# UK COVID-19 PUBLIC INQUIRY

_____

## Witness Statement of Professor Philip Banfield

_____

I, Professor Philip Banfield, of the British Medical Association (the BMA or the Association), will say as follows:

1. I am chair of the BMA's UK council, chair of the BMA's board of directors and a member of the chief officer team of the BMA. I am a Consultant Obstetrician and Gynaecologist based in North Wales and am honorary professor in the Cardiff University School of Medicine. Before being appointed as chair of council, I spent several years as a representative of BMA Cymru Wales, as chair of both Welsh council and the Welsh consultants committee. I have sat on the UK council since 2012.

2. I provide this statement in response to a request for evidence made on 15 December 2022 by the UK Covid-19 Public Inquiry (the Inquiry) under Rule 9 of the Inquiry Rules 2006 in connection with Modules 2, 2A, 2B and 2C of the Inquiry.

3. The headings used in this statement reflect the topics and questions set out in the Inquiry's Rule 9 request.

4. The Inquiry has also asked the BMA to produce a chronology illustrating the timeline and nature of the BMA's role in response to the Covid-19 pandemic, including events, advice and key decision-making in which the BMA was involved, and key meetings between 1 January 2020 and 30 May 2022. Chronologies covering events relevant to BMA UK, BMA Northern Ireland, BMA Scotland and BMA Cymru Wales have been provided to the Inquiry.

5. I took on the role of chair of council of the BMA in July 2022, after the period identified by the Inquiry as having particular relevance to the Rule 9 request (namely, 1 January 2020 to 30 May 2022). In providing this corporate statement to the Inquiry, I have therefore sought input and assistance from colleagues in BMA Northern Ireland, BMA Scotland and BMA Cymru Wales, as well as from relevant policy, communications and operational UK teams across the Association. The information contained within this statement is true to the best of my knowledge and belief.

1

Witness name:        Professor Philip Banfield
Statement number:    1

## A. BMA's role, function and responsibilities

6. The BMA is a professional association and trade union for doctors in the UK. It represents, supports and negotiates on behalf of all doctors and medical students in the UK, including across all branches of medical practice and specialities. It has a membership of approximately 186,000 (over half of practising doctors).

*Senior elected leadership*

7. The Association's senior elected leadership is comprised of four chief officers. These are:

   a. The chair of council, who chairs the UK council and the BMA's board. The chair provides strategic leadership in developing and implementing BMA policies and represents the views of all BMA members externally.

   b. The deputy chair of council deputises for the chair of council both internally and externally. The deputy chair leads on issues and strategic projects as delegated by the chair of council and sits on the BMA board.

   c. The chair of the representative body is responsible for chairing and the smooth running of the Annual Representative Meeting (ARM) and ensuring that the policy set by the ARM is acted on by the Association. The chair of the representative body sits on the BMA board and the BMA council, and leads the Association's policy work in particular areas, including workforce and climate change.

   d. The treasurer is responsible for the good stewardship of the Association's financial and property assets, and chairs key governance committees including the finance committee. The treasurer is a member of the BMA council and is deputy chair of the BMA board.

8. The BMA also appoints a President to serve a one-year term of office, commencing at the completion of the BMA's ARM held in June or July each year. The President undertakes work within and through the BMA on areas of interest and often represents the BMA at events or acts as media spokesperson on these issues. Past Presidents have undertaken projects focused on health inequalities, children's health and the

Witness name:        Professor Philip Banfield

Statement number:    1

economic value of health. The President's role is largely ceremonial, and they do not play a role in the day-to-day running of the Association, although they are invited to sit, ex officio, as a non-voting member on all committees, including the UK council (with the exception of the organisation committee).
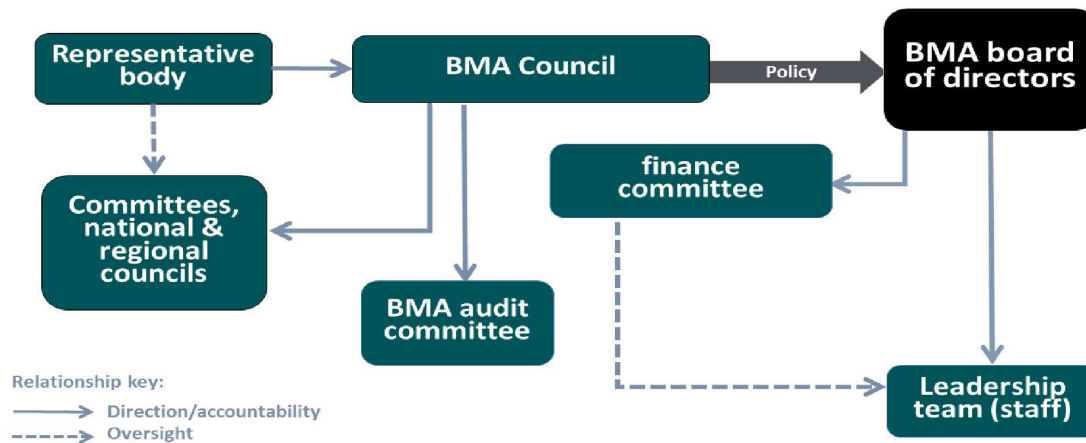
*Senior staff leadership team*

9. The BMA's senior staff leadership team works closely with the Association's chief officers and elected members. The co-chief executives lead the senior leadership team and BMA staff in the day-to-day running of the BMA. This involves the provision of services to members, such as employment advice, alongside delivering on the policies and priorities of BMA members, committees and their elected members in the BMA's role as a professional association and a trade union. The senior leadership team structure is set out below:
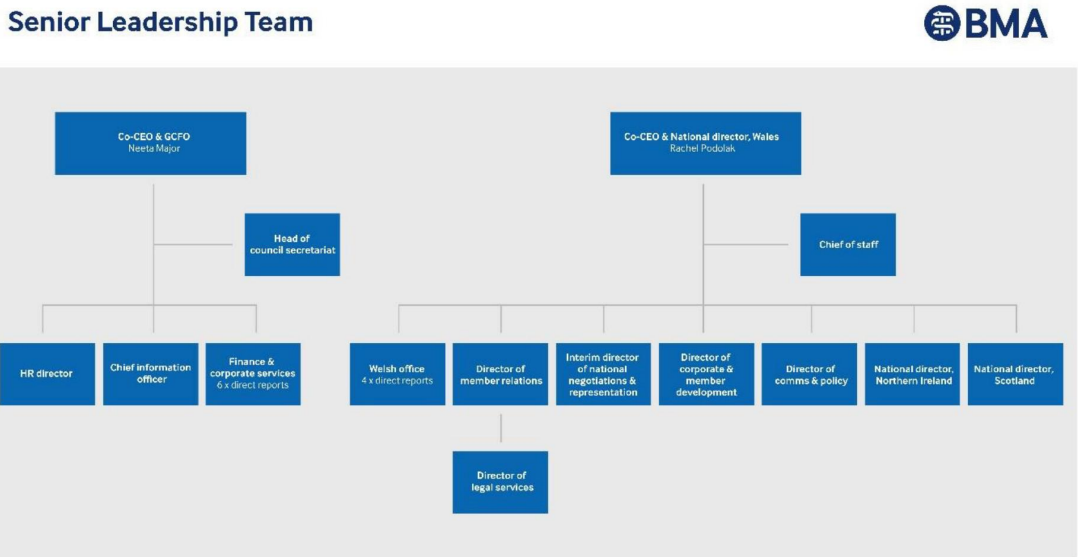


*Governance*

10. The BMA's elected representational structure involves several local, regional and national forums. The relationship between the different governance bodies of the BMA is illustrated by the following diagram:

Witness name:     Professor Philip Banfield

Statement number:     1

**Relationship key:**
→ Direction/accountability
---→ Oversight

11. The following bodies operate at a UK-wide level:

  a. **The representative body:** This is the main policy-making function for the BMA, meeting once a year at the ARM. Members of the representative body are elected by their peers, doctors and medical students from constituent bodies including divisions and branches of practice.

  b. **BMA UK council:** As the Association's principal executive committee, the UK council is responsible for the lawful conduct of the Association as a recognised trade union and as a professional association. UK council sets the strategic direction of the Association (with the board) and co-ordinates the implementation of policy decided by the representative body at the ARM. It has the power to formulate and implement policies in between meetings of the representative body.

  c. **Board of directors:** The board is responsible for the management of the finances, operational administration, and strategic direction (with the UK council) of the BMA, in addition to oversight of the British Medical Journal (BMJ) (which is wholly owned by the BMA). The composition of the board of directors is outlined in the Articles of Association and Bye-laws of the BMA and includes:

    i. the council chair (chair of the board);

    ii. the representative body chair;

    iii. the treasurer (deputy chair of the board);

    iv. the deputy chair of council;

4

v.   three medical persons as may be elected and/or replaced by council from time to time;

vi.   the chief executive officer;

vii.   the group chief finance officer;

viii.   one lay (non-medical) person experienced in business and commerce to be elected and/or replaced by council from time to time;

ix.   the BMJ chair.

Currently, the council has also appointed an additional lay (non-medical) person to the Board.

d.  **Branch of practice committees:** Reporting to the UK council, there are 12 UK branch of practice committees that represent doctors in different areas of medical practice, for example, GPs, consultants, junior doctors and public health. Branch of practice committees have delegated authority to negotiate terms and conditions of service. A list of branch of practice committees is included at paragraph 38 below.

e.  **Professional activities and special interest committees:** Reporting to the UK council, the professional activities and special interest committees represent the interests of doctors and patients across a range of professional activities and special interests. There are currently 11 UK professional activity and special interest committees. A list of professional activities and special interest committees is included at paragraph 45 below.

12. At the devolved level, the following bodies operate:

a.  **Northern Ireland council, Scottish council and Welsh council:** reporting to the UK council, the national councils consider all matters of specific relevance to the medical profession and healthcare in their nations. They determine policy and action where the application is exclusive to their nation. The BMA's national offices have their own elected branch of practice structure and executive-led teams to enact policies set at the ARM that are relevant to their respective countries. Branch of practice committees have delegated authority to negotiate terms and conditions of service.

5

b. **English Regional councils:** these are forums to discuss matters of regional interest, and report into the UK council. Regional councils do not have devolved authority.

13. The following structures also operate at a local level throughout the UK:

a. **BMA divisions:** Every UK BMA member belongs to one of 180 divisions, which bring together members in all disciplines and branches of practice in their local area.

b. **Local negotiating committees and forums:** Each trust and health board has a local negotiating committee that has the authority to make collective agreements with local management on behalf of medical and dental staff of all grades.

*Organisational roles within the BMA relevant to the pandemic response*

14. The Inquiry has asked the BMA to identify the names of individuals carrying out specific organisational roles within the Association that are relevant to the response to the Covid-19 pandemic, particularly any individual who was also a member of public health committees or scientific bodies in the UK or the devolved nation governments, including SAGE.

15. There were no individuals within the BMA who were designated roles specifically focused on the response to the Covid-19 pandemic. Given the wide-ranging impact of the pandemic on the BMA's membership and on so much of the BMA's work, a large number of elected members and staff were involved in the BMA's response to the pandemic.

16. At a UK level, this work was overseen by the BMA's chair of council at the time, Dr Chaand Nagpaul. The chair made decisions in close consultation with the following:

a. The BMA's chief officers.

b. Senior staff, such as the CEO and the Directors of Communication and Policy.

c. Staff with expertise in policy, communications and the negotiation of terms and conditions.

d. Senior elected members, such as the chairs and other representatives of BMA committees.

6

17. Within the devolved nations, the pandemic response was headed by the chairs of the relevant national council, supported by the national directors and other relevant staff.

18. Decision making across the BMA was supported more broadly by a wide group of members who shared their expertise and experience, primarily through the meetings described in paragraph 19 below, as well as through direct engagement with staff on specific issues.

19. From late March 2020, daily virtual meetings were established, internally within the BMA, to ensure that the leadership was well informed of the latest developments, key emerging evidence and the Government response, and to share insight and concerns that were emerging from the frontline of the NHS (including from the BMA's own member relations teams across the nations, which are responsible for closely supporting members in their place of work), from public health and from social care. The daily calls were attended by the CEO, chief officers of the BMA, chairs of the branch of practice and other key committees (e.g., ethics) and senior staff from across the organisation, including the Directors of the BMA Northern Ireland, Scotland and Wales Cymru offices.

20. These meetings reduced in frequency over time but continued on at least a weekly basis until the end of 2021 and then on at least a monthly basis, until the summer of 2022. Outside of the meetings, members of this group were updated via a dedicated email channel (known within the BMA as a 'listserver'), with many cascading that information to their respective constituencies.

21. To the best of my knowledge, no elected member of the BMA was a member of any official public health committee or scientific body with responsibility for advising or reporting to governments in the UK or devolved nations about the response to Covid-19, including SAGE.


*BMA's role, function and responsibilities relevant to the pandemic response*

22. Throughout the pandemic, the BMA has worked to protect and support doctors and the medical profession, healthcare staff, patients and the wider UK population through the following:

    a. Providing individual support to members, for example, through employment advice teams and the BMA's wellbeing services.

7

b. Providing guidance to doctors and their employers, particularly when this was not forthcoming from governments or their agencies, including in relation to risk assessments and ethical guidance.

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 (such as providing evidence to Select Committee Inquiries and devolved equivalents and responding to consultations). Key areas that the BMA sought to influence included:

  i. Standing up for the medical profession and challenging decisions that put healthcare staff and patients at risk, including in relation to Personal Protective Equipment (PPE), risk assessments, Covid testing and non-pharmaceutical interventions (NPIs).

  ii. Highlighting the disproportionate impact of Covid-19 on at-risk groups, including those from ethnic minority communities.

  iii. Calling for improved measures to protect the public's health, including better resourced public health functions and improved financial support for those having to self-isolate.

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 our policy and campaigning activities.

23. As discussed in more detail in paragraph 52, ways of working with governments varied across the UK nations. In particular in Scotland and Wales, the BMA was often working more collaboratively and in social partnership on issues, including the development of guidance on issues such as risk assessments.

*Structure, role, function and responsibilities of the BMA in the UK, England, Northern Ireland, Scotland, and Wales*

24. The BMA is a professional association and trade union. It is a leading voice advocating for outstanding healthcare and a healthy population, providing members with individual

8

services and support throughout their lives. As a trade union, the BMA is formally recognised for collective bargaining purposes at a UK, national and local level.

25. The BMA's current mission statement is 'We look after doctors so they can look after you'. Its vision is 'a profession of valued doctors delivering the highest quality health services, where all doctors:

    a. Have strong representation and expert guidance whenever they need it.

    b. Have their individual needs responded to, through career-long support and professional development.

    c. Are championed by the BMA and their voices are sought, heard and acted upon.

    d. Can connect with each other as a professional community.

    e. Can influence the advancement of health and the profession.'

26. Staff and elected members work to support, protect and represent BMA members across all four nations. This includes ensuring doctors' voices are heard by policymakers across the UK's governments and healthcare systems, negotiating on pay, terms and conditions and the provision of employment support and advice.

BMA UK

27. The structure of the BMA at a UK-wide level is set out at paragraphs 10 to 11 above.

28. As already mentioned, the BMA's UK council is the Association's principal executive committee. The UK council has 69 voting members who are elected every four years (except the three medical student members who are elected for a two-year term). Each member is directly elected by the BMA's membership to give a UK wide, geographical and branch of practice mix, in addition to five seats which are held for members who identify as from an ethnic minority. The UK council also has non-voting ex-officio members, including the BMA's President, UK chairs of branch of practice committees and chairs of national councils. The UK council appoints members to central boards and committees and can establish additional committees and working groups.

29. The chair of the UK council provides political leadership for the BMA at a UK level and leads on engagement with the UK Government.

9

Witness name:        Professor Philip Banfield

Statement number:    1

30. In each devolved nation, a national director leads a team of staff who work closely with their national chair of council, branch of practice chairs and committees in delivering the policies and priorities of the membership in that nation, as well as delivering employment support and advice for members working around the UK.

31. On an operational level, the national directors of each nation sit on the BMA's senior staff leadership team (see paragraph 9 above).

32. The BMA's Northern Ireland, Scottish and Welsh councils have full delegated authority to consider matters of specific relevance to the medical profession and healthcare in their nations. They determine policy and action where the application is exclusive to that nation. As with the UK council, a significant proportion of members of the Northern Ireland, Scottish and Welsh councils are directly elected and broadly reflect the geographical and branch of practice distribution of the profession in that nation.

33. The chair of each national council provides political leadership for the BMA in their respective nation and is a focal point for engagement with the devolved government in that nation and associated organisations and agencies.

34. National branch of practice committees in the devolved nations have full delegated authority to negotiate on devolved matters with their respective employers and governments. They report into their respective UK wide branch of practice committees and to their national council with branch of practice committee chairs sitting on their national council.

35. The Northern Ireland council has 24 directly elected members covering all branches of practice, the four BMA divisions in Northern Ireland and the five Health and Social Care Trusts. Members of council are elected every three years and the current constituted Northern Ireland council runs from 2021 to 2024.

36. The Scottish council has 35 voting seats, each assigned to a particular grade and/or region of Scotland: consultants, GPs, Specialty and Associate Specialist doctors, junior doctors, students, medical academics, retired members, and other branches of practice not represented, such as those working in the civil service, armed forces, or occupational health. The voting members are elected for a three-year term of office. The current term of office runs from July 2020 to July 2023.

37. The Welsh council includes the chairs of all Welsh branch of practice committees as voting members. This includes the Welsh Consultants Committee, the General

Witness name:        Professor Philip Banfield

Statement number:    1

Practitioners Committee (GPC) Wales, Welsh Staff Grades & Associate Specialists Committee, Welsh Junior Doctors Committee, Welsh Medical Students Committee, the Welsh Committee of Public Health Medicine, and the Forum of Welsh Local Negotiating Committees. There are also 15 directly elected members with voting rights, who are elected for three sessions (a session runs for 12 months between ARMs). Ex-officio members of the Welsh Council include the BMA chief officers, the president of the BMA, and any UK council member with a registered address in Wales. The chair of the Welsh Council is elected triennially for a maximum of six sessions, whereas the deputy chair is elected annually and is eligible for re-election.

*Role and function of branch of practice committees, including the Public Health Medicine Committee, Board of Science, and the Medical and Academic Staff Committee*

UK

38. The BMA's branch of practice committees represent and advance the interests of doctors working across all specialities, and at all stages of their career, to governments, devolved nation governments, and other organisations. They are officially recognised in national negotiations for NHS doctors and by the independent review body on doctors' and dentists' remuneration (DDRB). There are 12 UK branch of practice committees, as follows:

   a. Armed forces committee

   b. Civil and public services committee

   c. Consultants committee

   d. Forensic medicine and secure environments committee

   e. Junior doctors committee

   f. General Practitioners committee

   g. Medical academic staff committee

   h. Medical students committee

   i. Occupational medicine committee

   j. Public health medicine committee

   k. Retired members committee

   l. Staff, associate specialist and specialty doctors committee

11

39. The Inquiry has asked specifically about the Public Health Medicine Committee, the Board of Science, and the Medical and Academic Staff Committee.

40. The Public Health Medicine Committee considers matters affecting public health medicine and public health physicians in the UK but with a particular focus on England. This includes the terms and conditions of service of public health doctors, whether employed by the NHS, local authorities or private employers and defending and promoting public health as a medical speciality.

41. The Medical and Academic Staff Committee represents all medically qualified teachers and research workers that hold contracts of employment from a university, medical school, the Medical Research Council, or other non-NHS institutions engaged in medical research. It acts upon issues relevant to these groups of doctors, including in relation to pay and conditions, participation in research, clinical academic training and career development and advocates on behalf of academic medicine generally.

42. The committee structure in Northern Ireland includes the Northern Ireland Public Health Medicine Committee and the Northern Ireland Medical Academic Staff Committee, however these committees are currently inactive and were both inactive during the requested time period (1 January 2020 to 30 May 2022).

43. In Wales, the Welsh Committee for Public Health Medicine represents public health physicians in that nation. Formally, it reports to the BMA's Welsh council, but it also provides updates to the UK Public Health Medicine Committee at its quarterly meetings and at the intervening UK Public Health Medicine Committee Executive meetings. There is no Medical Academic Staff Committee in Wales.

44. There is no Public Health Medicine Committee or Medical Academic Staff Committee in Scotland, although these specialities are represented on the Scottish council.

45. The BMA's professional activities and special interest committees represent the interests of doctors and patients across a range of professional activities and special interests, providing reports to the BMA's UK council. There are 11 such committees, as follows:

   a.  Board of science

   b.  Community care committee

   c.  International committee

   d.  Junior members forum

Witness name:        Professor Philip Banfield

Statement number:    1

e. Medical ethics committee

f. Medico-legal committee

g. Patient liaison group

h. Pensions committee

i. Private practice committee

j. Professional fees committee

k. Medical managers committee

46. The Board of Science has a UK wide remit and promotes the medical and allied sciences, contributes to the development of effective public health policies, and supports medical research. It plays an influential role in forming government and public opinion on public health issues for the benefit of doctors and patients, through hosting events, publication of policy reports, web resources, guidance documents and briefings.

Devolved Nations

47. BMA Northern Ireland has the following functioning committees (in addition to the Northern Ireland council):

   a. Northern Ireland consultants committee;

   b. Northern Ireland general practitioners committee;

   c. Northern Ireland junior doctors committee;

   d. Northern Ireland Specialty and Associate Specialist committees;

   e. Northern Ireland medical students committee.

   f. Northern Ireland Forum of Local Negotiating Committees

48. Each committee has delegated authority to negotiate on issues affecting members in Northern Ireland including terms and conditions of employment. Members of each committee are elected from the membership of each branch of practice across Northern Ireland.

49. BMA Scotland has the following committees (in addition to Scottish Council):

   a. Scottish Consultants Committee

   b. Scottish General Practitioners Committee

13

c. Scottish Staff Grades and Associate Specialists Committee

d. Scottish Junior Doctors Committee

e. Scottish Medical students Committee

f. Scottish Local Negotiating Committees Forum

50. BMA Cymru Wales has the following committees (in addition to the Welsh council):

a. Welsh Consultants Committee

b. the General Practitioners Committee Wales (GPC Wales)

c. Welsh Staff Grades & Associate Specialists Committee

d. Welsh Junior Doctors Committee

e. Welsh Medical Students Committee

f. the Welsh Committee of Public Health Medicine

g. the Forum of Welsh Local Negotiating Committees.


## B. Liaison and communication with the UK Government and Devolved Nation Governments


51. The Inquiry has requested high level summaries of the BMA's working relationship with the Office of the Chief Medical Officer, the UK Health Security Agency or Public Health England, and the Secretary of State for Health or other ministers or senior civil servants within (i) the UK Government and (ii) the equivalent ministers/bodies in each of the Devolved Nations with regards to emergency response measures taken in relation to Covid-19 through the period 1 January 2020 to 30 May 2022.

52. The ways in which the BMA engaged with Government Ministers and senior civil servants throughout the pandemic, and the issues on which the BMA sought to influence, varied between the BMA UK office and offices in each of the devolved nations. This variation was the result of a number of factors:

a. The BMA's devolved nations' offices are significantly smaller with fewer staff and resources than the BMA's UK office based in London. Therefore, during the pandemic these teams tended to prioritise issues directly affecting their

14

members' and their working lives, leaving interventions on the wider Covid-19 response (such as NPIs) to the UK council chair and central BMA teams.

b. The devolved nations' Governments took different approaches to the UK Government on NPIs, often acting earlier to introduce protections and being slower to relax these.

c. There were different pre-existing relationships and established ways of working in each nation, with the devolved nation governments often working more collaboratively with stakeholders such as the BMA. As noted throughout this section, the political situation in Northern Ireland also complicated ways of working and relationships.

