The UK Covid-19 Inquiry

Written Submissions of the British Medical Association (BMA) on Module 3

Introduction

1. These submissions include:

    a. an overview of the impact of the pandemic on healthcare systems and workers;
    b. proposed issues for inclusion within Module 3;
    c. observations about issues that are relevant to multiple modules; and
    d. observations about expert evidence.

2. The BMA is a professional association and trade union for doctors in the UK, with a membership of over 176,000 doctors. It welcomes its designation as a core participant to Module 3 of the Inquiry.

3. The BMA has carried out its own Covid-19 Review, comprising five reports[1] addressing different aspects of the pandemic, its impact on healthcare and public health, and the response from government. In particular, the first report examines how well protected the medical profession was from Covid-19, the second report addresses in detail the impact of the pandemic on the medical profession, and the third report explores the impact on healthcare delivery. These three reports will be particularly relevant to the Inquiry's Module 3 work. The introduction to the second report, published in May 2022, is as follows:

> *At the beginning of 2020, the medical profession in the UK was struggling. Doctors were overworked and overstretched, with many considering leaving the health service altogether. Stress-related sickness absence rates were high and workforce planning was inadequate. The idea of having to work harder still, and in more dangerous conditions, seemed impossible. And yet that is exactly what doctors have had to do for the past two years since the COVID-19 pandemic arrived on UK shores.*
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> *In 2022, the experience of the pandemic among medical professionals remains varied. Some have had their livelihoods affected, many their health, and most their morale. Each experience has been unique, and in some cases influenced by their ethnicity, gender, or disability status.*

[1] https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/bma-covid-19-review

There is one word, however, which is used repeatedly by medical professionals to describe the last two years: 'devastating'. Doctors have been left exhausted, demoralised, and unwell.

UK health services will never quite be the same. Doctors have been significantly impacted by the pandemic, as this report sets out. However, while we may be out of the acute phase of the pandemic – largely due to the successful rollout of the national vaccination programme – doctors' jobs are not becoming any easier, as they begin to address the mounting backlog of care. Burnout, exhaustion, and poor mental health are therefore unlikely to improve overnight, and the intention to leave is high. Against this context, a key challenge for health services over the coming weeks, months, and years is ensuring there are enough staff to ensure every patient who needs help receives it promptly.

This report examines how medical professionals were impacted by the pandemic and outlines the lessons to be learned, asking us to consider how death, illness, financial harm, and threats to professional life may be mitigated in the future. The public inquiries into COVID-19 must continue to address these questions thoroughly to honour the victims of the pandemic. At the centre of the inquiries must be a willingness to allow their families and loved ones a deeper understanding of what happened, and if anything could be done differently next time to avoid so much suffering.

4. While much of these submissions are focused on the impact of the pandemic on health services and healthcare workers, the BMA wishes to make clear that the overwhelming priority of its members is to ensure that they provide patients with the best possible care and treatment, and that the concerns set out in these submissions, and elsewhere within the Inquiry proceedings, are all ultimately for the purpose of achieving this goal, as reflected within the BMA's mission statement, "We look after doctors so they can look after you."

Overview of the impact of the pandemic on healthcare systems and workers

5. The UK entered the pandemic with understaffed and under resourced public health and healthcare systems which were barely able to cope with pre-Covid levels of demand. Compared to other OECD nations, the UK entered the pandemic with far fewer doctors, hospital beds and critical care beds per 1,000 people, alongside high staff vacancy rates and frequently unsafe bed occupancy levels. This lack of pre-pandemic preparedness exacerbated the severe disruption to healthcare delivery during the pandemic and resulted in calls for retired doctors and nurses to return to service, medical students joining the workforce early and the use of volunteers. Staff had to be redeployed, often starting new roles without training or adequate supervision. One consultant in

England told the BMA's Covid-19 Review call for evidence:

> "*I am going to keep saying this. Staffing. Get vacancies filled and stop lying about the numbers of those. Pay, leave, pension etc are part of sorting that but what I needed most during the pandemic were the colleagues I was already missing*".

