The UK Covid-19 Inquiry

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

Introduction

1. Across the UK, the Covid-19 pandemic has been one of the most challenging and distressing periods of time for healthcare staff and patients. For those who lost loved ones, their lives have been altered irrevocably. Covid-19 was not experienced equally, and it brutally exposed the fault lines of inequality which were already evident in the UK. Moreover, the pandemic is not 'over'; Covid-19 continues to circulate, causing morbidity and mortality, while the legacy of the acute pandemic will continue to leave its mark for many years to come.

2. During the pandemic, healthcare staff in all settings worked tirelessly to safeguard the nation's health and care for those in need, often at great personal cost to their physical and mental health. The Inquiry's Module 1 report acknowledges that the impact of the pandemic on the UK's health services has been immense, and that the UK was spared a worse outcome because of the efforts of health and social care workers alongside so many others (pg. ix).

3. The impact on healthcare staff continues to this day, with ongoing experiences of Long Covid, burnout, trauma, and moral distress. These ongoing impacts cannot be under-estimated.

4. In Module 3 of the Inquiry the BMA seeks to highlight the significant impacts of the pandemic on healthcare staff in all settings, including their physical health, mental health, working lives, training and career development. The BMA wants to ensure that the voice of the medical profession is heard throughout this Module, including that the Inquiry considers and learns from the diversity of staff experiences.

5. As made clear in the Inquiry's Module 1 report, the question is not 'if' another pandemic occurs, but 'when' (pg. ix). The preventable failures that led to harrowing experiences for staff and patients during the Covid-19 pandemic cannot be allowed to happen again when the next pandemic or health emergency hits. There is therefore an urgent need for this module of the Inquiry to examine and publish recommendations that will:

    a. **Lead to better-resourced healthcare systems which improve patient care by having sufficient capacity for both day-to-day and emergency situations, and which support staff physical and mental health.** This includes recommendations that will address the endemic staff shortages, high vacancy rates, unsafe bed occupancy levels, the maintenance and modernisation of estates and improvements in digital infrastructure.

    b. **Reduce the impact of a future pandemic or health emergency on healthcare staff in all settings.** This includes ensuring staff are adequately protected, for example through effective and responsive Infection, Prevention and Control (IPC) guidance, adequate Personal Protective Equipment (PPE), risk assessments and arrangements regarding redeployment and returning to service. It also includes ensuring that, where unequal impacts exist, these are swiftly identified and mitigated.

    c. **Address health inequalities and improve population health**, including the drivers of ill health, which will improve the UK's resilience to a future health emergency. As outlined in the Inquiry's Module 1 report, resilience to a pandemic involves having a resilient population (pg. 70).

6. This opening written statement highlights, under four broad categories, the BMA's key concerns regarding matters within the scope of Module 3:

a. Healthcare systems entered the pandemic significantly under-resourced
b. Healthcare staff were not adequately protected from harm
c. The impacts of the pandemic were not felt equally
d. There was avoidable disruption to healthcare services, with ongoing impacts on patient health and staff wellbeing

Healthcare systems entered the pandemic significantly under-resourced

7. The UK entered the Covid-19 pandemic with healthcare systems that were significantly understaffed and under-resourced, barely able to cope with pre-Covid levels of demand. This played a major role in the inability of these systems to cope when Covid-19 arrived.
8. Compared to many other OECD nations, the UK had fewer doctors, hospital beds and critical care beds per 1,000 people[1]. Alongside this, healthcare systems had high staff vacancy rates, growing waiting lists, unfit estates, maintenance backlogs, and substandard IT infrastructure.
9. As outlined in the Inquiry's Module 1 report, numerous exercises between 2003 and 2018 repeatedly warned that a severe pandemic would overwhelm NHS and public health services, yet little action was taken (pg. 106-108). Similarly, for many years preceding the pandemic, the BMA had been raising concerns with governments about the state of the UK's healthcare systems.
10. It is the BMA's view that none of the issues within the scope of the Inquiry's Module 3 investigations can be considered without this vital context.
11. While a pandemic or health emergency is likely to put enormous strain on healthcare systems and the people who work within them, the extent of the impact was not inevitable and was made worse by pre-pandemic under-resourcing.
12. This poor state of the UK's healthcare systems exacerbated the severe disruption to healthcare delivery during the pandemic. It resulted in unprecedented measures to bring in additional staff, including calls for retired staff to return to service, medical students joining the workforce early and the use of volunteers. Staff had to be redeployed, often starting new roles without adequate training or supervision. Many elective procedures, diagnostic tests and routine outpatient services were suspended so that staff, resources and beds could be utilised for Covid-19 care. It also made it more difficult for some buildings to fully implement IPC measures due to poor ventilation and a lack of space to separate Covid from non-Covid patients. The impact of this under-resourcing was described by some of the BMA's members who said:

   > *"What I needed most during the pandemic were the colleagues I was already missing" (Consultant, country of work not specified)*
   >
   > *"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" (Consultant, England)*
   >
   > *"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*

[1] BMA – 'BMA Covid Review 3: Delivery of healthcare during the pandemic' (2022).

of Wuhan) I, at age 64y, was the only GP for a practice of 6,000 - and no GP locums available" (GP, Wales)

13. The consequences of this pre-pandemic under-resourcing, which the pandemic then exacerbated, are still impacting healthcare systems today, with millions on waiting lists for treatment.

