The UK Covid-19 Inquiry

Written submissions of the British Medical Association (BMA) on Module 2

Introduction

1. The BMA is a professional association and trade union for doctors in the UK, with a membership of almost 196,000 doctors and medical students in the UK. It advocates for outstanding healthcare and a healthy population, providing members with individual services and support throughout their lives.

2. The impact of the pandemic on the medical workforce across the UK cannot be underestimated. Doctors and other healthcare workers were on the frontline of the UK's response to Covid-19, and they worked tirelessly to treat and care for patients with Covid and those with other healthcare needs, often at great personal cost to their physical and mental health. They put themselves at increased risk from the disease itself - often without adequate protection - and from the stress and pressure of working through a public health crisis of this scale.

3. Throughout the pandemic, the BMA worked to protect and support doctors, healthcare staff, patients and the wider UK population by:

    a. Providing individual support to members (for example, through employment advice teams and the BMA's wellbeing services);
    b. Providing guidance to doctors and their employers, particularly when this was not forthcoming from governments or their agencies (for example, in relation to risk assessments or ethical guidance for doctors).
    c. Seeking to influence decision-makers on a wide range of matters related to Covid-19 through direct engagement, letters, media and press statements, and parliamentary processes (for example, providing evidence to Select Committee Inquiries and equivalents in the devolved nations and responding to consultations).
    d. Undertaking research to gather the real-time experiences of doctors, which has informed the BMA's policy and campaigning work.
    e. Closely monitoring relevant data and other developments related to Covid-19 to inform the BMA's guidance to members and the public, and our policy and campaigning activities.

4. In addition, the BMA carried out its own Covid-19 Review, comprising five reports addressing different aspects of the pandemic, its impact on healthcare and public health, and the response from government. This followed extensive feedback from BMA members during the course of the pandemic and through a call for evidence. The BMA's fourth report titled 'the public health response by UK governments to Covid-19' is particularly relevant to the scope of Module 2.

5. The BMA is a core participant in Modules 1, 2, 3 and 4 of the Inquiry. The Inquiry is in receipt of the BMA's evidence and is familiar with the submissions made on behalf of the BMA in other modules. However, for the benefit of Module 2 core participants and those who are engaging with the Inquiry's work for the first

time, the BMA reiterates that the overwhelming priority of its members is to ensure that they provide patients with the best possible care and treatment and in a way that is safe for them to do so. The issues raised in these submissions, and elsewhere in the Inquiry proceedings, are all ultimately for the purpose of achieving this goal. The BMA's mission statement is, "We look after doctors so they can look after you".

6. As has already been raised in Module 1, chronic underinvestment in the health services and public health systems across the UK meant that the UK was not as well prepared as it could have been when it entered the pandemic. Public health and healthcare systems were understaffed, under resourced and barely able to cope with pre-Covid levels of demand. The number of nurses, doctors and hospital beds in the UK per 1,000 people are lower than the OECD EU national average, and general health spending as a percentage of GDP was below that of comparable Western European neighbours. This placed patients and healthcare workers at increased risk when the pandemic started.

7. The BMA believes that the UK Government's response to the pandemic was categorised by a failure to take a sufficiently precautionary approach, despite repeated warnings from the BMA and others, and missed opportunities to learn lessons as the pandemic progressed. In particular:

    a. The UK government was slow to react to the emergence of Covid-19 globally and to act robustly on concerns raised by its own scientific advisory body, SAGE;
    b. Measures to protect the public and reduce transmission of the virus, including key non-pharmaceutical interventions (NPIs), were introduced too late and, in many cases, removed too early;
    c. There was a failure to prepare for a second and subsequent waves of Covid-19, notably over the summer of 2020. This included a missed opportunity to develop an effective test and trace system, drawing on local public health expertise, and insufficient and unclear public health messaging which failed to provide the public, or those working in health and care settings, with clear guidance on how they could best protect themselves, their patients and families from the ongoing threat of Covid.