*Working relationships at the UK level*

Secretary of State for Health and Social Care (SoS) and Ministers of State

53. The BMA considers that it had good access to the SoS and ministers within the Department of Health and Social Care (DHSC) during the pandemic, including the period covered by this Rule 9 request.

54. In particular, the BMA's chair of council had regular (approximately monthly meetings) with Matt Hancock when he was SoS. The BMA chair of council and senior staff also had regular meetings with Minister of State (September 2019 – July 2022) Ed Agar MP, and Minister of State (February 2020 and September 2021) Helen Whately MP, both on a 1:1 basis and as part of the Social Partnership Forum (SPF) Wider Group[1].

55. The chair of the BMA's General Practitioners Committee (GPC) for England also attended regular meetings with the Parliamentary Under Secretary of State for Primary Care and Public Health, Jo Churchill MP, between March and June 2020. From this point the meeting agenda changed from solely being to discuss Covid-19, but meetings continued throughout the pandemic which included Covid-19 as a substantive agenda

---

[1] The SPF brings together NHS Employers, NHS Trade Unions, NHS England, Health Education England and the DHSC to contribute to the development and implementation of policy that impacts on the health workforce. The SPF Wider Group is the most senior SPF Group and is chaired by a health minister although during the pandemic, chairing duties were often delegated to a senior civil servant. The SPF also has a number of sub-groups both ongoing and set up for particular issues. This included the SPF Covid-19 Engagement Forum which was established during the pandemic. More information about the SPF can be found here: INQ000236244

Witness name:         Professor Philip Banfield

Statement number:     1

item. The BMA chair of council also met with Jo Churchill when she was deputising for other ministers.

56. These meetings allowed the BMA to raise issues of concern to the BMA and its membership and to set out how the BMA thought the Government should respond on certain issues relating both to the wider public health response to the pandemic, including NPIs, but also on other matters directly affecting doctors and other healthcare workers (such as access to PPE or the impact of the pandemic on staff from a minority ethnic background). However, this engagement did not always lead to government decisions and actions that the BMA felt were appropriate. In these instances, the BMA was proactive in publicly criticising government actions or inactions that it considered put the wider population and healthcare workers (including doctors) at risk; that were likely to lead to greater transmission of the virus; or that were likely to increase pressure on healthcare services.

Chief Medical Officer (CMO) for England

57. While the BMA did not have regular recurring meetings with the CMO for England, the CMO made himself available to meet at the Association's request to discuss issues of concern. This was primarily with the BMA's chair of UK council, often with senior staff from the BMA's Public Affairs team in attendance. Occasionally other elected members of the BMA also attended, e.g., the BMA branch of practice committee chairs.

58. These meetings were held to discuss a range of issues during the pandemic, including availability and adequacy of PPE for healthcare staff and the UK Government's approach to relaxing lockdown measures (e.g., in Christmas 2020).

59. As well as providing an opportunity to raise concerns, these meetings allowed the BMA to better understand the factors which the CMO was considering when advising the UK Government on the UK's Covid-19 response. The BMA and CMO did not always agree on the best approach, but the relationship allowed for a free and frank exchange and for the BMA to put forward concerns on behalf of its members.

Public Health England (PHE) / UK Health Security Agency (UKHSA)

60. The BMA did not have regularly recurring meetings with representatives of PHE/UKHSA. Engagement was primarily through formal written communication on issues of concern, such as access to PPE for healthcare workers or the Infection Prevention and Control (IPC) Guidance. Details of these communications are included

Witness name:      Professor Philip Banfield

Statement number:      1

within the BMA's chronology and general disclosure, provided separately to the Inquiry.

61. BMA public affairs and policy staff also attended stakeholder calls with the IPC Cell, a body that includes senior representatives of PHE/UKHSA, at which updates were provided about changes to the IPC guidance.

62. The BMA received updates from PHE/UKHSA through the SPF Covid-19 Engagement Forum (detailed further at paragraph 94 below).

Department of Health and Social Care (DHSC)

63. As with PHE/UKHSA above, the BMA received updates on issues of relevance from senior civil servants and DHSC representatives through the SPF Covid-19 Engagement Forum (see paragraph 94 below).

64. Stakeholder meetings were hosted by the DHSC with speakers such as the Deputy CMO to brief attendees on the latest issues (e.g., the Deputy CMO stakeholder call on shielding for the general public held at the end of July 2020). DHSC also hosted briefing calls where details of some key government announcements were outlined in advance of the announcement being made.

65. Staff members from the BMA's Public Affairs team were also in regular email contact with contacts within DHSC to share information or seek clarity on particular issues.

NHS England

66. The BMA had significant engagement with senior officials from NHS England throughout the pandemic. This included regular meetings between the chair of the BMA's Consultant's Committee and Professor Stephen Powis, Medical Director for NHS England to discuss Covid-19. These were often weekly/fortnightly meetings and discussions included PPE, Covid-19 testing, risk assessments, and the disproportionate impact of Covid on ethnic minority staff. The chair of the BMA's GPC also attended regular meetings with Professor Powis, along with representatives of some of the Medical Royal Colleges. BMA staff were regularly in contact with NHS England colleagues on matters relating to the pandemic response. While these were often about operational issues, wider issues about the pandemic response were discussed.

67. Specific examples of the BMA's engagement with NHS England included, in relation to:

Witness name:     Professor Philip Banfield

Statement number:     1

a. PPE shortages and IPC guidance – letters dated 24 March 2020 (PB/87 – INQ000097932), 27 March 2020 (PB/193 – INQ000097943), 06 July 2020 (PB/194 – INQ000097855), 23 December 2021 (PB/195 – INQ000097930) and 30 December 2021 (PB/196 – INQ000097955), email communication on 31 March 2020 (PB/197 – INQ000117819) and 10 August 2020 (PB/198 – INQ000118065), and meetings on 02 April 2020 (PB/199 – INQ000117821), 10 August 2020 (PB/200 – INQ000117760) and 15 December 2020 (PB/201 - INQ000118248).

b. Disproportionate impact on ethnic minority communities – a letter dated 09 April 2020 (PB/72 - INQ000097864) and a meeting on 15 April 2020 (PB/202 – INQ000117849).

c. Risk assessments – letters dated 28 April 2020 (PB/56 – INQ000097947), 20 May 2020 (PB/57 – INQ000097908) and November 2020 (PB/118 - INQ000118181).

d. Covid-19 testing – letter on 28 March 2022 (PB/203 – INQ000097946).

*Working relationships within Devolved Governments*

68. BMA Northern Ireland has a constructive relationship with civil servants and the Minister for Health in Northern Ireland, and this continued throughout the Covid-19 period. The context in Northern Ireland was that following three years of having no functioning Executive or Assembly, the institutions reformed on 11 January 2020, when UUP MLA Robin Swann assumed the office of Minister of Health under the D'Hondt method. The five-party mandatory coalition in Northern Ireland meant that the full Executive had to agree on measures taken rather than one party making the decisions, which differed from other parts of the UK at that time. The Northern Ireland Health Minister would propose actions to the Executive which would then be agreed or not agreed.

69. In addition to regular engagement with the Minister for Health, BMA Northern Ireland engaged (albeit less frequently) with the Chair of the Northern Ireland Assembly Health Committee, Colm Gildernew MLA (Sinn Féin).

70. BMA Scotland had a good working relationship with the Scottish Government, CMO, Cabinet Secretary for Health and senior civil servants throughout the period in question, with regular telephone discussions, scheduled meetings and email

Witness name:    Professor Philip Banfield

Statement number:    1

exchanges between the BMA Scotland national director and her team, and relevant officials and civil servants. This included a clear and direct offer from the Cabinet Secretary, Jeane Freeman, to raise immediate problems directly with her office should BMA members become aware of any. This led to occasional meetings between the BMA Scotland chair of council and national director with the Cabinet Secretary for Health. Similarly, there were occasional meetings between the BMA Scotland chair of council and the CMO for Scotland.

71. The majority of BMA Scotland's engagement with Scottish Government Ministers, senior civil servants and the CMO throughout the specified period were through the established meetings between BMA staff and Government officials.

72. BMA Cymru Wales maintains ongoing, working relationships with relevant ministers, Welsh Government officials and NHS organisations across Wales, and this was also the case throughout the period 1 January 2020 to 30 May 2022. Well established forums in which the BMA participates, and which continued during the pandemic, include the Welsh Partnership Forum[2] and Joint Oversight Meetings[3], at which officials and the Deputy CMO for Wales were often present.

73. BMA Cymru Wales engaged with the CMO for Wales intermittently throughout the period and in a number of ways. Primarily, letters were exchanged outlining member views on responses to the pandemic. There were also occasional direct meetings, participation in wider meetings (e.g., alongside the Academy of Medical Royal Colleges in Wales), and invitations to the CMO to address BMA committees directly (e.g., in October 2021). Government officials established regular technical briefings for trade unions and other representative bodies on topics such as testing and PPE, and the Deputy CMO would on occasion address these briefings directly.

74. BMA Cymru Wales participated in a number of Ministerial groups, as well as specific individual meetings with the Minister for Health and Social Services to express member views on the Welsh Government response to the pandemic. Where appropriate, BMA

---

[2] The Welsh Partnership Forum is a tripartite group sponsored by the Welsh Government with representatives from the recognised healthcare trade unions for NHS Wales, senior management for NHS Wales and the Welsh Government. The main purpose is the development, support and delivery of workforce policies at a national, regional and local level. More information about the Welsh Partnership Forum can be found here: https://www.nhsconfed.org/wales/nhs-wales-employers/welsh-partnership-forum

[3] Joint Oversight Meetings were regular (usually quarterly) meetings between the NHS Wales Director General and the chairs of the BMA branch of practice committees.

Witness name:     Professor Philip Banfield

Statement number:    1

Cymru Wales council / committee chairs wrote to the Minister in relation to specific topics, details of which are included within the chronology for Wales, provided separately to the Inquiry.

75. BMA Cymru Wales, primarily via staff rather than elected members, maintained contact with Welsh Government civil servants and officials via emails and telephone calls as a means of communication between the Welsh Government and the wider medical workforce. Staff also attended weekly formal meetings where BMA, NHS Employers Wales representatives and Welsh Government officials were present (the NHS workforce planning cell). Welsh Government officials often led the regularly held technical briefings on testing and PPE (mentioned at paragraph 73 above).

*The BMA's awareness of the existence of Covid-19 and the UK Government's strategy in response between 1 January 2020 and 26 March 2020*

76. The BMA across the UK first became aware of the emergence of Covid-19 in Wuhan, China via the media. The BMA offices across the UK engaged in various ways with the UK and devolved nation governments in relation to their strategy in the early months of the pandemic, as set out in the following section.

UK Government

77. On 31 January 2020, the BMA sent a letter from the chair of UK council to the SoS, NHS England and PHE offering the BMA's support and expertise in whatever capacity may be required to respond to the emerging pandemic. This was the BMA's first engagement with government in relation to Covid-19. A copy of the letter is exhibited to this statement as PB/1 - INQ000097956.

78. The BMA attended numerous meetings with different DHSC representatives at which elements of the Government strategy were discussed. However, there was no set piece meeting where any overall strategy was presented, and strategy continually changed through the early stages and the entirety of the pandemic.

79. In the period up to 31 March 2020, the BMA held the following meetings or phone calls with senior officials in the UK Government and agencies, where elements of the Government's strategy were discussed, primarily in relation to how the strategy would impact on the healthcare system and healthcare workers but also covering wider issues. This engagement included:

- A briefing by the CMO for England on Covid-19 (4 March 2020).

20

- The UK council chair and chair of the BMA's representative body meeting with the CMO for England (26 March 2020) (PB/204 - INQ000117801). The discussion included the BMA's concerns about PPE and testing.

- An SPF meeting organised by DHSC with representatives from NHS England and DHSC among other organisations (31 March 2020) (PB/205 - INQ000117813). The discussion at this meeting included PPE.

80. As well as meetings with DHSC ministers and officials, NHS England also held meetings chaired by the NHS England Medical Director, Professor Stephen Powis, with stakeholders including the Medical Royal Colleges and the BMA (as set out at paragraph 67 above). These meetings ran throughout the specified period for the Inquiry and various issues regarding the Government's response were discussed, for example PPE and Covid testing.

Devolved Governments

81. On 28 February 2020, following the first confirmed case of Covid-19 in Northern Ireland and Covid-19 becoming a notifiable disease, a teleconference meeting was held by the Northern Ireland Department of Health attended by the chair of the BMA Northern Ireland council. Thereafter the BMA Northern Ireland council chair sent a letter to the Northern Ireland CMO on 2 March 2020, which offered support and raised questions. A copy of the letter is exhibited to this statement as PB/2 - INQ000116865.

82. The Northern Ireland Executive published its plans for actions throughout the pandemic period, following agreement by the Northern Ireland Executive, which is the main way that BMA Northern Ireland was aware of the wider strategy and response of the Executive.

83. BMA Scotland were usually alerted to Scottish Government strategies for responding to the pandemic when they impacted on the medical workforce. BMA Scotland was not routinely consulted or pre-briefed on wider population-based strategies around lockdowns or mask wearing. Given the First Minister and Scottish Government held close to daily briefings, BMA Scotland was able to monitor these and ensure that it kept up to date on all developments as they occurred.

84. The chair of GPC Scotland was contacted on 24 January 2020 with a draft circular from the Scottish Government about fluid resistant masks being made available to GP practices as a precaution for 'Wuhan Novel Coronavirus'. A copy of the circular is exhibited to this statement as PB/3 - INQ000116816.

21

85. An email from Public Health Wales (PHW) that was sent to a large number of recipients on 12 February 2020 is the first record identified by BMA Cymru Wales that refers to increasing Covid-19 cases and includes a statement from PHW and the UK Government on guidance for health professionals. A copy of the email is exhibited to this statement as PB/4 - INQ000116817.

*Key meetings between BMA representatives and representatives of the UK Government or Devolved Nations held principally to discuss Covid-19 and/or the imposition, non-imposition, amendment or end of use of NPIs*

<u>UK Government</u>

86. As already set out at paragraph 54, the BMA chair of council had regular approximately monthly meetings with the SoS principally to discuss Covid-19, as well as sporadic meetings with Minister of State Edward Agar and Minister of State Helen Whately MP. The BMA requested, and attended at request, meetings with other DHSC Ministers. These meetings were predominantly with the BMA chair of council but also with relevant BMA branch of practice committee chairs. These meetings invariably covered many aspects of the pandemic and pandemic response therefore it is difficult to identify any meetings solely dealing with NPIs. In addition, the BMA sought contact with the SoS, Ministers of State for Health, the CMO for England and senior civil servants at key junctures during the pandemic (e.g., ahead of the lifting of lockdown restrictions). To the best of the BMA's ability, the meetings have been detailed within the BMA chronologies provided separately to the Inquiry, and include:

- PPE: discussed with the SoS on 18 March 2020 (PB/200 – INQ000117760), 28 October 2020 (PB/206 – INQ000118179) and with the CMO for England on 26 March 2020 (PB/204 – INQ000117801).

- Testing and contact tracing: discussed with the SoS on 18 March 2020 (PB/200 – INQ000117760), 26 March 2020 (PB/204 – INQ000117801), 28 April 2020 (PB/207 – INQ117872), and with Dido Harding on 21 September 2020 (PB/208 – INQ000118118) and 19 October 2020 (PB/209 – INQ000118165).

- Shielding: discussed with the Deputy CMO for England on 23 July 2020 (PB/210 – INQ000118048).

- Social distancing and other lockdown restrictions: discussed with the SoS on 8 October 2020 (PB/211 – INQ000118157), and the CMO for England on 18

22

November 2020 (PB/212 – INQ000118207) and 07 April 2021 (PB/213 – INQ000118319). We expect that earlier calls that took place with the SoS would have covered a wide range of issues relating to the UK Government's response to the pandemic, including social distancing and other lockdown restrictions.

<u>Devolved Governments</u>

87. Minister Robin Swann committed to a call with BMA Northern Ireland every six to eight weeks during the pandemic or as required. This resulted in calls on the following dates: 21 April 2020; 11 June 2020; 22 July 2020; 27 August 2020; 7 October 2020; 24 November 2020; 4 January 2021; 17 February 2021; 29 April 2021; 5 July 2021; 14 October 2021; 26 January 2022. These calls were attended by the Northern Ireland council chair, Northern Ireland national director and Northern Ireland senior public affairs advisor. One meeting was attended by the Northern Ireland consultant committee chair and another by the chair of GPC Northern Ireland.

88. In Scotland and Wales, primary engagement between BMA national offices and the devolved nation governments was through pre-existing communication channels, such as:

- Regular meetings between the Scottish Government Primary Care Directorate and GPC Scotland's negotiating team

- Regular Health Workforce Senior Leaders meetings attended by BMA Scotland and representatives of the Scottish Government

- Joint Oversight meetings and Partnership Forum meetings in Wales, which had a heavy Covid-19 focus during the specified period.

89. In addition, BMA Cymru Wales was invited to attend weekly meetings of the aforementioned NHS workforce planning cell and ad-hoc Welsh Government technical briefings which covered a range of Covid-19 related issues during the specified period (as outlined at paragraphs 73 and 75 above).

*Regular meetings between BMA and UK Government or Devolved Nation representatives to discuss and/or consider the response to Covid-19*

<u>UK Government</u>

90. As mentioned above (at paragraphs 53 and 55), the BMA attended approximately monthly meetings with the SoS and regular meetings with DHSC ministers and the

Witness name:        Professor Philip Banfield

Statement number:    1

Parliamentary Under Secretary of State for Primary Care and Public Health (Jo Churchill) initially on a weekly basis from late March 2020, and then moving to a fortnightly basis until the end of June 2020.

91. Also as set out above (at paragraphs 64 and 65), BMA senior staff regularly attended meetings with senior civil servants or Government representatives (such as the SPF Engagement Forum).

Devolved Governments

92. In addition to the regular calls with Minister Swann, there were other established regular meetings in Northern Ireland which were not specifically about the Covid-19 response, but which inevitably featured Covid-19 issues, particularly during 2020 and 2021. These meetings included discussions on pay arrangements during the pandemic, PPE for medical staff, death in service arrangements and other topics relevant to the BMA's trade union function.

93. The regular meetings that took place between BMA Scotland and BMA Wales and the devolved nation governments have been outlined above at paragraphs 70 to 75.


*Bodies or committees formed by the UK Government or Devolved Nations to respond to Covid-19 attended by members of BMA*

UK Government

94. The SPF Covid-19 Engagement Forum was one of the main ways the BMA engaged with relevant officials including DHSC representatives, senior civil servants, PHE/UKHSA, Test and Trace and NHS England. This Engagement Forum was a sub-group of the SPF set up to deal with Covid issues. The group met weekly from 31 March 2020 until 21 July 2020, after which the meetings were fortnightly (and they stopped at the end of 2021). While these were not decision-making meetings, this was an important forum for the BMA to provide feedback and gather information on the Government's developing response to Covid-19.

95. The BMA provided feedback on, among other issues, PPE (22 April 2020, 20 May 2020, 30 June 2020), the collection of ethnicity data in infection and mortality statistics (9 June 2020), risk assessments (04 November 2020), test and trace daily contact pilots (23 March 2021), IPC guidance in the context of lifting restrictions (14 July 2021), patient testing (27 July 2021) and the vaccination programme (12 January 2022) (PB/214 - INQ000215039 to PB/222 - INQ000215046). The BMA also provided

24

feedback in relation to a number of issues that fall within the scope of Module 3 of the Inquiry such as staffing, elective care backlogs and operational guidance. In addition to these regular meetings, specific workshops were at times set up on key issues (e.g., an SPF vaccination workshop took place in January 2021, an IPC workshop took place in October 2021, and an Omicron workshop took place in January 2022) (PB/223 - INQ000118264 to PB/224 - INQ000118412).

96. In addition, staff members from the BMA's Medical Ethics team attended meetings of the Moral and Ethical Advisory Group (MEAG) set up by DHSC. While this group was established before the pandemic (being established for a three-year period from October 2019), once Covid-19 emerged, the meetings of the group were focused on ethical issues in the government and healthcare response to the pandemic. The first meeting of MEAG that focused on Covid-19 was on 20 March 2020. The attending BMA staff member contributed to discussion on most of the items on the agenda. In addition:

   a. 25 March 2020 – Sharing the BMA's guidance about PPE for healthcare workers who cannot shave or trim their beards for religious reasons (PB/225 - INQ000117797).

   b. 26 March 2020 – Commenting on a MEAG draft paper of a framework for clinical prioritisation, following discussion at a MEAG meeting on 20 March 2020 (PB/124 - INQ000145835)

   c. 20 May 2020 – Contributing to discussion of MEAG's involvement with the UK Government's Covid-19 recovery strategy, including highlighting areas of ethical concern within the Government's roadmap and emphasising the need to address inequalities in any plans to ease restrictions (PB/226 - INQ000117932).

   d. 02 December 2020 – Advising on a MEAG discussion paper about the ethical issues of immunity certification (PB/227 - INQ000118224).

   e. 20 January 2021 – Contributing to discussion about the function of MEAG during the pandemic (PB/228 - INQ000118260).

<u>Devolved Nations</u>

97. In Scotland, the Health Workforce Senior Leaders Group was established by the Scottish Government in response to the pandemic. BMA national councils in devolved nations attended numerous meetings in response to Covid-19, but mainly these were

Witness name:     Professor Philip Banfield

Statement number:     1

not meetings of bodies or committees formed for the purpose of responding to Covid-19.

*Contributions to Parliamentary select committees or Senedd or Executive Committees by the BMA regarding Covid-19 or the imposition, non-imposition, amendment or end of use of NPIs*

98. Below is a list of contributions made by the BMA at a UK-level to parliamentary select committees regarding NPIs. Relevant submissions and documents are included within the BMA's chronology and general disclosure provided to the Inquiry.

| Date | Committee | Topic | Type |
|---|---|---|---|
| 26/03/2020 | Health and Social Care Committee | Preparations for coronavirus | Oral Evidence |
| 01/05/2020 | Women and Equalities Select Committee and Joint Committee on Human Rights | Coronavirus and the impact on people with protected characteristics | Written Evidence |
| 14/05/2020 | Health and Social Care Committee | Delivering core NHS and Care Services during the Pandemic and beyond | Written Evidence |
| 05/06/2020 | Health and Social Care Committee | Social care: funding and workforce | Written Evidence |
| 17/06/2020 | Women and Equalities Select Committee | Action to address the impact of Covid-19 on BAME communities by implementing the recommendations for the PHE review | Written Evidence |
| 25/06/2020 | London Assembly's Health Committee | Impact of Covid-19, including on London's BAME communities | Written Evidence |
| 29/06/2020 | Lords Public Services Committee | Lessons from Covid-19 | Written Evidence |
| 07/07/2020 | Women and Equalities Committee | Unequal impact: Coronavirus (Covid-19) and the impact on people with protected characteristics | Written Evidence |

26

Witness name: Professor Philip Banfield

Statement number: 1

| Date | Committee | Topic | Type |
|------|-----------|-------|------|
| 17/07/2020 | All-Party Parliamentary Group on Coronavirus | Inquiry on the UK's handling of the coronavirus outbreak | Written Evidence |
| 07/08/2020 | Health and Social Care Committee | Workforce burnout and resilience in the NHS and social care | Written Evidence |
| 28/08/2020 | House of Lords COVID-19 Committee | Long-term impacts of Covid-19, including on BAME communities | Written Evidence |
| 27/11/2020 | Communities and Local Government Committee | Impact of Covid on homelessness and the private rented sector | Written Evidence |
| 30/11/2020 | Race and Ethnic Disparities Commission | Ethnic Disparities and Inequality in the UK | Written Evidence |
| 07/12/2020 | Public Accounts Committee | Procurement and supply of PPE during the Covid-19 pandemic | Written Evidence |
| 11/12/2020 | House of Lords COVID-19 Select Committee | Living online: the long-term impact on wellbeing | Written Evidence |
| 10/06/2021 | Public Accounts Committee | Initial lessons from the government's response to the Covid-19 pandemic | Written Evidence |
| Oct-21 | Health and Social Care Committee and the Science and Technology Committee | Joint committee inquiry into Coronavirus: Lessons Learnt | Written Evidence |
| 15/12/2021 | Public Accounts Committee | NHS backlogs and waiting times | Written Evidence |

Devolved Governments

*Northern Ireland*

99. BMA Northern was not invited to take part in Assembly committee sessions on NPIs. BMA's Northern Ireland GPC gave written evidence to the Northern Ireland Assembly Health committee inquiry into the impact of Covid-19 on care homes on 14 October 2020, and on general practice issues at a session of the Assembly Health committee on 21 March 2021.

