



BMA Covid Review 3

Delivery of healthcare during the pandemic



Executive summary

To what extent were the UK's health services able to meet the challenge of delivering healthcare during a major pandemic? In late 2021, the BMA conducted a call for evidence survey to understand the experience of the medical profession during COVID-19, as well as to learn lessons for the future. We found that the UK's health services were ill-prepared for managing the delivery of both COVID-19 and usual levels of care, despite the laudable efforts of healthcare staff. These failures, which are in large part down to the historical underfunding and under-resourcing in the decade preceding the virus, put the UK's health services in a weakened position even before the unprecedented pressure of delivering healthcare during a global pandemic.

This report finds that:

- In the decade prior to the pandemic, the UK's health services experienced chronic underinvestment and understaffing which produced a growing range of capacity constraints, including declining bed numbers and rising waiting lists.
- The extent of these pre-existing capacity constraints meant there was little slack in the system when the pandemic hit. Many elective procedures, diagnostic tests and routine outpatient services had to be suspended in order for staff, resources and beds to be utilised for COVID care.
- This resulted in enormous backlogs across the system. Care that could not be provided in secondary care due to cancelled services has instead been held by primary care, with many people experiencing worsening conditions as a result. We will not know the full scale of the long-term negative consequences of this lack of access for some time.
- Staff shortages, which were exacerbated by COVID-related absence, meant that doctors worked in intense and often unsafe conditions for much of the pandemic. Doctors often reported feeling overworked, exhausted, and left with no option but to take on an ever-increasing workload.
- The vaccination programme's success, delivered within primary care and by GPs in particular, must be strongly contrasted with the negative approach the UK government took towards GPs in the national media.
- The UK's health services remain under enormous pressure. Substantial investment is required across the system to address increasing need, bolster staffing, and make inroads to reducing the serious backlogs.

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Acknowledgments

We would like to thank everybody who responded to our survey detailing their experiences of the pandemic. The BMA understands the immense sacrifice that continues to be made by medical professionals. If you do not see any of the text from your response included in our reports, please do know that every response was read and used to inform our conclusions. We are very grateful indeed.

Our third COVID review report is the work of Mercedes Broadbent, Jenny Haigh, Claire Chivers, Margot Kuylen, Duncan Bland, Rob Kidney, Lena Levy, Alex Gay, and the BMA Wales, Scotland, and Northern Ireland teams. Contributions have come from BMA elected members and chief officers. The team of people in our Communications and Policy Directorate and staff across the BMA have made publication and promotion possible, including our strategic communications, media, public affairs and content and audience teams.

Foreword



Before COVID-19 hit our shores, the NHS was suffering a decade of austerity which had led to shortages of doctors and health funding well below that of comparator nations. By 2019 the spiralling recruitment and retention crisis had resulted in 111,864 vacancies across secondary care in England, while the UK Government promised 5,000 extra GPs that never materialised.

Even before the pandemic, waiting lists were at record levels and sharply rising across the UK and by February 2020, just as COVID-19 was forcing lockdowns in Lombardy, 4.43 million people in England were languishing on waiting lists. Cancer care targets were frequently missed and the number of people waiting for diagnostic tests had more than doubled in ten years.

With the NHS already in turmoil a novel virus posed a clear threat to the delivery of healthcare across the UK. Without the needed infrastructure, staff, capacity, or even adequate pandemic planning, routine healthcare was paused, significantly adding to a backlog which since then has grown, with subsequent waves of infection, to a record 6.5 million people on waiting lists in England, the greatest the NHS has ever seen.

Today the 18-week wait target enshrined in the NHS Constitution has been abandoned as two million people now wait longer, 310,000 people are waiting over a year for treatment and over 17,000 are waiting over two years. The UK Government admit that this situation is likely to deteriorate further, and the waiting list in England is expected to climb above 13 million. Between April 2020 and February 2022, there were over 31 million fewer outpatient appointments, pointing to a parallel medical care backlog (mental health, chronic care) which remains unknown, but likely hides the suffering of millions more people.

Despite this, the UK's health services delivered a staggering level of care during the pandemic and the efforts of healthcare staff across the four nations have been incredible. The vaccination programme – delivered within primary care and largely by GPs in addition to their regular workload – was an unprecedented success. But delivering care in already under-resourced systems, with the virus exacerbating staff absences, has forced doctors to continue to work in intense and often unsafe conditions. Now, more than ever, doctors report feeling overworked, exhausted, and many are considering leaving the NHS.

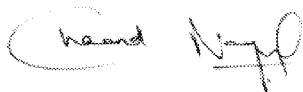
The shift to a new way of working resulted in arguably the biggest change in the way care was delivered through harnessing technology to enable remote video and online consultations, virtual ward rounds, and patient self-monitoring at home such as through the use of pulse oximetry. These changes have helped to maximise a limited workforce, and allowed those who had to isolate to work remotely if well enough. In this respect they have been positive for patients, albeit as this report and report 5 in this series set out, digital care is not appropriate for everybody and this shift created access challenges for some. However, adopting digital innovations ahead of schedule has allowed services to deliver care in the most efficient ways possible, alongside traditional face to face care. Such innovation must continue if we are to surmount this current crisis of care.

Managing a huge backlog of care is also diverting doctors' time away from patient care to administration. Patients on secondary care waiting lists are routinely attending their GP practices to chase up when they might be treated, and many deteriorate while waiting, requiring further support from their GP and eventually secondary care staff. Patients are rightly frustrated, and doctors and their teams are receiving increasing levels of abuse as they try their best in a system that is not meeting the needs of patients.

As this report shows, we are now at a critical juncture that ultimately requires honesty from the government about the scale of the challenge ahead. The UK Government needs to provide a tangible plan for how we can address workforce shortages and infrastructure deficits so there is a clear trajectory that can lead us out of this crisis, rather than political recovery targets that ignore the harsh realities on the ground.

The scale of suffering within the population cannot be overestimated. It is not just wrong, it is inhumane that anyone should endure years of wait for treatment, years which sadly, for many, will define the final years of their life. At a time when the public has dipped into their pockets to pay for the Health and Social Care Levy, transparency around the use of this money is needed more than ever to ensure it is not squandered and a plan with the confidence of the profession and the taxpayer is established.

During the worst days of the coronavirus pandemic, the Chancellor of the Exchequer promised that the NHS would get "whatever it needed". The Government today cannot ignore its moral obligation to care for the citizens of this country. It must take this care crisis just as seriously. Without a similar commitment, the NHS risks never fully recovering, always playing catch-up, with no end to that truly vicious cycle that only multiplies suffering.

A handwritten signature in black ink, appearing to read 'Chaand Nagpaul'. The signature is written in a cursive style with some loops and flourishes.

Chaand Nagpaul, BMA UK council chair

The BMA's COVID-19 review and research included in this report

Throughout the pandemic, the BMA has been critical of many elements of the UK governments' decisions and handling of the pandemic response for patients, the population's health, and healthcare workers. The handling of the pandemic was [described by a cross-party select committee](#) last October as 'one of the most important public health failures the United Kingdom has ever experienced', reflecting on inadequate supplies and procurement of PPE; a test and trace system that failed to deliver; and delays in implementing public infection control measures to prevent the virus spreading.

It is important to learn lessons from the pandemic response so that action can be taken in the immediate future – as the UK's health services grapple with several pressures because of the pandemic and the biggest backlog of care in their history – and to be best prepared for future pandemics and avoid repeating past mistakes.

During November and December 2021, the BMA contacted its members and other key stakeholders, including Royal Colleges and leading think tanks, to understand the impact of the UK and devolved governments' handling of the COVID-19 crisis. We wanted to hear how it affected the lives of doctors, the health service, patient care, and the public's health. Our survey was largely qualitative, providing us with the voices from frontline doctors that we quote verbatim in this report, while we also include quantitative data from other research conducted by the BMA during the pandemic, including COVID tracker surveys and viewpoint surveys (more information about these resources can be found in Appendix A). Overall we want to help inform a robust review into the handling of the pandemic, ahead of the statutory inquiries starting in 2022.

We are publishing five reports, each focusing on a particular aspect of the pandemic response.

- The protection of the medical profession from COVID-19
- The impact of the pandemic on the medical profession
- Delivery of healthcare during the pandemic
- The effectiveness of the UK Governments public health response to the pandemic
- The impact of the pandemic on population health and inequalities

Introduction

On 23 March 2020, to slow the spread of COVID-19 and to flatten the curve of the SARS-COV-2 virus, the United Kingdom was placed into an immediate and restrictive lockdown, with the twin aims of preventing ill-health and death and preventing the national health systems from becoming overwhelmed by COVID-19 cases. Prime Minister Boris Johnson, in an address to the nation, said:

‘Without a huge national effort to halt the growth of this virus, there will come a moment when no health service in the world could possibly cope; because there won’t be enough ventilators, enough intensive care beds, enough doctors and nurses.

And as we have seen elsewhere, in other countries that also have fantastic health care systems, that is the moment of real danger.

To put it simply, if too many people become seriously unwell at one time, the NHS will be unable to handle it – meaning more people are likely to die, not just from Coronavirus but from other illnesses as well.

So it’s vital to slow the spread of the disease.

Because that is the way we reduce the number of people needing hospital treatment at any one time, so we can protect the NHS’s ability to cope – and save more lives.’¹

This established early in the pandemic that the delivery of healthcare would be impacted by the spread of COVID-19. Indeed, the impact of COVID-19 upon healthcare delivery in the UK would prove seismic. Delivery of healthcare during the pandemic has been highly pressurised, especially during the first and second waves and in secondary care settings, and in some areas delivery of care had to be paused almost entirely. Throughout 2020, the pressures spread across the entire system – precipitating a further crisis in primary care which was already under severe pressure across the UK, as demands within general practice increased.

This report examines the impact of the COVID-19 pandemic on healthcare delivery across the UK. It first looks at how well prepared the UK’s health services were going into the pandemic and then considers the impact this had on care delivery during the first, second and third and fourth waves. The report concludes that recruitment and retention of staff must stay in line with properly modelled assessments of workforce needs, that the UK governments need to develop a plan to meaningfully develop hospital capacity, rescue General Practice and that governments and systems should explore how redeployment could be more appropriately managed in future. It should be read in conjunction with the other reports in this series, in particular [report two](#), which examines the impact of the pandemic on the medical profession and [report five](#), which will examine the impact of the pandemic on population health.

State of health and care systems going into the pandemic

Without question, COVID-19 has pushed health systems the world over into uncharted waters,² placing new pressures on staff and services and exacerbating the issues that existed before the pandemic. Delivering healthcare during a global pandemic presents an enormous challenge to any system, regardless of how well that system is prepared: mistakes will always be made, and hindsight is never gentle in revealing where they could have been avoided. However, the testimonies from our members that this report draws on – alongside the data and evidence from across the four UK nations that underpin their accounts – show that health and care services in the UK were poorly prepared in all senses for a shock event like a pandemic.

Several themes run throughout this report, which determine how the health services in England, Northern Ireland, Scotland and Wales have been able to deliver care through the pandemic. Broadly, these themes are:

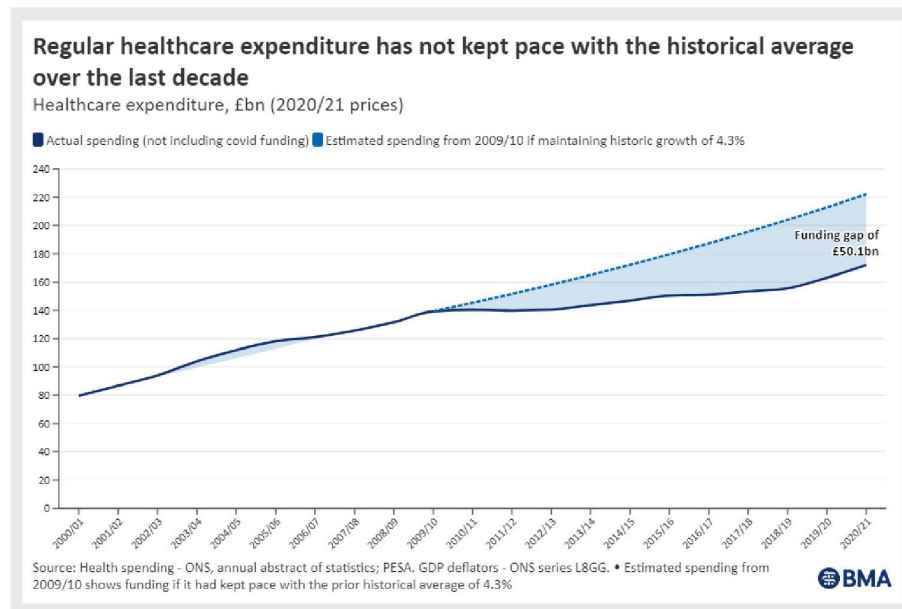
1. A decade of sustained under-investment
2. Acute staffing shortages
3. Year-round capacity issues and growing waiting lists
4. Neglected infrastructure and deteriorating equipment

The overall state of health and care systems in the years leading up to such a challenge no doubt plays a major role in the ability of a system to weather the storm when such an event arrives, and the reality is that health and care systems across the UK had been operating in environments of scarcity long before the virus hit.

The last decade has seen sustained underinvestment in healthcare in the UK

Prior to COVID-19, UK health funding was below the long-term average and had not kept pace with demand.³ UK healthcare spending has increased significantly since the NHS was established in 1948, reaching £172bn in 2020/21 (excluding COVID-19 spending).⁴ Growth in spending was to be expected given the UK population has grown by 34% since then.⁵ However, growth in health spending has not been consistent over the lifetime of the NHS – and during the decade before the pandemic, spending increases fell significantly below the long-term average.⁶ This slowdown in investment came out clearly in our call for evidence, captured by a Consultant in Northern Ireland's description of '*chronic gross underfunding of all departments [...] for at least 15 years.*'

Figure 1: UK health spending since 2000/01



Health spending was also below that of comparable OECD nations. In 2019, the UK was spending around 10.2% of GDP on healthcare compared to the 11.7% of GDP spent by Germany and the 11.1% spent by France.⁷ While the latest available data for 2020 suggests this has changed, with the UK catching up to other countries and all countries increasing the percentage of their GDP spent on health, this is largely down to increased spending during the pandemic and the impact of COVID-19 on the overall economy (the UK had the largest drop in GDP of the G7⁸).

The UK's health services entered the pandemic unquestionably underfunded and have since been playing catch-up. As respondents to our call for evidence said:

Put simply, there was not enough funding before the pandemic, there is still not enough funding, and even if more money was thrown at the NHS, it doesn't change the fact that there aren't enough doctors or nurses to employ and fill gaps
(GP Trainee, England)

Workforce planning has been severely neglected over the past decade

Across the UK workforce planning has been severely neglected over the past decade, meaning the UK's health services often did not have sufficient staffing levels to deliver safe care during normal times, and even less so during a pandemic.