8. These decisions had huge impacts for healthcare workers by putting extra pressure on already stretched and stressed healthcare and public health systems, increasing workload, and causing moral distress and injury for doctors and healthcare workers who felt unable to provide the right level of care for all who needed it, including for non-Covid patients. Government actions - and inaction - very likely led to greater transmission of the virus, increased risk of harm for those who caught Covid including due to long Covid, and adversely impacted patients who required non-Covid care and treatment.

9. Module 2 focuses on UK government core decision-making, including the extent to which decision makers had regard to vulnerable and at-risk groups, including healthcare workers. These submissions highlight, under three broad categories, the BMA's key concerns regarding matters within the scope of Module 2. The three categories are:

a. Decisions affecting the public's health, including in relation to test and trace, lockdowns and other NPIs, and public health messaging;
b. Government decisions that put medical professionals at risk, either directly for example, in relation to Personal Protective Equipment (PPE), Infection Prevention and Control (IPC) guidance, risks assessments, and Covid testing for healthcare workers and patients; or indirectly, by adding pressure to the healthcare systems in which they worked; and
c. The disproportionate impact of Covid-19 on at-risk groups, including those from ethnic minority backgrounds.

A. Decisions affecting public health

Non-Pharmaceutical Interventions

10. The BMA's view is that UK Government decisions to implement public health measures, including a number of NPIs, to reduce the spread of Covid-19 were too slow to be implemented and were lifted too early. While this was particularly notable in the early weeks of the pandemic, it remained a feature throughout. This negatively impacted on healthcare workers, who faced more pressure as a result and were placed at greater risk of contracting Covid-19, and on patients, who were less able to access care as, at the start of the pandemic the system had to shift almost exclusively towards the delivery of Covid-19 care, and later had to juggle not insignificant levels of Covid patients with non-Covid patients.

11. As noted above, the UK Government was slow to respond to the emergence of Covid-19 globally. When the first cases reached the UK, Government decisions, such as the decision not to cancel mass gatherings or large sporting events in March 2020, undoubtedly led to higher cases, hospitalisations, and very likely deaths. At the time the first UK-wide lockdown was implemented on 23 March 2020, 11 days after contact tracing was abandoned, there were already 4,873 people in hospital with Covid-19.

12. The introduction of mandatory face masks for the general public is another clear example of an NPI which was introduced far too slowly and much later than in many other parts of the world. In England, the UK Government announced on 4 June 2020 that face coverings would be mandatory on public transport and for patients in NHS settings from 15 June 2020. Prior to this announcement (and as early as 25 April 2020), the BMA had been calling for the introduction of face coverings for the public where social distancing was not possible. The BMA also made repeated calls for face coverings to be introduced in a wider range of settings, beyond the initial requirements of wearing them on public transport and in healthcare settings. However, it was not until 24 July that it became mandatory to wear face masks in shops and supermarkets, and it was September 2020 before they were mandatory in hospitality settings for staff and customers as the UK faced a second wave of Covid-19.

13. When the first lockdown restrictions were eased from 1 June 2020, the BMA published a briefing setting out its key principles for easing the lockdown. This emphasised the need to continue to protect healthcare settings and workers, including through the guaranteed provision of PPE for staff, as well as a warning

that lockdown could only be successfully ended when there were effective test, trace and contact systems in place in all areas of the UK, measures which it is now abundantly clear were not sufficient at the time. In particular, in its determination to ease restrictions such as lockdowns, it is the BMA's view that the UK Government missed a key opportunity in the summer of 2020 to better prepare for the second wave of Covid-19, which many doctors were warning was coming.

14. In late June 2020, the BMA along with other UK medical, nursing and public health organisations wrote an open letter to all UK political parties published in the BMJ, calling for a forward-looking cross party rapid review to enhance national preparedness prior to winter. This was a considered and constructive intervention, intended to avoid attributing blame, focused on areas of weakness in the UK's response during the first Covid-19 wave, with a view to learning lessons ahead of the next wave. The BMA did not receive a direct response and understands that none of the other co-signatories received a response either.

