Witness Name: Royal College of General Practitioners
Statement No.: M3/RCG/02
Exhibits:
Dated: 7/11/23

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Royal College of General Practitioners

I, Dr Michael Mulholland Honorary Secretary RCGP. will say as follows: -

Introduction and the role of the RCGP

1. The RCGP is a professional membership body of over 54,000 GPs across the UK. We are committed to improving patient care, supporting GPs to continually develop their skills and promoting general practice as a discipline. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement. The RCGP is an independent professional body with expertise in patient-centred generalist clinical primary care.
2. To become licensed to practise as a GP within the UK, doctors must pass the College's MRCGP examination, comprising the Applied Knowledge Test (AKT), Remote Consultation Assessment (RCA) and Workplace Based Assessment (WPBA) (the latter of which is managed by local NHS Deaneries). In 2020, the RCA succeeded the Clinical Skills Assessment (CSA) as a result of the pandemic whereby trainees were unable to be assessed face-to-face. The RCGP developed this replacement assessment in just under twelve weeks, enabling up to 8,000 GP trainees (since July 2020) to take their MRCGP exit exams and continue on into general practice as independent practitioners.
3. We also provide a one-stop-shop for CPD throughout a GP's career, enabling them to record and reflect on their learning journey and access high-quality CPD resources. CPD for the emerging information surrounding Covid-19 was vital for GPs during the pandemic (see below).
4. By harnessing the voice of our members, we help shape national policies and guidance in the UK that impacts how care is delivered in general practice, including engaging with

politicians and other national decision-makers in the health sector. We also deliver projects to help to identify and spread good practice.

5. The RCGP collaborates with the University of Oxford and the UK Health Security Agency (and previously Public Health England) in the running of the Research and Surveillance Centre, an internationally renowned primary care data informatics network and one of the oldest GP sentinel networks in Europe. Throughout the pandemic, the RSC carried out a range of activities such as Covid-19 surveillance virology and vaccine effectiveness. The RSC supplied Covid-19 testing kits to practices, and results to the Government that were unavailable elsewhere at the time. It underpinned the PRINCIPLE research trial – the urgent public health primary care platform trial that tested 7 different repurposed medications as potential acute Covid-19 treatments. The network was integral in supporting many investigational trials through the pandemic and informing many key decisions, including those on vaccine effectiveness and virology surveillance. The RSC also underpinned a Covid-19 management consultation tool study, monitored the consequences of Covid-19 and is still supporting a Covid-19 point of care test trial.

The RCGP role in pre pandemic planning

6. Prior to the pandemic the RCGP was represented on an informal pandemic planning group involving the BMA, RCGP and NHSE. These meetings were instituted recognising that a coordinated approach to an Emergency Prevention, Preparedness and Response (EPPR) incident involving primary care was needed. These meetings were, however, still in their infancy when the pandemic struck. Our view overall was that general practice was insufficiently included in pandemic planning for the UK.

The state of general practice prior to the pandemic

7. Long before Covid-19 hit, the RCGP had been expressing concerns about the fragile state of the NHS as a whole and general practice in particular, including in our 2019 report "Fit for the Future: A vision for general practice". We had long been warning that general practice was near breaking point and needed significant additional support.

GP availability within the NHS/HSC

8. It was widely accepted that there were not enough GPs to meet the level of demand prior to the pandemic. In England, the Government recognised this and committed in 2015 to expand the number of GPs by 5,000 by 2020 and then in 2019 committed to expand the number of practicing GPs by 6,000 by the end of this Parliament. However, despite these commitments according to figures published by NHS England, the number of fully qualified full-time equivalent (FTE) GPs has fallen since 2015.

9. In 2019, the RCGP published a roadmap identifying the challenges with a lack of workforce and steps we believed needed to be taken to address them.

10. RCGP Scotland's report 'From the frontline: The changing landscape of Scottish general practice' was published in June 2019. The report made clear that general practice faced significant workforce challenges in both recruitment and retention, highlighting the 4% decline in FTE GPs from 2013-2017. We called for the establishment of a new target to increase the number of FTE GPs by 2024/25 to meet growing demand, arguing that the Scottish Government's target of 800 additional headcount GPs by 2027 was not reliable in terms of accuracy. We now know that the Scottish Government is very unlikely to meet this target, and we continue to call for an FTE revised version. The paper also called for Health Boards to proactively identify and support practices that are going into difficultly by using predictive toolkits and local intelligence data. The report also highlighted the significant recruitment challenges facing the GP Out of Hours Service in Scotland, which then became particularly vulnerable during the pandemic due to staffing and infrastructure issues.

11. RCGP Cymru Wales published a report entitled 'Transforming general practice: Building a profession fit for the future' in December 2018. A copy of this report was emailed to the First Minister and the Minister for Health and Social Services in December 2018. This report highlighted the levels of stress and lack of capacity within the GP workforce. A further call from the report was for an increase in GP training places from 136 to 200 per year. It called for a return to spending 11% of the Welsh NHS budget on general practice, in order to "boost the GP workforce, create manageable workload, develop new roles in general practice, transform out of hours services, and support practices to deliver care to meet modern patient demand." It was felt that this approach would enable Welsh Government to achieve the shift of focus on health from secondary to primary and prevention, in line with their own publication 'A Healthier Wales'. In 2016/17, the proportion of the Welsh NHS budget invested in general practice was 7.30% compared to a UK average of 8.88%.

12. The First Minister responded on 9 January 2019 noting the Welsh Government's investment in general practice. The response highlighted existing schemes in place and committed to further working with RCGP and GPC Wales.

13. In November 2019, the College in Northern Ireland published 'Support, Sustain, Renew – A Vision for General Practice'. This report highlighted the mounting pressures within general practice locally and urged key stakeholders, including elected representatives, to support the vision for general practice. The report further called for a number of key actions to be taken to deliver a sustainable, fit-for-purpose general practice service in Northern Ireland, ensure high-quality education and training, address shortfalls in the GP

workforce, ensure the workload in modern general practice is manageable, optimise technology and innovation in healthcare, reform Out of Hours services and allocate sustainable funding for general practice.

14. According to the publication Family Practitioner Services (FPS) General Medical Services for Northern Ireland Annual Statistics 2019/20, as of 31 March 2020 there were 323 active GP practices in Northern Ireland, a fall of 8% compared to the 350 active in 2014. While the number of GPs (excluding locums) had increased by 16% to 1,324 since 2014, this represented headcount rather than whole time equivalent (WTE), which have seen a steady decline over time (Source: FPS General Medical Statistics for Northern Ireland 2019/20). According to Department of Health estimates released in March 2022, the total number of WTE GPs had fallen by 11.4% since 2014, with an estimated annual loss of around 4% of the WTE GP workforce (Source: Presentation to NI Health Committee by NR Head of General Medical Services, Health and Social Care Board, on Tuesday 15 March 2022). Multidisciplinary team roll-out had only started in three pilot areas, with many practices feeling the impact of a mismatch between demand and capacity. The Department of Health in 2017 had encouraged practices in Northern Ireland to consider adopting a telephone first based triage system "ask my GP" as a way to manage increasing demand, but only a small number of practices had taken this up. There were few practices using digital telephony and no digitally enabled triage systems in place. There was also no e-prescribing capacity in Northern Ireland and this remains the status quo.

15. The College in Northern Ireland had been highlighting the fragile state of general practice for several years with key stakeholders, as outlined above. The lack of functioning political institutions at Stormont between 2017 until resumption in 2020 also hampered the progress urgently needed to support general practice.

16. General practice was in a difficult place prior to Covid-19 across the UK and the pandemic exacerbated the challenges.

Variations in primary care delivery across different areas of the UK

17. A study of regional variation in practitioner employment in general practices in England looking at 2019 data found that there were significant regional variations in GP to patient ratios. These regional disparities have continued throughout and beyond the defined period the inquiry is considering. Data produced by the Office of National Statistics in their report into '*Trends in patient-to-staff numbers at GP practices in England: 2022*' published on 09/12/2022 showed that GP practices in the most deprived areas had 2,400 patients per fully-qualified doctor, while those in the least deprived areas had 2,100 patients, by October of 2022. Research from the Health Foundation in 2021

showed that GPs in deprived parts of England were earning 7% less per (need-adjusted) patient than GPs in affluent areas.

18. As outlined above, there were also major challenges faced by general practice in Scotland, Northern Ireland and Wales prior to the pandemic.

Funding

19. The RCGP has long argued that funding for general practice is insufficient. For example, in our 2019 vision for general practice, we outlined how funding was holding back practices from delivering the care patients need. We made the case in our 2013 'Putting Patients First' campaign that at least 11% of the NHS budget needed to be spent on general practice.

20. In June 2019, RCGP Scotland analysis found that Scottish funding for general practice as a share of the NHS budget lagged behind England and Northern Ireland. In our 'From the Frontline' report, we called for sufficient investment in general practice to underpin the wider asks in the report and to ensure that patients continued to receive the highest quality care.

Physical and digital infrastructure

21. In 2019, the RCGP published reports demonstrating the need to invest more into the digital infrastructure in general practice and workforce. In response to a survey, GPs reported that the key barriers to adopting these newer opportunities were a lack of IT infrastructure, insufficient funding and training, not enough time to adapt, concerns about safety, effectiveness, quality and liability, unequal access and lack of a legal framework governing newer technology.