27

100. BMA Scotland did not provide written evidence or attend to give oral evidence to any Scottish Parliamentary or Government Committee relating to the imposition or non-imposition, amendment of or end to the use of NPIs. In relation to Covid-19 more broadly, BMA Scotland submitted evidence to the Health and Sport Committee Inquiry on resilience and emergency planning (03 June 2020).

*Wales*

101. On 22 May 2020, BMA Cymru Wales provided written evidence to the Senedd Health, Social Care and Sport Committee's inquiry into the impact of the Covid-19 outbreak, and its management on health and social care in Wales, and the chair of Welsh council and I, in my then role as chair of the BMA Wales Consultants' Committee, provided oral evidence to the committee on 7 July 2020. BMA Cymru Wales also provided written evidence to the Equality, Local Government and Communities Committee's inquiry into Covid-19 on 26 June 2020.

*Overview of the role played by the BMA at the meetings outlined above and the mechanics by which significant meetings were conducted*

UK Government

102. In general, meetings between the BMA and SoS were all conducted in a similar manner. The BMA chair of council and SoS, Matt Hancock, had an existing relationship which allowed for open discussion. In general, agenda items were requested by the DHSC in advance and supplied by the BMA. All meetings were virtual and held over Microsoft Teams.

103. Often the items discussed were the differing views on government action or policy, which led to robust conversations at times. The BMA's opinion was often that the Government should be taking stronger or more strident action.

104. There were some meetings where BMA publications or statements were discussed, e.g., 'Exiting the lockdown – a strategy for sustainably controlling the transmission of COVID-19 in England' (November 2020) (PB/5 – INQ0000987566) and 'Taking a cautious approach to easing restrictions – measures to support near-elimination of COVID-19 from the UK' (February 2021) (PB/6 – INQ000118297).

28

Witness name:     Professor Philip Banfield
Statement number:     1

105.     These meetings were not decision-making meetings. They were opportunities for exchange of views and sharing of information.

106.     Following the resignation of Matt Hancock from his role as SoS, the BMA wrote to Sajid Javid and developed a new relationship. Meetings (in June 2021, August 2021 and October 2021) were largely held in the same manner although some, due to the relaxation of restrictions, were able to be held in person.

*Civil Servants*

107.     Meetings with civil servants were conducted in a similar manner – mainly over Microsoft Teams and with agenda items agreed in advance. Where the BMA was part of larger stakeholder meetings (such as the SPF) the BMA's primary role was to ask questions or raise concerns on specific issues. There was also an opportunity to suggest agenda items, albeit the BMA rarely took this up and the agenda was mostly set by the secretariat together with the chair(s).

108.     The MEAG secretariat was provided by DHSC who shared agendas in advance and minutes of previous meetings of the group, which were held remotely over Microsoft Teams. On one occasion that I am aware of, the BMA staff member attending the meeting took their own note and shared this with several BMA colleagues by email (PB/229 - INQ000215037 and INQ000215038). BMA colleagues were invited due to their expertise in ethical issues and their role was to share their views on the ethical issues being considered.

Devolved Governments

*Northern Ireland*

109.     Meetings with the Northern Ireland Assembly Health Committee take the form of an opening statement followed by questions from Committee members. Written evidence was submitted ahead of these oral evidence sessions (see paragraph 99).

110.     Meetings with the Minister involved submitting agenda items in advance to his/her office. Each item was raised by the BMA in the meeting. Ministerial meetings were held remotely using a virtual platform.

*Scotland*

111.     Meetings were held remotely using Microsoft Teams. BMA Scotland representatives had the opportunity to verbally update attendees using the

29

experiences and insights from BMA members working on the frontline in healthcare services. Civil servants took notes and kept action logs.

112.    On the occasions when BMA representatives met directly with the Cabinet Secretary for Health, the BMA had the opportunity to submit agenda items in advance.

*Wales*

113.    BMA Cymru Wales offered views on proposals set out at a range of meetings, including technical briefings, the Partnership forum, and Joint Oversight Meetings, and when providing evidence to the Senedd Health, Social Care and Sport Committee. Agendas were set by meeting organisers although the BMA had the opportunity to suggest agenda items in advance for regular meetings, such as Joint Oversight Meetings or direct Ministerial meetings.

*Processes for recording meetings*

UK Government

114.    There were no joint or agreed records/minutes of the meetings. The BMA's account of these meetings was often shared verbally (e.g., by the chair of council) at an internal meeting or shared via email by attending staff, but there was no formal process for recording the meetings. Where informal records have been identified (e.g., written notes from internal meetings or email updates) they have been disclosed to the Inquiry. Some of these records are not what one would consider formal meeting notes but, for example, bullets jotted down by staff who were attending these meetings.

115.    While formal records of the SPF Covid engagement group meetings have not been identified, it is believed that the secretariat to the group took notes of the meeting (which is the usual process with all SPF meetings). Where relevant informal records of these meetings have been identified, they have been disclosed.

Devolved Governments

116.    Meetings with the Northern Ireland Assembly health committee were recorded using the formal Assembly recording system. Following meetings with the Minister, BMA Northern Ireland would generally produce an informal note for internal use only (copies of which have been disclosed with the BMA's disclosure to the Inquiry). I am unaware if the Minister's office recorded their own note.

30

117. In Scotland, civil servants made notes and kept action logs. BMA staff did not separately record notes of the meeting.

118. In Wales, official records were taken by meeting organisers, such as Welsh Government (Partnership Forum, Joint Oversight Group) or Senedd Committees (Oral evidence sessions). BMA Cymru Wales is unaware of records taken at technical briefings. In some instances, the BMA took informal notes for internal sharing (e.g., from Welsh Government technical briefing meetings), and where they have been identified they are disclosed.

*Informal or private communications about significant decisions between the BMA and UK Government or Devolved Governments*

119. The BMA did not engage in any significant informal communications with Government and the majority of efforts to influence Government decisions were carried out via formal written communications and public statements.

120. There were a small number of private WhatsApp communications between the BMA chair of council and the SoS. A brief WhatsApp exchange took place in May 2020 between the BMA chair of council and the SoS with the SoS expressing disappointment at the BMA's position on schools reopening; the BMA chair of council responded to highlight that the BMA's concern at reopening schools at that time was specifically about the likelihood of increasing viral circulation, potentially among communities who might be more at risk (exhibit PB/105 – INQ000117918).

121. Separately, there were a small number of private WhatsApp communications between the BMA chair of council and the SoS in December 2020 and January 2021, related to the initial vaccine roll out to healthcare staff. As these matters are not relevant to NPIs they have not been disclosed.

122. The BMA is not aware of any elected officials or BMA staff being part of any WhatsApp groups with Ministers or Senior Civil Servants or having informal or private conversations about significant decisions.

Devolved Governments

123. No private or informal communication of this kind took place with BMA Northern Ireland or BMA Scotland staff, nor am I aware of any informal communication of this kind taking place between key elected members and Ministers/senior civil servants.

31

124. BMA Cymru Wales staff and/or members corresponded with Welsh Government and civil servants via official channels such as telephone, email, letter or documented face to face meetings in relation to significant Covid-related decisions.

125. There were a small number of WhatsApp exchanges between the BMA chair of council in Wales and the CMO for Wales, Sir Frank Atherton. The first exchange took place between the end of December 2020 and early January 2021, in relation to the rollout of initial vaccinations to healthcare workers.

126. A further brief WhatsApp exchange between the BMA chair of council in Wales and the CMO for Wales concerned the rollout of vaccinations in care homes. As these matters are not relevant to NPIs, these exchanges have not been disclosed.

*Overview of advice, briefings or letters to the UK Government or Devolved Governments by the BMA in relation to NPIs*

UK Government

127. The BMA were in regular contact with Government and raised multiple concerns and gave advice on various topics by written correspondence. The BMA regularly sent letters to the Government regarding various NPIs:

   a. PPE: Multiple letters were sent to the DHSC regarding the unacceptable shortage of PPE as well as the inadequate quality of PPE for healthcare workers (see PB/65 – INQ000097854, PB/66 – INQ000117840, PB/67 – INQ000097847, PB/70 – INQ000118291, PB/76 - INQ000097874, PB/89 – INQ000097875, PB/230 – INQ000097885).

   b. Testing: At the start of the pandemic, the BMA wrote to the SoS calling for healthcare workers, and their household members, to be tested for suspected Covid-19 as a priority (26 March 2020) (PB/7 – INQ000097941). This letter resulted in a phone call between the chair of council and the SoS (also on 26 March 2020).

   c. Restrictions and protections: The BMA also expressed concerns about the Government's plan to ease lockdown restrictions, calling for clarity and consistency in the guidance given to the population. The BMA wrote to the DHSC (26 June 2020) (PB/8 – INQ000097942), raising concerns about the Government's guidance on mask wearing, calling for wearing of face masks in all public places where social distancing was not possible. The BMA also made

Witness name:     Professor Philip Banfield

Statement number:     1

known its concerns about government plans to relax all protections in a letter to the SoS (5 July 2021) (PB/9 – INQ000097852).

128.    Where responses were received, they largely set out the Government's established position on the issue.

129.    Between June 2020 and March 2021, the BMA published a series of reports and briefings setting out key principles and considerations on easing restrictions. These included:

- Easing the lockdown – principles and priorities (June 2020) (PB/10 – INQ000117966)

- Reducing transmission of COVID-19 (October 2020) (PB/11 – INQ000118161)

- Exiting the lockdown – a strategy for sustainably controlling the transmission of COVID-19 in England (01 November 2020) (PB/5 – INQ000098756)

- Taking a cautious approach to easing restrictions (February 2021) (PB/6 – INQ000118297)

130.    "Reducing the transmission of COVID-19" was shared by email with DHSC on 9 October 2020. "Exiting the Lockdown" was published on 1 November 2020 and resulted in a meeting with the CMO for England on 18 November, specifically to discuss the paper.

131.    There was regular communication between the UK Government and the BMA throughout the pandemic. Regular and recurring issues included staff access to PPE, IPC guidance and the impact of the pandemic on healthcare workers and people in the wider population from an ethnic minority background (and their need for greater protection).

Devolved Nations

132.    BMA Northern Ireland sent a number of letters to the Health Minister and Northern Ireland Executive officials during the pandemic (as included within the Northern Ireland chronology and in disclosed documents). However, regarding NPIs, communication was primarily via public statements issued by BMA Northern Ireland and reported by the media, rather than letters to the Minister on this issue. The reason for this was the need for the Minister to achieve agreement to any NPI proposals from the members of the five-party Executive.

33

133. BMA Northern Ireland spoke at length in the media urging caution around the lifting of restrictions. This messaging was broadly in line with the decisions made by the Northern Ireland Executive, with the exception of autumn 2020 when BMA Northern Ireland called for lockdown measures to be fully introduced, a step not taken by the Northern Ireland Executive until January 2021.

134. There were a variety of emails from BMA Scotland to the Scottish Government responding to government consultations and requests for views on guidance on NPIs (included within the BMA Scotland chronology).

135. Letters, briefings and correspondence between BMA Cymru Wales and the Welsh Government are included within the BMA Wales chronology, including:

- PPE and mask wearing in non-clinical areas: see Technical Briefing document dated 9 June 2020.

- Public mask-wearing: see the letter from chair of GPC Wales on behalf of the BMA of 10 August 2020, and the CMO reply dated 20 August 2020.


*Instances when the UK Government or Devolved Governments did not follow advice or recommendations from the BMA in relation to NPIs*

UK Government

136. As the BMA's engagement outlined above and the documents disclosed in response to this Rule 9 request demonstrate, the BMA was proactive in seeking to raise issues and concerns about the UK Government's response to the Covid-19 pandemic. A range of methods and approaches were applied to raise concerns, lobby for change, and seek to influence Government decision making.

137. However, because the BMA's interests in relation to the pandemic response are wide ranging and we were often seeking to influence on multiple issues at any one time, it is difficult to identify the precise impact that BMA interventions had or did not have on government decisions, including specifically in relation to NPIs.

138. Further, the UK Government did not routinely provide responses or explanations when BMA advice or recommendations were not followed.

139. Notwithstanding this complexity, the BMA has identified a number of key issues relating to NPIs and related matters where it is the BMA's view that the UK Government adopted a different course from that recommended by the BMA (despite the BMA

34

public speaking out or directly advising the Government as to a different course of action).

*Mandating the wearing of face coverings (masks) by the public*

140.     The BMA lobbied for face masks for the general public to be introduced far earlier than they were and was critical of the delay in introducing mandated mask wearing across the UK and particularly in England, with BMA members arguing that the UK Government should have followed the example of the Scottish Government more rapidly in relation to mandatory mask-wearing in shops (see exhibit PB/106 – INQ000116859). More details of the BMA's position in relation to this issue and its interventions is set out at paragraphs 177 to 180 below.

*Testing and contact tracing*

141.     The BMA regularly called on the Government to do more to put in place effective systems for testing and contact tracing to help stop the spread of Covid-19. In July and November 2020, the BMA published documents setting out principles for exiting lockdowns and what needed to be in place, highlighting the need for a reformed test and trace system. The BMA was consistent in highlighting the good work done by local public health systems including its high success rates in contact tracing as well as the oddity of not using existing public sector testing infrastructure instead creating an unwieldy, less successful, vastly expensive and inefficient national system. As the pandemic progressed, more use was made of local public health teams for contact tracing, although this came late in the day.

*Exiting lockdowns safely*

142.     The BMA consistently called for a more cautious approach by government to ending lockdowns and reducing the public health protections in place. In July and November 2020, the BMA published documents setting out what it believed the UK Government should do to ease restrictions in a way that helped limit transmission of the virus and protected and prioritised the health and social care system (including health and social care workers working in them) and those most vulnerable to serious illness or death from Covid-19. While there were some occasions where the BMA believes the UK Government did respond to its calls for slower relaxation of public health protections (see paragraph 154 below), on the whole, it is the BMA's view that the UK Government acted too slowly to implement restrictions and was too quick to remove them. The majority of measures called for by the BMA were not enacted and certainly not in full, in particular:

Witness name:     Professor Philip Banfield

Statement number:     1

- The BMA consistently called for better self-isolation payments to ensure greater compliance, particularly for those who were least able to afford loss of income.

- More support for people who were vulnerable, including calling for steps to ensure that medical grade masks were available to vulnerable individuals, means tested access to testing (when it stopped being available) to reduce the spread of the virus, access to tests for contacts of the clinically vulnerable (rather than just the clinically vulnerable themselves) and, more recently, improved access to antiviral treatment.

- Provisions in relation to safe school opening.

- The BMA called for working at home to remain in place for longer and, after it was removed, sought its reinstatement when cases rose, particularly around the emergence of Omicron.

- The need to improve ventilation in schools, healthcare settings and other settings where social distancing was not possible.

143.     On 26 June 2020, the BMA's chair of UK council wrote to the SoS stating that the priority, as the UK Government moved towards ending the lockdown restrictions, must be the protection of the public's health and the need to maintain suppression of the virus while allowing the restarting of economic and social activity (PB/8 – INQ000097942). In this letter, the BMA called for clear and consistent communication to the public around issues such as social distancing and the wearing of face masks. In the BMA's view, the UK Government failed to provide the clear, consistent and visible public health messaging that was necessary throughout the pandemic and, particularly when the Government messaging and focus shifted to one of personal responsibility.

144.     Following the appointment of Sajid Javid as SoS, the BMA wrote to Mr Javid on 5 July 2021, urging the Government to proceed with caution as it was becoming clear that the Government intended to end restrictions (PB/9 - INQ000097852). The BMA highlighted the high hospitalisation and infection rates and the additional pressures that would be faced by healthcare workers (who were already tackling a mounting backlog) following any relaxation of protective measures.

*Acting on the evidence that Covid-19 was airborne*

145.     While not a specific NPI, the BMA contends that a key failure of the Government was, and continues to be, the failure to properly acknowledge (and at an

early enough stage), that Covid-19 was spread by aerosol transmission and to adapt their public messaging, guidance to health services or the focus of their NPIs appropriately. The BMA raised this issue repeatedly within the context of inadequacies in the Infection Prevention and Control (IPC) guidance issued by the four nation IPC cell which put healthcare workers and patients at risk (as it recommended the wearing of fluid resistant surgical masks rather than FFP2/FFP3 respirators for the routine treatment of Covid-19 positive patients). But this failure also had wider implications for decisions about what NPIs were implemented, for example, a greater focus on indoor ventilation and air quality monitoring (alongside the recommendation to meet outside where possible) could have reduced transmission of the virus, and taking steps to ensure FFP2/3 respirators were available for vulnerable people rather than surgical masks would have offered greater protection from infection, as well as having clearer public heath messaging on this issue.

### The impact of Covid-19 on people from ethnic minority backgrounds

146.     The BMA was one of the first organisations to publicly raise concerns about the impact of the pandemic on people from ethnic minority backgrounds, both those working in healthcare roles and the wider public. Paragraph 155 below provides more detail on how the BMA sought to raise these concerns.


### Devolved Governments

### Northern Ireland

147.     When cases were rising in late summer / early autumn 2020, the BMA Northern Ireland council chair called for the implementation of lockdown measures in a range of interviews with the aim of limiting the spread of the virus, reducing the number of infections and deaths, and protecting the local NHS by reducing pressure on services. This approach was operationalised in the media, with very regular coverage and interviews with senior BMA Northern Ireland spokespeople. When the Northern Ireland Executive announced limited restrictions in October 2020, BMA Northern Ireland's statement of response on 15 October was that it was 'too little, too late' and did not go far enough. In further interviews, the chair of BMA Northern Ireland council described plans to have hospitality open in the run up to Christmas as 'an act of reckless vandalism'. First Minister of Northern Ireland, Arlene Foster, responded in the media by saying that on this occasion she 'respectfully disagreed with the BMA' (16 October

37

2020) and that economic considerations were important when considering lock down measures.

148.     Following a further delay, new lockdown restrictions were finally brought in from Christmas 2020, and the 2021 Covid-19 wave led to a greater number of cases and greater pressure on intensive care services than in the first wave.

*Scotland*

149.     The guidance produced by the Scottish Government did not always reflect every comment and suggestion from BMA Scotland. However, the Scottish Government and BMA Scotland's position on key NPIs and their timing remained broadly in line, in particular, when the Scottish Government chose to act early and decisively on issues such as mask wearing etc. (set out in further detail within the BMA's chronology for Scotland). With tight resourcing within BMA Scotland any divergences in positions were not great enough for BMA Scotland to speak out publicly.

*Wales*

150.     BMA Cymru Wales maintained throughout the pandemic that face coverings should be made mandatory in enclosed and/or crowded areas, as a means of reducing transmission and protecting the public, and as part of a package of measures including social distancing and hand hygiene (see press statements of 5 June 2020 and 3 July 2020). BMA Cymru Wales pushed for the Welsh Government to strengthen their stance on face coverings in meetings with the Minister for Health and Social Services, the CMO for Wales, and NHS Wales Director General. The initial response was that the Welsh Government was not minded to recommend their use, eventually moving towards a position of mandatory face coverings on public transport only in July 2020. Eventually, on 14 September 2020, it was announced that face coverings were a legal requirement in shops and other indoor public places in Wales. It was also subsequently clarified that face coverings would be a requirement for anyone accessing primary care services, with GPs being able to exercise clinical judgement in determining when it was appropriate for patients to remove their face covering.

151.     BMA Cymru Wales also called for improved provision of PPE for healthcare workers, including through direct letters to Local Health Board CEOs, and interactions with the Welsh Government (as set out in the BMA's chronology for Wales). These calls continued throughout pandemic and were re-emphasised with the emergence of variant strains of Covid-19 (e.g., Delta and Omicron).

Witness name:      Professor Philip Banfield

Statement number:      1

*Instances of the BMA's representations leading to changes in the UK Government or the Devolved Nations' approach to NPIs*

<u>UK Government</u>

152.     The BMA proactively sought to influence Government decision making on a wide range of issues throughout the pandemic, including in relation to NPIs. This was often through media statements and interventions as well as direct engagement through meetings or letters. It is impossible to say with any certainty whether a particular intervention led to or influenced a government decision, although the BMA is a respected voice of the medical profession and on medical and scientific matters, and it is expected that BMA concerns on particular issues are considered by government ministers.

153.     There were, however, a number of occasions when the BMA made an intervention, which was closely followed by a Government decision that partially or fully aligned with the BMA's position (as set out at paragraphs 154 to 156 below). On other occasions, consistent BMA messaging and representations was followed by Government action, albeit delayed, in line with the BMA's position. The BMA's position is that it will be important for the Inquiry to consider both actions and interventions that had immediate influence and those that had influence over a longer period through consistent and cumulative pressure.

*Delay in easing lockdown in 2020*

154.     The BMA believes that its interventions on the easing of initial restrictions in the summer of 2021, including emailing DHSC and the CMO for England on 11 June 2021, contributed to the UK Government decisions to delay the easing of restrictions for two weeks.

*PHE review into the impact of the pandemic on people from ethnic minority backgrounds*

155.     The BMA was one of the first organisations to raise concern about the disproportionate impact of the pandemic on people from ethnic minority backgrounds. On 9 April 2020, the chair of council 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 rate of Covid-19 deaths amongst healthcare workers from these backgrounds (PB/72 - INQ000097864). Following this letter, on 10 April 2020, the BMA chair of council was quoted extensively in a Guardian article calling for an

Witness name:     Professor Philip Banfield

Statement number:     1

urgent review into why people from ethnic minority backgrounds are more vulnerable to Covid-19. A copy of the article is exhibited to this statement as PB/12 - INQ000116819. On 16 April, the UK Government announced they would be conducting a review, led by PHE. While the BMA had concerns about the review's findings, which were expressed in a letter to the Secretary of State of Health on 12 June 2020 (PB/81 – INQ000097872), it is an example of a BMA intervention leading to direct Government action.

*Design of the NHS Covid-19 app*

156.     The BMA worked closely with the Government and NHS England to support the design of the NHS Covid-19 app. In particular, the BMA raised concerns about privacy implications and secured improvements to the app in this area and help to alleviate concerns that may have meant fewer people were comfortable using the app. The BMA repeatedly raised concerns that an app built on a centralised contact tracing system (developed by NHSX) could undermine public confidence (and uptake as a result) as data would be stored centrally and used for purposes other than contact tracing I.e., for research and planning. As a result of the BMA's interventions, NHSX ultimately opted for an app built using the Google and Apple decentralised API (application programming interface). This meant that data would be stored only on the user's device thereby minimising the chance that uptake would be hampered by concerns over privacy.