Another consultant in England, said:

> "*Being understrength to begin with in terms of staffing, and already working with bed occupancy at or above 100%, pre-pandemic meant no headroom for managing the eventual large increase in demand.*"

6. Many elective procedures, diagnostic tests and routine outpatient services had to be suspended in order for staff, resources and beds to be utilised for Covid-19 care. This added to pre-existing backlogs leading to 8.9 million people across the UK now being on waiting lists for treatment (September 2022).[2] In addition, some people will have delayed seeking care, which is likely to have led to people presenting later to more severe conditions, increasing pressure on health services. All of this had, and continues to have, a significant impact on patients' health, especially affecting conditions needing timely treatment, such as cancer.

7. Higher absences amongst healthcare workers due to Covid-19 infection, self-isolation and long Covid compounded workforce shortages, which unsurprisingly, impacted patient care and forced remaining staff to take on more work. This meant that doctors worked in intense and often unsafe conditions for much of the pandemic.

8. Staff were redeployed to high-risk services where support was most needed. For many, redeployment was a stressful, difficult period in their working lives. Healthcare staff were asked to work within unfamiliar services, on different or more onerous rotas, and often started new roles without induction or training. Such high-pressure environments, alongside the cancellation of annual leave and other forms of respite, had an impact on staff burnout and wellbeing.

9. Training for doctors was disrupted, which caused a reduction in career progression opportunities and fewer opportunities to learn the vital skills needed to address the backlog of care. For many junior doctors and medical students, exams were suspended or cancelled at short notice while redeployment and disrupted rotations meant that some doctors missed out on placement and clinical exposure opportunities altogether.

[2] https://www.bma.org.uk/media/6578/bma-infrastructure-2-report-getting-it-right-dec-2022.pdf

10. The model of care delivery within primary care changed considerably, as seeing patients face to face carried huge infection risk. This drove a rapid shift to remote consultations to protect patients and staff, and to maintain access to services. GPs saw increased demand because of pressures and cancellations of care elsewhere, and they became the front line in managing health issues that were exacerbated by lockdowns or the cancelling of elective and other procedures.

11. The impact of the pandemic on the medical workforce across the UK cannot be underestimated. During the pandemic, doctors and other healthcare staff worked tirelessly to safeguard the nation's health within underfunded, understaffed, and underprepared systems. Staff were exposed to a deadly virus without adequate protection, and they have experienced moral distress and moral injury[3] as a result.

12. The pandemic seriously impacted the physical health of medical professionals, with ethnic minority doctors and disabled doctors at particular risk and more likely to become seriously ill from the virus. The lack of Personal Protective Equipment (PPE) and inadequate Infection Prevention and Control (IPC) policies led to staff being exposed to and contracting Covid-19 at work, sometimes with tragic consequences. One Staff, Associate Specialist and Speciality (SAS) doctor in England responded to the BMA's call for evidence as follows:

> "*Horrified to find myself caring for friends and colleagues on ITU. I'm tired of being the last person to ever speak to people before I anaesthetise, intubate and ventilate them and for them then to die. Tired of passing last words between husbands and wives, parents and children. There is no escape from it. I see dead colleagues in the Trust News emails, local and national press. I dream about it intermittently at night. I'm intermittently consumed by the ocean of sadness it has caused*".

13. Information collected by the BMA indicates that over 50 doctors died of Covid-19 of which more than 80% were from an ethnic minority background. However, this is not a definitive figure, and there may be other doctors who have died from Covid-19. Analysis by the Health Service Journal found that 94% of doctors who died up to April 2020 were from ethnic minority backgrounds.

14. This inadequate protection of healthcare workers from being infected with Covid-19 has led to doctors and healthcare workers acquiring long Covid, with

[3] Moral distress is the feeling of unease when institutional or resource constraints prevent an individual from taking an ethically correct action, for example providing patients with the right care at the right time; moral injury results from sustained moral distress.

many now dealing with the ongoing effects including being unable to work. One junior doctor in Scotland said:

> "*I caught covid in March 2020 from a colleague at work. I have been mostly bedbound since. My life as I knew it had ended. These are supposed to be the best years of my life but I'm spending them alone, in bed, feeling like I'm dying almost all the time*".

15. Occupational health services were (and still are) inadequately resourced, especially in primary care, which impacted the support to staff. In addition, staff from ethnic minority backgrounds said they felt their protection, despite being at higher risk from the virus, was sacrificed to maintain staffing levels.

