholetime	Retained	Control	Total
2004	31,856	13,015	1,519	46,390
2019	22,801	12,222	1,134	36,157
Change	-9,055	-793	-385	-10,233
%	-28%	-6%	-25%	-22%

Job cuts have not been as severe in the devolved administrations, but Wales has seen 15% of firefighters cut over the same period, with 7% cut in Scotland.

FIRE STATION CLOSURES

Place	2004	2018	Change
England	1,447	1,394	-53
Northern Ireland	67	68	+1
Scotland	390	356	-34
Wales	151	149	-2
UK	2,055	1,967	-88

Austerity cuts imposed by central government, local fire authorities and chief officers saw 12,000 firefighters jobs (20%) cut over the last decade across the UK. This reduced resilience for a range of risks including pandemics.

PLANNING

Analysis of the most recently published IRMPs show that 30 out of 50 (60%) do not even mention “pandemic” or “flu” as a risk. Almost all of those that do simply refer to the national or local community risk register. None set out the detailed steps that would be taken in the event of a pandemic. None appeared to reference a separate pandemic plan.

During 2018 and 2019, HMICFRS carried out its first inspections of fire and rescue services in England. Half of those reports, 22 of the 45 reports contained some criticism of business continuity arrangements. More than a third (16 out of 45) had business continuity identified by inspectors as ‘areas for improvement’.

5 FIRE RESPONSE: THE TRIPARTITE AGREEMENT

The fire and rescue service response to the Covid-19 pandemic has been managed uniquely through the UK-wide tripartite agreement between the FBU, fire service national employers and the National Fire Chiefs Council (NFCC).

Because of longstanding UK-wide collective bargaining arrangements through the National Joint Council (NJC), the FBU and fire employers began to ready the service in February. The first NJC circular on coronavirus went out on 21 February, well before central government warnings aimed at public services. The FBU also wrote to fire authorities on 15 March to cease non-essential activities, to protect the public and firefighters from spreading the virus.

On 23 March, the FBU signed a tripartite UK-wide agreement with fire service national employers and the NFCC. Under the agreement, firefighters would deliver essential items like food and medicines to vulnerable people; drive ambulances and assist ambulance staff; and moving the deceased, should the outbreak cause mass casualties.

On 9 April the agreement was extended to include face fitting for masks to be used by frontline NHS and clinical care staff working with Covid-19 patients and delivery of PPE and other medical supplies to NHS and care facilities. On 16 April the agreement was further extended to include non-blue light ambulance driving, Covid-19 testing and driving instruction by fire driver trainers to deliver training for non-fire personnel.

On 23 April, the agreement was further extended to include the assembly of single use face shields for the NHS and care work frontline staff, packing food supplies for vulnerable people and transfer to and from Nightingale hospitals. On 21 May, two further areas of work were agreed for training of care home workers.

The FBU's assessment of the agreement in June 2020 found:

- More than four-fifths of fire and rescue services had delivered packages of food, medicines and other essentials to vulnerable persons – the most frequent activity carried out by firefighters
- Three quarters of fire and rescue services had provided personnel for ambulance driving

- Almost three quarters of fire and rescue services have delivered PPE – mostly for the NHS and ambulance service
- Almost two-thirds of fire and rescue services had assisted with the movements of dead people to mortuaries
- Nearly half of fire and rescue services had assisted with face fitting.

Other industrial relations matters also stand out. Some services have such "lean" crewing models that they had little capacity to contribute to the additional work while maintaining fire cover. In other cases, requests were made by the Local Resilience Forums or ambulance trusts that were not subsequently needed.

In late April, it was estimated that more than 4,000 fire and rescue service staff from across the UK were volunteering to support the NHS and other key services on Covid-19 matters.

REGULAR DUTIES

Firefighters have continued to provide a 24/7 emergency service throughout the pandemic. This has included responses to domestic fires, fires at businesses, as well as wildfires. Although few figures have been published on this activity over the last three months, in Northern Ireland firefighters dealt with nearly 10% more incidents during pandemic than for the same time last year.

Thanks to the professionalism of firefighters, all fire and rescue service continued to function during the lockdown. Very few fire and rescue services reported problems with fire appliance availability during the pandemic to the FBU. By late April, no services were reporting appliances off the run. From the beginning, some services had an increase in retained firefighter availability as a result of primary employers sending their staff home or on furlough.