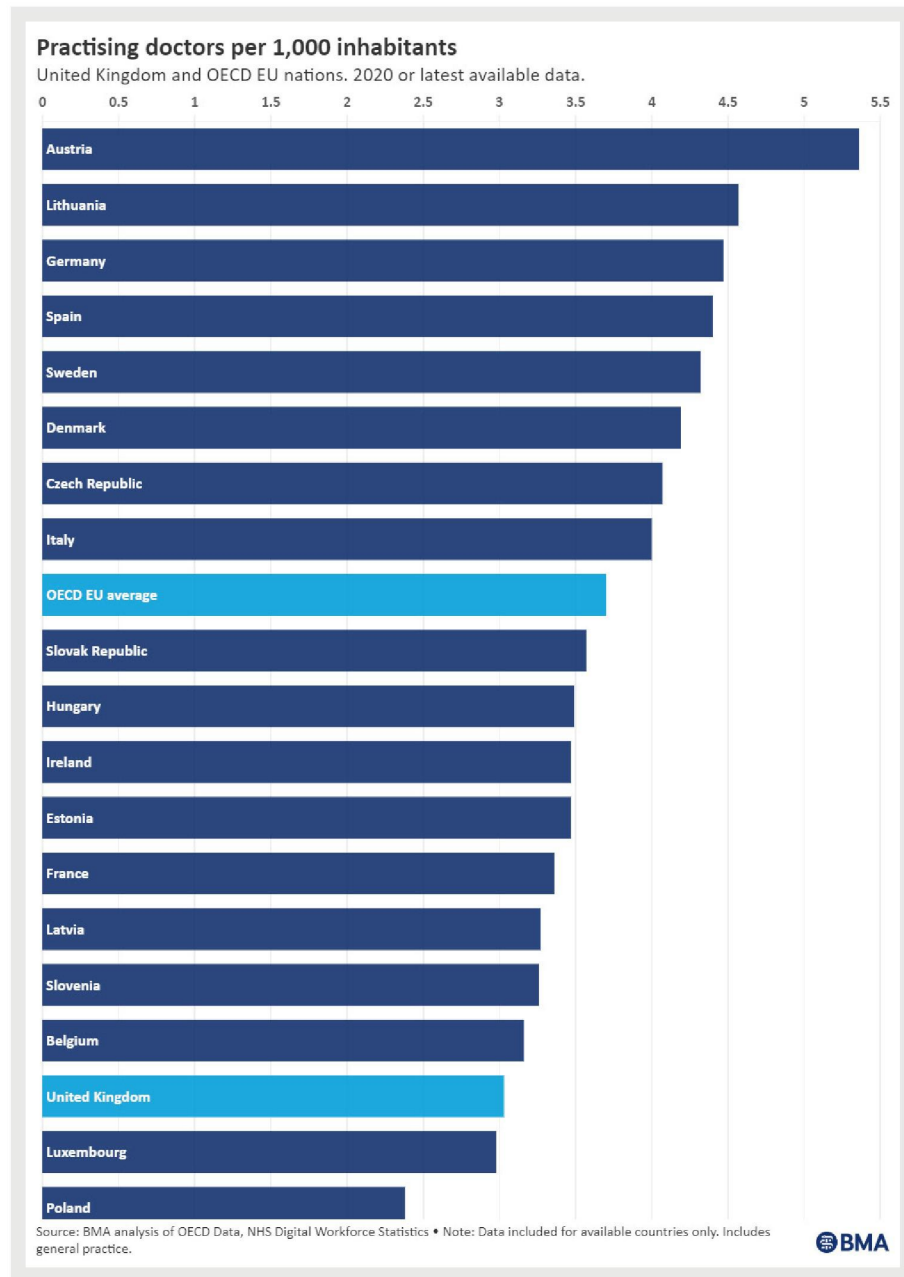
The Department of Health in Northern Ireland (DOHNI) published its health and social care workforce strategy in 2018,⁹ while Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) published their joint workforce strategy in October 2020.^{10,11} The Scottish Government published its latest integrated health and social care workforce plan in March 2022.¹² However, these strategies all have notable and significant shortcomings,¹³ and the publication of a strategy does not in itself guarantee sustained commitment to, or sufficient investment in, multi-year workforce growth and planning.

England did not have an up-to-date workforce strategy at the time of writing this report and has experienced a particularly notable lack of attention to workforce planning dating back to 2012, when the Health and Social Care Act became law. Considerable damage was done to NHS England's national and regional workforce planning at this time¹⁴ – and to this day, no individual or lead organisation is legally accountable or responsible for future NHS staffing projections and planning in England. The last proper public healthcare workforce strategy in England was published in 2012, at the same time as the Health and Social Care Act 2012.¹⁵

The medical workforce in the UK has long lagged behind comparator nations

In the absence of official workforce projections, one way to assess whether the UK has enough doctors is by comparing its proportion of doctors per 1,000 people to other comparable countries. The UK has long had a very low proportion of doctors relative to its population. The average number of doctors per 1,000 people in OECD EU nations is 3.7, but the UK has only 3:¹⁶ significantly below that of individual comparator nations such as Germany and Austria (see Figure 2). Data gathered from our call for evidence highlights these staffing shortages: of 1,720 survey respondents that answered the question, 56% reported clinical staffing levels at the start of the pandemic as either 'inadequate' or 'very inadequate'.

Figure 2: Practising doctors per 1,000 inhabitants



Staffing shortages span primary and secondary care. In primary care in England, the number of full-time, fully qualified GPs has been on a steadily downward trend since 2015, as has the number of GP partners which has significantly contracted in that time.¹⁷ As a result of the sharp contraction in the fully qualified GP workforce, the equivalent of 1,348 fewer fully qualified full-time GPs were working in the NHS in England when the pandemic hit in March 2020 than there were in 2015.¹⁸ While full-time equivalent data is not available for Scotland, Wales or Northern Ireland, GP headcount data suggests parallel problems existed and continue to exist (the variable collection of data across devolved nations is also an issue, given that data is not always collected in a comparable way). The number of GPs in Wales has remained largely the same since 2010,¹⁹ and Scotland has seen a very similar trend²⁰ despite rising demand and increasing co-morbidities among patients. In Northern Ireland, the number of GPs has seen a small rise since 2014.²¹ Our call for evidence echoes these trends:

We had been trying – and failing – to recruit replacement permanent GPs since the early 2010s. We had demonstrated – quantified – our shortages. As we went into Christmas 2019 (and no-one had yet heard of Wuhan) I, at age 64y, was the only GP for a practice of 6,000 [around three times that of average patients per GP in Wales²²] – and no GP locums available (Salaried GP, Wales)

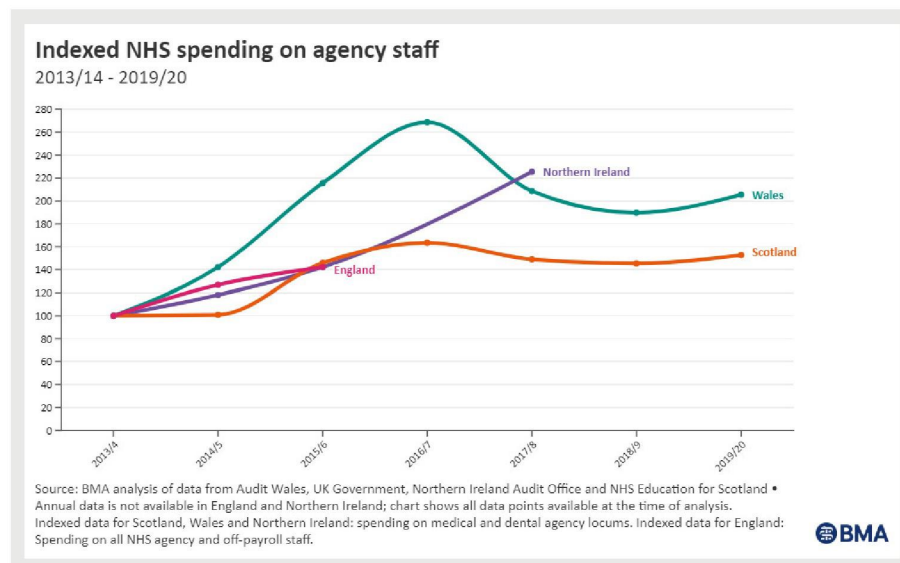
In secondary care, previous BMA research has shown that growth in the medical workforce across the UK does not match current or anticipated growth in demand.²³ Our call for evidence found similar themes:

Long term lack of staff and no qualified staff to recruit (Consultant, Northern Ireland)

Our workforce capacity was already well below what was required to provide a pre-pandemic service, so there was no resilience in the system to deal with the pressures of COVID (Consultant, Scotland)

In many cases, understaffing had resulted in dangerous levels of exhaustion and burnout amongst staff even before the pandemic hit, with staff constantly having to plug existing staffing gaps (see also report two in this series), as well as a chronic reliance on expensive agency or locum staff to cover gaps, as evidenced by the health services' growing spending on agency staff going into the pandemic (Figure 3). Reliance on temporary staff may patch over gaps in normal times but has serious consequences when crisis hits.

Figure 3: Indexed NHS spending on agency staff in the years preceding the pandemic



Medical school places have not seen sufficient expansion

The BMA and other organisations have lobbied for a doubling in the number of medical school places for many years,²⁴ but applications consistently exceed the availability of places, so the UK has not been able to properly capitalise on the growing appetite for a career in medicine. Despite some strides made in this arena,²⁵ from the 2012/13 academic year until 2019/20 the number of medical students in the UK increased by an average of only 229 places per year.²⁶ Medical school intake significantly jumped in 2020/21, but this was a result of the impact of COVID-19 on examination results rather than a planned boost, as in 2021 the UK Government temporarily lifted the cap on the number of medical school places in England after changes to assessments necessitated by the pandemic resulted in a 20% rise in applications after a greater number of students than usual attained sufficient grades.²⁷

Recruiting larger cohorts would have required many years of significant, long-term investment and strategic planning to increase university and hospital training infrastructure, significantly expand the medical educator workforce, and minimise bottlenecks by expanding the postgraduate training pathway. Workforce planning is intended to be vertically integrated in this way, but historic disjointed workforce planning has in effect disconnected each stage of the doctor pipeline from the next.

The UK's health services have historically relied on international medical graduates

The scale of workforce challenges means that overseas recruitment has for many years been a preferred pipeline for bolstering medical staffing in the UK's health services. Research by the Medical Schools Council has shown that while the number of doctors with a non-UK Primary Medical Qualification (PMQ) has been steadily rising, representing currently over half of all those joining the register,²⁸ the number of UK graduates has not kept pace.²⁹

The contribution of international medical graduates to the UK's health services – both during the pandemic and throughout the history of the UK's health services – is vital, invaluable, and should not be understated. However, overreliance on overseas recruitment as a strategy to compensate for poor domestic workforce planning is both risky and increasingly unsustainable. In the context of poorer nations bearing the brunt of growing global health workforce shortages, it is also ethically and morally questionable. The pitfalls of such a strategy have been made clear by a global pandemic which has severely restricted staff movement across international borders. As a respondent to our call for evidence described:

We are a small rural hospital and run on locums. The service provided is excellent however all staff groups are supplemented by locum staff [...] Many of our locum staff come from other countries so travel restrictions hit us hard
(Consultant, Scotland)

Health services have also struggled to retain staff

Chronic understaffing and increasing workload have made the UK's health services notoriously 'leaky buckets'. Additional issues – like years of demoralising pay erosion³⁰ and punitive pension taxation rules³¹ – have made it even harder to retain the doctors we have. Before the pandemic unfilled posts across the UK's health services were infamously high. Vacancy data is not only patchy and differently recorded across the UK but also likely represents significant under-recording making the full picture difficult to quantify, but the trust sector in the English NHS alone had been grappling with 102,421 total recorded staff vacancies per quarter on average³² between June 2018³³ and March 2020. The health service in Scotland has seen rapidly rising vacancies since 2012 and went into the pandemic already facing a record number of vacant posts,³⁴ while Northern Ireland had nearly twice the number of recorded vacancies in December 2019 than in March 2017 when their collection began.³⁵ Vacancy data for Wales was discontinued in 2011 and has not been reinstated despite the BMA's repeated calls to do so, but BMA analysis of recent FOI requests on consultant vacancies found that in one health board as many as 48% of consultant posts were not filled by a permanent consultant.³⁶

Working overtime to cover gaps has been standard practice in the UK's health services for a long time.³⁷ Chris Hopson, NHS Providers' chief executive, told the UK Health and Social Care committee in January 2021 in his oral evidence to the committee's inquiry into workforce burnout and resilience that 'discretionary effort is the rocket fuel that powers the NHS...if staff worked to contract we simply would not be able to provide anything like the quality of care that we need to.'³⁸ This 'good will' rhetoric was also evident from the responses to our call for evidence:

*My main place of work was understaffed and was already using many doctors' good will to do extra locum shifts and fill multiple long-term vacancies
(GP Trainee, England)*

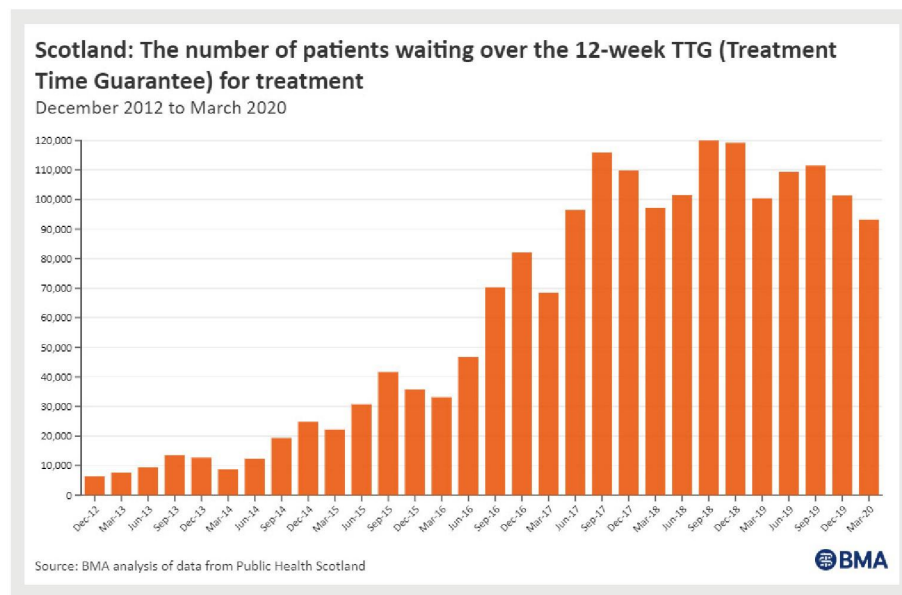
*The attitude was just that "oh well the trainee" (i.e. me) "will just take on more tasks"
(Junior Doctor, Scotland)*

Delivering care amid persistent shortages fosters an environment of chronic stress, normalising excessive workloads by continuously requiring overstretched staff to fill gaps to keep services running. When staff are exhausted and overstretched their health suffers, and they are more likely to leave (report two in this series looks in greater detail at the impact the pandemic has had on staff).³⁹ High turnover creates frequent gaps that further compound stress, and the cycle continues. Burnout caused by these pressures was a growing and prominent problem even before the brutalising demands on the pandemic, with 80% of respondents to a UK-wide BMA survey in 2018⁴⁰ reporting feeling at high or very high risk of burnout, mostly driven by exhaustion, while 90% felt their current working, training or studying environment had contributed to their condition either to a significant or partial extent.

Health services across the UK went into the pandemic with a backlog of care

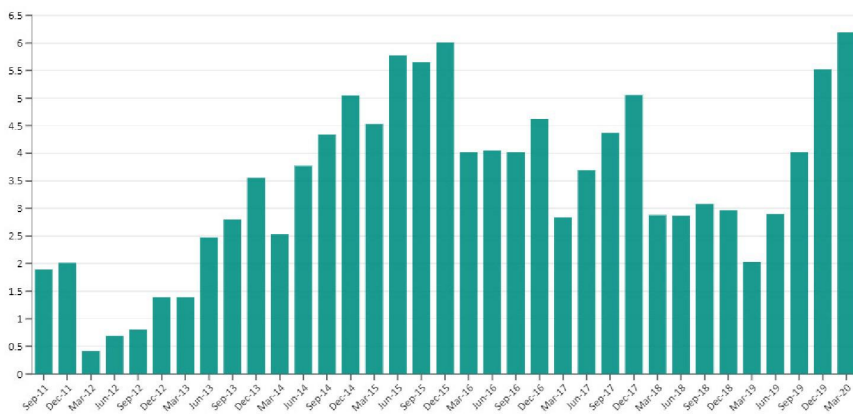
'The NHS backlog' as a term has become synonymous with the virus, but the health services in the UK went into the pandemic with a significant backlog of care already, as the figures below demonstrate.⁴¹ One respondent to our call for evidence described being 'already at breaking point for elective service delivery prior to the pandemic' (Consultant, Scotland).