16. The mental health and emotional wellbeing of medical professionals suffered considerably, and burnout, overwork, distress, trauma, and isolation have all been serious issues. Calls to the BMA's counselling service increased by over a third (37%) in the first year of the pandemic, and several respondents to the BMA Covid-19 Review survey stated they had left or would be leaving the profession. One consultant in Scotland said:

> "*I found the experience to be most disturbing of my career because of the stress of the unknown, the frustration around slow national response, the overwhelming pressure we were under and the emotional toll on almost everyone I was working with. I didn't sleep, often felt angry and suffered post-traumatic stress for a period*".

17. Violence against doctors was more acute during the pandemic. As the pandemic went on, reported instances of abuse rose from 10% in August 2020 to 48% a year later. One respondent to the BMA's survey said:

> "*I am now finding demand from patients has risen exponentially and with long delays in referrals to secondary care, we are receiving a lot of verbal abuse from angry and frustrated patients. This has not been helped by the negative impression of primary care perpetuated in the media and by the comments of some politicians. It has made me question if I want to continue in primary care once the pandemic is over*".

Scope of Module 3

18. The BMA suggests that the following issues are included within the scope of Module 3 (adopting the headings and numbering within the Inquiry's Module 3 Provisional Scope document, for ease of reference):

1. The impact of Covid-19 on people's experience of healthcare.

a. A specific focus on inequalities is key to understanding the impact of Covid-19 on people's experience of healthcare. This should include:
    i. The impact of pre-existing inequalities on health outcomes for people who required treatment for Covid-19 (including rates of infection, hospitalisation, long Covid and mortality).
    ii. How inequalities impacted on people's access to and experience of healthcare during the pandemic including, for example, those living in areas of higher deprivation, certain ethnic minority groups, people without official immigration status, people with disabilities, older people, those categorised as Clinically Extremely Vulnerable (CEV), those living in care homes etc.
    iii. The ongoing impact of the pandemic on healthcare systems, and the consequences of this for population health (both physical and mental health), which continues to impact some groups disproportionately. For example, people living in areas of higher deprivation are 1.8 times more likely to experience a wait for care of more than a year.[4]

2. Core decision-making and leadership within healthcare systems during the pandemic

a. Core decision-making and leadership within healthcare systems should include those decisions made by national bodies (for example, by NHS England and equivalent bodies in the Devolved Administrations). This should include the nature of the guidance issued (or failed to be issued) by governments and health bodies, including its timeliness, clarity and effective implementation, for example on workplace and individual staff risk assessments and infection, prevention and control, as well as clinical and ethical guidance, on issues such as resourcing decisions and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

b. Decision-making in relation to the vaccination rollout (unless this issue is intended to be addressed in a later module of the Inquiry), including the logistics of the rollout, the difficulties for some healthcare workers in accessing the vaccine in a timely manner (for example, juniors doctors, GP locums, medical students who were not yet deployed and doctors in private practice), and the barriers to accessing the vaccine for some population groups.

c. Decision-making around procurement of ventilators and oxygen

[4] https://www.kingsfund.org.uk/blog/2021/09/elective-backlog-deprivation-waiting-times

supplies and Personal Protective Equipment (PPE).

3. Staffing levels and critical care capacity, the establishment and use of Nightingale hospitals and the use of private hospitals

a. The state of healthcare systems entering the pandemic (including staffing, bed capacity, funding, condition of estates, IT) and the impact this had on all aspects of healthcare delivery. For the BMA, it is critical that there is an appreciation and understanding of how the lack of capacity and resource within the NHS, public health and social care systems, and the repeated failures to address the longstanding problem of staff recruitment and retention, has meant that the UK's health systems were desperately underprepared and had no spare capacity to deal with the pandemic.

b. Issues with transparency around contracting arrangements with private providers, and particularly whether those contracts delivered value for money. Consideration of the utilisation of additional capacity purchased by the NHS as well as the impact of these contracting arrangements on care delivery in the private sector.

