UK COVID-19 PUBLIC INQUIRY

Third Witness Statement of Professor Philip Banfield

I, Professor Philip Banfield, of the British Medical Association (the BMA or the Association), will say as follows: I am the chair of the BMA's UK council, chair of the BMA's board of directors and a member of the chief officer team of the BMA. I am a Consultant Obstetrician and Gynaecologist based in North Wales and an honorary professor in the Cardiff University School of Medicine. Before being appointed as chair of council, I spent several years as a representative of BMA Cymru Wales, as chair of both Welsh council and the Welsh consultants committee. I have sat on the UK council since 2012.

1. I provide this statement in response to a request for evidence made on 03 May 2023 by the UK COVID-19 Public Inquiry (the Inquiry) under Rule 9 of the Inquiry Rules 2006 in connection with Module 3 of the Inquiry.

2. I provided earlier witness statements to the Inquiry in connection with Module 1 of the Inquiry dated 12 April 2023, Module 2 (including submodules 2A, 2B and 2C) of the Inquiry dated 21 July 2023, and Module 2B of the Inquiry dated 01 February 2024.

3. I took on the role of chair of UK council of the BMA in July 2022, after the period identified by the Inquiry as having particular relevance to the Rule 9 request (namely, 01 March 2020 to 28 June 2022). During the relevant period covered by this Rule 9 Request I was Chair of BMA Welsh Consultants Committee and I have been a member of BMA UK Council since 2012. In providing this corporate statement to the Inquiry, I have sought input and assistance from colleagues in BMA Northern Ireland, BMA Scotland and BMA Cymru Wales, as well as from relevant UK policy and communications teams across the Association. The information contained within this statement is true to the best of my knowledge and belief.

Table of Contents

Introduction and overview of key messages

4. The BMA is a professional body and trade union for doctors and medical students in the UK, representing the views of doctors working in all branches of medical practice and specialties. Through the experience and insight of its membership, the BMA has a wealth of information and evidence about how the pandemic impacted on doctors and wider healthcare systems.

5. The overwhelming priority of the BMA's members is to ensure that they provide the best possible care and treatment for their patients. During the pandemic, doctors and other healthcare staff worked tirelessly to safeguard the nation's health and care for those in need, often at great personal cost to their physical and mental health.

6. Prior to the pandemic, the UK's public health and healthcare systems were understaffed and under-resourced, and barely able to cope with pre-COVID-19 levels of demand. Compared to many other OECD nations, the UK entered the pandemic with fewer doctors, hospital beds and critical care beds per 1,000 people, alongside high staff vacancy rates and frequently unsafe bed occupancy levels. Estates were increasingly unfit to deliver normal levels of care prior to the pandemic, with growing maintenance backlogs and substandard IT infrastructure.

7. The overall state of health and care systems across the UK in the years leading up to the pandemic played a major role in the inability of these systems to cope appropriately and adequately when COVID-19 arrived and exacerbated the severe disruption to healthcare delivery. It resulted in unprecedented measures to bring in staff, including calls for retired doctors and nurses to return to service, medical students joining the workforce early and the use of volunteers. Staff had to be redeployed, often starting new roles without training or adequate supervision. Significant staffing shortages impacted on the capacity to treat patients as well as the quality of care provided. Many elective procedures, diagnostic tests and routine outpatient services were suspended so that staff, resources and beds could be utilised for COVID-19 care. The consequences of these pre-pandemic failures are still impacting health services today, with 7.6 million people in England alone on waiting lists for treatment.

8. Being exposed to a potentially deadly virus while treating patients without appropriate PPE, no or inadequate risk assessments and initially limited COVID-19 testing has had a profound impact on the mental and physical health of the medical workforce. Many caught COVID-19 at work and over fifty doctors died from the virus (PB/238 -

INQ000397279). Experiences of burnout, trauma, moral distress, isolation and poor psychological safety were commonplace. A significant number acquired Long Covid and are still limited in their ability to work or train. To this day, doctors and healthcare workers are still not being provided with adequate respiratory protection as a result of Infection Prevention and Control (IPC) guidance continuing to fail to properly recognise that COVID-19 spreads at least partially via airborne transmission.

9. The impacts of the pandemic were not felt equally, for patients or staff. People from Black and South Asian ethnic backgrounds were more likely to be infected with COVID-19 during the first stages of the pandemic and people from certain ethnic backgrounds more often died from COVID-19 infection. Disabled people suffered worse physical and mental health outcomes and were more likely to die from COVID-19 than non-disabled people. BMA surveys indicate that ethnic minority doctors more commonly went without PPE, felt worried or fearful about speaking out, and felt risk assessments had been ineffective. The gender bias within PPE design meant that female doctors often struggled with poorly fitting PPE that left them exposed. Doctors with a disability or long-term health condition felt less protected than their colleagues, were more likely to experience worsening mental health and some experienced challenges with remote working. There was widespread disruption to training as a result of redeployment and a reduction in non-COVID-19 care which had a particular impact on medical students and junior doctors.

10. In terms of patient care, many doctors told us that they had experienced moral distress in relation to their own or colleagues' ability to provide adequate care during the pandemic. When explored further in a later survey, the reasons for moral distress, which included insufficient staffing to suitably treat all patients, individual mental fatigue, a lack of time to provide emotional support to patients and an inability to provide timely treatment. The BMA also had concerns about equipment, including the geographical distribution of ventilators, shortages of blood bottles and the potential for oxygen shortages.

11. Governments in the UK, and their associated bodies, failed to provide clear and adequate guidance on a number of issues affecting patients, healthcare workers and the delivery of healthcare during the pandemic. This includes guidance related to risk assessments; Infection Prevention and Control (IPC); decision-making, triage and resource allocation should resources become overwhelmed; profession-specific shielding advice and advice on supporting staff who were shielding to return to work. As

a result, the BMA published its own guidance on many of these topics. Even when government guidance was issued, it was not always well communicated or implemented.

12. Throughout this statement, we draw on the extensive BMA member surveys conducted throughout the pandemic to help us to understand the different experiences of doctors working on the front line of COVID-19. These surveys were conducted mostly on a UK wide basis and included extensive demographic questions to support detailed analysis, which was especially important in the early stages of the pandemic when less was known about the virus.

13. Each survey typically received several thousand responses, and the surveys were broadly representative, making it possible to identify the experiences of doctors based on factors such as gender, ethnicity, age, medical grade, and the sector in which they worked.

14. Throughout this statement, I have referenced and summarised letters sent by the BMA, and any responses received, where available. There may be instances where a response was received, but not documented. Similarly, the statement refers to guidance published by Government bodies and other organisations. Final versions of guidance have been exhibited where available and publication dates indicated where these are known.

A. The British Medical Association's role, function and aims and its role in response to the COVID-19 pandemic

15. The BMA is a professional association and trade union for doctors and medical students in the UK. It is a leading voice advocating for outstanding healthcare and a healthy population, providing members with individual services and support throughout their lives.

Senior elected leadership

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

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

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

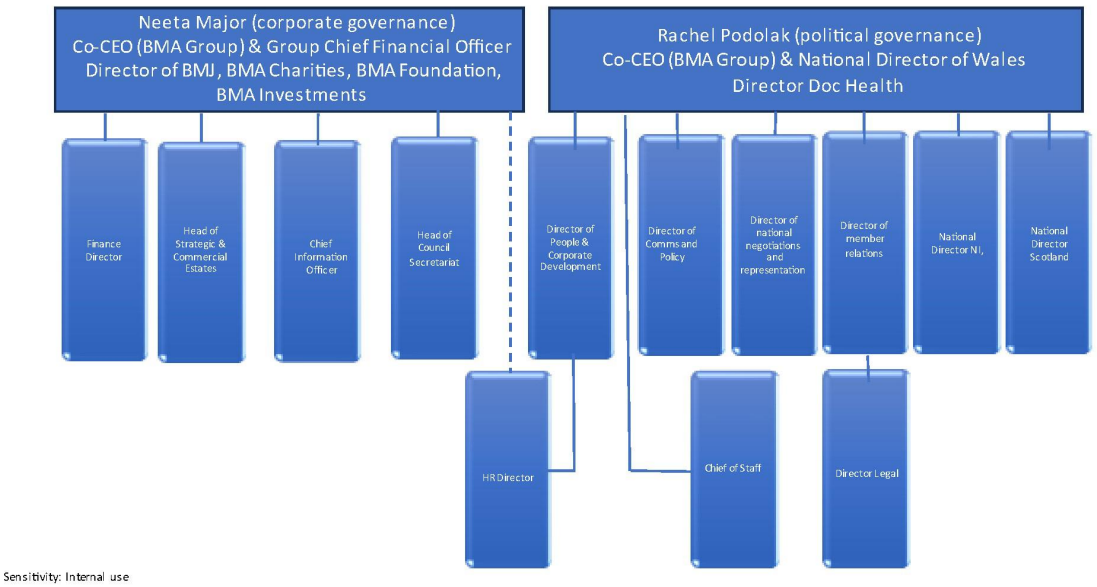
c. The chair of the representative body is responsible for chairing and the smooth running of the Annual Representative Meeting (ARM) and ensuring that the policy set by the ARM is acted on by the Association. The chair of the representative body sits on the BMA board and the BMA council, and leads the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

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

17. The BMA also appoints a President to serve a one-year term of office, commencing at the completion of the BMA's ARM held in June or July each year. The President undertakes work within and through the BMA on areas of interest and often represents the BMA at events or acts as a media spokesperson on these issues. Past Presidents have undertaken projects focused on health inequalities, children's health and the economic value of health. The President's role is largely ceremonial, and they do not play a role in the day-to-day running of the Association, although they are invited to sit, ex officio, as a non-voting member on all committees, including the UK council (with the exception of the organisation committee).

Senior staff leadership team

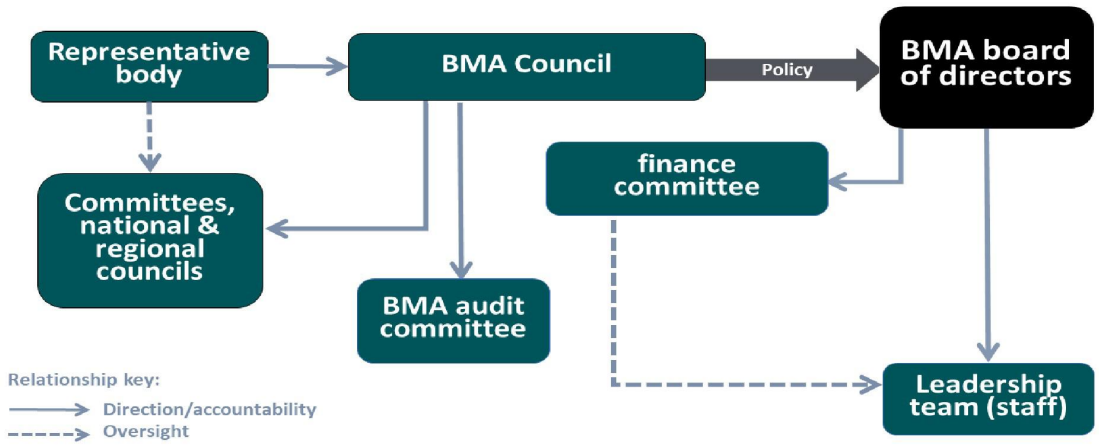
18. The BMA's senior staff leadership team works closely with the Association's chief officers and elected members. The co-chief executives lead the senior leadership team and BMA staff in the day-to-day running of the BMA. This involves the provision of services to members, such as employment advice,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



Sensitivity: Internal use

Governance

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



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

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

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

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

    - the council chair (chair of the board);
    - the representative body chair;
    - the treasurer (deputy chair of the board);
    - the deputy chair of council;
    - three medical persons as may be elected and/or replaced by council from time to time;
    - the chief executive officer(s);
    - the group chief finance officer;
    - one lay (non-medical) person experienced in business and commerce to be elected and/or replaced by council from time to time;
    - the BMJ chair.

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

d. **Branch of practice committees:** Reporting to the UK council, there are 12 UK branch of practice committees that represent doctors in different areas of medical

practice, for example, GPs, consultants, junior doctors and public health. Branch of practice committees have delegated authority to negotiate terms and conditions of service.

e. **Professional activities and special interest committees:** Reporting to the UK council, the professional activities and special interest committees represent the interests of doctors and patients across a range of professional activities and special interests. There are currently 11 UK professional activity and special interest committees.

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

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

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

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

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

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

The BMA's role, function and aims

23. As a trade union, the BMA is formally recognised for collective bargaining purposes at a UK, national and local level. It represents, supports and negotiates on behalf of all doctors and medical students in the UK and has a membership of just over 191,000 (over half of practising doctors).

24. Members of the BMA come from all branches of medical practice and specialities, for example GPs, consultants, public health, occupational medicine, medical academics, students and doctors in training.

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

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

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

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

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

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

26. Staff and elected members work to support, protect and represent BMA members across all four UK nations. This includes:

    a. Negotiating on pay, terms and conditions at a UK, national and local level, and supporting the safeguarding of health, safety and wellbeing at work.

    b. Providing individualised employment support and advice for members, including through the BMA's First Point of Contact service.

    c. Providing wellbeing support services, with a free confidential counselling line and peer support service available to all doctors and medical students.

    d. Providing other services for members, including advice related to immigration, ethics, equality and diversity, and specialist HR and employment law advice for GP partners.

    e. Ensuring doctors' voices are heard by policymakers across the UK's governments and healthcare systems. To do this the BMA conducts research, produces policy recommendations, runs campaigns and makes representations to governments and decision makers. The BMA also works with a range of European partners and makes representations at a global level as part of the World Medical Association.

The BMA's role across the UK in response to the COVID-19 pandemic

27. Throughout the pandemic, the BMA has worked across its structures, using policy, member relations staff (e.g., employment advisers) and members of BMA committees with specialist expertise, to protect and support the medical profession, healthcare staff, patients and the wider UK population including through the following:

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

    b. Providing guidance to doctors and their employers, accessible via the BMA website, particularly when this was not forthcoming from governments or their agencies, including in relation to risk assessments (see section G, PB/061 - INQ000355841, PB/055 - INQ000116842) and ethical guidance (PB/143 - INQ000117773 - see more information on this guidance in section D). The way in which BMA guidance was developed during COVID-19 varied, depending on factors such as: the nature of the guidance, whether it related to existing policy of the BMA or was exploring new areas, whether there was a specific BMA committee with responsibility for the policy area and the time frame in which guidance needed to be developed. For example, in the case of the ethical guidance referred to above, this was developed by expert BMA staff in the ethics team with input from the BMA's Medical Ethics Committee. In most cases, guidance was also sent to all BMA Branch of Practice and relevant specialist committees for comment.

    c. Seeking to influence decision-makers on a wide range of matters related to COVID-19 through direct engagement, letters, media and press statements, and parliamentary processes (such as providing evidence to Select Committee Inquiries and devolved nation equivalents and responding to consultations). Key areas that the BMA sought to influence included:

        - Standing up for the medical profession and challenging decisions that put healthcare staff and patients at risk, including in relation to Personal Protective Equipment (PPE), risk assessments and COVID-19 testing
        - Decisions about the introduction or removal of non-pharmaceutical interventions (NPIs) including mask wearing by the public and

lockdowns (especially where these measures impacted healthcare systems)

- Highlighting the disproportionate impact of COVID-19 on at-risk groups, including those from ethnic minority communities
- Calling for improved measures to protect the public's health, including better resourced public health functions and improved financial support for those having to self-isolate.

d. Undertaking research to gather the real-time experiences of doctors, which informed the BMA's policy and campaigning work.

e. Closely monitoring relevant data and other developments related to COVID-19 to inform the BMA's guidance to members and our policy and campaigning activities.

B. The pre-pandemic state of healthcare systems across the UK

28. The overall state of health and care systems across the UK in the years leading up to the COVID-19 pandemic played a major role in the inability of these systems to cope appropriately and adequately when COVID-19 arrived. In the decade prior to the pandemic, the UK's health services experienced chronic underinvestment, a lack of workforce planning, acute staffing shortages, reduced bed stock, unsafe high bed occupancy levels, year-round capacity issues, growing waiting lists, neglected infrastructure and deteriorating equipment (see for example PB/015 - INQ000185355, PB/113 - INQ000145849, PB/116 - INQ000145865). These fault lines were brutally exposed by the pandemic (e.g. leading to the need to stop significant amounts of non-COVID-19 care due to a lack of capacity, and difficulties in separating COVID-19 and non-COVID-19 patients as a result of the inadequate state of NHS estates).

29. This section sets out the range of areas in which the BMA believes UK healthcare systems were under-resourced prior to the pandemic and the actions the BMA took to raise these concerns publicly and with government ministers and departments to secure improvements.

The BMA and its members have been concerned about the state of the UK's healthcare systems for years

30. The BMA had concerns about the state of UK healthcare systems many years prior to the pandemic. These concerns were raised with the BMA directly by BMA members as well as arising from the BMA's own analysis of data and trends. Key avenues included:

    a. Concerns raised formally via the BMA's democratic structures (including UK branch of practice, specialist and professional committees, UK Council as well as Devolved Nation Councils and committees) and via policy resolutions passed at our ARM. This included concerns that led to the establishment of a special BMA UK Council working group on 'Working in a system under pressure' and an extraordinary meeting of members (a 'Special Representative Meeting') to discuss the state of the NHS that was held in 2016.

    b. Feedback on the state of healthcare systems from members via a range of research and engagement methods including quarterly omnibus surveys, web portals, single subject pan-profession surveys, in-depth surveys with individual branches of medical practice and focus groups.

    c. Concerns that arose from BMA staff's monitoring of the state of healthcare services through analysis of publicly available data (e.g. on investment, staffing numbers, beds, waiting lists or international comparators), raising concern about the increasing pressure the systems and our members working within them were under.

31. Key issues raised via these methods covered a range of issues, including:

    a. a lack of adequate government investment in UK health services

    b. insufficient staffing, including persistently high vacancy rates, and the effect of this on workload and morale as well as patient safety

    c. reductions in the number of hospital beds, including critical care beds, leading to persistently high bed occupancy rates

    d. rising waiting lists due to insufficient capacity to meet increasing demand

    e. the substandard quantity and quality of equipment and software used in health systems, and the substandard state of many healthcare estates

32. In the years preceding the pandemic, the BMA sought to raise these concerns and secure solutions to these issues and action by UK governments including through:

    a. published reports, often based on insights gained from in-house surveys about ongoing issues, for example our 2017 *'State of the health system: Beds in the NHS: UK'* report and our 2019 *'Caring, Supportive and Collaborative: Doctors' vision for change in the NHS'* report (PB/239 - INQ000397336 and PB/113 - INQ000145849)

    b. press releases and exclusive articles in news outlets

    c. campaigns such as our 2017 *Breaking Point* campaign, which aimed to highlight to the public and politicians the severe pressure NHS services were under (PB/240 - INQ000397320)

    d. direct engagement with the UK Government, including Ministers and civil servants in the Department of Health and Social Care, and NHS arms-length bodies, and equivalents in devolved nations

    e. annual representations to HM Treasury seeking increased funding for health services (PB/174 - INQ000145837, PB/178 - INQ000145846)

    f. annual representations to the DDRB (Review Body for Doctors and Dentists Remuneration) highlighting concerns about the state of the NHS (e.g. PB/241 - INQ000400490, PB/242 - INQ000400489, PB/243 - INQ000400493).

33. The remainder of this section sets out in more detail the nature of the BMA's concerns about the state of healthcare in the years leading up to the pandemic, how BMA members raised these concerns with the BMA and how the BMA in turn raised them with external stakeholders, decision makers and the public.

34. The extent of concern among BMA members about the state of UK healthcare services pre-pandemic was reiterated in the COVID-19 call for evidence survey (PB/036 - INQ000116838), which the BMA conducted in 2021 as part of its own COVID-19 review. The state of healthcare systems going into the pandemic was selected by 77% of respondents as a top priority that the Inquiry should look into.[1]

[1] BMA Call for Evidence survey (UK wide), December 2021. 1,968 respondents answered this question.

The UK's health systems faced a decade of underinvestment before the pandemic

35. By March 2020, UK health systems had suffered a decade of under-investment. Between 2009/10 and 2019/20 the UK's healthcare expenditure slowed, with spending increases falling significantly below the long-term average. Had real-terms health spending kept pace with the historical average of 4.1% prior to 2009/2010, there would have been £60 billion more funding available in 2020/21.[2]

36. BMA members often raised their concern about the lack of adequate funding for the NHS and the impact this had. Examples include:

    a. a motion passed during the ARM of 2017, warning that 'the woeful government underfunding of the NHS coupled with continued austerity cuts is the greatest threat to quality and safety in the NHS'

    b. a report to UK council from the short-life council working group, *Working in a system under pressure* (4 January 2018), stating that the NHS is facing unprecedented financial challenges as a result of insufficient funding and unachievable efficiency savings

37. On behalf of our members, on various occasions, the BMA urged UK governments to increase health funding. Examples include:

    a. A response to the *Department of Health Social Services & Public Safety Draft Budget 2015/16 Consultation* (December 2014), stating that the planned decline in resource and capital health funding forecast to 2018/19 would put further pressures on healthcare, and that continued under-investment in health and social care threatened the stability of the NHS in Northern Ireland (PB/244 - INQ000400504).

    b. A future vision for safe, sustainable secondary care in Scotland (August 2019), which projected a funding gap for NHS Scotland of £159m by 2023/24 and called for a sustainable long-term approach to funding that can meet the needs of the people of Scotland (PB/245 - INQ000397271).

[2] BMA Analysis of ONS Country and Regional Public Sector Finances 2021. Prices are real terms (2023/24). Excludes additional COVID-19 funding.

c. A response by BMA Scotland to an Audit Scotland report in October 2019, in which BMA Scotland warned of the growing gap between available resource and demand for care (PB/246 - INQ000397323).

d. A manifesto by BMA Cymru Wales in June 2015 calling on political parties to commit to a sustainable and high-quality NHS for the future (PB/247 - INQ000397238).

e. Annual representations to HM Treasury consistently seeking increased funding for health services in England. For example:

- the annual budget representation submitted in September 2018 stated that 'Future projected spending on the NHS remains below what the BMA and many policy experts believe is needed' and called 'on the Chancellor to invest further resources in the NHS, ensuring a real terms funding uplift of at least 4% every single year' (PB/174 - INQ000145837)
- the last representation made before the pandemic, in February 2020, stated that 'the Government's current spending plans fall short of what is needed to place the NHS back on a sustainable footing and ensure patients receive the best care' (PB/178 - INQ000145846).

f. Several letters to the Prime Minister (16 January 2017,18 January 2018, 29 July 2019, 11 October 2019 and 13 December 2019) outlining the impact on patients and staff of years of underfunding, including staffing shortages, high bed occupancy, long waiting times and a backlog of care (PB/248 - INQ000400513, PB/249 - INQ000400500, PB/250 - INQ000400359, PB/251 - INQ000400360, PB/252 - INQ000400488).

g. A letter to the UK Chancellor (15 June 2018) on the funding needed for health and social care services, including the need to invest in public health (PB/253 - INQ000400501).

38. This chronic under-investment in the UK's health services meant that the country was not as well prepared as it could have been when it entered the pandemic. This sustained under-investment left the UK's health services unable to sufficiently grow the workforce, tackle rising waiting lists – which were already at record highs before the pandemic even began – provide and staff sufficient numbers of beds, or modernise infrastructure,

equipment and estates in the years preceding the pandemic. As a result, UK health systems entered the pandemic with (1) low staffing levels, (2) high levels of vacancies and attrition, (3) insufficient critical care capacity, and (4) inadequate estates, equipment and infrastructure. As one respondent to the call for evidence conducted in 2021 as part of the BMA's COVID-19 review wrote, *'All system processes require an in-built 'safety net' - the consequences of years of 'efficiency savings', 'cost improvement programs' and so on mean that there is nothing in reserve when the systems are challenged to do more than normal. [...] overdoing efficiency reduces adaptability and risks leaving systems, staff, and processes under resourced at times of greatest need.'* This underfunding occurred alongside significant underfunding of public health services (as described in my witness statement for module 1) and meant the UK was less able to respond to the pandemic, because of this lack of `head room` and surge capacity.

Staffing levels were insufficient when the pandemic arrived on our shores

39. The UK entered the pandemic with significantly lower staffing levels than it should have had, including significant medical workforce shortages. Compared to many other OECD EU nations, the UK had far fewer doctors when the pandemic began: the 2019 average in OECD EU nations was 3.6 doctors per 1,000 population, compared to only 3.0 in the UK (PB/254 - INQ000148432).

40. Workforce planning had been severely neglected over the preceding decade, meaning the UK's health services often did not have sufficient staffing levels to deliver safe care. While the Department of Health in Northern Ireland (DOHNI) published its health and social care workforce strategy in 2018 and the Scottish Government published a workforce plan in December 2019, Wales and England had not published an up-to-date workforce strategy by March 2020. Health Education and Improvement Wales published a workforce strategy in October 2020 (PB/589 - INQ000466407) and eventually Welsh Government published its workforce implementation plan in January 2023 (PB/583 - INQ000442326), followed by England publishing its long-term workforce plan (LTWP) in June 2023 (PB/570 - INQ000292664).

41. Not only did the UK have fewer staff than other comparable nations, but there were also high vacancy rates for medical posts in March 2020, and high levels of attrition.

a. In March 2020, vacancy rates for medical posts were well above the 2.6% average vacancy rate across all sectors of the UK economy[3]. In England they stood at 6.3%,[4] in Scotland at 8.2%[5] and in Northern Ireland at 3.9%.[6] Vacancy data for Wales for the start of the pandemic are not available as collection was discontinued in 2011 and experimental data only began to be published again in June 2023 (following the BMA's repeated calls to do so). It is also worth noting that vacancy data itself are likely to be an understatement of staffing shortages, as some vacancies which are hard to fill or for which no more funding is available are no longer advertised.

b. Nursing levels were also low and nursing vacancy rates were high. In March 2020 they stood at 9.9% in England,[7] 5.6% in Scotland,[8] and 9.8% in Northern Ireland.[9]

42. High vacancy rates contributed to deteriorating working conditions. When the UK entered the pandemic, staff already had high levels of burnout and exhaustion from constantly having to plug existing staffing gaps. In 2019, 38% of medical and dental staff worked paid additional hours, and 75% worked unpaid additional hours; 37% reported having felt unwell because of work-related stress that year.[10] This was routinely reported by BMA members as well. For example, in the last regular BMA omnibus survey of 2019, seven in 10 doctors said they worked or trained 'often' or 'very often' outside of their regular hours. The fact that UK healthcare services did not have the staff they needed before the pandemic is also illustrated by growing waiting lists. In March 2020, the total

---

[3] ONS, Vacancies and Jobs in the UK, April 2020. Headcount. Based on data from January-March 2020.

[4] NHS Digital, NHS Vacancy Statistics England, April 2015 – March 2023. Full-time equivalent (FTE).

[5] TURAS, NHS Scotland workforce, December 2019. Full-time equivalent (FTE). Note: Data is for the quarter ending December 2019, as data collection for the quarter ending March 2020 was heavily affected by the COVID-19 pandemic.

[6] Department of Health, Northern Ireland health and social care (HSC) workforce vacancies, March 2020.

[7] NHS Digital, NHS Vacancy Statistics England, April 2015 – March 2023.

[8] TURAS, NHS Scotland workforce, December 2019. Full-time equivalent (FTE). Data is for the quarter ending December 2019, as data collection for the quarter ending March 2020 was heavily affected by the COVID-19 pandemic.

[9] Department of Health, Northern Ireland health and social care (HSC) workforce vacancies, March 2020.

[10] NHS Staff survey 2019.

waiting list for elective care across UK health systems stood at approximately 5.6 million.[11]

43. Staffing shortages were an issue of huge concern for BMA members in the years leading up to the pandemic. For example:

    a. Doctors raised concerns with the BMA's Ethics team that they were increasingly being asked to work beyond their competence because of staff shortages. The BMA's Medical Ethics Committee considered a paper on this issue in February 2017, relating to doctors working in systems with significant pressures and under staffing, observing that being asked to work outside their capacity was more commonplace than being asked to work out with their competence and the impact of this on both patient safety and doctors' wellbeing (PB/534 - INQ000400503, PB/535 - INQ000400502).

    b. A member working group report to Council, *Working in a system under pressure* (4 January 2018), which highlighted the pressures resulting from understaffing and under-resourcing at a time of increasing demand.

    c. A motion passed at the 2018 ARM warned 'that there is a chronic understaffing problem in the NHS' and demanded that 'the detailed scoping of staffing levels of doctors is carried out individually across all the disciplines of healthcare in the UK to highlight the shortage'.

    d. A survey by BMA Scotland in June 2018 found that doctors in Scotland were being 'pushed to the brink' by a lack of resources and staff shortages, with two-thirds of respondents saying 'inadequate' resources 'significantly' affected the quality and safety of care provided by the NHS.[12]

    e. The issue was also reflected in the BMA's UK-wide COVID-19 call for evidence survey, in which 56% of respondents reported that clinical staffing levels at the

[11] Figure obtained by summing the total waiting list for England (sourced from NHS England Referral to Treatment Waiting Times), the inpatient and outpatient waiting lists for Northern Ireland (sourced from Department for Health NI Hospital Waiting Times statistics), the inpatient and outpatient waiting lists for Scotland (sourced from Public Health Scotland NHS Waiting Times – Stage of Treatment) and the total waiting list for Wales (sourced from StatsWales Referral to Treatment – Patient Pathways Waiting to Start Treatment) at March 2020.

[12] The survey had 999 respondents.

start of the pandemic were 'inadequate' or 'very inadequate'.[13] Free-text survey responses from the same survey further reflected this, with respondents writing that '[*t]here were never enough staff to deliver effective care even before Covid'* (SAS doctor, England) and that *'[t]he woefully inadequate workforce planning of the NHS over many years has well and truly caught up with us'* (Consultant, England).

44. In the years preceding the pandemic, the BMA consistently voiced concerns about the number of doctors working in UK health systems, safe staffing levels, and the lack of adequate workforce planning. Examples include:

    a. A letter to the Secretary of State for Health (05 October 2016) highlighting the need for short and long-term action to increase the number of doctors in England (PB/255 - INQ000400356).

    b. A response to an Inquiry into medical recruitment by the National Assembly for Wales Health, Social Care and Sport Committee (18 November 2016). The submission stated the need for effective and sustainable workforce planning to meet future population needs, insufficient capacity in the workforce to meet current demand, and recruitment and retention challenges in primary and secondary care. It also highlighted workload increases in primary care and linked these to rising burnout levels (PB/256 - INQ000400358).

    c. A briefing raising concerns about the impact of Brexit on the medical workforce in the UK (November 2017), stating that 'any reduction in the number of doctors migrating to the UK will have a destabilising effect on the medical workforce, and the staffing of health and social care across the UK' (PB/257 - INQ000397263). This was followed, in 2019, by a further Brexit briefing, *A health service on the brink – the dangers of a 'no deal' Brexit* (PB/154 - INQ000145856) which warned of the very real risk that many EEA nationals, including highly skilled doctors, would chose to leave the UK or train and work elsewhere due to the ongoing uncertainty which, in the context of current workforce shortages, would 'hinder the NHS's ability to provide adequate staffing on wards and in GP practices, thereby putting greater strain on health services as doctors and other healthcare workers face more intense workloads and longer working hours.'