15. Throughout the remainder of 2020, the BMA publicly called on the UK Government to do more to control the spread of Covid-19 and to prepare for future waves of the virus, particularly in the lead up to the winter of 2020. This included publishing a second document, *Exiting the lockdown: a strategy for sustainably controlling the transmission of Covid-19 in England,* in November, ahead of the planned easing of restrictions following a shorter lockdown in England (which took place between 5 November and 2 December 2020) and which was followed by a tiered system of local restrictions. As well as reiterating the need for an effective test and trace system and ongoing surveillance of Covid-19, the BMA called for the ongoing use of certain NPIs, including mask wearing, reduced household mixing and better ventilation, and emphasised the need for greater support for vulnerable groups and action to reduce health inequalities.

Test and trace

16. There was a failure to adopt a strategy to detect and contain the spread of Covid-19 at scale, which meant there was no plan for mass testing and tracing. The decision to abandon contact tracing on 12 March 2020, but not mandate population wide NPIs for a further 11 days when community transmission was increasing, left the UK without any effective measures for controlling the pandemic at a critical time, and likely fuelled the number of infections and harms from them, including the number of deaths. It also increased demand for acute care, placing more pressure on healthcare services than necessary.

17. The decision to abandon contact tracing was ostensibly because the UK was moving from the 'contain' to the 'delay' stage of the pandemic, although it later emerged that the decision was at least partly due to a lack of testing capacity. However, as the Inquiry heard in the hearings for Module 1, the UK did have existing diagnostic capability within 44 NHS laboratories that simply was not fully utilised. There was also significant expertise within local public health teams for local contact tracing that could have been more effectively used and capacity increased had it been properly resourced.

18. The rationale for decisions to make relatively little use of existing public sector testing infrastructure and contact tracing expertise needs to be examined.

19. After the decision to abandon contact tracing on 12 March 2020, contact tracing was not reinstated for several months – a critical period during which there was sustained transmission of the virus. When contact tracing was resumed, it was delivered via an outsourced "National Test and Trace" programme.

20. The UK Government's justification for outsourcing contact tracing and testing to the private sector and creating new systems at significant cost to the public purse, remains opaque. As the pandemic progressed, more use was made of local public health teams for contact tracing, reportedly due to failures with the national test and trace system to reach the percentage of contacts of Covid-19 positive patients needed for it to be effective in controlling transmission of the virus.

Public health messaging

21. Throughout the pandemic, the BMA has highlighted the absence of effective and proactive public health messaging from the UK Government. While the introduction of daily press briefings by the UK Government at the start of the pandemic were positive, it is the BMA's view that, particularly as the pandemic progressed beyond the initial stages, the UK Government failed to provide clear, consistent and visible public health messaging, which was necessary throughout the pandemic, particularly when the government messaging and focus shifted to personal responsibility.

22. For example,

    a. There was unclear messaging between 16 and 23 March 2020, when the public were encouraged, but not required, to change their behaviour (for example, mass events were discouraged, by withdrawing the support of emergency services for instance, but the events were not banned, and shops, restaurants and businesses remained open).
    b. The clarity and simplicity of early pandemic messaging which was effective and contributed to high levels of public compliance - 'Stay home, protect the NHS, save lives' - gave way to more ambiguous instructions for the public, in England especially. The UK Government slogan of 'Stay alert, control the virus, save lives' from May to September 2020 sent an unclear message to the public about what exactly they needed to do.
    c. It is also likely that government messaging supporting schemes such as 'Eat Out to Help Out', which encouraged social mixing, confused public health messaging during 2020, indicating that it was safe for people to socialise before vaccines were available and when the risks of Covid-19 remained high. These schemes should be evaluated for their impact not just on the economy, but also on transmission rates.
    d. The government campaign around working from home initially encouraged working from home, then required it, then strongly

discouraged it, encouraged it again and then required it again. This confusing messaging around working from home came at the same time as messaging on the UK Government's Eat Out to Help Out scheme, which encouraged social mixing and is likely to have further confused public health messaging at this time.

e. When PCR testing became available to the general public at the end of August 2020, there was insufficient testing capacity to meet demand. With many people unable to get tested or being offered tests hundreds of miles from their homes, public health messaging around getting tested did not reflect capacity constraints and is likely to have caused confusion and worry.