4. 111, 999 and ambulance services, GP surgeries and hospitals and cross-sectional co-operation between services.

a. To include healthcare delivery in community settings; communication between healthcare systems (for example, the extent to which PPE was re-distributed or not); the circumstances of some healthcare providers having more PPE than others; interaction and coordination between healthcare and social care, particularly in relation to the discharge of patients from hospitals and access to healthcare for residents of care homes.

b. The impact of the pandemic on general practice and staff working in primary care, including:

   i. the shift to remote care delivery in general practice;
   ii. the impact that secondary care service disruption (e.g., cancelled operations, etc.) had on demand in general practice;
   iii. the operation of the Covid-19 Clinical Assessment Service (CCAS);
   iv. how the vaccination programme impacted general practice capacity, and the delivery of routine appointments alongside Covid-19 vaccination appointments.

5. Healthcare provision and treatment for patients with Covid-19, healthcare systems' response to clinical trials and research during the pandemic. The allocation of staff and resources. The impact on those requiring care for reasons other than Covid-19. Quality of treatment for Covid-19 and non-Covid-19 patients, delays in treatment, waiting lists and people not seeking or receiving treatment. Palliative care. The discharge of patients from hospital.

a. The state of healthcare systems prior to the pandemic (already highlighted at paragraph 5 above), which included backlogs of care, increasing waiting times, and staff shortages, all of which were exacerbated by increased absences due to Covid-19 infection and self-isolation, as well as the additional demand caused by the pandemic.

b. The longer-term impacts of the pandemic on healthcare provision, including recommendations for ensuring healthcare systems are more adequately prepared and resourced to respond to future health emergencies, particularly given the increased probability of extreme epidemics.[5] This includes ensuring healthcare systems have sufficient capacity to deliver care to the growing number of patients currently waiting for treatment, as well as the ongoing capacity to avoid the build-up of future backlogs, thereby ensuring health systems can better respond to future emergencies.

c. Staff supervision and training, particularly for those who were redeployed. A BMA survey in April 2020 found that of respondents who had been redeployed, 33% had not been provided with an induction into the new role and 32% had not been provided with training. Doctors held real concerns about the legal implications they could face in the future in relation to choices made in such high pressure, demanding environments.

d. The impact of inadequate existing IT infrastructure on healthcare delivery during the pandemic. Previous failures to deliver on digital transformation commitments resulted in healthcare systems entering the pandemic with insufficient basic hardware and software. In a BMA survey from May 2020, two months into the pandemic, over 50% of primary care respondents reported limitations on their ability to provide remote consultations as a result of IT hardware, telecoms infrastructure, IT software, mobile devices/apps and internet speed/bandwidth.

e. The processes for retired staff to return to the workforce, which was

[5] https://www.pnas.org/doi/10.1073/pnas.2105482118

different for each nation with varying (but generally low) proportions of applicants appointed. The reasons for the failure to fully realise the potential of this valuable resource. Similarly, the processes for allowing medical students to enter the workforce early and the impact this had on their education and training.

f. The processes and decision making in relation to the discharge of patients from hospital. In particular, healthcare providers being explicitly encouraged during the first wave of Covid-19 to discharge patients from acute beds to the community or their own homes. The impact of these decisions on mortality and on the physical and mental health of the patients, families and staff involved. Many hospital patients were discharged without being tested or, when testing did occur, care homes receiving these patients were at times not notified of test results in a timely manner. During this time, widespread shortages of PPE left care home staff and residents further exposed to Covid-19.

6. Decision-making about the nature of healthcare to be provided for patients with Covid-19, its escalation and the provision of cardiopulmonary resuscitation, including the use of do not attempt cardiopulmonary resuscitation instructions (DNACPRs).

a. The UK Government's decision not to issue guidance for healthcare systems and healthcare professionals on decision making, triage and resource allocation in the event that sufficient resources were not available, and the impact of this lack of guidance on patients and healthcare staff.