22. The RCGP Scotland 'From the Frontline' report called for enhanced IT infrastructure, in order to support the integration of members of the wider multi-disciplinary team (MDT), and to improve interoperability with secondary care. In conjunction with the RCGP Scotland Patient Group, we called for the full evaluation of all new digital services before wider adoption, to assess them for impact on patient safety, health inequalities and clinician workload. There was concern that without adequate digital infrastructure to support these new models, particularly in remote and rural areas where broadband speed and mobile signal may be poor, a new "digital Inverse Care Law" could result, with the use of such services dominated by those with least medical need. RCGP Scotland called for Health Equity Impact Assessments where each new digital implementation is evaluated for its impact on practices and patients in more deprived and remote areas.

How the RCGP worked with stakeholders

23. From the onset of the pandemic, the College sought to engage constructively with politicians and decision makers, but also maintained a high public profile and articulated our concerns in public where we considered it to be necessary. Throughout the crisis, we engaged in regular dialogue with politicians and decision makers at the highest levels.

24. The level of communication between the RCGP and government and healthcare bodies varied throughout the pandemic. We recognise that government bodies were dealing with a rapidly changing situation which impacted their ability to consult in the usual forms, and there were improvements to enable rapid two-way communications as the pandemic progressed. Overall, the RCGP feels that the level of consultation and input sought was broadly appropriate.

25. There were, however, times when it felt that general practice and primary care were an afterthought. This was more of an issue in the early stages of the pandemic, and in relation to early decisions around PPE and infection control. Much of the initial guidance and support focussed on the needs and context of hospitals and failed to adequately consider general practice. As outlined elsewhere in our response, over the course of the pandemic improvements were made to better integrate and consider the needs of primary care.

26. In England, our engagement included numerous meetings with the Secretary of State for Health, the Minister for Primary Care and the Chief Medical Officers, as well as meetings with Simon Stevens, NHSE Chief Executive and other senior staff in NHS bodies across the UK. Some of these were on a one-one basis but for many of these meetings, we met alongside other Royal Colleges and representative organisations coordinated through the Academy of Medical Royal Colleges.

27. Over the initial few weeks of the emergency situation being declared, regular meetings were established by the Academy of Medical Royal Colleges. This included weekly meetings with England's CMO and NHS England alongside other Royal Colleges. The RCGP acted as a voice to remind the system that their focus should not purely be on hospital capacity and acute care, that primary care was also being significantly impacted by the pandemic, and that if it wasn't given the support it needed patient care would suffer.

28. The RCGP maintained a good relationship with NICE during the pandemic. We were part of a rapid review team for all Covid-19 rapid guidance, often turning around comments within 24-48 hours, asking our team of GP clinical advisers to assist with

guideline development. We asked NICE to produce a rapid guideline on the long term symptoms of Covid-19 (Post Covid syndrome) and lobbied for funding from DHSC and NHSE for this. Once commissioned, the RCGP worked as a collaborative and equal partner with NICE and SIGN to create this guidance and then disseminate it, which supported NHSE with sharing guidance on Long Covid clinics.

29. The RCGP was also represented on the NHSE Primary Care planning group chaired by the Medical Director of Primary Care for NHS England, inputting on behalf of the College into policy and decision making on a wide range of subjects. In addition, the Chair of Council gave oral evidence to the Health and Social Care Select Committee on the issues around delivering NHS services during Covid-19 and beyond, and briefed the Committee Chair, Jeremy Hunt, on the profession's response to the pandemic.

30. Similar levels of engagement with politicians and NHS decision makers have been achieved in the devolved nations. In Wales, we gave oral evidence to the Senedd's Health Committee, and in Northern Ireland we appeared twice before the Assembly's Health Committee. In Scotland we provided written responses to Health and Sport Committee inquiries into testing and emergency and resilience planning. Our evidence appeared to be well received by the politicians and decision makers but it is impossible to truly assess how much impact it had when you consider all of the other sources of information and opinions they were dealing with.

31. We have supplied a list the letters we could find in our records that we sent to government and other parts of the system, consultation responses and press releases published in the defined period [INQ000298931] Some of these letters were sent privately and some were made available publicly.

How the RCGP reacted to the pandemic

32. The College made the strategic decision, to "pivot" RCGP outputs onto dealing with Covid-19 in March 2020. We established an internal advisory group which included senior leaders from the organisation and key GP expertise. The group met at least weekly during the early stages of the pandemic to steer College activity and regularly throughout, to ensure we were across the emerging issues of the pandemic as much as possible.

33. During the Covid-19 pandemic, the RCGP delivered a vast amount of work to support GPs to deliver the best possible care during extremely challenging times. The College followed the rapidly changing guidance given from national bodies and encouraged our members to do the same. Below we list a short description of our key actions.

Surveying members

34. To get a better understanding of what was happening on the ground we carried out regular surveys of our members, occasionally opening the survey up to other staff working in general practice. The results of those surveys have been included in sections below relating to different topics.

35. Decisions around when to deliver ad-hoc surveys of our membership, and on which issues related to the COVID-19 pandemic, were based on what we were hearing from our members through various other routes and intelligence we had about the emerging situation. As the phase of the pandemic moved we got back to more standard communications routes. We used a range of routes to gather the experiences and views of our members alongside the surveys. Our governance structure is designed around our membership: This includes regional Faculties and our Council, which consist of GPs with roles to gather and represent the views of RCGP members. There are regular meetings within these structures to gather intelligence and views, and these feed into quarterly UK Council meetings. These continued throughout the pandemic, albeit mostly virtually. As part of our Council, there are elected roles which form our Officer team, who play a key role in gathering intelligence from the frontline. As mentioned above, from the outset of the pandemic, we organised an internal Covid Advisory Policy Group (CAPG) which consisted of senior leadership and key GP experts. CAPG formed part of our intelligence gathering and decision making. On 24 March 2020, we launched a new online member forum, which has been used to informally gather intelligence and views through the pandemic and beyond. A full list of surveys has been included in the document shared with the inquiry labelled **INQ000298931.**

Adapting our exams and training

36. To become licensed to practise as a GP within the UK, doctors must pass the College's MRCGP examination, comprising the Applied Knowledge Test (AKT), Remote Consultation Assessment (RCA) and Workplace Based Assessment (WPBA) (the latter of which is managed by local NHS Deaneries). In order to ensure that the cohort of eligible trainee doctors were able to exit training as planned in August 2020, the College developed a new clinical skills assessment at speed, the Recorded Consultation Assessment (RCA), to replace the Clinical Skills Assessment (CSA) within the MRCGP tripos. The CSA came to an end in March 2020 with the new RCA in place for July 2020. Due to the risk of infection to our role players and GPs and to avoid transmission of infection across the UK before the national lockdown the CSA was stopped. In response to our trainees concerns about their future jobs, MP and government concern about the

training pathway and manifesto promise on future GP numbers RCGP worked with colleagues across the UK in the statutory education bodies to develop a new licensing exam that was in place for July 2020 to ensure no delays in completion of specialist training in general practice. This assessment enabled trainees to submit recorded consultations with real patients instead of a face-to-face examination with role-players portraying patients. This enabled the GP pipeline to continue at a critical time for general practice and the NHS in all four nations. The RCGP developed this replacement assessment in just under twelve weeks, enabling up to 8,000 GP trainees to take their MRCGP exit exams and continue on into general practice as independent practitioners.

37. A translation solution was found to also enable patients consulting in the Welsh language to be submitted as evidence for the RCA.

'General Practice Is Open' campaign

38. In November 2020, RCGP launched a resource for GP practices urging patients to continue accessing primary care services when they need to. The key message was that general practice is open – and has been throughout the pandemic – but because of Covid-19 the way patients are seen in primary care has changed.

39. The main aim of the campaign was to counter any danger that public messaging to stay at home might make some people not seek medical advice. We were concerned that messages in the national media about this was damaging as it could lead to patients not seeking the help they needed, putting patient safety at risk.

40. The secondary aim was to counter the negative media which falsely suggested that general practice was closed, causing concerns for our members about the potential negative impact on the doctor-patient relationship.

41. Our resource described the way in which services were offered – and how most appointments were carried out over the phone or via video in the first instance. We reiterated to patients that if a face-to-face appointment is needed, they would still be seen in person.

42. We provided downloadable posters and social media assets for practices to use and promoted the message heavily in the press as our best way to reach patients.

43. The campaign was UK wide and received significant national media coverage including interviews on LBC and Sky to coincide with its launch. In Wales, Dr Rowena Christmas gave an interview in April 2020 in which she updated on the situation, emphasised general practice was open and specifically called on those with non-Covid-19 conditions to come forward.

44. Dr Carey Lunan, who at the time was Chair of RCGP Scotland, assisted with the national TV and radio campaign. RCGP Scotland did extensive media work around this, as well as communicating with members on a regular basis in our weekly Chair's Blog, and with key stakeholder groups across the system through the various communication forums that had been established.

45. As time passed, and we better understood the data that was emerging around clinical activity across the system, and excess deaths, we also began to better understand people's possible reasons for not seeking care earlier, and we were able to tailor our messaging in the media to try to address these points. This included signs that some people had a fear of contracting Covid-19 in NHS premises, others had a fear of leaving home more generally, while others felt a sense of concern/guilt about overwhelming the NHS or 'bothering the doctor'.