23. Clear, culturally competent and accessible public health messages (for example, for those who were hard of hearing or who did not have English as a first language) was essential but the UK Government - unlike the devolved administrations in Scotland and Wales - did not provide British Sign Language interpreters for the daily press briefings, one of the principal ways the public received public health information and advice about Covid-19. In several instances, the High Court later ruled that this breached equalities legislation. There was also a failure to provide translations of Covid-19 guidance and, even where translations were provided, they were often not updated as the guidance changed.

24. The frequency and nature of changes, the lack of clarity and consistency, and the distinctions between UK countries, undermined the public's understanding of, and confidence in, core public health messaging. High-profile failures of MPs and government leaders to adhere to lockdown rules or comply with recommended NPIs, fuelled mistrust and misinformation, and further impacted the effectiveness of public health messaging.

25. The increasingly prevalent political rhetoric about easing restrictions or 'freedom' from the summer of 2021 signalled to the public that the pandemic was over, and led not just to a reduction in mask wearing but it also made the job of enforcing IPC in healthcare settings more difficult. The lack of clear messaging to the public on issues such as mask-wearing had a direct impact on BMA members. In the experience of a worryingly high proportion of doctors who took part in the BMA's research, this led to hostility from some patients if they were asked to wear a mask in a healthcare setting.

26. By contrast the BMA was active in calling for the precautionary retention of certain measures and more balanced public health messaging, with a focus on keeping in place relatively low-cost interventions (such as mask-wearing and meeting outdoors wherever possible) to minimise interruptions to people's lives and, as far as possible, limit the spread of Covid-19 and the likelihood of developing long Covid (as well as to protect clinically extremely vulnerable who were understandably very nervous about taking part in public life given they continued to be at high risk from Covid-19).

27. There were also practical limitations of centralised decision making about guidance and public health messages. Announcing highly significant changes in guidance to the public via the media, at the same time as they were being

communicated within the public health community, undermined the effectiveness of local public health functions. This approach increased the challenge for public health professionals in interpreting and disseminating information and forming effective, trusting relationships with the public. It also had the effect of undermining relationships with, and trust among, those who were expected to explain current advice or mandated actions, or indeed attempting to manage a local outbreak.

28. One public health consultant in England told the BMA:

> *"Central guidance was often not written and provided until long after changes in guidance were announced, leaving regional PHE teams with nothing to share with LA [local authority] teams and destroying local relationships."*

B. The safety of healthcare workers

29. It is the BMA's view that doctors and healthcare workers were not sufficiently considered in UK government decisions. Despite early government messaging being 'Stay Home, protect the NHS, save lives', protection for healthcare workers was lacking throughout the pandemic. In the BMA's call for evidence as part of its Covid-19 Review, 81% of respondents said they did not feel fully protected during the first wave of the pandemic.

30. While the BMA recognises that many of these issues will fall for consideration within Module 3 of the Inquiry, the BMA believes that the lack of protection afforded to healthcare workers because of central decision making (including around procurement and management of PPE stocks, Covid testing, IPC guidance, etc.) are reflective of wider issues in how governments (and the UK government in particular) responded to the pandemic.

Personal Protective Equipment

31. The BMA's position is that there is no doubt that the provision of PPE to healthcare workers during the pandemic was hopelessly inadequate. PPE supplies were largely under the central coordination of the UK Government and government decisions and actions in relation to PPE supply, PPE procurement, domestic manufacturing of PPE all contributed to healthcare workers in general, and certain groups of healthcare workers in particular, being placed at greater risk of exposure to Covid-19 and suffering adverse physical and mental health outcomes as a result.