[13] BMA Call for Evidence survey (UK wide), December 2021. 1,720 respondents answered this question.

d. The BMA report *Caring, supportive, collaborative* (September 2018) which voiced doctors' concerns about inadequate NHS resources and highlighted doctor shortages, emphasised the need for safe medical staffing levels to be enshrined in legislation (PB/258 - INQ000397264). This final report was the culmination of extensive stakeholder and member engagement including three roundtable events which informed the project (PB/259 - INQ000400498) and which were attended by Matt Hancock, Secretary of State for Health and Social Care and Simon Stevens, NHS England chief executive, among others. The report was subsequently shared with the Secretary of State and Chief Executive of NHS England amongst other stakeholders.

e. The BMA report *Medical rota gaps in England* (August 2018) flagged that rota gaps, long-term staff vacancies and intensifying workload were major issues across the NHS in England, and that 'members have consistently told us about the negative impact rota gaps have on training, morale, work-life balance and quality of care' (PB/260 - INQ000397313).

f. A letter urging HM Treasury (02 September 2019) to 'increase the Health Education England budget, which had experienced sustained real terms cuts of over £1 billion since 2013/14, highlighting that there were 'nearly 100,000 vacancies among hospital and community services' in England (PB/261 - INQ000400361).

45. As a result of these staffing pressures, UK healthcare systems were ill-equipped to respond to a pandemic:

a. Due to chronic understaffing, staff had to be redeployed to care for COVID-19 patients resulting in the reprioritisation of care.

b. Existing staff had already been expected to cover staff absences before the pandemic hit, meaning there was no further slack in the system to cover the increased absence rates as a result of COVID-19. This unfortunate situation – which the BMA had raised in its August 2018 report *Medical rota gaps in England* - continues to this day.

c. As a result, doctors and other staff were exhausted before the pandemic even started – and worked in intense and often unsafe conditions for much of it. In our COVID-19 call for evidence survey, doctors reported feeling overworked,

exhausted, and with no option but to take on ever increasing workloads. Section E sets out the impact of the pandemic on staffing levels in more detail.

d. It is not possible for the BMA to say with confidence what precise staffing levels would have prevented redeployment or would have been required to cover COVID-19-related absences. What is known is that persistent vacancies, the need for redeployment in the first place, international workforce comparisons and feedback from members working under pressure point to acute issues with understaffing. It is not within the scope, remit or capacity of the BMA to undertake national workforce planning or to assess the staffing levels required to cope with surges in demand or reduced supply. However, entering the pandemic, health systems across the UK were operating in an environment of scarcity. Chronic workforce issues were, and still are, commonplace, reducing the ability of the NHS to deal with additional demand. It is well known that the NHS 'runs hot' outside of pandemic times, especially in winter, with little to no slack in the system to deal with either a surge in demand or a drop in supply of staff.

The UK entered the pandemic with insufficient bed capacity

46. All four UK nations reduced their core bed stock in the decade before the pandemic, meaning the UK went into the pandemic with a very low total number of hospital beds and critical care beds relative to its population. In 2019, the UK had around 2.5 beds per 1,000 people, compared to the OECD average of 4.4.[14]

    a. In England, there was a 6% reduction in available general and acute core beds in the decade prior to the start of the pandemic. 'General and acute core beds' reporting includes beds designated at in-patient locations, with bedhead services - a fixed installation behind, to the side of, or above the bed or trolley position.' Maternity and mental health beds are excluded from these figures, and escalation beds are reported separately.[15] General and acute core beds numbers are included in the NHS England Urgent and Emergency Care Daily Situation Reports.

[14] OECD, Health at a Glance 2021: OECD indicators, 09 November 2021. Total hospital beds; includes beds in private hospitals.

[15] NHS England, Process and definitions for the daily situation report web form, 26 June 2023.

NHS England - General and acute core beds (from UEC Sit Rep data)[16]			
Average number of beds 2nd December 2010 - 20th February 2011	Average number of beds 2nd December 2019 - 20th February 2020	Change in average number of beds between 2nd December 2010-20th February 2011 and 2nd December 2019 - 20th February 2020	Percentage change in average number of beds between 2nd December 2010-20th February 2011 and 2nd December 2019 - 20th February 2020
99,852	93,829	-6,023	-6.0%

NHS England publishes quarterly `Bed Availability and Occupancy` data which includes the number of available and occupied beds open overnight or day-care only that are under the care of consultants. Beds are categorised by specialty (general and acute, maternity, mental health and learning disability). Both core and escalation beds that are open are included in the count. This data set shows that in the decade prior to the start of the pandemic, there was a 6.0% reduction in beds.[17]

NHS England - General and acute beds available overnight (core and escalation beds)			
Average number of beds 2010/11 Q3	Average number of beds 2019/20 Q3	Change in average number of beds between 2010/11 Q3 and 2019/20 Q3	Percentage change in average number of beds between 2010/11 Q3 and 2019/20 Q3
108,023	101,598	-6,425	-6.0%

[16] Urgent and Emergency Care Daily Situation Reports, NHS England, 22 February 2023. (Earliest data available is from November 2010. Winter 2019-20 data set begins on 2nd December 2019.)

[17] Bed Availability and Occupancy – KH03 Beds Time-series 2010-11 onwards (XLS, 118KB). NHS England, 22 February 2023. (The earliest available data for quarterly bed occupancy is 2010-11 Q1.)

b. In Scotland, there was a 9.5% reduction in the number of available beds in the decade prior to the start of the pandemic. The Annual Acute Hospital and NHS Beds publication includes beds in all specialties for non-obstetric and non-psychiatric hospitals and includes day case beds.[18,19]

NHS Scotland			
Average number of beds 2009/10	Average number of beds 2019/20	Change in average number of beds between 2009/10 and 2019/20	Percentage change in average number of beds between 2009/10 and 2019/20
14,614	13,229	-1,385	-9.5%

c. In Wales there was a 17.5% reduction in the number of available beds in the decade prior to the start of the pandemic. The data set includes all specialties and includes an average of all beds available daily. [Separate data for general/acute care beds is not available].[20]

NHS Wales			
Average number of beds 2009/10	Average number of beds 2019/20	Change in average number of beds between 2009/10 and 2019/20	Percentage change in average number of beds between 2009/10 - 2019/20
12,807	10,564	-2,243	-17.5%

d. In Northern Ireland there was an 8.6% reduction in the number of available beds in the decade prior to the start of the pandemic. Available beds include all beds

[18] Acute hospital activity and NHS beds information (annual) Annual - year ending 31 March 2020. Public Health Scotland, 10 September 2019, National Records of Scotland Web Archive.

[19] Acute hospital activity and NHS beds information (annual) Annual – year ending 31 March 2022. Public Health Scotland, 27 September 2022.

[20] NHS beds by organisation and year, 2009-10 onwards, StatsWales, 24 October 2023 (last update).

open overnight (day case beds are not included). Beds are counted for the 'acute programme of care' which includes all specialties, but excludes elderly care, mental health, learning disability, maternity and child health [but paediatric care is included in acute care].[21], [22]

Health and Social Care Northern Ireland			
Average number of beds 2009/10	Average number of beds 2019/20	Change in average number of beds between 2009/10 and 2019/20	Percentage change in average number of beds between 2009/10 and 2019/20
4,255	3,891	-364	-8.6%

47. Before the pandemic, bed occupancy rates throughout the UK often exceeded the recommended 85% bed occupancy safety threshold, indicating that spare bed capacity was low. In England, for example, overnight bed occupancy rates did not fall below 85% between March 2012 and the onset of the pandemic eight years later.[23]

48. High bed occupancy reduces the flexibility of a hospital to accommodate short term fluctuations in demand, leaving it vulnerable to even quite small changes in admissions or discharges. Occupancy above 85% is known to lead to increased numbers of hospital-acquired infections (PB/262 - INQ000397317). The extent of these pre-existing capacity constraints meant that there was little surge capacity in the system when the pandemic hit.

    a. The 85% threshold is widely considered the maximum safe bed occupancy level and is not specific to particular regions, trusts/hospitals or types of bed. It has been recommended or referenced by a wide range of medical and healthcare

[21] Hospital statistics: inpatient and day case activity 2009/10 to 2021/22, Department of Health Northern Ireland, 03 August 2023.

[22] Maternity and child health' Programme of Care includes Obstetrics; Obstetrics (Ante Natal); Obstetrics (Post Natal); Well Babies (Obstetrics); Well Babies (Paediatrics). The 'Acute Services' Programme of Care includes various areas of Paediatrics.

[23] NHS Bed Availability and Occupancy Data – Overnight, Beds Time-series 2010-11 onwards (adjusted for missing data). Accessed 08/08/2023.

organisations in the UK including the Royal College of Emergency Medicine[2425], the Royal College of Physicians[26], the Royal College of Surgeons[27], the Royal College of Psychiatrists[28], and NHS Providers.[29]

b. The National Audit Office, in a 2013 report, states that '… because the volume of emergency admissions can fluctuate, hospitals with average occupancy levels above 85 per cent can expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections.'[30]

c. The figure of 85% appears to originate from the research article 'Dynamics of bed use in accommodating emergency admissions: stochastic simulation model' published in the BMJ in 1999 which found "*Risks are minimal so long as the mean bed occupancy remains below about 85%. Above this level the risks become substantial (at 85%, a hospital can expect to be short of beds for admissions on four days in a year), and above a mean bed occupancy of 90% the system is regularly subject to bed crises*" (PB/561 - INQ000442316).

49. Concerns about bed capacity in the UK were regularly raised by BMA members:

a. Policy motions were consistently passed by ARM and by branch of practice conferences regarding concerns around bed numbers and capacity. For example:

- the Consultants Committee passed a motion in 2015 stating *'that the crisis in the NHS has reached a critical point, where patients' lives are being put at risk in A&Es full to bursting, from lack of beds'*

[24] Royal College of Emergency Medicine `RCEM: NHS in England needs over 4,000 extra beds this winter to avoid corridor care` 30 October 2019

[25] Royal College of Emergency Medicine `RCEM Explains: Hospital Beds` 2021

[26] Royal College of Physicians `RCP Responds to the latest NHS performance stats` 15 December 2023

[27] Royal College of Surgeons of England `NHS bed occupancy rates now at worst ever, new figures show` 24 May 2018

[28] Royal College of Psychiatrists `Response from the Royal College of Psychiatrists: Exploring mental health inpatient capacity`

[29] NHS Providers `Bed occupancy levels highlight scale of pressure across NHS` 19 August 2021

[30] Emergency admissions to hospital: managing the demand, National Audit Office, 25 October 2013.

- the same committee passed a motion in 2016 insisting that *'the Government tackles the bed crisis with more hospital beds and proper funding for care in the community'.*

b. Immediately prior to the pandemic, 54% of respondents to a BMA Quarterly Survey (February 2020) said that high levels of bed occupancy increasingly hindered their ability to treat patients compared to the previous winter.

50. The BMA has publicly raised the issue of bed availability and capacity on various occasions and called on governments directly to increase bed capacity in the years preceding the pandemic. Examples include:

a. The BMA's report *State of the health system - Beds in the NHS: UK* (2017) (see pages 8, 16, 21-23, 28, 30). This report noted that 'Our members report substantial problems and strains within the bed system' and collated data showing, amongst other things, that 'hospitals are increasingly operating at very high levels of occupancy, particularly during the winter months'. It called for a clear UK-wide bed plan that accounts for future service demands and ensures beds are sustainably funded and staffed (PB/239 - INQ000397336).

b. In BMA Cymru Wales's response to a 2016 Welsh Government Inquiry on winter preparedness (PB/263 - INQ000400357) and in a submission to a review of Health and Social Care in Wales in 2017 (PB/168 - INQ000145909).

c. In Scotland, BMA Scotland raised concerns about declining bed numbers in a 2019 report about secondary care (PB/245 - INQ000397271).

d. Beds were a key focus point of the BMA's *Breaking Point* campaign, featured in The Guardian, which found that in the first week of January 2017, almost three-quarters of English trusts had a bed occupancy rate of 95% on at least one day (PB/240 - INQ000397320). The BMA's report *Bed numbers in England by STP* (2018) highlighted that general and acute bed occupancy in England was over 90% for all but four days in the winter of 2017/18 and stressed the importance of bed capacity 'to the ability of the NHS to withstand peaks in demand' (PB/264 - INQ000397254).

e. A briefing, *NHS funding settlement: is it enough and how should it be spent?* (July 2018), urged the UK government to 'increase bed capacity in line with rising

demands on hospitals' in England, flagging dangerously high bed occupancy levels (PB/151 - INQ000145855).

51. Combined with staffing shortages, low bed capacity led to the need to deprioritise non-COVID-19 care, as not enough staffed beds were available to meet COVID-19 as well as non-COVID-19 demands.

Health services' equipment and infrastructure were unfit for purpose before the pandemic and impacted the ability of services to adapt to keep patients and staff safe

52. Hospital buildings and GP practices across the UK were already unfit for purpose before March 2020. In large part, this was due to the fact that capital investment in the UK's health services had been consistently low in the decade preceding the pandemic:

    a. The level of capital funding available to the UK's health services was impacted by the period of economic austerity following the 2008 financial crash, with revenue and running costs often taking precedence over longer-term capital investment – and funding being explicitly transferred out of capital budgets to make ends meet (PB/265 - INQ000397284).

    b. Comparison with other OECD nations further demonstrates that capital spend on health within the UK had been low preceding the pandemic. Between 2015 and 2019, the UK spent an average of 0.37% of its Gross Domestic Product (GDP) on capital health expenditure, well below the 0.55% OECD average.[31]

53. Insufficient capital investment meant that healthcare providers frequently lacked the funds necessary to make improvements or even remedial repairs and upgrades to their estate. It also affected the quantity and quality of available IT and other equipment e.g. ventilators and infrastructure (see section H).

54. Members raised concerns about these issues. For example:

    a. A motion was carried at the 2017 Junior Doctors Conference about 'the often-substandard quantity and quality of IT equipment and software used within the NHS'.

[31] OECD, Health at a glance 2021, November 2021. Capital spending on health includes private spending.

b. In a survey on GP premises, carried out by the BMA's General Practitioners Committee in 2018, only half of practices[32] considered their premises to be fit for present needs and only two in 10 practices[33] thought their premises were fit for the future when considering expected population growth (PB/266 - INQ000397299).

c. In a 2018 BMA survey of members in England on NHS IT, over one fifth (22%) of respondents believed that IT systems at their place of work were not fit for purpose and one third (32%) believed that they rarely had all the necessary IT equipment to perform their job to the best of their abilities without disruption.

55. The BMA has on various occasions raised concerns about the estates and infrastructure of UK healthcare systems and urged governments to increase capital funding. Examples include:

a. The BMA's annual budget representation to HM Treasury in 2019, which urged the UK government to 'set out [a] long-term capital spending plan beyond its recent announcement of a modest uplift of the capital spending limit', highlighting the NHS maintenance backlog in England of over £6 billion and the safety of patients and staff being compromised by buildings not fit for purpose. In the same letter, the BMA also urged the UK government to improve the basic IT infrastructure that doctors and other NHS staff use every day (PB/261 - INQ000400361).

b. The BMA's report *Technology, infrastructure and data supporting NHS staff (April 2019),* which drew attention to the presence of serious deficiencies within NHS IT systems in England, resulting in 'additional workload, stress and compromised patient safety' (PB/268 - INQ000397337).

c. A joint letter to the Prime Minister (05 August 2019) alongside the Family Doctors Association, National Association of Primary Care, the Patients Association, and the Royal College of General Practitioners, on the need to invest in primary care estates and infrastructure in England (PB/269 - INQ000400509).

[32] 979 practices responded to this question.

[33] 1,006 practices responded to this question.

56. When the pandemic began, the quality of health services' estates and IT systems significantly reduced their capacity to manage an outbreak of an infectious respiratory disease of the type and scale of COVID-19. For example:

    a. Many buildings were unsuitable for full implementation of infection control policies:

        i. lack of space meant it was difficult to deal with the additional influx of patients and difficult to separate COVID-19 from non-COVID-19 patients. Small spaces also made social distancing challenging.

        ii. Poorly ventilated buildings posed a huge issue for infection prevention and control, especially for a virus that spreads via the air.

    b. The state of IT infrastructure (and often connectivity) hampered staff ability to provide remote consultations where they were needed to keep patients and staff safe.

        i. The rapid switch to remote consultations highlighted the limitations of the IT infrastructure across the UK's health services. In response to our COVID-19 tracker survey on 28 May 2020, when asked about limitations on their ability to provide remote consultations for patients during the pandemic, 59% of primary care respondents reported being limited by IT hardware, 55% by telecoms infrastructure, 52% by IT software, 52% by mobile devices/apps and 50% by internet speed or bandwidth.

        ii. Similar limitations to providing remote consultations existed in secondary care. In response to our COVID-19 tracker survey on 28 May 2020, when asked about limitations on their ability to provide remote consultations for patients during the pandemic, 59% of hospital-based respondents reported being limited by IT hardware, 52% by telecoms infrastructure, 58% by IT software, 44% by mobile devices/apps and 42% by internet speed or bandwidth.

iii. The shift to remote working was less effective in secondary care than in primary care. This is due, in part, to the nature of primary care where tranches of work can be carried out remotely with commensurate levels of accuracy in diagnoses for minor conditions. Secondary care is inherently more specialised and often may require physical contact.

iv. Where routine work could be carried out remotely – such as post-operative outpatient appointments, the full potential was not realised. In England, much of the framework established to support the shift to remote working in primary care was coordinated and funded at a national level in close consultation with representatives from the BMA and the Royal College of General Practitioners (RCGP). In contrast, work to support the shift to remote consultations in secondary care was largely devolved to trusts except where Integrated Care Boards voluntarily took on responsibility. Doctors able to acquire VPNs or smart cards were able to offer some services remotely, however no central distribution system existed to provide them, and, in any case, there was no consensus and/or national guidance on what secondary care services could be provided remotely.

v. Compounding the above is the fact that the government's behaviour and public position on remote working was both erratic and extemporaneous, seemingly swerving between mandating a shift to remote consultations and castigating doctors for offering their service on a remote basis (see section F). Ultimately, as a result of these factors and the fact that pandemic control measures were gradually reduced throughout 2020, remote working in secondary care was never properly trialled to the extent that a balanced assessment can be made. Programmes including NHS@Home which uses technology to help people self-manage their health and care at home that were touted during the later stages of the pandemic were not fully operational until the pandemic in the UK had been declared

over. Similarly, virtual wards are, in some ways, the result of the cultural shift resulting from the pandemic rather than a response to the pandemic itself.

vi. Section L states what went well with regard to NHS IT.

C. Liaison and communication with the UK Government and Devolved Administrations

57. This section sets out high-level summaries of the BMA's working relationship with the UK Government and Devolved Administrations in relation to COVID-19 during the period 1 March 2020 to 28 June 2022. This includes the BMA's relationship with: the Chief Medical Officer for England; Public Health England (PHE) and the UK Health Security Agency (UKHSA); the Secretary of State for Health and Social Care (SoS), DHSC Ministers and the Chancellor of the Exchequer; the Department of Health and Social Care (DHSC); NHS England; regulators (the General Medical Council (GMC) and Care Quality Commission (CQC)); NHS Employers; Devolved Governments and their associated bodies.

58. The ways in which the BMA engaged with the above roles and organisations throughout the pandemic, and the issues on which the BMA sought to influence, varied between the BMA UK office and offices in each of the devolved nations.

Working relationships at the UK level

Chief Medical Officer (CMO) for England

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

60. These meetings were held to discuss a range of issues during the pandemic including: availability and adequacy of PPE for healthcare workers; lack of access to testing; and healthcare staff concerns about changes to the Pfizer-BioNTech vaccination rollout.

61. As well as providing an opportunity to raise concerns, these meetings allowed the BMA to better understand the factors which the CMO was considering when advising the UK government. The relationship allowed for a free and frank exchange of views and for the BMA to put forward concerns on behalf of its members.

62. The BMA also wrote letters to the CMO for England raising concerns about the lack of national guidance on resource allocation should demand for intensive care resources outstrip supply, changes to the Pfizer-BioNTech vaccination rollout and deficiencies in IPC guidance (PB/270 - INQ000400347, PB/271 - INQ000400438, M2B/PB/112 - INQ000118678 and PB/091 - INQ000097952). Where relevant, the CMO was cc'd into letters sent to other organisations, for example a letter sent to NHS England about the disproportionate impact of COVID-19 on ethnic minority communities and healthcare staff (PB/072 - INQ000097864).

63. In addition, staff members from the BMA's Medical Ethics team attended meetings of the Moral and Ethical Advisory Group (MEAG), set up by DHSC, which the CMO for England also sometimes attended.

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

64. The BMA's engagement with PHE/ the UKHSA was primarily through formal written communication on issues of concern.

65. A key area of concern raised by the BMA related to the adequacy of IPC guidance in providing healthcare workers with sufficient protection from COVID-19. There were a number of issues the BMA had concerns about:

    a. Early on in the pandemic the BMA raised serious concerns that the IPC guidance on PPE for healthcare workers caring for COVID-19 positive or suspected positive patients did not align with recommendations from other organisations, including the World Health Organisation (WHO), European Centre for Prevention and Disease Control (ECDC) and the USA's Centers for Disease Control and Prevention (CDC). The BMA outlined these discrepancies in a letter to PHE on 24 March 2020 (PB/087 - INQ000097932), including the WHO recommendation that staff in all healthcare settings where COVID-19 was suspected should use gowns and eye protection, which was not reflected in PHE guidance.

    b. In a letter to PHE on 19 April 2020 the BMA raised further concerns that PHE's guidance on the use of PPE during exceptional shortages was designed to fit around the availability of supplies rather than evidence of protection (PB/459 - INQ000097902). A response was received from PHE on 20 April 2020 outlining that the PPE advice issued was in accordance with global evidence, and that the Health and Safety Executive (HSE) agreed that the guidelines, given the need to optimise PPE supplies, were appropriate (PB/433 - INQ000466401). It was

clarified that the revised guidance was not intended to replace the guidance issued on 02 April 2020, but rather that it was in response to urgent requests from DHSC and NHS England, given PPE stocks were becoming low. The guidance, PHE stated, was intended to be used as a last resort in extreme circumstances, and if properly followed, it should present 'no additional infection risk' to healthcare staff. In addition, PHE stated that organisations themselves would need to consider whether they could develop and implement procedures and training for the safe re-use of PPE. Finally, PHE expressed concern that healthcare staff were being asked to fit check instead of fit test masks, and that NHS England would be alerted to this urgently as it was not in line with PHE, HSE or WHO guidance. It is the BMA's view that, even during extreme PPE shortages, guidance needs to remain based on evidence of protection.

c. The BMA, alongside the Resuscitation Council UK, Royal College of Nursing (RCN) and the Hospital Consultants and Specialists Association, also called on PHE to classify CPR (including chest compressions) as an Aerosol Generating Procedure (AGP) and as such ensure that FFP3 masks were recommended for staff undertaking these procedures (PB/088 - INQ000097926 and PB/273 - INQ000097842).

66. As the pandemic progressed, the BMA raised concerns with PHE (including via a letter on 13 January 2021) (PB/089 - INQ000097875) and other organisations including HSE and NHS England (PB/090 - INQ000097909 and PB/196 - INQ000097955) about decisions not to update IPC guidance in light of increasing evidence of airborne transmission of COVID-19 and new variants. These issues are set out in more detail in section G. In a 17 February 2021 response, PHE (PB/591 - INQ000466410) stated that IPC guidance does not 'belong solely to PHE' but that it was produced by the UK-wide Infection Prevention and Control (IPC) Cell which was comprised of multiple agencies, stressed that the IPC Cell had reviewed guidance in light of emerging variants and evidence on routes of transmission but recommended no changes to PPE. However, PHE said there was agreement within the IPC Cell, that existing IPC practices needed to be strengthened. Finally, PHE stated that the IPC Cell would continue to monitor the evidence and review the recommendations.

67. Another key area of concern relates to the rapid review undertaken by PHE in May 2020 into the disproportionate impact of COVID-19 on ethnic minority groups. The BMA wrote to PHE requesting a meeting to discuss how the BMA could engage with the review

team directly (PB/078 - INQ000097912), and was invited to submit a written contribution, which the BMA did (PB/079 - INQ000117943). However, when PHE's report was published, the BMA had serious concerns about its content and wrote to the Secretary of State about reports that a large number of pages and recommendations had been removed from the report (PB/081 - INQ000097872) which suggested a lack of transparency. The BMA also expressed concern that the report did not set out clear recommendations for immediate action needed to tackle the disproportionate impact COVID-19 was having on ethnic minority communities.

68. The BMA did not have regularly recurring meetings with representatives of PHE/ the UKHSA, however occasional meetings took place on topics such as PPE guidance, PPE adequacy, COVID-19 testing and the impact of COVID-19 on ethnic minority communities. For example, at a meeting on 27 March 2020 PHE discussed the BMA's concerns about a lack of clarity in relation to PPE guidance and supplies. On 22 June 2020, members of the BMA Public Health Medicine Committee met with PHE to discuss PHE's recent report on the impact of the pandemic on ethnic minority communities.

69. The BMA also received updates from PHE/the UKHSA through the SPF COVID-19 Engagement Forum (detailed further at section C).

Secretary of State for Health and Social Care (SoS), DHSC Ministers and the Chancellor of the Exchequer

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

71. In particular, the BMA's chair of UK council had regular (approximately monthly meetings) with Matt Hancock when he was SoS. The BMA chair of UK council and senior staff also had regular meetings with Minister of State (September 2019 – July 2022) Ed Agar MP, and Minister of State (February 2020 and September 2021) Helen Whately MP. Senior staff also met with some of these individuals as part of the Social Partnership Forum (SPF) Wider Group (see section C).

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

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

73. The BMA wrote a number of letters to the SoS and ministers throughout the pandemic.

74. This communication allowed the BMA to raise issues of concern to the BMA and its membership, including those within the scope of Module 3. Specific examples of communication with the SoS and Ministers of State included in relation to:

    a. **PPE shortages and the adequacy of recommended PPE** – letters dated 26 March 2020, 06 April 2020, 09 April 2020, 13 January 2021 (PB/007 - INQ000097941, PB/065 - INQ000097854, PB/066 - INQ000117840, PB/076 INQ000097874), and meetings with the SoS on 18 March 2020, Jo Churchill on 20 March 2020, and Helen Whately 27 March 2020. A response to the letter of 13 January 2021 was received from PHE on 17 February 2021 and is summarised at paragraph 66.

    b. **Lack of testing availability** – letters dated 26 March 2020 and 09 September 2020 (PB/007 - INQ000097941, PB/231 - INQ000118110), and meetings with the SoS on 18 March and 26 March 2020, and Helen Whately on 27 March 2020. A response to the letter of 09 September 2020 was received on 14 October 2020 from the Secretary of State, following a discussion with the BMA (PB/267 - INQ000466405). Regarding the BMA's concerns about testing capacity, (particularly due to low laboratory capacity), the SoS said that the government had expanded testing capability, increased capacity of labs and had set up new testing sites. They pledged to increase testing capacity to 500,000 a day and increase test site numbers to 500 by the end of October. Further, the SoS stated that more walk-in testing sites would be opened, and in conjunction with piloting new testing technology this would ensure faster results.

    c. **The disproportionate impact of the pandemic on ethnic minority communities** – letters dated 07 June 2020 and 12 June 2020 (PB/080 - INQ000117975, PB/081 - INQ000097872).

    d. **Death in service** – letters (to the Chancellor of the Exchequer) dated 30 March 2020, 22 April 2020 and 01 July 2020 (PB/274 - INQ000400370, PB/275 - INQ000400477, PB/276 - INQ000097843). The Chancellor of the Exchequer responded to these letters on 17 September 2020, outlining the new Life Assurance Scheme launched in May 2020 (PB/588 - INQ000466406). The

provisions of the scheme included a £60,000 lump sum to the families of frontline health and social care staff who contracted COVID-19 at work, including cases that occurred prior to the scheme's launch. Despite this scheme providing some support, the BMA repeatedly highlighted that it would not provide long-term financial support to those not eligible for the NHS pension scheme (such as junior doctors early in their careers) and the one-off payment would be disproportionate to the risk (and loss) faced by these crucial staff and their families during a national crisis. In addition, the BMA pointed out that removing the two-year membership rule for the pension scheme would be of relatively small cost to the Treasury. The Chancellor's response denied this, stating that removing the two-year vesting principle within the scheme would be a significant change to make.

e. **Redeployment** – a meeting with Helen Whately on 27 March 2020.

f. **Impact of the pandemic on doctors' mental wellbeing** – the meeting with Helen Whately on 27 March 2020.

g. **Vaccination rollout** – a letter dated 29 January 2021 (PB/277 - INQ000400483), WhatsApp exchanges on 30 December 2020, 04 January 2021 and 23 January 2021 (PB/541 - INQ000400432), and a meeting with the SoS on 30 December 2020.

h. **IT and digital enablement in healthcare** – letter dated 14 August 2020 (PB/278 - INQ000097886) and meeting with the SoS on 27 November 2020.

i. **Access to healthcare for refugees and migrants living in the UK** – letter dated 13 April 2020 (PB/279 - INQ000235275). On 29 June 2020 Ed Argar, the Minister of State for Health, responded that COVID-19 treatment is free for overseas visitors and migrants, including those who reside in the UK without permission (PB/592 - INQ000466399). However, this exemption would not apply to pre-existing conditions. Primary care, A&E services, and some vulnerable groups were exempt from charges. If charges were to apply, necessary treatment must be provided even if payment had not been received and national guidance was updated to emphasise this. Ministers considered the BMA request to suspend the charging regulation but did not consider that to be proportionate. The letter stated that, while it would be unnecessary for the NHS to share patient information with the Home Office for the purposes of obtaining immigration status, there would not be a total suspension of the data sharing arrangements between the NHS and the Home Office, due to the intention to ensure debts to

the NHS could be reclaimed. Such data sharing may 'help support a person's claim to entitlement to free treatment' where treatment is chargeable, but the person cannot provide documents in relation to the Immigration Health Surcharge. The government aimed to remove NHS and care home workers from the requirement to pay.

j. **Healthcare capacity and backlog of care** – letters dated 22 May 2020, 14 August 2020, 19 March 2021, 05 July 2021, 12 July 2021, 14 July 2021, 15 December 2021 (PB/280 - INQ000097923, PB/278 - INQ000097886, PB/281 - INQ000400355, PB/009 - INQ000097852, PB/282 – INQ000400345, PB/283 - INQ000097884, PB/284 – INQ000400349), and meetings with the SoS on 27 November 2020 and 28 April 2021. A response to the letter of 22 May 2020 was received from the SoS on 06 July 2020 and is summarised at paragraph 229.

k. **Abuse, threatening behaviour and violence towards staff** – letters dated 09 September 2021 and 21 September 2021 (PB/233 - INQ000097867, PB/234 - INQ000097914)

l. **Medical education and training** – letters dated 04 September 2020, 13 October 2020 and 15 December 2021 (PB/285 - INQ000400424, PB/286 – INQ000400346, PB/284 - INQ000400349). The Department for Health and Social Care responded to the BMA's letter of 4 September 2020 on 21 December 2020 (PB/590 - INQ000466408). In relation to the BMA's request for additional funding and support for medical schools following the increased intake of medical students in 2020, the DHSC said that the government had taken action to ensure funding was adequate, including a financial support package to education providers. The DHSC said they were working to address the shortages of medical academics (exacerbated by the increase in medical students requiring training), and that education and training tariff funding is reviewed annually. Addressing the key point made by the BMA in relation to the oversubscription to the UK Foundation Programme, the DHSC said that they would look to ensure that all medical graduates could access a place on the programme and were working with NHS providers, partners and the Devolved Administrations to monitor this issue.