46. Many patients who were more socially vulnerable than medically vulnerable were 'missing' from coming forwards to general practice during this time - such as people that were perhaps experiencing domestic insecurity, housing insecurity, financial insecurity, food insecurity. Often, they were not aware of the public health messaging, or how to keep themselves safe. Deep End practices (those practices serving the most deprived populations in Scotland) were especially aware that there were many vulnerable patients they were simply not hearing from. The Health Inequalities Steering Group of the RCGP created a number of UK relevant web resources to support practices during Covid-19 to care for their socially vulnerable.

47. Current Joint Chair of the College in Scotland Dr David Shackles also fronted a second campaign for the Scottish Government's 'Right Care, Right Place' campaign in December 2021 and again in winter 2022.

RCGP Covid-19 Resource Hub

48. The Covid-19 resource hub, hosted in the College's eLearning platform, was created to support GPs in understanding and managing the pandemic. The hub was home to a range of resources to upskill and support GPs and their teams to respond to Covid-19. This included dedicated sections on Clinical Management, End-Of-Life Care, Ethics and Health Inequalities, as well as many other topics. Each of these resources were developed by clinical leads and subject matter experts and were subject to a robust quality assurance process. The hub was updated on a day-to-day basis in accordance with changing member needs and new national policies.

49. The Covid-19 Hub was up and running by the middle of March 2020. Following the first week of the national lockdown (28th March – 5th April 2020) the hub had 90,000 visits.

50. The Covid-19 Hub was set up and managed by the eLearning team, which comprised both business and clinical staff. However, it was a collaborative effort by members of the College, who rallied round and provided their time and expertise to ensure the Hub was comprehensive and relevant for GPs, and wider HCPs where applicable.

51. The College's eLearning platform saw a 170% increase in users between 23/03/2020 - 27/05/2020 when compared to the previous period 17/01/2020 - 26/03/2020. By April 2021, the Covid-19 hub had hit one million clicks.

Supporting general practice wellbeing

52. There were significant pressures on the wellbeing of staff in general practice especially at the start of the pandemic. As soon as the scale of the pandemic was realised, the RCGP repurposed resources to focus on ensuring GPs had the necessary tools to be able to manage the impact the pandemic had on them. We carried out an analysis of the resources we had already and then identified the gaps that might appear. We brought in the skills of GPs with knowledge across many fields, from PTSD, to grief, to telephone consultation and more. We also worked with the Cameron Fund to ensure that we were signposting to any financial support services.

53. Resources included an online course covering areas particularly pertinent to the mental health and wellbeing of clinical staff in the context of the COVID-19 pandemic. This was produced as part of a wider project with the COVID-19 Healthcare Support Appeal (CHSA). We published screencasts covering traumatic events in primary care, mental ill health and burnout. We also held a number of online events and later in the period face to face events run by our local faculties to support GP wellbeing.

54. All the new resources we created were available online and all online resources were added to our online 'moodle' (an online learning platform). All our resources were made freely available to all health professionals in the UK and worldwide. We also signposted our members to a range of other organisation's wellbeing resources

55. The GMC website has advice for doctors with health concerns.

56. The NHS Practitioner Health service is a, free and confidential NHS service for doctors and dentists with issues relating to a mental or physical health concern or addiction problem, especially when it might affect their work.

57. The NHS GP Health Service is a part of the NHS Practitioners Health service which acts as a confidential self-referral NHS service for GPs and GP trainees in England. The GP Health Service can help doctors with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might

affect work. GPH is provided by health professionals who have additional expertise in addressing the issues concerning doctors.

58. The Government and NHS bodies across the UK may have other systems for supporting GPs financial, well-being, mental health and other issues, but the above are the main resources in England we are aware of.

59. A list of resources has been supplied to the inquiry [INQ000298931]

'Covid-19 Clinical Solutions' launched by the British Journal of General Practice

60. The British Journal of General Practice (BJGP) is published by RCGP but is editorially independent. The BJGP is the highest impact primary care research journal in the world, and as such, has a remit and audience beyond that of the RCGP.

61. In March 2020 the BJGP was receiving requests from the primary care academic community to rapidly publish descriptive and experiential information related to Covid-19. This was different to the information that the journal would normally publish, so the BJGP Covid-19 Clinical Solutions rapid communications platform was set up.

62. The platform was launched in early April 2020 as a platform to share best practice, ideas, new processes, and innovations in clinical practice. The initiative sat outside the usual BJGP framework for research and was created as a rapid access format for sharing information. Information was gathered through the Covid-19 Clinical Solution form, which asked the following questions:

    - What did you do? Please describe in one sentence what you did (50 words max)
    - Who are you? Please list the names of those who did the work (3 max) and the address of your practice/health centre, etc.
    - What was the problem? Please describe the nature of the problem you needed to address (50 words max)
    - What was the solution? Please describe how you addressed the problem and, as far as possible, give some indication of the success or failure. (Improvement of process, numbers of consultations, patients, etc; 250 words max)
    - Where can we find out more? Please add practice email and a URL if relevant.

63. Content was peer reviewed by the BJGP Editor and hosted on BJGP's Covid-19 Clinical Solutions page, with the last entry in December 2020. The BJGP Covid-19 Clinical Solutions rapid communications platform went on to complement the information available in RCGP's Covid-19 Resource Hub.

The development of guidance on workload prioritisation

64. During the Covid-19 pandemic, we regularly heard from our members that they were struggling with unprecedented workload demand and that there was a lack of guidance centrally on how to handle balancing the pandemic and business as usual. In March 2020, 92% of our members said that they were concerned about their practice's ability to provide business as usual services.

65. While there was an overall drop in patients contacting practices in the early days of the pandemic, this trend soon reversed and there was a significant increase in demand for general practice appointments, including patients who were more unwell because they hadn't sought medical attention sooner. There were also significant fluctuations in workload during the onset of different waves of infection and across different parts of the country. During later stages of the pandemic, there was also a need for general practice staff to support the vaccination effort, alongside their usual care. According to the National Audit Office's report into the rollout of the Covid-19 vaccination programme in London, by the end of October 2021, GP practices working in PCN groups and community pharmacies had delivered 71% of all doses of the Covid-19 vaccine administered in England.

66. In March 2020, the College wrote to the Care Quality Commission (CQC) to call for the cessation of inspection activity. We also joined with the British Medical Association (BMA) in calling for the suspension of Quality and Outcomes Framework (QOF), Local Enhanced Services (LES) and Directed Enhanced Service (DES) and appraisal activity, and raised the issue in Parliament through a question from the Shadow Secretary of State.

67. Given these challenges and the lack of guidance nationally available, the College decided to work rapidly with the BMA GPC to produce guidance to help clinicians make difficult decisions on which activities they should prioritise when it became challenging to do everything. We worked quickly with the BMA to develop and distribute the guidance, using the expertise and knowledge we had available to us at the time and tapping into our clinical expertise. [INQ000280653]

68. We sought informal feedback from stakeholders in NHS England and the CQC about the guidance as it was developed. We recognised the need for speed in getting the guidance out to GPs who were struggling, and therefore it was agreed with stakeholders that it would be best for this to be a piece of guidance by RCGP and the BMA in the first instance, rather than going through formal sign-off channels at NHS England or the CQC. Feedback from NHS England and the CQC was taken into account in development of the guidance and there was broad agreement on the direction of travel, although ultimately the RCGP and BMA made the final decisions on the detail of the guidance.

69. As the pandemic progressed, we sought to co-produce updates to this guidance with NHS England. However, while NHSE said they saw the benefits of the RCGP and the BMA developing this guidance, and fed back that they were broadly content with our overall approach, they were not able to co-produce or endorse guidance from an organisational perspective. This meant that the risks associated with deprioritising work sat with the RCGP and the BMA in publishing the guidance, and ultimately with individual practices for implementation. Anecdotal feedback from our members was that the lack of public endorsement caused confusion, and it meant that some practices were concerned about using the guidance for fear of being criticised by NHS bodies or regulators at a later stage.