14. To help mitigate the impact on staff and patients in a future pandemic, it is essential that the Inquiry examines and makes recommendations in Module 3 that will lead to better-resourced healthcare systems with sufficient capacity for both 'normal' times and emergencies.

Healthcare staff were not adequately protected from harm

15. The nature of their work means healthcare staff are more likely to be exposed to infectious diseases, including patients with Covid-19. As such, it is essential to ensure that adequate protections are in place.

16. However, at every turn during the pandemic, healthcare workers were not protected from harm. Instead, there were significant shortcomings in protection which left them unnecessarily exposed to infection.

17. It is vital that this Module of the Inquiry fully examines these shortcomings and makes recommendations to ensure that future pandemics or health emergencies do not leave staff similarly exposed to harm.

Impact on staff physical health

18. As the Inquiry is aware from evidence heard during Module 2, healthcare staff experienced higher levels of Covid-19 infection than the general population. ONS data from the first wave showed that healthcare workers in patient-facing roles were six times more likely to be infected than the general population[2].

19. Many staff, including more than fifty doctors, tragically lost their lives and many lost loved ones, friends and colleagues. In the words of a SAS doctor working in England:

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

20. The majority of staff who lost their lives in the first wave were from ethnic minority backgrounds; the Health Service Journal (HSJ) estimated that in the first month alone over 60% of NHS staff who died were from an ethnic minority background[3]. Inequalities in the impact on staff physical health are outlined further in paragraphs 39 – 42.

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[2] ONS – 'Coronavirus (Covid-19) Infection Survey, characteristics of people testing positive for Covid-19, UK' (07 July 2020). Table 8.
[3] HSJ – 'Exclusive: deaths of NHS staff from covid-19 analysed' (22 April 2020).

21. Long Covid has and is severely impacting the lives of healthcare workers in all settings, leaving them unable to work or train, and putting additional pressure on other staff who are still working amidst an already stressed healthcare system. The latest ONS data estimated that in March 2023 4.4% of healthcare staff were suffering from Long Covid[4].

22. This impact on physical health was described by some of the BMA's members who said:

> *"I caught Covid in March 2020 from a colleague at work. I have been mostly bedbound since. My life as I knew it had ended. These are supposed to be the best years of my life but I'm spending them alone, in bed, feeling like I'm dying almost all the time." (Resident Doctor[5], Scotland)*

> *"I caught covid in December 2020 and have not been able to regain my physical strength. I continue to suffer from anosmia and breathlessness. On reading a BBC news piece, I saw a picture of a paramedic I had worked with who had died from covid and could not stop crying for a day" (GP, Scotland)*

<u>*Impact on staff mental health*</u>

23. For many staff, the experience of providing care during the pandemic came at a great personal cost to their mental health. As outlined in paragraphs 39 - 42, this impact on mental health was not equal.

24. Staff experienced the trauma of seeing patients and colleagues under threat from a novel virus, describing their experience as *"horrific"*, *"devastating"* and *"overwhelming"*. Staff were often helpless witnesses to the devastation Covid-19 caused to families who were unable to see their loved ones, often providing the only means of communication between dying patients and their families.

25. As described by some of the BMA's members:

> *"Immense grief which I still feel now. Grief for those I cared for, grief for other healthcare professionals that have died" (Resident Doctor, England)*

> *"To this day, I can become reduced to tears when I think of the horrors of the deaths, the married couples who died on my wards. The horrors of having to tell so many people over the phone that their relative was going to die [...] and that they could not even come in to see their loved one to say goodbye" (GP Trainee, England)*

> *"I have flashbacks to wheeling patients to an overfull morgue and denying relatives entry to ED [Emergency Department] during the first wave as their relatives were dying" (GP, Scotland)*

26. Many staff experienced fear and anxiety during the pandemic. Being insufficiently protected from infection contributed to staff very quickly becoming aware of the potential risks to their own lives, with some taking out additional life insurance or updating their wills. They simultaneously feared for others' lives and safety, including fears of unwittingly passing

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[4] ONS – 'Prevalence of ongoing symptoms following coronavirus (Covid-19) infection in the UK' (30 March 2023). Table 4.