7. The impact of the pandemic on doctors, nurses and other healthcare staff, including on those in training and specific groups of healthcare workers (for example by reference to ethnic background). Availability of healthcare staff. The NHS surcharge for non-UK healthcare staff and the decision to remove the surcharge.

a. The extent to which under-resourced and understaffed healthcare services contributed to adverse physical and mental health impacts for staff.

b. Inequalities in the impact on staff and missed opportunities to mitigate this inequitable impact, including the disproportionate rates of infection and mortality among ethnic minority healthcare workers.

c. The lack of adequate protection from infection in the workplace (that continues to this day), associated in some cases with long Covid and death.

d. The impact on staff mental health and emotional wellbeing. This includes grief/trauma; moral distress (the feeling of unease when institutional or resource constraints prevent an individual from taking an ethically correct action, for example providing patients with the right care at the right time); moral injury (sustained moral distress); poor psychological safety (fear of infection and passing virus to others); burnout and overwork due to lack of capacity and staff shortages.

e. The impact on staff training, progression and opportunities to learn clinical skills needed for the future of the medical workforce.

f. The lack of capacity within occupational health services (as a result of underfunding) to provide adequate support for staff.

g. The circumstances relating to the development of long Covid among healthcare workers, including the impact of unnecessary exposure to Covid-19 infection as a result of a lack of access to PPE, inadequate PPE and IPC guidance. The impact of long Covid on healthcare staff, including the physical, mental and financial impact.

h. Increased levels of violence and abuse experienced by healthcare workers, including the impact of media and UK Government narratives which failed to vocally support the medical profession. In a BMA survey from July 2021, more than a third of doctors had faced recent abuse from patients or those close to them, with those working in primary care experiencing even higher levels of abuse.

8. Preventing the spread of Covid-19 within healthcare settings, including infection control, the adequacy of PPE and rules about visiting those in hospital

a. IPC guidance: its timeliness in being produced and updated to respond to a fast moving situation; how it was communicated; variation in implementation (in the very early stages of the pandemic, some medical professionals were explicitly forbidden from wearing PPE); its adequacy in light of growing evidence about aerosol transmission of Covid-19 and international guidance; and decision-making around changes to the IPC guidance in January 2022 which appeared to recognise the role of airborne transmission with recommendations for appropriate PPE (i.e. respiratory protective equipment (RPE) such as FFP2/3 masks) to mitigate this risk before the guidance reverted again in March 2022 to state that fluid resistant surgical masks (FRSM) (which are not PPE) were adequate protection for healthcare workers treating Covid-19 patients.

b. PPE: supply shortages and the consequences of these (no PPE, homemade PPE, expired, reused items); fit testing (including gender bias); and user guidance and training.

c. Risk assessments: timeliness and quality of risk assessment guidance/tools; adequacy of communicating employers' Health and Safety obligations; and impact on certain groups of staff (particularly ethnic minorities and staff with a condition or disability that made them clinically extremely vulnerable to Covid-19).

d. Reporting of workplace-acquired Covid-19 infections as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), including the extent of underreporting, and the impact of this underreporting on understanding the spread of infection within healthcare settings and on protection for staff and patients. The impact of underreporting on the ability for healthcare workers to access compensation for workplace acquired post-acute Covid complications, including long Covid.

e. Testing: the impact of testing infrastructure/capacity on transmission in healthcare settings; and whether tests were always available for staff and patients who needed one (at first testing was only for those in intensive care).

f. Estates: the ability to implement suitable infection prevention and control policies (e.g., ventilation) given the poor standard of facilities and infrastructure in the healthcare estate.

g. Inequalities experienced by healthcare staff, such as people from ethnic minority backgrounds or those engaged on non-permanent contracts, to include: the different levels of protection provided; whether particular groups felt able to speak up about lack of protection; and whether particular groups felt pressured to work without adequate protection.

9. Communication with patients with Covid-19 and their loved ones about patients' condition and treatment, including discussions about DNACPRs.

10. Deaths caused by the Covid-19 pandemic, in terms of the numbers, classification and recording of deaths, including the impact on specific groups of healthcare workers, for example by reference to ethnic background and geographical location.

a. The factors that contributed to a disproportionate number of deaths by

specific groups of healthcare workers, including lack of sufficient and appropriate PPE and the quality and timeliness of risk assessments.

b. When and how Governments became aware of the disproportionate number of deaths amongst healthcare workers from ethnic minority backgrounds and what action they took to address the increased risk to these groups of healthcare workers.

c. The circumstances surrounding the publication of the PHE Review into disparities in the risk of acquiring and the outcomes of an infection with Covid-19, including the decision to redact pages prior to publication.