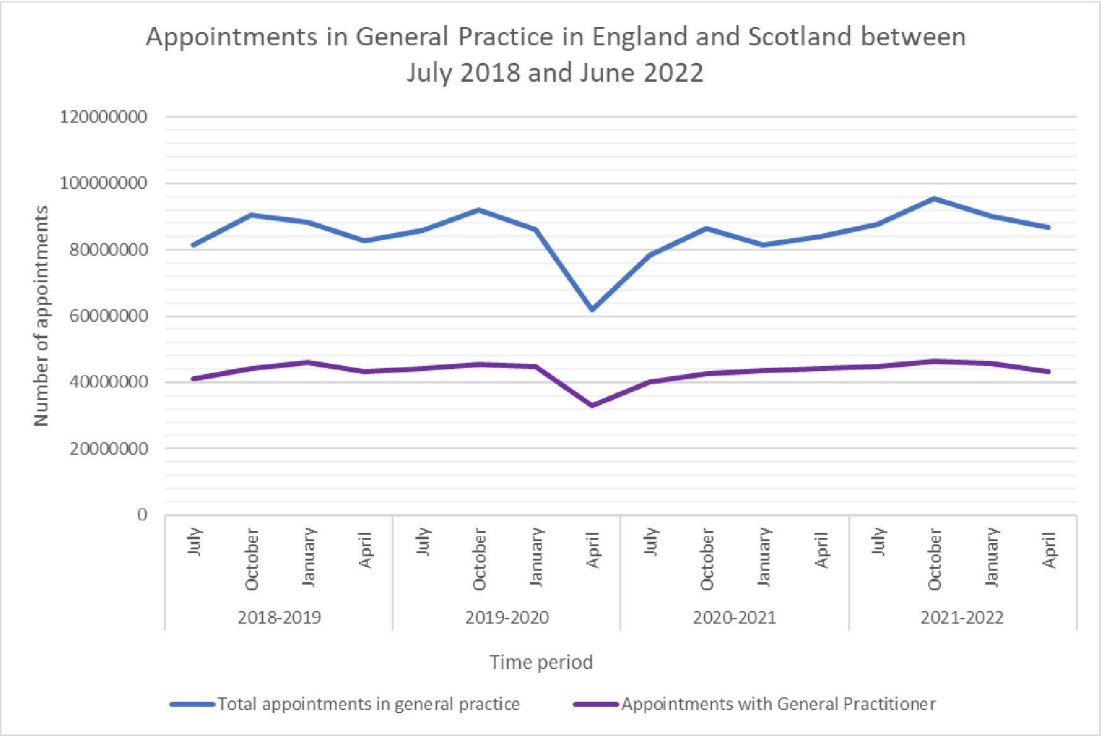
70. The guidance was regularly updated, with versions published in March 2020, April 2020 [INQ000280653], June 2020 [INQ000280655, INQ000280656], November 2020 [INQ000280660] and January 2021 [INQ000280654]. We updated the guidance to adapt to the evolving situation, using the information we had at the time about the impact of the pandemic and the intelligence we had about the major challenges faced by our members and their patients.

71. During the Omicron variant surge in winter 2021/22 we were asked by the Chief Medical Officer to do whatever we could to encourage GPs to continue to play a major active role in the vaccination programme. In a survey carried out between the 15th and 28th of January 2021, we found that 80% of GPs said that they were concerned about being able to deliver essential business as usual work on top of the vaccination programme. We therefore responded by updating our workload guidance, along with running a webinar with the Chief Medical Officer on the importance of GPs continuing to support the vaccination effort.

72. Our workload prioritisation guidance has been extensively downloaded. We received very positive informal feedback from members about our original and updated guidance. Much of the feedback reflected that our guidance was providing useful help on how to deliver safe care and prioritise care for patients who needed it most. Over the course of the pandemic, we have monitored changes in the volume and mix of practice activity using data obtained through the College's research and surveillance centre, NHS England appointments data, and surveys of our members.

How general practice was impacted by the pandemic

73. The data below shows the annual change in the number of GP consultations over the years 2018-19 to 2021-22 in England and Scotland from data published by NHS England and NHS Scotland. The data for Northern Ireland and Wales are not published.



74. Figures for England and Scotland for between March 2020 and 28 June 2022 are outlined in the table below. Data is calculated from July to June each year.

	2021-22	2020-21	2019-20	2018-19
Total GP consultations	183,203,106	173,584,906	169,918,261	175,557,807
GP consultations in England	158,473,634	150,050,560	146,954,267	153,403,276
GP consultations in Scotland	24,729,472	23,534,346	22,963,994	22,154,531

75. There was a 4% fall in appointments in 2019-20 compared to the previous year and this has gradually increased so that now practices are seeing a record number of patients. These annual figures do, however, hide significant fluctuations during certain periods across certain weeks of the year, as different waves of Covid-19 significantly impacted general practice.

76. In Wales, the government does not publish consultation numbers. The National Survey for Wales found that in 2019/20, 76% of people saw their GP (circa 2.4 million) and that this figure fell to 64% (circa 2 million) during 2020/21, but this does not account for repeat appointments.

77. There were several factors that led to a fall in patient contacts, especially the steep fall at the start of the pandemic. These included:

    a. Patients being understandably scared of attending face-to-face appointments. GP surgeries are often in buildings where it is not possible to have comprehensive infection controls and there is a large overlap between the groups who attend general practice most frequently and those who are most at risk from Covid-19.

    b. Government messaging around staying at home to protect the NHS. This is covered in more detail in the section below on stay-at-home messaging.

    c. Disruption of services caused by the need to follow government guidance for GPs to transfer from a largely face-to-face system to a total remote triage system with a reliance on remote consultations where possible. More details in the section below on remote access.

    d. High levels of Covid-19 infections amongst staff and large number of general practice staff being transferred to other jobs (such as focussing on vaccinations), led to staff shortages making it harder to meet patient needs.

    e. Steps by the system to ensure that practices focused on activities that needed to be prioritised, such as the temporary suspension of QOF in England.

    f. Some people reported feeling a sense of guilt or concern about overwhelming the NHS and therefore may have been more reluctant to seek medical attention.

78. After the development of the Covid-19 vaccines, GPs played a major role in supporting the vaccination rollout drive. During the period from December 2020 - June 2022, primary care delivered 63,622,854 vaccinations in England. This had a significant impact on GPs' ability to deliver business as usual care, with our survey of members in January 2021 finding that 81% of respondents were concerned about being able to deliver essential business as usual work on top of the vaccination programme.[1]

79. Other factors that led to increased activity in general practice included a significant number of patients who needed support with "Long Covid". More details on this can be found in the Long Covid-19 section.

80. It is also likely that an increase in the availability of remote consultations meant that some people were able to access an appointment more easily, as they may not have previously been able to spare the time to visit their practice in person, for example if they find it difficult to take time off work or if they have caring responsibilities. It is also possible that some practices found it easier to make more remote consultations available, as staff were able to carry out some consultations from home.

81. Some of the higher demand for appointments later on in pandemic will have been partly because of the backlog of patients who had put off contacting their GP in the earlier stages of the pandemic. These patients often needed more support because their conditions had deteriorated while they were waiting to contact their GP.

82. Current demand for general practice is higher than ever, with many GPs reporting that they are seeing more patients who are sicker with more complex problems. They are also dealing with patients who have been waiting for specialist services for longer periods. It is difficult to identify how much of this is because of the backlog of patients needing to access primary or secondary care and how much is from other demographic, health and social factors.

83. In response to the GP consultation data from NHS Digital, the RCGP released a statement on 25th of February 2021 to explain the lack of clarity as to the extent work associated with the Covid-19 vaccination programme was reflected in the data. The statement also set out that a much lower prevalence of common winter illnesses was apparent at the time, likely to be due to the combination of social distancing measures and lockdown restrictions as well as a very high take up of the flu vaccine. The College reiterated that general practice services were available as they had been through the pandemic and encouraged patients to seek medical advice via 111 or their GP practice if they were concerned about their health.

84. On the 25th of March 2021, the RCGP responded to NHS Digital's GP consultation data acknowledging the drop-off in general practice consultations being delivered. The statement explained that this could have been down to various factors, including reluctance from patients to seek medical care for fear of contracting Covid-19 or concerns that they were being a burden on the NHS during the pandemic, or a lack of clarity around 'stay at home' guidance. The statement also set out how GPs and their teams were taking a leading role in the Covid-19 vaccination programme, and that it was unlikely that this had been fully reflected in the data.

85. On the 29th of April 2021, the RCGP responded to NHS Digital's GP Consultation data, stating that the figures showed the pressure under which general practice was working and the challenges that GPs face to provide patient care. The statements set out the RCGP's calls for more GPs and other members of the practice team to manage the increasing workload in general practice, exacerbated by the pandemic.

Move to remote care and making practices safer for patients and staff

86. During the Covid-19 outbreak, practices had to strike a delicate balance between providing face-to-face patient care where clinically necessary and minimising the number of face-to-face patient contacts in line with national infection control protocols. In

England, prior to the national lockdown in March 2020, just over 70% of GP appointments and almost 80% of appointments in general practice overall were delivered face-to-face. During the first national lockdown, these proportions changed dramatically, with data from the RCGP Research and Surveillance Centre finding that approximately 70% of GP appointments and over 65% of general practice appointments were being undertaken remotely by telephone or video.

87. These changes were not, however, made without significant difficulties. In our survey of members in March 2020, we found that 85% of respondents said that they wanted better guidance on how to best manage appointments with a mix of remote working and triage.[2] In April 2020 NHS England published advice on how to establish a remote 'total triage' model in general practice using online consultations. This was updated on 15 September 2020.

88. There were also significant technical difficulties for GPs working remotely, with our survey in field from 3 to 8 April 2020 finding that 50% said they were not working from home. This was largely because they could not access practice laptops (44%), patient records (34%) or software for online consultations (33%). The College raised these concerns publicly[3] and directly with DHSC and NHS bodies.

89. As well as a shift towards remote consulting, the way that patients are 'triaged' – the process of screening and signposting a patient to the appropriate staff member for a consultation or to another service – went through a dramatic transformation. Governmental guidance was to implement a 'total triage' model to aid screening for Covid-19 symptoms prior to any contact with a clinician, and to help to ensure face-to-face care was used only when clinically necessary.

90. GPs rapidly responded to NHS guidance to move to an operating model of largely remote consultations, with the then Secretary of State declaring that even after the pandemic, 'all consultations should be tele-consultations unless there's a compelling clinical reason not to'.

91. In August 2020 we worked with NHS England to jointly publish a document 'Principles for supporting high quality consultations by video in general practice during COVID-19' to support our members with video consultations.