[5] From September 2024 the BMA and the Department of Health and Social Care (DHSC) agreed to change the job title of 'Junior Doctor' to 'Resident Doctor' to better reflect their expertise.

infections on to patients, colleagues and loved ones. Staff also experienced anxiety about making mistakes when redeployed, with fears of being held liable for decisions made when working under difficult circumstances in a different service or speciality, particularly if staff had received insufficient training for new roles. Alongside this were concerns that vital supplies might run out, that patients might not be able to receive the care they need, and that frequently changing information may lead to vital information being missed.

27. Burnout, exhaustion and chronic stress were also commonplace. Both primary and secondary care experienced increased demand and growing waiting lists as a result of the reprioritisation of services. Staff felt overworked, exhausted and as if they had no option but to take on ever-increasing workloads. This came off the back of already high workloads and burnout before the pandemic arrived. This has been described by the BMA's members as:

> *"Awful - in ITU the staff are exhausted and the pressure is relentless. This will have long-lasting effects to the staffing of ITU" (Consultant, England)*
>
> *"Staffing levels have gotten worse as people take leave for burn out or leave the profession completely. Staff are treated as disposable and expected to work until they physically collapse or have a mental health break down. The demands are beyond what the workforce can manage and only continue to grow" (GP Trainee, England)*

28. Some staff experienced moral distress and moral injury in relation to their own or colleagues' ability to provide care during the pandemic. Moral distress is a feeling of unease when institutional or resource constraints prevent an individual from taking an ethically correct action, for example providing patients with the right care at the right time. Moral injury results from sustained moral distress. The reasons for moral distress related to demand outstripping capacity, including insufficient staffing to suitably treat all patients, a lack of time to provide emotional support to patients and an inability to provide timely treatment.

29. The impacts of the pandemic on staff mental health did not simply end when restrictions were lifted. The trauma that staff experienced has powerful long-term effects, and staff continue to struggle today. Indeed, over three in four NHS staff are currently struggling with their mental health[6], and over a quarter of all NHS staff sickness days in 2023 were due to stress-related illnesses[7]. Improving and sustaining staff wellbeing in the long-term will ensure that the workforce is more resilient and better able to cope when the next pandemic or health emergency arrives.

Severe shortcomings in staff protection

30. The impacts of the pandemic on staff physical and mental health were monumentally worse than they could otherwise have been due to a lack of protection from infection, something the BMA persistently raised concerns about throughout the pandemic.

31. Healthcare staff experienced widespread challenges accessing appropriate PPE in the early months of the pandemic. Initially, in the very early stages of the pandemic, some staff were explicitly forbidden from wearing PPE and accused of scaremongering. As described by some of the BMA's members:

[6] NHS Charities Together – 'Three in four NHS staff struggled with their mental health in the past year' (17 April 2024). Poll of 1,078 NHS staff undertaken in February 2024.
[7] The British Psychological Society – 'Investment in NHS staff mental health services urgently needed, says BPS' (26 April 2024).

"I recall 1 incident of when infection prevention and control attended the ward to remove our PPE as they felt it was frightening the patients [...] I still recall how absolutely undervalued and worthless I felt when this was done. I felt that clearly my life was not valued by my hospital" (Resident Doctor, England)

"Several of us were told not to wear facemasks on rehab wards for fear of frightening the patients. This was true in many hospitals" (Consultant, England)

"Some colleagues started wearing fluid resistant masks early in March, only to be threatened by management with disciplinary action due to scaremongering the rest of the department" (Consultant, Scotland)

32. During the first wave in particular, PPE shortages meant that staff had to go without PPE, reuse single-use items, use items that were out of date with multiple expiry stickers visibly layered on top of each other, or use homemade/donated items. This led to perceptions, which persist to this day, that cost was being prioritised over safety. Evidence heard by the Inquiry in Module 2, for example an email sent by Jonathan Van-Tam in January 2020, support this view. Shortages were so severe that the BMA had to produce guidance on rights/moral obligations if staff did not feel adequately protected. Not all staff felt equally able to speak up about issues they were concerned about, including in relation PPE. This was particularly the case for doctors from an ethnic minority background or who had a disability or long-term health condition (LTC) (see paragraphs 40 - 41). Where PPE was available, there was poor availability of fit testing (or fit testing happened but only poorly-fitting PPE was subsequently available). There was also a large degree of variation in the training that staff received to safely take PPE on and off. As described by some of the BMA's members:

"No PPE available for the first 3 weeks. When it arrived it was years out-of-date. The elastic straps on FFP3 masks had perished and would unpredictably snap during the working day thereby exposing the wearer" (SAS doctor, England)

"We had no PPE. Our first delivery was a box of 20 masks on 16 March 20, just before full lockdown. Exp date June 2016 (though a sticker had been put over this a saying April 2021). This was for a surgery of 22,000 patients and 50+ staff. We made our own face shields with acetate overhead sheets and the use of a 3D printer loaned to us" (GP, England)

"We were sent 6 pairs of gloves and 6 aprons in an envelope approximately 3 weeks after the start of lockdown" (GP, Northern Ireland)