Devolved Nations

157.     In Northern Ireland, following the 2021 Covid-19 wave, NPIs remained in place for longer than in England and the BMA suggests that this change in approach, with caution in place for a much longer time, was at least in part due to the warnings of BMA Northern Ireland about the length of time needed for infections to begin to fall during the second wave.

*The absence of public health expertise at the highest levels of decision making in relation to the Covid-19 pandemic response*

Basis for the BMA's view

158.     The lack of independent public health expertise informing and supporting the public health response to the pandemic has been a consistent message from elected members of the BMA who work in public health roles and has been identified by the

Witness name:       Professor Philip Banfield

Statement number:     1

BMA's Public Health Medicine Committee as a key concern in relation to the Government's public health response. A review of SAGE attendance shows that, while experts in public health (such as the Chief and Deputy Chief Medical Officers) attended, particularly in the early weeks and months, there were few *independent* public health specialists attending SAGE, including when decisions were being made around lockdowns, test and trace, or other NPIs. On the other hand, concerns have been raised about the overreliance on behavioural expertise particularly in the early stages of the pandemic, including in attendance at SAGE meetings. In the BMA's view this impacted critical decisions by government, particularly around containing the spread of the virus, and test and trace. Respondents to the BMA's call for evidence as part of its COVID-19 Review also commented on this issue and its perceived impact on Government decision making.

*BMA members as members of SAGE or the Technical Advice Group*

159.     To the best of my knowledge, no elected members of the BMA (or immediately past elected members) were also members of SAGE, the Technical Advice Group or equivalents in Northern Ireland, Scotland and Wales during the specified period.

*Highlighting the BMA's concern to UK Government or relevant Devolved Nations, SAGE or Office of the CMO*

160.     The BMA raised its concern about the lack of independent public health expertise on SAGE via its COVID-19 Review, as set out in the Fourth Report. However, the BMA also publicly raised concerns about the restructure of PHE during the pandemic and the lack of public health expertise sought into that decision, and reiterated the need for public health organisations to be independent of government.

## C. BMA COVID-19 Review

*Research carried out by the BMA relevant to Modules 2, 2A, 2B and 2C of the Inquiry and shared with the UK Government between January 2020 and May 2022*

161.     In order to inform and shape the UK's current and future pandemic response, the BMA conducted its own lessons learned exercise, the "BMA COVID-19 Review" in consultation with its members. The views, findings and recommendations of the BMA and its members are set out within five published reports:

41

a. BMA Covid Review Report 1 (published 19 May 2022): How well protected was the medical profession from Covid-19? (PB/13 - INQ000118474)

b. BMA Covid Review Report 2 (published 19 May 2022): The impact of the pandemic on the medical profession (PB/14 - INQ000118475)

c. BMA Covid Review Report 3 (published 26 June 2022): Delivery of healthcare during the pandemic (PB/15 - INQ000185355)

d. BMA Covid Review Report 4 (published 28 July 2022): The public health response by UK governments to COVID-19 (PB/16 - INQ000185356)

e. BMA Covid Review Report 5 (published 28 July 2022): The impact of the pandemic on population health (PB/17 - INQ000185357)

162. All relevant research conducted by the BMA within the period January 2020 to May 2022 was included in the COVID-19 Review. The Review drew in part from 12 Covid Tracker surveys and five Viewpoint surveys of BMA members[4]. These surveys were undertaken fortnightly between 6 April and 18 June 2020, before moving to monthly and then bi-monthly. In addition, the BMA undertook surveys of its members during the initial vaccine rollout between January and April 2021, which, in the absence of official figures from the UK Government, allowed the BMA to monitor doctors' access to first and second vaccine doses. In total, the BMA's surveys for the period relevant to the Inquiry received approximately 192,000 responses. A copy of each of the surveys conducted throughout the period are exhibited to this witness statement as PB/18 - INQ000116820 to PB/35 - INQ000116837.

163. During the pandemic, the BMA's commitment to research among its members was extensive and prioritised information about critical areas, such as the availability of PPE and doctors' own safety, as well as issues of specific relevance to Module 2 of the Inquiry, such as doctors' views on what restrictions were needed to curb the spread of the pandemic.

164. The BMA did not have a formal process for sharing the information from these surveys with governments. However, the BMA surveys formed a key plank of the

---

[4] The BMA undertook regular research with its members through the pandemic. This began in 2020 with Covid Tracker surveys which were mostly UK wide and dedicated specifically to issues of the pandemic. Later in 2021, Viewpoint surveys were introduced, which supported research on a wider range of subjects but retained a strong focus on Covid. Additionally, during the initial vaccine roll out at the start of 2021, the BMA conducted 10 vaccine surveys of members to monitor access to the new vaccines among the medical profession, in absence of published national data.

42

Witness name: Professor Philip Banfield

Statement number: 1

evidence gathering that was used to understand the experience of doctors on the front line, to brief elected BMA officers, including the chair of council, ahead of meetings or media interviews, and to inform the BMA's communication with government officials. Press releases launching the surveys' findings and more detailed results were frequently published on the BMA website. On occasion, BMA staff shared survey results directly with governments (e.g., the Scottish Director of Health Workforce throughout April and May 2020, the SPF Wider Group in May and November 2020, and the UK Minister for Care and Mental Health in October 2020). Selected survey findings were also regularly used in letters and meetings with the SoS. This includes within the following letters:

a. 09 September 2020 – reports related to the lack of testing availability (PB/231 - INQ000118110).

b. 14 January 2021 – survey findings related to the need for emergency legislation to protect healthcare professionals at risk of inappropriate legal challenge when treating Covid-19 patients (PB/232 - INQ000097881).

c. 05 July 2021 –survey findings related to the impact of the pandemic on doctors' mental health (PB/9 - INQ000097852).

09 September 2021 and 21 September 2021 –survey findings related to doctors' experiences of abuse, threatening behaviour and violence (PB/233 - INQ000097867 and PB/234 - INQ000097914).

*How the BMA canvassed the views of its members as part of the COVID-19 Review, or any other survey or research*

165. The BMA COVID-19 Review included research that was conducted among BMA members throughout the pandemic, prior to publication of the Review reports. Specifically, to inform the BMA COVID-19 Review, the BMA conducted an additional and wide-ranging call for evidence from members, encouraging them to pause and reflect on their experience during the pandemic. The call for evidence was held online between 10 November and 17 December 2021 and received 2,484 responses from across the profession. The Association used BMA communications channels, including social media, the website, email and newsletters to ensure that the call for evidence achieved a wide reach and encouraged both members and non-members to take part. The call for evidence combined a range of quantitative and qualitative questions, providing doctors with an opportunity to describe the impact of Covid-19 in their own

Witness name:        Professor Philip Banfield

Statement number:    1

words. A copy of the call for evidence questions is exhibited to this statement as PB/36 - INQ000116838.

166.     In preparing the evidence for the COVID-19 Review, the BMA also engaged with other stakeholder organisations between November 2021 and January 2022, including unions representing healthcare workers, Medical Royal Colleges and think tanks, to ensure that the Review reports would be comprehensive and properly informed by others with a significant role in shaping the healthcare environment during the pandemic. The BMA hosted two round table events in March and April 2022 attended by some of these stakeholders, to obtain further information for the COVID-19 Review.

*Significant findings from the BMA's research relevant to Modules 2, 2A, 2B and 2C of the Inquiry*

167.     The BMA's findings from the COVID-19 Review, Covid Tracker surveys and Viewpoint surveys that are of most relevance to Module 2 of the Inquiry, are largely described within reports one and four of the BMA COVID-19 Review.

168.     While protection of healthcare workers is also a very relevant question for Module 3, the BMA believes the lack of protection afforded to healthcare workers, because of fundamental decision making, including around procurement and management of PPE stocks, its central coordination, Covid testing strategy and deficient IPC guidance, are reflective of wider issues in how governments (and the UK Government in particular) responded to the pandemic. This also had implications for the wider public health measures that were introduced (for example, in relation to mask wearing and ventilation). Relevant findings from report one of the BMA COVID-19 Review (How well protected was the medical profession from COVID-19?) demonstrate the impact of these decisions on healthcare workers (as set out at sub-paragraphs 168.k to 168.r below).

Report 4: The public health response by UK governments to Covid-19

a.   The UK Government was slow to react to the emergence of Covid-19 globally, failing to respond to the increasingly clear threat posed by the virus in China and later Italy, or to act robustly on concerns raised by SAGE. The absence of a strong independent public health presence on SAGE, the body providing scientific advice to the UK Government in emergencies, exemplified what

44

respondents to the call for evidence believed was a lack of public health involvement in key decisions (see paragraphs 158 and 160 above).

b. The UK was generally slow to introduce facemasks for the public and the BMA lobbied the UK Government in particular to mandate their use in a wider range of public settings (PB/37 - INQ000116839).

c. The decision to shift capacity away from contact tracing on 12 March 2020, but not mandate population wide NPIs for a further 11 days when community transmission was increasing, likely fuelled the number of infections, increased demand for acute care and increased deaths.

d. It is likely that schemes such as Eat Out to Help Out and government messaging to support it, created avoidable ambiguity in public health messaging during 2020 and these should be evaluated for their impact on the economy and transmission rates.

e. The UK Government's justification for outsourcing contact tracing and testing at a cost of £37bn, choosing to make relatively little use of existing public capacity, remains opaque. The system was inefficient at tracing and its original perceived merits over publicly delivered systems was, and remains, unclear.

f. The BMA recognised the rationale for imposing enhanced restrictions in localities ('local lockdowns') later in the pandemic, where greater disruption to the lives of a smaller population is balanced against the need to minimise economic and other harms across a wider region/country. However, this strategy lacked effective local public health involvement supported by data sharing, was hampered by tensions resulting from centralised decision making, and mostly failed to drive down cases. In England, efforts to better explain decisions over local lockdowns came too late to give confidence in them.

g. The clarity and simplicity of early pandemic messaging, e.g., 'Stay home, protect the NHS, save lives', gave way to more ambiguous instructions for the public, in England especially. The frequency and nature of changes and the distinctions between UK countries undermined understanding of core public health messaging.

h. The increasingly prevalent political rhetoric about easing restrictions or 'freedom' from the summer of 2021, led to reduced mask wearing among the public, even in healthcare settings.

Witness name:       Professor Philip Banfield

Statement number:    1

i. In England, the government-dubbed 'Freedom Day' (19 July 2021) did not signify the literal or legal end of Covid-19 restrictions, yet the narrative was likely intended to generate a sense that necessary limitations on people's lives brought about by the pandemic had come to an end. Consequently, it sent the message that the threat of the virus had been fully contained via vaccination, something which public health advice actively disputed.

j. 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. This position was a justified precaution at the time and was subsequently vindicated by the need for the UK to reintroduce such measures with the emergence of the Omicron variant at the end of 2021.

Report 1: How well protected was the medical profession from COVID-19?

k. PPE supplies (largely under the central coordination of the UK Government) were insufficient. In the early phases of the pandemic, shortages of vital PPE were especially acute, such as full-face visors, googles and FFP3 respirators (which provide the greatest protection from aerosol transmission of infections or viruses), even in settings where aerosol generating procedures were routine (circumstances in which the Governments' IPC guidance recommended their use). Medical professionals on the frontline often had to go without PPE, buy their own, reuse single-use items or use homemade or donated items, especially in the spring of 2020.

l. Protection for healthcare workers was lacking throughout the pandemic. In the BMA's call for evidence, 81% of respondents said they did not feel fully protected during the first wave.

m. 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 are imperative in healthcare settings to protect staff and patients. IPC guidance relating to Covid-19 first appeared in January 2020, although at this stage it reflected uncertainty around the virus and an understanding that Covid-19 was not circulating in the community. However, while that situation changed rapidly, IPC guidance was

46

not updated until 20 March 2020 when nearly 2,000 patients were in hospital with Covid-19. After this date, IPC guidance was updated frequently, although respondents to the BMA's survey reported that it was often unclear, poorly communicated within the health and social care sector, and that the frequency of changes made it difficult to implement. There was also concern that the guidance failed to change as the evidence base around Covid transmission developed (with increasing evidence that Covid-19 spreads via the air), and current IPC guidance still does not require healthcare professionals to have access to PPE (such as FFP3 respirators) when dealing with Covid-positive or suspected positive Covid cases outside of when undertaking a limited range of aerosol generating procedures.

n. Training and fitting procedures for PPE were often inadequate within healthcare settings. Poor availability of fit testing and poorly fitting PPE left some doctors not properly protected, with female and ethnic minority doctors disproportionately affected.

o. 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. Tests were limited to those entering intensive care and this left little capacity available for other patients in hospital, or those being discharged into social care settings. We now know this had severe implications for many living in care homes.

p. 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 without the recommended PPE. Given the shortage of available tests for medical professionals during the early stages of the pandemic, and delays in getting results, this meant that Covid was transmitted unwittingly to other patients and colleagues.

q. 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 in 2020. By May 2020, 64% of respondents to the BMA's Covid Tracker survey had not been risk assessed in

47

relation to their potential contact with Covid. Around 4 in 10 of the respondents who had had a risk assessment felt their risk assessment was ineffective at protecting them at work. Ethnic minority doctors were most likely to hold this view, which was especially concerning given that ethnic minority doctors made up 44% of the profession.

r. 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. The number of nurses, doctors and beds in the UK per 100,000 population are lower than the OECD average, and general health spending as a percentage of GDP was below that of comparable western European neighbours.

*When and how were the results of the BMA's research provided to the UK Government and/or Devolved Nation Governments*

169.     Throughout the specified period, the BMA's research and findings were published and widely communicated. Research was often press released to media organisations and in many instances, BMA research was made publicly available via the BMA website.

170.     As set out at paragraph 164 above, the BMA did not have a formal process for sharing the findings from its research with governments. However, BMA surveys were a key part of the BMA's evidence gathering from frontline healthcare workers, and they informed the Association's wider influencing activities, including briefings for elected BMA officers such as the chair of council (including ahead of meetings with the SoS and CMO), communication with government officials, press releases and official letters. On occasion, BMA staff and elected officers shared survey findings and BMA publications directly with governments.

*The BMA's Fourth Report – 'Public Health Response by the UK Governments to Covid-19'*

171.     The Inquiry has asked for further information on a number of statements made within the BMA's fourth COVID-19 Review Report.

The impact of different public health structures across the UK

172.     At page 11 of the fourth report, it is stated:

Witness name:          Professor Philip Banfield

Statement number:     1

*"Furthermore, having different structures for public health in each of the devolved nations presented challenges for the pandemic response, such as data access across the multiple public health systems. Within England, the division of public health responsibilities across multiple organisations impacted the clarity and dissemination of advice and information".*

173.    The structure of public health in England – divided between national bodies and local public health functions residing within Local Authorities – means that effective information sharing between these functions is critical. This did not always work smoothly with issues around data access, for example, timely access to testing data. This is illustrated by the experience of the UK's first local lockdown in Leicester in the summer of 2020.

174.    Those with public health expertise and understanding of the local population in Leicester (including elected officials) had only partial access to relevant data, which was slow in being shared with them. Local authorities were initially only receiving 'pillar 1' data, namely the results of swab tests from PHE laboratories of people with a clinical need and health and care workers. They did not receive the testing data for the wider local population (the 'pillar 2' data). Local leaders were therefore unable to fully explain decision-making to their constituents and were also hampered in the extent to which they could be proactive in public health messaging. Arguably, the Leicester experience undermined, at a very early stage, the principal of a localised approach to managing restrictions in England (see exhibit PB/38 - INQ000116840, BMJ article published on 5 August 2020 titled 'Leicester lockdown: could better data have prevented it?').

175.    The Inquiry has asked for an overview of the type of data that was difficult to access across multiple health systems. The BMA has not explored this issue directly (for example, through specific surveys addressing access to data or data sharing), but this was the BMA's broad assessment based on research for the BMA's fourth COVID-19 Review Report and can be illustrated by the Leicester example outlined above.

176.    The Inquiry has asked in what way the clarity and dissemination of advice and information impacted the health sector in England. Page 10 of the fourth COVID-19 Review report sets out the practical limitations of centralised decision making about guidance and public health messages. Announcing highly significant changes to the public, at the same time as those working in public health roles around England learnt of them, undermined the effectiveness of local public health functions. It also had the effect of undermining relationships with, and trust among, those who were key to

49

Witness name:        Professor Philip Banfield

Statement number:     1

explaining current advice or mandated actions, or indeed attempting to manage local outbreaks. 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 teams and destroying local relationships"*.

BMA lobbying for earlier introduction of face coverings

177. In England, the UK government announced on 4 June 2020 that face coverings would be mandatory on public transport from 15 June 2020. Prior to this announcement, the BMA had been calling for an introduction of face coverings for the public where social distancing was not possible. This was included in:

a. Media interventions, for example, in the Telegraph article of 25 April 2020, titled 'All key workers must get masks and public should cover faces, says BMA' (PB/39 - INQ000116841), which reports the BMA's *"calls for ministers to ask members of the public to wear face coverings outside of their homes"* given the *"'emerging evidence' that covering mouths and noses 'may help' to control the spread of Covid-19 and therefore save lives"*.

b. The BMA's paper on 'Easing the lockdown – principles and priorities' (2 June 2020) (PB/10 - INQ000117966), in which the BMA identified the following as priority actions for easing lockdown restrictions:

   i. The public should be encouraged and supported to wear face coverings or masks in situations where physical distancing is not possible, for example on public transport or while shopping.

   ii. Governments should provide clear guidance on the public wearing of face-coverings and ensure provision of, or access to, appropriate masks or coverings for the public as has been done in other nations.

c. Guidance to the public on 'Tourism in the time of Covid' (4 June 2020) (PB/40 - INQ000117971) in which the BMA warned that people on holiday may be less vigilant in adhering to the basic control measures for Covid-19, including physical distancing, handwashing and wearing face coverings which may increase risk. It advised that people can be infectious for up to 48 hours before developing symptoms and outlined the benefits of wearing a mask or face-covering to reduce the risk of transmitting Covid-19 when infectious. It also

50

advised that businesses should consider mandating the wearing of face coverings in enclosed spaces.

178. The BMA also made repeated calls for face coverings to be introduced in a wider range of settings beyond the initial requirement of wearing them on public transport only. Examples include in:

a. media interventions, for example, in the Sky News report on 5 June 2020 titled, 'Coronavirus: People should start wearing face masks now – and not just on public transport, doctors say' (PB/37 - INQ000116839), which reports the BMA's position that "*plans to make face coverings compulsory on public transport do not go far enough*".

b. A letter sent to the SoS (26 June 2020) (PB/8 - INQ000097942) which calls for absolute clarity in the Government's public health guidance and "*for the wearing of face coverings in all public places where social distancing is not possible*".

c. Evidence to the Lords Select Committee (29 June 2020) (PB/41 - INQ000118011).

d. Guidance to the public, for example through an infographic on (1 August 2020) (PB/42 - INQ000118056).

179. The BMA did not receive a specific response from the UK Government or from any public bodies to its public lobbying on this issue at the time.

180. There was however some direct contact with Government on the issue. The BMA's chair of council met with the Equalities Minister, Kemi Badenoch, on 11 September 2020, during which he expressed the BMA's view that face coverings should be mandatory in the hospitality sector (PB/74 – INQ000097950 and PB/43 – INQ000118164). On 22 September, the UK Government announced that this would be the case from 24 September 2020, and this was later confirmed by the Minister in a letter to the BMA received on 16 October 2020 (PB/43 - INQ000118164).

*Devolved Nations*

181. Face coverings were announced as mandatory in Northern Ireland from 1 August 2020, to be enforced from 20 August 2020, which was later than some other parts of the UK. The reason for this was that all NPIs required agreement from the five parties in the Northern Ireland Executive before they could be implemented. While BMA members supported the wearing of face coverings, BMA Northern Ireland was

51

clear in responding to questions in the media that it was a decision for the Northern Ireland Executive (PB/44 – INQ000116923).

182.     BMA Scotland did not lobby separately on the issue of face coverings being worn by the public in Scotland.

183.     In July 2020, BMA Wales called, via the media, for the use of face coverings/masks to be extended to all public areas where social distancing was not possible (PB/45 - INQ000118591). It also made representations to the CMO for Wales calling for the mandatory use of face coverings in all enclosed areas (GPCW letter of 10 August 2020).

Preparations for a second wave

184.     At page 28 of the BMA's fourth report, it is stated:

*"Despite the optimism of some during the summer of 2020, the BMA joined other organisations in calling on the UK governments to prepare for a second wave and was increasingly cognisant of the risk a further wave of COVID-19 presented. This included an explicit call for a rapid, forward-looking, and cross-party review focused on evaluating national preparedness in the lead up to winter".*

185.     In 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, focussed 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), and the UK Government continued to insist that any review would take place at a later time, without specific reference to when. A copy of the letter is exhibited to this statement as PB/46 - INQ000117995.

186.     The BMA reiterated this call in December 2020 in a letter to the Prime Minister when the BMA, alongside other organisations, supported the call by Covid Bereaved Families for Justice for an immediate statutory public inquiry into the pandemic, including a rapid review first phase (to report back within weeks), to improve the current

pandemic response at the time. A copy of the letter is exhibited to this statement as PB/47 - INQ000118234.

187.    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 Covid-19, particularly in the lead up to winter 2020. The BMA published a range of documents, including:

- Easing the lockdown – principles and priorities (2 June 2020) (PB/10 - INQ000117966)

- Exiting the lockdown – a strategy for sustainably controlling the transmission of COVID-19 in England (November 2020) (PB/5 - INQ000098756)

188.    Documents such as these were published on the BMA website, shared on social media channels, shared with stakeholders (such as the Medical Royal Colleges and health sector think tanks), regularly press released, and regularly shared directly with the DHSC. These publications were also at times referenced by the SoS in meetings with the BMA (see paragraph 104 above).

Devolved Nations

*Northern Ireland*

189.    On 25 June 2020 the Northern Ireland Executive announced the reduction of social distancing from 2 metres to 1 metre. The BMA Northern Ireland statement in response referred to the possibility of a second winter wave of the virus (PB/48 - INQ000116932):

> *"We also want to see how the Northern Ireland government will measure the impact of this latest relaxation and to show there are clear and robust measures to ensure these changes do not result in more people becoming infected, ill, or die; or contribute to a second spike which could overwhelm the health service should that occur this winter".*

190.    Planning for subsequent waves of the pandemic in Northern Ireland was raised with Minister Swann by the chair of BMA Northern Ireland's GPC at a meeting on 27 August 2020 and by the chair of the BMA's Northern Ireland council at a meeting with Minister Swann on 7 October 2020 (PB/49 – INQ000116886).

Witness name:       Professor Philip Banfield

Statement number:   1

191.    A BMA Northern Ireland public statement on 22 September 2020 (PB/50 - INQ000116919) stressed the need for restrictive measures and encouraged the public to follow these:

> "*Speaking to doctors over the past few weeks I am in no doubt that they are all very, very apprehensive about a second wave. Many are still fatigued from the first wave so it is key that we reduce the infection levels and continue to protect our NHS*".

192.    Public messaging by BMA Northern Ireland was then calling for further full lockdown measures from the autumn of 2020, which were finally brought in from January 2021.

*Scotland*

193.    I am currently unaware of communication, if any, between the BMA in Scotland and the Scottish Government specifically relating to warnings on a second wave. Should any further information come to light, I will update the Inquiry.

*Wales*

194.    In Wales, the BMA called via the media for clearer public information and more visible messaging on rules and guidelines, including on mixing with people from outside your household, to offset a potential second wave in the winter of 2020. BMA Wales also called for improvements to test and trace so people did not have to travel many miles to access testing (see for example PB/51 - INQ000118611). During this time, the BMA continued to engage with the Welsh Government on matters such as testing and PPE, through the NHS Wales workforce planning cell and staff-side regular technical briefings.