92. While GPs responded to the NHS guidance and understood the need to protect patients and staff by minimising chances for the disease to spread, a significant proportion expressed concerns about the potential impact of moving long-term to a largely remote service. In our survey of members on remote working (in field between 10 and 12 September 2020) we found that 58% of respondents thought a higher proportion of face-to-face appointments were needed to best meet patients' needs and that high levels of

remote consultations made them anxious about delivering good patient experience and health outcomes.

93. The RCGP has supported members with significant advice and support on this subject on our Covid-19 hub. This includes guidance for clinicians on which mode of consultation to use when.

94. The RCGP was also represented on the NHSE groups writing guidance on how to manage safe remote consultations.

95. The RCGP is aware that some patients have different needs and that for certain patients, remote care is not appropriate and could lead to patient safety concerns. This has been clear in our guidance. We called on government to ensure that health inequalities are not worsened by the shift to remote care and we were clear that face to face appointments should continue to be available to patients who need them.

96. In our May 2021 report "The future role of remote consultations and patient 'triage'", we note that "Evaluation is needed to establish what 'good' looks like for triage systems for both patients and staff, in order to capitalise on their potential. This must ensure that systems do not exacerbate health inequalities" And that "Some patients, including those who don't have good IT access or digital literacy, will always need to be able get an appointment through traditional routes such as over the telephone or in person. If digital-first triaging platforms are retained post-COVID by a majority of practices across the UK, significant capacity for traditional routes of access will need to be retained and promoted to patients who may need these channels. This will be essential for preventing the further worsening of health inequalities." One of our key recommendations for UK governments and health systems is to "Commission further research into the different modes of consultations and the impact on general practice care, including the impact on health inequalities."

97. During the very early stages of the pandemic, the media and public messaging from government bodies was highly supportive of the NHS. However, there appeared to be a clear shift in the media narrative over time to a strong sense of blame towards GPs for a perceived lack of face-to-face appointments. There was a strong feeling from our members that not enough was done by governmental and NHS bodies to counter this narrative and explain that GPs were following guidance given to them by the system to protect patient and staff safety.

98. This feeling of being unfairly blamed was exacerbated when in September 2021, the Secretary of State said in Parliament that "more GPs should be offering face-to-face access, and we intend to do a lot more about it" and stated an intention to publish the proportion of face-to-face appointments by each practice. While the Secretary of State

said that this was not intended to create a league table, it did appear that newspapers would be then able to "name and shame" practices who were not seeing patients face-to-face.[4]

99. Many of our members reported that they felt demoralised by what they perceived as the constant media attacks and the lack of support from DHSC and NHS England press briefings or statements in Parliament and by ministers more broadly.

100. The reaction and misinformation in the media had a major impact on levels of abuse and harassment that GPs have received. The lack of perceived support from government and NHS bodies of GPs on this issue may make it harder in the future to encourage GPs to embrace new ways of working if they feel the system will not support them for following guidance if the media starts to produce a negative narrative.

Stay at Home messaging

101. As a College, we recognised that a potential unintended consequence of the "stay at home, protect the NHS, save lives" messaging would be that people were fearful or reluctant to seek medical care when they needed it.

102. We recognised, however, that without clear messaging, NHS staff and patients would be put in significant danger due to the infectious nature of Covid-19, and there were risks of the health service being overwhelmed. We also recognised that there would be some less urgent issues that could be self-managed at home and the risk of infection may outweigh the risk of late or non-presentation.

103. We took the decision that it was the role of government bodies to make decisions on the messaging needed to protect lives, as we felt they had the most relevant expertise, information and data available at the time.

104. To try to mitigate the risk that some patients would not seek medical attention when they needed to, we put out messaging through our own channels that general practice was open and that people should seek medical help when needed, as outlined above.

Impact of Covid-19 on GPs health and practice closures

105. Staff in general practice felt very vulnerable during the pandemic. In August 2020, the Health Foundation said that it was a conservative estimate that 7.9% of GPs are at high or very high risk of death from Covid-19.

106. One difficulty that GPs faced was a lack of guidance from the NHS on which staff should be considered as most vulnerable to Covid-19. Without any rating system published by the NHS centrally, each individual practice had to make their own risk

calculations based on different scales published by other organisations. This was particularly difficult for partners in small practices with very little cover for staff.

107. We paid tribute to our members who died during the pandemic. We do not have access to data on the full number of GPs who died from Covid-19. We would expect this is something that the NHS would have been monitoring centrally, but we have not seen any data on this.

108. In April 2020, we publicly recognised the disproportionate impact of Covid-19 on members of the BAME communities, including four GPs who we were aware of who had died of Covid-19.

109. RCGP is not able to keep records of practice closures and this information lies with the different NHS bodies throughout the four nations. Our members have, however, reported hearing about occasional situations where a whole team caught Covid-19 at the same time, leading to the temporary closure of a service. In these circumstances, we understand that care was diverted to 111 and out of hours GP services.

110. Many GPs have been impacted by "Long Covid" and we are aware of members who are no longer able to work because of ongoing symptoms. As a membership body and not the employer or regulator we do not keep a list of all members impacted.

111. GPs work in small businesses that are contracted to provide NHS services, with no centrally provided occupational health support, as there is across secondary services. The RCGP has called for a nationally funded primary care occupational health service This has not been established in England during the pandemic although the NHS England Long Term Workforce Plan published in June 2023 has now said ICSs should expand their occupational health and wellbeing provision across primary care organisations.

Covid-19 testing in primary care

112. Access to Covid-19 testing for primary care staff was not available at the outset of the pandemic, and it took some time before a good staff testing system was in place, and this put practice stability at risk. Many staff were extremely concerned about infecting other staff members and their patients.

113. Once testing for NHS staff became available, there was issues with getting timely access to tests. It was almost impossible to get rapid test results, which were much more readily available to hospitals at earlier stages of the pandemic. In small or single-handed practices this put patient care at significant risk.

114. During the early phase of the pandemic, an important focus of the College's campaigning was to press for priority testing for general practice staff and their families,

so that staff who tested negative could return to frontline practice. This was rolled out in England in the second week of April 2020.

115. The College also wrote an open letter on 14 May 2020 to the Secretary of State for Health and Social Care in England, calling for a comprehensive testing strategy for Covid-19 based on testing the 'right people at the right time', as a vital component of easing lockdown restrictions and protection against the risk of a second wave of infection. [INQ000280663] In our letter, we emphasised the need for GP records to be updated with test results and, following feedback from our members, a commitment to improving the sensitivity and specificity of tests. The letter generated extensive media coverage, including an appearance by the Chair of Council on the Today Programme, and led to a meeting with Dido Harding, the newly appointed chair of the Government's "test and trace" programme. We also had regular meetings with Lord Bethell, the Minister responsible for the Government's test, track and isolate policy.

116. On the 28 May 2020 the Government launched the Test and Trace strategy, which while not a perfect system, significantly expanded the ability to test the 'right people at the right time'.

117. In September 2020, we responded to the Chair of the Health Select Committee's comments on the need for weekly testing of all NHS staff. We talked about the need for strong, unambiguous guidance from NHS England, outlining how workforce capacity would be protected and the need for detailed plans on how these tests would be carried out in practice and assurance from the government that there was capacity to fulfil this initiative. In November 2020 NHS England introduced twice weekly testing for all NHS staff.

118. In Northern Ireland, we issued a joint media statement with other local Royal Colleges calling for better access to testing for healthcare workers. In Wales, the Government responded positively to our call for test results to be shared directly with GPs and we also pushed for faster processing of results and distribution of testing sites.

119. In relation to the rollout of contact tracing, we stressed that while GPs should not be expected to undertake this themselves due to the impact on workload, GPs needed to be involved in local decision making in order to ensure a joined up and patient centred approach.

120. We were involved in discussions with a variety of external stakeholders on the design of a contact tracing infrastructure. As part of this, we had several discussions with the Chief Executive of NHSX and others concerning the development of the Government's NHS Covid-19 tracing app.

121. In December 2021, the Chair of the RCGP was still expressing concern that GP staff were struggling to access Covid-19 tests. This included that "we cannot afford for healthcare staff, right across the NHS, to be unable to safely return to work simply because they cannot access a test".

PPE in primary care

122. There were challenges with PPE provision for primary care in the early stages of the pandemic and confusion around PPE guidance. In the early stages of the pandemic, there was a lack of clarity about how PPE should be used in primary care, with our survey of members in March 2020 finding that 76% said that it was very important to have more guidance on how to use personal protective equipment (PPE). We heard from members that the guidance they were looking for included more information on fitting and training for use of PPE.

123. Early on in the pandemic, we heard anecdotal reports from members about PPE being sent to primary care that was out of date.

124. On 26 March 2020, the RCGP publicly expressed concerns about the availability of and guidance for PPE. We wrote to the Secretary of State for Health and Social Care saying that it was vital that urgent clarity was provided as to whether GPs should begin wearing PPE for all face-to-face patient consultations.

125. At the time of the letter, the World Health Organisation April 2020 interim guidance on PPE made recommendations that included that GPs should be using eye protection and gowns for consultations. However, most practices did not have sufficient access to eye protection and there were outstanding concerns around the use of aprons and whether clinicians should have full body cover when seeing patients. GPs were understandably concerned that the type of PPE available to use in the UK was not what the WHO recommended.