Figure 4: Examples of the pre-pandemic backlog of care in Scotland, Wales, Northern Ireland and England



Wales: The percentage of patients waiting over 36 weeks from referral to treatment

September 2011 to March 2020

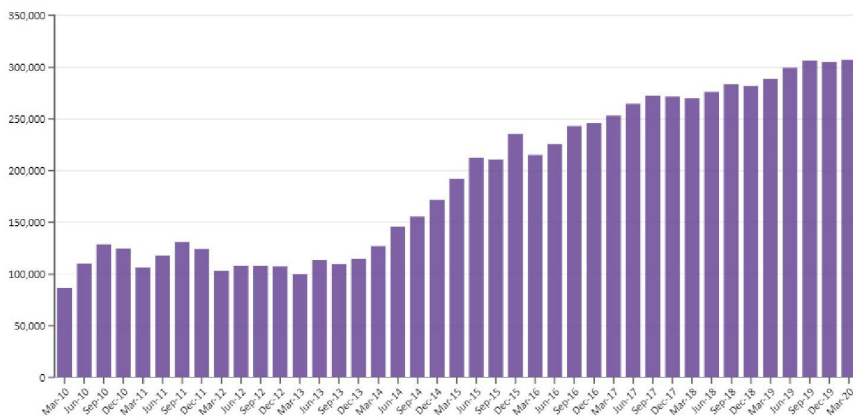


Source: BMA analysis of data from Stats Wales



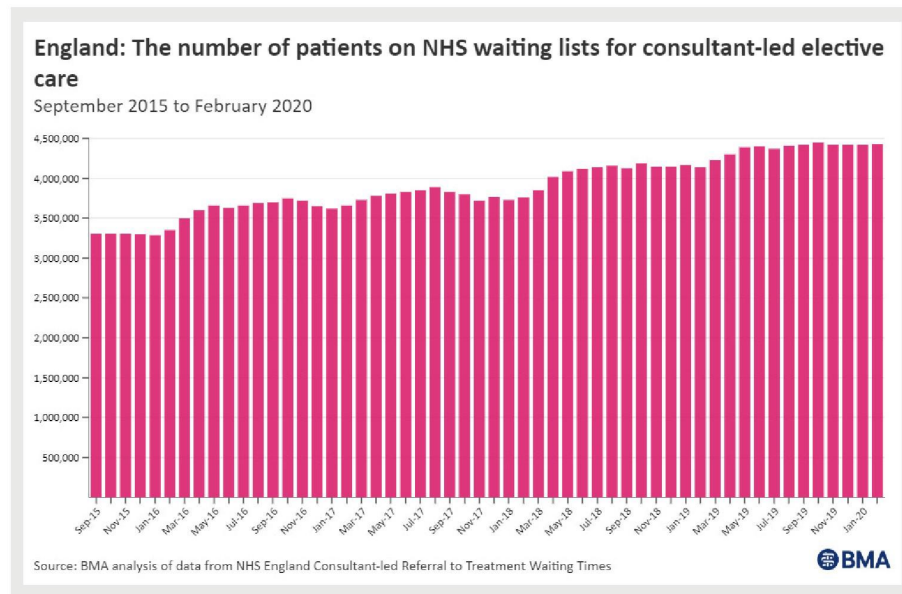
Northern Ireland: The number of patients on the waiting list for a first consultant-led outpatient appointment

March 2010 to March 2020



Source: BMA analysis of data from Department of Health, Northern Ireland





The UK's bed and ICU stock had been in decline before COVID hit

Bed capacity has been a critical limiting factor in the ability of health services around the world to cope with the virus. The decision taken over a decade ago to start reducing bed stock in the UK's health services therefore had a significant impact on their ability to respond to the pandemic. This was done under the premise of transforming healthcare by moving to preventative strategies – however, when combined with staffing shortages, an insufficient core bed stock means that hospitals are less able to cope with large influxes of patients during winter or shock periods of high demand – like a pandemic.

Data is collected differently across the UK, but all four UK nations have reduced their core bed stock significantly over the last decade. Between 2010/11 and 2019/20 the average daily total of available beds contracted by 8.3% in England⁴² and 14.9% in Wales.⁴³ In Scotland, the daily average available staffed beds for acute services also fell by 8.3% between 2010/11 and 2019/20,⁴⁴ while in Northern Ireland the average available beds in wards that are open overnight fell by 14% over the same period.⁴⁵

These reductions meant that the UK went into the pandemic with a very low total number of hospital beds relative to its population. The average number of beds per 1,000 people in OECD EU nations is 4.6, but the UK has just 2.4.⁴⁶ Germany, by contrast, has 7.9. The UK also had a remarkably low stock of critical care (ICU) beds relative to its population, with just 7.3 critical care beds per 100,000 people – less than half the average in OECD EU nations (15.9).⁴⁷

Bed occupancy was frequently above safe levels

A declining bed stock mixed with growing demand is a fatal combination for any health service, and it is no surprise that bed occupancy rates in the UK have been rising in the years prior to the pandemic. Bed occupancy in Scotland had risen from 84% in 2010/11 to 87% in 2019/20,⁴⁸ and from 82% to 86% in Wales.⁴⁹ In England, occupancy has consistently surpassed 85%, the level generally considered to be the point beyond which safety and efficiency are at risk, with many trusts regularly exceeding 95% capacity in the winter months.⁵⁰ Data in Northern Ireland shows very high occupancy rates for most hospitals.⁵¹ Excessively high bed occupancy reduces the flexibility of the hospital to accommodate short term fluctuations in demand, leaving it vulnerable to even quite small changes in admissions or discharges.

This situation led to increased use of the private hospital sector in England

As a result of these pressures the use of private sector capacity is now a major strategy in England's plan to reduce the elective care backlog brought on by the pandemic,⁵² but the role of Independent Sector Providers (ISPs) in the delivery of care had already been steadily rising over the years before the pandemic. In the face of a chronic undersupply of doctors and growing waiting lists, purchasing the use of private sector capacity was seen as a method of securing additional capacity to bolster the declining performance of NHS services.⁵³

BMA analysis shows that private sector hospitals provided approximately 626,590 NHS-funded elective episodes in 2019-20 – 419 times the amount delivered by the private sector in 2003-4.⁵⁴

Winter pressures were extending into spring and summer, while public satisfaction fell

Because of these service capacity limitations, in recent years “winter pressures” in the UK became a year-round experience. Respondents to our call for evidence described a healthcare system with no slack left in it when COVID-19 arrived:

Staff already working at close to capacity prior to the pandemic; workload pressures have increased hugely

(SAS doctor, Scotland)

Being understrength to begin with in terms of staffing, and already working with bed occupancy at or above 100%, pre-pandemic meant no headroom for managing the eventual large increase in demand that came in acute mental health services

(Consultant, England)

Public opinion prior to the pandemic reflects these pressures, with results from the British Social Attitudes Survey⁵⁵ showing that overall public satisfaction with health services in England, Scotland and Wales was just 60% in 2019, the year before the pandemic.

Insufficient capital funding has resulted in deteriorating estates and rising maintenance backlogs

Although capital investment into the UK's health services has increased in recent years,⁵⁶ overall funding over the past decade has failed to keep pace with requirements. This meant that at the onset of the Covid-19 pandemic in March 2020, those health services lacked the capacity or quality of hospitals and wider facilities necessary to manage the outbreak of an infectious respiratory disease. The level of capital funding available to the UK's health services was impacted by the period of economic austerity following the 2008 financial crash, with revenue and running costs often taking precedence over longer-term capital investment. This has meant that, while capital budgets and investment levels are now beginning to increase, for some time healthcare providers have frequently lacked the funds necessary to make improvements or even remedial repairs to their estate.

This shortfall in capital funding has been especially acute in England, where a total of £4.5 billion was transferred from the DHSC capital budget to the revenue budget between 2014-15 and 2019-20 (when this practice was halted).⁵⁷ This was done to plug gaps in day-to-day running costs of the NHS, such as paying for staff salaries and the cost of medicines. However, it left very little to put into NHS estates and infrastructure.

The Northern Ireland Draft Budget of 2022-25 specified that the capital budget for 2022-23 would be £349 million and that it would increase slightly in 2023-24 to £369 million. However, despite this increase, the capital funding allotted will still be insufficient to clear an outstanding maintenance backlog and maintain current provision.⁵⁸

An audit of the NHS estate in Scotland also found that capital funding from the Scottish Government in 2018-19 (£334 million) was a reduction of 63% in real terms since 2009-2010. However, capital funding is expected to have risen significantly since then. Without investment to keep them in good working order, many hospital buildings and GP practices across the UK have been left to decay. This has had enormous implications on patient safety and the ability of healthcare staff to deliver timely care in the years preceding the pandemic, and many assets are now in such a state of neglect that the cost to the health services of bringing them back to working order (known as the maintenance backlog) is enormous (see Figure 5).

Figure 5: The estimated maintenance backlogs for health services' estates England, Scotland, Wales and Northern Ireland

Nation	Maintenance backlog	Year
England ⁵⁹	£9.2 billion	2021
Scotland ⁶⁰	£914 million	2019
Wales ⁶¹	£559.7 million	2019
Northern Ireland ⁶²	£739 million	2016

None of the above data includes the maintenance needs of buildings and equipment in primary care or social care. It has been estimated that 85% of the UK's care home stock is more than 40 years old,⁶³ while the BMA has long highlighted the sorry state of general practice premises.

Respondents to our call for evidence highlighted this poor state of some of their general practice premises:

Poorly resourced due to lack of adequate premises provision impacting the ability to recruit or retain staff
(GP Contractor/Principal, Scotland)

With health services' estates across the UK increasingly unfit to deliver normal levels of care prior to the pandemic, the virus brought into sharp relief the reality that many buildings across the UK's health services are outright unsuitable in the context of a pandemic – particularly a highly infectious respiratory disease that requires additional measures such as ventilation, isolation rooms, and social distancing to keep patients and staff safe.

The building we work in is not fit for purpose and is an infection control nightmare, making Covid outbreaks inevitable
(Consultant, Scotland)

Pandemic planning for healthcare delivery was inadequate across multiple fronts

The recommendations set out in the UK Government's pandemic simulation exercise, Exercise Cygnus, were largely overlooked which meant that the UK started out at a significant disadvantage with regards to ICU ventilator capacity. The failure to action the recommendations meant that at the onset of the pandemic there was a real risk of the UK running out of ventilators. The UK government's own publicly available roadmap documents – Influenza Pandemic Preparedness Strategy (2011), Health and Social Care Influenza Pandemic Preparedness and Response (2012), and the [Pandemic Influenza Response Plan \(2014\)](#) – did not even include ventilators as a possible area of healthcare delivery need.

Exercise Cygnus also identified further work required to manage surge arrangements for a reasonable worst-case scenario, including: the necessity of a plan to move health service staff around the country if needed to support delivery in hot-spot areas, and for a parallel social care staff plan; the necessity to ensure that a plan existed for a rapid discharge protocol for use in the community; and to ensure that resource sharing could take place.⁶⁴ There is little evidence that serious action was taken on the recommendations which arose from Exercise Cygnus, or indeed opportunity for the public to scrutinise action as the decision was taken to keep the report secret as the UK Government considered its findings too 'terrifying' for public consumption.⁶⁵

These factors meant the health services were ill-prepared to face a crisis

Across the UK, health and care services were dealing with increasingly little slack in the system year on year in the decade preceding COVID-19. By the time the pandemic took hold in March 2020, the pressures that had been typically associated with winter were extending nearly all year-round, with long waits for treatment and a workforce in crisis. The UK's health services, and the patients they care for, had been suffering long before the pandemic compounded these critical, underlying issues.⁶⁶

These fault lines were brutally exposed over the course of the pandemic with too few staff, too few beds, and buildings that were unsuitable for proper infection control policies. A pandemic is not a regular event, and there is no healthcare system across the world that did not feel the challenges of providing care during this time. However, a system that is strong and healthy from proper resourcing, funding, staffing, and planning in the years prior to such an event is in an inherently better position to weather such a storm. The UK's health services were simply ill-prepared to withstand a shock like the COVID-19 pandemic, and what follows of this report will illustrate the devastating impact the pandemic had on healthcare delivery as a result.

First wave of COVID-19 (February 2020 – September 2020)

By mid-February, immediately after coping with a challenging winter, the UK's health services had begun to plan and adjust for the increasingly likely possibility of a COVID-19 pandemic. In England, NHS Chief Executive Simon Stevens [wrote to all trusts on 17 March 2020](#)⁶⁷ instructing all non-urgent elective operations to be postponed from April alongside a range of other actions to free up the maximum possible inpatient capacity and resources. By mid-March services across all four nations had received directions to help manage the response to an unprecedented medical emergency.

On 23 March 2020, Prime Minister Boris Johnson announced a national lockdown, and shortly after [the Coronavirus Act \(2020\)](#) was enacted and implemented. As March progressed into April, COVID-19 cases began to be admitted to hospital in ever more overwhelming numbers: in England alone, over a comparable 62-day period during the first wave, from 20 March to 20 May 2020, there were 93,000 admissions, averaging out to 1,500 admissions per day.⁶⁸

The following months would test the health services across the UK immensely, further exposing the dire consequences of underfunding and understaffing for staff and patients. Early indications even from the start of the first wave – such as the immediate scramble to ensure there would not be a shortage of mechanical ventilation – suggested that health services would struggle, and these challenges continued until cases began to fall in the summer.

Historic workforce shortages meant extraordinary efforts were needed to staff health services

Rising COVID-19 infections amongst staff and staff needing to self-isolate exacerbated existing workforce shortages. The pandemic also significantly impacted international recruitment from March 2020 onwards. 2021 data reveals a sharp reduction in both 2020 and 2021 in international medical graduates from outside the EEA (IMGs) joining the UK workforce, which is unsurprising given travel restrictions and other issues created by the pandemic.⁶⁹ Wider clinical recruitment was also impacted, as prior to COVID-19, the UK's health services had become increasingly reliant on overseas-trained nurses, who accounted for 15% of the UK total of registered nurses in 2019, distinctly higher than in most other OECD countries. The impact COVID-19 had in this period was extremely stark; the number of nurses trained outside the EEA (European Economic Area) joining the NMC's (Nursing and Midwifery Council) permanent register dropped from 1,348 in March to only 35 in April.⁷⁰

In a UK-wide BMA survey of members on 16 April 2020, 81% of respondents reported that self-isolation and sick leave due to Covid were having an impact due to reduced capacity or increased workload. COVID-19 related illness alone caused a staggering 30.6% of recorded staff absences in England in April. Similarly in Wales NHS sickness absence rates across March, April and May were 6.8% on average, up from an average of 5.1% during the same months in 2019.⁷¹ In Scotland, the number of NHS hospital and community staff absences related to COVID-19 was highest between April and June 2020, hitting over 10,000 COVID-19 related absences per day in early April 2020.⁷²

We have wards and theatres empty because we don't have enough nursing teams to staff them
(Consultant, England)

Currently, my hospital is severely understaffed to cope with clinical demand. 30 patients under one consultant is the norm, meaning consultant ward rounds lasting from 9-5 causing further delays in job completion and discharge, damaging patient care
(Junior Doctor, Scotland)

Understaffing also drove a huge overreliance on agency and bank staff, which was often in practice just the same group of core staff doing overtime rather than an additional extra pool of staff, which came at a considerable cost both to staff and to the public finances.⁷³

Despite this huge spend and the clear need for more doctors, we know anecdotally from our members that some locums, particularly in general practice, were left unemployed. This was likely a result of shifting care delivery models locally, as well as cancelled staff leave and the absence of a national system for matching staff to roles in high-need areas (which had been recommended by Exercise Cygnus).

Staff were redeployed to high need services

Redeployment programmes were implemented to direct staff to the areas of the service where support was most needed. Ultimately, around 14% of staff in the NHS in England had been redeployed to new duties at some point by February 2021,⁷⁴ and this helped maintain at the very least a base level of service provision across critical and emergency care. GMC data shows that this had a significant impact on junior doctors in England, with 40% of junior doctors having been redeployed within their speciality and 30% outside of their speciality entirely.⁷⁵

The BMA [produced detailed guidance](#) on the redeployment of doctors, covering issues including giving consent to being redeployed, training, terms and conditions, raising concerns and wellbeing. For many doctors, redeployment was a stressful, difficult period in their working lives, where annual leave and other forms of respite were cancelled to help keep services going for the long, grinding early months of the pandemic. Many staff were also shifted onto different and more onerous rotas in order to cover gaps brought about by redeployed colleagues or ill and isolating staff. As detailed in the second report the BMA has produced on the pandemic, the requirements of the pandemic had a significant negative impact on the wellbeing and working lives of doctors, both physically and psychologically.