11. Shielding and the impact on the clinically vulnerable (including those referred to as "clinically extremely vulnerable").

a. Identification processes, including the adequacy of identification processes and consistency across geographies (local variation and between UK nations), the impact of pre-existing data limitations on identification processes, and the adequacy of communication to those on shielding lists. Across the UK, some people who were clinically extremely vulnerable were not identified until mid-May 2020, while others were initially identified incorrectly and were not removed until June and July 2020. A change in the risk assessment tool in England resulted in a further 1.7 million people being added to the shielding list in February 2021. These variations and delays created confusion, with some unsure whether they needed to shield. In addition, not everyone who received a shielding letter could read and understand its contents and in some places, there was an initial lack of available translations and easy-read versions.

b. Testing: decision-making in relation to the testing available for those who care for someone who is clinically extremely vulnerable, and the impact of these decisions on the physical and mental health of those involved.

12. Characterisation and identification of Post-Covid Condition (including the condition referred to as long Covid) and its diagnosis and treatment.

a. Definition - there is no internationally agreed clinical definition of 'long Covid' or what constitutes a post-Covid condition in terms of range and length of symptoms.

b. Prevalence – accuracy and consistency of data collection. UK Government is still relying on self-reported data.

c. Identification – the support provided to GPs to understand the variable symptoms of long Covid/ post-Covid conditions.

d. Treatment – the information available on support (including mental health support), and how to refer people to it.

e. Treatment – the level of consistency in Covid clinics across the UK in terms of waiting time, treatment, multi-disciplinary services available and treatment for specific groups such as children and young people.

Issues that are relevant to multiple Modules

19. Now that work on the first three Inquiry modules is underway, it is apparent that there are a number of issues that will require detailed consideration across multiple modules, and the BMA would welcome guidance from the Inquiry about how it intends to address these issues within its modular approach.

20. Issues falling into this category with particular significance for the BMA include:

    a. The lack of availability and suitability of PPE, which placed healthcare workers, including BMA members, at unnecessary risk within the workplace, of infection from a deadly disease; and

    b. The historic lack of resourcing and staff shortages within health services and public health systems, that left them hopelessly underprepared and with no spare capacity to face the pandemic.

21. Taking PPE first, this is an area of very significant and ongoing concern for the BMA's membership, and the BMA would be grateful to understand at what stages within the Inquiry proceedings the various aspects of PPE will be considered.

22. Even when suitable and appropriate PPE became available (e.g., FFP2 and FFP3 masks) deficiencies within the IPC guidance meant that they were not always provided to staff who were treating patients. Apart from in the very early weeks of the pandemic and for a brief period from January to March 2022, the IPC guidance stated (and continues to state) that a fluid resistant surgical mask (FRSM) which is not appropriate PPE, was suitable protection for healthcare staff providing care to patients who were known or suspected to be positive for Covid-19, outside of a limited list of specified Aerosol Generating Procedures (AGPs) (and even then, the AGP list did not include all relevant procedures such as chest compressions for cardiopulmonary resuscitation as advised by the Resuscitation Council). Therefore, issues of PPE are not simply historic, and they remain an ongoing issue of concern.

23. The Inquiry has already helpfully provided the following information about how it intends to investigate issues of PPE:

    a. The Inquiry's July 2022 Opening Statement refers to the fact that during the pandemic, "*procurement and the sourcing and supply of personal protective equipment (PPE) became matters of national concern*", and that later modules following Modules 1-3 will include the subject of "*Government procurement and PPE*".

    b. Counsel to the Inquiry's note of 14 February 2023 for the Preliminary Hearing in Module 3 indicates, at paragraph 33, that the scope of Module 3 will include the availability and suitability of appropriate PPE, and the impact within healthcare systems of the PPE that was available at the time.

24. The recent clarification provided within the note from Counsel to the Inquiry is welcomed and has provided the BMA with assurance in this area. However, the Inquiry will be aware that the BMA has also proposed within its written submissions on Module 1 that the lack of adequate and suitable PPE stock and supply should be specifically included within the scope of Module 1, because it is so integral to the issues of preparedness to be examined within that Module. For example, the Provisional Outline of Scope for Module 1 specifically includes the learning from past simulation exercises, and it should be noted that the recommendations of the simulation exercises, Exercise Alice (2016) and Exercise Cygnus (also 2016), include a review of stocks of PPE, the need for pandemic stockpiles in order to ensure sufficient and appropriate PPE was available, and to develop a whole system approach to the distribution of PPE to health and care staff.