126. At the same time, we wrote to the Minister for Health and Social Services in Wales raising the same concerns. We also raised concerns that the release of PPE in Wales through the NHS Wales Shared Services Partnership had been based on an allocation basis of just 200 symptomatic patients per practice/OOH centre, and that there was no option for practices to ask for further supplies. A response was received in early May which highlighted revised guidance on PPE use which had been issued in April. The reply also referenced the four-nation approach to PPE procurement and the role of the Life Sciences Hub Wales in working with industries to develop the supply of PPE.

127. On 2 April 2020, we publicly recognised that improved PPE guidance was issued in England.

128. Following emergency guidance to hospitals in April against the backdrop of concerns that some items of PPE could run out, the College joined a number of other Medical Royal Colleges in writing publicly to the Secretary of State for Health and Social Care emphasising the importance of a transparent and open approach and calling on him to work more closely with the medical community to rebuild trust and confidence. We also wrote in similar terms to the newly appointed PPE tsar, Lord Deighton.

129. In Wales and Northern Ireland, our lobbying led to improved supplies to GPs on the frontline and improvements in guidance.

130. In Scotland, we received extensive media coverage after we wrote to the Cabinet Secretary for Health and Sport, jointly with Scottish Care and the Royal College of Nursing, to raise concerns over the level of PPE available for those delivering care in the community.

The process for recruiting retired or non-practising GPs to the NHS/HSC workforce

131. From the outset, the College worked closely with key partners to support work to enable GPs who had previously left the workforce to return to assist with the pandemic response.

132. As part of the response to the Covid-19 pandemic, the UK Government activated section 18a of the Medical Act (1983), which enabled the GMC to grant temporary emergency registration. On the 22 September 2022, the Secretary of State for Health and Social Care announced that this form of registration would remain open until 2024.

133. Following the introduction of new provisions for reinstatement onto the GMC register and the medical performers list, the College joined the BMA and NHS England in writing to GPs not currently working in general practice outlining how they could contribute to the Covid-19 response.

134. Many members of the College, who had previously left practice due to retirement or other reasons, became Emergency Registered Practitioners (ERPs) as a result of this. Whilst this emergency registration was granted quickly and effectively, problems started thereafter, as many retired GPs reported not hearing back from NHS bodies or practices after getting through the initial emergency registration process.

Issues with onboarding

135. One of the main themes we heard from members who returned to practice was that the onboarding process, in particular for the Covid-19 Clinical Assessment Service (CCAS111) was bureaucratic and slow. We heard that the process took several weeks

and GPs had to prove they were eligible to work in the UK, despite being in receipt of an NHS pension. For example, one member has told us that they sent their application in March but did not manage to speak to a patient until May due to these processes.

136. At the outset of the process being implemented, returning staff had to carry out eleven mandatory training modules, including on heavy lifting and fire safety, even for people who would only ever be working remotely at home. The number of mandatory training modules were subsequently reduced to a small number after representations from the RCGP and others that they were overly cumbersome.

137. Some GPs never completed onboarding due to the slow pace, wasting hours on training and communication with the CCAS service. Other GPs spent hours onboarding and undertaking mandatory training to support the CCAS service to never be offered work. This was frustrating for those who were trying to help in the pandemic.

138. Similarly, returning GPs that chose to volunteer as vaccinators found the process initially bureaucratic and cumbersome. We raised this issue with NHSE and DHSC and wrote about it in a comment piece in the Daily Mail in January 2021.

139. Once returning GPs were able to carry out work, they were satisfied with the support they were providing to the pandemic efforts and many contributed significantly to patient care during this period.

Issues with general practice work

140. GPs who were Emergency Registered Practitioners (ERPs) were also told they could work in GP practices more broadly to help with pandemic work. This, however, was left up to individuals to organise with individual practices. Many GPs who did this work went back to their old practices, but many were unable to easily establish connections and set up new short-term working agreements.

141. Feedback from our members is that better use could have been made of ERPs in primary care, not just for the CCAS111 work, if better systems had been in place to easily deploy them to work within practices.

142. Many returning GPs chose to do triage work rather than face-to-face as they were in the at-risk group for Covid-19, although some did carry out face-to-face consultations. For those that did carry out face-to-face clinical work, adequate PPE was not easily available at the early stages of the pandemic, as set out above, which caused safety concerns.

Lack of support for doctors

143. There was some sentiment amongst returning GPs that they felt unwelcomed by the NHS and faced too many barriers to contribute. Communication could have been more prompt, as many individuals had to repeatedly follow up to receive updates on their applications and felt demoralised by slow responses or none at all. Processes could have been more efficient to allow doctors to take up roles quicker and more effectively.

144. The RCGP produced its own guidance for GPs on how to return and contribute to the system, but we also called on NHS bodies to do more to support returners and to ensure they were better utilised.

145. We have worked with stakeholders to try to streamline the processes for returning GPs, including through a joint letter with the BMA to NHS England raising concerns about the length of time taken to process prospective returners and the complexities of navigating the system.

146. Following our work raising these issues with system leaders, the GMC agreed to automatically re-register GPs who had been out of practice for up to 10 years and NHS England developed streamlined processes to get them back on the performers list rapidly. NHS England also developed a limited scope of practice "Medical Support Worker" role for staff out of practice for more than five years.

Integrating doctors other than GPs within the primary care workforce

147. Emergency legislation passed in response to Covid-19 allows for relaxation in national regulations governing who can work in primary care, including (in certain circumstances) allowing non-GP doctors to practice in primary care on a temporary basis. We were clear throughout the pandemic that the maintenance of standards in general practice is paramount and worked to ensure that any relaxation would be time-limited and to obtain clarity around the role and scope of non-GPs working in primary care. We are not aware of any information regarding whether or how this change in the law was used in practice. We have raised concerns about the possibility of making these changes permanent without sufficient analysis of the implications or other actions required to integrate these roles effectively, and we continue to discuss the matter with DHSC and other key stakeholders.

Physical or verbal abuse directed towards staff working in general practice

148. During the early onset of the pandemic, patients showed a strong understanding of the pressures on general practice and the wider NHS. Towards the end of the pandemic, there was a clear shift in public opinion. There were numerous reasons for the underlying issues causing discontent, including the fact that it took longer to see patients face-to-face because of the extensive infection control processes.

149. Increased waiting times and delays to care across the NHS, alongside the impact of ongoing negative rhetoric in the media about GPs as explored above, meant that abuse became more common. This ranged from phone insults towards receptionists to destruction of property and threats to life, with some resulting in police action.

150. By August 2021, there were a significant number of press reports about abuse towards GPs, to which the RCGP Chair responded that "It's entirely unacceptable for anyone working in general practice to be at the receiving end of abuse of any kind, let alone the threat of physical violence".

151. RCGP Scotland discussed the issues being faced by GPs and practice staff on numerous occasions with the Scottish Government throughout the pandemic. RCGP Scotland reviewed the material for a media campaign which Scottish Government produced on respect, violence and aggression in September 2021.

RIDDOR and risk assessments in the workplace

152. Although we had significant concerns about the safety in general of our members and others working in general practice, we do not have records that our members raised concerns about Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) risk assessments in relation to the provision of Covid-19 risk assessments with us and we have no record that we raised it with decision makers during the relevant period. We are aware that the BMA General Practice Committee had more involvement in this area given their expertise, but it is not something we are able to provide expert commentary on.

153. The RCGP and BMA called for sustainable occupational health services to be provided for general practice. This was not introduced during the time covered by this inquiry but the NHS England Long Term Workforce Plan has now said that every ICS should look to extend occupational health and wellbeing provision across primary care organisations.

Shielding

154. The process of identifying, advising and supporting patients to shield has been a significant piece of work for GPs across the country as they have sought to understand the advice, reassure worried patients, and review patient lists in very short spaces of time.

155. The decision to designate some of those at high risk to be part of a 'shielding' group caused an immense amount of work in general practice. Someone in every general practice had to go through their systems identifying patients who should be on the shielding group without an agreed national system and without the full information they

needed to make decisions. From the outset, it was very unclear who should be in the shielding group and who should not, according to the available information.

156. As well as identifying patients who were in the shielding group, practices took a significant number of calls to and from patients to clarify shielding status and discuss anticipatory care planning discussion. These discussions were sometimes carried out in person, with family members present to support, and often completed over a series of conversations.

157. The College did not attempt to set its own criteria for shielding, but instead sought to work with the respective Chief Medical Officers to push for clarity of guidance and for improved communication, both with GPs and their teams and with patient groups.

158. We were asked by NHSE and the Chief Medical Officer's office to input into shielding policy with our Honorary Secretary as our representative in March 2020. This included the original discussions regarding which groups were to be included and which weren't.

159. The decision on who to include on shielding lists was difficult and changed over time as more information about the impacts of Covid-19 became available. For example, patients with diabetes were included in the list of those to shield at the beginning, then taken out, but then added in again at a later date.

160. The RCGP worked with NHSE and NHS bodies in the Devolved Nations to educate both the workforce and the wider public and put out guidance and eLearning courses.

161. For shielding, there was no "database" that we could directly use and therefore NHS Digital (and equivalents in the Devolved Nations) built a database from the ground up – this used GP data, hospital data and hospital prescribing data. None of the individual databases were fully "accurate" and they were not properly linked up, causing delays. For example, if someone was prescribed an immunosuppressant in a hospital setting, it did not appear automatically in either their GP record or a hospital record.