33. A Consultant working in England described the harrowing personal impact of this lack of protection:

"We had no choice but to work in an environment which we knew to be unsafe. As headlines of health worker deaths came through and the ethnic risk factors, and age made me look at my department and wonder which if us may not be here. Every colleague of mine extended their life insurance. We received the bare minimum protection [...] We did not feel safe. I know now how it must feel to be a soldier on the front line"

34. Furthermore, except for a brief period in the early weeks, the IPC guidance in all four nations was inadequate throughout the pandemic and remains inadequate to this day, putting staff

and patients at risk. The IPC guidance has a focus on protecting staff performing aerosol-generating procedures (AGPs) with Respiratory Protective Equipment (RPE) (i.e. FFP3 respirators – the equipment needed to protect staff from airborne infection). Other staff providing routine care to patients with confirmed or suspected Covid-19 have access only to Fluid Resistant Surgical Masks (FRSMs), which do not protect from airborne infection. However, this categorisation into AGPs and non-AGPs, which was developed before the pandemic, is not a reliable way to protect against infection and does not take into account that daily actions such as coughing, talking and breathing, can also generate significant levels of aerosols. Staff caring for Covid-19 patients outside of areas where AGPs are performed therefore continue to have inadequate protection from aerosol transmission. As described by some of the BMA's members:

> *"I was redeployed to a hospital where 8 out of 9 wards became covid wards, and [I] was on a covid ward. We did not have CPAP [Continuous Positive Airway Pressure] on the ward I was on, so surgical masks only as not around AGPs. It was available but inadequate when so many patients were coughing. I contracted Covid within 2 weeks of working there" (Medical Academic Trainee, England)*
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> *"The NHSE guidance on when to wear PPE didn't make sense. We were advised full PPE for Covid positive patients ONLY if they were 'aerosol generating'. Covid positive patients were constantly coughing. In my opinion, coughing is aerosol generating too. But apparently, getting ourselves exposed to [a] Covid positive patient's cough is OK and only [a] flimsy plastic apron and blue mask are enough to protect one" (Consultant, England)*
>
> *"The PPE guidance was based not on safety, but rather the lack of preparedness. False platitudes of staff safety were peddled out, when in fact staff were left at higher risk" (SAS doctor, Scotland)*

35. It is the BMA's view that during the pandemic employers were more likely to follow the IPC guidance, rather than their legal obligations under Health and Safety Law. This may be because they believed that the IPC guidance superseded their legal obligations (which it did not), or they may have not understood the relationship between the guidance and the law. It is the BMA's view that the IPC guidance in place for the majority of the pandemic did not recognise aerosols as a significant route of Covid-19 transmission nor did it recommend effective control measures for healthcare staff providing routine care to Covid-19 patients as it recommends a FRSM rather than a respirator.

36. The IPC guidance was inadequate, but the risks this posed to staff and patients in all settings could have been mitigated if employers had focused on their legal obligations under Health & Safety Law. The BMA believes that the Health and Safety Executive (HSE) should have taken a more proactive approach in ensuring employers were aware of – and complied with – their legal duties (in particular their duty to protect staff and conduct risk assessments as laid out in the 1974 Health and Safety at Work Act and subsequent regulations), and that the failure of HSE to issue their own detailed guidance as it does with other occupational hazards (e.g. asbestos) was an abrogation of their responsibility as the workplace health and safety regulator. The two main aspects of this lack of enforcement of Health & Safety Law are risk assessments and RIDDOR:

    a. Employers have a legal duty to conduct risk assessments and act on the recommendations. Many staff did not receive risk assessments, particularly early in the pandemic. When these did happen, they were often self-assessments (without input from their manager or occupational health) and were perceived as a tick-box

exercise as recommendations were not fully implemented. There was also variation in approach to risk assessments between employers. Had more staff had access to a timely and comprehensive risk assessment and had the recommendations been implemented, it is likely that more would have been protected from infection. It is unacceptable for staff to go without risk assessments, and this highlights how staff were expected to carry on working regardless of risk, especially in the early stages of the pandemic. In the words of a Consultant working in England:

> *"I was risk assessed approximately 8 months after the first wave. Way too late. Just a tick box online. Not sure anyone ever read it."*

b. Many employers failed to report staff Covid-19 infections via RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations), despite it being a legal requirement to report workplace-acquired infections. Reporting practices varied, with some finding it 'impossible' to get their workplace to report their infection under RIDDOR. One reason for the under-reporting is likely the confused guidance issued by the HSE. The guidance changed at different times during the pandemic and, in the BMA's view, set a higher threshold for reporting than was required under the relevant regulations. This is likely to have created confusion about whether a RIDDOR report was required and may have discouraged reporting. Reporting is crucial to understanding patterns of infections within healthcare settings as well as how to better protect staff and patients. Reporting also assists staff with Long Covid from a workplace-acquired infection in seeking access to benefits such as NHS Injury Allowance or wider compensation. There is evidence that, when reporting did occur, the HSE failed to appropriately investigate a robust sample of the staff infections and deaths that were reported[8]. The emotional impact of this has been described by some of the BMA's members as:

> *"19 months post infection still unwell. I contracted COVID at work and they have rejected my RIDDOR request. It's unacceptable that work is not held responsible" (Consultant, England)*
>
> *"My second COVID infection (both infections occupationally acquired) has left me with damage to my spinal cord. I now walk with crutches and cannot walk more than about 200m without them. I also have bladder and bowel problems and have to intermittently catheterise. There is not a day that goes by where I don't have some form of pain [...] Sadly they are not willing to acknowledge this and act with integrity by RIDDOR reporting my infection" (Medical Academic Trainee, England)*

37. Shortages of testing early in the pandemic meant staff were not able to test all patients with symptoms (for example tests were initially limited to patients with specific travel histories). This lack of regular testing for staff and patients early in the pandemic likely meant that fewer infections were picked up, leading to increased viral spread in all settings. This initial lack of testing capacity also impacted workforce capacity and placed additional strain on health services. In the words of a Resident Doctor working in England:

> *"There was a delay in allowing testing of all patients with possible COVID symptoms. I was seeing patients in A&E and being told I could not test them because they had not travelled to relevant countries. When testing was later allowed some of these patients unsurprisingly ended up testing positive"*

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[8] The Guardian – 'Safety regulator refused to investigate some NHS staff Covid deaths' (26 May 2022). Information disclosed in response to a Freedom of Information request by the Pharmaceutical Journal.

38. Many hospital buildings and GP practices across the UK were already unfit for purpose before March 2020. This was largely due to consistently low levels of capital investment in the decade before the pandemic. As mentioned in paragraph 12, this infrastructure impacted on the ability of services to keep staff and patients safe, as some buildings found it difficult to fully implement IPC measures due to poor ventilation and a lack of space to separate Covid from non-Covid patients. Improving healthcare estates now will put UK health services in a better position to respond to a future pandemic or health emergency. As described by some of the BMA's members:

> *"We had no ventilation, no windows in the Covid Zone of ED [Emergency Department]" (Consultant, England)*
>
> *"Our building is less than adequate and in poor repair. There is no way to provide adequate social distancing in the waiting area. The computer system and software is barely fit for purpose" (GP, England)*

The impacts of the pandemic were not felt equally

39. The impacts of the pandemic were not felt equally, for patients or for staff. As highlighted in the Inquiry's Module 1 report, "when the pandemic struck, many of those who suffered and many of those who died were already vulnerable" (pg. 70).

40. Disabled people were one of the most affected groups. In all four UK nations, disabled people made up around six in 10 of all deaths involving Covid-19 during the first months of the pandemic[9]. In addition to increased risk of physical harm, those with a disability were also more likely to have poor or steadily deteriorating mental health during the pandemic[10]. For healthcare staff, doctors with a disability or LTC more commonly felt unprotected during the first wave compared to their peers without a disability or LTC. They lacked access to adequate, well-fitting PPE (e.g. clear masks to enable Deaf staff to lipread) and were more fearful about speaking out about issues they were concerned about. They were also more likely to report worsening mental health. Staff who were categorised as Clinically Extremely Vulnerable (CEV) and who had been shielding felt guilt, anxiety, loneliness and frustration, alongside concerns about the safety of returning to face-to-face work.

41. Healthcare staff have been described as the 'canary in the coalmine' because they are often the first group to be infected. As mentioned in paragraph 20, according to the HSJ over 60% of NHS staff who died in the first month of the pandemic were from an ethnic minority background. In a letter to NHS England in April 2020 the BMA was one of the first organisations to call for an urgent review into the disproportionate impact of Covid-19 on ethnic minority groups. This letter highlighted a recent report from the Intensive Care National Audit and Research Centre (ICNARC) which found that, despite making up 13% of the population, 35% of people critically ill with Covid-19 were from ethnic minority backgrounds. During the first wave the risk of death from Covid-19 was 3.7 times greater for Black African men than for White British men, and during the second wave Bangladeshi men were nearly five times more likely to die than White British men[11]. For healthcare staff, BMA surveys indicate that ethnic minority doctors more commonly experienced PPE shortages

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[9] BMA analysis of data from ONS (59% of deaths in England and Wales between 2 March and 14 July 2020), National Records of Scotland (58% of deaths in Scotland between 16 March 2020 and 31 January 2021) and NISRA (66% of deaths in Northern Ireland between March and September 2020).

[10] Pierce et al. (2021). 'Different mental health responses to the Covid-19 pandemic: latent class trajectory analysis using longitudinal UK data', SSRN.