75. However, this engagement did not always lead to government actions that the BMA felt were appropriate. In these instances, the BMA was proactive in publicly criticising

government actions or inactions that it considered put the wider population and healthcare workers (including doctors) at risk or that were likely to increase pressure on healthcare services. This ranged from interventions relevant to module 2 (e.g. the timing of lockdowns), to interventions relevant to module 3 such as PPE shortages and the inadequacy of recommended PPE, outlined in more detail in section G.

Department of Health and Social Care (DHSC)

76. The BMA received updates on issues of relevance from senior civil servants and DHSC representatives through the Social Partnership Forum (SPF).[34] The SPF Wider Group is the most senior SPF Group and is chaired by a health minister although during the pandemic, chairing duties were often delegated to a senior civil servant. During the relevant period, the SPF had a number of sub-groups both ongoing and set up for particular issues. These included:

    a. The SPF COVID-19 Engagement Forum, which was established during the pandemic. Topics of discussion included, among others, PPE, risk assessments, staff testing, staff returning to practice, the physical and mental impact of the pandemic on healthcare staff and the vaccination rollout.

    b. The SPF Strategic Group, which reports into the SPF Wider Group and is co-chaired NHS Employers and staff side trade unions, enables more detailed policy discussions at an early stage of development. During the pandemic, this group (and the SPF Wider Group) was attended by the BMA's Head of Professionalism and Guidance and the BMA's Head of Public Health and Healthcare.

    c. The SPF Workforce Issues Group (WIG), which does more detailed work on workforce issues and reports into the SPF Strategic Group. During the pandemic this group met on a monthly basis and was attended by the BMA's Head of Workforce and Innovation. The group discussed issues such as the Digital Staff Passport, redeployment, risk assessments, occupational health, violence against staff and staff health and wellbeing, and met on a monthly basis.

    d. The SPF Terms & Conditions (T&Cs) subgroup which was the key forum where terms and conditions updates about COVID-19 were discussed at a cross-union level. The subgroup met weekly and discussed issues such as the COVID-19

[34] The SPF brings together NHS Employers, NHS Trade Unions, NHS England, Health Education England and the DHSC to contribute to the development and implementation of policy that impacts on the health workforce. More information about the SPF can be found here: INQ000236244.

sickness leave arrangements, redeployment, annual leave, shielding and car parking. It was attended by senior staff within the BMAs National Negotiation and Representation (NNR) team. A union representative of this group provided updates to the SPF COVID-19 Engagement Forum, although active discussion of T&C work remained within this subgroup.

77. The BMA also attended some stakeholder meetings hosted by the DHSC with speakers such as the Deputy CMO to brief attendees on the latest issues, for example updates the shielding programme (July 2020) or the government's PPE plan (April 2020).

78. In addition to this, the BMA received updates through the NHS Staff Council, which is the joint negotiating forum for Agenda for Change unions and Employers/DHSC, on which the BMA has three seats. The NHS Staff Council met at least twice a year over the reference period.

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

NHS England

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

National-level engagement

81. At a national level engagement included:

    a. **Raising concerns about PPE shortages, PPE adequacy and IPC guidance** – letters dated 24 March 2020, 27 March 2020, 06 July 2020, 23 December 2021 and 30 December 2021 (PB/087 - INQ000097932, PB/193 – INQ000097943, PB/194 - INQ000097855, PB/195 - INQ000097930, PB/196 -

INQ000097955), email communication on 31 March 2020, 16 July 2020 and 10 August 2020 (PB/197 – INQ000117819, PB/579 - INQ000433858, PB/581 - INQ000433859, PB/198 – INQ000118065), and meetings on 02 April 2020, 29 May 2020, 10 August 2020 and 15 December 2020 (PB/200 - INQ000117760, PB/201 – INQ000118248).

b. **The need to address the disproportionate impact on ethnic minority communities and doctors** – a letter dated 09 April 2020 (PB/072 - INQ000097864) and meetings on 15 April 2020, 05 May 2020 and 05 June 2020 (PB/272 - INQ000117891, PB/575 - INQ000400404, PB/200 - INQ000117760).

c. **Calling for more support to undertake risk assessments** - letters dated 28 April 2020, 20 May 2020, 05 June 2020 and November 2020 (PB/056 - INQ000097947, PB/057 - INQ000097908, PB/059 – INQ000097851, PB/118 - INQ000118181) and a meeting on 01 May 2020 (PB/200 - INQ000117760).

d. **Calling for death in service cover for staff not in the NHS pension scheme** – a meeting on 25 March 2020 at which NHS England told the BMA this would be a Government/Treasury decision.

e. **Calling for the continuation of free COVID-19 testing** - a letter dated 28 March 2022 (PB/203 - INQ000097946).

f. **Raising operational concerns related to the vaccination rollout** – letters about General Practice IT systems (26 November 2020), prioritisation within the healthcare worker category of those at greatest risk (03 December 2020, 21 December 2020, 29 December 2020), local variation in staff access to the vaccine (21 December 2020), and the need to avoid vaccine wastage (25 January 2021) (PB/287 - INQ000400428 - , PB/288 - INQ000400429, PB/289 - INQ000400474, PB/290 - INQ000400485, PB/291 - INQ000400481).

g. **Highlighting ways to manage changes to care delivery** - letters dated 16 July 2020, 17 September 2020 and 14 January 2022 (PB/292 - INQ000400350, PB/293 - INQ000400352, PB/294 - INQ000400468).

h. **Calling for the UK to participate in EU procurement schemes for medical equipment** – a letter dated 27 March 2020 (PB/193 - INQ000097943).

i. **Seeking clarification on redeployment of staff** – a letter dated 14 December 2020 (PB/295 - INQ000400348).

j. **Raising concerns about the deployment of retired staff to high-risk roles** – a letter dated 09 April 2020 (PB/072 - INQ000097864).

k. **Agreeing changes to working arrangements for Consultants, Consultant Clinical Academic and SAS doctors with NHS Employers** – a joint statement published in May 2020 on contracts (PB/297 – INQ000400495).

l. **Agreeing changes to working arrangements for Junior Doctors** - a joint statement published in April 2020 on managing rotas (PB/300 - INQ000400515).

m. **Raising concerns about proposed changes to terms and conditions in general practice** - a letter dated 21 October 2021 (PB/296 - INQ000400473).

n. **Requesting support for general practice** – letters dated 17 July 2020 and 29 October 2020 (PB/298 - INQ000400351, PB/299 - INQ000400484).

o. **Making recommendations for safely addressing the backlog of care** – letters dated 22 May 2020, 19 March 2021, 30 July 2021 and 02 August 2021 (PB/301 - INQ000097922, PB/302 – INQ000400354, PB/303 – INQ000400486, PB/304 – INQ000400339).

82. On issues related to IT and data sharing in the NHS, the BMA's GPC England met regularly with senior NHS England officials via the Joint GP IT Committee (this is a joint committee between the BMA and RCGP focused on IT issues in General Practice and has a UK-wide remit) and Joint GP IT Liaison Group (this is a smaller subgroup of the full committee) – the former meets on a quarterly basis and the latter on a monthly basis. Issues discussed included hardware provision to GPs to support remote working, patient data flows for COVID-19 testing and vaccination, patient data used for direct care as well as research and pandemic planning.

Regional-level engagement

83. At a regional level in England, regional SPFs (Social Partnership Forums) met frequently (with many meeting fortnightly) to take updates from public bodies including NHS England regional teams and PHE/UKHSA. These meetings were attended by regional BMA staff, such as Regional Coordinators and Industrial Relations Officers and discussed local issues of concern, such as changes to IPC guidance, testing regimes, shortages of PPE or redeployment.

84. BMA Regional Coordinators and Industrial Relations Officers were also engaging at a system level via ICS (Integrated Care System) Partnership Forums, with Health

Education England (via postgraduate deans) and with NHS employers/trust management. A wide variety of issues were discussed regionally and locally including staff redeployment, movement of staff, establishment of Nightingale hospitals and surge centres, separation of COVID-19/non-COVID-19 care, shortages of PPE and equipment, risk assessments, IPC, shielding, returning to work, impacts of the pandemic on redeployment and early deployment on medical training, vaccination rates and the wellbeing of staff.

Working relationship with regulators

General Medical Council (GMC)

85. The BMA had ongoing engagement with the GMC (General Medical Council) throughout the pandemic as it considered the impact of the pandemic on its regulatory remit. This engagement included:

    a. The BMA calling in March 2020 for the GMC to produce a bespoke pandemic version of their 'Good Medical Practice' standards which sets out the principles and values for all doctors to work in line with. It was the BMA's view that producing a bespoke version of these standards would reassure doctors who feared regulatory sanctions may follow if they deviated from their traditional working patterns. The GMC instead decided to produce additional online guidance and FAQs, which it felt to be a more agile approach. The BMA provided feedback on the guidance and on the range of issues they addressed including appraisal and revalidation, professional regulation in challenging times, and fitness to practice (PB/305 - INQ000400505) and the GMC responded in detail to the BMA's queries (PB/306 - INQ000400366).

    b. Being consulted on the GMC's updated COVID-19 guidance for fitness to practice decision-makers, which the BMA agreed with, and was published in the first wave of the pandemic to help decision-makers ensure that they could fully take the context of the emergency into account when assessing complaints about doctors.

    c. Engaging with the GMC's implementation of temporary emergency registration following notification by the Secretary of State that the conditions existed to trigger the relevant part of the Medical Act 1983 (for further information on redeployment see also section E).

d. Involvement in discussions on implementing temporary changes (derogations) to postgraduate curriculum requirements, where postgraduate training (which the GMC quality assures) was disrupted by the pandemic. The BMA wrote to the GMC on 03 August 2020 (PB/307 - INQ000400422) to raise our concerns about the transition from medical student to foundation year training during the COVID-19 crisis and to make some proposals about how this might be developed for the future. For example, taking a consistent approach across the UK to providing additional learning opportunities for those who experienced gaps due to loss of teaching and placement time; and medical schools having joint and integrated responsibility for FY1 doctors which includes mentoring and continued access to online learning and library tools during the FY1 year to ensure new graduates can maintain their skills over an extended period.

e. Seeking clarification from the GMC in January 2021 on the use of the Pfizer BioNTech vaccination administered by doctors and their teams in line with the recommendations of the JCVI and the four Chief Medical Officers, but outside of manufacturers' instructions. The BMA was assured that regulatory action would be highly unlikely if GPs followed national guidance (PB/308 - INQ000400511, PB/309 – INQ000400467).

Care Quality Commission (CQC)

86. The BMA also communicated with the CQC (Care Quality Commission) in March 2020 to raise concerns about the CQC's statement that inspection and regulation activity would continue during the pandemic. The BMA wrote letters dated 12 and 13 March 2020 (PB/310 - INQ000400510, PB/311 - INQ000398841, PB/312 - INQ000400434) raising concerns that continuing routine inspections in the midst of a pandemic would have a significant adverse impact on the health service, as the focus of staff needed to be on providing continued care to patients. In these letters the BMA urged the CQC to halt all routine inspections and to instead dedicate their resources to supporting hospitals, trusts and GP practices to meet the demands placed upon them.

87. The CQC suspended routine inspections on 16 March 2020 and wrote to all registered health and social care providers about how it was adapting its regulatory approach in response to the COVID-19 outbreak. The new approach was positive as the suspension of CQC inspections allowed services and doctors to directly focus on patient care.

88. Since then, the CQC has adopted a risk-based approach for primary care settings, responding to new and emerging information of concern and prioritising inspections where there is inherent risk, including those services in special measures; services rated as inadequate or requiring improvement; newly registered services; and inspections to follow up enforcement action. The CQC is also responding to new and emerging information of concern in NHS organisations, including inspecting core services and assessing whether they are well led. This includes NHS acute hospitals, ambulance, community health and NHS 111 services. It is prioritising services with inherent risk including unrated locations and locations not yet inspected. It continues to inspect mental health services and independent health providers and is carrying out Mental Health Act (MHA) monitoring visits as planned.

89. On 01 April 2020 the BMA issued a joint statement with the CQC, the Royal College of General Practitioners and the Care Providers Alliance (PB/313 - INQ000400508) on the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Notices (which is discussed in more detail in section H).

Working relationship with NHS Employers

90. Throughout the Module 3 period there was regular engagement between NHS Employers and the BMA across many branches of practice.

91. Letters sent by the BMA to NHS Employers include:

    a. A letter on 19 March 2020 (PB/314 - INQ000400364) raising concerns about inappropriate contracts offered to medical students taking on contracts of employment within the NHS to help the COVID-19 response, emphasising the need for clarity on the duties that students can be expected to perform. Similar concerns were raised by BMA Cymru Wales (see paragraph 199b).

    b. A letter on 22 June 2020 (PB/315 - INQ000400478) raising concerns about the downgrading of PPE requirements in certain clinical settings in some hospital trusts. The BMA highlighted that this was out of step with PHE national guidance and occurred at a time of sustained COVID-19 transmission.

    c. A letter on 23 December 2020 (PB/316 - INQ000400430) about the implementation of medical appraisals and the need for employers to promote individual flexibility, as advised by Professor Powis, NHS England Medical Director.

92. Regular meetings took place between representatives of the **BMA's Junior Doctors Committee** and NHS Employers' Workforce and Reward team to discuss all issues that affected junior doctor pay and terms and conditions of service as a result of the pandemic.

93. The **BMA Consultants Committee** also had regular engagement with NHS Employers throughout the relevant period:

    a. The committee sought to enter discussions with NHS Employers in England to set an agreed rate for additional activity undertaken by consultants in response to the pandemic, such as COVID-19 rotas and resident shift working (which is normally extra-contractual). This was intended to create fairness, allow the option of time off in lieu and to ensure that appropriate rates were paid that reflected the value of consultants' time. Regrettably, NHS Employers took the view that this was not something they were willing to discuss and as such it was a matter for local negotiation. This led to the BMA introducing its own rate card for extra-contractual activity in July 2022.

    b. The BMA Consultants Committee also engaged with NHS Employers in England to discuss the running of contractually guaranteed Local Clinical Excellence Award (LCEA) rounds. These schemes can be administratively burdensome for NHS Trusts and require applications supported by evidence from consultants, many of whom would necessarily have their usual opportunities to demonstrate clinical excellence limited by their redeployment to pandemic-related activity. The BMA and NHS Employers agreed an approach for the 2020/21 and 2021/22 award rounds where the funding available would be equally distributed among all eligible consultants. Discussions about the introduction of a new awards scheme to replace the LCEA scheme began in 2021 with the BMA, DHSC, NHS Employers and NHS England, however no agreement could be reached and these talks ended in early 2022 with the parties making different recommendations about how the award rounds for 2022/23 and beyond should be handled. However, the parties did agree some minor changes to the national consultant contract to clarify arrangements around LCEAs (e.g. clarifying the nature of the annual LCEA funding calculation) to remove ambiguities. This was not the case in Wales where, in my role as Chair of Welsh Consultants Committee, I talked directly to the Minister for Health and Social Services and agreed steps forward for consultants and SAS doctors, that were then enacted

by government officials and employers in Wales. This also enshrined the rights of doctors redeployed during the pandemic to revert to their previous job plans afterwards, and was issued as an advisory note by Welsh Government (PB/594 - INQ000466414).

94. Formal negotiations concerning the introduction of new contracts for SAS grade doctors were able to continue during the pandemic between the **Specialist, Associate Specialist and Specialty Doctors Committee (SASC)** and NHS Employers. These negotiations started prior to the pandemic and involved the national health departments and NHS employer bodies of England, Northern Ireland and Wales. The negotiations continued virtually and concluded in early 2021.

95. The BMA also engaged with NHS Employers in England about the continuation of free car parking for hospital staff, which had been directed by the UK Government for the duration of the pandemic. The BMA lobbied for it to apply to a wider range of staff and to be extended beyond April 2022, however these changes were not made. NHS staff car parking charges do not apply at almost all hospitals in Wales.

96. Numerous pieces of guidance were issued jointly by the BMA and NHS Employers during the pandemic. This included:

    a. A joint statement in April 2020 on the application of contractual protections during the pandemic (PB/300 - INQ000400515). The statement recognised that in order to meet the immense challenges presented by COVID-19, it might be necessary for some employers to put in place new working arrangements that were not compliant with the entirety of the national terms and conditions of service, after exhausting all other options to ensure safe patient care.

    b. An advisory note in May 2020 concerning consultant, clinical academic, and SAS doctor contracts during the pandemic, which offered thanks and noted that temporary changes to working patterns to respond to COVID-19 should continue for no longer than necessary (PB/297 - INQ000400495).

    c. Guidance around pay protection for doctors whose training was affected by the pandemic, which was jointly agreed by NHS Employers in England and the BMA during the period covered by Module 3 and published in November 2022 (PB/317 - INQ000397301).

Working relationships with Devolved Governments

Northern Ireland

97. The context in Northern Ireland was that following three years of having no functioning Executive or Assembly, the institutions reformed on 11 January 2020, when UUP MLA Robin Swann assumed the office of Minister of Health under the D'Hondt method. The five-party mandatory coalition in Northern Ireland meant that the full Executive had to agree on measures taken. The Northern Ireland Health Minister would propose actions to the Executive which would then be agreed or not agreed.

98. BMA Northern Ireland had a constructive relationship with the **Minister for Health** in Northern Ireland, with nine meetings occurring between April 2020 and January 2022. Topics discussed at these meetings include PPE, risk assessments, death in service cover for frontline staff, healthcare capacity, the backlog of care, the impact of the pandemic on staff and the vaccination rollout. BMA Northern Ireland sent letters to the Minister for Health dated 02 January 2021 and 07 January 2021 raising healthcare workers' concerns about changes to the Pfizer vaccination rollout (PB/092 - INQ000116898, PB/318 - INQ000116901).

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

100. BMA Northern Ireland and the **Department of Health Northern Ireland** met to specifically discuss workforce issues at HR Engagement Forum meetings, which began prior to the pandemic. During the Module 3 period, these forums took place on 14 May 2020, 30 September 2020, 06 May 2021 and 05 May 2022. Topics discussed include the adequacy of recommended PPE, changes to ways of working, death in service cover, returners and students entering the workforce, healthcare delivery and capacity, staff wellbeing and strategic workforce issues. These meetings were attended by Departmental officials and the Deputy Chief Medical Officer, Dr Naresh Chada.

101. In addition, between April 2020 and December 2021 the National Director of BMA Northern Ireland had bi-monthly phone calls with the **Director of Workforce Policy at the Department of Health Northern Ireland** at which issues were discussed including terms and conditions, death in service benefits, pensions, staff wellbeing services, staff vaccination policies, pay award schedules, workforce strategy, medical vacancies, staffing pressures, and a new single lead employer for doctors in training.

102. BMA Northern Ireland also had a specific meeting about the vaccination rollout with the **COVID-19 vaccination lead at the Department of Health Northern Ireland** on 16 December 2020, followed by a letter dated 05 January 2021 seeking clarification on the rollout of the Pfizer vaccination (PB/319 - INQ000116899).

103. BMA Northern Ireland members attended meetings of the **Chief Medical Advisors Committee** (04 November 2020, 15 November 2021), chaired by the Northern Ireland CMO. COVID-19 was an item at these meetings where BMA Northern Ireland members would share views with the CMO and his team. BMA Northern Ireland sent a number of letters to the CMO for Northern Ireland, including on the topics of: PPE (02 March 2020, 17 April 2020, 20 July 2020), healthcare capacity (02 March 2020), the impact of the pandemic on healthcare staff (02 March 2020), staff training (02 March 2020), the provision of abortion services (09 April 2020), risk assessments (29 May 2020), and Pfizer vaccination dosing (06 January 2021, 11 January 2021) (PB/002 - INQ000116865, PB/320 – INQ000116866, PB/321 – INQ000116876, PB/322 – INQ000400342, PB/062 - INQ000116868, PB/323 – INQ000116900, PB/324 - INQ000400487). In addition, the Chair of BMA Northern Ireland occasionally communicated with the CMO via text message (PB/325 - INQ000400519).

104. BMA Northern Ireland met with the **Public Health Agency** on 30 June 2021 and 19 May 2022. Discussion included the impact of COVID-19 on the medical workforce and service provision. BMA Northern Ireland sent letters to the Public Health Agency on 21 October 2020 about flu vaccination supplies and 13 January 2021 about a COVID-19 vaccination surveillance strategy (PB/326 - INQ000400475, PB/327 - INQ000116904).

105. On occasion BMA Northern Ireland met with each Health and Social Care Trust individually to discuss issues affecting doctors at that time. Meetings were with Belfast Trust (21 May 2020 and 22 April 2021), South Eastern Trust (18 June 2020, 10 February 2021 and 09 February 2022), Northern Trust (16 July 2020), Southern Trust (22 July 2020 and 20 January 2021), and Western Trust (23 July 2020 and 03 February 2021). BMA Northern Ireland also sent a letter to the CEO of each Health and Social Care Trust on 29 July 2021 highlighting the aerosol transmission of COVID-19 and asking them to provide FFP3 respirators to all healthcare staff working with COVID-19 positive patients (PB/328 - INQ000116913). Local Negotiating Committee meetings took place with each trust during the period, attended by senior trust management and BMA representatives, to discuss local on-site issues.

Scotland

106. BMA Scotland had a good working relationship with the Scottish Government, Cabinet Secretary for Health and senior civil servants throughout the period in question, with regular telephone discussions, scheduled meetings and email exchanges between the BMA Scotland national director at the time and her team, and relevant officials and civil servants.

107. This included participation in a number of regular meetings with the **Scottish Government** including:

    a. Regular meetings with members of the Directorate for Community Health and Social Care in the Scottish Government. The BMA does not hold minutes of these meetings and, due to staff changes, has not been able to ascertain what was discussed at these meetings.

    b. Daily meetings of the Scottish Government's Workforce Senior Leadership Group. These reduced in frequency to two or three meetings a week between April and August 2020, and then moved to weekly or fortnightly following August 2020. Agenda items included: health and social care workforce capacity, death in service, practical support for staff, PPE guidance and availability, childcare, medical students, changing facilities, workforce planning, workforce gaps during COVID-19, the NHS Louisa Jordan hospital, recruitment, clinical prioritisation, vaccinations and COVID-19 testing.

    c. Weekly/fortnightly meetings of the Management Steering Group (MSG) between April 2020 and June 2020. The MSG is a joint body formed of the Scottish Government Health Directorate and NHS Scotland Employers, which existed prior to the pandemic. This group facilitated discussion between BMA Scotland and the Scottish Government, and covered matters including working patterns, renumeration, death in service and support for staff.

    d. Joint meetings between the Cabinet Secretary for Health, BMA Scotland and the RCN. Discussions included PPE concerns, interpretation of PPE guidance, modelling for opening the Louisa Jordan hospital, redeployment, and the recovery period from COVID-19.

    e. Participation in the Care Home Rapid Action Group. Set up in April 2020, this group was led by the Scottish Government's Directorate for Community Health

and Social Care. It discussed issues affecting care homes during the pandemic, including COVID-19 testing and infections, PPE, staffing, communications and visiting.

108. There was a clear and direct offer from the Cabinet Secretary, Jeane Freeman, to raise immediate problems directly with her office should BMA members become aware of any. This led to occasional meetings between the BMA Scotland chair of council and national director of BMA Scotland at the time with the Cabinet Secretary for Health, for example a meeting on 01 May 2020 which discussed NHS recovery, care homes and the latest BMA COVID-19 Tracker survey.

109. BMA Scotland also engaged with the Scottish Government between April - July 2020 in relation to shielding communications for patients and GP practices (PB/329 - INQ000117010, PB/330 - INQ000400391, PB/331 - INQ000117085, PB/332 - INQ000400414, PB/556 - INQ000400415, PB/333 - INQ000117184).

110. BMA Scotland raised key issues of concern with the Scottish Government via email, including in relation to PPE, risk assessments and winter respiratory guidance (PB/063 - INQ000117069, PB/334 - INQ000117062, PB/335 - INQ000117063 , PB/336 - INQ000117058, PB/337 - INQ000400395, PB/338 - INQ000116990, PB/339 - INQ000400458, PB/340 - INQ000400463, PB/341 - INQ000400469, PB/542 - INQ000400470, PB/342 - INQ000117309). BMA Scotland also shared the BMA's COVID-19 Tracker survey results with the Scottish Government via email in April 2020 and May 2020 (PB/343 - INQ000117023, PB/344 - INQ000400408, PB/540 - INQ000400409).

111. On occasion, communications staff from BMA Scotland met with communications staff from the Scottish Government on an informal basis. This provided staff from BMA Scotland with an opportunity to highlight key issues, for example related to PPE, and to be kept informed about timings of upcoming Government announcements and briefings.

112. There was very little one-to-one engagement between BMA Scotland and the **CMO for Scotland** up until August 2021, and only intermittent engagement from then on. Key topics that were discussed when meetings did happen were around NHS recovery and PPE. BMA Scotland also communicated in writing with the CMO for Scotland via letter and email, including in relation to patient management in care homes (24 April 2020), ethical guidance (27 April 2020), PPE (07 April 2020, 13 January 2021) and doctors' appraisals (15 January 2021) (PB/345 - INQ000400402, PB/346 – INQ000400403)

PB/272 - INQ000117891, PB/343 - INQ000117023, PB/347 - INQ000400446, PB/348 - INQ000400448).

113. To the best of my knowledge, BMA Scotland did not have any direct communication with **Public Health Scotland** that was specific to the pandemic response, although it is likely that Public Health Scotland would have attended some of the same wider meetings as BMA Scotland.

114. The Chief Executive of NHS Scotland is simultaneously the Scottish Government's Director General of Health, and therefore there is a significant degree of overlap in communications to **NHS Scotland** and the Scottish Government through the channels outlined above. Similarly, NHS employers were part of the Workforce Senior Leadership Group and Management Steering Group (MSG) mentioned in paragraph 107.

Wales

115. BMA Cymru Wales maintains ongoing, working relationships with relevant ministers and Welsh Government officials, and this was also the case throughout the period 01 March 2020 to 28 June 2022.

116. BMA Cymru Wales participated in a number of ministerial groups, as well as specific individual meetings with the Minister for Health and Social Services to express member views on the Welsh Government response to the pandemic. Where appropriate, BMA Cymru Wales council/committee chairs wrote to the Minister in relation to specific topics. Engagement with the **ministers and Welsh Government officials** included:

    a. **Partnership forums**: The NHS Wales Partnership Forum[35], a well-established forum in which the BMA participates, and which continued during the pandemic. It is a tripartite group sponsored by the Welsh Government with representatives from the recognised healthcare trade unions for NHS Wales, senior management for NHS Wales and the Welsh Government. The main purpose is the development, support and delivery of workforce policies at a national, regional and local level. The GP Forum - which also continued during the pandemic - is a similar body for primary care which brings together the BMA General Practitioners Committee Wales, Welsh Government primary care officials and Health Board representatives.

[35] More information about the Welsh Partnership Forum can be found here: https://www.nhsconfed.org/wales/nhs-wales-employers/welshpartnership-forum

b. BMA staff also attended weekly formal meetings of the **NHS workforce planning cell** where the BMA, other Partnership Forum trade unions, NHS Employers Wales representatives and Welsh Government officials were present. Essential information was shared at these meetings and operational decisions were made.

c. **Technical briefings**: Welsh Government officials often led the regularly held technical briefings for information sharing with trade unions and the third sector, which took place between April 2020 and February 2021. These technical briefings were an opportunity to ask the Welsh Government questions and focused on regular topics, in particular testing and PPE, and, occasionally, risk assessments for NHS staff.

d. **Meetings**: On occasion, the Chair of the BMA's Welsh Council met with the Minister for Health and Social Services to raise specific concerns. This included: a meeting on 17 September 2020 to discuss PPE supplies, flexibility of contract changes in a second wave, the COVID-19 vaccination rollout and plans for non-COVID care; on 17 June 2021 a meeting to discuss the recovery plan; and on 09 December 2021 a meeting to raise concerns about the need for respiratory protective equipment (RPE) for healthcare workers. Discussion between the Minister for Health and Social Services and elected members of BMA Cymru Wales led to the Welsh Government agreeing to protect staff terms and conditions and issuing of an advisory notice regarding payment for additional hours.

e. **Email and telephone contact between staff**: BMA Cymru Wales, primarily via staff rather than elected members, maintained routine contact with Welsh Government civil servants and officials via emails and telephone calls as a means of communication between the Welsh Government and BMA membership.

f. **Written communications with Ministers**: Letters were sent to the Minister for Health and Social Services, for example on the topics of death in service cover for all healthcare workers (22 April 2020); COVID-19 testing (08 July 2020); the Pfizer vaccination rollout (08 January 2021); PPE (23 February 2021, 23 December 2021); and healthcare capacity (19 March 2021) (PB/349 –

INQ000400396, PB/350 - INQ000118581, PB/ 351 - INQ000118674, PB/352 - INQ000118686, PB/053 - INQ000118727, PB/353 - INQ000118690).

g. Letters were also sent to other Welsh Government Ministers and officials, for example on the topics of changes to healthcare delivery in primary care (19 March 2020, 24 March 2020); COVID-19 testing (16 April 2020, 04 December 2020); contracts, flexibility and support offered to medical students (24 April 2020, 22 May 2020); risk assessments (28 April 2020); staff mental health (05 November 2020); and PPE (22 January 2021) (PB/354 - INQ000400362, PB/355 - INQ000400367, PB/356 - INQ000118538, PB/357 - INQ000118653, PB/358 - INQ000400401, PB/359 - INQ000400407, PB/360 - INQ000118541, PB/361 - INQ000118647, PB/362 - INQ000118679).

117. BMA Cymru Wales engaged with the **CMO and DCMO (Deputy Chief Medical Officer)** for Wales intermittently throughout the period and in a number of ways. Primarily, letters were exchanged outlining member views on responses to the pandemic. These include the topics of pulse oximetry (06 July 2020); healthcare capacity and delivery (10 August 2020, 19 March 2021); and the vaccination rollout (08 January 2021) (PB/363 - INQ000118578, PB/364 - INQ000118597, PB/365 - INQ000118600, PB/366 - INQ000118689, M2B/PB/109 - INQ000118672). There were also occasional direct meetings (e.g. with the CMO on 10 August 2020 and with the DCMO on 25 March 2020 and 14 December 2021), participation in wider meetings (e.g. alongside the Academy of Medical Royal Colleges in Wales), and invitations to the CMO to address BMA committees directly (e.g. the CMO attended the Welsh Public Health Medicine Committee in October 2021). Government officials established regular technical briefings for trade unions and other representative bodies on topics such as testing and PPE (mentioned at paragraph 116c above), and the Deputy CMO would on occasion address these briefings directly.

118. BMA Cymru Wales sent a letter to **Public Health Wales** on 22 May 2020 requesting a process for Public Health Wales to directly upload COVID-19 test results into GP records in order for them to answer patient queries (PB/368 - INQ000118550). Apart from this letter, BMA Cymru Wales did not have any other communication with Public Health Wales that was specific to the pandemic response. The two organisations did however continue their routine interaction on employment and terms and conditions matters through the Public Health Wales Joint Medical and Dental Negotiating Committee.