162. Asthma was originally put into the shielding group – primarily based upon experience with flu. However, it became apparent that those with mild to moderate asthma are not at high risk from Covid-19. This caused enormous difficulties within the NHS, as patient groups and charities felt that those with asthma should be included.

163. We have spoken publicly about the complexities involved, such as in a front-page story in the Sunday Times warning that age alone should not be a criterion for shielding [INQ000280661]. In Scotland, we wrote to the Interim Chief Medical Officer regarding those undergoing splenectomies not being included on the shielded list. [INQ000280659]

164. Together with the BMA in Scotland we developed a briefing paper on emerging issues in relation to shielding, which we shared with the Scottish Government. [INQ000280658] This paper covered workload implications for GPs, confusion over the duration of shielding for patients, concerns over the evidence base for SIGN guidelines on shielding, unwarranted variation on who is included in Group 7 of the shielding guidelines, inaccuracies in identifying patients to be shielded and the potential for complaint and litigation. We do not have records of receiving a direct response to this letter. The policy on shielding in Scotland did evolve and improve over time, but it is not possible to say whether this was in response to our letter.

165. There were conflicting communications from NHS England (for example, about whether those who had a splenectomy should shield), some areas where different decisions were made. We are also aware that some voluntary organisations and charities gave out incorrect information and encouraged patients who did not need to shield to get a shielding letter from their GP, suggesting patients should complain if it was not provided.

166. Coding issues caused problems, for example with some patients wrongly advised to shield due to sickle cell trait (rather than sickle cell disease), or others due to a medication that they had long since stopped, or a single slightly low neutrophil count several years before the pandemic.

167. A joint effort between the RCGP and NHS Digital saw the early publication of an eLearning module on shielding, which distilled tens of pages of information down into a short presentation. This received positive feedback, with comments on social media that it had been used at practice and CCG level to plan services for patients who were shielding. RCGP eLearning staff regularly answered questions about shielding on social media.

168. In June 2020, we wrote to the Secretary of State for Work and Pensions regarding the need to support patients who may not be able to work because they need to shield. We were concerned that there would be a significant proportion of patients who would not to be able to physically return to work, in line with government advice, and yet would not be issued with a fit note or qualify for statutory sick pay. We requested additional guidance be provided to employers, employees and primary care to offer clarity. In particular, we wanted to, (a) establish whether shielded patients unable to work would be protected from losing their jobs, and (b) whether shielded patients were guaranteed a contribution of 80% of their salary when their furlough ended or whether they were only guaranteed to receive statutory sick pay.

Home visits

169. GPs had to maintain the health of patients at home who would normally have been treated in hospital for both acute and chronic conditions, adding to their workload and clinical risk taking. GPs needed to make balanced risk assessments of seeing patients face to face and risking infection and seeing remote and potentially less effective diagnosis.

170. Many GPs continued to provide home visits through the pandemic, in line with national guidance, often using infection control procedures.

171. The RCGP produced a document on care homes providing innovative ways to care for those in care homes, which was commented on positively by the Secretary of State at the time. This document looked at ways to increase video consultations to triage care and to help staff already in care homes to carry out examinations as a way of limiting the movement of staff between care homes.

111 services

172. NHS 111 played a key role in the early stages of the pandemic in some areas of the UK, but we are aware that there were some significant capacity issues. The service could have potentially played a bigger role and had a more positive impact if there was a larger group of doctors able to contribute to the service. However, challenges to the onboarding process of previously retired GPs who wanted to come back and work on 111 made this difficult, as outlined above.

173. In Scotland, the RCGP worked through the Scottish Academy, Government and BMA to put out an appeal for a wider pool of doctors to work in NHS24 (111 in Scotland).

174. In the early part of the pandemic, the existence of different points of contact for online and telephone advice between the nations presented an unnecessary obstacle to patients seeking information. In particular, 111.nhs.uk, which is an NHS England service, simply informed people putting in a Welsh postcode that the service was not available to them rather than redirecting to the equivalent online resource from NHS Wales. This will have likely led to more concerned patients, adding to the already high number making use of the 111 phone service and contacting their GPs. RCGP raised this matter with Welsh Government, and a link to the Welsh services was added to the NHS England site.

175. 111 was rapidly rolled successfully across Wales in the early weeks of the pandemic.

Shortage of medicines and end of life care

176. In April 2020, we wrote to the Home Secretary Priti Patel calling for a temporary easing of restrictions around controlled end of life drugs to avoid delays in administering drugs

to patients whose Covid-19 symptoms develop rapidly. We flagged our concern that the NHS risked running out of essential medications unless there was a temporary 'urgent relaxation' of the legal restrictions that meant controlled drugs - such as morphine, which is used to help control severe breathlessness and pain in patients - could only be given to named patients, and then destroyed if not used. This was featured by the Financial Times and Channel 4 News.

177. In response to our letter the Government introduced new emergency legislation (The Misuse of Drugs (Coronavirus) (Amendments Relating to the Supply of Controlled Drugs During a Pandemic etc.) Regulations 2020). They also published a new standard operating procedure on running a medicines re-use scheme in a care home or hospice setting, which was an important change to government guidance.

178. Following changes in the Coronavirus Act to allow remote verification of death and in response to confusion about the process, we worked with the BMA to produce guidance on the remote verification of expected death. This has been supported by NHSE and has gone on to influence the relevant government guidelines.

179. In Scotland, we inputted into the messaging for a national campaign on Anticipatory Care Planning. We also worked with the Scottish Government and the BMA to produce a letter to practices designed to support them with Anticipatory Care Planning for patients in very high-risk groups [INQ000280657, INQ000280664] This support for Anticipatory Care Planning included guidance on how to update and use the Key Information Summary for 'at risk' patients on both IT systems Vision and EMIS, with a template for practice activity for people with severe frailty to enable discussions on patient preferences for active treatment. This was subsequently adapted by RCGP Wales and issued to all Welsh GPs, jointly badged with the Welsh Government, NHS Wales and BMA Cymru Wales.

Home Oximetry

180. The RCGP promoted oximetry and virtual wards to colleagues in October 2020 as we believed it was clinically the right thing to do to ensure more reliable measurements to help promote patient safety outside of hospitals.

181. We published video webinars we made freely available on our Covid-19 hub on 'Covid-19: Patient Assessment – the role of physiology and oximetry' on 30th April 2020. This was viewed 11000 times in the first week. The webinar was led by Dr Jonathan Leach, RCGP Honorary Secretary and COVID Lead, NR Primary Care Clinical Lead at West of England AHSN and Dr Simon Stockley, RCGP Lead for Acute Deterioration and Sepsis. The webinar covered Clinical features of COVID-19, the importance of oximetry in COVI, Clinical judgement and physiology in patient

assessment, the role of NEWS2 in general practice and Care Homes and remote oximetry in the assessment and management of COVID disease in the community.

182. We used the Covid-19 hub to link to the NHS England guidance 'Pulse oximetry to detect early deterioration of patients with Covid-19 in primary and community care settings' on 23rd June 2020.

183. We published 'Covid-19 Oximetry @home webinar: an overview for primary care' on our Covid-19 hub on 12th January 2021. his webinar highlighted the association between oxygen saturations and COVID-19 which underpins the need for the COVID Oximetry @home pathway.

184. Potential issues regarding darker skin tones and the effect on accuracy of the oximeter only came to light later in the pandemic. A paper which highlighted these issues in the New England Journal of Medicine study 'Racial Bias in Pulse Oximetry Measurement' was published in December 2020. The study found that in two large cohorts, Black patients had nearly three times the frequency of occult hypoxemia that was not detected by pulse oximetry as White patients.

185. In November 2021 the DHSC launched an independent review to look at potential bias in items like oxygen measuring devices and the impact on patients from different ethnic groups. This was planned to be a rapid review with initial findings expected for late January 2022

186. In August 2022, the Independent Review on Equity in Medical Devices led by Professor Dame Margaret Whitehead put out a call for evidence launched to discover if and how medical devices and technologies may be exacerbating inequalities in healthcare.

Hot hubs

187. Initially in the pandemic, some GP surgeries split into red (Covid-19) and green (non-Covid-19) areas, aiming to keep respiratory infections to the 'red' area so spread could be reduced and to allow those who were immunocompromised to feel safer.

188. For many GP surgeries, such as those in small buildings, this was very difficult and so clinics were sometimes held outside from the patient's car, a car park, or the practice garden.

189. Seeing the pressures that practices were facing, the RCGP advocated for the provision of additional resources such as 'hot hubs', or respiratory overflow clinics, so that patients with Covid-19 could be separated from other patients in primary care.

190. There was considerable local flexibility in how these systems were managed. GPs played a key role in helping to set up and run these. In our survey of members from 6

to 23 July 2020 we found that 37% of GPs had worked in a "physical Covid-19 hot site, e.g. Covid-19 Assessment Centre, hot hub, or dedicated practice space". Over a third of these were working outside of their normal hours, while the rest were working in a new role.

191. These hot hubs allowed other GPs to focus on their core work, significantly improving their ability to deliver care, while patients with potential Covid-19 symptoms were supported by the hot hubs.

192. In Scotland, the RCGP worked through the Scottish Academy, Government and BMA to put out an appeal for a wider pool of doctors to work in local Covid-19 assessment centres.

193. In Northern Ireland, the RCGP supported the Government in setting up Covid-19 centres for each HSC Trust area.

194. In Wales the RCGP also supported the Welsh Government's establishment of the hot hub model.

Long Covid

195. Early in the pandemic, GPs started reporting to the College that a significant number of patients did not seem to be recovering from Covid-19 in the two weeks that was generally expected from guidance available at the time. Over time this became known as "Long Covid".