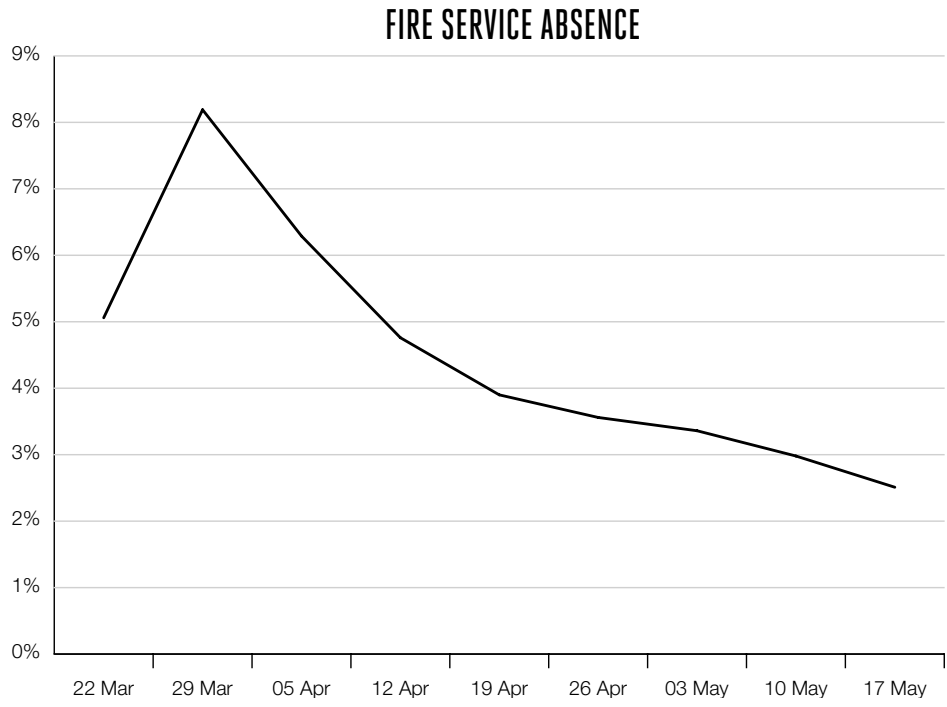
No fire and rescue service was unable to function during the pandemic. From late March to the middle of April around a third experienced some impacts on their functioning, but this did not impede the provision of fire cover.

6 INDUSTRIAL RELATIONS ISSUES

Thanks to the national agreement and the involvement of FBU officials at every level, the fire and rescue service managed to cope through the worst of the first wave. However it would wrong to pretend that there were no problems on the ground. Staff absence, equipment shortages and limited testing were all evident. Risk assessments are still necessary to protect health and safety. All these issues need to be addressed as the lockdown eases and while further waves remain likely.

ABSENCE

In recent months, fire and rescue services across the UK did not experience very high levels of absence that can occur with pandemics. Fire and rescue service Covid-19 absence in England and Wales was already more than 5% in the days immediately before lockdown began. Fire absence from Covid-19 peaked at just over 4,000 (8%) at the end of March. It then fell after that and by mid-April was half the peak level, with around 2,000 absent (4%). Absence continued to fall into May.



FBU members in Cleveland, South Yorkshire, Nottinghamshire, Warwickshire, Essex, London and Cornwall fire and rescue services reported absence of 10% or higher by the end of March. The FBU published detailed figures on the Easter weekend (11-12 April), which showed that nearly 3,000 fire and rescue staff were in self-isolation and unable to work. This represented 5% of the UK's overall fire and rescue workforce. Just under 2,600 were operational firefighters and control staff. The highest absences by brigade were Bedfordshire, Cleveland and London at around 9%.

Northern Ireland Fire and Rescue Service (NIFRS) provided the most detailed data on absence. Daily absence peaked at 162 (8%) on 3 April and 4 April. By the end of May overall absence was less than 100 (5%). The figures include some staff shielded due to health conditions as well as absence with symptoms. The worst days for wholetime firefighters were 4 April and 5 April, when 79 were absent, 9% of the wholetime workforce. The worst day for retained firefighters was 6 April, when 37 were absent, 4% of the retained workforce.

In the Scottish Fire and Rescue Service (SFRS), absence rose from nearly 4% at the time of lockdown to just under 5% by the Easter weekend. By the end of April absence dropped to around 3% and remained between 3% and 4% during May.