Respondents to the BMA's call for evidence working in secondary care described redeployment to assist with COVID-related care:

We started understaffed on our ICU [intensive care unit] and we were only able to cope with demand at the peak of COVID waves by redeploying staff from other areas and stopping that elective activity. We have rallied round as an MDT [Multi-Disciplinary Team] and looked after each other, but it has taken a huge toll and my ICU nursing colleagues particularly are totally exhausted and close to tears nearly all the time
(Consultant, England)

Several highlighted the impact redeployment has had on staff burnout and resignation:

Redeployed nursing staff are exhausted and reasonably so, they were expected to give so much
(Junior Doctor, Northern Ireland)

Negative experiences of redeployment has resulted in any staff who can retire or leave doing so and not being replaced, impacting on service capacity
(Consultant, England)

Some respondents described the challenges of redeployed staff being inexperienced within that setting or speciality:

[The most challenging aspect was] redeployment to areas not within your training scope
(Locally Employed/Trust Grade Doctor, Wales)

This was also stressful for the redeployed staff, many of whom had to start without training. Our UK-wide Covid Tracker survey in April 2020 found that of respondents who had been redeployed, 33% said they had not been provided with an induction into the new role and 32% said they had not been provided with training related to the new role. In addition to this, doctors held understandable fears about working in high pressure, demanding environments, where there could be potential future liabilities in relation to choices made in such environments, and some doctors held real concerns about the legal implications that they could face in the future, some of which are beginning to become evident in 2022.

Furthermore, redeployment placed additional pressures on staff who remained behind, particularly when redeployment lasted longer than anticipated:

*Not enough resources; staff spread to cover in both amber and green clinic areas; redeployment leaves gaps which are then filled creating gaps elsewhere
(Consultant, Wales)*

*Staffing during the first wave was focussed solely on the red areas. However this left skeleton teams to deal with the green areas and it was mostly the green area staff that were overworked
(Junior Doctor, England)*

Retired and non-practicing doctors were asked to return to the service

Between 26 March 2020 and 24 June 2020, the GMC gave 28,076 doctors TER (temporary emergency registration) or restored their licences⁷⁶ under its emergency powers. This included over 12,000 doctors who were GMC-registered but did not currently hold a licence to practise, and 16,000 doctors with a UK address who had given up their registration between three and six years earlier.

By April 2020, over 5,000 clinicians had returned to employment in the English NHS through the Bringing Back Staff programme.⁷⁷ Returners' roles varied, and included ad hoc deployment to assist with pandemic management, later in the pandemic assisting the vaccination programme, and to meet operational need.⁷⁸

NHS England and NHS Improvement took the additional decision not to ask any doctor aged over 69 to return to practise via the national recruitment initiatives due to the increased risk to health in that age cohort. Doctors over the age of 69 could ask to return to work through their local providers and offer to return to the NHS by contacting employers directly.

Despite being widely advertised and receiving media attention, the returners programme was not well-utilised. There was a **low-level of deployment of returners**, due to issues with matching processes between national and regional NHS England teams and trusts, some returners being hesitant to work in frontline roles, and some trusts not actually needing returners because of the substantial redeployment programme that had been implemented. This may have ultimately also been disappointing for returners themselves, as many qualified clinicians were eager to return to help the NHS at a time of great crisis, and sadly in some cases highly qualified individuals were turned away.

Scotland, Wales and Northern Ireland predominantly used existing returner programmes and ran campaigns to boost returner recruitment. In Scotland, returners initially contacted their local health boards to offer their services, and ultimately 2,000 former health and social care staff signed up within the first two days of recruitment through the Health and Social Care COVID-19 Accelerated Recruitment Portal, which was created to streamline recruitment and to give a national picture of the skills mix on offer.⁷⁹

Wales [produced national guidance for returners](#), and in Northern Ireland the HSC Workforce Appeal was announced, which led to 3,323 clinical applications, including 123 doctors volunteering to return to the service from retirement or from previously leaving the health system.⁸⁰ The HSC Workforce Appeal was criticised in 2021, as data eventually showed that only 16% of those who applied were appointed.⁸¹

Some respondents to the BMA's call for evidence, most commonly those working in primary care, described the introduction of the returners programme for recently retired doctors:

My role was entirely created by the Pandemic. I was working from home, triaging Primary Care staff and organising PCR swabs the same day. I was additional to existing staff

(Retired doctor not currently working, country not stated)

Some GP returners found fulfilment in returning to the workforce and had positive experiences, with ultimately one in six considering returning to the workforce permanently in a survey carried out by the GMC⁸² highlighting the potential of better using retired staff in times of need. While in some cases these experiences were positive, others also expressed challenges related to the speed, complexity or bureaucracy of the process:

I volunteered my services as a retired GP but was disappointed in the re-registration process which was over complicated and cumbersome. In the end I withdrew my offer to volunteer

(Retired doctor not currently working, Scotland)

Medical students joined the UK's health services early

On 26 March 2020, the GMC announced that early provisional registration for final year medical students would be available, as well as acceleration of registration for Foundation Year 1 doctors to help combat COVID-19.⁸³ The BMA [produced guidance](#) for medical students on medical schools and trusts or boards offering the opportunity to take on contracts of employment in the UK's health services due to COVID-19.

Overall, the GMC brought forward provisional registration for almost 7,000 UK medical school graduates, and ultimately 4,662 FY1 posts were filled between April and July 2020.⁸⁴ GMC surveying found that 63% of FY1 posts were working on inpatient medical wards, and 27% on inpatient surgical wards.⁸⁵

A small number of respondents to the BMA's call for evidence described medical students' early commencement of work, and praised the work carried out by them as essential to efforts to keep systems going:

We had valuable help from the new FY1s (those who were due to start in August 2020 but joined the workforce early)

(Consultant, England)

As detailed in the BMA's second COVID report, the impact on medical students from early commencement of work in the health services was substantial and often negative, and medical students reported interruptions to their training, and some reported failing their exams or even wanting to leave the medical profession because of their lack of access to training and education.

The public stepped up to volunteer

In addition to returner and redeployment programmes, volunteer programmes were set up across the UK. More than 21,000 people volunteered to help the health service in Scotland in 2020.⁸⁶ In Wales volunteers were able to sign up through their local council,⁸⁷ while in Northern Ireland a similar scheme was coordinated by the Community Development and Health Network.⁸⁸ In England, the [NHS England Volunteers Responders Programme](#) was set up to help the health service cope during the pandemic. By May 2021, [436,000 people had volunteered](#), and carried out almost two million tasks for those who needed to stay at home during the pandemic, ranging from phone calls to the isolated to delivering medicines and medical devices.

The model of care delivery within primary care changed considerably

General practice, which was under immense pressure before the pandemic began, was significantly impacted by the first wave, as seeing patients face to face carried huge infection risk and therefore only took place when judged to be clinically necessary. This drove a rapid shift to remote consulting.⁸⁹

In England (the only UK nation for which data on GP appointments is available), overall consultation numbers dropped within the first wave as many patients stayed away from healthcare settings out of fear of becoming infected with the virus, from 25 million appointments in March 2020⁹⁰ to 16.6 million in April⁹¹ and 17 million in May,⁹² however, research shows that GPs maintained a focus on older patients, shielding patients, and patients with poor mental health.⁹³

In Wales all GP practices were given access to a new system in April 2020 to allow video consultations to be carried out, which also gave doctors and other clinicians self-isolating at home the ability to continue to work.⁹⁴ By August, service leaders in Scotland said that remote consultations would become the new normal.⁹⁵

Respondents to the BMA's call for evidence had a wide variety of experiences in relation to remote working. For some, this assisted in managing the increased workload and allowed staff to continue working while isolating:

We adapted overnight and went digital first. As instructed. We had used digital means for about 10% of our encounters but this went to 90-95% immediately. We had the technical resources already to hand, thanks to the CCG etc.

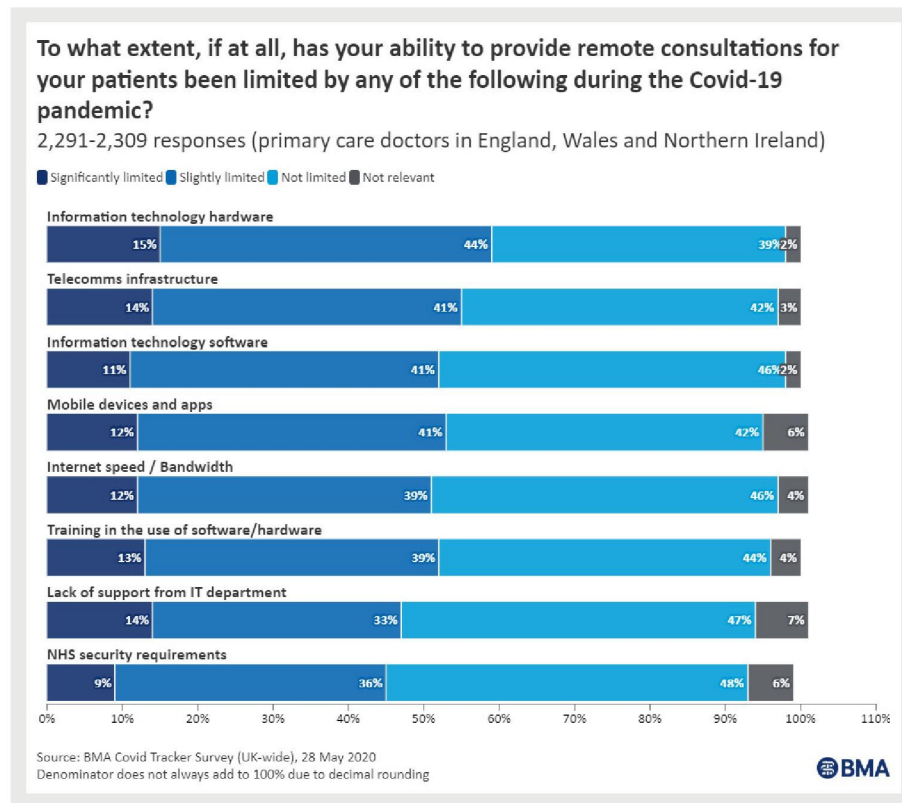
(Salaried GP, England)

However, the rapid switch to remote consultations highlighted the limitations of the IT infrastructure across the UK's health services. In response to our COVID tracker survey on 28 May 2020, when asked about limitations on their ability to provide remote consultations for patients during the pandemic, 59% of primary care respondents reported being limited by IT hardware, 55% by telecoms infrastructure, 52% by IT software, and 52% by mobile devices/apps and 50% by internet speed or bandwidth (see Figure 6). As described in our call for evidence:

We cannot work remotely for much of our job because our IT and connectivity does not allow it

(GP Contractor/Principal, Scotland)

Figure 6: Limitations on GPs' ability to provide remote consultations at the start of the pandemic



Remote/virtual appointments were broadly lauded and considered essential to stop the spread of COVID-19, but by September 2020, there were [early stirrings of discontent](#) from the UK Government and NHS England about the continued use of digital consultations and the fact there were more of them than face-to-face appointments (this was in itself the result of the guidance to GPs given by NHS England at the time).⁹⁶ NHS England [sent a letter to practices](#) instructing them that they must offer face to face appointments, and the BMA responded by making it clear that in person appointments had existed for patients who needed face to face care throughout the pandemic. This initial confrontation on the issue of face-to-face appointments was a prelude of a much more significant confrontation yet to come and what became a sustained attack on the profession by the UK Government and media which, while centred initially on England, started to spill into the devolved nations, with negative commentary on GP appointments in the wider media and also initially from the Scottish Government.

In comparison, the Welsh Government signalled early on their wish for remote consultations to play a continued role in the way that patients access primary care in the future, with the Welsh Government's First Minister setting out in [September 2021](#) that "remote consultations are here to stay" and that "over half of consultations by primary care clinicians are now carried out face to face". In July 2021, BMA Cymru Wales co-signed a letter with RCGP Wales, NHS Wales and the Welsh Government which thanked practices for their efforts during the pandemic and recognised the unprecedented and sustained pressures upon the system.

Alongside a change to how care was delivered, GPs also saw increased demand as a result of pressures and cancellations of care elsewhere (see also below). Respondents to the BMA's call for evidence also highlighted that GPs were the front line of managing health issues that had been exacerbated by lockdowns and the cancelling of elective and other procedures, and therefore were constantly responding to demand created across the rest of the service, especially regarding access to mental health services:

Another major limiter has been the predictable explosion of mental health issues and the rather parlous state of the services pre covid. This has meant difficulty in providing adequate care and this is especially the case with children's and adolescent mental health where there is almost no service and the schools were obviously under intense pressure too

(Salaried GP, England)

In the first wave, key areas of service delivery in secondary care were disrupted

The impact of the pandemic on non-COVID care was immediate and substantial, and resulted in a near-complete shut-down of all but the most urgent care, including most elective surgery. This was necessary because of a lack of system capacity and the impact of infection prevention control (IPC) measures.

Bed capacity was a limiting factor

Despite shutting down a lot of non-COVID care, there were severe beds shortages across the UK's health services during the first wave due to low bed numbers upon entering the pandemic, inadequate estates, and the need to control infections and repurpose beds.

Hospital capacity had to be organised in new ways during the pandemic. This was necessary to comply with enhanced IPC measures, and because of the necessity of separating out COVID-positive and COVID-negative patients. Many beds compatible with mechanical ventilation also had to be repurposed reducing bed numbers further.

Ventilated beds occupancy numbers were high in Wales during the first wave,⁹⁷ and there was a small reduction in average available ICU beds in Northern Ireland.⁹⁸ The number of acute beds available in Scotland during the first wave fell by 2.5% and was the lowest available for a decade.⁹⁹ In England, the number of general and acute beds available for use dropped to a low of 92,559 in the first quarter of 2020/21, a drop of 8.87% from the same quarter the previous year.¹⁰⁰

Across all settings, respondents to the BMA's call for evidence described how inadequate premises placed limitations on capacity and their ability to see patients:

Staffing is just about adequate however the incredibly old real-estate means that there is inadequate provision of side-rooms. COVID outbreaks have led to closures of significant amounts of beds and this has led to overload in the emergency department

(Junior Doctor, England)

Poorly resourced, inadequate space in clinical areas and waiting areas to see patients safely and within guidelines meant reduced capacity

(SAS Doctor, Northern Ireland)

Many trusts spent a significant period operating above 'safe-occupancy' thresholds, despite there being substantial capacity in trusts in close geographical distance, and that this also impacted delivery. However, the UK's health services broadly avoided the extreme pressures that some international health systems found, where some hospitals ran out of intensive care beds entirely. However, this was largely only achieved by redefining what an intensive care bed is, which was not without consequences for patient care.

Due to the necessary isolation of these patients with covid, they occupy a substantial proportion of our beds in critical care. The management have made no provision for this. Pre covid we were at 90% occupancy with 16 beds, they now expect us to put this work though 10 beds (which of course is impossible) and they seemed shocked when elective cases are cancelled because of lack of higher level of beds

(Consultant, England)

*A large amount of wards were changed to COVID wards and bed-flow for non-COVID patients was very difficult so these patients were often outliers and not getting the right level of attention or waiting ages for a bed
(Junior Doctor, Wales)*

Despite huge efforts made to ensure that bed capacity remained above a level that would be considered an emergency, the combination of low bed capacity and staffing issues ensured that many services struggled to provide adequate care across settings, with the ultimate result that many patients had adverse experiences as they waited to be admitted to services, and in England trolley waits increased every month from May onwards.¹⁰¹

Technology was harnessed to support remote care

With the swift uptake of remote consultations, primary care arguably saw the biggest change in the way care was delivered, but remote monitoring, virtual wards (allowing patients to get the care they would normally get in hospital at home) and remote follow-up outpatient appointments were all harnessed in secondary care too to minimise unnecessary patient-patient and patient-doctor interactions with a view to maximising the efficiency of a limited workforce and reducing the potential for transmission.

None of these methods of delivering care were new, however their deployment was catalysed by the needs of the pandemic. The use of virtual wards in particular enabled trusts to manage the rate of hospital admissions and reserve capacity for fluctuating numbers of COVID patients. This is not to say that this enabled trusts to fully manage the range of competing demands, but rather that it provided one way of mitigating the impact of the pandemic to some extent.

Fears over ventilator and oxygen shortages prompted action

Given the impact of the virus there was an immediate need to ensure that the UK's health services had sufficient ventilator capacity. The UK government began preparation on ventilators in early 2020, and in late February and early March conducted a survey of NHS trusts in England which indicated that the NHS in England only had access to an absolute maximum of around 7,400 mechanical ventilators. Significant planning capacity therefore went into acquiring 1,800 new ventilators by mid-April, the peak of the first wave.¹⁰² The Scottish government similarly ordered 300 new ventilators in order to double ventilator capacity in March.¹⁰³

The UK Government was invited to participate in the EU-wide effort to procure ventilators but ostensibly missed the deadline. The Government instead contracted private companies – many of which had no former appropriate experience or expertise in manufacturing ventilators – to build up capacity in the UK's health services.