BMA warnings regarding the spread of the Omicron variant of Covid-19

195.    Following the decision to implement 'Plan B' for England, the BMA urged the UK Government to go further to limit the spread of the emergent Omicron variant and prevent Covid-19 from worsening the NHS workforce crisis during the winter of 2021, through a rapid rise in the infection of healthcare staff. The BMA estimated there could be up to 50,000 doctors, nurses and other NHS staff in England off sick with Covid-19 by Christmas Day if the Government did not introduce further measures to stop the spread of the virus, including but not limited to, reducing social mixing and contact between households, ensuring healthcare staff were better protected by FFP3

Witness name:    Professor Philip Banfield

Statement number:    1

respirators and reintroducing mask wearing in all indoor public settings. The approach to modelling these figures is described as follows.

a. The BMA calculated staff on leave from Covid-19 by Christmas Day 2021 by applying case rates in the wider UK population to the NHS workforce in England. Isolation rules required staff to self-isolate for a period of 10 full days from a positive test, so it accumulated all those with a positive test from 15 December 2021 until Christmas day to give the total number of NHS staff off sick due to Covid on Christmas Day.

b. The BMA used the most recent three-day average case rates for both 15 and 16 December 2021, and then forecasted case rates forward on doubling rate assumptions (set out below). Although isolation, at the latest, occurs from the date of a positive test rather than the date reported, at the time of analysis, data was not available on the date of test in previous days (as it comes with a week's lag). The BMA considered the most recent three-day average case rates to be a reasonable proxy for daily rates of initial isolation. It used case rate data for the UK because data for England is again only available with a time lag, but media reports suggested that rates in England were likely to be higher than the UK average at this time, so this was a conservative assumption.

c. The BMA considered three key scenarios, based on variation in the number of days taken for Covid doubling, and whether healthcare staff were just as or less likely than the general population to test positive. On the one hand, healthcare staff are more highly vaccinated, but on the other they are more exposed to the virus, and they are more likely to be compliant with testing and therefore the need to isolate.

   o Best case scenario – estimated case rates doubling every 4 days, and rates of infection in healthcare staff being 75% of UK population: i.e., 32,960 staff of sick.

   o Middle scenario – estimated case rates doubling every 3 days, and rates of infection in healthcare staff being 75% of UK population: i.e., 46,307 staff off sick.

   o Worst case scenario – estimated case rates doubling every 2 days, and rates of infection in healthcare staff being the same as the UK population: i.e., 130,631 staff off sick.

55

d. The BMA used the most recent data on the total headcount of healthcare staff in England, combining headcount data in NHS Hospital and Community Health Services in England and headcount data for General Medical Practice staff, and 2021 population projections for the UK.

e. Staff numbers were rounded to the nearest 1,000.

196.   The BMA published its projections in a press release to media, embargoed for 18 December 2021 (PB/52 - INQ000118448). This was based on the middle scenario rounded up. Although the BMA did not achieve the robust measures to limit transmission that it called for (such as reducing social mixing and reintroducing mask wearing in indoor public settings), NHS guidance was updated around this time stating that healthcare staff would not need to self-isolate for 10 days if, after an initial positive PCR test, they were retested and produced a negative PCR result and were medically fit to return to work, thereby limiting the acute impact on the healthcare workforce.

*Devolved Nations*

197.   BMA Northern Ireland continued to urge caution in the lifting of restrictions throughout the winter of 2021 in its media commentary, urging all eligible people to take up the vaccine and particular caution over the festive period. To the best of my knowledge, BMA Northern Ireland did not engage directly with the Minister for Health or Northern Ireland Executive in relation to Omicron.

198.   To the best of my knowledge, BMA Scotland did not publicly raise any warnings about the rise of the Omicron variant or raise specific concerns with the Scottish Government.

199.   In Wales, engagement with the Welsh Government in relation to Omicron focused on concerns about PPE for healthcare workers. On 9 December 2021, the chair of the Welsh council met the Minister for Health to discuss PPE concerns in light of Omicron, which was followed up by a letter from the chair of council on 23 December 2021 (PB/53 - INQ000118727). The Minister replied to BMA Wales on 25 January 2022 stating that the IPC guidance remained in force (PB/54 - INQ000118729). However, given the BMA's longstanding concerns about the IPC guidance, this response did not allay concerns. Subsequently, on 27 January 2022, BMA Wales joined with the Royal College of Nursing in Wales to write to the Minister restating our concerns regarding PPE in light of the Omicron wave.

Witness name:      Professor Philip Banfield

Statement number:      1

## D. Data, research and advice about at risk and vulnerable groups

200.    The Inquiry has asked about any information or advice provided by the BMA to UK governments regarding the effect of proposed legislation or regulations upon at-risk and vulnerable groups including those with protect characteristics under the Equality Act 2010 and equality categories under the Northern Ireland Act 1998, and in particular those from ethnic minority groups.

201.    The BMA did not provide information or advice to Governments specifically with regards to the effect of proposed legislation and regulations upon at-risk and vulnerable groups.

202.    Throughout the pandemic, however, the BMA has been proactive in highlighting particular at-risk or vulnerable groups including healthcare workers, people from ethnic minority backgrounds, clinically vulnerable people, people on low incomes and people who were homeless or at risk of homelessness.

203.    The BMA highlighted the risks to these groups through:

- Direct communications with Governments (letters, meetings and phone calls)

- Regular meetings which the BMA attended (e.g., the SPF)

- Providing input into the PHE review into Covid disparities (and subsequently highlighting the gaps within this review)

- Media interventions

204.    The main occasion on which our advice was sought related to the process for identifying people who should be added to the shielding list. This is detailed under the section on clinically vulnerable/extremely vulnerable groups (paragraphs 225 to 228 below). The BMA's advice was also specifically sought by governments in relation to the impact of the pandemic on ethnic minority communities and healthcare staff, for example through inviting the BMA to a meeting with NHS England and the CMO for England on 15 April 2020 (PB/202 - INQ000117849). This meeting was organised by the CEO of NHS England, with invites sent to senior staff within NHS England as well as other organisations including the Royal College of Nursing, NHS Confederation and the British Association of Physicians of Indian Origin (BAPIO).

57

Witness name:       Professor Philip Banfield

Statement number:   1

205. The BMA also undertook work to raise awareness of, and to address vaccine hesitancy amongst certain groups, particularly some ethnic minority communities. In particular, the BMA ran a social media campaign on this issue.

206. This section is structured by the relevant at-risk or vulnerable groups in order to provide clarity and to avoid repetition. Each section includes relevant information about identification of at-risk groups, BMA activity in relation to the impact of NPIs and wider government decision making on these groups, and any key correspondence, meetings or publications that may be relevant to the Inquiry.

*Healthcare workers*

207. The BMA includes healthcare workers as an "at-risk group" due to their greater exposure to the virus through their work. As the trade union and professional association for doctors, they were the BMA's main focus but the majority of the concerns and issues we raised also applied to other frontline health and social care workers. There were also doctors and other healthcare workers who were more at-risk or vulnerable due to factors such as their health or disability status. It also became clear early in the pandemic that healthcare workers from some ethnic minority backgrounds were disproportionately affected.

Identification of differential risks to healthcare workers

208. To understand the different experiences of doctors working on the front line of Covid, BMA member surveys included extensive demographic questions to support detailed analysis, which was especially important in the early stages of the pandemic when less was known about the virus. As already set out at paragraph 169 above, the BMA's research was published on the website and used widely in BMA policy influencing and in supporting interventions in the media.

209. From these surveys, which each received several thousand responses and were broadly representative, it was possible to separate out the experiences of doctors based on factors such as gender, ethnicity, age, medical grade and whether they were working in primary, secondary or another care sector. Surveys also frequently asked about the hazard exposure of respondents to understand if they were working in close contact with patients who were Covid-19 positive or suspected positive.

210. Through this survey data, it was possible to identify the emerging and largely consistent differences among certain key groups, for example in respect of access to

58

risk assessments, access to PPE, the fit testing of PPE, and the extent to which such groups felt protected from Covid-19 at work. It also included differences in members' beliefs about whether substantive protective action was taken following the outcome of a risk assessment.

211.    BMA member surveys for the purpose of understanding the different experiences of doctors working on the front line of Covid-19, were conducted mostly on a UK wide basis. The overall purpose of the surveys was the same for each country, with findings occasionally reported separately in each devolved nation, including to the media.

Adequacy of risk assessments and need for government guidance

212.    Findings from BMA member surveys showed that access to risk assessment in the workplace was far from comprehensive and at the start of the pandemic, inadequate. Doctors from ethnic minority backgrounds experienced particular issues in relation to risk assessments and more commonly felt these were ineffective in providing protection, compared to their white colleagues.

213.    As part of the BMA's work to support members and the wider profession, the BMA also drew on the research expertise of elected members in their respective fields, for example the BMA Medical Academic Staff Committee.

214.    As part of his academic professional work, the chair of the Medical Academic Staff Committee led a research group during the first Covid wave examining the relative risk of mortality and hospitalisation from Covid-19 against key demographic variables, using emerging data. This research used data for the general population (where the weight of available evidence was far greater than for healthcare staff alone) to produce a user-friendly risk stratification tool that was made freely available to download through the BMA website, UK-wide, in addition to the BMA's other guidance for the profession. This research has subsequently been published by peer review (PB/55 - INQ000116842).

215.    Given the importance of the issue of risk assessments to our members and the wider profession, and in the absence of sufficient guidance from the Government, the BMA took the following action to raise its concerns with Government for all doctors, as well as raising particular concerns about those at heightened risk:

- Called for NHS England to develop a risk profiling framework to assist employers in conducting risk assessments that would take into account not only age, but other

factors such as ethnicity, sex and comorbidities (letter to Chief Executive of NHS England of 28 April 2020) (PB/56 - INQ000097947). When such guidance was published in May 2020, the BMA remained concerned about variation in how it was being applied locally and called for more practical advice to organisations, sharing examples of tools produced and offering to work with NHS England and NHS Employers on establishing a risk assessment tool (letter to NHS England on 20 May 2020) (PB/57 - INQ000097908).

- Called on NHS England to reduce the age at which frontline staff are categorised as 'at-risk' to 60, from the current threshold of 70, in line with the WHO's advice on 11 March 2020 (PB/58 - INQ000116843) that people over 60 were one of the groups at higher risk of getting severe Covid-19 disease (also included in the letter to the Chief Executive of NHS England dated 28 April 2020 (PB/56 – INQ000097947)).

- Highlighted the need for greater support to conduct risk assessments in general practice (letter to NHS England on 5 June 2020) (PB/59 - INQ000097851).

216.    In the absence of sufficient guidance from governments on risk assessments, the BMA also published its own guidance and advice for members, including:

- BMA guidance on risk assessments for general practice (18 June 2020) (PB/60 - INQ000117990), which was shared with NHS England on 16 June 2020, prior to publication.

- Publication on the BMA website and dissemination of the risk stratification tool described in paragraph 214 above (5 July 2020) (PB/61 - INQ000118016).

217.    In the devolved nations the BMA national offices shared similar concerns:

a. On 29 May 2020, BMA Northern Ireland wrote to the Northern Ireland CMO (PB/62 - INQ000116868) to draw attention to the need for appropriate risk assessment of doctors from ethnic minority backgrounds, and those with disabilities and long-term health conditions which may make them more vulnerable to Covid-19. The letter included a link to the NHS Employers Risk Assessment available at that time.

b. In Scotland, BMA Scotland raised similar concerns about staff risk assessments via email to the Director General of Health and Social Care on 29 April 2020 (PB/63 - INQ000117069), followed by sharing the BMA's risk assessment tool directly with the Director of Health Workforce on 4 June 2020.

60

c. In Wales, BMA Cymru Wales raised concerns about the adequacy of risk assessment tools with the Director of NHS Workforce and PHW (21 May 2020), and with the Covid-19 Workplace Assessment Sub Group (12 June 2020). BMA Cymru Wales also called for workers in 'at risk' groups, such as retirees who offered to return as part of the pandemic response, to be deployed away from front-line care in favour of non-patient facing roles.

PPE

218.    As referenced in detail in section C of this statement, government decisions and actions in relation to PPE supply, PPE procurement, domestic manufacturing of PPE, adequacy of PPE guidance and PPE fit testing 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 adverse physical and mental health outcomes as a result. Doctors from ethnic minority backgrounds more commonly experienced shortages and pressure to work in environments without sufficient PPE and ethnic minority doctors and those with a disability or long-term health condition were more likely to report feeling worried or fearful to speak out about a lack of PPE.

219.    The BMA raised concerns about this issue directly with the Prime Minister, the SoS, DHSC Ministers, the CMO for England, PHE, NHS England, the Health and Safety Executive and via media interventions. Further detail is included in the BMA's chronology provided separately to the Inquiry, but key examples include:

- Letter to the Prime Minister on 21 March 2020 from the BMA chair of council expressing the BMA's deep concerns regarding the inadequacy of PPE being provided to the medical profession and seeking urgent clarification on the apparent discrepancy between recommended PPE in IPC guidance and that recommended by the WHO. This letter also raised concerns about the lack of testing available (see paragraph 220 below) (PB/64 - INQ000097910).

- Meeting with the SoS on 18 March 2020

- Letters to the SoS on 6 April 2020 and 9 April 2020 (PB/65 - INQ000097854 and PB/66 – INQ000117840)

- Letter to the Secretary of State for Business, Energy and Industrial Strategy on 3 April 2020 (PB/67 - INQ000097847)

- Letter to Lord Deighton (Government lead for PPE procurement) on 21 April 2020 (PB/68 - INQ000097911)

Witness name:        Professor Philip Banfield

Statement number:    1

- Letter to the Health and Safety Executive on 01 December 2020 (PB/69 - INQ000118222)

- Joint letter to the Prime Minister on 18 February 2021 (alongside 20 other organisations representing health and care workers and patients, including the Royal College of Nursing and Royal Pharmaceutical Society) (PB/70 - INQ000118291) This letter called for amendments to the IPC guidance to recognise aerosol transmission, thereby providing staff with appropriate PPE.

Testing and contact tracing

220.    Decisions of the UK Government in respect of Covid-19 testing also impacted on doctors and other healthcare staff. This included decisions about the testing availability, prioritisation and capacity. The BMA raised concerns with the Prime Minister, the SoS, DHSC Ministers, the CMO for England, PHE and via media interventions. See the chronology for further details, but key examples include:

- Letter to the Prime Minister on 21 March 2020 expressing concern about the lack of testing for healthcare staff and their families (PB/64 - INQ000097910)

- Meetings with the SoS on 18 March 2020, 26 March 2020, 28 April 2020, and 23 September 2020.

- Letter to the SoS on 26 March 2020 about lack of testing for healthcare workers and their families, despite the SoS and Prime Minister's announcement that it was being prioritised (PB/7 - INQ000097941)

- Meeting with the DHSC Minister of State on 27 March 2020 (PB/71 - INQ000117802)

Doctors from ethnic minority backgrounds

221.    From April 2020, the BMA was raising concerns about the disproportionate impact of the pandemic on people from ethnic minority groups, including doctors and other healthcare workers. The BMA raised these concerns with NHS England, the Number 10 Special Adviser, DHSC and Equality Ministers, PHE, MPs (via parliamentary briefings) and via media interventions, including:

- Letter to the Chief Executive of NHS England (copying the CMO for England and PHE) on 9 April 2020 (PB/72 - INQ000097864) expressing concern about the impact of Covid-19 on the ethnic minority population and the high number of deaths

Witness name:    Professor Philip Banfield

Statement number:    1

among doctors from ethnic minority backgrounds and calling for better data collection and sharing to understand the impact on these doctors.

- Meeting with NHS England on 15 April 2020

- Meeting with DHSC Minister for Social Care on 15 October 2020

- Publicly calling for an urgent review into why people from ethnic minority backgrounds are more vulnerable to Covid-19, in a Guardian article on 10 April 2020 (PB/12 - INQ000116819)

- Following PHE publishing their review into *COVID-19: inequalities and disparities in risk and outcomes* on 2nd June 2020, the BMA wrote to the Minister for Equalities Kemi Badenoch, who was responsible for further work in this area, on 5 June 2020 (PB/73 - INQ000097850), to seek urgent action from Government and ask them to publish recommendations that would have a tangible impact. The BMA met with the Equalities Minister, Kemi Badenoch, on 11 September 2020 and wrote again to her on 29 September 2020 (PB/74 - INQ000097950) to seek immediate Government action as cases once more began to rise.

222.     The BMA also consistently raised 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. The BMA raised these concerns with NHS England, DHSC and the British Safety Industry Federation, including:

- Letter to the Chief Executive of NHS England on 9 April 2020. This covered a range of issues affecting ethnic minority doctors including the need to ensure there is sufficient supply of effective PPE to meet different needs, including those who wear beards for religious reasons (PB/72 - INQ000097864)

- Letter to the British Safety Industry Federation (a joint letter with the Royal College of Nursing) on 28 May 2020 (PB/75 - INQ000097948). This letter highlighted concerns around the production of FFP3 respirators which disproportionately do not fit smaller, often female, face shapes, and the consequences for female staff as a result, calling for the industry to review the design of PPE.

- Letter to Jo Churchill MP, Parliamentary Under Secretary of State (DHSC Minister for Prevention, Public Health and Primary Care) on 13 January 2021 (PB/76 - INQ000097874). This letter highlighted ongoing concerns about female doctors struggling to find respirator masks that pass fit testing and called for appropriate

PPE to urgently be made available to meet the diverse needs of the healthcare workforce.

*At-risk or vulnerable groups in the wider population*

223.　　In March 2021, the BMA published a report "Mitigating the impact of COVID-19 on health inequalities" (26 March 2021) (PB/77 - INQ000099287). This drew on existing evidence and publications to set out the emerging evidence about the impact of the pandemic on certain groups and made a number of recommendations to Government to mitigate these impacts and prevent widening inequalities. The report set out five key priorities for Government:

- Reducing overall transmission of the virus

- Ensuring vaccine access for groups most vulnerable to the virus

- Improving financial security to ameliorate the impact of the pandemic on those already on low incomes

- Protecting the long-term (health) outcomes of children living in deprivation, which were particularly impacted as a result of the pandemic

- Investing in a strong public mental health response

Ethnic minority communities

224.　　In addition to raising concerns about the impact of the UK Government's decisions on ethnic minority healthcare workers (paragraph 155), the BMA also raised concerns about the impact on members of the public from ethnic minority backgrounds. The BMA raised these concerns with PHE, the SoS for Health, the Equalities Minister Kemi Badenoch MP, the CMO for England, MPs (via parliamentary briefings) and via media interventions. This included:

- Calling for a review into the disproportionate deaths and serious illness experienced by ethnic minority groups (9 April 2020) (PB/72 - INQ000097864)

- Communication with PHE about their review (21 May 2020) (PB/78 - INQ000097912) and submitting a written contribution as part of the review (24 May 2020) (PB/79 - INQ000117943)

- Highlighting the significant gaps within the review's report, including reports that some pages and recommendations from the report had been removed, in letters

64

to the Equalities Minister, Kemi Badenoch, on 5 June 2020 (PB/73 - INQ000097850), the SoS and Equalities Minister on 7 June 2020 (PB/80 - INQ000117975), and the SoS on 12 June 2020 (PB/81 - INQ00097872).

- Meeting with the Number 10 Special Adviser on Civil Society and Communities, Samuel Kasumu on 28 April 2020 (PB/235 - INQ000117871). At this meeting the BMA discussed its concerns about the review being undertaken by PHE and proposed key ways to address the disproportionate impact on ethnic minority communities such as a consideration of ethnicity within risk assessments.

- Meeting with the SoS on 28 October 2020 (PB/206 - INQ000118179). At this meeting the BMA raised concerns about the proportion of ethnic minority patients in intensive care and stressed the need for effective public health support for ethnic minority communities.

- The BMA's 'Exiting the lockdown' paper (launched on 1 November 2020) (PB/5 - INQ000098756), which was discussed with the CMO for England on 18 November 2020.

- Meeting with the Equalities Minister, Kemi Badenoch, on 14 December 2020 (PB/236 - INQ000118243). At this meeting the BMA highlighted the need for culturally competent communications, for the Government to build trust with communities and for data collection on Covid-19 infection rates to be broken down by factors such as ethnicity and occupation.

People who were clinically vulnerable to poor outcomes from Covid-19

*Identification of clinically vulnerable people for shielding lists*

225.    The BMA was not directly involved in the decision making which underpinned the development of shielding lists for England and were only aware of the patient groups defined as being at higher risk following a letter by the National Medical Director and CMO for England of 21 March 2020 (PB/82 – INQ000116844). However, later in the pandemic, the BMA's GPC was consulted on the development of a risk tool by NHS England that ultimately helped to identify a wider group of people for inclusion within the shielding list. The following contact took place:

- 2 April 2020 - BMA representatives, alongside the Royal College of General Practitioners (RCGP), met with PHE and agenda items included shielded patients (PB/237 - INQ000117820). Attendees agreed that the shielding definition was not clear and discussed the risks associated with this.

Witness name:       Professor Philip Banfield

Statement number:    1

- 23 July 2020 - BMA Head of Science and Public Health participated in a stakeholder call with the Deputy CMO about support provided by Government once shielding comes to an end (PB/210 - INQ000118048).

- 05 October 2020 - BMA's GPC was involved in the development of a risk tool by NHS England to identify people within GP patient lists that were vulnerable. Members of the GPC Executive met with NHS England on 5 October 2020 to discuss this issue. This tool ultimately helped to identify a wider group of people for inclusion within the shielding list.

226.   BMA Cymru Wales received reports from practices and members that they had been contacted by members of the public who believed they should have received shielding letters but had not (e.g., renal patients, transplant recipients). BMA Cymru Wales wrote to Welsh Government officials to raise these concerns, and also issued a briefing to Assembly Members to outline the situation. Members of GPC Wales engaged with Welsh Government medical officers to agree an improved process. A letter was issued on 3 April 2020 (PB/83 - INQ000116845) that clarified that GPs could view the central shielding list on a secure portal, and if they determined that a patient, due to their particular vulnerability, should have received a shielding letter (but had not) then they could issue one directly from the practice and a particular clinical code was added to the patient record so that the person would be added to the list of vulnerable groups.

227.   BMA Scotland was invited to comment on various versions of Scottish Government guidance on this issue. Following an announcement by the UK Government on 16 March 2020 on a package of measures to advise those at greatest risk of severe illness from Covid-19, the BMA's Scottish GPC provided input on the Scottish Government's communications to GPs in relation to identifying this group of patients in Scotland.

228.   Advice of BMA Northern Ireland was not formally sought to identify groups at risk.

*Impact on clinically vulnerable people*

229.   Throughout the pandemic, the BMA sought to raise concerns about those who were clinically vulnerable, or extremely clinically vulnerable, due to pre-existing medical conditions or other factors. 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 (such as access to tests for their contacts). The specific

Witness name:      Professor Philip Banfield

Statement number:    1

interventions the BMA called for evolved as the pandemic progressed and more was known about the risks of Covid-19 for different groups and the effectiveness of different protective measures, including face coverings. Specific interventions included:

- Letter from Chair of UK Council to Deputy CMO for England calling for the provision of Fluid Resistant Surgical Masks to vulnerable adults and people over 60 to bring UK guidance and practice in line with the WHO recommendations at the time (27 October 2020) (PB/84 - INQ000118178)

- BMA Publication, "Exiting the lockdown – A strategy for sustainably controlling the transmission of COVID-19 in England" called for the provision for Fluid Resistant Surgical Masks to vulnerable adults and people over 60 in line with the WHO recommendations at the time (1 November 2020) (PB/5 - INQ000098756)

- BMA publication, "Taking a cautious approach to easing restrictions" outlined the WHO recommendations at the time (medical-grade masks for vulnerable adults and people over 60) and called for wider use of industrially produced masks with higher filtration capacity in line with the requirements for indoor public spaces in several European countries (28 February 2021) (PB/6 - INQ000118297).