[11] ONS – 'Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021' (26 May 2021).

during the first wave, felt pressure to work in environments without sufficient PPE, felt risk assessments had been ineffective and felt fearful about speaking out about issues they were concerned about. This will very likely have had additional consequences for their mental health due to fears for their own and others' lives and safety. In the words the BMA's members:

> *"I caught Covid in March 2020. This was frightening as I was ill on my own at home [...] listening to news stories about how many Asian men (my demographic) were dying from Covid" (Resident Doctor, Scotland)*
>
> *"Ethnic minorities need to be protected - the numbers of ethnic minority healthcare staff that have sacrificed their lives in this pandemic are shocking and unacceptable" (Consultant, England)*

42. As the Inquiry is aware from evidence heard during Modules 1 and 2, the gender bias within PPE design meant that female staff often struggled with poorly fitting PPE that left them exposed[12]. BMA surveys showed that female respondents more commonly reported a decline in good mental health and reported higher levels of stress and burnout. This gender discrepancy may have been partly due to additional commitments outside work, such as childcare or other caring responsibilities, a duty still largely borne by women. It may also be due to inequalities in physical protection as a result of PPE design. As described by some of the BMA's members:

> *"I had initially struggled to get a face fit mask which worked for me as a small woman. When I did have a successful face fit, masks were never delivered to my workplace in the correct size and style." (GP, Scotland, female)*
>
> *"Women NHS workers have suffered hugely due to the added responsibility of childcare that typically falls at our feet." (Consultant, England, female)*

There was avoidable disruption to healthcare services, with ongoing impacts on patient health and staff wellbeing

43. The impact of the pandemic on the delivery of healthcare services was unprecedented in the history of the NHS.
44. The under-resourcing of healthcare systems prior to the pandemic was already having an impact on patient care before Covid-19 arrived. For example, in March 2020 the total waiting list for elective care across UK health systems stood at approximately 5.6 million[13].
45. The failure to adequately invest in the UK's health workforce, infrastructure and services prior to the pandemic and, as outlined in the Inquiry's Module 1 report (pg. 74), failure to properly plan for the surge capacity that would be required in the event of a pandemic, meant that healthcare services were more severely disrupted than they might otherwise have been. This significantly impacted staff wellbeing and had devastating consequences for patients, the long-term impacts of which are still being experienced.

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[12] BMJ – 'Personal protective equipment is sexist' (09 March 2021)
[13] BMA analysis of data from NHS England (Referral to Treatment Waiting Times – total waiting list), Department of Health NI (Hospital Waiting Times – inpatient and outpatient waiting lists), Public Health Scotland (NHS Waiting Times, Stage of Treatment – inpatient and outpatient waiting lists) and StatsWales (Referral to Treatment, Patient Pathways Waiting to Start Treatment – total waiting list).

46. It is important that this module of the Inquiry examines the impact on staff and patients in all healthcare settings, including primary care and mental health services, and makes recommendations to ensure the impact is mitigated in future pandemics or health emergencies.

Impacts on patients

47. At the outset of the pandemic, Government guidance directed hospitals to urgently discharge all patients who were medically fit to leave in order to maximise hospitals' capacity to meet anticipated demand for acute care facilities such as ventilated and ICU beds. A lack of testing capacity at the time resulted in the widespread discharge of many hospital patients into care homes and the community without being tested. Many of these patients were discharged into care homes, where other residents were more at risk of severe outcomes from infection with the virus. This risk was further compounded by the possibility of asymptomatic transmission. It was not until a month later (mid-April 2020) that a policy of testing those being discharged was introduced. This policy, alongside challenges care homes faced accessing PPE at the onset of the pandemic, likely played a major part in increased deaths in care home settings.

48. As outlined in paragraph 12, at the start of the pandemic many elective procedures, diagnostic tests and routine outpatient services were suspended and staff from these settings were often redeployed to help maintain service provision for critical and emergency care. The delivery of care was also impacted by IPC measures which – while crucially important – reduced the number of patients able to be treated (e.g. needing to separate Covid and non-Covid patients). During the pandemic this situation was exacerbated as staffing levels were impacted by staff becoming ill with Covid-19 and having to isolate, as well as the need to respond to growing numbers of Covid-19 patients. As described by some of the BMA's members:

> *"We were not well resourced. Nowhere was - it's why the waiting lists have skyrocketed. If we were adequately resourced we would have been able to carry on normal work in addition to COVID. 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)*
>
> *"The hospital was not prepared for the amount of staff going off sick and couldn't fill the gaps" (Resident Doctor, Wales)*

49. The result was that many patients could not access elective treatment, while others (e.g. in maternity care) received treatment that was significantly impacted by strict yet necessary IPC measures. Elective waiting lists and waiting times for outpatient appointments – which had been rising before the pandemic – rose even more sharply. In a BMA survey from December 2020, 92% of respondents said they had been unable to provide patients with the right care at the right time at some point during the pandemic.

50. A wider implication of the pandemic was that some patients were reluctant to seek medical care, despite having symptoms of major ill-health. For some this was due to anxiety about infection, for others this may have been due to wider messaging about the NHS being overwhelmed. This was described by a Consultant working in Scotland, who said:

"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."