32. In the early weeks and months of the pandemic, shortages of vital PPE were especially acute, such as full-face visors, goggles, gloves, gowns and FFP3 respirators (which provide the greatest protection from aerosol transmission of infections and viruses). The BMA heard from many of its members that they either did not have the right protective equipment, or enough of it.

33. Medical professionals on the frontline often had to go without PPE, buy their own, use homemade, donated or expired items, and reuse single-use items.

Staff reported having to use items with multiple expiry stickers visibly layered on top of each other. The BMA was told:

> *"We made our own, and bought our own when we could find any, we depended on friends sourcing FFP3 masks, my son's school 3D printing visors."*

34. The Inquiry was told by several witnesses in Module 1 that the UK never ran out of PPE nationally and the challenge related to the logistics of delivering PPE across the country. However, this claim requires careful examination, particularly as the feedback from BMA members was that sufficient quantities and the right types of PPE did not reach them when they needed it. A medical academic consultant in England told the BMA:

> *"I was not allowed to use the PPE that I had personally paid for […] they said, it will be unfair to the rest of the staff if I used my own. When I said that I would be happy to share with people that I work with, they said, unless I could provide [for] everyone in the Trust, it won't be 'fair'."*

35. Being exposed to a deadly virus while treating patients without appropriate protection had a profound effect on the physical and mental health of doctors and other healthcare workers. Many doctors felt pressured to work in environments without sufficient PPE. This led to many healthcare staff being forced to work unprotected from the virus placing them at significant risk. Tragically doctors and healthcare workers died because of Covid-19 infection acquired in their workplace, and significant numbers are suffering from long Covid. Many more saw their mental health and wellbeing suffer, with high numbers during the pandemic reporting moral distress, which for some would have resulted in moral injury or post-traumatic stress disorder (PTSD).

36. The BMA consistently raised the shortages of PPE for healthcare workers and the disproportionate impact of PPE decisions on women and some staff from ethnic minority backgrounds (for example those who wear a beard or hair covering for religious reasons), who faced greater difficulties in finding well-fitting masks from the inadequate supply provided. In addition to this, doctors from an ethnic minority background and those with a disability or long-term health condition also were more fearful about speaking out.

37. From an early stage in the pandemic, the BMA also raised concerns that the PPE being supplied to healthcare workers fell short of the requirements recommended by the World Health Organisation (WHO) and was less adequate than equipment provided to healthcare staff in other countries. The BMA highlighted in correspondence to the Prime Minister, Public Health England (PHE) and NHS England the discrepancy between the level of PPE recommended by PHE, and that of the WHO and other nations.

38. This caused understandable concern amongst healthcare workers and created uncertainty about the levels of PPE to use. The BMA heard reports from doctors who were threatened with disciplinary actions for wearing PPE due to 'scaremongering' other staff and patients. A trust grade doctor in Wales told the BMA:

> *"I was redeployed to ICU [Intensive Care Unit] part way through from AMU [Acute Medicine Unit]. The difference in protection was stark. In ICU we had full PPE for anyone suspected and were told by consultants to take our own PPE to any ward patients to protect ourselves […] On the AMU side, even though there is an undifferentiated take, self bought masks were not permitted (as they would frighten patients!) until a while after the CDC [Centres for Disease Control and Prevention] and WHO [World Health Organisation] recommendations were made. It was clear that ICU was prioritised and wards were having other 'guidance' to protect PPE levels. This is not equity, and judging by the level of staff COVID sickness in wards compared to ICU, and patient breakouts, there are indicators that staff and patients came to harm during this time due to these differences."*

Infection Prevention and Control guidance and aerosol transmission of Covid-19

39. A key failure of government decision-making was, and continues to be, the failure to properly consider and acknowledge (and at an early enough stage) that Covid-19 was spread by aerosol/airborne transmission. This impacted on the protections available to healthcare workers, resulted in inadequate IPC in healthcare settings and insufficient stocks of appropriate PPE.