25. The BMA's position is that there needs to be detailed consideration within Module 1 of the apparent failure to implement the recommendations of previous pandemic exercises, and of the failure to ensure sufficient stock and supply of appropriate PPE more generally, including the extent to which this was contributed to by inadequate IPC guidance. However, if it is not the intention of the Inquiry to examine these issues in detail within Module 1, then the BMA would be grateful to understand at what stage it is envisaged that the failure to ensure sufficient and appropriate stock and supply of PPE will receive detailed consideration, for example, within Module 3 or within a later 'Government procurement and PPE' module?

26. The issue of resourcing, capacity, and staffing levels is also critical for the BMA, as will be clear from these submissions, and the BMA has noted the guidance provided by the Inquiry to date, within the Inquiry's July 2022 Opening Statement confirming that Module 3 will investigate healthcare systems, governance, and NHS backlogs. The Provisional Outline of Scope for Module 3

also states that staffing levels and the allocation of staff and resources, are within scope, and Counsel to the Inquiry's note of 21 October 2022, indicates that Module 3 will be a UK 'system' module and will include consideration of the capacity of healthcare systems to respond to a pandemic.

27. Account has also been taken of the recent clarification within the note of Counsel to the Inquiry of 14 February 2023, at paragraph 34, that "*It is not part of the Inquiry's Terms of Reference to consider the state of healthcare systems in the United Kingdom prior to the pandemic, save where necessary to understand how the pandemic impacted on healthcare systems*."

28. In this regard, the BMA wishes to make clear its position, as a specialist healthcare organisation representing the interests of over half of all practising doctors in the UK, that the lack of resource, capacity, and staffing within health services prior to and during the pandemic meant that the adverse impact of the pandemic on patients, doctors, and other healthcare workers, was and continues to be more severe, including worse outcomes for patients and more serious physical and mental health impacts for doctors and other healthcare workers, than would have been the case had there been better resourcing, capacity, and staffing. And that it considers these issues to be fully within the Inquiry's Terms of Reference.

29. As with PPE, the BMA's position is that there should also be consideration of resources and staffing within Module 1 because years of underinvestment and repeated failures to address longstanding issues of staff recruitment and retention, meant that health systems were desperately underprepared and had no spare capacity to deal with the pandemic.

30. It is also the BMA's position that resourcing and staffing should be considered within Module 2 when considering whether the damaging impact of lockdown would have been necessitated to the same extent had health systems been better able to cope. While appreciating that the slogan "Stay Home, Protect the NHS…" was in part an effective message that resonated with the public, it was also necessitated because otherwise the NHS would have become overwhelmed.

31. The BMA appreciates that the Inquiry will be giving careful consideration to how best to handle common issues across multiple modules without unnecessary duplication, and the Chair's direction for a list of issues in Module 1 by 8 March 2023, will be helpful guidance to core participants in this regard.

32. The BMA suggests that another useful exercise will be for the Inquiry to circulate proposals for addressing significant issues such as PPE and resourcing/capacity (outlining how and when different aspects will be examined across multiple Inquiry modules) and to invite representations from core participants. Other

issues that may benefit from this type of approach include, equalities issues, and workplace risk assessments.

Suggested experts

33. Given the likely diversity of expert opinion in respect of the topics identified by the Inquiry, the BMA would strongly recommend that groups of experts are appointed to each topic rather than a single expert, so that any areas of broad consensus and those areas where differences of expert opinion remain, can be identified for the Inquiry's benefit. The BMA would commend this type of approach to the Inquiry, particularly as it is not necessary for the Inquiry to indicate a preferred expert opinion, and if there is legitimate difference of opinion within the expert topics identified by the Inquiry, this ought to be reflected in the evidence considered by the Inquiry.

34. The BMA will seek to identify specific experts for nomination and will revert to the Inquiry in this regard if it is able to suggest suitable experts. If there are any key topics or areas where the Inquiry believes the BMA may be able to identify experts, the BMA will be pleased to assist.

21 February 2023