51. Delayed access to care, either due to increased waiting lists or reluctance to seek care, led to patients receiving diagnoses and treatments later than would have otherwise been the case. Alongside other factors (see paragraph 28), delayed access to care can contribute to staff experiencing moral distress due to feeling unable to provide patients with timely treatment. As described by the BMA's members:

    "It is even worse as so many staff have left. I think everyone agrees that none of us can provide the level of care that we should, or that we would want for our own family members and friends" (GP Trainee, England)

    "Demand has gone up dramatically and we do not have enough hours in the day to practice safely and to the standard that we would like to" (GP, England)

52. In addition to the significant disruption to non-Covid care, Long Covid is still limiting the ability of many patients and staff to work, train and undertake day-to-day activities, with consequences for their mental health. The latest ONS data estimated that in March 2023 over 1.8 million people in the UK were experiencing Long Covid[14].

Staffing changes

53. Staff who were redeployed reported this as a very stressful, difficult period in their working lives, where annual leave and other forms of respite were cancelled to help keep services going. In many cases, staff were redeployed outside of their speciality. A GMC survey from 2020 found this to be 15% of respondents in Northern Ireland, 21% in Scotland, 25% in England and 27% in Wales[15].

54. Staff held understandable fears about working in high-pressure, demanding environments, where they felt less confident due to working in a different service and they were not always given adequate induction or training. Some staff also received a lack of notice about being redeployed and felt pressured to agree to redeployment. These changes had a significant negative impact on staff wellbeing and their working lives, both physically and mentally. As described by some of the BMA's members:

    "I, a medical student working as a band 3 clinical support worker, spent several night shifts during the first wave as the only healthcare professional in my ward section due to there not being enough nurses to cover all the sections. Not really an equivalent substitution, and not something I was really comfortable with since whilst I felt competent doing what was asked, and supported by nearby staff, I was not at all trained for the job I was doing" (Medical student, England)

    "I was often the most senior doctor on the ward, acting well above my level of training "(SAS doctor, England)

55. The widespread disruption to training as a result of redeployment and a reduction in non-Covid care had a particular impact on medical students and resident doctors, including for

[14] ONS – 'Prevalence of ongoing symptoms following coronavirus (Covid-19) infection in the UK' (30 March 2023). Table 1.

[15] General Medical Council – 'The state of medical education and practice in the UK 2020' (November 2020).

final year students who joined health services early. In a BMA survey from April 2021, 40% of doctors in training told us they were unable to gain enough experience in non-urgent and scheduled care to fulfil the competencies required for progression in their career, and nearly 30% said the same about urgent and unscheduled care. This will likely have had additional impacts on their mental health. The disruption to training has been described by a medical student in Northern Ireland:

> *"Disruption to clinical placements and also clinical education and simulation. When on placement the infection prevention and control measures make clinical education difficult as there is a significant decrease in clinical opportunities when compared to before the pandemic"*

56. Redeployment also placed additional pressures on staff who remained behind in their usual work areas, particularly when redeployment lasted longer than anticipated. Many staff were shifted onto different and more onerous rotas in order to cover gaps brought about by redeployed colleagues.

57. At the same time as redeployment, measures had to be taken to bring in additional healthcare staff, including an unprecedented call for retired staff to return to service, for medical students to join the workforce early, and an increased use of volunteers. These schemes were essential but some of them were not without challenges.

58. For example, although the returners programmes were well-advertised, several factors impacted their success. The processes for returning were cumbersome and overly bureaucratic, there was local variation in the ability to match returners to suitable roles, and the increased risk of serious illness from infection faced by older retired staff meant that some were unable (due to risk factors and/or comorbidities) or unwilling (due to concerns about the risk to their health and safety) to return to face-to-face roles. Ultimately, highly qualified and experienced staff were not utilised as effectively as they could have been. Had health systems been better prepared, with existing processes for returning, vetting and matching large numbers of staff to areas of need, it would likely have helped more non-Covid care to continue alongside the response to the acute pandemic.

<u>*Increased demand*</u>

59. The delays in patients being able to access secondary care services (such as elective procedures, diagnostic tests and routine outpatient services) significantly increased workload for general practice, which found itself managing patients awaiting secondary care. This increasing reliance placed on GPs to support patients with out-of-hospital care goes far beyond the capacity they are resourced for.

60. Moreover, after the first wave of the pandemic the UK's health services were attempting to deliver both Covid and non-Covid care simultaneously. This occurred amidst a continued reduction in staffing capacity due to ongoing redeployments, Covid-19 illness and self-isolation. On top of this, staff were battling burnout and exhaustion from the demands of the first wave, having had no respite. In the words of a Consultant working in England:

> *"We can do increased ICU patients, but we cannot do increased ICU patients and retain an elective service. We have been asked to increase elective surgery by 25% I have no idea how this will be achieved"*

61. As noted in paragraph 51, delayed access to care led to patients receiving diagnoses and treatments later than would have otherwise been the case, with some requiring more intensive treatments due to conditions being more advanced.