40. Due to the nature of their work, it is not unusual for medical professionals to be disproportionately exposed to harmful substances or viruses, meaning that proper occupational hygiene and IPC procedures, including access to good quality PPE, are imperative in healthcare settings to protect staff and patients.

41. Deficiencies in IPC guidance meant that respiratory protective equipment (RPE) (such as FFP2/3 respirators) were not always provided to staff who were treating patients with confirmed or suspected Covid-19. Apart from in the very early weeks of the pandemic, and for a brief period from January to March 2022, the IPC guidance for Covid-19 in healthcare settings – produced by the four-nation IPC Cell and published by PHE/the UK Health Security Agency (UKHSA) – has stated that a fluid resistant surgical mask (FRSM) is suitable protection for healthcare staff providing care to patients who were known or suspected to be positive for Covid-19, outside a limited list of specified Aerosol Generating Procedures (AGPs).

42. The limitations of surgical masks were well known prior to the pandemic, highlighted, for example, in a research report for the Health and Safety Executive in 2008 evaluating the relative levels of protection afforded by surgical masks and respirators against an airborne virus. This report concluded that surgical masks should not be used in situations where close exposure to infectious aerosols is likely.

43. There is evidence before the Inquiry that the lack of availability of FFP3 respirators was because cost considerations were prioritised ahead of safety in pandemic planning, leaving doctors and healthcare workers inadequately protected while delivering healthcare when the pandemic started.

44. Updated IPC guidance in January 2022 appeared to recognise the need for healthcare workers to have access to RPE when providing routine care for Covid-positive patients, but this was removed when the guidance was updated in March 2022.

45. Current IPC guidance continues to put healthcare workers and patients at risk by stating that surgical masks/FRSM are adequate protection for healthcare workers carrying out routine care for Covid positive patients, even though the same guidance acknowledges that Covid-19 can be spread by aerosols as well as droplets. The guidance also states that RPE "*must* be considered when *a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route* (emphasis added)."

46. Throughout the pandemic – and to this day – IPC guidance therefore fails to properly take account of the fact that actions such as coughing and sneezing are capable of generating more aerosol than AGPs. FRSMs do not provide adequate protection against a virus that is spread by the airborne route, which continues to leave healthcare workers unnecessarily exposed to the virus. One consultant in England told the BMA:

> *"We were advised full PPE for Covid positive patients ONLY if they were 'aerosol generating'. Covid positive patients were constantly coughing. In my opinion, coughing is aerosol generating too. But apparently, getting ourselves exposed to [a] Covid positive patient's cough is OK and only [a] flimsy plastic apron and blue mask are enough to protect one."*

47. The failure to provide healthcare workers with the right level of protection is therefore not simply historic but remains an ongoing issue of serious concern to the BMA and its members. Governments should have acted with greater caution and done more to protect against the airborne risk of Covid-19 by ensuring that IPC guidance recommended adequate protection for healthcare workers. This would have reduced the serious harm that affected so many of the BMA's members and the wider healthcare workforce, many of whom are still suffering today with long Covid acquired in their workplace.

48. The BMA has heard from countless doctors who are concerned about the failure to provide adequate respiratory protection:

> "*We were seeing patients who had COVID but because of the advice that was behind the curve, they were deemed to be low risk…We needed proper protection with FFP3 masks, but these were not considered necessary and were not provided. It was in April 2020, whilst wearing inadequate PPE that I caught coronavirus from a patient.*"

49. In addition to these deficiencies, respondents to the BMA's surveys reported that IPC guidance was often unclear, poorly communicated within the health and social care sector (including that it was often released late on a Friday), and that the frequency of changes made it difficult to implement. A consultant in England told the BMA:

> *"Rules that changed constantly. So frequently at the outset infection control couldn't produce the guidance before it changed again. Trust PPE guidelines were changed frequently once the pandemic started, and changes were sent out often in the evening or at weekends."*

Covid testing for patients and healthcare workers

50. There was an initial lack of testing capacity in the community and health and social care settings, which became more critical as Covid began circulating widely. This initial lack of capacity meant that even though testing was reserved for health and social care settings, there were not enough tests for all patients who needed one.