119. BMA Cymru Wales had various engagement with NHS Wales. The former Chief Executive of NHS Wales, Andrew Goodall, was simultaneously the Welsh Government's Director General for Health and Social Services. Therefore, there is a significant degree of overlap at the executive leadership level between **NHS Wales** and Welsh Government.

    a. Engagement with the CEO and Deputy CEO of NHS Wales: BMA Cymru Wales sent letters to Andrew Goodall, the Chief Executive of NHS Wales, about the recovery of health services (02 July 2020, 19 March 2021), and to raise concerns that some Health Boards were asking GPs to re-refer patients at a later date instead of maintaining a list of referred patients (23 March 2020) (PB/369 - INQ000118574, PB/370 - INQ000118688, PB/371 - INQ000400365). A number of meetings also took place with Simon Dean, Deputy CEO of NHS Wales, with topics discussed including PPE, testing, COVID-19 infections, backlogs, winter plans for healthcare delivery, the vaccination rollout, staff wellbeing and the easing of restrictions. These meetings took place on 05 June 2020 (with Andrew Goodall also in attendance), 30 September 2020, 24 November 2020, 05 March 2021 and 20 July 2021.

    b. Joint Oversight Meetings: Joint Oversight Meetings were regular (usually quarterly) meetings between the NHS Wales Director General and the chairs of the BMA branch of practice committees of which I was chair of the consultants committee in Wales at that time. Officials and the Deputy CMO for Wales were often present at these meetings. Topics included COVID-19 infections, testing, risk assessments, PPE, the vaccination programme, rotas, shielding healthcare workers, occupational health provision and NHS estates.

120. On occasion BMA Cymru Wales communicated with **Health Boards and Trusts** as employers. This includes a letter to all Health Boards on 07 April 2020 about PPE and risk assessments, and a letter on 12 January 2021 about the vaccination rollout and access to PPE (PB/372 - INQ000118537, PB/373 - INQ000400507).

D. Guidance issued by governments in the UK

121. Other sections of this statement set out the BMA's views on the following guidance issued by governments during the pandemic:

a. shielding advice for healthcare staff (see section J)

b. Infection Prevention and Control (IPC) guidance (see section G)

c. discharge from hospital guidance (see section I)

d. Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) guidance (see section H).

122. To the best of my knowledge the BMA did not take a formal view on guidance relating to hospital admission criteria, escalation of care policies or COVID-19 treatment protocols. This was largely clinical guidance which would be more within the remit of the Royal Colleges. That being said, BMA Cymru Wales sent a letter to the Welsh CMO on 06 July 2020 raising concerns about the practicalities of using pulse oximetry to identify deteriorating COVID-19 patients in primary care (PB/363 - INQ000118578) and received a response on 16 July 2020 (PB/364 - INQ000118597).

123. This section therefore focuses on one key issue on which the BMA believes there was a failure to issue guidance, emergency triage guidance.

There was a failure to issue guidance on decision making when demand outstripped already limited resources

124. No government guidance or prioritisation protocols were issued setting out the criteria and policies for determining which patients would be admitted into intensive care units within hospitals or be treated with specific interventions, such as mechanical ventilation, in the event that demand outstripped already limited resources or services were overwhelmed. The BMA considers this a key failure, given that the lack of capacity in the health service pre-pandemic was largely due to many years of underinvestment by the government.

125. Circumstances in which demand outstrips supply raise serious ethical and professional challenges and give rise to the potential for moral injury among those doctors responsible for making final decisions on care escalation, as well as wider concerns about the potential for discrimination in the application of criteria.

126. As the pandemic intensified, the BMA was aware of discussion on social media, between medical bodies such as Royal Colleges and some of the BMA's members, about the need to develop and issue guidance urgently to enable healthcare workers to be properly prepared and supported when making decisions about how to allocate limited resources. This was considered by the BMA to be important even if it never

needed to be utilised. A lack of guidance in circumstances of extreme uncertainty created anxiety amongst doctors and other healthcare professionals.

127. The BMA raised the urgent need for clinical staff to have guidance on decision making, triage and resource allocation in the event that resources became overwhelmed through the Moral and Ethics Advisory Group (MEAG) set up by DHSC. The Chair of the BMA's Medical Ethics Committee also emphasised the importance of pan-professional guidance being issued urgently and the principles that should underpin it in an email to Stephen Powis, NHS Medical Director on 23 March 2020 (PB/582 - INQ000117789). The BMA staff member who attended MEAG strongly emphasised the need for such guidance at these meetings and the issue was discussed by the group. Pan-profession guidance was commissioned by the four UK CMOs, and a small group that included Jonathan Montgomery, a member of MEAG, were tasked with producing draft guidance. At this stage, the BMA shared the draft guidance being developed by the BMA with the Chair of MEAG. Draft guidance was produced by the group and was discussed at a MEAG meeting on 25 March 2020 (PB/374 - INQ000117794). The minutes of the meeting (PB/225 - INQ000117797) show that MEAG members attending the meeting raised a number of concerns about the draft guidance which covered a range of issues including the impact on patients (including in relation to how religious and cultural sensitivities would be considered), how the guidance would work in practice in relation to issues such as withdrawing treatment already started if a patient who could benefit more from the treatment was admitted or whether beds could be held open for more serious cases. Members also flagged issues around the potential legal implications for healthcare workers, the need to show decisions were based on evidence not on an individual healthcare workers' views and ensuring that age was not used as an isolated indicator of 'wellbeing'. Other issues included the status of the guidance and whether it was mandatory, and issues around promotion and communication and ensuring the guidance aligned with other guidance being published. Professor Jonathan Montgomery responded to these concerns by stating that the guidance was formulated using some pre-existing ethical principles established by the Committee on Ethical Aspects of Pandemic Influenza (CEAPI), that it would need to be put in practice very soon but that it would be a living document that could be updated in response to changing circumstances and to ensure that those who received care are those who will benefit most from it. However, by 30 March 2020 the UK Government decided not to issue this

guidance in order to avoid raising public anxiety unnecessarily as they felt that resources would not be exhausted (PB/125 - INQ000117806).

128. The BMA is not able to confirm whether the need for a threshold for admission to intensive care or use of scarce intensive treatments ever arose during the pandemic in any part of the United Kingdom. DHSC and NHS England and equivalent bodies in the devolved nations would be better placed to provide specific data or responses to this question. However, as set out in section H below, the BMA is aware of shortages of important equipment and supplies during the pandemic, including oxygen, which was important in the treatment of COVID-19 patients. Doctors told the BMA that the need to ration oxygen impacted on the care they could provide to patients. Decisions about who received oxygen is a decision that would have been made easier with clear central government guidance. The Inquiry has also heard evidence in earlier modules from a range of witnesses about how close the NHS came to being completely overwhelmed in the early weeks and months of the pandemic.

129. As a result of the UK Government's decision not to issue guidance or any protocols for prioritising care, the BMA issued its own guidance for the profession (PB/143 - INQ000117773) and a set of Frequently Asked Questions (PB/144 - INQ000433852 and PB/145 - INQ000117787), as did a number of other organisations. However, having multiple sets of guidance, instead of a central source, created the risk of different interpretations and a lack of clarity for staff.

130. A summary of the BMA issued ethical guidance is as follows. It covers three main areas:

    a. **Decisions about resource allocation where demand outweighs resource availability:** The guidance outlined examples of the difficult moral and ethical decisions doctors may need to make, such as withholding treatment that would have been otherwise received outside of a pandemic. Such difficult decisions, where there is radically reduced capacity, would be lawful and ethical provided that appropriate prioritisation policies were followed under an ethical framework. All decisions concerning resource allocation must be:

        - Reasonable in the circumstances
        - Based on the best available clinical data and opinion
        - Based on coherent ethical principles and reasoning

- Agreed on in advance where practicable, while recognising that decisions may need to be rapidly revised in changing circumstances
- Consistent between different professionals as far as possible
- Communicated openly and transparently
- Subject to modification and review as the situation develops.

b. **The threshold for admission to intensive care**: Where choices between individuals with equal need must be made, an egalitarian approach should be taken. Based on the 'capacity to benefit quickly' principle, some of the most unwell patients may be denied access to ICU or intensive treatments. Despite the indirect discrimination this may give rise to, the guidance states that this would be lawful under the Equalities Act during a serious pandemic. The guidance also considers the need to maintain essential services by ensuring those employed within them are given some priority in order to get them back into the workforce, however this moves beyond the usual resource allocation system, and it would be for the government, to define the categories of workers and the tests to be applied in these circumstances. This is not the responsibility of doctors.

c. **Management of risk to health professionals***:* the BMA's view is that there are limits to the level of risk doctors can reasonably be expected to be exposed to. Employers have a legal and ethical responsibility to protect their staff, i.e. provision of appropriate protective equipment and risk assessments.

131. At the time, there was great concern amongst the medical profession that front line doctors would be called upon to make ethically and legally challenging decisions in the absence of robust guidance. Had workable central guidance been available, in the BMA's view, this would have gone a considerable way towards addressing doctors' legitimate concerns, including about personal or legal liability, would have helped manage moral distress and helped to build confidence among the profession during a time of unprecedented challenge. It would also have meant that all health professionals would have been following the same guidance. Having multiple sets of guidance, instead of a central source, created the risk of different interpretations and a lack of clarity for staff.

132. The implications of a lack of national guidance for healthcare workers was brought into sharp relief when, on 2 November 2020, the Prime Minister rightly warned that if the NHS became overwhelmed the UK could face a "medical and moral disaster" where doctors and nurses "could be forced to choose which patients to treat, who would live and who would die." This was followed by the chief medical officers of the UK issuing a joint statement on 4 January 2021 stating that there was a material risk of the NHS in some areas being overwhelmed within three weeks. This prompted the BMA, along with two of the largest medical defence unions and others, to write to the Secretary of State for Health on 14 January 2021 (PB/232 - INQ000097881) calling for emergency legislation to protect healthcare professionals who could find themselves at risk of inappropriate legal challenge when treating COVID-19 patients in a highly pressured and challenging environment without sufficient capacity or resources. This letter highlighted that there was no national guidance backed up by a statement of law on when life sustaining treatment can be lawfully withheld or withdrawn from a patient in order to benefit a different patient, and if so under what conditions.

133. Subsequently, the BMA published updated guidance in January 2022 (PB/375 – INQ000400494), to reflect the fact that although the context in respect of COVID-19 had changed, notably with the successful rollout of the vaccination programme, healthcare staff continued to be required to provide care in highly pressured circumstances in the face of resource constraints.

E. Staffing

134. The arrival of COVID-19 on UK shores had a significant impact on healthcare staff across the UK. Existing and long-term staffing shortages (set out in more detail in section B), were exacerbated as staff absences increased as a result of sickness and shielding, and redeployment caused disruption to healthcare delivery, with a substantial impact on patient care and staff wellbeing. At the same time unprecedented measures had to be taken to bring additional staff into the healthcare system including an unprecedented call for retired doctors and nurses to return to service, medical students joining the workforce early, and an increased use of volunteers. Though these measures ensured continuous care provision in certain high-need areas, it created large gaps elsewhere in the system.

135. The BMA identified several issues with the processes through which doctors were deployed or brought into the system, which were often complex and perceived by many doctors as overly bureaucratic. There were also significant issues around training and supervision for redeployed, new and returning staff. Details of these changes and their impact are set out in detail later in this section.

136. This section sets out the key impacts of the pandemic on staffing numbers and the ways in which staff were deployed during the pandemic; it highlights issues for specific groups of doctors including International Medical Graduates and retired doctors returning to work in the health services; and it describes the impact these staffing issues had on the continued delivery of care as well as the impact on doctors themselves, physically and mentally (although the broader impacts of the pandemic on staff health and wellbeing is covered in more detail in section F).

The COVID-19 pandemic exacerbated pre-existing staffing shortages

137. The pandemic exacerbated pre-existing staffing shortages due to a combination of factors, including increased absences amongst healthcare staff and disruption due to staff redeployment. For example:

    a. In England, the absence rate for NHS staff increased from 4.5% in February 2020 to 6.2% in April 2020, and remained relatively high during the entire relevant period.[36] Absence rates for NHS doctors specifically doubled between February and April 2020, increasing from 1.5% to 3%. In Wales, NHS sickness absence rates increased from 5.6% in February 2020 to 7.5% in April 2020.[37] The BMA is not aware of absence data over a comparable time period for Scotland as the data set is not broken down by month.[38] The BMA is not aware of publicly available absence data for Northern Ireland. After these initial peaks, absence rates fluctuated across the UK but remained relatively high compared to pre-pandemic months.

    b. The workforce was stretched in many places, as staff were redeployed to high-need services to help maintain service provision in critical and emergency care. Ultimately, around 14% of staff in the NHS in England had been redeployed to

[36] NHS Digital 'NHS Sickness Absence Rates' data

[37] Stats Wales 'NHS staff sickness absence, percentage absent by staff group and date' data

[38] NHS Education for Scotland TURAS `NHS Scotland workforce, sickness absence` data

alternative duties at some point by February 2021 (PB/376 - INQ000397304). Amongst doctors specifically, a 2020 GMC survey found that 15% of respondents in Northern Ireland had been redeployed outside their speciality; 27% of doctors in Wales; 21% of doctors in Scotland; and 25% of doctors in England (PB/559 - INQ000433873). This led to gaps elsewhere in the system, causing the build-up of backlogs in other areas, particularly in the provision of elective healthcare services.

c. The negative impact of the pandemic on staffing came through clearly in the BMA's member surveys. Two months into the pandemic, in April 2020, 22% of respondents to the BMA's UK-wide COVID-19 tracker survey said they had experienced pandemic-related staffing shortages *within the last week*.[39] Almost a year on, in our February 2021 COVID-19 tracker survey, 42% of respondents[40] had experienced issues with pandemic-related staffing shortages *within the last month.* Staffing shortages were so acute that they were selected as the main concern for the next few months by 66% of respondents to our October 2020 COVID-19 tracker survey.[41]

d. Staffing shortages were also frequently mentioned by members in our COVID-19 call for evidence. A consultant in England wrote: *'Staffing levels are now much patchier (every day is a staffing lottery)…We weren't keeping up with day-to-day demand before so there is no way we are going to encompass day to day demand as well as extra to get on top of the waiting lists when staffing is probably worse now than it was when the pandemic started.'* Another consultant in England wrote: *'I am going to keep saying this. Staffing. Get vacancies filled and stop lying about the numbers of those. Pay, leave, pensions etc are part of sorting that but what I needed most during the pandemic were the colleagues I was already missing.'*

[39] BMA Covid Tracker survey (UK wide), 30 April 2020. 14,296 respondents answered this question.

[40] BMA Covid Tracker survey (England, Northern Ireland and Wales), 08 February 2021. 6,972 respondents answered this question.

[41] BMA Covid Tracker survey (England, Northern Ireland and Wales), 22 October 2020. 7,152 respondents answered this question.

COVID-19 infections meant many staff were unable to work

138. Many doctors and other healthcare staff caught COVID-19 during the pandemic resulting in them having to take time off work. In a proportionately small but not insignificant number of cases (in their hundreds) these infections resulted in long COVID-19, leading to even longer and continuing sickness absences.

139. COVID-19 related illness alone caused a staggering 30.6% of recorded NHS staff absences in England in April 2020.[42] In Scotland, the number of NHS hospital and community staff absences related to COVID-19 was highest between April and June 2020, hitting over 10,000 COVID-19 related absences per day in early April 2020.[43] In Wales, the percentage of NHS staff absent due to COVID-19-related illness ranged between a peak of 2.5% during the week commencing 14 April 2020 and1.6% during the week commencing 26 May 2020.[44] The equivalent statistics could not be found for Northern Ireland.

140. These absences impacted already understaffed health services significantly. As a Junior Doctor from Wales, who responded to our COVID-19 call for evidence survey, wrote: *'[t]he hospital was not prepared for the amount of staff going off sick and couldn't fill the gaps'*.

141. Among those doctors and healthcare workers who developed long COVID, some were unable to work for very long periods of time; indeed, others have still been unable to return to work and lost their jobs as a consequence. In January 2023, the BMA undertook an in-depth survey of doctors experiencing post-acute health complications of COVID-19 ('long COVID') (PB/377 - INQ000373375). Around 60% of respondents reported that the post-acute effects of COVID-19 impacted their ability to carry out day-to-day activities on a regular basis. The impact of long COVID on doctors is set out in more detail in section F.

142. The BMA believes that more adequate protection of healthcare workers, for example through proper risk assessment and access to PPE, including Respiratory Protective Equipment, would have resulted in fewer absences due to COVID-19 infection. These issues are set out further in section G.

---

[42] NHS Digital 'NHS Sickness Absence Rates', May 2020

[43] Scottish Government 'Coronavirus (COVID-19): Trends in Daily Data'

[44] StatsWales `NHS staff absence and self-isolation rate, by staff group and date`

Repeated periods of self-isolation left many staff unable to come into work

143. In addition to acute COVID-19 infection necessitating the need to take time off work, many staff were also unable to attend work due to the need to isolate as a result of being in contact with an infected person, either someone they knew or because they were notified via the NHS app.

    a. In our COVID-19 tracker survey of April 2020, 66% of respondents said self-isolation had a slight (51%) or significant (15%) impact on staffing capacity and workload.[45]

    b. Similarly, respondents to our COVID-19 call for evidence survey wrote that *'[s]elf-isolation had a negative impact on already poor staffing levels'* (SAS doctor, Northern Ireland) and that *'[c]oping with the unpredictability of staff having to isolate has been challenging'* (Consultant, England). Another respondent described the challenge of *'regular episodes of staff being off to self-isolate each time a member of their family has any symptoms. In families with children, that's most weeks!'* (GP contractor/principal, Scotland).

144. When testing in health and care settings and the community became widely available, this reduced the number of staff having to self-isolate who may not have had COVID-19 or been experiencing symptoms. However, even then the need to self-isolate – while absolutely being the right thing to do to reduce the spread of the virus – continued to impact staffing levels, especially at points when tests were in short supply.

Clinically vulnerable staff had to shield and were unable to deliver face-to-face care

145. Doctors and other healthcare workers who were designated clinically extremely vulnerable (which meant that because of a pre-existing condition they were more likely to become seriously ill from COVID-19) were unable to provide face-to-face care and, in many cases, this affected their ability to work (see section J).

Redeployment resulted in increased staffing shortages in some areas

146. Redeployment placed additional pressures on staff who remained behind in areas of care which were not prioritised, particularly when redeployment lasted longer than anticipated. In our call for evidence, a junior doctor from England wrote: '*The trust's*

[45] BMA Covid Tracker survey (UK wide), 30 April 2020. 13,838 respondents answered this question.

entire weight was thrown into management of COVID-19 and a small fraction remained to treat everything else. We did not have capacity for non-COVID care'.

147. Respondents to our call for evidence told us that redeployment contributed to the backlog of care in some departments. For example, a consultant in England wrote: *'During the first surge the focus was on ICU and palliative care…staff were redeployed in a slightly haphazard way. Since then, we seem to have been playing catch up with increasing[ly] exhausted staff working flat out to deal with the backlog of patients with other illnesses. Radiology, endoscopy, surgery are now the overstretched and under-resourced areas.'* Similarly, a Junior Doctor in England wrote: '*My speciality is mainly outpatient based and work was greatly reduced so staff could be redeployed. We are still seeing the after effects of this decision […] growing frustration from patients about delays along with large backlogs*'.

Burnout and other mental health issues impacted staffing levels

148. Burnout and other mental health issues amongst doctors and healthcare staff caused or exacerbated by the pandemic also resulted in some doctors not being able to work.

149. In our February 2021 COVID-19 tracker survey, 32% of respondents[46] said they or direct clinical colleagues had been on sick leave due to mental health issues caused by working during the pandemic. Some respondents to our call for evidence also told us their mental health had prevented them from working. For example, a GP from England wrote: *'I am currently off work with stress and burnout - first time in my medical career of over 30+ years'.* Similarly, a GP from Wales wrote: *'I had to stop working as my mental health was so impacted. I have now resigned and feel I am unlikely to return'.*

150. The impact of the pandemic on doctors' mental health is outlined further in section F.

The pandemic impacted international recruitment

151. The NHS and social care services in the UK have always depended on international recruitment, with international staff playing a crucial role in keeping the UK's health services running and helping to fill staffing gaps since its creation. However, international medical recruitment faced difficulties during the pandemic due to the combined impact of pandemic-related travel restrictions and regulations resulting from the UK leaving the European Union coming into effect. These impacted people's ability to move to the UK,

[46] BMA Covid Tracker survey (England, Northern Ireland and Wales), 08 February 2021. 7,253 respondents answered this question.

reduced the overall attractiveness of the UK as a destination to be located since it changed the registration processes for doctors with non-UK qualifications (PB/378 - INQ000397282) and reduced international recruitment into the UK's health and care services, as discussed later in this section.

152. This impact can be seen in publicly available data, as well as in concerns raised by BMA members:

a. Data from the GMC reveals a sharp reduction from 2020 to 2021 in international medical graduates (IMGs) from outside the EEA joining the UK workforce (PB/379 - INQ000326298).

b. Research by the Nuffield Trust (PB/380 - INQ000397303) has shown that the rate of growth in EU and EFTA (European Free Trade Association) staff within four specialties with a relatively high proportion of European staff was below projected growth after the Brexit referendum.[47]

c. In addition to this, BMA members raised concerns about the impact of Brexit on medical recruitment through policy motions. For example, in 2020, a motion was passed at the BMA's ARM expressing concern 'that a further peak of COVID-19 infection may occur at the same time as the Brexit transition period ends' and that 'the NHS staffing shortage will be greatly exacerbated unless the problems of EU citizens' rights have been effectively resolved'.

d. Respondents to the BMA's COVID-19 call for evidence survey told us how COVID-19 travel restrictions impacted staff availability. For example, a consultant from Scotland wrote that they worked at *'a small rural hospital'* where *'all staff groups are supplemented by locum staff'*, and that *'[m]any of our locum staff come from other countries so travel restrictions hit us hard'*. The BMA is also aware of many IMG doctors who were unable to return to the UK and to their jobs as a result of travel restrictions. Furthermore, IMGs with relatives abroad were unable to visit them which caused distress.

<u>The vaccination programme was extremely successful, but impacted staff availability</u>

153. In addition to these points, and especially in general practice, members told us that their delivery of the extremely successful vaccination programme further reduced their already limited workforce capacity to provide routine care. This was a theme that

[47] The four specialties are anaesthetics, paediatrics, cardio-thoracic surgery and psychiatry.

emerged in our 2021 call for evidence survey. A GP from Northern Ireland wrote: '*We have been stretched so thin covering COVID centres and also delivering vaccine programmes[,] this has had a huge impact on our staff*' while a GP from Scotland wrote: '*Having to provide staff to go to the COVID vaccination centres has been very challenging*'.

COVID-19 testing was crucial, but likely affected the availability of staff

154. The BMA holds no data on the impact of the introduction of COVID-19 testing on the exact number of healthcare workers, including doctors, available to work during the relevant period.

155. However, the BMA did raise concerns on several occasions that a lack of testing availability for healthcare workers was impacting workforce capacity and placing additional strain on the health service. Examples include in the early weeks of the pandemic before testing was routinely available:

    a. A letter from the BMA chair of Council to the Prime Minister on 21 March 2020 in which the BMA raised concerns that healthcare workers and their households were not being prioritised for testing, with significant impacts on workforce capacity (PB/064 - INQ000097910).

    b. A letter to the Secretary of State for Health and Social Care on 26 March 2020 which again raised concerns about the impact of a lack of priority testing on workforce capacity, with staff eager to return to work but unable to do so because of a lack of testing (PB/007 - INQ000097941).

156. Shortages of tests continued at times, even once symptomatic testing for frontline staff was introduced at the end of April 2020. The BMA raised these on a number of occasions, including:

    a. A letter to the Secretary of State for Health on 09 September 2020 which highlighted recent experiences of doctors and patients being unable to book a test, being sent to testing sites long distances away, and facing difficulties and delays in accessing test results (PB/231 - INQ000118110).

    b. A letter to NHS England on 30 December 2021 which raised concerns about the limited availability of lateral flow devices which, combined with high rates of staff isolation, were impacting general practice capacity (PB/196 - INQ000097955).

157. The impact of the availability of testing on staffing levels will likely have varied at different stages of the pandemic. For example:

a. Staff were not able to test all patients with relevant symptoms early in the pandemic, when tests were restricted to patients returning to the UK from certain countries (e.g. China or Italy). Whether the overall impact of this was a reduction in the number of staff is difficult to know. On the one hand, the lack of regular testing will have meant that fewer infections would have been picked up (especially mild or asymptomatic ones), meaning some infected staff may have remained in work. On the other hand, increased viral spread due to lack of testing would have resulted in higher infection levels and thus staff absences.

b. Early in the pandemic there were widespread challenges with accessing tests, with reports of people having to travel miles across the country to access a test. The BMA believes that better testing availability could have enabled staff who had been in contact with an infected person but had no symptoms to return to work following a negative PCR test. For example, on 22 April 2020, the BMA issued a press release calling for testing sites in all major towns to enable tens of thousands of healthcare staff to return to work, following analysis by the BMA that around 100,000 healthcare workers and family members could be self-isolating (PB/381 - INQ000397242).

c. When tests started to become more widely available and asymptomatic testing of staff and patients was rolled out, it is possible that this – in the first instance – negatively impacted staffing numbers, as asymptomatic infections would have been picked up (which would not have been picked up when only symptomatic staff were tested) requiring staff to self-isolate. However, staff who tested positive but were otherwise well, were in some circumstances able to continue to deliver care remotely (although this was dependent on having IT equipment and infrastructure that facilitated this, which, as highlighted in section B, was hampered by the pre-existing limitations with IT infrastructure in health services). However, this regular testing was crucial for protecting staff and patients and is something the BMA called strongly for. In the longer term, more widespread testing is also likely to have reduced staff absence by reducing the spread of the virus.

158. The net impact of all of these effects (picking up more cases, reducing infections and enabling the earlier leaving of isolation) is, however, very difficult to measure, and the BMA has not attempted to do so.

Some areas may have suffered particular shortages of doctors

159. The BMA holds no specific evidence regarding areas with particular shortages of doctors during the pandemic and suggests this may be an area that the Inquiry focuses on with NHS Employers and/or NHS England and equivalent health bodies in Wales, Scotland and Northern Ireland.

160. That being said, the BMA is aware of areas which historically suffer from doctor shortages and suggests that in most cases pandemic pressures will likely have exacerbated these pre-existing shortages.

    a. Rural areas traditionally struggle more to recruit doctors (PB/382 - INQ000397318).

    b. Smaller GP practices inherently had lower resilience.

    c. Certain specialties struggle more to fill vacancies, such as emergency medicine, psychiatry, general practice, paediatrics, geriatric medicine, and radiology (PB/383 - INQ000397265). However anecdotal feedback from members suggests that redeployment may have improved historic staffing shortages in emergency medicine, at least during the first wave of the pandemic – when staff were not expected to deliver COVID-19 and non-COVID-19 care simultaneously. For example, a trainee doctor from England wrote in our call for evidence: *'Initially working in A&E we were very well staffed due to emergency rota and increased medical staff. Since then [working elsewhere] staffing has been woefully inadequate to cope with workload, most noticeably in primary care'*.

    d. It is also worth noting that the pattern of virus transmission will likely have impacted staffing shortages (e.g. staff absences will likely have followed the waves of infection of different variants). For example, the Omicron variant started in the South-East of England, in Kent, (and will at that time have increased staff absences in that area) before spreading to other parts of the UK (and increasing staff absences there).

Low staffing levels impacted on the capacity of health services to treat patients

161. The pressures of the pandemic itself, including pressures caused by increased staffing shortages (as set out earlier in this section), further impacted the capacity of health systems, which were already under strain before the pandemic, to treat patients.

162. This is clear from what members told the BMA. For example:

    a. In our COVID-19 tracker survey from October 2020, 39% of respondents[48] said direct clinical colleagues had been absent due to illness or self-isolation, either reporting a moderate (25%) or significant (14%) impact on patient care. Of those reporting an impact on patient care[49], 49% reported that self-isolation and sick leave due to COVID-19 had reduced the number of patients who could be seen, and 40% reported it had resulted in cancelled appointments.

    b. In our COVID-19 tracker survey from December 2020, 75% of respondents[50] said that staffing shortages had resulted in either a significantly reduced (30%) or somewhat reduced (45%) ability to see and treat patients in a timely and efficient way.

    c. This issue was also reflected in qualitative responses to our 2021 COVID-19 call for evidence. For example:

        - A consultant in England wrote that consultants were *'spread too thinly'* and that *'[d]emand far exceeds capacity'*.
        - A consultant in Scotland wrote that their *'organisation managed only by restricting routine care and diverting resources'* and that *'there was no spare capacity to deal with COVID'*.
        - A GP from England said that *'We are constantly trying to think of ways to improve access and reduce burnout amongst staff but every new idea seems to just involve rearranging of the same imbalance of demand and supply […] we never know if staff are going to be off self*

[48] BMA Covid Tracker survey (England, Wales and Northern Ireland), 22 October 2020. 7,423 respondents answered this question.

[49] BMA Covid Tracker survey (England, Wales and Northern Ireland), 22 October 2020. There were 3,220 respondents who reported an impact on patient care.

[50] BMA Covid Tracker survey (England, Wales and Northern Ireland), 17 December 2020. 5,878 respondents answered this question.

isolating or ill with covid and, approaching the winter, this seems likely to just get worse.'

- A consultant in England wrote that *'We have wards and theatres empty because we don't have enough nursing teams to staff them.'*

163. The BMA raised concerns about the impact of the pandemic on the capacity of health systems to treat patients in numerous ways including in its report *'In the balance: Ten principles for how the NHS should approach restarting 'non-Covid care''*, which it shared with the SoS and NHS England in letters on 22 May 2020 (PB/384 - INQ000397312, PB/280 - INQ000097923, PB/301 - INQ000097922). It raised similar concerns in its *'Rest, Recover, Restore'* report, which it shared via letters to the SoS, NHS England, Welsh Health Minister, NHS Wales, and the CMO for Wales on 19 March 2021 (PB/156 - INQ000118308, PB/281 - INQ000400355, PB/301 - INQ000097922, PB/353 - INQ000118690, PB/366 - INQ000118689, PB/370 - INQ000118688). These concerns were also highlighted in a letter to the SoS on 05 July 2021 (PB/009 - INQ000097852).

Low staffing levels impacted on the quality of care provided

164. Staffing shortages also took their toll on the quality of care provided. These shortages were a significant contributing factor to the extent that care reprioritisation was needed, which affected not just capacity to care, but also the quality of care. This comes out clearly in the research the BMA did with its members and the feedback we received from them.

    a. In the BMA's COVID-19 tracker survey of 30 April 2020, over half (56%) of respondents[51] said prioritisation of COVID-19 patients was slightly (26%) or significantly (30%) worsening the care available to other patients.

    b. In the BMA's COVID-19 call for evidence survey (2021), respondents described being unable to deliver the standard of care they would have liked, linking this to low staffing levels. For example:

        - A salaried GP in Wales wrote that *'due to low staffing levels, the workload is excessive and at times feels unsafe and clinically risky'*.

        - A junior doctor in Scotland wrote that their hospital was *'severely understaffed to cope with clinical demand […] damaging patient care'*.

[51] BMA Covid Tracker survey (UK wide), 30 April 2020. 13,846 respondents answered this question.