Jointly purchasing ventilators with other EU countries could have secured better value for money on the basis that pooling requests could reduce the cost of equipment through improved bargaining power. Rather, by August 2020, the Department of Health and Social Care and Cabinet Office's emergency procuring of 26,000 ventilators UK-wide cost the taxpayer £569 million and only approximately 10% were used.¹⁰⁴ This included the very expensive purchase of Chinese ventilators at the cost of £50,000 per unit – prices that were significantly higher than earlier prices for the same device – and which due to their unfamiliarity were not always intuitive for staff to use, adding to the pressure they were under.¹⁰⁵

Ultimately, the new ventilators were not needed and there is no evidence that a patient who needed to access a ventilator was unable to receive the care needed.¹⁰⁶ The Public Accounts Committee of the House of Commons concluded that the UK's health services managed to provide ventilator care to all patients who needed it despite the UK government being unprepared and slow to react to hospital need.¹⁰⁷

Potential oxygen shortages followed a similar pattern: there were points during the first wave where the lack of sufficient planning to maintain oxygen supply left some

organisations on the precipice of running out of oxygen, and after a major London teaching hospital almost ran out of oxygen at the end of March 2020,¹⁰⁸ NHS England released a letter instructing senior managers to take urgent action to prevent their organisations running out of oxygen supplies.¹⁰⁹

HSIB (Healthcare Safety Investigation Branch) would ultimately make safety recommendations, in response to the emerging safety risk of appropriate access to oxygen, to ensure that trusts were adequately staffed to handle medical oxygen apparatus, including a recommendation that “NHS England and NHS Improvement review and further specify the key roles, responsibilities and competencies of individuals identified in the health technical memorandum (HTM) for medical gas pipeline systems, including identifying how the appointment and training of designated officers may be supported”.¹¹⁰

Planned surgeries, diagnostics and routine outpatient services were severely delayed or cancelled

Planned surgery began to be cancelled in Wales from March 14,¹¹¹ and on 17th March 2020, NHS England issued a directive to Trusts advising them to postpone all non-urgent elective operations from 15th April 2020. On 23 March 2020, Barking, Havering and Redbridge Trust was the first hospital trust in England to cancel all routine cancer surgery due to pressures from COVID-19. In Scotland around 240,000 fewer operations took place in 2020, due to COVID-19 pressures.¹¹²

A large proportion of respondents to the BMA’s call for evidence who were working in secondary care mentioned the reductions or cancellations of non-COVID work during the first wave, with respondents frequently stating things like:

My organisation managed only by restricting routine care and diverting resources. There was no ‘spare capacity’ to deal with COVID

(Consultant, Scotland)

This cancellation of care, especially elective procedures, created a significant backlog which added to pressures on the UK’s health services in later waves. This is likely to have had a significant impact on patients’ health, especially affecting conditions needing timely treatment, such as cancer.

It is noteworthy that 40,000 fewer people had started cancer treatment by the end of 2020 in England than would normally have been expected to – likely caused by suspension of services to treat cancer, but also by suspension of diagnostic services and partly by many patients not seeking care for fear of catching the virus or overstressing the NHS. Endoscopies, for example, which are vital for diagnosing many forms of cancer, were almost entirely stopped because they were considered too risky for both staff and patients, and by 30 May 2020 more than 180,000 people in England were waiting for an endoscopy – a 44% rise on the previous year.¹¹³

As a result of delays like these, many future cancer patients will have been living with cancer unknowingly in 2020 and into the present.¹¹⁴ As a respondent in our call for evidence described:

We were already struggling to meet demand after multiple consultants had left, so the pandemic has created a massive waiting list, eg bowel cancer screening cases waiting six months for a scope. It exposed the fragility in the system and the issues of lack of investment in endoscopy in Wales as well as the historic poor management of our consultant workforce

(Consultant, Wales)

Field hospitals were established but under-utilised

To increase physical capacity, new temporary field hospitals were set up in late March 2020 to help the system cope, but staffing them was a significant challenge given the pressures elsewhere in the system.

In Scotland, the NHS Louisa Jordan hospital was set up at the SEC Centre in Glasgow.

England introduced the NHS Nightingale programme to help manage the potential for the NHS to become entirely overwhelmed by COVID-19. There were initially intended to be seven critical care hospitals set up to help manage overflow of care. They were to act as emergency field hospitals if required and had the potential to hold thousands of patients. Initially there was widespread praise for how quickly they were set up, but by summer 2020 it became clear that they were not admitting patients in large numbers; fewer than 1,000 patients were admitted across all seven sites.¹¹⁵

In Wales, a total of 19 field hospitals were set up by Health Boards during March to April 2020, most notably being the repurposing of the Principality Stadium, Cardiff as Ysbyty Calon y Ddraig, at a maximum bed capacity of 2,000. But again this capacity was underutilised. During a meeting of the Senedd Health and Social Care Committee in March 2021, the NHS Wales Director General, Dr Andrew Goodall, stated that the maximum number of patients treated in Welsh field hospitals was 227 from a maximum technical capacity of 2,700.¹¹⁶

In Northern Ireland, there was a single NHS Nightingale centre in the first wave, based in the tower block at Belfast City Hospital, which opened in April 2020 and had a 230-bed capacity, however it was stood down the following month due to lack of demand.¹¹⁷

Some respondents to the BMA's call for evidence also found the deployment of staff to these field hospitals difficult, as it caused staff shortages elsewhere in the system:

We were thin on the ground prior to the pandemic. Then came the deployment of staff to other areas of work they were unfamiliar (nightingale hubs). That made work unbearable (Consultant, England)

During the second wave, these hospitals were often used as step-down facilities, with a different focus than was originally intended. Ultimately, however these field hospitals were under-utilised, and there is existing research by the King's Fund questioning the financial efficacy of the NHS England Nightingales programme. Meanwhile a report by the House of Commons Health and Social Care Select Committee found that "As the Nightingale hospitals were not extensively used it is difficult to evaluate their true effectiveness. Nonetheless, the speed at which these hospitals were created across the UK is remarkable".¹¹⁸

Private sector hospitals were used to boost capacity

As a result of the lack of capacity within the English health service in March 2020 NHS England signed a contract with the private hospital sector whereby in return for the NHS covering all their operating costs, a large number of private hospital companies would agree to make 100% of their facilities available to the NHS.

Much of the financial information about this agreement is still not available, but in practice very few COVID-19 patients were treated in private hospitals, and it is likely that this was not a good use of public money. One of the reasons for this is that many staff who work in the private sector also work in the public health services, meaning the UK Government's deal often simply secured access to hospital buildings and equipment but without the staff to run them. It is also worth noting that the agreement meant many private sector hospitals stood empty while private sector waiting lists were growing and doctors working exclusively in the private sector had their ability to work temporarily restricted. The BMA's report "[Outsourced: the role of the independent sector in the NHS](#)" looks at this in more detail.

In Scotland, the health service spent more than £20.8 million on access to the private sector during the first wave of the pandemic, primarily to ensure that cancer provision continued. This was especially required in the health board area covering Lanarkshire, which had the highest usage of private sector provision, where more than 4,900 outpatient activities were carried out on behalf of NHS Lanarkshire.¹¹⁹

In Northern Ireland, private hospitals were also contracted to continue treatment for urgent elective cancer patients while Trust hospital sites concentrated on COVID-19 patients. An FOI request issued to Trusts shows that private hospitals were paid £27 million to treat over 40,000 patients in the initial three-month agreement.¹²⁰ This figure is likely to be an underestimation given that not all trusts provided up-to-date data. It is important to note that this lack of transparency means that it is difficult to determine whether good value for taxpayer money was ascertained through these deals.

Patients were discharged early into community settings

A similarly contentious issue, and one of the least successful areas of healthcare delivery during the first wave of COVID-19, was the discharge of patients to care homes from secondary care. NHS providers across the UK were explicitly encouraged to discharge patients from acute beds to the community or to their own homes, in an attempt to free up capacity in hospitals. At the time, testing for COVID-19 was not widely available, but even in situations where testing was available, many hospital patients were discharged from acute care without being tested (see below).

In Wales public health doctors were even asked to reassure care homes concerned about taking in those discharged from hospital, presenting serious ethical dilemmas for them in the context of what we set out below. FOI evidence from Wales suggests that in May 2020, 2,355 people were discharged from Welsh hospitals into care homes, and only approximately 700 (30%) of these patients discharged were tested for COVID-19.¹²¹

In Scotland, there were 3,599 discharges from hospitals into care homes between 1 March and 21 April 2020; due to clinical guidance at the time only 18% of these were tested for COVID-19. A further 1,605 discharges into care homes took place between 22 April and 31 May 2020, however changes in guidance meant that by then 93% of these were tested for COVID-19.¹²²

In Northern Ireland the policy to test all patients being discharged from hospital into a care home was not introduced until 19 April 2020, and tests were not needed if the care home was the patient's previous residence. Moreover, there was reportedly also pressure on care homes for testing not to hold up a timely discharge.¹²³

In England, hospitals were asked on 17 March 2020 to urgently discharge all hospital patients who were medically fit to leave.¹²⁴ It was not until 15 April 2020 that a policy was introduced to test those being discharged. It is estimated that around 25,000 people were discharged into care homes between 17 March and 15 April 2020, although the exact figure is unknown. Many of these individuals would not have been tested for COVID-19 due to the policy at the time prioritising those with respiratory illness or flu-like symptoms. A high court ruling in April 2022 would find that the UK Government acted unlawfully when it sent patients into care homes without coronavirus testing.¹²⁵

When testing did occur, positive results also did not always prevent discharge, for example care homes in Northern Ireland and England were told in April 2020 to accept COVID-positive patients if isolation was possible.^{126,127} Moreover, care homes taking in patients from hospital were at times not notified of test results or results were not received in a timely manner.¹²⁸ Many also struggled to access whole-home testing for all residents and staff.¹²⁹

All of this, along with challenges by care homes in accessing PPE at the start of the pandemic, likely led to increased deaths in care home settings. The exact role of hospital discharge on deaths in care homes is still subject to debate.

An analysis conducted by Public Health England established a link between COVID-positive patients proven to have this highly infectious respiratory disease being discharged into demonstrably underprepared and under resourced care homes and subsequent COVID-19 outbreaks in these settings.¹³⁰ This report suggests that only a small percentage of outbreaks was linked to hospital-associated infection. However, a BMJ piece suggests that these official numbers are a likely underestimate, as many residents were not tested at the time and would not have been picked up by the PHE study. The study also excludes people who did not reside at a care home prior to admission. An analysis published by the Northern Ireland Department of Health and national cohort study in Wales did not establish a link between hospital discharge and outbreaks in care homes.¹³¹ But in an evidence summary on the matter, the International Long-Term Care Policy Network (LTC) has concluded that these and similar studies are 'subject to substantial uncertainty due to data limitations'.¹³² A report by Public Health Scotland states that a link between patients discharged from hospital and subsequent outbreaks in care homes, though hard to prove, cannot be ruled out.

The role of untested patients being discharged into care homes in the death of care home residents is therefore an area the UK Government public inquiry should look at further – it is already part of the draft terms of reference for the Scottish Inquiry.

Blanket DNAR (Do Not Attempt Resuscitation) policies were issued

During the first wave of the pandemic, concerns were raised about the inappropriate practice of applying blanket DNAR (Do Not Attempt Resuscitation) orders on patients' medical records by healthcare providers. While this is not a new phenomenon, the pandemic exacerbated the longstanding issue of decision-making and communication around DNARs which increased due to a lack of clear, national guidance.¹³³

Indeed, an interim report published in December 2020 by the CQC (Care Quality Commission) found that the unprecedented pressures on care providers coupled with the rapidly developing guidance may have contributed to inappropriate advance care decisions proposed at the 'local level'.¹³⁴ DNAR directives were ordered in a blanket fashion for entire groups of people, such as care home residents or people with learning disabilities, rather than on a careful assessment of each patient's individual circumstance. Moreover, these were also applied without consulting patients or their families despite this being a legal requirement.¹³⁵

The BMA released joint guidance with the CQC, Care Provider Alliance and the Royal College of GPs in response to the CQC's report 'Protect, Respect, Connect – decisions about living and dying well with COVID-19' that found some DNACPR notices did not meet standards and had caused potentially avoidable deaths. The guidance supported and reaffirmed existing guidelines on best practice for advance care planning and the sensitive discussions that are required to encourage people to think about what they would want to happen if they should suffer a cardiac or respiratory arrest.¹³⁶

Second wave (September 2020 – April 2021)

By the autumn/winter of 2020, rapidly rising COVID-19 case numbers were exacerbated by the emergence of the Alpha variant. In addition to normal winter pressures, IPC measures and the need to segregate patients according to their COVID-19 status continued to impact delivery of care.

In the second wave, the UK's health services were attempting to deliver COVID and non-COVID care concurrently, but non-COVID settings were operating with rapidly declining capacity as critical care bed stock had to be further expanded beyond the surge capacity created during the first wave, with some associated staff redeployments too. On top of this, staff were battling burnout and exhaustion from the first wave, having had no respite from the demands of the first wave, and continued to suffer from COVID and self-isolation requirements like everyone else, further reducing staffing capacity. The winter of 2020/21 was a perfect storm of unprecedented pressure and severely constrained capacity which pushed the UK's health services across the four nations into previously unseen crisis.

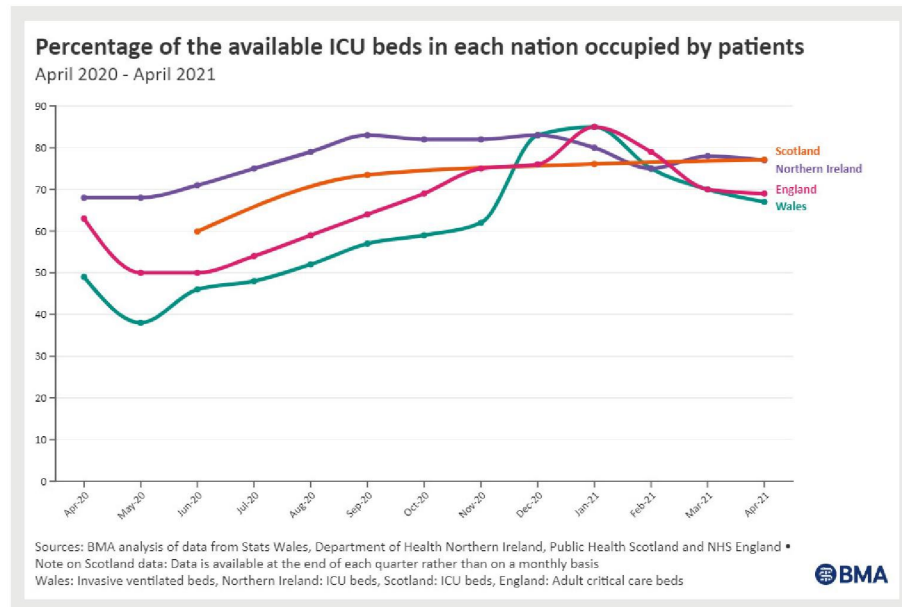
In the absence of an official date for when the second wave began this report dates it at around September/October 2020, which is when the UK Government had to start reintroducing legislation in response to growing levels of infection. On 22nd September Boris Johnson introduced a limited suite of new restrictions,¹³⁷ hoping to avoid a further full lockdown again, while similar measures were announced in Wales,¹³⁸ Scotland,¹³⁹ and Northern Ireland.¹⁴⁰ By December 2020, the number of daily infections in the UK had surpassed previous records and the whole of the UK was in a third lockdown by the first week of January.¹⁴¹

Key indicators show health services in the second wave were pushed to new limits

By early December 2020, several areas of concern were starting to emerge in the UK's winter data. The number of ambulances being held outside hospitals or diverted elsewhere was rapidly worsening across the UK and was significantly higher than during the winter in the previous years.¹⁴²

Bed occupancy, a significant issue in the first wave, was again becoming a growing area of concern. By early January 2021, record numbers of patients were being admitted into hospitals across the UK.¹⁴³ In Wales ICU bed occupancy in early January 2021 was 89%,¹⁴⁴ in Northern Ireland it was 83%¹⁴⁵ and in Scotland it was 77%.¹⁴⁶ In London trusts in the first week of January, more than nine in ten beds were occupied, with 7,000 of the capital's 12,668 beds taken up by COVID-19 patients.¹⁴⁷