People who were homeless or at risk of being homeless

230.    The BMA raised concerns about the disproportionate impact of the pandemic on those who were homeless or at risk of being homeless. This included:

- Joint letter to Secretary of State for Housing on 19 August 2020 urging him to extend the eviction ban and address long-term housing insecurity. Coordinated by Medact, other signatories included a large number of medical royal colleges, the Faculty of Public Health and the Royal Pharmaceutical Society (INQ000236245).

- BMA position statement on Covid-19 and homelessness in England (21 August 2020) which called for immediate action from all UK governments to protect those at risk of homelessness as a direct result of the Covid-19 pandemic, and continued funding for efforts to protect those currently homeless from contracting the virus. (PB/85 - INQ000118103)

- Media intervention on the consequences on lifting the eviction ban (19 September 2020) (PB/86 - INQ000116856)

- BMA policy paper on mitigating the impact of COVID-19 on health inequalities (26 March 2021) (PB/77 - INQ000099287)

Witness name:        Professor Philip Banfield

Statement number:    1

<u>People on lower incomes</u>

231.     The BMA raised concerns about the financial barriers to following public health guidance experienced by those on lower incomes. This impacted the effectiveness of government's public health measures to control the spread of the virus as well as the risk to individuals themselves:

- Joint letter to the Prime Minister on 17 December 2020.

- BMA publication "Taking a cautious approach to easing restrictions" (28 February 2021) (PB/6 - INQ000118297) called for further financial and practical support to be made available to enable self-isolation, particularly for those on low incomes and with insecure employment.

- The BMA policy paper on mitigating the impact of Covid-19 on health inequalities (26 March 2021) (PB/77 - INQ000099287) set out a range of recommendations for improving financial security for vulnerable groups and making it easier for them to self-isolate when they had Covid-19.

*The BMA's Fifth Report – 'The impact of the pandemic on population health and health inequalities'*

<u>How the BMA carried out its survey on this topic and who participated</u>

232.     During November and December 2021, the BMA conducted a wide-ranging call for evidence survey of doctors in all four UK nations, which received 2,484 responses. The survey was open to all doctors and medical students, including non-BMA members. The survey questions were largely qualitative, allowing respondents to share their experiences in their own words. The survey included a number of questions on the impact of the pandemic on population health and health inequalities, including:

> *"The pandemic has highlighted disparities within society, widening health inequalities, and impacted groups differently (e.g. elderly, ethnic minorities, clinically vulnerable, those with disabilities, women or key workers). What solutions would you like to see in response to such disparities, to reduce the impact of a future public health crisis?"*

233.     In addition to the call for evidence survey during November and December 2021, the BMA conducted regular surveys of its members between 6 April 2020 and 8 April 2022 in the form of Covid-19 Tracker surveys and Viewpoint surveys (see Section

68

C: BMA COVID-19 Review). Approximately half of these surveys were UK-wide, while the remainder covered either England, Wales and Northern Ireland, or only England and Wales. These surveys included questions across a wide variety of topics. Questions of relevance to the impact of the pandemic on population health and health inequalities include:

- How concerned, if at all, are you about the likely health outcomes of patients who have had to wait longer than before the pandemic to be seen or treated?

- Thinking about your place of work / training, how confident are you that people with chronic diseases, long-term health issues, mental health problems, and waits for medical specialist care (not surgical) will receive the care they need without further deterioration?

- Compared to one year ago, to what extent are you concerned that patients may suffer avoidable harm to their health from delayed admission or arrival at hospital?

234.    The BMA's Fifth Covid-19 Review Report also includes secondary data sources including from governments, health services, the ONS, the Royal College of Psychiatrists, the Health Foundation and the Kings Fund.

Methods by which the effect of the Pandemic or the response to the Pandemic, on at-risk groups, was monitored by the BMA

235.    The source of the BMA's information on at-risk groups were the experiences of healthcare professionals, and the responses they provided to our surveys. These could be examined along lines of gender, age, disability or long-term health condition, ethnicity, work setting and role. Examples of the intelligence gathered and the monitoring and action the BMA took as a result are set out in paragraphs 207 to 231 above.

236.    The BMA also monitored the impact of the pandemic on at-risk groups in a number of other ways, including:

- Frequent monitoring of data related to: Covid-19 infections; Covid-19 hospitalisations; Covid-19 vaccinations; and rates of long Covid. Where available, this data was examined by factors such as age, ethnicity, disability and deprivation (for general population data).

- Examining inequalities in Covid-19 deaths, including in relation to deprivation, ethnicity and disability (PB/77 - INQ000099287).

69

- Beyond formal monitoring, the BMA was kept informed of the lived experience of at-risk groups among the wider public through links between the BMA's Patient Liaison Group and a number of at-risk communities and patient groups.

237.    No specific monitoring related to these issues was undertaken in any of the Devolved Nations although the BMA tracker and other surveys were largely UK-wide.

*Whether the interests of doctors were adequately considered when decisions about the response to Covid-19 were made by the UK, Scottish or Welsh Governments or the Northern Irish Executive*

UK/England:

238.    It is the BMA's view that doctors were not sufficiently considered in UK Government decisions. Examples include:

a. Scientific Advisory Group for Emergencies (SAGE) - the failure to ensure adequate independent specialist public health doctor knowledge on SAGE, undermining the breadth and depth of its advice to Government.

b. Pandemic planning exercises – decisions to ignore key lessons negatively impacted healthcare professionals.

c. NPIs – the decisions around when certain NPIs were implemented such as mandatory mask wearing and national lockdowns. Decisions to implement such measures were too slow, negatively impacting on healthcare workers, who as a result faced more pressure, and on patients, who were less able to access care as the system had to shift almost exclusively towards the delivery of Covid-19 care. For example:

- At the time the first UK-wide lockdown was implemented on 23 March 2020 there were already 4,873 people in hospital with Covid-19

- Decisions around mask wearing at the start of the pandemic meant that masks were only recommended in healthcare settings and were not initially recommended for use by the public. The BMA lobbied for face masks for the public to be introduced far earlier. Subsequent decisions not to ensure adequate, consistent, and easy to understand public messaging around mask wearing and other NPIs negatively impacted adherence and the spread of the virus, and also increased pressure on healthcare systems.

70

Witness name:      Professor Philip Banfield

Statement number:    1

- The decision not to cancel large sporting events in March 2020 undoubtedly led to higher cases, hospitalisations and possibly deaths.

d. PPE – decisions related to the PPE stockpile, domestic manufacturing, international procurement schemes, and the relabelling of expired PPE, placed doctors at risk.

e. IPC guidance – the type of PPE recommended, the settings in which PPE was recommended to be used and the communication of this guidance all knowingly left doctors at risk. This included:

- The IPC guidance in the UK not aligning with guidance from the WHO, European Centre for Prevention and Disease Control (ECDC) and Centers for Disease Control and Prevention (CDC), particularly around the use of long-sleeved gowns and eye protection. The BMA raised this in a letter to Public Health England on 24 March 2020 (PB/87 - INQ000097932).

- Decisions not to classify CPR (including chest compressions) as an aerosol generating procedure, which impacted on the provision of PPE to staff and left them unnecessarily exposed to the virus. The BMA raised this with Public Health England in a joint letter with the Resuscitation Council UK (RCUK), Royal College of Nursing (RCN) and the Hospital Consultants and Specialists Association (HCSA) on 23 April 2020 (PB/88 - INQ000097926).

- Decisions not to update IPC guidance in light of evidence of aerosol transmission. This meant that the guidance recommended Fluid Resistant Surgical Masks (FRSMs) for staff in contact with Covid-positive or suspected Covid-positive patients rather than Respiratory Protective Equipment (RPE) outside of procedures specifically designated as aerosol generating. FRSMs do not provide adequate protection against a virus that is spread by the airborne route. The BMA raised this on many occasions including letters to Public Health England (13 January 2021) (PB/89 - INQ000097875), the Health and Safety Executive (21 January 2021) (PB/90 - INQ000097909), and the Prime Minister (18 February 2021) (PB/70 - INQ000118291).

71

- The decision to retract acknowledgement of aerosol transmission from the IPC guidance in March 2022, after including it in the January IPC guidance. The BMA raised this in a letter to the CMO for England on 30 March 2022 (PB/91 - INQ000097952).

- Decisions about the communication of IPC guidance, with reports that guidance was often unclear, poorly communicated to staff and difficult to implement, including due to the fact it was often released late on a Friday.

f. Health and safety – the failure of government to publish clear, practical risk assessment guidance for NHS employers that included the need for employers to continue to adhere to pre-existing health and safety legal requirements for employers (e.g., the conduct of risk assessments) and decisions about the provision of risk assessment tools. The BMA highlighted that risk assessments were particularly important given the number of ethnic minority healthcare workers and given these were disproportionally affected by Covid-19, especially during the first Covid wave.

g. Testing and tracing – the following decisions and failures placed doctors at risk: the lack of testing capacity (which meant many healthcare workers did not have access to tests initially); the decision to abandon contact tracing in mid-March 2020; the decision to outsource the contact tracing programme to external organisations (rather than use local experience and infrastructure), with implications for contact tracing success rates; and the removal of free testing (which meant fewer patients were testing). Greater testing and tracing capacity would have supported healthcare workers by protecting their health while working in high-risk settings and would have reduced the considerable pressure on healthcare workers from mounting cases.

Devolved Nations

*Northern Ireland*

239.     BMA Northern Ireland was not specifically consulted before decisions about the Covid-19 response were taken by the Northern Ireland Executive. BMA Northern Ireland did raise its views at meetings with the Northern Ireland Health Minister who would seek approval on his policy positions from the Northern Ireland Executive. BMA Northern Ireland expressed strong views objecting to the increased interval between the first and second doses of the Pfizer vaccine, in writing to the Minister on 2 January

2021 (PB/92 - INQ000116898), in an urgent meeting (listed in the Northern Ireland chronology) and in the media. This was a particular concern for doctors in Northern Ireland as staff working in care homes were receiving the second Pfizer dose at a three-week interval, yet a doctor who was seeing patients in these care homes had a 12-week interval between doses. Despite raising these concerns on behalf of the medical profession, the 12-week interval remained in place.

*Scotland*

240.      BMA Scotland considers that, on the whole, the views of doctors were taken into consideration by the Scottish Government, particularly in relation to NPIs. However, the most notable example of where this did not happen is in relation to the decision to increase the interval between the first and second dose of the Pfizer covid vaccination for the health workforce. BMA Scotland made a number of representations, mainly by telephone and in the media on this issue. This was a particular concern for doctors in Scotland as, similar to doctors in Northern Ireland, staff working in care homes were receiving the second Pfizer dose at a three-week interval, yet a doctor seeing patients in care homes was waiting 12-weeks between doses. Despite raising these concerns on behalf of the medical profession, the 12-week interval remained in place.

*Wales*

241.      BMA Cymru Wales participated in group meetings, individual meetings and other forums with the Welsh Government to set out the views of the medical profession. This partnership working was broadly welcome and successful in ensuring the views of doctors were appropriately considered.

242.      The extent to which these representations of BMA Cymru Wales were adequately considered is mixed. For example, concerns were raised around the availability of appropriate PPE to the medical profession and the application of risk assessments (see below). However, BMA Cymru Wales considers that, for the most part, where issues were raised, action was taken to address concerns.

243.      Despite initial disagreement on the detail within the Welsh Government's risk assessment tool, BMA Cymru Wales were able to work in social partnership to agree FAQs to support implementation. The risk assessment tool was updated in August 2020 with the pausing of shielding by the CMO for Wales, and pressure from BMA Cymru Wales (as part of the partnership forum staff side) ensured that any shielding

73

individuals would automatically score 7 and thus be termed 'Very High Risk', having the most stringent adjustment measures put into place.

244.    Communications around the availability of PPE was poor early on, something BMA Cymru Wales highlighted. In response to the BMA's representations the Welsh Government rapidly engaged to improve co-ordination of procurement and provide regular updates on availability of stock, so that BMA members could be reassured.

245.    One notable example where BMA Cymru Wales felt views of doctors were not heeded was the decision to increase the interval between the first and second doses of the Pfizer vaccine. A number of representations were made to the Welsh Government, but the 12-week interval remained in place.

*Summary of any data held by the BMA regarding transmission of Covid-19 amongst its members*

UK/England:

246.    The BMA collected the names of doctors in the UK who died from Covid-19 while working in the health service during the pandemic. Through this, the BMA identified 53 doctors. However, this figure is not exhaustive, and there may be other doctors who have died from Covid-19. These doctors were not necessarily members of the BMA.

247.    In the absence of government reporting on Covid-19 infection rates among healthcare staff, the BMA included questions related to infection in its Covid tracker surveys between July 2020 and April 2021. This information was self-reported by those who chose to respond to each survey. Answers could be filtered by characteristics including gender, ethnicity, age and disability or long-term health condition (LTC). The table below provides a summary of these responses:

| | *Question: Do you believe that you previously have, or may have, contracted Coronavirus?* | | *Question: Have you personally contracted Coronavirus?* | | | |
|---|---|---|---|---|---|---|
| **Survey date** | 09.07.2020 | 13.08.2020 | 22.10.2020 | 17.12.2020 | 08.02.2021 | 19.04.2021 |
| **Coverage** | England & Wales | England & Wales | England, Wales & Northern Ireland | England, Wales & Northern Ireland | UK wide | UK wide |

Witness name:    Professor Philip Banfield

Statement number:    1

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| All respondents | | Y | 33% (1,624) | 29% (1,091) | 19% (1,264) | 22% (1,405) | 23% (1,645) | 23% (1,061) |
| | | N | 67% (3,343) | 71% (2,613) | 81% (5,264) | 78% (4,866) | 77% (5,408) | 77% (3,572) |
| Gender | Female | Y | 33% (956) | 29% (586) | 18% (686) | 22% (772) | 23% (923) | 22% (575) |
| | | N | 67% (1,962) | 71% (1,423) | 82% (3,054) | 78% (2,794) | 77% (3,107) | 78% (2,039) |
| | Male | Y | 32% (652) | 30% (489) | 21% (565) | 24% (620) | 24% (708) | 24% (482) |
| | | N | 68% (1,355) | 70% (1,164) | 79% (2,155) | 76% (2,011) | 76% (2,241) | 76% (1,495) |
| Ethnicity | White | Y | 31% (1,093) | 28% (746) | 19% (880) | 22% (976) | 23% (1,116) | 22% (729) |
| | | N | 69% (2,384) | 72% (1,896) | 81% (3,790) | 78% (3,478) | 77% (3,787) | 78% (2,540) |
| | Ethnic minority | Y | 36% (497) | 33% (309) | 21% (359) | 23% (383) | 25% (494) | 24% (310) |
| | | N | 64% (871) | 67% (635) | 79% (1,337) | 77% (1,247) | 75% (1,499) | 76% (961) |
| Age band | 25 and under | Y | 49% (81) | 38% (30) | 28% (46) | 30% (124) | 37% (102) | 45% (30) |
| | | N | 51% (86) | 63% (50) | 72% (120) | 70% (294) | 63% (173) | 55% (36) |
| | 26 – 35 | Y | 41% (376) | 36% (254) | 25% (295) | 32% (310) | 34% (327) | 31% (182) |
| | | N | 59% (531) | 64% (452) | 75% (877) | 68% (658) | 66% (627) | 69% (405) |
| | 36 – 45 | Y | 34% (403) | 31% (245) | 18% (279) | 24% (319) | 23% (358) | 22% (225) |
| | | N | 66% (771) | 69% (555) | 82% (1,257) | 76% (1000) | 77% (1,181) | 78% (778) |
| | 46 – 55 | Y | 31% (435) | 29% (304) | 19% (379) | 21% (379) | 22% (495) | 23% (344) |
| | | N | 69% (970) | 71% (737) | 81% (1,669) | 79% (1,437) | 78% (1,707) | 77% (1,125) |
| | 56 – 65 | Y | 25% (267) | 23% (186) | 17% (218) | 17% (222) | 19% (307) | 20% (237) |
| | | N | 75% (792) | 77% (620) | 83% (1,103) | 83% (1,091) | 81% (1,319) | 80% (964) |
| | 66 – 75 | Y | 23% (46) | 20% (37) | 16% (34) | 10% (35) | 12% (44) | 15% (38) |
| | | N | 77% (156) | 80% (144) | 84% (177) | 90% (303) | 88% (330) | 85% (223) |
| | 76 and over | Y | 19% (5) | 15% (6) | 10% (2) | 10% (5) | 9% (4) | 9% (2) |
| | | N | 81% (22) | 85% (35) | 90% (18) | 90% (43) | 81% (39) | 91% (20) |
| Disability or LTC | Yes | Y | 32% (227) | 29% (166) | 20% (178) | 22% (207) | 23% (203) | 23% (160) |
| | | N | (68% 477) | 71% (416) | 80% (719) | 78% (751) | 77% (678) | 77% (527) |
| | No | Y | 33% (1,367) | 30% (900) | 19% (1,063) | 22% (1,161) | 23% (1,412) | 23% (883) |
| | | N | 67% (2,807) | 70% (2,134) | 81% (4,428) | 78% (4,015) | 77% (4,632) | 77% (2,984) |

75

## E. Public Health Communication

*The role that the BMA played in the development of public health messaging during the pandemic*

248.    The BMA was not directly involved in shaping or influencing central government messaging in relation to the pandemic.

249.    The BMA was, however, often critical about the communication from government, especially when government was not listening to concerns that were raised regarding the clarity of public health messaging. The BMA therefore appealed directly to the public through, for example:

   a. Calling repeatedly for the earlier introduction of mask wearing by the public, including in media responses highlighting the public health benefits of mask wearing by the public (see paragraphs 177 and 178 above).

   b. Developing an infographic for the public on face coverings (PB/42 - INQ000118056).

   c. Producing guidance for the public on safe tourism (June 2020) (PB/40 - INQ000117971 and PB/93 – INQ000116857).

   d. Calling for culturally competent public health communications to address vaccine hesitancy (e.g., the comment to the Eastern Eye on 16 December 2021) (PB/94 - INQ000217259).

   e. Urging the public to minimise mixing with other households indoors over the festive period, and to reconsider holiday plans, to limit transmission of the virus. Where mixing happened, reminding people of the importance of ventilation and social distancing and wearing masks (16 December 2020) (PB/95 – INQ000098795).

   f. In May 2021, the BMA launched a campaign to tackle vaccine mistrust and hesitancy. The campaign worked with social media influencers, predominantly from ethnic minority backgrounds, to help combat mistrust of the vaccine and of health services in some ethnic minority communities in the UK (see PB/96 - INQ000099354 - PB/97 INQ000217258, see also INQ000236246).

   g. In April 2022, the BMA called on the public to remain cautious and avoid social mixing if they had Covid symptoms. At the same time, the BMA called on the

Witness name:        Professor Philip Banfield

Statement number:    1

UK Government to reinstate free testing for patients and the public to protect those most vulnerable and the health services. This was during a period of rising infection rates in the spring of 2022.

h. The BMA also issued specific guidance for healthcare workers throughout the pandemic on how they could best protect themselves and raise concerns with employers, for example, around inadequate PPE (e.g., 22 April 2020) (PB/98 - INQ000117758), access to risk assessments (e.g., 16 June 2020) (PB/60 - INQ000117990), reducing infection risk to staff (26 November 2020 and 1 August 2021) (PB/99 - INQ000118214 to PB/100 - INQ000118397). On several occasions, the BMA wrote directly to NHS Trusts reminding them of their duties under health and safety law to protect their workers and to properly assess and mitigate the risks of Covid-19, including through provision of PPE, improved ventilation and social distancing, for example (PB/101 - INQ000117919 and PB/102 - INQ000097857).

Devolved Nations

250. BMA Northern Ireland provided frequent public health messaging directly to the public via press statements, newspaper, television and radio interviews. Regular output was maintained throughout all phases of the pandemic, encouraging a cautious approach from members of the public and for them to follow all public health guidelines to reduce the spread of infection.

251. Early in the pandemic, in April 2020, BMA Northern Ireland members created a local video campaign for social media[5], encouraging the public to stay at home over Easter. This included Northern Ireland doctors on the front line of Covid-19 speaking directly to the public via social media videos. The basis of the public health advice was in line with that published by the Northern Ireland Public Health Agency, encouraging social distancing, hand hygiene, following all restrictions and minimising non-essential travel.

252. When restrictions were being eased, BMA Northern Ireland members encouraged the public, through the media, to exercise caution when returning to bars and hospitality venues to reduce potential pressure on local emergency departments. BMA Northern Ireland spokespeople also regularly highlighted the ongoing risks to

_____

[5] For example, see the first video posted on 8 April 2020: INQ000236247

Witness name:      Professor Philip Banfield

Statement number:      1

clinically extremely vulnerable people despite the easing of restrictions for the general population in press and media statements.

253.    BMA Scotland was not consulted on public health messaging, but it broadly supported the Scottish Government's messaging to the public. The BMA's Scottish GPC did encourage the Scottish Government to establish central points of contact for Covid-19 information (and treatment) so that GP practices were not the first port of call.

254.    BMA Cymru Wales played a limited role in the development of public health messaging in Wales, instead focussing on tailored messaging and FAQs for healthcare workers. For example, BMA Cymru Wales supported the development of guidance for GPs on what they can do safely (PB/103 – INQ000118528 and PB/104 – INQ000118693), co-signing contractual letters issued by the Welsh Government. On occasion elected members from BMA Cymru Wales featured on media interviews to answer public questions regarding COVID-19 and the interventions put in place.


*Clarity of public health communication and confidence in campaigns by the UK Government and Devolved Nations*

255.    Throughout the pandemic, the BMA has highlighted the absence of effective and proactive public health messaging from the UK Government. Consistency and ease of understanding are important aspects of public health messaging, but which were lacking in UK Government communications and messaging was subject to frequent changes (for example, in relation to mask wearing requirements or work from home measures).

256.    A lack of clarity was particularly apparent when the UK's strategies for living with Covid were published. For example, although the UK Government's living with Covid strategy contained useful public health advice, there was a glaring absence of public health messaging to accompany and promote that advice, which meant that the public's understanding of living with Covid-19 became synonymous with the removal of restrictions and the notional end of the threat of Covid-19, rather than a carefully managed policy.

How members were asked for their views on public health communications

257.    When conducting the BMA's COVID-19 Review, the BMA sought the views of its members about public health communications through its call for evidence survey (see paragraph 165 above). Respondents commented on the clarity of public health

Witness name:      Professor Philip Banfield

Statement number:      1

communications and their confidence in governments' communications campaigns throughout multiple free-text questions in the survey (PB/36 - INQ000116838).

258.    The BMA's Covid Tracker and Viewpoint surveys also included questions of relevance to the clarity of public health communications and members' confidence in governments' communications campaigns, such as:

a.  How confident are you that you understand the current IPC measures for Covid in your place of work?

b.  To what extent are you confident in the current approach to managing spread of Covid-19 infection in your country?