Control staff absence has generally been higher than the overall fire and rescue service figures. At the beginning of April, 11 NIFRS control staff were absent, 19% of the control workforce. Control staff absence in Wales peaked at around 15% in the first week of April. In England, control staff absence peaked at 12% at the end of March. Higher control staff absence persisted into April.

Control staff absence in some individual brigades was also considerably higher. Fire control staff told the FBU they had experienced some days with more than 20% absence. This included fire controls in Cleveland, Tyne and Wear, West Yorkshire, North West Fire Control, Lincolnshire, North Wales, Essex, Thames Valley and Avon.

EQUIPMENT AND PPE

The fire and rescue service experienced significant equipment shortages at the beginning of lockdown. In late March, firefighters in more than three-quarters of fire and rescue services reported having supply chain problems. The main concerns were the supply of respiratory masks, hand sanitiser, wipes, cloths and Tyvex coveralls. FBU members in Cambridgeshire, Hampshire, Hertfordshire, Isle of Wight, Merseyside, Leicestershire, Mid and West Wales and West Midlands reported breathing apparatus (BA) supplier issues with essential cleaning products.

In early April, firefighters in a number of fire and rescue services were still reporting problems with face mask cleaning products, respiratory protective equipment and other PPE items. West Midlands FBU members reported a range of issues with servicing appliances, getting spare parts and some tools. Suffolk firefighters reported problems with appliance spares due to supplier lockdowns elsewhere in Europe. Computer hardware was also affected. Essex firefighters reported problems with computers and headsets, while Cambridgeshire and Lancashire had concerns about washing fire kit. Tyne and Wear and Hampshire members also reported supplier problems.

TESTING OF FIRE PERSONNEL

Testing frontline personnel is crucial to containing any pandemic. Workers expected to work come into contact with the public and with each other, with the potential to spread the virus. This is particularly important in the emergency services, where close contact is routine.

The FBU wrote to ministers in all four governments on 20 March to demand priority testing for firefighters. In reply, the Welsh government provided a guarded but positive response, while the fire minister at Westminster evaded the issue. In April testing for firefighters first became available in Scotland. However it was not until 17 April that the health minister at Westminster announced that firefighters could be tested – although only those showing symptoms were eligible.

So far only a tiny percentage of fire and rescue service personnel have been tested. The FBU estimates probably less than 5%. Records of tests and those testing positive by occupation are not published by governments or fire authorities. This makes controlling the virus at work far harder.

The FBU continues to campaign for regular weekly testing for all firefighters, including those who are asymptomatic.

CONCLUSIONS

The Covid-19 pandemic has starkly highlighted the crisis in our society and the failures of the Westminster government. Although the fire and rescue service has weathered the first wave, the pandemic has exposed a range of issues the FBU has warned about for a considerable time.

1. The Westminster government should be held to account for its failures during this pandemic. An **independent inquiry** is necessary to learn lessons swiftly and to prepare for future waves.

2. The Westminster government needs to fund the NHS and social care to ensure the service is robust in the face of future pandemics. It means decent pay and **PPE** for all health and social care workers. It also means the end of private sector encroachment on what must be a fully public service. It means a publicly-run **track and trace system** integrated with local public health.

3. The Westminster government and devolved administrations must commit to **investment** to the fire and rescue service. They should implement a **moratorium** on cuts, reduced crewing levels on pumping appliances, and on fire station closures. They must fund the initial employment of **an extra 5,000 firefighters** to complement the existing professional workforce, with a review to examine further recruitment.

4. Governments must ensure that **risks and resilience are assessed UK-wide** as well as locally, to ensure adequate resource planning and response and to guarantee national standards are maintained and improved. Such standards for appliances, equipment and other operational requirements would cut down on waste and duplication in research and development and to enhance cross-border cooperation. Governments must ensure central guidance and oversight of local integrated risk management planning (IRMPs).

5. Governments must create a **new statutory advisory body** to oversee standards and best practice in fire and rescue services across the UK. It would advise ministers on all fire and rescue service policy, develop standards and ensure lessons are learned from incidents, including wide risks from pandemics, climate change and other threats.

6. Governments, fire authorities and chief fire officers must ensure that firefighters have the necessary PPE and other equipment in the event of further outbreaks. Firefighters should also have access to testing for Covid-19, whether symptomatic or not. This is to protect both the public and firefighters' own safety and health.

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