196. From 27 August to 8 September 2020, the RCGP surveyed members on the impact of Long Covid. We had 300 responses to this survey. At that point, GPs who responded said they were on average supporting 3 patients who had been experiencing symptoms for more than 12 weeks, 2 patients who had been experiencing symptoms between 6 and 12 weeks, and 2 patients who had been experiencing symptoms between 2 and 6 weeks. However, it's important to recognise that it was difficult to diagnose some of the longer-term symptoms of Covid-19 at this stage due to the lack of guidance and information.

197. The survey found that only 23% of GPs had access to a Long Covid clinic that they could refer patients to. 65% of respondents said they did not feel confident treating patients with Long Covid symptoms and 81% said they needed more guidance on how to treat Long Covid symptoms.

198. As a result, the RCGP wrote a "top tips" document for GPs to help them treat patients and wrote to NHSE to request that they commission NICE to publish guidelines for Long Covid, working with the Colleges and the Scottish Intercollegiate Guideline Network (SIGN).

199. We were pleased that NICE responded to our request, and we worked as co-authors of the guidelines, collaborating with NICE and SIGN and chairing the work on the definition of the new disease.

200. In response to the NHSE Long Covid Plan 2021/2022, the RCGP published a statement on 20 November 2021, calling for investment into diagnostic and treatment services within the community as well as more investment into community rehabilitation services. The statement detailed how the College updated joint clinical guidance with NICE and SIGN, and that the RCGP was running free monthly educational sessions to support GPs to keep up to date with any emerging evidence on 'long Covid'.

201. As soon as the definition was agreed, the RCGP worked with the Professional Records Standard Body and NHS Digital to create new codes to enable this new condition to be tracked and monitored from GP records.

202. Following publication of the guidance, the RCGP worked to disseminate the guideline and we authored an eLearning module on long-term symptoms of Covid-19. We also gave multiple presentations to GPs, NHS England, DHSC and the House of Lords.

203. The RCGP has continued to lead on the dissemination of information and has worked in with NHSE to try to ensure that the commissioning guidance for Long Covid clinics was aligned with guidance. The RCGP continues to work in partnership with NICE as a co-author of the guidance and with NHSE to improve the care for this group of patients, who are central to ongoing research into this area of medicine.

Primary care for women requiring maternity services

204. The College spoke about the importance of six-week post-natal checks continuing throughout the pandemic. We believed that maternal postnatal checks, the 6-8-week infant examination and routine childhood vaccinations should continue as high priority services during the COVID-19 pandemic as it is critical not to overlook serious issues for mother and infants, and to protect against the resurgence of other vaccine-preventable disease. We also updated our Covid-19 hub to include a guide for 'General Practice Postnatal Maternal and Infant Care during the Covid-19 Pandemic'. This covered Clinical Considerations for the Maternal Postnatal Check during the COVID-19 Pandemic, Clinical Considerations for the 6-8 Week Infant Examination During the COVID-19 Pandemic Childhood Vaccinations during the COVID-19 Pandemic, and Postnatal and Infant Care following Maternal or Infant COVID-19 as Inpatients-Information for the GP.

How guidance was shared

205. There are important lessons that need to be learnt around how the system communicates during a pandemic. System communications need to be reliable, rapid and consistent. It is also important that it takes account of the different fields and audiences it is needed for. Too often it seemed as though guidance was written for secondary care and other parts of the NHS and health and care systems were an afterthought.

206. It is important that governmental bodies work with organisations like medical royal colleges in developing and communicating guidance and ensure that guidance covers the entire health and social care workforce and makes use of their expertise. While this happened sometimes during the pandemic at other times it felt like primary care was not considered and the RCGP could have provided further expertise.

Do not attempt cardiopulmonary resuscitation (DNACPR)

207. The RCGP did not (and does not) have any role in formulating DNACPR notices, advance care plans or the Recommended Summary Plan for Emergency Care and Treatment forms.

208. There was a lack of central guidance for GPs on DNACPR and how best to implement the policy. When this was introduced to a stretched and stressed workforce there was a risk of misjudgement and miscommunication.

209. As GP visits to care homes were kept to a minimum to reduce the risk of infection, in line with national guidance, it was sometimes difficult to develop relationships in which patients felt comfortable discussing advance care planning. There were also increases in patient and family anxiety due to media reports that suggested blanket DNACPR decisions.

210. We heard reports from GPs who were asked to do frailty scores on care home patients and the elderly, to document escalation plans, and complete DNACPR plans. We do not have full information on exactly which areas this happened in, but the CQC reported that there was a significant increase during this time of people reporting concerns about DNACPR. It appeared to be that frailer patients had less chance of survival, so the GP should provide palliative care.

211. We heard nationally that GPs were pressured to make these decisions at speed and without time for adequate discussion with patients and families, especially those without capacity.

212. In March 2020, we wrote a joint statement on advance care planning with the BMA, CQC, and the Care Providers Alliance. The statement set out the importance of having a personalised care plan in place, especially for older people, people who are frail, or

those with other serious conditions. We stressed that it remained essential that DNACPR or ReSPECT forms were made on an individual basis. We made it clear that it is unacceptable for advance care plans, with or without DNAR form completion, to be applied to groups of people of any description. This document was intended to reinforce the importance of personalised shared decision making in advanced care planning in response to uncertainty we had heard from GPs in parts of the country, where frailty scores and other measures were being used to make advanced care planning decisions. This was to support existing national guidance on shared decision making published by the NHS and to clarify that we believed some local interpretations of the NHS guidance was incorrect.

213. The guidance was produced rapidly in very difficult circumstances to deal with an emergency situation and ensure that we got clear messages out quickly to our members on this. The guidance was formulated by GP experts and was approved by our senior management and Officer team. This was in consultation with our Ethics Committee who include ethicists and clinicians.

214. The RCGP does not have a record of specific feedback from members following the publication of the joint statement. However informal feedback from our members was that the joint statement we wrote provided helpful information for them to ensure patients were given the best care possible in difficult circumstances.

Specific conditions

a. **hip replacement surgery**

b. **CAMHS/CYPMHS**

c. **ischaemic (coronary) heart disease**

d. **colorectal cancer**

215. As a generalist College, we do not have much specific information on each of the specific conditions that the inquiry has chosen to focus on. When consultations dropped in the initial phase of the pandemic there was a corresponding drop in referrals to secondary services such as the ones listed.

216. On colorectal cancer: GPs were encouraged to use the HM-JACKarc or OC-Sensor quantitative faecal immunochemical tests (FIT). FIT tests can be useful tools, and given the long waiting lists for colonoscopies, they have an important role to play in identifying when referrals on to secondary care are most necessary. However, it is important that this does not become the only, or primary, criteria for referral. FIT tests are not 100% accurate and GPs, as highly qualified medical professionals, still need to be able to refer urgently based on their clinical suspicions.

Inequalities issues

217. The above evidence covers the main inequalities issues (relating to any protected characteristic under the Equality Act 2010 or characteristic identified in s.75 Northern Ireland Act 1998) affecting GPs that either arose or were exacerbated or identified during the relevant period. For such a long difficult period it is impossible to say that there were not other important inequalities issues that we have not been able to cover in this response.

Recommendations in order to improve primary health care and the conditions for GPs in the event of a future pandemic

218. To summarise some of the earlier points, the main recommendations the RCGP would make to improve the conditions for general practice and subsequently the wider NHS in the event of a future pandemic are:

- Expand the general practice workforce to build resilience into the system to manage surges in the health needs of populations, during the pandemic but also in the aftermath.
- Ensure primary care is considered and consulted at an early stage in key guidance and emergency plans. General practice carries out the majority of the consultations in the NHS and therefore must be at the core of any health emergency response to avoid unintended consequences to patients' healthcare.
- Maintain strong lines of communications between government and professional leadership bodies, including the RCGP.
- Documents like the workforce prioritisation guidelines that were written to respond to a national emergency should have been nationally led and badged by NHS England and in the devolved nations. This would have supported GPs who had to vary their clinical practice as a result of the pandemic.
- Bureaucracy and 'red tape' should be stripped back as much as possible where appropriate, to enable flexibility in the response to health emergencies. More thought needs to be given to the longer-term solutions to ensure there is more flex in the system, so that short term pauses of requirements (contractual or otherwise) are less relied upon.
- Invest in a nationally funded Occupational Health service for general practice to support the wellbeing of staff.

Statement of Truth

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

Signed: Personal Data

Dated: 7/11/23

Witness Name: Royal College of General Practitioners
Statement No: M3/RCG/02
Exhibits: 12

UK COVID-19 INQUIRY

Appendix for Module 03 Statement of Royal College of General Practitioners

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Paragraph Number(s)	Exhibit Reference	Unique Reference Number ("INQ")
31; 35; 59	MM/01	INQ000298931
67; 70	MM/02	INQ000280653
70	MM/03	INQ000280654
70	MM/04	INQ000280655
70	MM/05	INQ000280656
70	MM/06	INQ000280660
115	MM/07	INQ000280663
163	MM/08	INQ000280659
163	MM/09	INQ000280661
164	MM/10	INQ000280658
179	MM/11	INQ000280664
179	MM/12	INQ000280657