259.    To ensure that the reports adequately reflected the views and experience of public health doctors, the BMA also undertook an additional, supplementary exercise, examining the public health response during the pandemic from the expert point of view of public health doctors. Supplementary questions were gathered from the BMA's Public Health Medicine Committee, which includes doctors working across a range of public health organisations (including the UKHSA), in June 2022. Approximately 30 public health doctors on the Public Health Medicine Committee were asked the following questions, which while not all directly referred to public health communications, will all have impacted on public health functions' ability to communicate such information:

a.  How, if at all, could local public health expertise (e.g., in health promotion or protection) have been used more effectively in the response to Covid-19?

b.  Based on your experience, please provide an example of ineffective communication between organisations involved in implementing IPC measures during the pandemic.

c.  Similarly, based on your experience, please provide an example of effective communication between organisations involved in IPC measures during the pandemic.

d.  How, if at all, could organisations involved in implementing IPC measures have been better connected during the Covid-19 pandemic?

e.  How, if at all, has a pre-pandemic shortage of public health specialists/consultants in your main place of work impacted your ability, or the ability of colleagues, to perform critical functions during the Covid-19 pandemic? (if you have not experienced any shortages, you may leave blank)

79

f.  If your role changed in response to Covid, how did this impact your ability, or the ability of others, to carry out critical functions during the pandemic?

g.  How has this impacted the ability of local public health to respond and act on behalf of their populations during the Covid-19 pandemic? (e.g., it may be useful to think about access to data, experience, expertise, structure or funding in your answer)

h.  How would you describe your ability to practise autonomously or give robust advice on Covid-19 during the pandemic? If you have experienced barriers to your professional autonomy or felt discouraged from giving robust advice, please tell us a little about the circumstances.

260.  Although the BMA did not report on and publish the results of these supplementary questions separately, they directly informed the Fourth Report of the BMA's COVID-19 Review.

261.  As stated at paragraph 162 above, the BMA had over 192,000 responses to its surveys throughout the pandemic, including responses from members living across the UK.

Opinion of BMA members on the effectiveness of public health communications

262.  Overall, participants in the BMA's research thought that governments' public health communications were too varied in their clarity and quality, in particular in England, which impacted on the public's understanding and confidence. The key findings from the BMA's COVID-19 Review were:

a.  While some aspects of governments' public health communications were clear and effective – particularly the UK Government's initial message of 'Stay home, protect the NHS, save lives' – many messages were unclear, inconsistent and changed too frequently.

b.  Participants particularly disagreed with the approach of announcing changes in guidance to the public via the media at the same time they were being communicated within the public health community. This approach increased the challenge of public health professionals in interpreting and disseminating information and forming effective, trusting relationships with the public. One consultant in Northern Ireland responded:

    *"The messaging early on from government and PHA [Public Health Agency] was poor leading to staff confusion and worry"*.

80

c. Participants also mentioned the impact of publicly discussing a change in restrictions prior to this change coming into force (e.g., 'Freedom Day').

d. Some participants noted that having different measures in each of the UK nations and local variations within England at times, caused additional confusion and complicated public health messaging, for example:

> *"The four nations approach was understandable but led to lots of confusion about what was and wasn't 'allowed'."* (Consultant, Scotland)

> *"Difficult having the different nations of the UK all adopting different public health measures and messaging – confusing and affects the public's compliance".* (Consultant, Wales)

263.    The lack of clear messaging to the public on issues such as mask-wearing also 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.

Any national variation in the confidence of those surveyed on the communication strategies

264.    It should be noted that the relevant questions in the BMA's call for evidence survey regarding government communication and messaging were qualitative, and therefore they cannot be assessed for statistical significance or variation in any meaningful way. However, the clarity of governments' public health communications was a theme raised by participants in all four UK nations.

265.    That being said, the perception of government communications was not uniform across the UK, for example, one salaried GP in Wales told the BMA:

> *"… as a citizen and resident in Wales, I – and all my neighbours and colleagues – have consistently felt that the firm and cautious control (and communication) by the Welsh Government has been safer than, and much preferable to, that of 'London' – the Westminster UK/England government",*

and a GP contractor/principal in Scotland responded with the following:

> *"I think measures in Scotland were more effective as consistent messages throughout helped to clarify what was and was not allowed".*

81

Influence of public health messaging in England on those living in devolved nations

266. Respondents to the BMA's call for evidence reported that having different guidance and measures in the devolved nations, alongside heavy UK-wide media coverage of the UK Government's decisions, increased confusion amongst the public and that, during 2021 and at previous points in the pandemic, messaging from the UK Government also influenced those living in the devolved nations. This theme was most commonly mentioned by respondents in Wales.

267. The main example of this given by survey participants was the UK Government's frequent framing of the removal of restrictions in the context of 'freedom'. The narrative around 'Freedom Day' from the UK Government and media sent the message that the virus was no longer a threat, despite restrictions remaining in Northern Ireland, Scotland and Wales.

*BMA views on the effectiveness of public health messaging*

UK/England:

268. The Inquiry has asked the BMA to provide examples of when the BMA thought public health messaging was effective. Generally, the BMA was critical of the UK Government's communication and messaging strategies, although it recognises that the following examples demonstrated effective communication:

   a. The daily nature of the television broadcasts from the UK Government (and the Scottish Government) were effective in keeping the public up to date, although the BMA had concerns about inconsistencies in the UK Government's approach and messaging, particularly in the early weeks of the pandemic leading up to the first lockdown.

   b. The UK Government slogan of 'Stay at home, protect the NHS, save lives' from 23 March to 11 May 2020 was simple and easily understood.

269. Examples of public health messaging that the BMA considered ineffective include:

   a. Unclear messaging between 16 and 23 March 2020, when the public were encouraged, but not required, to change their behaviour (e.g., mass events were discouraged, for example by withdrawing the support of emergency services, but not banned).

Witness name:       Professor Philip Banfield

Statement number:    1

b. 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 to stay alert and control the virus.

c. Although the daily nature of television broadcasts from the UK Government was helpful, more could have been done to ensure that these updates were inclusive (e.g., by using BSL interpretation). In addition, the broadcasts were often the first time that front-line public health teams heard about changes to rules or guidance, which left them unprepared in their day-to-day roles. These updates stopped on 23 June 2020, which contributed to the narrative that Covid-19 was no longer important. They then resumed in mid-August 2020. (In contrast, the Scottish Government briefings reduced in frequency during July 2020 but did not stop.)

d. The introduction of the 'one metre plus' messaging in June 2020 was unclear and subjective as to what 'plus' required.

e. There were high-profile failures to adhere to lockdown rules, which impacted the effectiveness of public health messaging.

f. There were frequent changes to certain protections/NPIs, which led to public health messaging that was inconsistent and hard to understand. Examples include:

   o Face masks: the lack of decisiveness on the part of Government and the piecemeal introduction of mandatory mask wearing by the public caused confusion. There was a lack of clear public messaging regarding the quality or composition of masks. Evidence showed that FFP2 respirators were more effective than, for example, a home-made face covering. This information would have been especially important to those who are most vulnerable to severe illness or death from infection and their relatives. Some official government communications showed images of people wearing inappropriate masks (for example masks with valves)[6] and senior government figures were also pictured wearing these types of masks. Given the frequency of changes to mask wearing requirements, public health messaging should have been clearer.

---

[6] For example, see the video posted on the No.10 Downing Street twitter feed on 14 July 2020: INQ000236248.

83

Witness name:      Professor Philip Banfield

Statement number:    1

- Working from home: 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 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.

- Local lockdowns/restrictions: there was poor communication about why a region was placed in a specific tier of restrictions, with local leaders not having much advanced notice or clarity about the areas covered.

- The failure of Government messaging and rules leading up to Christmas 2020 and the Prime Minister's repeated assurances that people would be able to mix at Christmas, with a last-minute reversal and tightening of restrictions eventually announced on 20 December.

g. PCR testing: 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.

Devolved Nations

270.    The Northern Ireland Department of Health's public health messaging reflected public health guidance to prevent the spread of infection. Following the 2020/21 second wave, the Northern Ireland Executive kept a range of NPIs in place during 2021 when England had removed all restrictions in July 2021.

271.    BMA Scotland was content with the public health messaging in Scotland and the regular updates from the Scottish Government. BMA Scotland and BMA Wales highlighted the issues around UK Government messaging, which encroached or became mixed or confused with Scottish or Welsh Government messaging, in particular when NPI measures began to differ significantly. The issue of UK Government messaging intermingling with, and potentially undermining, announcements from the devolved nation governments remained prominent throughout the pandemic.

Witness name:        Professor Philip Banfield

Statement number:    1

*Misinformation regarding NPIs*

272.     Respondents to the survey noted that there were periods during the pandemic when public compliance with some NPIs was low. Many respondents felt that governments' communication with the public had been poor, with inconsistent information about NPIs and instances of MPs and government leaders not complying with the recommended NPIs fuelling mistrust and misinformation. This was particularly mentioned in relation to mask wearing and the impact this had in healthcare settings. In a BMA survey in September 2021, 36% of respondents in England, Wales and Northern Ireland said they did not feel supported by their government to ask a patient or visitor to wear a face mask if they were not already doing so. 20% of respondents reported that they themselves or a colleague had experienced hostility from patients or visitors when requesting that they wear a face mask.

## F. Lessons Learned

*What worked well and the difficulties or challenges encountered by the BMA in supporting key decision-making by the UK governments*

The BMA's interaction and collaboration with the UK Government, in particular with the Cabinet Office, Cabinet Committees or DHSC

273.     As set out at paragraphs 53 to 59 above under Section B, the BMA had reasonably good access to the SoS, DHSC ministers and the CMO (in England). The BMA was generally able to have a meeting or call with them when it had issues of concern to discuss.

274.     However, the BMA was often critical of the approach adopted by the UK Government in relation to the public health response to Covid-19, including in relation to the introduction or removal of NPIs. While the BMA had the opportunity to air these concerns with the SoS, Ministers and Senior Officials, the Association was regularly dissatisfied with the action taken by government. In addition to the BMA's direct engagement, it regularly issued publications or media statements or resorted to formal written correspondence in order to encourage the UK Government to change its approach. In these communications, the BMA sought to set out what the BMA believed was a better course of action to minimise the spread of Covid-19, to protect the public, and to reduce the impact on healthcare services and healthcare workers, including

Witness name:        Professor Philip Banfield

Statement number:    1

BMA members (specific examples are set out in other sections of this statement, for example, at paragraphs 140 to 145 above).

275.     The BMA rarely received an explanation as to why the Government was choosing not to follow the approach recommended by the BMA, although in a number of cases (such as the PHE review or the request to delay lifting lockdown restrictions in 2021, as set out at paragraphs 154 to 155 above), I believe that interventions by the BMA either directly to Ministers, to civil servants or publicly, did have an influence on government decision making.

The BMA's interaction and collaboration with the Northern Ireland Executive

276.     BMA Northern Ireland had meetings with the Northern Ireland Minister for Health during the pandemic period and interactions were cordial. As discussed at above (at paragraph 68), the Northern Ireland Executive is formed by a mandatory coalition of political parties, which means that policies which the Northern Ireland Minister of Health wishes to implement must be agreed by the other parties in the Executive. For example, in the autumn of 2020, when BMA Northern Ireland was calling for lockdown measures to prevent the spread of Covid-19, these restrictions were opposed by the DUP, despite them not holding the post of Minister for Health. The mandatory coalition structure had to be taken into account when decisions were being scheduled.

The BMA's interaction and collaboration with the Scottish Government

277.     The relationship between the Scottish Government and BMA Scotland worked well, and the early establishment of the Health Workforce Senior Leaders Group in response to the pandemic, which met regularly throughout the pandemic, was an effective way of working collaboratively, and identifying and addressing issues. These issues included the key NPI-related actions and interventions to support and protect the health workforce including for example; PPE supply, PPE guidance, social distancing in the workplace, isolation, risk assessment and protection of vulnerable workers, vaccination, testing, long-covid, appraisal, wellbeing resources, retired-returners, staffing of the Louisa Jordan hospital, redeployment of staff, recruitment of students and a range of short-term changes to conditions of service.

Witness name:      Professor Philip Banfield

Statement number:      1

The BMA's interaction and collaboration with the Welsh Government

278. BMA Cymru Wales broadly welcomed the opportunities afforded to it, and to other trade unions and member organisations, to meet with the Welsh Government and its officials during the course of the specified period. These meetings had a range of benefits, enabling fast paced information sharing, offering the opportunity to relay concerns of BMA Cymru Wales' membership, and to call for appropriate action to address the concerns raised.

279. The extent to which BMA Cymru Wales' calls were heeded is mixed, for example, concerns were raised around the availability of appropriate PPE to the medical profession and the application of risk assessments which were not addressed (see paragraphs 151 and 217.c). For the most part however, BMA Cymru Wales considers that where issues were raised, action was taken to address concerns.

The BMA's interaction and collaboration with public bodies including PHE/UKHSA, NHS England, and equivalents in the Devolved Nations

UK

280. The BMA considers that it had good access to NHS England throughout the pandemic, through 1:1 meetings with the NHS England Medical Director and communication with the CEO of NHS England. This did not always mean the BMA's concerns were acted upon and the BMA frequently raised concerns with NHS England staff about a range of issues, particularly around the protection of healthcare workers.

281. The BMA did not have regular meetings with PHE or the UKHSA and its engagement with these bodies was primarily through written correspondence. There were also several stakeholder meetings held by these organisations on specific topics, which BMA staff members attended, such as on IPC measures and guidance. Details of all meetings are included within the BMA's chronologies, provided separately to the Inquiry.

282. One key challenge in terms of the BMA's engagement was that guidance from PHE/UKHSA was, on occasion, released late in the day (often on a Friday) preceded by minimal, if any, consultation. This made it difficult for the BMA to engage with the guidance and even more difficult for healthcare professionals and leaders on the ground who were required to implement it.

283. A particular issue in terms of the BMA's engagement was in relation to Covid-19 guidance from the four-nation IPC Cell. The BMA regularly publicly criticised the

87

guidance and the risk it posed to healthcare workers and patients, as well as raising this issue in meetings with officials from NHS England and other public agencies and sending formal correspondence. However, these interventions did not result in the changes sought by the BMA and to this day, the IPC guidance for healthcare settings across the UK states that a FRSM is adequate protection for healthcare workers working with patients with suspected or confirmed Covid-19, outside a limited list of aerosol generating procedures, placing them at risk from Covid-19, including the risk of long Covid in their workplaces.

*Devolved Nations*

284.     Northern Ireland does not have an equivalent to NHS England, and interactions took place with the Northern Ireland Department of Health. BMA Northern Ireland did not have significant interactions with local administrations during this time. As stated above, BMA Scotland found that the early establishment of the Health Workforce Senior Leaders Group was an effective way of working collaboratively with health agencies in Scotland. Beyond the interactions stated elsewhere in this witness statement, BMA Cymru Wales had limited engagement with individual health organisations and Local Health Boards. Primarily engagement took the form of letters sent to CEO's (such as those referred to at paragraph 151 above). BMA Cymru Wales has no record of specific engagement with local authorities in Wales.

**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signature:

**Personal Data**

Name: Philip Banfield

Date: 21.07.2023

88

Witness name:     Professor Philip Banfield

Statement number:     1

## List of exhibits to the written statements of Prof Philip Banfield

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| **Module 2 exhibits** | | | |
| PB/001 | INQ000097956 | 31-Jan-20 | Letter from the BMA council chair to the Secretary of State for Health, NHS England and PHE |
| PB/002 | INQ000116865 | 02-Mar-20 | Letter from the BMA Northern Ireland council chair to the Northern Ireland CMO |
| PB/003 | INQ000116816 | 24-Jan-20 | Draft circular from the Scottish Government to chair of GPC Scotland regarding fluid resistant masks for GP practices |
| PB/004 | INQ000116817 | 12-Feb-20 | Email from Public Health Wales referring to increasing Covid-19 cases |
| PB/005 | INQ000098756 | 01-Nov-20 | BMA paper, 'Exiting the lockdown – a strategy for sustainably controlling the transmission of Covid-19 in England' |
| PB/006 | INQ000118297 | 28-Feb-21 | BMA report, 'Taking a cautious approach to easing restrictions, measures to support near-elimination of Covid-19 from the UK' |
| PB/007 | INQ000097941 | 26-Mar-20 | Letter from the BMA chair of council to the Secretary of State for Health |
| PB/008 | INQ000097942 | 26-Jun-20 | Letter from the BMA council chair to the Secretary of State for Health |
| PB/009 | INQ000097852 | 05-Jul-21 | Letter from the BMA council chair to the Secretary of State for Health |
| PB/010 | INQ000117966 | 02-Jun-20 | BMA paper, 'Easing the lockdown – principles and priorities' |
| PB/011 | INQ000118161 | 09-Oct-20 | BMA paper, 'Reducing transmission of Covid-19' |
| PB/012 | INQ000116819 | 10-Apr-20 | Guardian article, 'UK government urged to investigate coronavirus deaths of BAME doctors' |
| PB/013 | INQ000118474 | 19-May-22 | BMA Covid Review Report 1: How well protected was the medical profession from Covid-19? |
| PB/014 | INQ000118475 | 19-May-22 | BMA Covid Review Report 2: The impact of the pandemic on the medical profession |
| PB/015 | INQ000185355 | 26-Jun-22 | BMA Covid Review Report 3: Delivery of healthcare during the pandemic |
| PB/016 | INQ000185356 | 28-Jul-22 | BMA Covid Review Report 4: The public health response by UK governments to Covid-19 |
| PB/017 | INQ000185357 | 28-Jul-22 | BMA Covid Review Report 5: The impact of the pandemic on population health |
| PB/018 | INQ000116820 | 06-Apr-20 | Covid Tracker 1 |
| PB/019 | INQ000116821 | 16-Apr-20 | Covid Tracker 2 |
| PB/020 | INQ000116822 | 30-Apr-20 | Covid Tracker 3 |
| PB/021 | INQ000116823 | 14-May-20 | Covid Tracker 4 |

Witness name:     Professor Philip Banfield

Statement number:     1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/022 | INQ000116824 | 28-May-20 | Covid Tracker 5 |
| PB/023 | INQ000116825 | 18-Jun-20 | Covid Tracker 6 |
| PB/024 | INQ000116826 | 09-Jul-20 | Covid Tracker 7 |
| PB/025 | INQ000116827 | 13-Aug-20 | Covid Tracker 8 |
| PB/026 | INQ000116828 | 22-Oct-20 | Covid Tracker 9 |
| PB/027 | INQ000116829 | 17-Dec-20 | Covid Tracker 10 |
| PB/028 | INQ000116830 | 08-Feb-21 | Covid Tracker 11 |
| PB/029 | INQ000116831 | 19-Apr-21 | Covid Tracker 12 |
| PB/030 | INQ000116832 | 08-Jul-21 | Viewpoint 1 |
| PB/031 | INQ000116833 | 02-Sep-21 | Viewpoint 2 |
| PB/032 | INQ000116834 | 26-Nov-21 | Viewpoint 3 |
| PB/033 | INQ000116835 | 04-Feb-22 | Viewpoint 4 |
| PB/034 | INQ000116836 | 08-Apr-22 | Viewpoint 5 |
| PB/035 | INQ000116837 | 27-Feb-22 | Vaccination Survey |
| PB/036 | INQ000116838 | 09-Nov-22 | Covid Review call for evidence |
| PB/037 | INQ000116839 | 05-Jun-20 | Sky News article, 'People should start wearing face masks now - and not just on public transport doctors say' |
| PB/038 | INQ000116840 | 05-Aug-20 | BMJ article, 'Leicester lockdown: could better data have prevented it?' |
| PB/039 | INQ000116841 | 25-Apr-20 | Telegraph article, 'All key workers must get masks and public should cover faces, says BMA' |
| PB/040 | INQ000117971 | 04-Jun-20 | BMA guidance, 'Tourism in the time of Covid' |
| PB/041 | INQ000118011 | 29-Jun-20 | Memorandum of evidence from the BMA to the House of Lords select committee on public services inquiry 'Public Services: Lessons from Coronavirus' |
| PB/042 | INQ000118056 | 01-Aug-20 | BMA infographic, 'Protect others, prevent the spread – wear a face covering' |
| PB/043 | INQ000118164 | 16-Oct-20 | Letter from the Minister for Equalities to the BMA council chair |
| PB/044 | INQ000116923 | 05-Jun-20 | BMA Northern Ireland statement on face coverings for BBC Northern Ireland Talk Back |
| PB/045 | INQ000118591 | 13-Jul-20 | Press statement, 'BMA Cymru Wales response to Welsh Government announcement on mandatory face coverings' |
| PB/046 | INQ000117995 | 23-Jun-20 | Open letter from the BMA and UK medical, nursing and public health organisations to the leaders of all UK political parties, 'Call for a rapid forward-looking review of the UK's preparedness for a second wave' |

90

Witness name:     Professor Philip Banfield

Statement number:     1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/047 | INQ000118234 | 03-Dec-20 | Letter from Covid Bereaved Families for Justice to the Prime Minister |
| PB/048 | INQ000116932 | 25-Jun-20 | BMA Northern Ireland statement on changes to social distancing |
| PB/049 | INQ000116886 | 07-Oct-20 | Note of meeting between BMA Northern Ireland and Minister Swann |
| PB/050 | INQ000116919 | 22-Sep-20 | BMA Northern Ireland statement |
| PB/051 | INQ000118611 | 13-Sep-20 | Wales Online article, 'Second peak of coronavirus is 'very likely' this winter say doctors in Wales' |
| PB/052 | INQ000118448 | 17-Dec-21 | Internal BMA email enclosing embargoed press release, 'BMA warns that without further measures, NHS could face almost 50,000 staff off sick with Covid-19 by Christmas Day' |
| PB/053 | INQ000118727 | 23-Dec-21 | Letter from the BMA Cymru Wales council chair to the Minister for Health and Social Services |
| PB/054 | INQ000118729 | 25-Jan-22 | Letter from the Minister for Health and Social Services |
| PB/055 | INQ000116842 | 01-Jul-21 | BMJ article, 'Development and presentation of an objective risk stratification tool for healthcare workers when dealing with the Covid-19 pandemic in the UK: risk modelling based on hospitalisation and mortality statistics compared with epidemiological data' |
| PB/056 | INQ000097947 | 28-Apr-20 | Letter from the BMA council chair to the Chief Executive of NHS England |
| PB/057 | INQ000097908 | 20-May-20 | Letter from the BMA chair of council to the Chief Executive of NHS England and the Chief Executive of NHS Employers |
| PB/058 | INQ000116843 | 11-Mar-20 | WHO Coronavirus disease 2019 (Covid-19) situation report - 51 |
| PB/059 | INQ000097851 | 05-Jun-20 | Letter from the BMA GP Committee chair to the Chief Executive of NHS England |
| PB/060 | INQ000117990 | 16-Jun-20 | BMA guidance on risk assessments for GPs |
| PB/061 | INQ000118016 | 05-Jul-20 | BMA Covid-19 risk stratification tool |
| PB/062 | INQ000116868 | 29-May-20 | Letter from the BMA Northern Ireland council chair to the Northern Ireland CMO |
| PB/063 | INQ000117069 | 29-Apr-20 | Email from BMA Scotland to the Director General of Health and Social Care |
| PB/064 | INQ000097910 | 21-Mar-20 | Letter from the BMA council chair to the Prime Minister |
| PB/065 | INQ000097854 | 06-Apr-20 | Letter from the BMA council chair to the Secretary of State for Health |
| PB/066 | INQ000117840 | 09-Apr-20 | Letter from the BMA council chair to the Secretary of State for Health |