- A GP Trainee in England wrote that *'so many staff have left'* and *'none of us can provide the level of care that we should, or that we would want for our own family members and friends'.*
- A GP in England described *'Feeling helpless when unable to help when knowing what the patient needs but cannot get'.*
- The BMA raised these concerns in its June 2021 report on moral distress and moral injury (PB/385 - INQ000397269), which highlighted the impact of resource constraints on the quality of patient care and the substantial rise in doctors feeling moral distress in connection to this during the pandemic.

Low staffing levels impacted the physical and mental wellbeing of healthcare staff

165. Finally, but crucially, staff shortages took their toll on the physical and mental wellbeing of healthcare workers, including doctors. Delivering care amid persistent staff shortages fosters an environment of chronic stress, normalising excessive workloads by continuously requiring overstretched staff to fill gaps to keep services running.

166. As a result, doctors often reported feeling overworked, exhausted, and left with no option but to take on an ever-increasing workload, go off sick, or quit:

    a. Calls to the BMA's wellbeing services regarding work-related demands increased by 150% between 2019 and 2021, and calls regarding work-related stress increased by 63%.

    b. In our 2021 COVID-19 call for evidence, respondents told us how staffing shortages were contributing to exhaustion and burnout. For example:

        - A consultant in England wrote that emergency medicine had been *'severely hampered by staff sickness*'; and that *'[w]ith the workload now higher than at any time on record we are drowning […] staff are having to work harder and for longer. It is breaking people'.*
        - A GP trainee in England wrote that *'[o]nce doctors started going off ill and having to isolate, there were not enough doctors to fill all the shifts, so other doctors (and nurses) were having to work even more extra shifts just to keep the rota at a safe level, which meant many of them burnt out and became exhausted very early on'.*

- *'I'm just so tired'*, wrote one salaried GP in England, *'Work is unrelenting - especially now staff levels are so low. I'm constantly asked to work on my days off but I don't have the energy'*.

c. In this context, it is not surprising that 59% of respondents[52] to the BMA's October 2020 COVID-19 tracker survey said their level of fatigue or exhaustion from working or studying was higher than before the pandemic.

167. The BMA regularly raised concerns about the pandemic's impact on the wellbeing of staff. For example:

a. **We raised our concerns in meetings with key government officials:**

- In **England**, in a meeting with Helen Whately (27 March 2020) and in letters sent to the SoS (05 July 2021), DHSC ministers (08 October 2020), NHS England (02 August 2021) and the Chancellor of the Exchequer (25 February 2021). Concerns specifically related to an increase in violence and abuse against staff were raised in letters to the SoS on 18 May 2021, 09 September 2021 and 21 September 2021 (PB/071 - INQ000117802, PB/009 - INQ000097852, PB/386 – INQ000097859, PB/233 - INQ000097867, PB/387 - INQ000097938, PB/388 - INQ000097897, PB/234 - INQ000097914, PB/304 – INQ000400339).
- In **Northern Ireland**, staff wellbeing was a topic discussed at meetings with the Minister for Health, in HR Engagement Forum meetings and in the bi-monthly phone calls with the Director of Workforce Policy at the Department of Health Northern Ireland (see paragraph 101).
- Similarly, in **Scotland**, staff wellbeing was discussed within meetings of the Management Steering Group (see paragraph 107c).
- In **Wales**, staff wellbeing was raised at meetings with Simon Dean, Deputy Chief Executive of NHS Wales, and in letters to Eluned Morgan on 05 November 2020, in her role as Minister for Mental Health and Wellbeing, and 13 May 2021, in her role as Health Minister (PB/361 -

[52] BMA Covid Tracker survey (England, Northern Ireland and Wales), 22 October 2020. 7,467 respondents answered this question

INQ000118647, PB/389 - INQ000118705) (see paragraphs 116g, 119.a and 122).

b. **We published a number of external reports:**

- On 20 May 2020, the BMA published *The mental health and wellbeing of the medical workforce – now and beyond Covid-19.* This sets out ten recommendations for a long-term strategy to protect the mental health consequences of the pandemic on the NHS workforce (PB/390 - INQ000397335).
- On 21 May 2020, the BMA published *In the balance: Ten principles for how the NHS should approach restarting 'non-Covid care*. This report called for measures to safeguard staff wellbeing, including being able to take time off, being supported to work flexibly, and the continuation of staff wellbeing support initiatives. The BMA shared this report with the SoS and NHS England directly (PB/384 - INQ000397312, PB/280 - INQ000097923, PB/301 - INQ000097922).
- In March 2021, the BMA published its *Rest, recover, restore* report, highlighting that 'the pressures of delivering care during a pandemic have not only compounded the existing wellbeing crisis but added further trauma and fatigue to daily working life', and called 'for a realistic approach to restoring non-COVID care'. The BMA shared this report with the SoS, NHS England and the Chair of the Health and Social Care Select Committee directly (PB/156 - INQ000118308, PB/281 - INQ000400355, PB/302 - INQ000400354, PB/391 - INQ000400353).
- In June 2021, the BMA conducted a survey and published a report setting out the moral distress and moral injury experienced by doctors during the pandemic, as they often were unable to provide the high level of care they wanted and were expected to because of institutional and resource constraints (PB/385 - INQ000397269).

c. **Through Select Committee evidence:** The BMA also provided evidence to the House of Lords Select Committee in June 2020 and the Health and Social Care Select Committee in August 2020 (PB/041 - INQ000118011, PB/392 - INQ000400423). In this evidence, the BMA highlighted the proportion of doctors

suffering with poor mental health relating to their work and made recommendations for change.

d. **Through media interventions:** The BMA issued various press releases drawing attention to the impact of the pandemic on NHS staff and health services. For example, on 18 December 2021 the BMA became so concerned about staff absences in light of the rapidly spreading Delta variant of COVID-19 that we issued a press release warning the public to take a cautious approach to social mixing in the lead up to, and over, the Christmas period. This was on the back of the BMA's own modelling which suggested that the NHS in England could face almost 50,000 staff off sick with COVID-19 by Christmas Day. The BMA shared this press release with DHSC directly via email and discussed these concerns with the CMO for England on 21 December 2021 (PB/052 - INQ000118448, PB/393 - INQ000400465, PB/576 - INQ000118449).

Some of this impact could have been avoided

168. Had the UK entered the pandemic with a better resourced healthcare system to start with, as well as established methods for rapidly increasing staffing levels (e.g. through an established reserve) and better protecting healthcare workers (e.g. through adequate PPE provision) the impact on the UK's health systems' capacity to care, the quality of care delivered, and the impact on staff's physical and mental wellbeing, would not have been as severe.

169. This point was made by some respondents to our 2021 COVID-19 Review call for evidence. For example, a consultant in England wrote:

> '*We were not well resourced. Nowhere was - it's why the waiting lists have skyrocketed. If we were adequately resourced, we would have been able to carry on normal work in addition to COVID. Within emergency medicine (where I work) we have been severely hampered by staff sickness. Our staffing levels are inadequate at the best of times and any sickness causes a problem. With the workload now higher than at any time on record we are drowning'.*

Pre-pandemic staff shortages meant schemes to increase the number of registered medical practitioners were essential, but they were not without challenges

170. Given the significant staffing challenges the UK's healthcare systems faced when the pandemic hit, the BMA believes it was vital to increase the workforce through the

measures that were taken, including recruiting and re-registering retired or non-practising doctors to the NHS/HSC workforce, early provisional registration of final year medical students and early full registration of foundation year one doctors.

171. 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 to qualified medical practitioners who were not currently registered with the GMC or were registered but did not hold a current licence to practise medicine. In 2020, 34,446 doctors were added to the GMC register temporarily in response to the pandemic. Following temporary registration, approximately 6,500 chose to remove themselves from the register, leaving approximately 28,000 added temporarily as of May 2020.

172. There were different schemes across the UK to utilise the doctors who had been added to the GMC register. Scotland, Wales and Northern Ireland predominantly used existing returner programmes and ran campaigns to boost returner recruitment.

    a. In **Scotland**, returners initially contacted their local health boards to offer their services, and 2,000 former health and social care staff signed up within the first two days of recruitment through the Health and Social Care COVID-19 Accelerated Recruitment Portal, which was created to streamline recruitment and to give a national picture of the skills mix on offer.

    b. In **Wales**, the Welsh Government produced national guidance for returners. A report by the GMC stated that there were 1,123 doctors in Wales with temporary registration as of November 2020 (PB/394 - INQ000397296).

    c. In **Northern Ireland** the HSC Workforce Appeal was announced, which led to 3,323 clinical applications, including 123 doctors volunteering to return to the service from retirement or from previously leaving the health system.

173. In **England**, the Bringing Back Staff programme recruited almost 5,000 doctors, nurses, midwives and other health professionals into employment in the NHS by April 2020 (PB/395 - INQ000397322). Returning doctors' roles varied and included ad hoc deployment to assist with pandemic management, support to meet operational need (e.g. as part of NHS 111) and later in the pandemic, assisting the vaccination programme.

174. The BMA had raised concerns about how the returners scheme would be implemented in England but did not make any specific representations to governments or publicly with respect to those schemes in Scotland, Northern Ireland, and Wales. On 12 March 2020, prior to the launch of the scheme in England, the BMA wrote to the Chair of the Health and Social Care Select Committee (PB/396 - INQ000400343) to raise concerns that the Government had not provided clarity on a number of issues including: GMC registration; scope of practice; indemnity; death in service benefits; impact on pensions; and how doctors would be trained and integrated back into work. At this stage it was also unclear on what terms and conditions retired doctors would return. It was later communicated that they would return to the contract they were on when they retired.

175. A month later NHS England reached out to the BMA in April 2020 seeking input on a guide for trusts about where returning doctors could be deployed. BMA staff and elected members contributed to the guide, which was produced by NHS England, Health Education England and NHS Employers. Our comments focused on the type and setting of work retired doctors would return to (e.g. frontline vs non-patient facing roles and full-time vs part time work) as well as the need to risk stratify the returner workforce looking at age, gender and ethnicity (PB/397 - INQ000400393, PB/595 - INQ000400394, PB/398 - INQ000400397). The BMA does not hold information relating to the exact publication date of this guidance.

176. By the end of 2021, doctors wishing to return to service in England were encouraged to volunteer to help with the vaccination effort, whether administering jabs or assisting in consenting patients for vaccination. This followed advice from NHS England given to the BMA in an email communication to a BMA staff member (PB/400 - INQ000400471) and communicated to retired members in an email from the chair of the Retired Members Committee.

177. In early 2022, NHS England then advised the BMA by email (PB/400 - INQ000400471) that retired doctors wishing to return should register with the soon-to-be-announced reservist programme where they could take up roles that did not require GMC registration such as assisting at vaccination centres or working as a ward clerk.

178. During 2021 and 2022 BMA staff liaised with NHS England to explore ways retired doctors could support the health service based on feedback from members that many were finding the process of returning to clinical work an administrative challenge. Discussions took place via email and informal virtual meetings. Based on these

discussions, the BMA produced guidance for retired members wishing to return to the health service (PB/401 - INQ000400517) and later how to enrol in the NHS England reservist scheme which was established in England to centrally coordinate efforts (PB/402 - INQ000397258).

179. The BMA also co-signed a letter with the RCGP to GP returners signposting to guidance from our respective organisations to support returners (PB/403 - INQ000400514).

<u>There were issues with the processes for recruiting and re-registering retired or non-practicing doctors to the NHS/HSC workforce</u>

180. Despite being widely advertised and receiving widespread media attention and interest, the returners programmes were not well-utilised. In Northern Ireland the HSC Workforce Appeal was criticised in 2021, as data eventually showed that only 16% of those who applied were appointed. In England there was also a low level of deployment of returners (PB/404 - INQ000371171). This was due to a variety of reasons set out in more detail below. Most of these were issues across the UK, albeit some were more specific to England as it created a whole new returners programme during the pandemic. The BMA raised these issues with NHS England in informal meetings between staff and the National Medical Director for Clinical Effectiveness. NHS England were generally receptive to our concerns and equally wanted to see better uptake by doctors.

181. The BMA does not hold specific data on whether, or to what extent, this cohort of returning doctors mitigated any shortage of doctors. In reality, many of these staff will have helped increase capacity, albeit within the limitations set out below. It is unlikely, however, given the numbers that the returners programmes managed to deploy, that this fully compensated for historic understaffing of health services and the changes to staffing levels as a result the pandemic described earlier in this section.

182. One reason why the returners programme was less successful was the fact that older retired doctors were at an increased risk of serious illness from COVID-19 infection. The BMA raised concerns about these doctors being deployed to high-risk areas and how they would be protected (i.e. ensuring they had adequate PPE/RPE) (PB/066 - INQ000117840). Due to being at higher risk because of their age, many retired doctors were unable (due to risk factors and/or comorbidities) or unwilling (due to concerns about the risk to their health and safety) to return to frontline roles, which of course reduced the number of available returners and limited the type of work they could

perform. Some will also have had caring responsibilities which would have limited the type and amount of work they could undertake. In the draft NHS England guide (referenced above in paragraph 175), doctors over 65 years of age returning to work were advised not to return to frontline roles (remote only). The BMA asked NHS England to consider lowering the age threshold based on emerging evidence of higher risk for those in the 50-59 age group at the time.

183. Another reason was frustration with the process and how long it was taking. The BMA received feedback at the time from members eager to return to help the NHS at a time of great crisis but frustrated with how long the process was taking. Some felt that processes for returning were cumbersome, including the requirement to undertake mandatory compliance training that was not essential to ensure patient safety and the use of digital platforms to upload employment documentation (some retired doctors did not have access to the digital tools necessary to do this). The BMA called for changes to the former in its *Weathering the Storm* report (PB/158 - INQ000118442). For GPs, the process of returning was especially onerous as they required registration on the Performer's List, on top of GMC temporary emergency registration. In our 2021 UK-wide COVID-19 call for evidence survey, respondents mentioned challenges relating to the speed, complexity, or bureaucracy of this process. For example, a retired doctor in Scotland who volunteered to return as a GP wrote that they were *'disappointed in the re-registration process which was over complicated and cumbersome'* and withdrew their offer to volunteer as a result. Another doctor in England commented that it was "*[w]oefully slow to deploy returning doctors in any roles*".

184. There were also issues finding suitable roles despite many returners being willing and able to return to work. This issue was highly localised depending on demand for returners in local areas and in individual hospitals. For example, in some areas, the redeployment programme for existing staff meant some hospitals were simply unable to find suitable roles for returners (albeit redeployment of course impacted care delivery in the areas those being redeployed came from). For GP returners, there were also capacity constraints in general practice which meant that there was limited time to onboard and train returners. This issue had come to our attention through informal feedback from retired members who wanted to return but faced barriers in doing so locally. This appeared to be more of an issue in England for the reasons stated previously (e.g. the novelty of the scheme). We cannot say with any certainty whether

there were specific local fluctuations in the utilisation of returners across the devolved nations.

185. Given that the England programme was new, it was not surprising that there were some problems with implementation of processes and protocols. NHS England had reported in at least one national Social Partnership Forum meeting that an initial wave of returners created delays as HR departments had issues processing them in a timely manner (and doing necessary checks, such as safeguarding checks).

186. Ultimately, highly qualified and experienced doctors were not utilised as effectively as they could have been. Had the NHS been better prepared, with existing processes for returning, vetting and matching large numbers of staff to areas of need, this would likely have helped ameliorate the impact of historical understaffing to some extent and may have meant more non-COVID-19 care could have continued alongside the response to the acute pandemic. In June 2021, members of the BMA's Retired Members Committee endorsed calls for an investigation into the flawed re-registration and recruitment processes faced by many retired doctors (PB/405 - INQ000397283).

<u>There were further challenges integrating non-practising doctors and in ensuring adequate supervision and training of re-registered medical practitioners</u>

187. For retired doctors returning to practice, many challenges presented, especially early in the pandemic. These included not only ensuring that their clinical competencies and skills were up to date to ensure safe working, but also the fact that proper inductions were not always offered, and training and supervision were sometimes inadequate.

188. In December 2020, the BMA surveyed retired members (PB/560 - INQ000433874) in all four UK nations (however, there were no responses from retired members in Wales) to ascertain how many had returned to practice and what their experience had been. This was an internal BMA survey undertaken to get a better understanding of member concerns and the results have not been published. The survey was only of those retired doctors who had notified the BMA that they had returned to work in the pandemic and is therefore likely to be smaller than the total number of retired doctors within the membership who returned to work during the pandemic. The findings[53] presented a mixed picture in terms of how doctors returning to practice had found the process.

[53] The findings are based on a relatively small sample size of 93 members who responded to the survey, from 228 members that had notified the BMA they had returned to work during the pandemic; a response rate of 41%.

a. While most reported they had received adequate training and satisfactory guidance and support (especially from their employer and the GMC), some still reported problems (especially with guidance received from NHS or public health organisations coordinating their deployment).

b. On training, while most respondents had received training relevant to their role, less than half (49%) said they had received training for specific adaptation to the role or specialty they had been slotted into and only 52% had received a formal induction. Free text responses highlighted unmet training needs or poor training related to deployments to NHS111 and the Covid Clinical Assessment Service (CCAS)[54], including that online training did not include content appropriate for returning doctors leading to some feeling insufficiently connected to their new role/organisation.

c. Overall, the responses demonstrated a high degree of variability across settings in how doctors returning to practice were supported.

<u>There were issues with the redeployment of medical practitioners to different areas and specialisms</u>

189. To support the provision of acute COVID-19 care, large scale programmes of redeployment were initiated across UK healthcare settings. Staff were rapidly moved into high-need services such as emergency departments, intensive and respiratory care.

190. For many doctors, redeployment was a really stressful, difficult period in their working lives, where annual leave and other forms of respite were cancelled to help keep services going for the long, grinding early months of the pandemic. Many staff were also shifted onto different and more onerous rotas, in order to cover gaps brought about by redeployed colleagues or ill and isolating staff. Redeployment placed additional pressures on staff who remained behind in their usual work areas, particularly when redeployment lasted longer than anticipated.

191. These changes had a significant negative impact on the wellbeing and working lives of doctors, both physically and psychologically. As some respondents to our 2021 COVID-19 Review call for evidence noted, experiences of redeployment contributed to

[54] The COVID-19 Clinical Assessment Service (CCAS) was an emergency service accessed via the NHS 111 service to provide a remote, clinical review of patients with COVID-19 symptoms and direct them to the most appropriate care for their needs.

higher staff burnout and resignation (see section F for more on the impact on BMA members).

192. Doctors held understandable fears about working in high-risk, high pressure, demanding environments. They were concerned not just about their own health, but also about potential future liabilities in relation to choices made in such environments, where they felt less confident working in a different service or felt they were not given adequate training or supervision. As a consultant from Scotland wrote: *'out of area working was awful-stressful-had no idea what I was doing a lot of the time and no evidence base to back up decisions that I made. The first 5 months were awful'.*

193. There were also issues with the process for redeploying staff to new care settings to support the COVID-19 response.

    a. **Lack of notice of being redeployed:** There was variation in how redeployment arrangements were managed locally, even within the same trust. For example, in a letter to NHS England on 14 December 2020 (PB/295 - INQ000400348) the BMA shared reports it had received from junior doctors who were redeployed to the Exeter Nightingale hospital in England without notice or consultation and informed only the day before. However, consultants being redeployed to Exeter Nightingale hospital were given weeks of notice of the proposed redeployment, including their proposed pattern of work.

    b. **Pressure to be redeployed:** The BMA received reports from members who felt pressured into redeployment or were led to believe they had no option but to agree to being redeployed, despite the voluntary nature of redeployment programmes.

    c. **Pressure to agree to different terms and conditions:** At a regional and local level in England, redeployed staff were being asked to sign Memoranda of Understanding (MOUs). The BMA had concerns that these MOUs would trump national terms and conditions and worked with NHS England to clarify that this was not the case in national guidance. This was not the case in Wales.

    d. **Lack of adequate induction or training:** Like many returners, many redeployed staff had to start their deployment without adequate induction or training. Our UK-wide COVID-19 tracker survey in April 2020 found that of respondents who had been redeployed, 33% had not been provided with an induction into the new role and 32% had not been provided with training related to the new role.

e. **Administrative burdens:** Redeployment came with an administrative burden for staff who had to repeatedly provide documentation to host employers including background checks and occupational health reports. To ease this burden, NHS England developed a digital staff passport for England. The BMA was actively engaged with NHS England via the Social Partnership Forum's Workforce Issues Group in the digital staff passport's development.

194. Redeployment also had particular impacts on specific groups of staff:

a. **Junior doctors:** Redeployment had a particular impact on the supervision and training of trainee doctors and medical students. GMC data shows that 30% of junior doctors had been redeployed within their specialty and 40% outside of their specialty entirely (PB/559 - INQ000433873). This impacted training opportunities with some respondents to our 2021 COVID-19 call for evidence survey noting that they missed out on placement opportunities altogether due to redeployment, leaving them unable to train for their desired specialty. The BMA highlighted the issue of lost training and delayed progression of junior doctors in its *Rest, Recover, Restore* report and called for solutions to remedy this (PB/156 - INQ000118308). The BMA's *Weathering the Storm* report called for training to be protected wherever possible, particularly for trainees who have already had their progression impaired by the impacts of the pandemic (PB/158 - INQ000118442).

b. **Those more at risk of serious illness from a COVID-19 infection:** The BMA also raised concerns about the risks of redeploying staff who were at greater risk of serious illness from a COVID-19 infection, particularly ethnic minority and older staff, to high-risk roles. This concern arose primarily from growing concerns at the time over the emerging evidence of the disproportionate impact on older and ethnic minority staff. This concern was raised in letters to NHS England on 09 April and 28 April 2020 and in the BMA's submission to the PHE review in May 2020 (PB/072 - INQ000097864, PB/079 - INQ000117943).

195. While the BMA was supportive of the redeployment programme, the BMA had concerns about the logistical and psychological impacts of redeployment on staff, particularly where reasonable requests were not made and notice not communicated. To support members, the BMA produced its own detailed guidance published on 24 April 2020 on the redeployment of doctors, covering issues including giving consent to being

redeployed, training, terms and conditions, raising concerns and wellbeing (PB/406 - INQ000397261). In addition to this the BMA:

a. Wrote to Professor Steven Powis in December 2020 seeking clarification on the process for redeploying staff and raising a number of the concerns mentioned above (PB/295 - INQ000400348).

b. Provided comments on NHS England's *Enabling Staff Movement toolkit* in December 2020 where we highlighted concerns and requested clarification on issues including contractual arrangements, pay, indemnity, and consultation with staff ahead of redeployment.

c. Issued a statement on 24 November 2021 about junior doctor rostering during the pandemic, which outlined the principles that employers should adhere to when adapting working arrangements in response to COVID-19 cases in order not to compromise staff and patient health, safety and wellbeing (PB/407 - INQ000397273).

Issues with early provisional registration of final year medical students and early full registration of foundation year 1 doctors to help staffing levels

196. It is to the credit of medical students that many volunteered immediately to help in any way they could with frontline care at the start of the pandemic. To further maximise the number of doctors working on the frontline to support the COVID-19 response, the UK Government granted powers to medical schools to graduate final year medical students early if they had met the competencies required to become a doctor. The GMC subsequently provisionally registered any final year medical students who applied, subject to their medical school confirming that they had graduated and had no fitness to practice considerations.

197. The GMC also accelerated full registration for Foundation Year 1 doctors to help combat COVID-19.

198. Overall, the GMC brought forward provisional registration for almost 7,000 UK medical school graduates, and ultimately 4,662 FY1 posts were filled between April and July 2020. GMC surveying found that 63% of FY1 posts were working on inpatient medical wards, and 27% on inpatient surgical wards.

199. Throughout the period, the BMA was clear that any medical student involvement must be based on that individual's own decision and whole cohorts of students should not be

conscripted without their consent. The BMA wrote to the chair of the Health and Social Care Select Committee on 12 March 2020 (PB/396 - INQ000400343) about this and other issues with medical students being drafted in to support medical colleagues as set out below:

a. **Training and supervision:** Medical students reported interruptions to their training, and some reported failing their exams or even wanting to leave the medical profession because of their lack of access to training and education. The BMA's second COVID-19 report sets out in more detail the impact on medical students from early commencement of work in the UK's health services, which was substantial and often negative.

b. **Contractual issues:** There was variation in how medical students were being contracted to work in health services with some being offered employment contracts and some being encouraged to volunteer their time. Local contracts with highly variable pay and terms and conditions were being offered. The BMA wrote to NHS Employers (PB/314 - INQ000400364) raising concerns about local contracts and remuneration for medical students who took up employment in the NHS. To support students entering the workforce, the BMA sought to develop a framework contract for medical students (which was ultimately not agreed with NHS Employers in England) and published guidance on our website (PB/408 - INQ000397260) which was later updated (PB/566 - INQ000442334). In Wales, BMA Cymru Wales raised concerns with the Welsh Government about the process for ensuring medical students could support the workforce and as a result reached an agreement on a suitable contract. However, BMA Cymru Wales continued to raise concerns about the lack of flexibility in the hours offered to students (PB/358 - INQ000400401).

c. **Acting outside of competence:** The BMA was concerned about medical students being asked to act outside of their competence and we were clear that any student taking up work in the health service early would require additional supervision. As stated above, to prevent this, the BMA issued guidance for medical students stating that it is essential that they must not be asked to work beyond their competencies and always be adequately supervised where supervision is required. The guidance also stated that, in line with GMC guidance, medical students may be able to help carry out duties that do not require registration (such as working as healthcare assistants). The BMA also

wrote to the Medical Schools Council on 19 March 2020 (PB/409 - INQ000400363) raising concerns about medical students stepping into roles where they may be acting beyond their competency and to request that communication to students about local contracts be halted until the BMA was able to develop a framework contract for these specific roles. As stated above, a framework contract was ultimately not agreed with NHS Employers. While we received a number of subsequent reports of medical students being placed on inadequate or incorrect contracts, we are not aware of any significant issues having been raised with regard to medical students working outside of their competency.

International Medical Graduates were especially impacted by the pandemic

200. The pandemic had an impact on international medical graduates (IMGs) working in UK health systems, as well as on international students.

Number of IMGs working in UK health services

201. The BMA does not hold data on the number of IMGs working within the NHS/HSC during the relevant period or on the roles that they were working in. The headline data, publicly available from the GMC, is summarised below:

    a. There were 95,733 IMGs registered in the UK in 2020, 104,384 in 2021, and 112,007 in 2022. It is worth noting however, that while being registered with the GMC is a precondition to working in the UK it does not necessarily equate to having a licence to practice (which is linked to revalidation which occurs every five years) or to working within the health service.[55] So the actual number of doctors working during the relevant period may have been lower.

    b. The other publicly available information concerns the number of IMGs on the emergency register. Between 2020 and 2022, over one in five doctors on the emergency register were IMGs (20.3% in 2020, 20.7% in 2021, and 21.7% in 2022).[56]

[55] Data extracted from the GMC Data Explorer on 19/07/2023. Available at: https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report. Includes all registration types (full, temporary, and provisional registration).

[56] Percentages obtained by dividing the number of IMGs in Emergency Medicine (Primary Specialty Group) by the total number of doctors registered under this group. Data obtained from GMC Data Explorer on 19/07/2023. Available at: https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report.

Process for bringing IMGs into UK health services

202. International doctors are required to undertake an English language test (IELTS or OET[57]) as well as a PLAB (Professional and Linguistic Assessments Board) test before they can obtain full GMC registration and license to practice in the UK (PB/410 - INQ000397341).

203. The BMA identified significant disruptions for IMGs trying to take the PLAB exam during the pandemic. Delays and cancellations of both the PLAB and English language tests due to the pandemic resulted in delays to international doctors being able to register with the GMC.

204. The BMA was aware that over 220 overseas doctors on visitors' visas had come to the UK to complete their PLAB test but were unable to take their tests at the scheduled time due to cancellations. As a result, they risked overstaying their visa, which incurred a risk of future UK visa applications being affected. The BMA sent a joint letter, signed by several other organisations, to the Home Secretary to raise this issue (PB/411 - INQ000400479).

205. Following lobbying by the BMA, new guidance was issued in August 2020 by UK Visas and Immigration which meant doctors whose visa or leave to remain had been due to expire between 24 January and 31 July 2020 were given further time to complete their PLAB assessments (PB/412 - INQ000397295).

Impact of the pandemic on the physical and mental wellbeing and retention levels of IMGs

206. The pandemic had a significant impact on the physical and mental wellbeing of IMGs working in the UK, as well as international students studying here, during the relevant period. For example:

    a. Being unable to visit families abroad meant a usual source of comfort was taken away for many. Qualitative data from our 2021 COVID-19 call for evidence survey showed that an acute sense of isolation was felt among IMGs and international students. As one medical academic trainee wrote (who was unable to see their family abroad for two years as IMGs were forced to include quarantine time in annual leave or go unpaid), being unable to visit *'affected morale really bad'*.

[57] IELTS stands for International English Language Testing System and OET for Occupational English Test.

b. Many IMGs are also from ethnic minority backgrounds, and therefore, experienced the same disproportionate impact as other minority ethnic doctors during the relevant period. Doctors from minority ethnic backgrounds often reported feeling more exposed in the workplace reporting ineffective risk assessments, less access to PPE and/or being asked to work in higher risk areas compared to their White counterparts, while at the same time feeling less able to raise concerns. It is also worth noting that IMGs are often employed on non-nationally agreed, local contracts, which can exacerbate these challenges. The BMA raised the disproportionate impact of the virus on people from ethnic minority backgrounds early on during the pandemic and was instrumental in securing PHE's review into the disproportionate impact of the pandemic on ethnic minority groups.

c. For IMGs who fell ill during the pandemic, there was a high degree of uncertainty about their future which impacted their mental wellbeing. This included:

    i. uncertainty about the continuation of their employment and thus their right to remain in the UK; and

    ii. what would happen to their family and dependants should they die. The BMA successfully lobbied the Home Office to give indefinite leave to remain to the dependants of international doctors who died while working in the NHS during the COVID-19 pandemic (PB/413 - INQ000397297).

207. The impact of the pandemic on international recruitment of doctors is covered in earlier in this section.

<u>The BMA called for visas to be extended for IMGs</u>

208. On 13 October 2020, the BMA co-signed a letter with the RCN and Unison to the Home Secretary calling on her to renew the visa extension granted for healthcare workers between 31 March and 1 October 2020 (PB/414 - INQ000400426).

<u>The BMA called for and subsequently supported the removal of the NHS Surcharge</u>

209. The BMA has called for the NHS Surcharge to be scrapped for all healthcare workers since the fee was first introduced in 2015. We reiterated those calls during the pandemic, when asking international healthcare staff who were risking their lives to look after patients in the UK to pay the charge became increasingly unfair. We welcomed the UK

Government's announcement in May 2020 that the charge would be removed for healthcare workers.

210. The BMA has not monitored the impact of removing the NHS Surcharge, however we believe that lifting the surcharge sent a positive signal to IMGs about their value and worth.

F. The impact of the pandemic on the BMA's members

211. The pandemic had a severe and long-lasting impact on the BMA's members. They became sick with COVID-19, with some acquiring long COVID, as a result of working in high-risk services without proper protection. Some tragically lost their lives and many lost loved ones, friends, and colleagues. Their mental health was impacted with many suffering from psychological trauma. They experienced moral distress and moral injury when they felt they were unable to provide the quality of care they wanted to provide. Many had their careers, education, training, and livelihoods impacted. In the course of providing care, some doctors became victims of violence and abuse from frustrated patients as they sought to keep their patients and themselves safe, and as the media and government officials laid blame at the feet of doctors when the implementation of safety measures impacted access to health services.