62. In addition, staff working in public health, which had experienced a decade of underfunding prior to the pandemic, did not have the resources, workforce or capacity that they needed to respond to the emerging and continuing threat of Covid-19. As highlighted in the Inquiry's Module 1 report, it was known since at least 2005 that there was limited capacity in the public health system to surge staff resources in the event of a prolonged outbreak (pg. 105). These pressures on public health staff were then compounded by other factors, for example the challenge of interpreting and disseminating rapidly changing advice when this advice was announced by governments in the media at the same time it was communicated to public health professionals.

Remote care provision

63. Early in the pandemic a significant amount of care, particularly in general practice, moved to remote care provision to keep patients and staff safe. This change was considered essential to stop the spread of Covid-19, to help to maximise a limited workforce and to allow those who had to isolate to work remotely if well enough. This was a directive from government and NHS bodies, and it remained in place throughout much of the pandemic.

64. This was a significant change for patients, and for some an extremely difficult adjustment to make, causing considerable uncertainty and fear. GPs continued to provide face-to-face appointments when clinically necessary, and maintained a focus on older patients, shielding patients and patients with poor mental health[16]. In Scotland, for example, an average of 57% of GP appointments during the pandemic were face-to-face, while 43% were remote[17]. A similar balance occurred in England, with 58% face-to-face and 39% remote[18].

65. While in the early days of the pandemic there tended to be widespread public support for healthcare staff, frustration with this lack of perceived access grew during the later months of the pandemic and patients often directed this frustration at GP practices and their staff.

66. The government guidance regarding remote consultations continued to remain in place and was a key protection against Covid-19 infection for both patients and staff. However, the UK Government failed to explain to the public why this measure continued to be necessary. This was coupled with unhelpful narratives in the media suggesting that healthcare staff were responsible for the limitations on accessing face-to-face appointments.

67. It is the BMA's view that a lack of publicly declared UK government support for healthcare staff, combined with these unhelpful media narratives, damaged the reputation of the medical profession amongst the public, particularly in England, and resulted in staff being subject to unrealistic expectations at a time when pressure on GPs – who were looking after more patients unable to access secondary care – was already significant.

68. This led to healthcare staff, particularly GPs and their practice staff, experiencing increased levels of abuse from patients. In a BMA survey in July 2021 almost half of respondents said that instances of threatening behaviour, violence or verbal abuse had increased over the past year. This has been described by some of the BMA's members as:

> *"After the first wave of the pandemic, and after the "clap for the NHS" ended, the abuse of myself and staff has ramped up enormously,*

[16] Joy et al. (2020) 'Reorganisation of primary care for older adults during COVID-19: a cross-sectional database study in the UK', British Journal of General Practice, 70, 697.

[17] BMA analysis of data from Public Health Scotland - Primary care in-hours General Practice activity visualisation. Averages between 01 March 2020 and 01 June 2022.

[18] BMA analysis of data from NHS England – Appointments in General Practice. Averages between 01 March 2020 and 31 May 2022.

fuelled by governmental propaganda and briefing against General Practitioners" (GP, England)

"This attitude in press and by politicians is doing possibly irreparable damage to the morale of GPs and the respect/attitude patients have for us." (GP, Scotland)

69. The increase in remote consultations during the pandemic also highlighted the limitations of the IT infrastructure across the UK's health services. For example in a BMA survey in May 2020, over half of respondents in both primary and secondary care reported that their ability to provide remote consultations for patients was limited by IT hardware, IT software and telecoms infrastructure. Fixing this will be important to ensure that high-quality remote consultations can be undertaken, if necessary, in a future pandemic. As described by a Consultant working in England:

    "The complete lack of IT support meant most of us 'remote working' meant using our own mobile phones and laptops at home to try and access a creaking and unreliable hospital system. It meant trying to do outpatient consultations without access to the patient or any information about them."

Conclusion

70. It is vital that during its Module 3 investigations, the Inquiry examines and makes tangible recommendations that address the concerns outlined in this opening written statement.

71. In particular, the BMA looks forward to recommendations relating to the issues which were referred to, but not fully examined within, the Inquiry's Module 1 report, including the capacity and resilience of health and social care systems, the capacity of public health systems, and the protection of healthcare workers. The BMA also calls on the Inquiry to ensure that when the Module 3 report is published, the findings within the body of the report are fully reflected within the report recommendations. This approach would ensure that important findings are not overlooked.

72. Ultimately, as highlighted in the Inquiry's Module 1 report, unless lessons are learned and fundamental change is implemented, the effort and cost of the Covid-19 pandemic will have been in vain (pg. ix). For staff and patients across all healthcare settings and nations of the UK, the impact of the pandemic has already been monumentally high.

22 August 2024