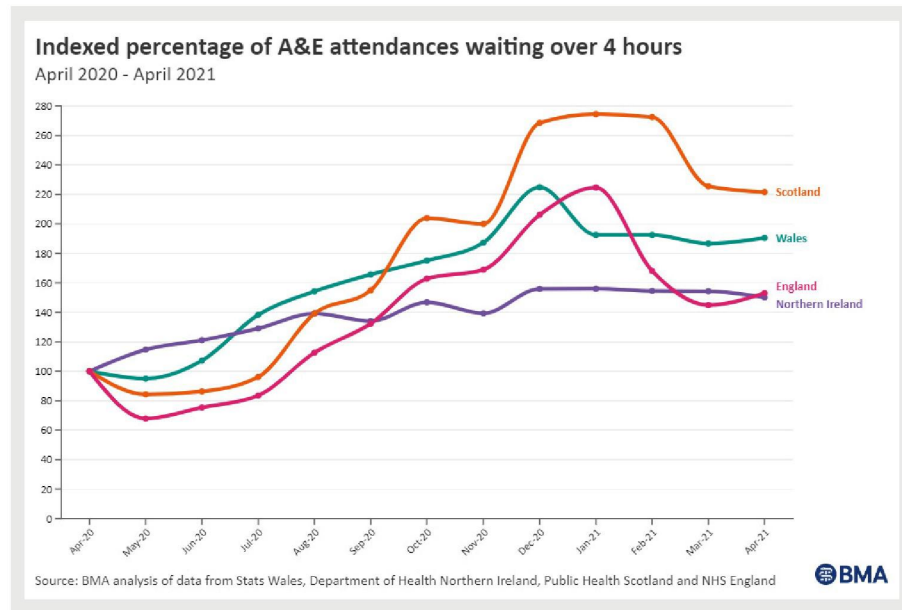
Figure 7: ICU bed occupancy in Wales, Northern Ireland, Scotland and England during the first and second waves



Demand for critical care beds – which are used for COVID-19 patients who require mechanical ventilation to keep breathing – was so extensive during this period that trusts were forced to further expand adult critical care capacity by repurposing yet more beds from different sectors, in order to create adequate surge capacity to get through the winter. By the end of January 2021, one week after the UK recorded over 100,000 registered COVID-19 deaths, the number of critical care beds in England and ICU beds in Northern Ireland both reached record highs.¹⁴⁸

Access to non-COVID emergency care was also affected. Unsurprisingly, attendances in A&E dropped as the UK was in various stages of lockdowns – however, over the same period, waiting times skyrocketed as capacity constraints, staffing absences and infection control measures placing limits on the amount of people that could physically be in buildings made it difficult to see patients within normal timeframes.

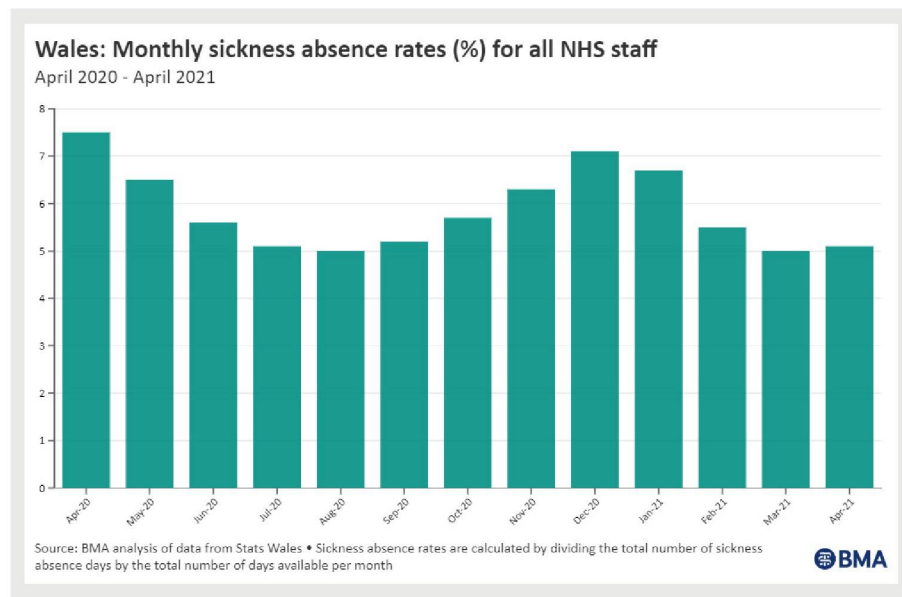
Figure 8: Indexed percentage change of A&E attendances waiting over 4 hours in Wales, Northern Ireland, Scotland and England during the first and second waves

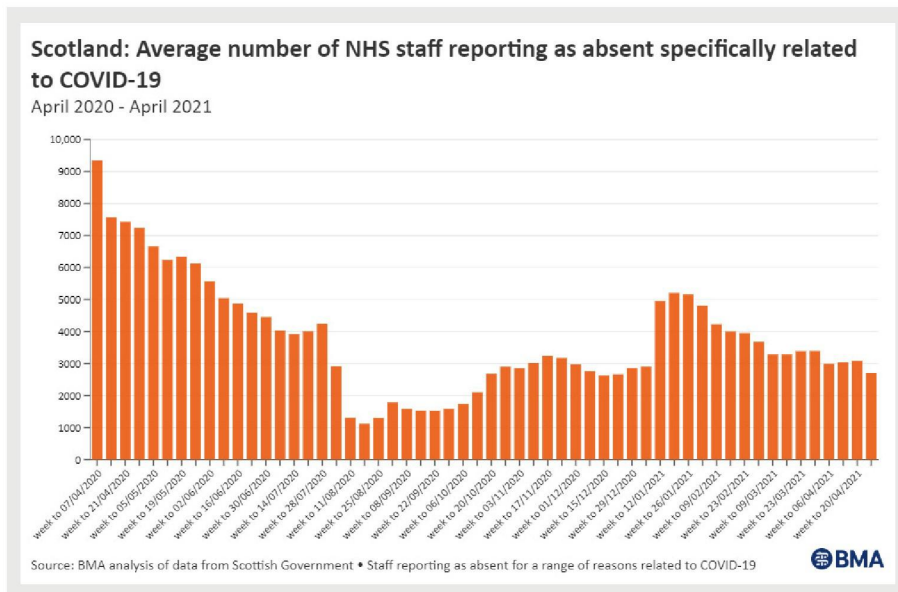
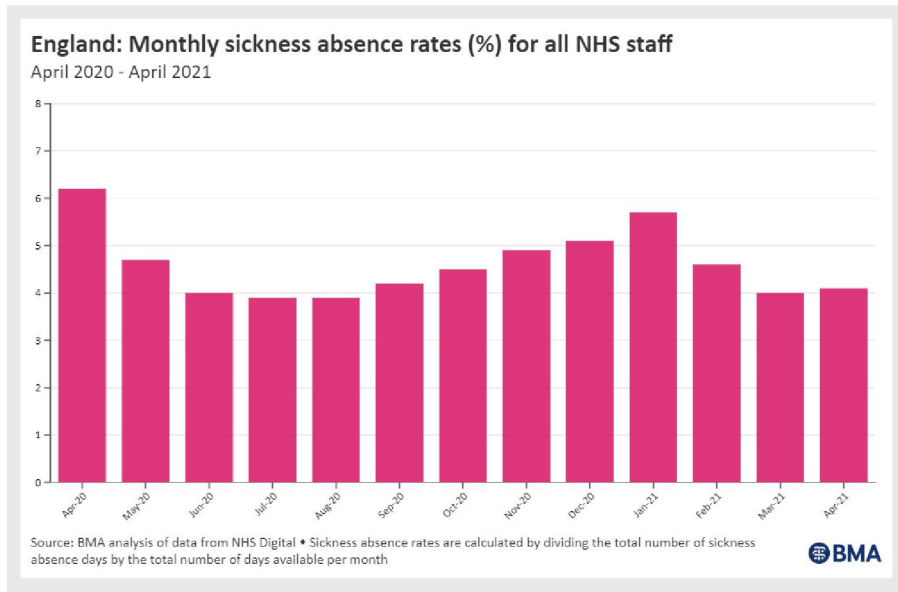


Staff absences were also increasing, further reducing capacity

The winter of the second wave was also characterised by growing staff absences, which peaked in December 2020 and January 2021 (Figure 9).¹⁴⁹ Respondents in our call for evidence described a combination of absences due to repeated self-isolations, COVID-19 infection, long COVID, short-notice childcare demands due to family member isolation, and burnout.

Figure 9: NHS staff sickness absence in Wales, England and Scotland during the first and second waves (data for Northern Ireland not available)





The impact of such a sustained period of considerable absence is significant on an already understaffed system. This took its toll both on capacity of the UK's health services and on the mental health and wellbeing of its staff (for more detail on the impact of the pandemic on staff see our second report in this series). In many cases the level of staffing absence pushed services and wards into dangerously unsafe staffing levels for prolonged periods (report five in this series looks at the impact of the pandemic on population health). As described by respondents in our call for evidence:

Awful – in ITU [intensive therapy unit] the staff are exhausted and the pressure is relentless. This will have long-lasting effects to the staffing of ITU

(Consultant, England)

We are even more understaffed than before, people are off sick/isolation until covid tests, children needing covid tests, home schooling etc. etc.
(Consultant, Scotland)

Within emergency medicine (where I work) we have been severely hampered by staff sickness. Our staffing levels are inadequate at the best of times and any sickness causes a problem. With the workload now higher than at any time on record we are drowning. We do not have extra staff to deal with the extra patients we are seeing. The only change is staff are having to work harder and for longer. It is breaking people.
(Consultant, England)

Sometimes, due to low staffing levels, the workload is excessive and at times feels unsafe and clinically risky
(Salaried GP, Wales)

Demand for routine work however has soared in recent months and has left us all exhausted and feeling that workload is unsafe
(GP Contractor/Principal, Scotland)

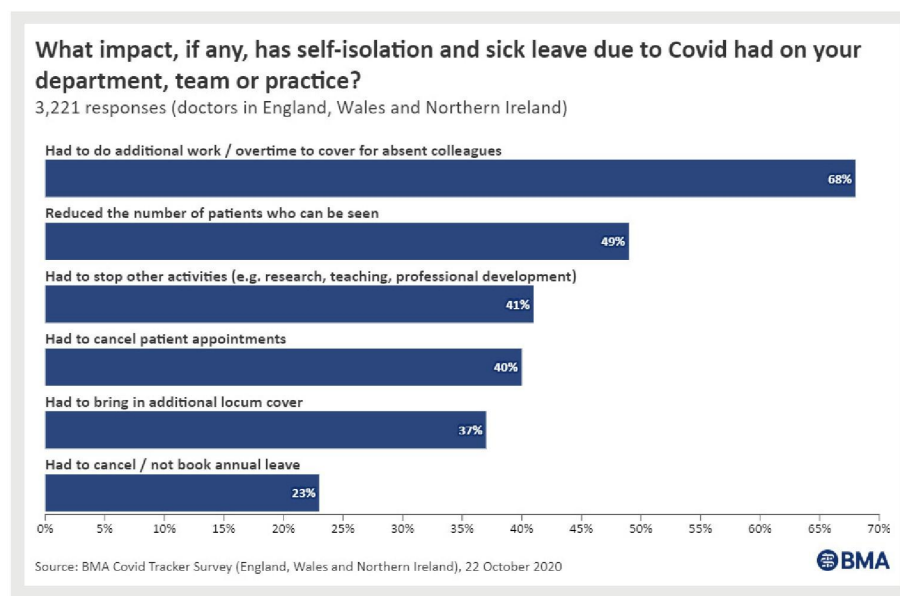
Unsurprisingly, this impacted patient care as well as forcing remaining staff to take on more work. The BMA's COVID Tracker survey from October 2020 (England, Wales and Northern Ireland only) found that 49% of respondents reported that self-isolation and sick leave due to COVID had reduced the number of patients who could be seen, while 68% reported they had to do additional work or overtime in order to cover for absent colleagues (see Figure 10). In December 2020, we found that 48% of respondents reported working additional hours during the second wave, over and above their contractual requirements. This was highest amongst respondents in primary care (57%). These experiences came through in our call for evidence:

You end up covering an unfamiliar ward/team/speciality on your own at short notice – you can be bleeped in the morning to go and cover another ward starting now
(Locally Employed/Trust Grade Doctor, Wales)

Once doctors started going off ill and having to isolate, there were not enough doctors to fill all the shifts, so other doctors (and nurses) were having to work even more extra shifts just to keep the rota at a safe level, which meant many of them burnt out and became exhausted very early on
(GP Trainee, England)

Coping with the unpredictability of staff having to isolate has been challenging and staff are frequently moved to other areas with no notice to fill gaps or asked to stay after their shift has ended
(Consultant, England)

Figure 10: The impact of COVID-related staff absences on healthcare delivery



In order to cope, services were again forced to prioritise

In the first wave, to prioritise the immediate and critical need to look after COVID-19 patients, many strands of non-COVID care were paused, while elective surgeries and other procedures were routinely cancelled. In the second wave, despite best efforts to continue non-COVID care alongside COVID care, cancellations inevitably became necessary again. In Wales, for example, the Aneurin Bevan health board postponed all non-urgent care in December 2020.¹⁵⁰ In Scotland there was a reduced number of scheduled elective operations, particularly during January and February 2021, with overall 42% fewer elective operations scheduled during the second wave compared to the same September-April period in 2018/19.¹⁵¹ In England, one of the largest hospitals in London, the Royal Free Hospital – which was receiving 12 new COVID inpatients every day in December 2020 – cancelled all non-emergency surgery until mid-February 2021.¹⁵²

This came out strongly in our call for evidence with respondents noting:

We started off from a position of 'just managing'. Went through a 'doing nothing but covid', and are now doing 'nothing but the critically ill'. No return of elective work, patients coming to harm on the waiting list, yet we are still told no staff

(Consultant, England)

The non-covid care is all but stopped, my waiting list has more than quadrupled

(Consultant, Scotland)

Alongside this reduction of non-emergency care, hospitals increased the facilities available for COVID-19 patients. For example, Northern Ireland saw the opening of a new Nightingale COVID facility in Whiteabbey Hospital in November 2020¹⁵³ and an expansion of COVID facilities at the Belfast Nightingale Hospital in January 2021.¹⁵⁴

By now, backlogs were significant – and growing

UK health services made considerable progress in restoring non-COVID activity after the initial outbreak, but the second wave of the virus caused further disruption to routine care. As in the first wave waiting times for those on treatment lists skyrocketed over the second wave.¹⁵⁵

The waiting list is a visible backlog, but the shutdown of most non-COVID services in the first and second waves combined with changes in patient behaviour created a growing 'hidden backlog'¹⁵⁶ of unmet need for patients that require care but have either not yet presented, or who have had referrals cancelled due to reprioritisation or refused due to a lack of capacity. Respondents to our call for evidence confirmed this, describing a greater complexity of conditions when patients did present:

Patients stopped presenting as freely, so cancers etc are now being diagnosed late

(GP Contractor/Principal, Scotland)

There is a cohort of patients whose care has been delayed or altered in such a way that when they do present they are sicker than they would be in a non-pandemic setting

(Consultant, Scotland)

Patient numbers were and are high, and acuity is off the charts. These both mean that we're seeing more patients and spending more time with them

(Locally Employed/Trust Grade Doctor, Wales)

Worse pathology due to delayed care for patients

(Junior Doctor, Northern Ireland)

There are different ways to calculate the true level of this hidden backlog. The BMA's own estimates for England show that between April 2020 and January 2022, compared to pre-COVID averages there were 4.44 million fewer elective procedures and 30.79 million fewer outpatient attendances than would have otherwise been expected.