51. Medical professionals told the BMA that they were unable to test incoming patients, which meant that doctors were often coming into contact with Covid-positive patients. The shortage of available tests for medical professionals during the early stages of the pandemic, and delays in getting results, meant that Covid was transmitted unwittingly to patients and colleagues. A junior doctor in England told the BMA:

> *"There was a delay in allowing testing of all patients with possible COVID symptoms. I was seeing patients in A&E and being told I could not test them because they had not travelled to relevant countries. When testing was later allowed some of these patients unsurprisingly ended up testing positive. I saw these patients with no PPE due to hospital rules around when PPE was allowed to be worn."*

52. The lack of testing capacity also meant that healthcare workers did not have access to tests, which had a significant impact on workforce capacity. The BMA made repeated calls to prioritise testing for healthcare workers and their families to minimise the numbers of NHS staff required to self-isolate for up to 14 days, not knowing whether or not they had the virus, which was particularly important given the increasing shortages of frontline staff at the outset of the pandemic.

Risk assessments

53. Risk assessments are mandatory under health and safety law, an integral part of IPC practice, and an important tool in ensuring that employees are safe and protected at work. Yet these were often not performed or were inadequate, particularly during the first wave of Covid-19 in 2020.

54. It is the BMA's view that the UK Government failed to ensure that employers met their responsibilities under health and safety law and did not provide sufficient guidance or support for employers to undertake risk assessments in response to the risks posed to workers by Covid-19 in the workplace. This was a particular issue in environments where individuals were more exposed to the virus, such as in healthcare settings, leading to staff coming to harm.

55. Healthcare workers, including those more susceptible to serious illness from Covid-19, for example due to factors such as age, ethnicity, sex or underlying

health conditions, did not receive timely and adequate workplace risk assessments which could, if undertaken and acted upon, likely have prevented the death and long-term illness of some workers.

56. By May 2020, 64% of respondents to the BMA Covid tracker survey had not been risk assessed in relation to their potential contact with Covid. Around 4 in 10 of the respondents who had had a risk assessment felt that their risk assessment was ineffective at protecting them at work. Doctors from ethnic minority backgrounds experienced particular issues in relation to risk assessments and more commonly felt that these were ineffective, which was especially concerning given that ethnic minority doctors made up 44% of the profession.

57. In addition, some doctors from ethnic minority backgrounds, despite being at higher risk from the virus, told the BMA that they felt their protection was sacrificed to maintain staffing levels. The BMA heard that:

> *"Risk assessment was not carried out. I think this was because high BAME staff numbers which would have led to more staff being off isolating."*
>
> (Salaried GP, England, African)

> *"[Risk assessment] was not automatically initiated, when pushed to get assessed, was initially taken as trying to get out of work. As a BAME, >45 yrs, [Diabetes] and Asthma, I was expected to continue doing home visit[s]."*
>
> (Salaried GP, England, has a Disability/LTC, Indian)

58. In a letter dated 28 April 2020 the BMA asked NHS England to develop a national risk profiling framework to assist employers in conducting risk assessments, to take account of factors such as age, ethnicity, sex and underlying health conditions to enable proportionate action to protect healthcare workers at heightened risk from Covid-19.

59. It was not until 24 June 2020, three months into the pandemic, that NHS England issued a letter reminding employers of their legal responsibilities to undertake risk assessments for their staff.