91

Witness name:     Professor Philip Banfield

Statement number:     1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/067 | INQ000097847 | 03-Apr-20 | Letter from the BMA council chair to the Secretary of State for Business, Energy and Industrial Strategy |
| PB/068 | INQ000097911 | 21-Apr-20 | Letter from the BMA council chair to Lord Deighton |
| PB/069 | INQ000118222 | 01-Dec-20 | Letter from the BMA Occupational Medicine Committee chair to the Health and Safety Executive |
| PB/070 | INQ000118291 | 18-Feb-21 | Joint letter from the BMA and other organisations representing health and care workers and patients to the Prime Minister |
| PB/071 | INQ000117802 | 27-Mar-20 | BMA note of meeting with the Minister of State for Care |
| PB/072 | INQ000097864 | 09-Apr-20 | Letter from the BMA council chair to the Chief Executive of NHS England |
| PB/073 | INQ000097850 | 05-Jun-20 | Letter from the BMA council chair to the Equalities Minister |
| PB/074 | INQ000097950 | 29-Sep-20 | Letter from the BMA council chair to the Equalities Minister |
| PB/075 | INQ000097948 | 28-May-20 | Joint letter from the BMA and RCN to the British Safety Industry Federation |
| PB/076 | INQ000097874 | 13-Jan-21 | Letter from the BMA council chair to the Parliamentary Under Secretary of State (DHSC Minister for Prevention, Public Health and Primary Care) |
| PB/077 | INQ000099287 | 25-Mar-21 | BMA report, 'Mitigating the impact of Covid-19 on health inequalities' |
| PB/078 | INQ000097912 | 21-May-20 | Letter from the BMA council chair to Public Health England |
| PB/079 | INQ000117943 | 24-May-20 | BMA submission to the PHE review into the disparities and outcomes of Covid-19 |
| PB/080 | INQ000117975 | 07-Jun-20 | Letter from the BMA and a number of other organisations representing black, Asian and ethnic minority healthcare professionals to the Secretary of State for Health and the Equalities Minister |
| PB/081 | INQ000097872 | 12-Jun-20 | Letter from the BMA council chair to the Secretary of State for Health |
| PB/082 | INQ000116844 | 21-Mar-20 | Letter from the CMO and NHS England on shielding |
| PB/083 | INQ000116845 | 03-Apr-20 | Email from the CMO Wales to all GPs in Wales |
| PB/084 | INQ000118178 | 27-Oct-20 | Letter from the BMA council chair to the Deputy CMO |
| PB/085 | INQ000118103 | 21-Aug-20 | BMA position statement on Covid-19 and homelessness in England |
| PB/086 | INQ000116856 | 19-Sep-20 | BMA comment, 'Lifting eviction ban could have devastating consequences, says BMA' |

92

Witness name:     Professor Philip Banfield

Statement number:     1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/087 | INQ000097932 | 24-Mar-20 | Letter from the BMA council chair to the Chief Executive of PHE and the Chief Executive of NHS England |
| PB/088 | INQ000097926 | 23-Apr-20 | Joint letter from the BMA, the Resuscitation Council UK, the RCN and the Hospital Consultants and Specialists Association to the Chief Executive of PHE |
| PB/089 | INQ000097875 | 13-Jan-21 | Letter from the BMA council chair to PHE |
| PB/090 | INQ000097909 | 21-Jan-21 | Joint letter from the BMA and RCN to the Health and Safety Executive |
| PB/091 | INQ000097952 | 30-Mar-22 | Letter from the BMA council chair to the CMO for England |
| PB/092 | INQ000116898 | 02-Jan-21 | Letter from the BMA Northern Ireland chair to the Minister for Health |
| PB/093 | INQ000116857 | 04-Jun-20 | BMA poster for people holidaying during Covid-19 |
| PB/094 | INQ000217259 | 16-Dec-21 | Eastern Eye article, 'Exclusive: Alarm as Asians shun booster jabs' |
| PB/095 | INQ000098795 | 16-Dec-20 | BMA press release, 'BMA urges people to keep festive mixing to a minimum to avoid putting loved ones at risk of getting Covid' |
| PB/096 | INQ000099354 | 18-May-21 | BMA press release, BMA fronts social media campaign to encourage uptake of Covid-19 vaccinations among ethnic minority communities' |
| PB/097 | INQ000217258 | 18-May-21 | BMA news story, 'Doctors launch campaign to promote vaccine to ethnic minorities' |
| PB/098 | INQ000117758 | 22 April 2020 (last updated 29 June 2020) | BMA guidance, 'Covid-19: refusing to treat where PPE is inadequate' |
| PB/099 | INQ000118214 | 26-Nov-20 | BMA report, 'Reducing infection risk to staff in healthcare settings' |
| PB/100 | INQ000118397 | 01-Aug-21 | BMA guidance, 'Reducing infection risk in healthcare settings' |
| PB/101 | INQ000117919 | 18-May-20 | Letter from the BMA to Trust CEOs |
| PB/102 | INQ000097857 | 07-Jul-21 | Letter from the BMA council chair to the Trust CEOs |
| PB/103 | INQ000118528 | 23-Mar-20 | Letter from the GPC Wales chair to GPs |
| PB/104 | INQ000118693 | 29-Mar-21 | BMA Cymru Wales poster, 'Covid-19 visiting your GP surgery' |
| PB/105 | INQ000117918 | 16-May-20 | WhatsApp exchange between the BMA council chair and the Secretary of State for Health |
| PB/106 | INQ000116859 | 14-Jul-20 | BMA news report, 'Government makes wearing face masks mandatory' |

93

Witness name:      Professor Philip Banfield

Statement number:      1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| **Module 1 exhibits** | | | |
| PB/107 | INQ000145893 | 2008 | Health and Safety Executive research report, 'Evaluating the protection afforded by surgical masks against influenza bioaerosols' |
| PB/108 | INQ000145858 | 20-Aug-20 | BMJ article, 'Airborne transmission of covid-19' |
| PB/109 | INQ000118441 | 25-Nov-21 | Letter from the BMA and others to the Chair of the Health and Safety Executive |
| PB/110 | INQ000118447 | 15-Dec-21 | Letter from the Chair of the Health and Safety Executive to the BMA and others |
| PB/111 | INQ000145872 | 06-Nov-20 | HSE news, 'Further guidance on RIDDOR reporting of Covid-19' |
| PB/112 | INQ000145868 | 16-Mar-18 | BMA webpage, 'Feeling the squeeze: The local impact of cuts to public health budgets in England' |
| PB/113 | INQ000145849 | Sep-19 | BMA summary report, 'Caring, supportive, collaborative: Doctors' vision for change in the NHS' |
| PB/114 | INQ000145852 | 05-Dec-22 | BMA report, 'Building the Future 1: Brick by Brick: the case for urgent investment in safe, modern, and sustainable healthcare estates' |
| PB/115 | INQ000145853 | 05-Dec-22 | BMA report, 'Building the Future 2: Getting IT Right: The case for urgent investment in safe, modern technology and data sharing in the 2 UK's health services' |
| PB/116 | INQ000145865 | 2019 | BMA report on escalation beds, 'NHS trusts forced to open thousands of extra beds to cope with year-round pressures' |
| PB/117 | INQ000145891 | 24-Jun-20 | Letter from NHS England and NHS Improvement to Chief Executives, Chief Nurses and Medical Directors and HR Directors of all NHS Trusts and Foundation Trusts |
| PB/118 | INQ000118181 | 01-Nov-20 | Letter from the BMA chair of council to the National Medical Director of NHS England & NHS Improvement |
| PB/119 | INQ000145899 | 04-Feb-21 | Public Accounts Committee report, 'Covid-19: Government procurement and supply of Personal Protective Equipment' |
| PB/120 | INQ000145895 | 25-Nov-20 | National Audit Office report, 'DHSC: The supply of personal protective equipment (PPE) during the Covid-19 pandemic' |
| PB/121 | INQ000145860 | 06-May-20 | BMJ article, 'Covid-19: Lack of capacity led to halting of community testing in March, admits deputy chief medical officer' |
| PB/122 | INQ000145859 | 17-Aug-20 | BMJ article, 'Covid-19: Is local contact tracing the answer?' |

94

Witness name:     Professor Philip Banfield

Statement number:     1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/123 | INQ000145894 | 20-Nov-20 | Local Government Association briefing, 'Suggested steps for increased localisation of testing and tracing' |
| PB/124 | INQ000145835 | 24-Mar-20 | BMA commentary on MEAG Paper on Clinical Prioritisation Framework |
| PB/125 | INQ000117806 | 30-Mar-20 | Emails between the BMA and MEAG regarding guidance on critical care prioritisation |
| PB/126 | INQ000097953 | 30-Apr-21 | Letter from the BMA chair of council to the Chief Executive of UK Health Security Agency |
| PB/127 | INQ000145863 | 13-Feb-09 | Minutes of meeting of the Emergency Planning Clinical Leadership Advisory Group (EPCLAG) |
| PB/128 | INQ000145864 | 10-Jul-09 | Minutes of meeting of the Emergency Planning Clinical Leadership Advisory Group (EPCLAG) |
| PB/129 | INQ000145836 | Dec-09 | BMA and RCGP guidance, 'Pandemic influenza: guidance for GP practices, swine flu H1N1 preparedness' |
| PB/130 | INQ000145877 | Undated | Draft guidance from the Department of Health regarding workforce issues and pandemic flu preparations |
| PB/131 | INQ000145876 | 07-Sep-09 | BMA comments on draft DH guidance |
| PB/132 | INQ000145842 | 17-Jun-11 | BMA response to Department of Health consultation on UK Influenza Pandemic Preparedness Strategy 2011 |
| PB/133 | INQ000145878 | 14-Jan-10 | BMA email regarding National activities on H1N1 |
| PB/134 | INQ000145875 | 23-Feb-09 | Emails between BMA and the Department of Health regarding demand and capacity in healthcare in a pandemic |
| PB/135 | INQ000145911 | 2009 | BMA document provided to the Department of Health titled, 'Withdrawing and Withholding treatment during pandemic 'flu' |
| PB/136 | INQ000145880 | 28-Apr-09 | Emails between the BMA and the Department of Health regarding flu algorithm |
| PB/136(2) | INQ000145881 | 27-Apr-09 | Draft report titled manual flu assessment - clinical protocol |
| PB/137 | INQ000145874 | 22-Feb-10 | Emails between the BMA and the Department of Health |
| PB/138 | INQ000145887 | 06-Apr-10 | Email on behalf of Dame Deirdre Hine to Professor Nathanson |
| PB/139 | INQ000145888 | 06-Apr-10 | Letter from Dame Deirdre Hine to Professor Nathanson |
| PB/140 | INQ000145901 | Jul-10 | Report, 'The 2009 Influenza Pandemic: an independent review of the UK response to the 2009 influenza pandemic by Dame Deirdre Hine DBE FFPH FRCP' |

95

Witness name:       Professor Philip Banfield

Statement number:      1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/141 | INQ000145866 | 26-Oct-20 | Internal BMA email including excerpt from Medical Ethics Committee meeting from 6 December 2016 |
| PB/141(2) | INQ000145867 | 2016-2017 | Draft report from the BMA titled 'Prioritisation and triage during an influenza pandemic - presentation from NHS England's Emergency Preparedness, Resilience and Response team' |
| PB/142 | INQ000117785 | 23-Mar-20 | Emails regarding BMA ethical guidance |
| PB/143 | INQ000117773 | 16-Mar-20 | BMA guidance note on Covid-19 ethical issues |
| PB/144 | INQ000117772 | 19-Mar-20 | BMA FAQs on Covid-19 ethical issues (easy read version) |
| PB/145 | INQ000117774 | 19-Mar-20 | BMA FAQs on Covid-19 ethical issues |
| PB/146 | INQ000145862 | 08-Apr-20 | BMA draft statement about the use of age and/or disability in BMA guidance |
| PB/147 | INQ000145907 | 29-Sep-20 | Emails providing BMA reflections on MEAG |
| PB/148 | INQ000145834 | 19-Feb-16 | BMA report, 'NHS funding and efficiency savings' |
| PB/149 | INQ000145838 | May-17 | BMA manifesto 2017, 'A vote of health' |
| PB/150 | INQ000145870 | 05-Mar-18 | BMA letter to Lord Darzi responding to the Institute for Public Policy Research call for evidence, 'Lord Darzi Review of Health and Care' |
| PB/151 | INQ000145855 | 18-Jun-18 | BMA report, 'NHS funding settlement: Is it enough and how should it be spent? |
| PB/152 | INQ000145902 | 12-Sep-18 | BMA report, 'Prevention before cure: Securing the long-term sustainability of the NHS' |
| PB/153 | INQ000145903 | 28-Mar-19 | BMA report, 'Prevention before cure: Prioritising population health' |
| PB/154 | INQ000145856 | Aug-19 | BMA Brexit briefing, 'A health service on the brink: the dangers of a 'no deal' Brexit' |
| PB/155 | INQ000145857 | 26-Nov-20 | BMA Cymru Wales manifesto 2021, 'A manifesto for health' |
| PB/156 | INQ000118308 | 19-Mar-21 | BMA report, 'Rest, recover, restore: Getting UK health services back on track' |
| PB/157 | INQ000145854 | 12-Jul-21 | BMA report, 'Medical staffing in England: a defining moment for doctors and patients' |
| PB/158 | INQ000118442 | 19-Nov-21 | BMA report, 'Weathering the storm: vital actions to minimise pressure on UK health services this winter' |
| PB/159 | INQ000145906 | May-22 | BMA Public Health Specialists manifesto |
| PB/160 | INQ000145840 | 01-Aug-22 | BMA Northern Ireland 2022, 'A manifesto for health' |
| PB/161 | INQ000145843 | Mar-11 | BMA response to consultation, 'Liberating the NHS: Developing the Healthcare Workforce' |
| PB/162 | INQ000145889 | 07-Nov-13 | BMA written evidence to the Public Health Committee on Public Health England - PHE0011 |

Witness name:     Professor Philip Banfield

Statement number:     1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/163 | INQ000145908 | 18-Dec-15 | BMA Northern Ireland response on the review of the Public Health Act (NI) 1967 |
| PB/164 | INQ000145905 | 13-Jan-16 | BMA written evidence to the Public Health Committee on Public Health England post-2013 - PHP0023 |
| PB/165 | INQ000145890 | 22-Jan-16 | BMA written evidence to the Health Committee on the impact of the comprehensive spending review on health and social care - CSR0063 |
| PB/166 | INQ000145897 | 20-Jul-16 | BMA Northern Ireland response on Draft Programme for Government Framework 2016-21 |
| PB/167 | INQ000145898 | 04-Jan-17 | BMA response to the Public Accounts Committee inquiry into the financial sustainability of the NHS |
| PB/168 | INQ000145909 | 12-May-17 | BMA Cymru Wales response to the Parliamentary Review of Health and Social Care in Wales |
| PB/169 | INQ000145910 | 30-May-17 | BMA Cymru Wales supplementary response to the Parliamentary Review of Health and Social Care in Wales |
| PB/170 | INQ000145900 | Feb-18 | BMA memorandum of evidence to the Public Accounts Committee on sustainability and transformation in the NHS |
| PB/171 | INQ000145896 | 23-Aug-18 | BMA Northern Ireland response to the NI Affairs Committee inquiry into funding priorities in the 2018-19 Budget: Health |
| PB/172 | INQ000145844 | 28-Sep-18 | BMA submission to NHS England on the Long-Term Plan for the NHS |
| PB/173 | INQ000145851 | Sep-18 | BMA memorandum of evidence to the Health and Social Care Select Committee inquiry on 'impact of a 'no deal' Brexit on health and social care |
| PB/174 | INQ000145837 | Sep-18 | BMA representations on UK Government budget |
| PB/175 | INQ000145845 | Oct-18 | BMA memorandum of evidence to the Public Accounts Committee on DHSC accounts |
| PB/176 | INQ000145848 | Oct-18 | BMA response to consultation, ' Advancing our health: prevention in the 2020s' |
| PB/177 | INQ000145839 | Nov-19 | BMA Manifesto for health |
| PB/178 | INQ000145846 | Feb-20 | BMA representations on the UK Government Budget |
| PB/179 | INQ000117799 | 26-Mar-20 | Oral evidence to the Health and Social Care Committee on preparations for coronavirus |
| PB/180 | INQ000117896 | 12-May-20 | BMA submission to the National Audit Office: readying the NHS and social care for the Covid-19 peak |
| PB/181 | INQ000118549 | 22-May-20 | BMA Cymru Wales response to the Inquiry into the impact of the Covid-19 outbreak and its management on health and social care in Wales |

97

Witness name:      Professor Philip Banfield

Statement number:      1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/182 | INQ000118573 | 02-Jul-20 | BMA oral evidence to the Health, Social Care and Sport Committee of the Welsh Parliament |
| PB/183 | INQ000145847 | Sep-20 | BMA representations on the UK Government Comprehensive Spending Review 2020 |
| PB/184 | INQ000118117 | 18-Sep-20 | Letter from the BMA to the DHSC consultation response team on changes to Human Medicine Regulations to support the rollout of Covid-19 vaccines |
| PB/185 | INQ000118235 | 07-Dec-20 | BMA submission to the Public Accounts Committee inquiry on Government procurement and contracts for PPE |
| PB/186 | INQ000145871 | 10-Dec-20 | BMA submission to the Foreign Affairs Committee's inquiry on Global Health Security - GHS0014 |
| PB/187 | INQ000145841 | 20-Jan-21 | BMA Northern Ireland response to 2021-22 budget |
| PB/188 | INQ000145869 | 22-Mar-21 | BMA Northern Ireland response to Programme for Government draft outcomes framework |
| PB/189 | INQ000145892 | Apr-21 | BMA written evidence to the Health and Social Care Committee's inquiry into the Health and Care White Paper |
| PB/190 | INQ000145850 | 05-Apr-21 | BMA response to the DHSC consultation on transforming the public health system: reforming the public health system for the challenges of our times |
| PB/191 | INQ000118350 | 10-Jun-21 | Written evidence submitted by the BMA to the Public Accounts Committee - ILG0004 |
| PB/192 | INQ000118424 | 21-Oct-21 | Written evidence submitted by the BMA to the Health and Social Care Committee and the Science and Technology Committee - CLL0129 |
| **Additional Module 2 exhibits** | | | |
| PB/193 | INQ000097943 | 27-Mar-20 | Letter from BMA council chair to NHS England Director for Acute Care to NHS |
| PB/194 | INQ000097855 | 06-Jul-20 | Letter from BMA council chair to the Chief Executive of NHS England |
| PB/195 | INQ000097930 | 23-Dec-21 | Letter from BMA council chair to Chief Executive of NHS England |
| PB/196 | INQ000097955 | 30-Dec-21 | Letter from the chair of the BMA General Practitioners Committee to the Chief Executive of NHS England |
| PB/197 | INQ000117819 | 31-Mar-20 | Feedback from the BMA on PPE shortages across England accurate as at 31 March 2020 |
| PB/198 | INQ000118065 | 10-Aug-20 | Emails between the BMA and NHS England regarding IPC guidance |
| PB/199 | INQ000117821 | 02-Apr-20 | Emails between the BMA and NHS England |

98

Witness name:      Professor Philip Banfield

Statement number:      1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
| PB/200 | INQ000117760 | 10-Aug-20 | Notes extracted from BMA Public Affairs Covid-19 Issues and Evidence Log March – August 2020 |
| PB/201 | INQ000118248 | 15-Dec-20 | BMA notes of NHS England / NHS Improvement meeting on clear masks held on 15 December 2020 |
| PB/202 | INQ000117849 | 15-Apr-20 | Email from NHS England regarding meeting on the impact of Covid-19 on BAME population |
| PB/203 | INQ000097946 | 28-Mar-22 | Letter from BMA chair of council to the Chief Executive of NHS England |
| PB/204 | INQ000117801 | 27-Mar-20 | Summary notes of internal BMA meeting on 27 March 2020 |
| PB/205 | INQ000117813 | 31-Mar-20 | Notes of SPF Strategic Group meeting |
| PB/206 | INQ000118179 | 29-Oct-20 | Summary notes of internal BMA meeting on 29 October 2020 |
| PB/207 | INQ000117872 | 28-Apr-20 | Internal BMA emails and notes of meeting on 29 April 2020 |
| PB/208 | INQ000118118 | 21-Sep-20 | BMA briefing in advance of meeting with Baroness Harding on 21 September 2020 |
| PB/209 | INQ000118165 | 19-Oct-20 | Internal BMA email with notes of meeting between the BMA chair of council and Baroness Harding on 19 October 2020 |
| PB/210 | INQ000118048 | 23-Jul-20 | Internal BMA email and notes of DHSC stakeholder meeting on shielding |
| PB/211 | INQ000118157 | 08-Oct-20 | Internal BMA emails and notes of meeting between the BMA chair of council and the Secretary of State for Health and Social Care |
| PB/212 | INQ000118207 | 18-Nov-20 | Summary notes of internal BMA meting on 19 November 2020 |
| PB/213 | INQ000118319 | 08-Apr-21 | Summary notes of internal BMA meeting on 8 April 2021 |
| PB/214 | INQ000215039 | 22-Apr-20 | BMA summary notes of SPF meeting |
| PB/215 | INQ000215040 | 20-May-20 | BMA summary notes of SPF meeting |
| PB/216 | INQ000118021 | 30-Jun-20 | SPF Covid-19 Engagement Group Action Note |
| PB/217 | INQ000215041 | 09-Jun-20 | BMA summary notes of SPF meeting |
| PB/218 | INQ000215042 | 04-Nov-20 | BMA summary notes of SPF meeting |
| PB/219 | INQ000215043 | 23-Mar-21 | BMA summary notes of SPF meeting |
| PB/220 | INQ000215044 | 14-Jul-21 | BMA summary notes of SPF meeting |
| PB/221 | INQ000215045 | 27-Jul-21 | BMA summary notes of SPF meeting |
| PB/222 | INQ000215046 | 12-Jan-22 | BMA summary notes of SPF meeting |
| PB/223 | INQ000118264 | 20-Jan-21 | BMA summary notes of SPF workshop on vaccines |
| PB/224 | INQ000118412 | 01-Oct-21 | NHS England and NHS Improvement workshop slides on IPC for seasonal respiratory infections in |

99

Witness name:       Professor Philip Banfield

Statement number:    1

| Exhibit No | Unique Reference No | Date | Description |
|---|---|---|---|
|  |  |  | health and care settings including SARS-CoV-2 for Autumn/Winter 2021/2022 |
| PB/225 | INQ000117797 | 25-Mar-20 | DHSC Note of MEAG meeting |
| PB/226 | INQ000117932 | 20-May-20 | Themes for MEAG involvement with the UK Government's Covid-19 recovery strategy |
| PB/227 | INQ000118224 | 02-Dec-20 | Ethical issues on immunity certification: a discussion paper, for MEAG meeting on 2 December 2020 |
| PB/228 | INQ000118260 | 20-Jan-21 | Emails between members of MEAG |
| PB/229 | INQ000215037 | 02-Apr-20 | Internal BMA email regarding MEAG meeting |
|  | INQ000215038 | 02-Apr-20 | BMA notes of MEAG meeting on 1 April 2020 |
| PB/230 | INQ000097885 | 14-Jul-21 | Letter from the BMA and other organisations to the Prime Minister |
| PB/231 | INQ000118110 | 09-Sep-20 | Letter from the BMA chair of council to the Secretary of State for Health and Social Care |
| PB/232 | INQ000097881 | 14-Jan-21 | Letter from the BMA and other organisations to the Secretary of State for Health and Social Care |
| PB/233 | INQ000097867 | 09-Sep-21 | Letter from the BMA and other organisations to the Secretary of State for Health and Social Care |
| PB/234 | INQ000097914 | 21-Sep-21 | Letter from the BMA chair of council to the Secretary of State for Health and Social Care |
| PB/235 | INQ000117871 | 28-Apr-20 | Internal BMA emails and summary notes of meeting with No. 10 |
| PB/236 | INQ000118243 | 14-Dec-20 | BMA note of meeting between the BMA chair of council and the Equalities Minister |
| PB/237 | INQ000117820 | 02-Apr-20 | Minutes of RCGP/BMA/RCN Covid 19 Liaison Committee meeting |

100

Witness name:      Professor Philip Banfield

Statement number:      1