212. Doctors from ethnic minority backgrounds were disproportionately impacted by the pandemic. Many were fearful of speaking up. IMG doctors were unable to visit family abroad, worried what would happen to their employment if they fell ill or to their dependents if they died. Doctors very quickly became aware of the potential risks to their own lives, with some taking out additional life insurance or updating their wills. As one consultant described in our COVID-19 call for evidence: "*As headlines of health worker deaths came through and the ethnic risk factors and age made me look at my department and wonder which of us may not be here. Every colleague of mine extended their life insurance*".

213. More detail on the impact of the pandemic can be found in the BMA's second COVID-19 review report (PB/014 - INQ000118475) which examines the impact of the pandemic on the medical workforce.

Disproportionate impact on ethnic minority communities, including healthcare staff

214. The pandemic had a large disproportionate impact on staff from ethnic minority backgrounds (who were more likely to become severely ill from the virus or die from it) and the BMA was one of the first organisations who called for an investigation into this disproportionate impact. These concerns were raised with the SoS, PHE, the Equalities Minister, NHS England, the CMO for England and NHS Trusts. While it is difficult to pinpoint precisely when and how the BMA became aware of this issue, on 9 April 2020, Dr Chaand Nagpaul, then chair of UK Council, called on NHS England chief executive Sir Simon Stevens to investigate the disproportionate effect of COVID-19 on people from BAME backgrounds, including IMGs (see section E above on the impact of the pandemic on IMGs) referencing that the British Association of Physicians of Indian Origin had previously raised this concern with NHS England and highlighting data from a recently published Intensive Care National Audit and Research Centre report which found that 35% of people who were critically ill with COVID-19 were from BAME backgrounds (PB/072 - INQ000097864). The BMA received a reply to its letter to the Equalities Minister on 07 August 2020 (PB/415 - INQ000118063). As outlined in section C above, the BMA actively engaged with PHE's review undertaken in May 2020 and was strongly critical of the report when it was published as it did not set out clear recommendations for immediate action and there were reports that a large number of pages and recommendations had been removed.

The mental health and wellbeing of doctors was severely impacted

215. The BMA monitored the mental health and wellbeing of doctors during the relevant period through various mechanisms, which highlighted the significant and negative impact the pandemic had on doctors' mental health and wellbeing:

    a. **Regular surveys** of its members between 06 April 2020 and 08 April 2022 in the form of COVID-19 Tracker surveys and Viewpoint surveys. Approximately half of these surveys were UK-wide, while the remainder covered either England, Wales and Northern Ireland, or only England and Wales. These surveys included questions across a wide variety of topics and frequently included questions on the health and wellbeing impact on doctors working during the pandemic. These showed a significant downward trend in the mental health of doctors, for example:

i. Two months into the pandemic, in our COVID-19 tracker survey of 30 April 2020, 29% of respondents said their mental health[58] was worse than before the pandemic.

ii. The impact on staff mental health worsened as the pandemic progressed. In April 2021, one year into the pandemic, half of the respondents to our COVID-19 tracker survey said their mental health suffered because of their work or study.

iii. By November 2021, the percentage of respondents suffering from a work or study-related mental health condition had grown to 64%.

b. The **BMA's wellbeing services**. The services' logs show that calls to the BMA's counselling services increased by over a third (37%) in the first year of the pandemic. Between 2019 and 2021, there was a 343% increase in calls regarding anxiety, a 95% increase in calls regarding depression, and a 46% increase in calls regarding low mood.

c. The **BMA's 2021 COVID-19 Review call for evidence**. The call for evidence showed that many doctors suffered from anxiety and/or depression during the pandemic, and in some cases, this was exacerbated by worries over making mistakes when redeployed and being held liable for decisions made in extremely difficult circumstances, often in new environments and with limited resources. Poor mental health was also compounded by feelings of isolation, with a locum junior doctor in England describing how they *"lost [their] personal support network"* and *"cried a lot"*. The results from this survey relevant to this part of the rule 9 request are summarised in the second COVID-19 review report, *The impact of the pandemic on the medical profession* (PB/014 - INQ000118475).

216. These sources also highlighted inequalities in the impact of the pandemic on the mental health of medical professionals. For example, the BMA COVID-19 tracker survey of 26 November 2021 showed that a decline in good mental health was more common in female respondents (56%) relative to male respondents (46%) out of 4,361 respondents overall. Worse mental health was also reported as more common in

[58] This includes depression, anxiety, stress, burnout, emotional distress or other mental health condition relating to or made worse by work. This survey was UK wide and the question was answered by 13,792 respondents.

respondents with a disability or long-term condition (69%) than those without (48%). These unequal impacts are summarised in the BMA's second COVID-19 review report.

The BMA provided a range of support services to support its members during the pandemic

217. The BMA provided a variety of support services to members and non-members during the relevant period. These were:

    a. **Wellbeing services**, with free confidential counselling and peer support available to all doctors and medical students (including non-members). In addition to this we were able to extend our existing telephone/video counselling offering to also include the provision of face-to-face counselling to doctors and medical students in the UK over a 12-month period from the end of April 2021 due to being awarded a grant by the COVID-19 Healthcare Support Appeal (CHSA).

    b. **'First Point of Contact' (FPC) service**, providing individualised employment support and advice for members. This service continued during the pandemic but with extended opening hours to provide access to this support later into the evening and at weekends. As part of this extended offer members could call the hotline between the hours of 8pm and 8am to receive emergency advice when PPE was not available. FPC would then flag this with the relevant BMA Industrial Relations Officer who in turn would raise it with the relevant trust as soon as possible afterwards.

    c. The BMA partnered with John Lewis to provide **care packages** to frontline healthcare workers working in hospitals in England – the first tranche of these were delivered in April 2020 and the scheme was repeated again in early 2021 (PB/416 - INQ000397257, PB/417 – INQ000397309). These boxes included essentials to support frontline workers, such as snacks, socks or shaving foam, as well as guidance from the BMA and details about our wellbeing services. BMA offices in Scotland, Wales and Northern Ireland provided their own, similar, care packages known as BMA Care Boxes, which were initially distributed and replenished by BMA staff or elected members.

    d. The BMA provided a range of **guidance** to BMA members (see also section D above), which was regularly reviewed and updated as necessary, including guidance on risk assessments, refusing to treat if PPE was inadequate, guidance

for shielding staff, doctors isolating and those in vulnerable groups, supporting wellbeing, COVID-19 terms and conditions, redeployment, early deployment of medical students, retired doctors returning to work, remote working and rationing/triage (PB/061 - INQ000355841, PB/143 - INQ000117773, PB/297 - INQ000400495, PB/300 - INQ000400515, PB/401 - INQ000400517, PB/402 - INQ000397258, PB/406 - INQ000397261, PB/407 - INQ000397273, PB/408 - INQ000397260, PB/060 - INQ000117990, PB/098 - INQ000117758, PB/420 - INQ000117206, PB/421 - INQ000118051, PB/422 - INQ000400373, PB/423 - INQ000397259).

e. We also **lobbied for key changes** to support our members. These ranged from the NHS surcharge mentioned above to areas such as death in service benefits for relatives of staff dying in the course of duty. Without our intervention and the creation of these Coronavirus Life Assurance schemes (further detail later in this section), staff not part of the NHS pension scheme - such as students joining the service early - would not have seen any payments to their relatives.

f. We also made changes to **how we communicated with members**. We doubled the frequency of our members' newsletters, ensured regular engagement with them through social media and launched a BMA COVID app to ensure members had faster access to the latest BMA guidance and information.

g. The BMA also continued to provide **its other regular services** for members throughout the relevant period, including advice related to immigration, ethics, equality and diversity, and specialist HR and employment law advice for GP partners.

h. The BMA also supported a range of projects through its charitable arm, **BMA Giving**:

    i. In 2020, the charitable arm of the Association, BMA Giving, distributed over £350,000 to charities for projects to support the health and wellbeing of doctors, medical students and patients during the pandemic. Through these grants, the BMA supported the successful charities on a wide range of projects, including: support for doctors experiencing financial hardship; initiatives to support mental health and wellbeing; and projects to mitigate the effect of the pandemic on health and care workers from Black, Asian and minority ethnic

backgrounds. The BMA Giving grants have funded specific projects, including:

i. Partnering with Child Bereavement UK to provide webinars and online resources to support doctors' wellbeing whilst working with loss and bereavement.

ii. Working with Mind to produce guidance for NHS managers to help those working on the frontline with their mental health including a webinar, where 92% of attendees rated it as very or extremely useful.

iii. Assisting the Royal Medical Benevolent Fund to support doctors, medical students and their families who needed financial assistance because of the impact of COVID-19.

iv. Working alongside Melanin Medics to deliver 'Mind Us', an initiative to support the mental wellbeing of Black African and Caribbean medical students and doctors who have been adversely affected by COVID-19.

v. Connecting Olly's Future, a suicide prevention charity, to our membership so that medical students had a better understanding of their own, their peers and their patients' mental health.

i. In 2021, the BMA Giving committee distributed £175,000 to charities who share our mission – we look after doctors, so they can look after you. The BMA supported charities which offered help to a wide range of doctors, medical students and patients from all backgrounds. As well as donating to UK-registered charities, BMA Giving also provided a total of £25,000 in financial support to organisations supporting doctors in India following the deadly surge in COVID-19 infections in the country in early 2021.

Additional support was provided by Government and NHS/HSC bodies to staff

UK wide schemes

218. Alongside support from the BMA, there was wider support provided by UK governments to healthcare staff, including the BMA's members. I have provided a headline summary of those that the BMA was aware of.

a. **Coronavirus life assurance schemes:** On 27 April 2020 the UK Government announced a new life assurance scheme which would be open to all frontline NHS and social care staff (including students and returning doctors who had previously retired) on their death from COVID-19 if they had contracted the virus in the course of their duties. The Government stated that this was in recognition of the increased risk faced by NHS and social care staff during the pandemic. This scheme included a one-off payment to the deceased's family and was in addition to payments linked to the NHS pension scheme death in service benefits (for those that were part of the pension scheme). Funding was also made available to the devolved nations to establish such schemes. There were however differences between these schemes. For example, England, Wales, and Northern Ireland required COVID-19 to be 'wholly or mainly' the cause of death, and covered deaths occurring until 31 March 2022 in England and Northern Ireland, and 30 June 2022 in Wales. The scheme in Scotland included deaths where COVID-19 was 'a factor' on the death certificate or the death was 'at least partially attributable' to COVID-19 and, like Wales, covered deaths occurring up until 30 June 2022. The BMA had lobbied strongly for the provision of death in service benefits for all doctors and medical students risking their lives in the UK's health services (see for example PB/274 - INQ000400370) and was pleased when the scheme was eventually announced, giving those putting their lives on the line on the frontline at least some assurance in case they died while treating others.

b. **Special COVID-19 Leave:** The government announced special provisions for COVID-19-related sickness and self-isolation whereby staff would receive full pay, self-isolation would not be counted as sickness absence and COVID-19 related sickness would not count towards sickness absence triggers. These were vital provisions for staff who would otherwise have been forced into an incredibly difficult position of compromising patient safety by returning to work. However, COVID-19 special leave provisions have now ended in all four UK nations, something the BMA raised in letters to the SoS on 06 July and 26 August 2022 (PB/424 - INQ000400516, PB/425 - INQ000400512), and this continues to have significant adverse consequences, particularly for healthcare staff with long COVID (further detail below).

c. **Free car parking** was offered for NHS staff in England and Northern Ireland from March 2020. Charges were reinstated in Northern Ireland in September 2021 and in England in April 2022. In England, staff working night shifts and staff with a shift starting after 19:30 and finishing before 08:00 still receive free car parking, as do disabled employees. In May 2022, a Private Members Bill in Northern Ireland to prohibit parking charges at health and social care trusts received royal assent but does not come into effect until May 2024. In comparison, Scotland and Wales offered free car parking at most sites prior to the pandemic, with charges temporarily suspended at the small number of sites in Scotland that were not already free. The BMA wrote to Edward Argar MP on 09 July 2020 to urge the UK Government to support the continued provision of free parking for NHS staff in England (PB/426 - INQ000400491). In Northern Ireland, BMA Northern Ireland responded to the call for evidence for the Hospital Parking Charges Bill, supporting the removal of parking charges in health and social care trusts there. In addition to these national programmes, individual employers may have had their own programmes in place. The BMA holds no information on these schemes, and suggests that NHS Employers, NHS England or the health bodies in Scotland, Wales and Northern Ireland may be able to provide additional information.

219. The level of support individual doctors ultimately received for their mental, as well as physical, health was determined by awareness of national programmes, as well as local implementation of these programmes, government advice and guidance, and the actions taken or not taken by local employing organisations, departments and/or managers. We were aware from members that a high degree of variation existed across the UK which meant that some BMA members were not able to access certain types of support (see below).

NHS England wellbeing support offer

220. NHS England launched a health and wellbeing support offer for all NHS staff during the pandemic which included, among other interventions, a helpline, access to wellbeing hubs, free access to mental wellbeing apps, and support and training for managers.

221. The NHS People Plan (England) was also published following the first wave of the pandemic in July 2020, and built on innovations and support made available at the start of the pandemic. The plan had been in development prior to the start of the pandemic

and the BMA was closely involved in its development via the National People Plan Advisory Group. The plan contained many of the BMA's key priorities for the workforce, although we had concerns about the lack of detailed implementation plans (including funding) and how the plans ambitions would result in real, meaningful change for staff. Furthermore, it is worth noting that funding for some of the support in the plan (such as wellbeing hubs) has been significantly reduced, despite the fact that staff still suffered from exhaustion, poor mental health and wellbeing in the aftermath of the pandemic.

Health and wellbeing initiatives in Wales, Scotland and Northern Ireland

222. In **Wales,** with trade union support, NHS Wales and Health Education and Improvement Wales offered NHS staff access to a free confidential psychological and mental health support service, an online course to help manage stress, anxiety and depression, and staff were also able to access the Samaritans support helpline (available to staff in both England and Wales). The BMA wrote to the Welsh health and social care minister, Eluned Morgan, in May 2021 urging additional support for staff who were working through the pandemic (PB/389 - INQ000118705). The letter cites the experiences of members suffering from depression, anxiety, stress, burnout, emotional distress or other mental health conditions, as well as those whose level of health and wellbeing was either the same or worse than during the first wave of the pandemic. Several health boards in Wales offered additional psychological `safe spaces` staffed by redeployed clinical psychology teams during the first wave, which were withdrawn when such teams were required back on frontline duties.

223. In **Scotland**, NHS Education for Scotland offered online support resources and the NHS Recovery Plan published in August 2021 announced an increase of £3 million a year for enhanced wellbeing support. The BMA in Scotland published several reports and briefings highlighting the need for better support for doctor wellbeing, including the report *Supporting junior doctor wellbeing – now and for the future* (October 2021) and a briefing for a Scottish Government debate on healthcare system recovery (June 2021) (PB/427 - INQ000397274, PB/428 - INQ000400497).

224. In **Northern Ireland** the HSC published *Supporting the Well-being Needs of our Health and Social Care Staff during COVID-19: A Framework for Leaders and Managers* in April 2020. The HSC Public Health Agency provided guidance and online resources for individuals and managers to look after health and wellbeing, as well as access to psychological helplines.

The BMA raised a number of issues with the support provided by employers and governments to its members during the pandemic

225. The BMA called for additional support for doctors and healthcare workers in a number of areas affecting staff physical and mental health, raising these issues through direct engagement with government as well as through publications and media statements.

Calling for additional support for staff mental health and wellbeing

226. Large numbers of doctors were suffering from depression, anxiety, stress, burnout or other mental health conditions relating to or made worse by the COVID-19 crisis. The harrowing circumstances many witnessed, the fear for their own life and that of their loved ones should they bring the virus home, the extreme pressure and challenges they worked under, and the inability to deliver care to the standard they would have liked, all impacted doctors' mental health.

227. What made matters worse was that many traditional avenues for doctors and other healthcare staff to get a break were removed during the pandemic. For example, break rooms were closed due to IPC measures and historic staffing shortages meant that staff had limited opportunity to take leave.

228. The BMA was concerned about doctors' mental health and, in an effort to improve matters, made calls in a number of reports for additional support for staff mental health, along with recommendations to safeguard staff wellbeing while tackling the backlog safely. Recommendations made by the BMA included access to adequate and safe rest facilities, ensuring doctors were able to take breaks, and psychological health risk assessments. Examples of reports include:

    a. *In the balance: Ten principles for how the NHS should approach restarting 'non-Covid care'* (May 2020) (PB/384 - INQ000397312)

    b. *The mental health and wellbeing of the medical workforce – now and beyond COVID-19* (May 2020) (PB/390 - INQ000397335)

    c. *The impact of COVID-19 on mental health in England* (July 2020) (PB/493 - INQ000397275)

    d. *Rest, Recover, Restore* (March 2021) (PB/156 - INQ000118308)

    e. *Weathering the Storm* (November 2021) (PB/158 - INQ000118442).

229. The BMA shared the *In the balance* and *Rest, Recover, Restore* reports directly with the SoS and NHS England (PB/384 - INQ000397312, PB/280 - INQ000097923, PB/281 - INQ000400355, PB/390 - INQ000397335, PB/301 - INQ000097922, PB/156 - INQ000118308, PB/302 - INQ000400354), and received a reply from the SoS on 06 July 2020 in response to the first of these reports (PB/429 - INQ000400418) in relation to the safe restarting of non-COVID-19 care but not in relation to staff wellbeing. In his response, the SoS stated that the guidance issued to the NHS in April 2020 set out a cautious approach to restarting services which he said balanced the need to return non-COVID-19 services for patients, with the need to maintain capacity to respond to future COVID-19 demand. He further stated that services would be restarted based on clinical priority, with the most urgent first and that guidance on infection prevention and control for both planned and urgent care had been issued by NHS England. The SoS said that decisions about which individual services were restarted must be made locally, based on local demand and capacity, and emphasised this must be informed by clinical expertise. Finally, he said that he wanted non-COVID-19 services to return, but that restarting services would be much more difficult for the NHS than pausing them.

230. The BMA also raised our concerns about staff wellbeing and mental health in a meeting with Helen Whately on 27 March 2020 and in a letter to Nadine Dorries, the Mental Health Minister, on 08 October 2020 (PB/386 - INQ000097859).

231. BMA Northern Ireland raised similar concerns, for example, by sharing BMA tracker survey results with the Department of Health.

232. BMA Scotland also flagged concerns around the wellbeing and mental health of doctors, submitting evidence to the Health and Sport Committee inquiry on resilience and emergency planning in June 2020 (PB/430 - INQ000397243). Recommendations included access to rest facilities, provision of hot food, free parking, dedicated time for continued professional development, and the creation of a doctors' health service.

233. BMA Wales also raised concerns about the mental health of the medical workforce. For example, BMA Wales chair Dr David Bailey wrote to the Wales Deputy Minister for Mental Health and Wellbeing on 19 November 2021 (PB/431 - INQ000356019), stating that the worst of the mental health consequences for NHS Wales staff were still to come, and asking for an increase in staffing levels, and additional support for staff who have been working throughout the pandemic, including appropriate mental health support for staff. BMA Wales also included wellbeing of the medical workforce as a priority in

response to a consultation by the Health and Social Care Committee in September 2021 (PB/432 - INQ000118719).

Calling for additional support for staff physical health

234. In addition to the mental health impacts of the pandemic that staff experienced, the pandemic also had a significant impact on staff physical health, with many getting infected with the virus, a significant number developing long-COVID and sadly some dying.

235. Alongside calling for greater support for staff mental health, the BMA was also vocal about the need for measures to support staff's physical health, many of which were also crucial to improve mental health (for example because the fear of exposure to the virus due to inadequate PPE negatively impacted staff's mental health). Some of these areas (such as risk assessments or PPE) are set out in greater detail elsewhere in this witness statement or will be the focus of future modules (e.g., vaccinations). I am therefore only providing a brief summary overview of our work here.

    a. **Access to adequate PPE including RPE (for more detail on this issue see section G):** The lack of access for many staff to adequate, well-fitting PPE that provided protection from airborne transmission was a key concern raised by the BMA in its communications to governments and government bodies. This included for ethnic minority staff, those categorised as clinically extremely vulnerable (CEV), staff with a disability or health condition, and women. The BMA raised these concerns with the Prime Minister, SoS, the Parliamentary Under Secretary of State for Primary Care and Public Health, PHE, NHS England, the HSE and the CMO for England. The BMA received replies from PHE on 20 April and 24 April 2020, NHS England on 30 July 2020 and the CMO for England (via the UKHSA) on 19 April 2022 (PB/433 - **INQ000466401**, PB/434 - INQ000400400, PB/435 - INQ000400421, PB/436 - INQ000118464). Equally the BMA's devolved nation offices raised concerns: for example, BMA Northern Ireland wrote to Michael McBride (CMO for Northern Ireland) on 02 March 2020, calling for PPE to be made available in all clinical areas, especially primary care, so that staff were protected (PB/002 - INQ000116865). Dr Tom Black, chair of BMA Northern Ireland Council, followed this up with another letter on 17 April 2020, again flagging the shortage of PPE equipment such as eye protection and goggles (PB/320 - INQ000116866).

b. **Access to risk assessments (for more detail on this issue see section G):** Throughout the pandemic the BMA called for additional support for employers to undertake and implement risk assessments that would take into account not only age, but also other factors such as ethnicity, sex and comorbidities. The BMA raised these concerns with the HSE, NHS England and NHS Trusts. The BMA received replies from NHS England on 25 June 2020 and 12 October 2020, and from the HSE on 28 April and 15 December 2021 (PB/437 - INQ000118007, PB/438 - INQ000400425, PB/439 - INQ000400457, PB/110 - INQ000118447). While the BMA has no record of a response from NHS Trusts, NHS England explained in its 12 October 2020 letter that they had issued a request to NHS Trusts and primary care contractor groups on 24 June 2020 for local employers to deploy risk assessments with a focus on at risk groups (PB/438 - INQ000400425). In the 25 June 2020 letter concerning primary care, NHS England stressed the obligations of primary care employers for ensuring staff are risk assessed and able to access an occupational health assessment and signposted to other guidance (PB/437 - INQ000118007). BMA Cymru Wales engaged directly with the Welsh Government expressing similar concerns, being clear that a comprehensive range of factors should be considered in any staff focussed risk assessment (PB/360 - INQ000118541), and in the subsequent period influenced the process which resulted in an all-Wales staff side risk assessment. BMA Northern Ireland also took action, writing to the CMO for Northern Ireland on 29 May 2020 to highlight the issues with risk assessments, and their particular importance to doctors with disabilities, co-morbidities, and those from a minority ethnic background (PB/062 - INQ000116868).

c. **Access to occupational health services:** The pre-pandemic under-resourcing of occupational health services meant that when the pandemic struck, the ability to support healthcare staff, including medical professionals, was limited. This impacted the ability of these services to support risk assessment processes, which will have disproportionately impacted those most at risk to serious illness from COVID-19 infection, for example ethnic minority staff, staff with a disability or health condition, or those categorised as CEV. The BMA raised these concerns in letters to NHS England on 20 May and 05 June 2020 and to Helen Whately on 14 July 2021, as well as within our report *The impact of COVID-19*

on mental health in England in July 2020 (PB/057 - INQ000097908, PB/059 - INQ000097851, PB/283 - INQ000097884).

d. **Access to vaccinations** when these became available. While the vaccination programme and the speed with which it was rolled out was a resounding success, there were a small number of areas in which the BMA highlighted the need for improvements to protect staff's health. This included inequitable access across different trusts and employers and considering prioritisation *within* healthcare staff for those most at risk. These issues were raised in letters to NHS England on 30 November and 21 December 2020, and to NHS Trusts on 31 December 2020 (PB/288 - INQ000400429, PB/289 - INQ000400474, PB/290 - INQ000400485, PB/291 - INQ000400481, PB/440 - INQ000400433). In addition, the BMA in all four nations raised member concerns with changes made to the dosing interval between the first and second dose of the Pfizer vaccine, which were not at the time supported by the manufacturer and caused significant concern to healthcare staff (PB/271 - INQ000400438, PB/092 - INQ000116898, M2B/PB/112 - INQ000118678, PB/319 - INQ000116899, PB/351 - INQ000118674, PB/441 - INQ000400440, PB/442 - INQ000400437, PB/555 - INQ000355928). In the BMA's 2021 call for evidence, there was some divergence in experience between certain groups of medical professionals around access to the first dose. For example, junior doctors, GP locums and medical students who were not yet deployed and doctors who work in private practice – and therefore did not get offered the jab through their employer – were more likely to report difficulty in accessing their first vaccination. There was also changing advice for those who were pregnant, which some respondents in our call for evidence described as sending "unhelpful" mixed messages.

Many doctors became ill, a not insignificant number particularly from ethnic minority backgrounds died, and many more developed long COVID

236. In the absence of government reporting on COVID-19 infection rates among healthcare staff, the BMA included questions related to infection in its COVID-19 tracker surveys between July 2020 and April 2021. This information was self-reported by those who chose to respond to each survey. The table below provides a summary of these responses, but generally speaking doctors, as well as other health care workers experienced higher levels of infection compared to the general population (PB/443 - INQ000352907).

			Question: Do you believe that you previously have, or may have, contracted Coronavirus?		*Question: Have you personally contracted Coronavirus?*			
Survey date			**09.07.20**	**13.08.20**	**22.10.20**	**17.12.20**	**08.02.21**	**19.04.21**
Coverage			**England & Wales**	**England & Wales**	**England, Wales & Northern Ireland**	**England, Wales & Northern Ireland**	**UK wide**	**UK wide**
All respondents		Y	33% (1,624)	29% (1,091)	19% (1,264)	22% (1,405)	23% (1,645)	23% (1,061)
		N	67% (3,343)	71% (2,613)	81% (5,264)	78% (4,866)	77% (5,408)	77% (3,572)
Gender	**Female**	Y	33% (956)	29% (586)	18% (686)	22% (772)	23% (923)	22% (575)
		N	67% (1,962)	71% (1,423)	82% (3,054)	78% (2,794)	77% (3,107)	78% (2,039)
	Male	Y	32% (652)	30% (489)	21% (565)	24% (620)	24% (708)	24% (482)
		N	68% (1,355)	70% (1,164)	79% (2,155)	76% (2,011)	76% (2,241)	76% (1,495)
Ethnicity	**White**	Y	31% (1,093)	28% (746)	19% (880)	22% (976)	23% (1,116)	22% (729)
		N	69% (2,384)	72% (1,896)	81% (3,790)	78% (3,478)	77% (3,787)	78% (2,540)
	Ethnic minority	Y	36% (497)	33%(309)	21% (359)	23% (383)	25% (494)	24% (310)
		N	64% (871)	67% (635)	79% (1,337)	77% (1,247)	75% (1,499)	76% (961)
Age band	**25 and under**	Y	49% (81)	38% (30)	28% (46)	30% (124)	37% (102)	45% (30)
		N	51% (86)	63% (50)	72% (120)	70% (294)	63% (173)	55% (36)

	26 – 35	Y	41% (376)	36% (254)	25% (295)	32% (310)	34% (327)	31% (182)
		N	59% (531)	64% (452)	75% (877)	68% (658)	66% (627)	69% (405)
	36 – 45	Y	34% (403)	31% (245)	18% (279)	24% (319)	23% (358)	22% (225)
		N	66% (771)	69% (555)	82% (1,257)	76% (1000)	77% (1,181)	78% (778)
	46 – 55	Y	31% (435)	29% (304)	19% (379)	21% (379)	22% (495)	23% (344)
		N	69% (970)	71% (737)	81% (1,669)	79% (1,437)	78% (1,707)	77% (1,125)
	56 – 65	Y	25% (267)	23% (186)	17% (218)	17% (222)	19% (307)	20% (237)
		N	75% (792)	77% (620)	83% (1,103)	83% (1,091)	81% (1,319)	80% (964)
	66 – 75	Y	23% (46)	20% (37)	16% (34)	10% (35)	12% (44)	15% (38)
		N	77% (156)	80% (144)	84% (177)	90% (303)	88% (330)	85% (223)
	76 and over	Y	19% (5)	15% (6)	10% (2)	10% (5)	9% (4)	9% (2)
		N	81% (22)	85% (35)	90% (18)	90% (43)	81% (39)	91% (20)
Disability or LTC	**Yes**	Y	32% (227)	29% (166)	20% (178)	22% (207)	23% (203)	23% (160)
		N	(68% 477)	71% (416)	80% (719)	78% (751)	77% (678)	77% (527)
	No	Y	33% (1,367)	30% (900)	19% (1,063)	22% (1,161)	23% (1,412)	23% (883)
		N	67% (2,807)	70% (2,134)	81% (4,428)	78% (4,015)	77% (4,632)	77% (2,984)

237. It is an absolute tragedy that some of these doctors died, and the vast majority of those who died in the first wave, were ethnic minority doctors (PB/444 **- INQ000352887)**. The

BMA identified 53 doctors in the UK who died from COVID-19 while working in the health service during the pandemic. However, this figure may not include all doctors who have died from COVID-19. These doctors were not necessarily members of the BMA, but they were our colleagues and friends, as were many other staff who lost their lives treating and caring for others over themselves during the pandemic.

Long COVID had a significant and long-lasting impact on the medical workforce

238. A significant number of doctors who were infected with COVID-19 during the pandemic developed long COVID. The prevalence of long COVID - a multi-system condition defined as signs and symptoms which continue or develop after acute COVID-19 infection, continue for more than 4 weeks, and are not explained by an alternative diagnosis (PB/445 - INQ000397326) - is around 50% higher in those working in healthcare than in the general population (PB/571 - INQ000272181).

239. The BMA has monitored the impact on members suffering from long COVID during the acute pandemic and since, informing our call for recognition of its potentially debilitating and career threatening long-term impact on doctors and other healthcare workers. Responses to our 2021 call for evidence survey had already begun to paint a devastating picture of long COVID among a significant number of doctors who had worked during the pandemic. And in a BMA Viewpoint survey in February 2022, 12.5% of 1,038 respondents reported having developed long COVID. Of those, 51% reported that long COVID had impacted their quality of life.

240. To address the lack of systematic information on the long-term effects of COVID-19 among doctors specifically, the BMA undertook the first in-depth survey of doctors experiencing post-acute health complications of COVID-19. More than 600 doctors who self-identified as suffering the long-term effects of COVID-19 beyond the acute infection, responded to our online survey. Many of our research findings have been published in our report *Over-exposed and under-protected: the long-term impact of COVID-19 on doctors* (PB/377 - INQ000373375). The survey enquired about the health effects of 'post-acute COVID' and also collected qualitative and quantitative data about the impact of the condition on respondents' health, daily lives, employment and finances. Doctors reported a wide range of continuing symptoms and conditions including, but not limited to, fatigue, memory loss and other cognitive impairments, and autonomic nervous system dysfunction, such as heart rhythm disturbances or postural hypotension. Below, we have described the impact of these conditions, including through a small selection of

quotes from survey respondents. More detail about our research findings can be found in our report *Over-exposed and under-protected: the long-term impact of COVID-19 on doctors* (PB/377 - INQ000373375).

The long-term impact of COVID-19 is debilitating for a significant proportion of doctors

241. Around 60% of doctors who responded to our survey reported that post-acute COVID-19 ill health impacted their ability to carry out day-to-day activities on a regular basis, while only 6% said their symptoms did not impact their day-to-day life.