The Health Foundation's analysis of clinical pathways in England shows that four million fewer people completed elective treatment in 2020 compared with 2019 (down to 12 million from 16 million), and that 5.9 million fewer people were added to the waiting list for consultant-led elective care in England in 2020 than in 2019.¹⁵⁷

General practice played a pivotal role in leading the vaccination programme

On 2 December 2020, the Pfizer-BioNTech COVID-19 vaccine was approved for use in the UK¹⁵⁸ – the first to be authorised anywhere in the world. On 30 December, this was followed by the cheaper and more easily distributable Oxford-AstraZeneca vaccine.¹⁵⁹ A third vaccine produced by Moderna was approved for use in the UK on 8 January.¹⁶⁰

In December 2020, the government published a list of nine priority groups, following the advice of the independent Joint Committee on Vaccination and Immunisation (JCVI). The rollout started with the most vulnerable, including health and social care workers – something the BMA had lobbied hard for (more detail on the rollout of vaccinations to healthcare staff can be found in [report one](#) in this series) – and then moved down through age groups.¹⁶¹

All four nations took a mixed-delivery approach, using a large network of vaccination sites including hospital hubs, GP surgeries and pharmacies, and Mass Vaccination Centres (MVCs). Vaccine delivery is separately overseen by each UK nation, given health policy is a devolved matter.¹⁶² To increase capacity to be able to deliver what was a huge vaccination programme legislation was passed in England to allow a wider range of individuals to give vaccinations and by recruiting clinical and non-clinical paid staff and volunteers.¹⁶³

The COVID-19 vaccination rollout is widely regarded as an unprecedented success. Vaccinations were delivered remarkably quickly in comparison to other nations,¹⁶⁴ and the UK government hit its ambitious target of offering the vaccine to all adults by July 2021.¹⁶⁵

General practice did an exceptional job at spearheading the programme and delivered a large portion of the vaccines. By the end of October 2021, 71% of vaccines in England had been administered by GPs and community pharmacies, and as of 28 March 2022, 38% of vaccines in Northern Ireland had been delivered by GPs.¹⁶⁶ The GPs and their teams that stood at the helm of this exceptional feat have, rightly, been widely praised.¹⁶⁷ A report by the National Audit Office (NAO) also highlights the 'goodwill, flexibility, and dedication' that had been required to set up and run vaccination sites at such pace and scale.¹⁶⁸

Vaccinations were delivered in addition to standard general practice workload

This achievement is all the more remarkable considering that the vaccination rollout was delivered in addition to standard workload, not instead of it. As described in our call for evidence:

We have been stretched so thin covering COVID centres and also delivering vaccine programmes this has had a huge impact on our staff

(GP Contractor/Principal, Northern Ireland)

We worked all weekends delivering vaccine with volunteers, clinicians and patients and friends. Part time doctors became full time. Retired doctors revalidated and manned 119 etc, 5 receptionists resigned, unable to cope

(Medical Academic GP, England)

Demand on general practice has been consistently high throughout the pandemic, with demand only increasing due to the backlog of unmet need in the community as a result of many secondary care services closing. With many services unable to accept referrals due to capacity constraints, and with many people waiting months or longer to access treatment, this demand for care has not disappeared. Instead, it has been 'held' by general practice who have been managing and caring for these patients in the interim. The COVID-19 vaccination programme also increased the need for cover, as locums were needed to cover for GPs redeployed into the vaccination programme, or GPs covered for other practice staff redeployed from their practices into the vaccination programme.

These themes came through in our call for evidence:

There has been little support for primary care to cope with the increase in work load/backlog of patients having not consulted about serious health problems at the height of the pandemic

(GP Locum, Scotland)

For GPs one of the significant pressures is the difficulty of being able to refer on to secondary services, long waiting lists [...] leave us holding distressed and angry patients

(Salaried GP, England)

Having to provide staff to go to the COVID vaccination centres has been very challenging. We have not been able to provide our usual level of care for those with LTCs [long-term conditions]

(GP Contractor/Principal, England)

Practices that were coping pre pandemic are now finding themselves with larger workloads, a shortage of locums and are struggling to fit consultations in to the 8am to 6.30pm period with partners routinely working later than this to deal with results etc. It is hard to carry out holistic consultations in the time available

(GP Locum, Wales)

Unlike in the first wave, where non-COVID services were intentionally paused and large numbers of staff were diverted into the frontlines of the pandemic response, the second wave saw the health services attempting to deliver both COVID and non-COVID care concurrently. This created a difficult situation for the staff delivering this care, who were largely exhausted from the unrelenting demands of the first wave, having had no opportunity to rest and recuperate before the next variant hit. Staffing absences and the ongoing need to prioritise delivery of care meant backlogs and waiting lists grew further, and the impact on patient care became more and more apparent.

Third and fourth waves (November 2021 onwards)

The third wave of COVID-19 began with the Delta variant causing stubbornly high case numbers across summer 2021, significantly higher than summer 2020. Figures showed that on 20 August 2021, case numbers in the UK stood at 37,314, compared to 1,182 on 20 August 2020.¹⁶⁹

Early indications of the next wave began to intensify in November, when the first Omicron cases were identified in the UK.¹⁷⁰ The exponential growth of the Omicron variant necessitated significant efforts to be expended on the delivery of a booster vaccination programme, and delivery would be pushed to new heights, reaching a peak of 626,000 vaccinations in a single day in England in December 2021.¹⁷¹ By January 2022, COVID-19 cases reached the highest number of cases recorded to date as the fourth wave started in earnest, and case numbers remain high at the time of publication. All the while, backlogs continued to grow despite more and more non-COVID care being delivered.

A booster programme was delivered across the UK

In September 2021, the UK government confirmed it would begin to offer vaccines to 12–15-year-olds, and, with some evidence emerging suggesting the potential of waning immunity from vaccination, begin a programme of 'booster' vaccines for the priority groups identified in the original rollout.

Only two months later, in November 2021, amid concern about the new Omicron variant, the government announced boosters would be extended to all UK adults from three months after their second dose, with the aim of offering all adults a booster by the end of January 2022. This was then brought forward by a month to the end of December on 12 December among rapidly rising case numbers and the start of the fourth wave. The original plan would have seen the doses offered first to older adults and those at risk before moving down age groups in turn, as in the original rollout. However, everyone aged over 18 was able to book their booster jab from 15 December. Second doses were also available to 12–15-year-olds 12 weeks after their first dose.

Pressure in general practice increased further

The third and fourth waves put increasing pressure on all areas of the health service, but deeply affected general practice. With premises used to deliver the booster shots as quickly as possible to as many people as possible, the booster programme resulted in an ever-increasing number of virtual appointments to meet demand.

A handful of respondents to the BMA's call for evidence, particularly those working in primary care in England, described unsupportive narratives from government and the media as the pandemic continued.

*Very difficult as increased patient expectation fuelled by negative media campaign and negativity from Health Minister
(GP Locum, England)*

Such criticism during this period added to the febrile atmosphere, as the UK Government consistently focused on the delivery of virtual appointments as a negative, insisting that GPs had to 'return' to face to face appointments. In September 2021, NHS England wrote to all GP surgeries instructing them that patients must be able to see a GP face to face if needed.¹⁷²

This instruction was interpreted as an insult by the profession, as it strongly implied that face to face appointments were not already available for those that needed them and ignored the fact that many appointments took place virtually due to [NHSE's own guidance to the profession](#). The BMA responded strongly to this criticism and described the insinuation that face-to-face appointments had not been taking place as "an affront to GPs".¹⁷³ The BMA ultimately wrote to the UK Government in September 2021 to ask for an urgent meeting to discuss concerns, and to ask the government to help GPs to manage workload.¹⁷⁴

Some respondents believed Government and media narratives would have a longer-term impact on patients' trust in doctors:

The newspapers, especially the Telegraph and Mail actively campaigned against General Practice for months on end, it was so unbelievably morale-sapping and still is. [...] The damage is now done and patients are furious with us – the relationship between primary care and its patients has been severely damaged if not broken

(GP Locum, England)

Government ministers, the media and social media providers have created a level of mistrust and false accusations which will damage doctor/patient relationships for years if not forever

(Retired doctor not currently working, Northern Ireland)

With an increasing media and Government narrative about GPs not being open for business and increasing access issues for patients, GPs and their staff faced increasing levels of abuse. While this was mostly a narrative centring on England with the UK government highly critical of access issues, all parts of the UK had some experience of this as set out earlier (e.g. in Wales the media narrative had an impact despite a supportive government). However, although there was negative media coverage in Scotland, the Scottish government [signed a joint letter with the BMA](#) which acknowledged the work GPs had done, condemning abuse and recognising that changes to social distancing guidelines would soon allow GPs to offer more face to face appointments.

The impact these media narratives had on raising unrealistic patient expectations was particularly difficult, especially in areas where GPs had been struggling significantly before the pandemic, such as in Northern Ireland. Respondents to the BMA's call for evidence described this change in patient expectations as the pandemic continued into the second and third waves – which some attributed to public messaging about what the UK's health services were realistically able to provide – with patients feeling growingly frustrated about access issues in secondary care. In many cases this led to a rise in abusive behaviour from patients towards practice staff:

The long waiting lists grew even more longer [sic] now more than 18 months for few specialist reviews. Impacts GP work load as patients are frustrated and come back with same problem multiple times. Staff have been abused verbally due to long waiting lists

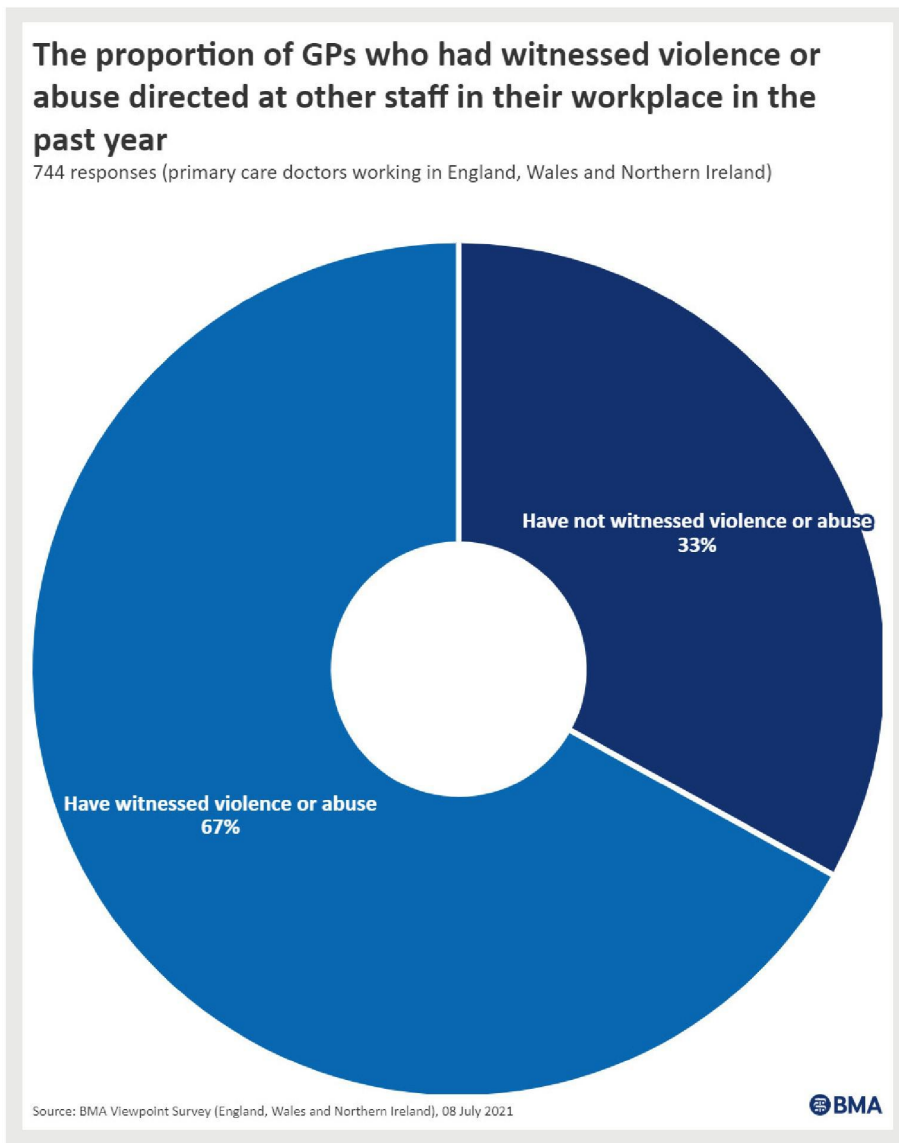
(GP trainee, England)

Reception staff regularly verbally abused and very stressed

(GP Contractor/Principal, Scotland)

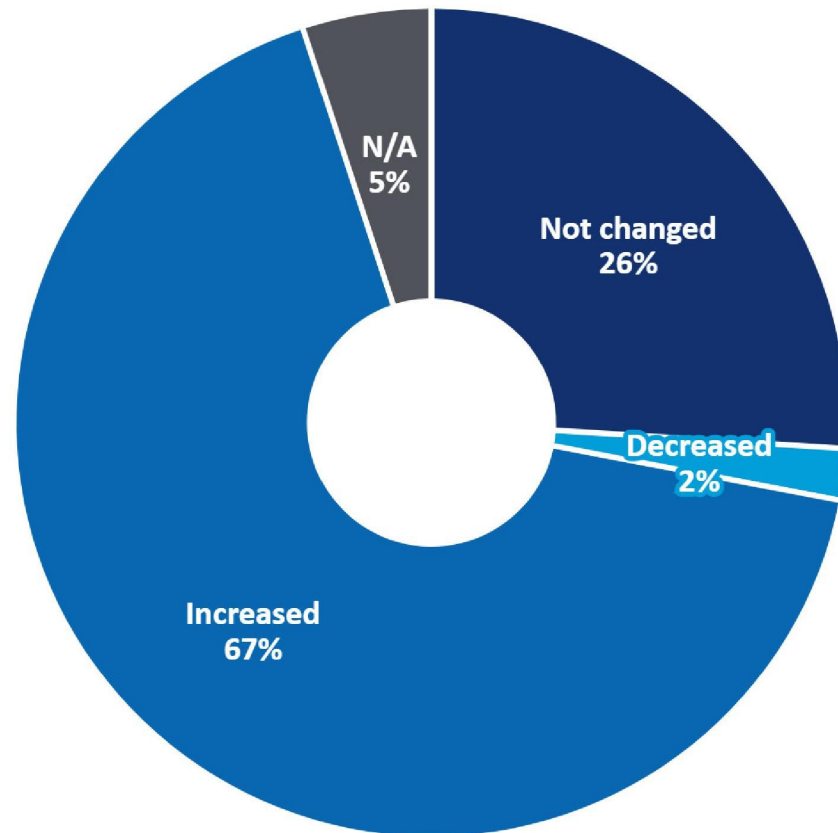
Abusive behaviour (see Figure 11 and report 2 in this series) took place both in person and through electronic communications, and invitations to have a vaccination appeared to act as a significant driver of unacceptable behaviour.¹⁷⁵ These reports included incidences of physical violence against staff and the destruction of property within surgeries.

Figure 11: GP experiences of violence and abuse within the past year



How GP experiences of threatening behaviour, violence or verbal abuse from patients has changed compared to one year ago

740 responses (primary care doctors working in England, Wales and Northern Ireland)



Source: BMA Viewpoint Survey (England, Wales and Northern Ireland), 08 July 2021



Health services must now be supported to recover and become fit for the future

Health services must now balance the requirements of COVID-19 and non-COVID-19 care, as patients who were not able to or had been reluctant to access services during the height of the pandemic began seeking care. An increasing emphasis has been placed on the recovery of elective care, and the recovery in Accident and Emergency departments.

Winter pressures were a significant issue in the winter of 2021/22 and the elective care backlog started to have a significant impact across the system. For example, in England [A&E attendances reached pre-pandemic levels](#), with almost 2.2 million patients visiting emergency departments in October 2021, the same level as in pre-pandemic October 2019. However, a record high of over 7,000 of these people were waiting over 12 hours following a decision to admit in emergency departments in October 2021, almost 10 times the number waiting more than 12 hours in October 2019.

The picture was similar across the four nations. In Northern Ireland, waiting times targets were consistently missed – the target of 95% of patients treated and discharged or admitted within four hours was missed in the July to September 2021 period, with only 54% seen within that timeframe,¹⁷⁶ and again in October-December, with just 53% seen within that timeframe.¹⁷⁷ In Wales, by October 2021 performance on the 95% window

was also worryingly low, with 68% of patients attending an accident and emergency department in Wales seen within that timeframe.¹⁷⁸ In Scotland, performance against the four-hour target was also poor, although better than in other parts of the UK, with 75% of patients being seen within the four-hour window by January 2022.¹⁷⁹

In a BMA Viewpoint survey in November 2021 80% of doctors in England, Wales and Northern Ireland said that, compared to one year ago, they were now more concerned that patients may suffer avoidable harm to their health from delayed admission or arrival at hospital.