60. Ultimately, in the absence of clear guidance from national bodies, the BMA produced its own risk assessment tool for members along with separate guidance for GPs. The fact that the BMA was required to take this step, is clear evidence of the failure of central government, NHS employers and the Health and Safety Executive to ensure that the legal duties to keep healthcare workers safe in their place of work were met.

C. Inequalities

61. The pandemic highlighted disparities within society, widened health inequalities, and impacted groups differently.

62. People from some ethnic minority backgrounds, including Black and South Asian people, were more likely to become infected with Covid-19 and were

more likely to die from Covid-19 than people from white British backgrounds, particularly in the first wave of the pandemic. Analysis by the Health Service Journal found that 94% of doctors who died up to April 2020 were from ethnic minority backgrounds, even though this group makes up only 44% of NHS medical staff.

63. The BMA was one of the first organisations to publicly raise concerns about the disproportionate impact of the pandemic on people from ethnic minority backgrounds, both those working in healthcare roles and the wider public right at the start of the pandemic. On 9 April 2020, the chair of council for the BMA wrote to the CEO of NHS England raising concerns about the disproportionate impact of Covid-19 on people from ethnic minority backgrounds and the high rates of Covid-19 deaths amongst healthcare workers from these backgrounds. The BMA also highlighted underlying structural and social inequalities and the need for these factors to be considered when developing guidance and measures. On 10 April 2020, the BMA's chair of council called publicly for an urgent review into why people from ethnic minority backgrounds are more vulnerable to Covid-19, which the UK Government announced on 16 April PHE would be undertaking. The BMA engaged constructively with the review, but expressed disappointment when it was published, including raising concerns that the review lacked tangible recommendations and also about reports that pages had been removed from the report before publication.

64. Throughout the pandemic, the BMA raised concerns about particular at risk or vulnerable groups, including healthcare and other key workers, people from ethnic minority backgrounds, clinically vulnerable people (due to pre-existing medical conditions or other factors), the elderly, those living in care settings, people with a disability, people on low incomes or living in areas of higher deprivation, people who were homeless or at risk of homelessness, those without official immigration status, women, and children and young people. This often focused on the easing of restrictions and the need to ensure people who were vulnerable were not forgotten and measures were in place to protect them from the ongoing risks of Covid-19.

65. The BMA also consistently called for better self-isolation payments to ensure greater compliance with self-isolation measures, particularly for those who were least able to afford loss of income. The financial barriers to following public health guidance impacted the effectiveness of the government's public health measures to control the spread of the virus and increased the risk to individuals.

66. Assessments of the likely impact of NPIs on vulnerable groups in the context of existing inequalities is central to the Inquiry's Module 2 investigation. The BMA submits that the Inquiry should also examine the timeliness of any assessments, the extent to which early warnings about disproportionate impacts were adequately taken into account in decision making, and the extent to which action was taken as a result of these assessments to mitigate disproportionate impacts on vulnerable groups.

67. It is not just in the context of NPIs that vulnerable groups were impacted by government decisions. In order to free up the maximum possible inpatient and

critical care capacity, NHS England and NHS Improvement asked NHS providers on 17 March 2020 to urgently discharge all hospital inpatients who were medically fit to leave. Significant numbers of these patients were at increased risk of Covid-19 mortality as a result of their age and long-term health conditions and were discharged into care homes whose residents were also more vulnerable to the impact of Covid-19. It was not until 15 April 2020 that a policy to test those being discharged was introduced in England and it is estimated that by this time some 25,000 people had been discharged into care homes (although the exact figure is unknown).

68. In evidence to the Health and Social Care Committee in October 2021, the BMA described this decision as a major failure, and it has been widely accepted as such. This decision needs to be examined carefully so that the Inquiry can evaluate the decision-making process, assess what, if any, consideration was given to the likelihood of Covid-19 transmission to vulnerable individuals, and understand the impact of this decision on infection and mortality, particularly in the context of a widespread lack of PPE and Covid-19 testing, as previously outlined.