242. A junior doctor told us: *'My ability to tolerate any kind of exertion is significantly affected – I get postural and inappropriate tachycardia/shortness of breath symptoms with simple activities like dressing, rolling over in bed, doing my hair etc. I have become very weak compared to previous and struggle with many household activities (doing bins, laundry etc). Due to cognitive symptoms I often struggle with following many step recipes/instructions'.*

243. Many participants explained that the impact of their condition also extended to those around them. A consultant said: *'I am unable to carry out most activities of daily living and my children are having to help me around the house. I am almost housebound and have had to buy a mobility scooter for the few occasions that I am well enough to get out. For the last 6 weeks I have been relying on family members to help me look after my children'.*

The occupational damage suffered by doctors is severe for some

244. Post-acute COVID-19 complications have been profoundly injurious with around one fifth (18%) of respondents to our survey left unable to work or train because of their condition. Around one in three doctors (31%) said they were working or training full-time, compared to more than half (57%) before acquiring COVID-19. A locum GP who participated in the study said: *'I can barely work at all. I only do 8 hours [a week] as that is all I feel well enough to do. And most of that is telephone consulting. It's devastating'.*

245. Nearly half (48%) said they had experienced loss of earnings because of post-acute COVID-19. For some this loss has been total, and earnings loss has impacted doctors from a range of professional backgrounds and career stages. A salaried GP commented: *'I can no longer work, finances are ruined. I didn't have employment protection so am now unemployed and penniless'.* While a junior doctor said: *'I've had to use up all my*

savings and am in £3k debt because I couldn't work locum shifts to cover recent expenses'.

For much of the UK, the experience of doctors with long COVID has been marked by a lack of protection, recognition and withdrawal of support

246. For most of the UK, the loss of job and income security for doctors with significant ill health, has been greatly exacerbated by the removal of the NHS Covid Special Leave scheme in 2022 (PB/446 - INQ000397287). This change of policy brought an end to full sick pay for COVID-19 related illness for NHS employees. It has precipitated an unjust situation where some doctors are not well enough to work as they did previously, either part of the time or at all. This happened despite strong lobbying by the BMA (as well as other unions) to continue the scheme. In August 2022, the BMA published *Addressing the health challenge of long COVID* (PB/447 - INQ000238595), a report which examined the impact of long COVID on the general population, as well as examining issues specific to doctors and other healthcare workers. The report included a number of the BMA's calls to government to support healthcare workers with long COVID, including a call for COVID-19 sick pay provisions to be reinstated and a compensation scheme to be implemented for doctors and health care workers who have long COVID. We also released media statements condemning the decision to end the sick-pay schemes and wrote to the SoS on 26 August 2022 calling for COVID-19 sickness pay provisions to be reinstated (PB/425 - INQ000400512).

247. The position in Wales, however, is different as a consequence of consensus working. BMA Cymru Wales has worked in a tripartite group with other health unions, the Welsh Government and NHS Wales Employers to develop fresh guidance intended to support healthcare workers who are absent sick following infection with COVID-19. The guidance (PB/448 - INQ000339537) applies to healthcare workers who became ill during the acute pandemic and those who could contract COVID-19 in future.

248. As of 1 July 2022, individuals who had received full pay for 12 months or more would move to half-pay for the length of time corresponding to each individual's contractual entitlement to half pay, i.e. based on their length of service.

249. Those who had been absent for less than 12 months on 1 July 2022 with COVID-19 sickness absence, continued to receive full pay up to the anniversary of the start of their sickness absence, with half pay re-instated at the end of their full pay 'top up' period, for

the length of time corresponding to each individual's contractual entitlement to half pay, i.e. based on their length of service.

250. Where individuals develop long COVID after 1 July 2022 and their absence extends beyond the contractual entitlement to full pay, organisations can consider whether it is appropriate to provide ongoing support above half pay or no pay.

251. Feedback from BMA Cymru Wales's member relations team on the arrangements so far, is that bespoke phased return to work plans, including multiple returns in the event of episodic sickness, have been important in supporting the return to work for many doctors and aided recovery. Regular communication with managers and enhanced access to health, wellbeing and occupational health services has also provided a notable role in ongoing support.

252. The BMA's 2023 report (PB/377 - INQ000373375) sets out a number of recommendations on the urgent need to improve the financial and wider support available to doctors with long COVID. This includes:

    a. **Recognition of long COVID as an occupational disease for healthcare workers:** This would allow workers in this sector to receive Industrial Injuries Disablement Benefit for contracting the condition at work and potentially support wider legal claims for compensation (although see section G about issues relating to reporting of COVID-19 infections in healthcare settings). In the UK, the Industrial Injuries Advisory Council (IIAC) has so far recommended five specific and limited circumstances in which pathological complications following COVID-19 should be prescribed as an occupational disease in healthcare workers based on evidence available (PB/449 - INQ000339411). However, these recommendations have not yet been implemented by the UK Government, despite the IIAC making its recommendations in November 2022. Our survey also demonstrates that a wider range of symptoms have impacted a significant cohort of doctors, with only around 1 in 10 respondents reporting symptoms covered by the current recommendations, suggesting the need to revisit the original IIAC recommendations in addition to the Government taking action on them.

    b. **Immediate provision of financial support:** Alongside this, the BMA feels that the UK Government needs to act quickly to provide financial support now to the many doctors and healthcare workers and their families who have suffered

significant financial losses as a result of contracting COVID-19 in the workplace, leading to post-acute COVID. With the ending of COVID-19 special leave provisions in England, Scotland and Northern Ireland, and the severe lack of financial support, many doctors and healthcare workers suffering the impact of severe post-acute COVID are now facing unemployment.

c. **Better treatment support:** 66% of doctors responding to our survey said their post-acute COVID symptoms had not been investigated thoroughly and effectively by an NHS long COVID clinic or centre. Almost half reported not even being referred to an NHS long COVID clinic at all, making it far more difficult than it should be for doctors to access the support they need to address their health problems and, hopefully, get better. This is an issue that affects all those with long COVID, not just healthcare workers (PB/447 - INQ000238595). In the case of healthcare workers, this lack of effective treatment and care has implications for the wider health system and impacts on the significant workforce shortages and pressures outlined in section E, above.

d. **Better support for staff returning to work, including access to phased returns and occupational health support.** Around 3 in 10 doctors (27%) responding to our survey told the BMA that support and adjustments (such as phased returns and changes in shift patterns) had not been provided to help them return to work. Relatedly, around a third of survey respondents (34%) reported they had frequently gone to work despite not being well enough. It is therefore unsurprising that over half of doctors responding to our survey reported that they had been fearful of making a medical error in work or training. Providing adjustments, such as phased returns to work and working with occupational health teams to implement adjustments, would support doctors to continue to work at levels that are safe for them and their patients, as demonstrated by feedback in relation to the scheme implemented in Wales. To improve this, a better resourced and thus more effective occupational health service is needed as mentioned earlier in this witness statement. The BMA has called upon health education bodies across the UK to fund increased occupational medicine training posts to meet demand in the workforce, and health service employers must prioritise timely access to occupational health services and assessments for staff with post-acute COVID.

Doctors experienced higher levels of abuse during the pandemic

253. Not only did doctors work in highly pressured environments with increasing workloads for most of the pandemic, while putting their lives on the line, they were also subject to increasing levels of abuse and discrimination.

254. Throughout the relevant period our surveys showed increasing levels of abuse being experienced by medical professionals.

    a. In August 2020, 10% of respondents to our COVID-19 tracker survey had experienced unusual levels of bullying, harassment or discrimination from patients or the public within the previous two weeks.

    b. Nearly a year later, by July 2021, almost half of our survey respondents (48%) said that instances of threatening behaviour, violence, or verbal abuse had increased over the past year. The same survey found that more than a third of doctors had faced recent abuse from patients or those close to them. For GPs, the number was higher, with half reporting verbal abuse in the past month.

255. This abuse appears to have arisen from patient frustration with accessing appointments, especially face-to-face appointments. Early in the pandemic, a significant amount of care, especially in General Practice, moved to online provision to keep patients and staff safe. This was the guidance from government bodies, and it remained in place throughout much of the pandemic. Failure by the UK Government to explain to the public why this was necessary, damaged the reputation of the medical profession, particularly in England. The BMA believes that a lack of publicly declared UK government support for doctors, combined with unhelpful media narratives suggesting doctors were responsible for face-to-face appointment access limitations, resulted in medical professionals being subject to unrealistic expectations at a time when pressure on GPs – who were looking after more patients unable to access secondary care where backlogs were mounting – was already significant. In our call for evidence, a handful of respondents linked increased abuse by patients to this poor government support. For example, a GP in England wrote that *'After the first wave of the pandemic, and after the "clap for the NHS" ended, the abuse of myself and staff has ramped up enormously, fuelled by governmental propaganda and briefing against General Practitioners'.*

256. The BMA raised concern about this situation with the UK Government and NHS England in several ways. This includes:

a. Writing to Sir Simon Stevens, the Chief Executive of NHS England in September 2020 (PB/293 - INQ000400352) to raise serious concerns about, and insisting on an apology for, an unacceptable media briefing by NHS England regarding GP access/face to face appointments. The letter highlighted the BMA's view that NHS England was fuelling a harmful public narrative that GPs were responsible for access limitations. The BMA raised concerns about GP practices receiving complaints and staff being subject to abuse as a result of inaccurate and damaging stories in the media.

b. Writing to the SoS in May 2021 (PB/388 - INQ000097897) raising concerns about abuse as a result of patients not being able to access face to face appointments.

c. Co-signing a letter with the RCGP, NHS Confederation and the Institute of General Practice Management to the SoS in September 2021 (PB/233 - INQ000097867) to express concern about the lack of central support, or public challenge by Government, of increasing instances of abuse being directed towards those working in general practice.

d. Writing again to the SoS in September 2021 (PB/234 - INQ000097914) raising concerns about escalating abuse and threats faced by GPs.

e. The BMA also worked with the Social Partnership Forum which, in 2019, established a specific 'Violence Reduction Subgroup' to support the delivery of NHS England's violence prevention and reduction work programme, including work on a national violence reduction standard.

257. GPs outside England were not immune to this type of rhetoric with some inaccurate and unhelpful commentary amongst media and politicians in **Scotland**, but generally sentiment was fuelled by the UK Government and London/UK based media with coverage inevitably being picked up across the border. This is shown by the following quote from a GP in Scotland who wrote: '*This attitude in press and by politicians is doing possibly irreparable damage to the morale of GPs and the respect/attitude patients have for us'.* BMA Scotland called publicly for this to stop, for example, in an open letter to GPs in August 2021 (PB/450 - INQ000397342).

258. In comparison, in **Wales** the Welsh Government signalled early on their wish for remote consultations to play a continued role in the way that patients access primary care in the future, with the Welsh Government's First Minister setting out in September 2021 that "*remote consultations are here to stay*" and that "*over half of consultations by*

primary care clinicians are now carried out face to face". In July 2021, BMA Cymru Wales co-signed a letter with RCGP Wales, NHS Wales and the Welsh Government which thanked practices for their efforts during the pandemic and recognised the unprecedented and sustained pressures upon the system.

G. Infection prevention and control (IPC) and personal protective equipment (PPE)

259. Throughout the pandemic there were significant shortcomings in how staff working in healthcare settings were protected from the virus, spanning inadequate IPC guidance, a lack of adherence to health and safety law, shortages of PPE and access to well-fitting PPE where PPE was available. This impacted all healthcare workers negatively, with certain groups impacted even more due to their individual characteristics.

IPC guidance was (and continues to be) inadequate and there was a lack of adherence by employers with health and safety law

260. Infection Prevention and Control guidance on COVID-19 in healthcare settings, which was intended to keep staff and patients safe, has been inadequate, putting both staff and patients at risk. The fact that employers followed this guidance rather than existing health and safety law, and that government and the HSE have been unmoved by requests by the BMA and others to make changes to the guidance to improve it, sadly mean these shortcomings persist to the current day.

The focus on AGPs in IPC guidance meant staff did not receive adequate PPE

261. For the majority of the pandemic, except for a brief period in the early weeks of the pandemic and between January and March 2022, the four nation UK IPC guidance for healthcare settings (which was updated regularly) stated that only a small number of 'aerosol generating procedures' (AGPs) required access to respiratory protective equipment (RPE) such as FFP2 or FFP3 respirators (which provide the most protection against an airborne virus) and that a Fluid Resistant Surgical Mask (FRSM) (which are not intended to provide protection against infectious aerosols) is appropriate protection for a healthcare worker caring for patients with confirmed or suspected COVID-19 (PB/451 - INQ000145893).

262. The categorisation of procedures into AGPs and non-AGPs was developed before the pandemic. AGPs include procedures, like endotracheal intubation to secure the airway to enable mechanical ventilation, where there was a defined risk of aerosols being

generated because of the procedure. However, in practice this categorisation has not been a reliable method of mitigating the risk of COVID-19 infection, because it is not always possible to distinguish procedures that generate aerosols from those that do not.

263. The BMA also did not consider the category to be sufficiently inclusive, as it excluded CPR (including chest compressions) and the BMA raised this with PHE in a joint letter with the Resuscitation Council UK, the RCN and the Hospital Consultants and Specialists Association on 23 April 2020 (PB/088 - INQ000097926).

264. Further, this false dichotomy between AGPs and other activities does not take account of the fact that daily actions such as coughing, talking and breathing can generate more aerosol than so-called AGPs (PB/452 - INQ000145858, PB/453 - INQ000397302).

265. Previous versions of the COVID-19 IPC guidance for healthcare settings are no longer available online. The section that follows sets out the BMA's understanding of the guidance at relevant moments in time, based on the recollection of BMA staff and the documents we have available, including the publicly available minutes of NERVTAG, where IPC guidance was sometimes discussed. However, the BMA recommends that the Inquiry seeks to obtain a systematic, chronological record of IPC guidance relating to COVID-19 to allow the guidance to be appropriately examined.

266. It is the BMA's recollection that the first UK IPC guidance for healthcare settings relating to COVID-19 was published on or around 10 January 2020. At this stage COVID-19 was classified as a High Consequence Infectious Disease (HCID). The recommended PPE for healthcare staff caring for a patient with a suspected or confirmed case of COVID-19 included an FFP3 respirator. We believe that this recommendation was downgraded in March 2020. NERVTAG minutes from 6 March 2020 (PB/567 - INQ000087540) state (at paragraph 2.1): *"...PHE were asked by the CMO to update the secondary care guidance. For suspected cases, healthcare workers will be wearing glove, apron, a surgical facemask and eye protection on risk assessment of splashing*". At this point the recommendation for confirmed cases continued to include an FFP3 respirator. NERVTAG subsequently considered revised COVID-19 IPC guidance at its meeting on 13 March 2020 (PB/568 - INQ000212195). While the guidance is not specifically quoted or reproduced in the minutes, the discussion shows that the downgrading of recommended PPE for staff caring for patients with a confirmed case of COVID-19 outside of AGP hotspots or when conducting an AGP was discussed. Paragraph 2.9 states: *"Members noted that the guidance is recommending the use of*

fluid resistant surgical masks (FRSM) outside of AGP hotspots as per pandemic flu as opposed to the HCID recommendations of FFP3 respirators". The same meeting also discussed the potential downgrading of COVID-19 as a HCID.

267. The new IPC guidance for COVID-19 in healthcare settings was then published on or around 14 March 2020. This stated that the predominant mode of transmission of COVID-19 was assumed to be droplet or contact, and recommended staff wear FRSM unless performing an AGP or working in so-called AGP hotspot areas treating COVID-19 patients, such as Intensive Care Units. This downgrading of recommended PPE caused concern amongst many healthcare professionals, as reported by the Health Services Journal on 28 March 2020 (PB/598 - INQ000442319). Also on 28 March 2020, a circular was issued to all NHS organisations in England and copied to a range of organisations including the BMA. Signed by the Medical Directors for NHS England and PHE and the Chair of the Academy of Medical Royal Colleges, the letter stated that the change to the IPC guidance was because COVID-19 had been declassified as a HCID. It also sought to allay concerns about the change to the guidance in relation to recommended PPE when providing close contact care to a person with COVID-19. Astonishingly, the letter specifically states: *"Covid-19 is not airborne, it is droplet carried." (*PB/585 - INQ000130506).

268. The four nation COVID-19 specific IPC guidance for healthcare settings was updated throughout the pandemic. Later in the pandemic it was expanded from COVID-19 specific guidance to include other seasonal respiratory infections in health and care settings. The final version of the guidance was withdrawn on 22 May 2022. There is now separate IPC guidance in each of the four nations that covers all relevant risks to health, including COVID-19 (although Wales has adopted Scotland's National Infection Prevention Control Manual).

269. The guidance in all four nations continues to state that a FRSM is adequate protection for a healthcare worker undertaking routine care of a COVID-19 positive or suspected positive patient, although in Scotland, a new annex 19 was published in May 2023 that states: "*Where staff have concerns, they may choose to wear an FFP3 respirator rather than a fluid resistant surgical mask (FRSM) when providing patient care, provided they are fit tested. This is a personal PPE risk assessment*". How this interacts with the rest of the guidance is unclear and it further places responsibility on the healthcare worker to raise concerns and ensure they have the necessary fit testing.

270. The understanding of the significance of airborne routes of transmission of COVID-19 evolved over the pandemic. What has been known for a long time though is that respiratory protective equipment, such as FFP3 respirators provide significantly greater protection for healthcare staff compared to FRSMs for an airborne virus. This was included in a 2008 report prepared for the HSE which found that where there is a respiratory risk of infection, the use of FFP3 devices represents best practice, and where these are not available then FFP2 may be an acceptable, pragmatic compromise (PB/451 - INQ000145893). The report also explains that filtering facepiece respirators are classified as FFP1, FFP2, and FFP3 according to the level of protection they afford, with FFP3 offering the most protection (99% filter efficiency and an assigned protection factor of 20), with FFP2 (94% filter efficiency and an assigned protection factor of 20), and FFP1 (80% filter efficiency and an assigned protection factor of 4) providing correspondingly less protection. The greater protection offered by FFP3 respirators compared with FRSM against COVID-19 was demonstrated by a research study undertaken during the pandemic (PB/455 - INQ000408843). However, despite this, IPC guidance on the use of RPE among healthcare workers was not altered to either take account of evidence predating the pandemic or real-world observational studies during the pandemic, which demonstrated the superior protection provided by filtering facepiece respirators, and accordingly recommend more routine use of RPE in healthcare settings. This left and continues to leave staff at risk from a potentially deadly virus.

271. The seeming assumption that aerosol transmission only occurs during AGPs and that, outside of these specific procedures, droplet and fomite transmission was the primary pathway for COVID-19 transmission had profoundly consequential adverse consequences for the IPC guidance. Additionally, while current IPC guidance (PB/456 - INQ000397321) does recognise droplet and airborne transmission routes for COVID-19, it continues to recommend FRSMs for most routine care of patients with confirmed or suspected COVID-19 (non-AGPs). Moreover, elsewhere in the guidance it is stated that filtering face piece respirators should be considered in the presence of a pathogen spread wholly or partly by airborne routes, which is contradictory. We know airborne transmission of COVID-19 is significant, but the recommended use of RPE has been, and remains, strictly limited. In the BMA's view, the current guidance is inconsistent and confusing. More than three years after the virus came to the UK's shores, it continues to leave healthcare workers unprotected against the continuing risks from COVID-19.

272. Assumptions around airborne transmission, particularly early in the pandemic, also had consequences for indoor ventilation and air quality monitoring which is used to mitigate the risks of airborne pathogens. Where adequately prioritised, enhanced ventilation can help mitigate risks to staff and patients. However, many parts of the NHS/HSC found such improvements hard to deliver. More than 4 in 10 respondents (42%) to the BMA's COVID-19 tracker survey in April 2020 said their place of work did not have adequate capacity to improve ventilation, underlining the difficulties some parts of the NHS/HSC estate had and continue to have (see also section B).

273. In the UK, actions recommended during the pandemic to mitigate airborne routes of transmission in healthcare settings, therefore appear broadly dissonant with official guidance relating to community transmission which recognised the airborne spread of the virus much more. For example, the priority given to limiting indoor mixing in wider society increased emphasis in public health messaging of the importance of ventilating rooms (PB/457 - INQ000223595) and the intrinsic basis for the NHS COVID-19 app, which notified subscribers of their proximity to infectious contacts.

<u>Deficiencies in IPC guidance and implementation left, and continues to leave, doctors exposed and anxious</u>

274. This apparent dissonance in how guidance was formed was not lost on medical professionals - many of whom had already experienced PPE with multiple shelf-life stickers layered over each other and faulty PPE - leading to perceptions, which persist to this day, that cost had been prioritised over safety. Participants in the BMA's call for evidence in November 2021, said they often felt they were left deeply and worryingly exposed.

    a. *'No PPE availability. Failure to acknowledge that speaking singing coughing etc [sic] are all aerosol generating procedures, that healthcare staff cannot assess patients without getting close. Therefore, ALL categories of staff should be provided with PPE'. (GP trainee, England)*

    b. *'The fact we still use FRSM masks now is a joke given that we know it's an airborne virus'. (GP contractor/principal, Wales)*

    c. *'We were advised full PPE for Covid positive patients ONLY if they were 'aerosol generating'. Covid positive patients were constantly coughing. In my opinion, coughing is aerosol generating too. But apparently, getting ourselves exposed to*

[a] Covid positive patient's cough is OK and only [a] flimsy plastic apron and blue mask are enough to protect one'. (Consultant, England).

275. In our COVID-19 tracker survey of February 2021, only 40% of respondents felt safely protected by the PPE provided to them in 'non' AGP areas. Of those who said they did not feel safe, 87% wished to be provided with filtering face piece respirators when working in 'non' AGP areas. Our Viewpoint survey five months later and several months into the pandemic, in July 2021 showed that 4 in 10 doctors (40%) were only supplied with FRSMs by their place of work, despite working with COVID-19 positive or suspected positive patients. The BMA also heard numerous examples of inadequate and insufficient PPE being provided to doctors and other healthcare staff.

276. Ensuring staff are provided with the most effective protection is also important to the psychological safety of those being relied upon on the healthcare frontline. This is one of the reasons why, even in the early months of the pandemic when there was a lack of consensus about whether and to what extent COVID-19 was spreading via the airborne route, the BMA argued for a precautionary approach.

277. While we may be through the acute COVID-19 pandemic, UK IPC guidance and consequent RPE provision is not an academic matter. COVID-19 continues to circulate meaning staff not offered adequate protection continue to be put at risk. In addition, our in-depth survey of doctors with post-acute complications of COVID-19 (e.g. long COVID) (see section F above) showed that only a minority of these doctors (26%) were supplied with an item of RPE, such as a FFP2 or FFP3 respirator, around the time they acquired COVID-19, with the great majority also believing they contracted COVID-19 at work. These findings indicate that inadequate respiratory protection could have contributed to occupational disease, with COVID-19 being contracted in the workplace. A failure to provide PPE in the beginning of the pandemic has also been directly implicated in the death of at least one doctor, with evidence of requests for equipment being declined (PB/458 - INQ000397294). In our letter to the SoS on 9 April 2020, the BMA identified the separate but equally tragic death of Abdul Mabud Chowdhury, who himself felt moved to write to the Prime Minister just weeks before pleading with him to provide all NHS workers with the PPE that was urgently needed (PB/066 - INQ000117840).

<u>The BMA has raised concerns about IPC failings throughout the pandemic</u>

278. Throughout the pandemic, the BMA has made representations to individuals, departments and agencies either responsible for, or with the ability to influence, decision

making to correct what we believe were and are major failings. This includes a failure to recognise the growing significance of airborne transmission and reflect this in IPC guidance by mandating access to RPE for staff dealing with suspected or confirmed COVID-19 cases.

279. In the earlier phase of the pandemic, this included:

a. IPC guidance in the UK not aligning with guidance from the WHO, European Centre for Prevention and Disease Control (ECDC) and US Centers for Disease Control and Prevention (CDC), particularly around the use of long-sleeved gowns and eye protection. The BMA raised this in a letter to PHE on 24 March 2020 (PB/087 - INQ000097932) and in a letter to the Prime Minister on 21 March 2020 expressing the BMA's deep concerns regarding the inadequacy of PPE being provided to the medical profession and seeking urgent clarification on the apparent discrepancy between recommended PPE in IPC guidance and that recommended by the WHO (PB/064 - INQ000097910). This letter to the Prime Minister was shared by BMA Scotland with the Director General for Health and Social Care and the CMO for Scotland on 21 March 2020 (PB/577 - INQ000433847), and by BMA Cymru Wales with the CEO of NHS Wales on 22 March 2020 (PB/513 - INQ000118526).

b. We wrote to PHE again on 19 April 2020 to convey our alarm that PHE's guidance on the use of PPE during exceptional shortages was driven by availability rather than evidence on protection of users (PB/459 - INQ000097902).

c. Decisions not to classify CPR (including chest compressions) as an AGP, which impacted on the provision of PPE to staff and left them unnecessarily exposed to the virus (as mentioned earlier in this section). The BMA raised this with PHE in a joint letter with the Resuscitation Council UK, RCN and the Hospital Consultants and Specialists Association on 23 April 2020 (PB/088 - INQ000097926).

d. Raising a number of concerns via email with NHS England about proposed updated IPC guidance in August 2020, which downgraded PPE for use in designated 'low-risk' settings, including removing airborne protections for AGPs in this setting. At this time, the BMA also raised concerns about how the guidance would be communicated and highlighted the loss of confidence amongst

healthcare professionals, largely due to the shortages of PPE they had experienced in the early stages of the pandemic, and highlighted the need for the guidance to reassure staff that their safety would not be prejudiced in order to deliver increased NHS throughput.

280. As the pandemic developed, we increasingly highlighted the relevance of aerosol transmission, the greater protection of respirator masks compared to FRSMs (PB/451 - INQ000145893) and the limited recommendation for when frontline healthcare staff should wear RPE, which we believed – and our long COVID survey confirms - has left doctors and other healthcare workers unnecessarily at risk. This led to a range of further interventions later in 2020 and throughout 2021 and 2022, including:

    a. A letter to the HSE on 01 December 2020 (PB/069 - INQ000118222) on the connected issues of routes of aerosol transmission not being appropriately recognised and the failure of IPC guidance to recommend RPE outside of AGPs, also drawing attention to research by the Health and Safety Laboratory for HSE back in 2008 which showed that FRSMs were not suitable protection against small aerosols (PB/451 - INQ000145893).

    b. The ongoing decision not to update IPC guidance in light of evidence of aerosol transmission, to ensure healthcare staff are adequately protected by RPE, outside of procedures specifically designated as aerosol generating. The BMA raised this on many occasions including in letters to PHE (13 January 2021) , the HSE (21 January 2021), and a joint letter to the Prime Minister (18 February 2021) (alongside 20 other organisations representing health and care workers and patients, including the RCN and the Royal Pharmaceutical Society), in which we called for amendments to the IPC guidance to recognise aerosol transmission, thereby providing staff with appropriate RPE (PB/089 - INQ000097875, PB/090 - INQ000097909, PB/070 - INQ000118291).

    c. BMA Scotland shared the 13 January 2021 letter to PHE with Health Protection Scotland and the CMO for Scotland (PB/347 - INQ000400446) and the Scottish Government's Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) programme (PB/580 - INQ000433863). BMA Scotland continued to raise concerns with several parties within the Scottish Government, for example with senior leaders within the Health Workforce Directorate on 09 July 2021

(PB/339 - INQ000400458) and with the ARHAI programme on 25 November 2021 (PB/340 - INQ000400463).

d. BMA Cymru Wales wrote to the Minister for Health and Social Services in Wales on 23 February 2021 to express concern at the body of evidence supporting the significance of aerosol transmission of COVID-19, including outside AGPs, and urged that FFP2 and FFP3 masks be made available to all frontline healthcare staff (PB/352 - INQ000118686). BMA Cymru Wales reiterated these calls to the Minister for Health and Social Services in a letter on 23 December 2021 (PB/053 - INQ000118727) and again in a joint letter with RCN Wales on 27 January 2022 (M2B/PB/093 - INQ000118731).

e. To the best of my knowledge, BMA Northern Ireland did not write to any health body or to the department of health in relation to IPC guidance or aerosol transmission.

f. In addition, the BMA highlighted the fact that the significance of aerosol transmission of COVID-19 had appeared to have been acknowledged in the IPC guidance in January 2022, only to be retracted in March 2022. The BMA raised this in a letter to the CMO for England on 30 March 2022 (PB/091 - INQ000097952). On 31 January 2022, BMA Cymru Wales called upon the Welsh Government to make FFP2 and FFP3 available to healthcare staff in Wales in light of the change to the IPC guidance around aerosol transmission, stating that the official position on use of RPE had become 'untenable' (PB/460 - INQ000118732).

281. Throughout the pandemic, IPC guidance from PHE/UKHSA was updated regularly and was, on occasion, released late in the day (often on a Friday) and preceded by minimal, if any, consultation. This made it difficult for the BMA to engage with the guidance and even more difficult for healthcare professionals and leaders on the ground who were required to implement it, given it usually came into force with immediate effect or with only a few days' notice, and when there was guidance on a range of different topics also being issued to NHS and public health organisations that they were expected to implement.

Deficiencies in IPC guidance could have been made up if employers had followed their responsibilities under Health and Safety law and if HSE had played a more proactive role

282. It is the BMA's view that, during the pandemic, employers were more likely to follow the IPC guidance, rather than their legal obligations under Health and Safety Law. This may be because they believed that the IPC guidance superseded their legal obligations, or they may have not understood the relationship between the guidance and the law. As set out above, the IPC guidance was clearly deficient. However, the risks this posed to staff and patients could have been mitigated if employers had focused on their legal obligations under Health and Safety laws and if the HSE had taken a more proactive approach in ensuring employers were aware of – and complied with – these duties.

283. Health and Safety laws pre-dating the pandemic, such as the 1974 Health and Safety at Work Act and the Control of Substances Hazardous to Health Regulations (COSHH), set out employers' legal duty to protect staff from harm in the workplace, including through conducting individual and workplace risk assessments to identify hazards and ameliorate the impact of them on staff. Importantly, these legal duties were not superseded by IPC guidance for COVID-19 in healthcare settings, and IPC or other processes to mitigate hazards should not be seen as divorced from them (PB/461 - INQ000397281).

284. As the regulator responsible for the health and safety of UK workers, the BMA was surprised that the HSE did not take a more proactive approach in ensuring compliance across healthcare settings with existing health and safety legislation, and by engaging with, or challenging as necessary, industry-specific guidance.

285. During the pandemic, the BMA called for proactive risk management in healthcare settings in accordance with health and safety law. On several occasions, the BMA wrote directly to the Chief Executives of NHS acute Trusts in England reminding them of their duties under health and safety law to protect their workers and to properly assess and mitigate the risks of COVID-19, including through provision of RPE, improved ventilation and social distancing (for example PB/101 - INQ000117919 and PB/102 - INQ000097857). These letters were shared with BMA offices in the Devolved Nations and, in some cases, these were adapted and sent to respective Health Boards or NHS organisations. For example, the Chair of BMA Council Northern Ireland wrote to Health and Social Care Trust CEOs on 29 July 2021 about the IPC guidance, the need for risk

assessments and calling for the provision of FFP3 masks or equivalent to all health and social care staff who treat patients with COVID-19 (PB/328 - INQ000116913). Early in the pandemic, BMA Wales also wrote to Health Board Chief Executives on several issues including the need for risk assessments (PB/372 - INQ000118537).