At the release of NHS England's [delivery plan](#) for tackling the backlog of COVID-19 care, the BMA [highlighted that](#) without a workforce strategy plans for elective care recovery are highly unlikely to be successful. The [Scotland NHS Recovery Plan](#) also intends to tackle the backlog in care in Scotland, and the health system in Wales is working towards [a recovery plan](#) announced much earlier, in March 2021. In a BMA Viewpoint survey in April 2022, however, 87% of doctors in England, Wales and Northern Ireland felt that Government aims to tackle the backlog were unachievable with the existing healthcare workforce.

This is unsurprising when considered in the context of staff recovery needs, given that NHS staff had by November 2021 been working on an emergency footing for 18 months, and exhaustion and burnout was endemic across the profession. Ultimately, without a costed, national, comprehensive workforce strategy, goals set around recovery will be extremely difficult for the health services to meet. The workforce shortages that have been so long in development even before they were sharply exacerbated by the pandemic will take years to resolve, meaning much of the burden of recovery will fall on the existing staff, exhausted and demoralised as they are, and the workforce strategy is going to have to focus on staff retention as much as training and recruitment.

Outsourcing to the private sector has increased to help tackle waiting lists

A key feature of the English government's elective recovery plan is the outsourcing of NHS-funded activity to the private sector. It proposes to significantly increase the use of the private sector through a range of factors, including the expansion of patient choice, long-term contracts and partnerships with ISPs (Independent Sector Providers), and the development of a payment regime to incentivise increased activity.

However, BMA research (2022)¹⁸⁰ found that doctors are largely divided as to whether purchasing additional capacity from the private sector would improve the ability to manage pressures on NHS hospitals. Two in five doctors (39%) feel that private sector contracting will significantly worsen the ability to manage NHS pressures, compared to just 30% who believe it would improve. Moreover, over four in five (83%) doctors expressed concern about the availability of NHS staff as a result of the existing limited pool of staff taking on additional work in the private sector.

The devolved nations have a smaller private hospital sector compared to England. Regardless, the relationship between the Welsh NHS and the private sector, for example, has developed following closer collaboration during the pandemic. However, Wales has been clear that the capacity within these settings is restricted due to demand for private healthcare and consequently outsourcing proposals have reduced. There are however other ongoing outsourcing initiatives that will see patients being offered virtual appointments in for example, dermatological or cardiology services.¹⁸¹

The 2021 roadmap for tackling hospital waiting lists in Northern Ireland involves the private sector through the Republic of Ireland Reimbursement Scheme. This new framework, that is based on the Cross-Border Healthcare Directive, allows self-paying patients to purchase routinely commissioned elective care in the Republic of Ireland, and subsequently have their costs – up to the cost of treatment in the HSC in Northern Ireland, recompensed. Up until February 2022, 1,864 applications were submitted to the scheme, with 1,470 of these being approved.¹⁸²

Conclusion

The health services across the UK have delivered a staggering level of care during the four waves of the COVID-19 pandemic that have taken place to date. This level of care delivery is especially pertinent when considered in the context of the decade of underfunding and long-term staffing shortages that preceded the pandemic. The UK's health services moved with great agility towards forms of care provision on a scale that would have previously been unthinkable, particularly with regards to digital healthcare provision, whilst at the same time adapting flexibly to redeployment and reorganisation and a wholly new vaccination programme being delivered. The widening of access to healthcare across different forms of provision has benefitted both patients, who are now able to access some forms of care remotely if they both want and are able to, and staff, who have in many cases felt the benefits of a move to more flexible working. It is extremely important that this choice and flexibility for everyone is not lost as the system is increasingly able to return to more 'normal' ways of working, however, it is crucial that any remote or flexible working does not compromise patient safety.

The UK's health services are still running hot. All four health services are still understaffed and overstretched, and the pandemic is not yet over. There may well be additional waves or new variants in the coming months that push the UK's health services back into the critical capacity crises we have highlighted in this report, and both the visible and hidden backlogs of care will continue to grow despite the very best efforts of staff to tackle them. This pandemic will at some point end, but its legacy will continue for many years yet to come. If the UK governments wish the health services to prioritise reducing waiting lists and the wider backlogs of care, the UK health systems must be provided with the resources necessary to achieve this.

As the pandemic moves out of the acute phase and health services turn towards the future, it is essential that the UK governments acknowledge the reality that healthcare staff cannot continue to work under such continuous and intense pressure. Staff are our health services' greatest asset and care cannot be delivered without them, but the pressure of providing care during a pandemic, on top of many years of covering staffing shortages and working in increasingly unsafe conditions in buildings of varying degrees of deterioration, has pushed the UK's healthcare workforce beyond its limits. We are facing an immediate retention crisis that must be addressed, and in the longer term we must expand the workforce significantly. The long lead times for training expert medical professionals means existing shortages will be magnified in the months and years to come, and gaps will be worsened by retention issues that will likely worsen before they get better. The need for transparent, multi-year workforce planning and proper, publicly available modelling has never been greater. Crucially, this must include proper consideration of all aspects of the pipeline that creates a doctor; from the provision of medical school places to foundation posts, to the availability of specialty training and GP, SAS doctor and consultant posts, as well as the growing and equally important other avenues a medical career can take, e.g. medical academics who teach our doctors of the future, public health doctors who have played a crucial role in the pandemic response (which report four in this series will look at), specialist occupational physicians (whose importance both report one and two in this series examine), prison and armed forces doctors etc, and the infrastructure and teaching capacity needed to train them.

It is also vital that the UK governments are willing to communicate honestly with patients and the public about health service pressures. The health services will never look exactly the same as they did before this pandemic, and they will also need sustained investment in resourcing and staffing in order to deliver the level of care that the public understandably expect. This will take time. Our focus is on the medical profession, but we must not forget that it is the public who have been most impacted by this virus. Many are suffering with conditions that will now take much longer to treat than they would have before, and for some their conditions have become or will become untreatable as a result of delays and service reorganisation. Patients have suffered, and will continue to suffer, harm that could

have been avoidable if the UK's health services had been in a stronger, healthier position entering the pandemic. The impact on population health too, including mental health, is and will be significant (this is something report five in this series will examine in further detail). Governments must take accountability for properly communicating this message in order to foster a compassionate relationship between the public – people who need care – and those providing that care.

Questions for the public inquiries and recommendations for Governments

The inquiries must consider the following questions:

- How could the health services have been adequately staffed entering the pandemic? What impact could this have had on healthcare delivery during the pandemic? How should the system enact workforce planning going forward?
- How did low bed numbers impact healthcare delivery during the pandemic? How can they be sustainably expanded, distinguishing between ward beds and critical care beds, in addition to beds in care and nursing homes?
- How did the poor quality of the health service estate impact staff and patients during the pandemic? How can this be improved in the future?
- How did inadequate funding, and historical underfunding, impact healthcare delivery during the pandemic?
- What lessons can be learned from the deployment of staff across the service during the pandemic, including the use of returners, early deployment of medical students, and the use of the private sector?
- What were some of the positive changes brought about because of COVID-19, and how might some of them be maintained?
- Where returner programmes, such as the Bringing Back Staff returner programme in England, were not well utilised, what lessons can be learnt about what went wrong?
- How can redeployment in future crises be better managed, considering the issues raised by members around contractual arrangements, the voluntary nature of redeployments, disruption of training, excessive hours, and the impact on areas from which staff were redeployed?
- What can be learnt from the success of the Volunteers Programmes? Is there scope to retain and continue to use volunteers?
- What plans for use and staffing projections were made before deciding to invest in field hospitals. What additional lessons can be learned about the deployment of field hospitals during the pandemic?
- What did the government spend on contracts to retain exclusive use of private hospitals? What calculations were done on staff availability to match additional physical capacity?
- What was the evidence base for discharging patients early to free up capacity, including to care homes? How was the decision taken to allow for discharge of patients without testing and what impact did it have on deaths of care home residents?

Recommendations

Ensure health services are safely staffed and able to respond effectively to future pandemics

- Recruitment of staff must stay in line with properly modelled assessments of the workforce needed to meet current and future patient demand, based on long-term and independent projections of demographics and need.
- Efforts must be made to improve staff retention and reduce the high rate of attrition across all grades of doctors by addressing, amongst other problems, pay erosion and punitive pension rules, and ensuring staff are able to continue to work flexibly where possible and where this is safe for patients, and that they feel valued by the service and the government.
- To increase the number of doctors the UK is able to train domestically, the UK governments must significantly expand all aspects of the medical training pipeline. In addition to funding greater numbers of medical school places and specialty training posts, this must include increasing university and hospital and primary care training capacity and infrastructure as well as expanding the medical educator workforce.
- Junior doctors and medical students must be assured that their efforts to support the delivery of care during the acute waves of the pandemic will not disproportionately impact on their future careers due to time away from formal training and must be supported to flexibly access training opportunities to make up for those lost, remembering that training programmes are supposed to be competency based and not time-based. If this is not addressed, it could have a significant and negative knock-on impact on the senior medical workforce in the future.
- Assurances must be made that redeployed staff, who were not always given adequate training for their new, temporary roles, will not be left vulnerable to legal challenges for negative outcomes.
- General wellbeing support – including timely and accessible occupational health assessments and support to access psychological support services - must be made available for staff at all levels and regardless of location, with specific support also offered to ensure staff are able to recover from the pressure and burnout of delivering care during a pandemic
- Obstacles that prevented a greater uptake of returners programmes must be addressed and processes streamlined to ensure that staff can return if they wish with greater ease and flexibility, and with fewer administrative and bureaucratic barriers.

Increase capacity to respond to future pandemics

- Governments across the UK must develop a credible plan to meaningfully increase hospital capacity and ensure that the UK's health services are not reliant on private sector capacity in the long-term.
- Action must be taken to ensure that the core bed stock grows to reach a level that will cope with year-round demand – this must include the re-opening of acute beds closed during the pandemic and a sufficient workforce to staff them safely.
- UK health services estates must be improved – this includes expanding physical space, implementing improved ventilation and infection control measures and addressing the backlog of maintenance costs.
- IT infrastructure (including hardware, software, and training) must be updated to enable more flexible and streamlined remote working and video consulting, as well as freeing up clinical capacity by improving IT provision and data-sharing for direct care.
- Additional funding is required across the UK to help health services work through the backlog of non-COVID care. Existing resources and funds must also be directed to where they are needed the most.

Ensure better planning to avoid service disruption

- Conduct proper pandemic planning and readiness exercises for future pandemics and implement recommendations from these exercises
- The UK and Devolved Nations Governments should collaborate to more closely align their collection and publication of health and care data, with a particular focus on supporting the Devolved Nations to enhance their data collection and reporting programmes.

Appendix A

Overview of BMA COVID research

Title	Date	Responses	Coverage
Covid Tracker survey 1	6 April 2020	1,924	UK wide
Covid Tracker survey 2	16 April 2020	6,126	UK wide
Covid Tracker survey 3	30 April 2020	16,343	UK wide
Covid Tracker survey 4	14 May 2020	10,328	UK wide
Covid Tracker survey 5	28 May 2020	8,455	UK wide
Covid Tracker survey 6	18 June 2020	7,497	UK wide
Covid Tracker survey 7	9 July 2020	5,905	England/Wales
Covid Tracker survey 8	13 August 2020	4,279	England/Wales
Covid Tracker survey 9	22 October 2020	7,820	England/Wales/Northern Ireland
Covid Tracker survey 10	17 December 2020	7,776	England/Wales/Northern Ireland
Covid Tracker survey 11	8 February 2021	8,153	UK wide
Covid Tracker survey 12	19 April 2021	5,521	UK wide
Viewpoint survey 1	8 July 2021	2,478	England/Wales/Northern Ireland
Viewpoint survey 2	2 September 2021	1,749	England/Wales/Northern Ireland
Viewpoint survey 3	26 November 2021	2,424	England/Wales/Northern Ireland
Viewpoint survey 4	4 February 2022	1,320	England/Wales/Northern Ireland
Viewpoint survey 5	8 April 2022	1,194	England/Wales/Northern Ireland
Call for evidence	17 December 2021	2,484	UK wide

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- 13 The BMA responded to the Scottish workforce strategy (2022) [here](#), to the Welsh workforce strategy (2020) [here](#), and to the Northern Irish consultation on the future planning model (2021) [here](#)
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- 130 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005583/Nosocomial_Seeding_OF_care_home_outbreaks_report_Official_Sensitive-3.pdf – The report identified 5,882 outbreaks in care homes in England between January and October 2020, of which 97 (1.6%) were potentially seeded from hospital-associated COVID-19 infection. These hospital-associated outbreaks involved 804 residents and 286 deaths (2.1% of the 13,791 confirmed COVID-19 resident deaths during this time).
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- 143 <https://nhsproviders.org/nhs-winter-watch-202021/week-5>
- 144 <https://gov.wales/nhs-activity-and-capacity-during-coronavirus-covid-19-pandemic> [89% invasive ventilated bed occupancy as of 08/01/2021]
- 145 <https://www.health-ni.gov.uk/publications/daily-dashboard-updates-covid-19-march-2022> [83% ICU bed occupancy as of 08/01/2021]
- 146 <https://www.opendata.nhs.scot/dataset/hospital-beds-information> [82% average ICU bed occupancy during Q1 of 2021]
- 147 <https://nhsproviders.org/nhs-winter-watch-202021/week-6>
- 148 In England, there were an average of 6,153 adult critical care beds open each day in the last week of January 2021, 86%, of which were occupied: <https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/urgent-and-emergency-care-daily-situation-reports-2020-21/> Similarly in Northern Ireland, 29 January 2021 marked the highest number of ICU beds available throughout the pandemic, with 76% of them occupied: <https://www.health-ni.gov.uk/publications/daily-dashboard-updates-covid-19-march-2022>
- 149 In Wales, staff absence (including non-covid absence) during the second wave peaked at 7.1% in December 2020, up from 6.1% during the same month in 2019. In Scotland, the second wave saw over 5,000 covid-related staff absences per day in mid/late January 2021. In England, the highest daily figure of the second wave was recorded on 14 January 2021, with nearly 108,000 members of staff absent from work. Over half of these were COVID-19 related (52.1%). Staff absence data is not available in Northern Ireland.
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- 155 In Scotland the number of outpatients waiting to be at the end of March 2020 saw an increase of 10.7% from 30 September 2020. The same period in Wales saw a 9.7% increase in the number of patients on the waiting list, while in England saw the number of people on a waiting list for consultant-led elective care increased by 13% from October 2020 to April 2021.
- 156 <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis>
- 157 <https://www.health.org.uk/news-and-comment/charts-and-infographics/elective-care-how-has-covid-19-affected-the-waiting-list>
- 158 <https://www.gov.uk/government/speeches/an-update-on-the-coronavirus-vaccine-2-december-2020>

- 159 <https://www.gov.uk/government/news/oxford-universityastrazeneca-covid-19-vaccine-approved>
- 160 <https://www.gov.uk/government/news/moderna-vaccine-becomes-third-covid-19-vaccine-approved-by-uk-regulator>
- 161 Department of Health and Social Care, UK COVID-19 vaccines delivery plan, 11 January 2021, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951284/UK_COVID-19_vaccines_delivery_plan.pdf
- 162 In England, the rollout is the responsibility of the Department of Health and Social Care (DHSC), working with NHS England, NHS Improvement and what is now the UK Health Security Agency (which replaced the now-defunct Public Health England in October 2021). In Wales, it is the responsibility of NHS Wales, working with Public Health Wales, NHS Trusts and health boards (as well as NHS Wales Informatics Service, NHS Wales Shared Services, the Welsh Blood Service and Welsh Courier Service). Delivery in Scotland is the responsibility of NHS Scotland, working with local NHS boards. In Northern Ireland, vaccine rollout is overseen by Health and Social Care (HSC), working with HSC Trusts.
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- 166 <https://covid-19.hscni.net/ni-covid-19-vaccinations-dashboard/>
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- 168 <https://www.nao.org.uk/wp-content/uploads/2022/02/The-rollout-of-the-COVID-19-vaccination-programme-in-England.pdf>
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- 173 <https://www.bma.org.uk/bma-media-centre/suggestion-that-face-to-face-appointments-were-stopped-is-an-affront-to-gps-says-bma>
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- 182 <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-interim-progress-report-feb-2022.pdf>

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