286. The BMA and RCN also wrote jointly to the HSE on 21 January 2021 (PB/090 - INQ000097909) seeking "*...a precautionary approach and to use your role as a regulator to ensure employers and those developing national guidance meet and understand their responsibilities*". We requested a review of IPC guidance for healthcare settings in respect of aerosol and airborne transmission because of common physiological activities such as coughing and talking, an assessment of PPE appropriate across settings and an examination of ventilation, especially in light of emerging variants.

287. On 25 November 2021, the Deputy Chair of the BMA Occupational Medicine Committee wrote, jointly with the RCN, the British Occupational Hygiene Society, FreshAirNHS and the Covid Airborne Protection Alliance (CAPA), to the HSE calling for a review of IPC guidance, greater scrutiny of NHS practices relating to the supply of RPE, and asked HSE to give specific additional guidance to complement or correct, as appropriate, IPC measures in effect at the time (PB/109 - INQ000118441). On 15 December 2021, HSE Chair Sarah Newton replied to this letter (PB/110 - INQ000118447). The HSE set out its position that "*All employers, including those in the NHS, are expected to assess the risks to their workers created by their work activity and to implement appropriate measures to control these risks*". The HSE also stated that they would not undertake a review of IPC guidance as this had already been formed by the DHSC, UKHSA and the devolved administrations which they regarded as 'competent bodies' and that they had already undertaken investigations and enforcement actions at employer level or given verbal advice. We find this approach particularly concerning given the HSE itself had commissioned relevant research on respiratory protection prior to the pandemic, which showed that FRSMs were not adequate protection against small aerosols (PB/451 - INQ000145893).

<u>Lack of adherence to health and safety law included insufficient reporting of workplace exposure to COVID-19</u>

288. Healthcare workers were at higher risk of infection with COVID-19 compared to the general population. A report of the Office for National Statistics titled, 'COVID-19

Infection Survey Characteristics Datasets' (INQ000271363) referenced within Professor Sir Ian Diamond's witness statement for Module 2 (INQ000271436) shows that this risk was approximately six times greater. Professor Jonathan Van Tam referred to healthcare workers within an email dated 14 January 2020 as the "*canary in the coalmine*" as they were usually the first to be infected (INQ000151314). Healthcare workers became infected due to exposure at work, because of the lack of protection, including appropriate RPE and inadequate or non-existent risk assessments. An Independent Report from the Industrial Injuries Advisory Council, *Covid-19 and Occupational Impacts*, laid before Parliament as a Command Paper on 16 November 2022 (PB/449 - INQ000339411) found that there was "*a large body of consistent supporting evidence showing that, for Health and Social Care Workers, whose work brings them into frequent close proximity to patients or clients, there is a significantly increased risk of infection, subsequent illness, and death*".

289. However, many employers failed to report COVID-19 infections of staff via RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations), despite it being a legal requirement for employers to report instances of workplace acquired COVID-19 infections. Reporting practices varied throughout the pandemic, with reports of some doctors finding it 'impossible' to get their workplace to report their COVID-19 infection under RIDDOR (PB/462 - INQ000397252). Only 3% of respondents to the BMA's survey of doctors with post-acute COVID-19 complications (most participants believed they acquired acute COVID-19 at work) said they were aware of their potential occupational exposure to COVID-19 and subsequent illness having been reported using RIDDOR (PB/377 - INQ000373375).

290. Reporting is crucial to understanding infections at health service staff level, how infection spreads within healthcare settings and how to better protect staff and patients. The need for this is clearly demonstrated within the email chain between Number 10 and the Cabinet Office over 13 and 14 April 2020 (INQ000198046), which raised concerns that 20% of infections and 10% of deaths were due to infections acquired in hospitals and that while the R number had been brought below 1 within the community, this was not the case in hospitals and care homes.

291. Reporting also assists staff with long COVID as a result of an infection acquired at work, in seeking access to benefits, such as NHS Injury Allowance or wider compensation. The considerable under-reporting and subsequent failure to investigate that we believe took place across the NHS has made access to this financial

recompense significantly more difficult for those staff suffering from long COVID who wish to form a claim.

RIDDOR guidance issued by HSE was confused

292. One reason for the under reporting is likely to be the confused guidance issued by the HSE both before and during the pandemic. The guidance changed at different times throughout the pandemic and, in the BMA's view, set a higher threshold for reporting than was required under the relevant regulations. At the very least, this is likely to have created confusion about whether a RIDDOR report was required and we expect that at least at some periods of time, it acted as an active discouragement of RIDDOR reporting of cases of COVID-19, including in health and care settings.

293. Regulation 9 of RIDDOR requires the reporting of a disease **attributed** to occupational exposure to a biological agent. The BMA considers that the appropriate threshold for establishing attribution for the purposes of a reporting requirement of this nature is 'reasonable grounds' (which may be alternatively expressed as 'reasonable evidence').

294. However, the HSE guidance imposes a higher threshold of 'balance of probabilities' (alternatively expressed as 'more likely than not') (PB/584 - INQ000442328). Examples of the HSE guidance on RIDDOR reporting are as follows:

a. The current RIDDOR reporting guidance for health and social care employers (published by HSE on their website) was issued in 2013 and is titled, *Reporting injuries, diseases and dangerous occurrences in health and social care* (PB/593 - INQ000466413). At page 4, the guidance states:

> "*Infections that could have been acquired as easily in the community as in work are not reportable, unless there is* ***reasonable evidence*** *[emphasis added] that the infection was due to an occupational exposure to a biological agent. This means that it should be* ***more likely than not*** *[emphasis added] that the person's work activity was the source of exposure*".

b. This approach is repeated within the HSE's specific guidance about reporting COVID-19 under RIDDOR titled, *RIDDOR reporting of COVID-19*, which is undated but available on the HSE website at the date of this witness statement (PB/465 - INQ000397285). This guidance states as follows:

*"You need to consider if there is **reasonable evidence** [emphasis added] that a work activity is the likely cause of the infection. This includes both deliberately working with the virus or being exposed to it incidentally…*

Reasonable evidence of occupational exposure

*There are some general principles that can help you decide whether exposure is **likely** [emphasis added] to have been caused by work activity…*

*For an occupational exposure to be judged as the **likely** cause of the disease it should be **more likely than not** [emphasis added] that the person's work activity was the source of exposure to coronavirus*".

c. Further specific COVID-19 guidance was issued by HSE titled, *Further guidance on RIDDOR reporting of COVID-19* (PB/111 - INQ000466412). The BMA has exhibited a pdf version of this guidance date stamped 6/11/2020, but there may have been other versions before and after this time. This guidance does not appear to be available on the HSE website at the date of this witness statement. This guidance both conflates the thresholds of 'reasonable evidence' and 'more likely than not' (in keeping with earlier versions of the guidance), but then goes further and establishes a two stage test and, by virtue of the second test, actively discourages reporting, as follows:

"***Reasonable evidence of occupational exposure***

When deciding if a report is required, the responsible person must make a judgement, based on the information available, as to whether or not a confirmed diagnosis of COVID-19 is likely to have been caused by an occupational exposure, i.e. whether or not there is reasonable evidence that a work related exposure is the likely cause of the disease. Whilst this should be considered on a case by case basis, there are some general principles which can assist in making this judgement.

*There must be **reasonable evidence** linking the nature of the person's work with an increased risk of becoming exposed to coronavirus…*

*Additionally, for an occupational exposure to be judged as the **likely** cause of the disease, it should be more likely than not that the person's*

work was the source of exposure to coronavirus as opposed to general societal exposure. ***Such cases may not be easy to identify*** *[emphasis added] when COVID-19 is prevalent in the general population".*

d. HSE published a management update on 17 April 2023 titled, *Management Information: Coronavirus (COVID-19) disease reports made by employers to HSE and Local Authorities* (PB/572 - INQ000269879). This document contains the following statement with which the BMA agrees as it sets the threshold as 'reasonable evidence', although it is not how HSE's guidance above is expressed:

> *"Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), certain cases of COVID-19 in workers where there is reasonable evidence to suggest that it was caused by occupational exposure are reportable to the relevant enforcing authority. Up until 31 March 2022, RIDDOR reporting guidance required all confirmed cases of COVID-19 where there was reasonable evidence to suggest that it was caused by occupational exposure to be reported".*

It will be noted that within this management update there is no reference to the higher threshold of 'balance of probabilities' or 'more likely than not'. However, the management update goes on to introduce a third threshold of suspicion (albeit not purporting to be guidance) when stating, *"Over the two-year period 10 April 2020 – 31 March 2022, there were 44,458 notifications of COVID-19 in workers where occupational exposure was* ***suspected*** *[emphasis added]…"*

295. The HSE guidance and management information referenced above is confused and inconsistent (referencing three different thresholds – suspicion, reasonable grounds/evidence, and balance of probabilities); it conflates different thresholds of reasonable evidence and balance of probabilities; it imposes an unnecessarily high threshold for reporting occupational disease; and at points, it actively discourages reporting through the introduction of a confused two-stage test, and by statements such as "*[s]uch cases may not be easy to identify…"*

296. An additional and significant concern in the document, *Further guidance on RIDDOR reporting of COVID-19* (PB/111 - INQ000466412), is the inclusion of the following in the factors to take into account when deciding if the 'reasonable evidence' threshold has been met:

"Whether or not the person's work directly brought them into contact with a known coronavirus hazard ***without effective control measures, as set out in the relevant PHE guidance, in place such as personal protective equipment (PPE) or social distancing*** *[emphasis added]".*

297. As set out earlier in this statement, it is the BMA's view that the IPC guidance in place for the majority of the pandemic did not recognise aerosols as a significant route of COVID-19 transmission nor did it recommend effective control measures for healthcare staff providing routine care to COVID-19 positive patients as it recommends an FRSM rather than a respirator. This is particularly the case, as the HSE itself clearly states (in their Pandemic Flu – Workplace Guidance – PB/596 - INQ000442329) that a surgical mask (FRSM) is not classified as PPE, stating: *"Whilst they will provide a physical barrier to large projected droplets, they do not provide full respiratory protection against smaller suspended droplets and aerosols. That is, they are not regarded as personal protective equipment (PPE) under the European Directive 89/686/EEC (PPE Regulation 2002 SI 2002 No. 1144)"*. This issue may have been avoided had the HSE issued their own detailed guidance on COVID-19 protection for healthcare workers as it does with other occupational hazards such as asbestos, rather than deferring to guidance from PHE, which the BMA views as an abrogation of their responsibility as the workplace health and safety regulator. The BMA and the RCN had asked the HSE to produce such guidance to protect healthcare workers (PB/109 - INQ000118441), but the HSE did not do so.

298. The BMA is deeply concerned that HSE RIDDOR guidance should cite flawed PHE guidance, and that the provision of inadequate PPE such as FRSM, which do not protect against aerosol transmission, may have been relied upon as the basis for not making a RIDDOR report, thus leading to underreporting of COVID-19 cases amongst healthcare workers. It is clear from the testimony of doctors reporting their experiences to the BMA, including through surveys of the profession, that many took specific actions to limit their contact with their families and the general public, especially prior to the availability of the COVID-19 vaccinations (see further below) which means it was likely that they contracted the virus in the workplace. Therefore, the inconsistencies in the HSE guidance outlined above, and the flawed reliance on PHE guidance, not only impacted individual doctors and other healthcare workers but meant that the HSE failed to gather crucial data that would have helped it to protect healthcare workers subsequently.

299. Rather than seeking to limit the number of reports made under RIDDOR, the BMA believes that the HSE ought to have issued clear and detailed guidance to the healthcare sector and widely publicised this, to make clear that the significantly higher incidences and risk of infection experienced by healthcare workers was itself sufficient to establish reasonable evidence of occupational disease requiring a report under RIDDOR.

HSE did not act on concerns about RIDDOR reporting raised by the BMA

300. Acting on concerns from members about RIDDOR reporting practices 'on the ground', on 1 December 2020 and later on 24 March 2021, the Chair of the BMA's Occupational Medicine Committee wrote to the HSE to clarify the circumstances in which likely exposure to COVID-19 in a workplace is reportable under RIDDOR as well as seeking clarification on responsibility for determining the correct level of RPE which would negate the need for RIDDOR reporting (PB/069 - INQ000118222, PB/463 - INQ000400480).

301. The BMA has no record of a response to our 01 December 2020 letter; however, on 28 April 2021, HSE replied to the BMA's 24 March letter (PB/439 - INQ000400457). This included a link to guidance, *RIDDOR reporting of Covid-19* that included a section setting out principles to consider in determining 'reasonable evidence of occupational exposure' (PB/465 - INQ000397285). However, as set out above, this guidance was confusing and set an unnecessarily high threshold for reporting.

There was significant underreporting via RIDDOR and under investigation by HSE of RIDDOR reports

302. The Trades Union Congress concluded that there had likely been widespread under-reporting of COVID-19 cases through RIDDOR (PB/466 - INQ000119177). Employers may have felt, due to the confused guidance, that the threshold for reporting had not been met or that cases were not reportable.

303. Further, even if the BMA is found to be mistaken in its belief that the correct threshold for RIDDOR reporting is reasonable grounds, and the Inquiry determines that a balance of probabilities test is more appropriate, this ought to have made almost no difference to the number of reports required because on either test a report was required based on the "*large body of consistent supporting evidence showing that, for Health and Social Care Workers, whose work brings them into frequent close proximity to patients or clients, there is a significantly increased risk of infection, subsequent illness, and death*" (PB/449 - INQ000339411).

304. As outlined in the previous section, the BMA is aware of many doctors taking exceptional measures to prevent the risk of infecting family and loved ones, including in some cases staying in hotels or sleeping in separate rooms and avoiding social mixing, making it more difficult to have contracted COVID-19 anywhere else except in the work place, even at times when there was high prevalence in the community.

305. There is also evidence, including from information disclosed in response to a Freedom of Information request by the Pharmaceutical Journal, that suggests the HSE failed to investigate a number of NHS staff deaths from COVID-19, even when they were reported under RIDDOR (PB/467 - INQ000397330). Pre-pandemic, it is the BMA's understanding that it would be the norm for every death reported under RIDDOR to be investigated by the HSE as well as a significant number of other cases. Even allowing for the fact that there may have been capacity constraints impacting the HSE's ability to investigate every report under RIDDOR, the BMA would expect that there should have been a rigorous system in place for triaging and ensuring a robust sub-sample of cases was investigated including all deaths. We believe the Inquiry undertaking an examination of the data from the HSE on this issue would be extremely helpful.

306. This section reflects the BMA's analysis and understanding of the problems with RIDDOR during the pandemic for healthcare workers, which can be summarised as:

    a. A lack of enforcement by HSE of employers' duties under health and safety law including RIDDOR, evidenced by HSE not publishing detailed guidance for employers on health and safety in the workplace in relation to COVID-19.

    b. A failure by HSE to issue clear, accurate guidance on RIDDOR reporting of COVID-19 and to actively publicise and enforce the guidance, which led to under-reporting and, at times, a deterrence of reporting.

    c. A failure to appropriately investigate RIDDOR reports of cases of COVID-19 in healthcare workers, including some deaths.

307. The guidance issued by the HSE relating to RIDDOR changed during the pandemic. Earlier versions of guidance are not easily accessible online. This makes it difficult to fully understand the guidance on RIDDOR and the decisions that were taken by the HSE that impacted on RIDDOR reporting and investigation.

308. We therefore ask that the Inquiry seeks disclosure from the HSE of the following:

a. All copies of the RIDDOR guidance issued by the HSE on COVID-19, including the dates published and the dates of any revisions or changes to the guidance.

b. An explanation and accompanying documentation setting out the process by which the guidance was decided (including drafts and revisions), who within the HSE was responsible, and the extent of external input from other government departments and agencies. This should include internal documents, minutes of meetings, correspondence including emails and other relevant documents.

c. The evidence, including appraisals by the HSE used to determine the appropriate guidance. In particular, any evidence used by the HSE to determine that the recommendations in the IPC guidance constituted 'effective control measures'.

Many staff were either not, or ineffectively, risk assessed, not helped by inadequate guidance

Governments failed to issue clear practical individual risk assessment guidance

309. An integral part of IPC practice and an important tool in ensuring that employees are safe and protected at work, risk assessments of the environment and, where appropriate, the individual, are a legal duty. An employer in healthcare would, by law, have been expected to undertake risk assessments immediately when an actual or potential hazard is identified and to review them regularly.

Access to risk assessments for individual doctors was inadequate, particularly at the start of the pandemic

310. Findings from BMA member surveys showed that risk assessment for individual doctors, to identify any factors which could place a person at increased risk of severe disease and adverse outcome if infected by COVID-19, was far from comprehensive and at the start of the pandemic, inadequate. By May 2020, 64% of respondents to a BMA COVID-19 tracker survey had not been risk assessed in relation to their potential contact with COVID-19. Around 4 in 10 of the respondents to the survey who had had a risk assessment felt their risk assessment was ineffective at protecting them at work. By October, around 7 in 10 respondents (73%) to a BMA tracker survey said they had been risk assessed which indicated that, although assessments were not yet comprehensive, they were increasingly widespread[59].

[59] BMA Covid-19 tracker survey (England, Wales, Northern Ireland), 22 October 2020. 7,820 respondents answered this question.

311. Respondents to our 2021 call for evidence also told the BMA about their experiences with risk assessments, many of which were negative (PB/013 - INQ000118474). The main reason cited among those who had negative experiences was that the recommendations made in the risk assessment were not fully implemented. This was often because of the nature of doctors' roles, their working environment or staff pressures meant they were not able to work in the way their risk assessment recommended.

    a. *'Individual assessments were carried out but not implemented due to pressure of work.' (Consultant, Scotland)*

    b. *'Irrespective of your risk profile if you are Duty GP and there is a sick patient who needs to be seen you have to see them.' (GP contractor/principal, England)*

312. There was also variation in approach to risk assessments between employers. On 10 September 2020, the BMA published an opinion article featuring a junior doctor who explored this variation (PB/468 - INQ000397244). They highlighted that, in the absence of clear and uniform national guidance, clinically vulnerable staff were having to do a lot of the 'leg-work' themselves to complete risk assessments and work safely.

313. Many staff had to self-complete their risk assessments, without input from their manager or, importantly, occupational health. In Wales, risk assessments were done on-line via the Electronic Staff Record. Almost half of respondents to the BMA survey of doctors with post-acute COVID-19 complications ('long COVID') who had been individually risk assessed (48%), said this was a self-completed assessment, compared with one quarter who said a senior clinical colleague/manager had been involved (26%), versus just 6% that involved an occupational health specialist. This is likely to be a factor in risk assessments being perceived by some doctors as little more than a 'tick box exercise' without clear outcomes.

314. Had more staff had access to an appropriate risk assessment, and had the recommendations within their risk assessments been implemented, it is likely that more would have been protected from infection. Among respondents to our long COVID survey, 46% reported not being risk assessed before they contracted COVID-19. Most believed they acquired COVID-19 in the workplace and the highest proportion of respondents (77%) were likely to be of this view if they were infected in 2020, when restrictions on non-essential activities were most strict and doctors were often working in relative social isolation. Respondents were also least likely to have been risk

assessed if infected in 2020 (23%) but more likely in 2021 (64%) or 2022 (77%). This data, which should also be seen in context with what we consider was a failure to supply adequate PPE and RPE (further details later in this section), indicate the likely material consequence of a failure to implement a universal programme of risk assessment among doctors and other healthcare workers when the pandemic began.

Ethnic minority doctors experienced particular issues with risk assessments

315. Recently published independent data from UK-REACH (the United Kingdom Research Study into Ethnicity and COVID-19 Outcomes in Healthcare Workers) gives an important insight into how experiences of risk assessment varied during the pandemic. UK-REACH is an interdisciplinary, multi-centre study funded by the National Institute for Health Research and UK Research and Innovation, tasked with investigating if, how, and why ethnicity affects COVID-19 outcomes in healthcare workers. Findings from an ethnically diverse sample of UK healthcare workers (PB/469 - INQ000397311), suggests that between December 2020 and March 2021, those from an ethnic minority background were more likely than their White counterparts to have been offered and completed a risk assessment, after adjusting for occupation. However, ethnic minority healthcare workers were less likely to report having changes made to working practices after risk assessment and more likely to have unfulfilled wishes for changes to their working practices.

316. Four in ten respondents to our call for evidence for the BMA's 2021 COVID-19 Review said they believed that risk assessments were mostly or completely ineffective at protecting them (39%). Respondents from an ethnic minority background were even more likely (48%) to say risk assessments had been mostly or completely ineffective, whereas around one third (35%) of their White colleagues were of this view. This is particularly concerning given that 44% of doctors are from an ethnic minority background but this group made up 94% of all those who lost their lives during the first wave (PB/444 - [redacted] - **INQ000352887)**

317. It is not possible to conclusively say why ethnic minority doctors and healthcare workers report differently on risk assessment, though their experience should be seen in context with the disproportionate number of deaths among ethnic minority doctors and other healthcare workers, especially early in the pandemic (PB/444 **- INQ000352887)**

318. The fact that twice as many ethnic minority doctors as White doctors reported feeling pressured to work in high-risk settings without adequate PPE (another finding of our

2021 call for evidence) and a greater fear of raising concerns (and impacting ones career or being judged negatively by colleagues) in an NHS which still faces a significant degree of institutional racism, will likely have played a role in ethnic minority doctors reporting of the lack of effectiveness of risk assessments compared to their White colleagues (PB/469 - INQ000397311).

The BMA raised concerns about risk assessments on a number of occasions

319. Doctors going without individual risk assessments is unacceptable. This highlights that healthcare workers were expected to carry on working regardless of risk, especially in the earlier stages of the pandemic. Timely and comprehensive risk assessments could have picked up on doctors' individual circumstances, identified significant risk factors from the virus and mitigated vulnerabilities in the presence of IPC advice that failed (and still fails) to recommend appropriate RPE.

320. The BMA was aware of inadequate risk assessment of doctors through our COVID-19 tracker surveys and, in the absence of sufficient guidance from the Government, took the following action to raise its concerns with Government for all doctors, as well as raising particular concerns about those at heightened risk (including ethnic minority doctors).

In England the BMA:

a. Called in April 2020 for NHS England to develop a risk profiling framework to assist employers in conducting risk assessments that would take into account not only age, but other factors such as ethnicity, sex and comorbidities (PB/056 - INQ000097947). When such guidance was eventually published in May 2020, the BMA remained concerned about variation in how vigorously it was being applied locally and called in a letter on 20 May 2020 (PB/057 - INQ000097908) for more practical advice on how to mitigate risks to health, stronger direction for organisations (including primary care where occupational health services were not available to most staff) and offered to work with NHS England and NHS Employers on establishing a risk assessment tool that would engender confidence among organisations and the diversity of the medical profession which urgently required risk assessment in England. The BMA was clear that it was vital that doctors and other frontline staff were properly protected by both a risk assessment of the environment to which they were deployed, an individual

risk assessment (of which a risk profiling framework should be part), and the provision of the appropriate PPE they needed to practise safely.

b. Called in the same letter to NHS England on 28 April 2020 (PB/056 – INQ000097947) to reduce the age at which frontline staff were categorised as 'at-risk' to 60, from the then threshold of 70, in line with the WHO's advice on 11 March 2020 (PB/058 - INQ000116843) that people over 60 were one of the groups at higher risk of getting severe COVID-19 disease.

c. Highlighted in June 2020 the need for greater support to conduct risk assessments in general practice (PB/059 - INQ000097851).

In the devolved nations, the BMA national offices shared similar concerns about risk assessments:

d. On 29 May 2020, BMA **Northern Ireland** wrote to the Northern Ireland CMO (PB/062 - INQ000116868) to draw attention to the need for appropriate risk assessment of doctors from ethnic minority backgrounds, and those with disabilities and long-term health conditions which may make them more vulnerable to COVID-19.

e. In Scotland, BMA **Scotland** raised similar concerns about staff risk assessments via email to the Director General of Health and Social Care on 29 April 2020 (PB/063 - INQ000117069), followed by sharing the BMA's risk assessment tool (see below) directly with the Director of Health Workforce on 04 June 2020 (PB/470 - INQ000400410).

f. In Wales, BMA Cymru **Wales** raised concerns about the adequacy of existing risk assessment tools with the Director of NHS Workforce and Public Health Wales (21 May 2020), and with the COVID-19 Workplace Assessment Sub-Group (12 June 2020) (PB/471 - INQ000118548, PB/472 - INQ000118557). As a consequence of direct engagement with the Welsh Government and NHS Wales representatives throughout this period, BMA Cymru Wales influenced changes to the proposed framework for an all-Wales staff-side risk assessment, giving greater confidence it would help to minimise risks for more vulnerable staff members.

In the absence of clear practical guidance from governments, the BMA produced its own guidance and practical tools for doctors

321. In the absence of stronger direction from the UK government on risk assessments, the BMA also published its own guidance and advice for members, including:

    a. BMA guidance on risk assessments tailored for the needs and context of general practice, recognising the dual role of GP contractors as practitioners and employers and the role of salaried/employed GPs within practices (18 June 2020), which was shared with NHS England on 16 June 2020 prior to publication (PB/473 - INQ000400412) and was later updated in 2022 (PB/474 - INQ000397249).

    b. Publication on the BMA website and dissemination of a risk stratification tool and guidance for all members, which had been developed by the chair of the BMA's Medical Academic Staff Committee as part of his professional academic work and made freely available to download via the BMA website (05 July 2020) (PB/061 - INQ000355841).

Medical professionals often worked without adequate protection due to a lack of adequate and appropriate PPE

322. Delayed procurement, delivery and PPE not fit for purpose meant that medical professionals on the frontline often had to go without PPE, reuse single-use items, items that were out of date with multiple expiry stickers visibly layered on top of each other, or use homemade or donated items, especially in the Spring of 2020. This section provides a summary of the issues relating to PPE that doctors experienced during the pandemic, including access to PPE, PPE fit testing, guidance on use and access to PPE for particular groups. This section also sets out the BMA's action to ensure appropriate protection for members. This section should be read alongside the earlier section on the IPC guidance deficiencies and the consequences of this for the PPE recommended and provided to doctors.

323. Like many issues in the COVID-19 pandemic, PPE and its lack of availability did not impact the medical profession equally. Adequacy of PPE guidance and PPE fit testing all contributed to healthcare workers in general, and certain groups of healthcare workers in particular, being placed at greater risk from COVID-19 and adverse physical and mental health outcomes as a result. Doctors from ethnic minority backgrounds more commonly experienced shortages and pressure to work in environments without

sufficient PPE[60] and ethnic minority doctors and those with a disability or long-term health condition were more likely to report feeling worried or fearful to speak out about a lack of PPE[61].

324. The BMA repeatedly highlighted that medical professionals were not being provided with the PPE they needed throughout the pandemic, and our surveys captured at first hand these acute shortages.

325. Shortages were reported in both AGP and non-AGP settings. Respondents to the BMA's April 2020 UK-wide COVID-19 tracker survey working outside of AGP environments, but with patients with possible or confirmed COVID-19, reported shortages of PPE. One in three respondents (30%) said they lacked eye protection, nearly four in 10 (38%) were without scrubs, and 16% reported a lack of even basic FRSMs[62]. Shortages were also experienced in settings where AGPs were carried out (these were the procedures where the IPC guidance required the highest level of PPE, including RPE). By early April 2020, respondents who worked in an AGP setting told us that there were still considerable shortages or no supply of full-face visors (71%), disposable goggles (65%) and FFP3 masks (54%)[63] (see Figure 1).

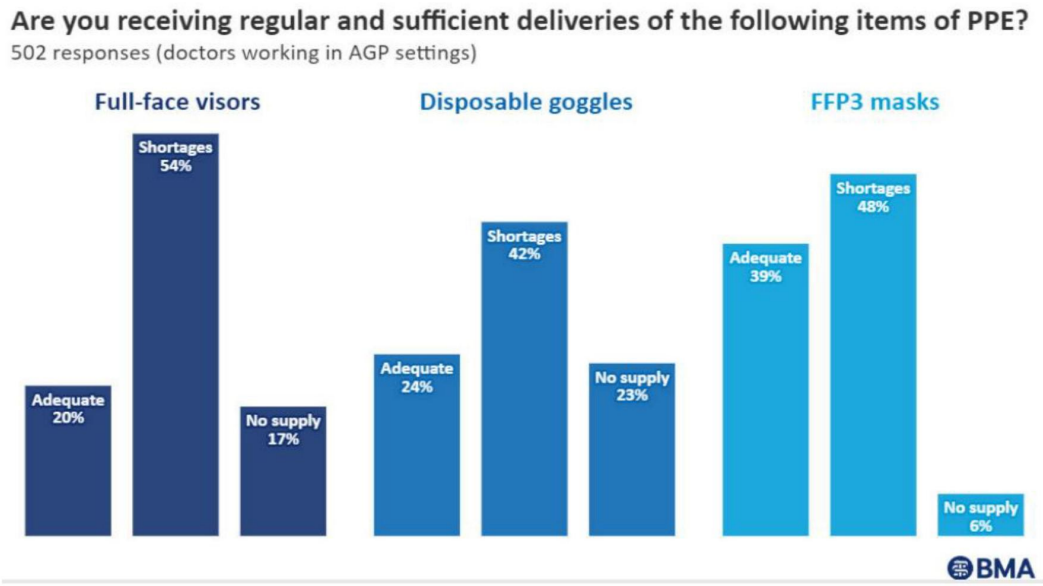
Figure 1. Shortages of PPE reported by doctors in the BMA Covid Tracker survey, 6 April 2020 taken from the Covid Review Report 1: How well protected was the medical profession?

[60] BMA Covid Tracker survey (UK wide), 30 April 2020.

[61] BMA Covid Tracker survey (UK wide), 14 May 2020.

[62] BMA Covid Tracker survey (UK wide), 30 April 2020.

[63] BMA Covid Tracker survey (UK wide), 6 April 2020.



326. PPE shortages were also frequently mentioned in our 2021 COVID-19 call for evidence by respondents working in both AGP and non-AGP settings. Many described how exposed, poorly protected and incredibly let down they felt:

    a. *'At the start, despite knowing of the virus spread, no PPE was provided. Not even masks let alone thinking of level 2 PPE for aerosol generating procedures.'*

    b. *'Amazed at how paltry it was, [I] felt undervalued. Like going over the top in WW1 with a bow and arrow.'* (GP contractor/principal, Northern Ireland).

    Others described the lengths to which they, and others desperate to support them, would go to supply vital equipment.

    c. *'We made our own, and bought our own when we could find any, we depended on friends sourcing FFP3 masks, my son's school 3D printing visors.'* (SAS doctor, England)

327. The accounts of PPE shortages from BMA members in Wales were documented in the Audit Wales 2021 report: Procuring and Supplying PPE for the COVID-19 Pandemic (PB/476 - INQ000214235) and broadly reflected the UK wide picture. GPs in Wales in one health board were issued with a single FFP3 mask each for the duration of the pandemic by the health board and ended up buying RPE from on-line retailers and local DIY stores.

328. PPE shortages were most acute in the first COVID-19 wave, with 81% of respondents in the BMA's 2021 call for evidence saying they did not feel fully protected during the

first wave. However, protection for healthcare workers was lacking throughout the pandemic. Although they had begun to ease by July 2020, shortages remained for FRSMs (10%) and also for respirators for clinical care with AGP procedures (15%).[64] This meant that many staff were working with COVID-19 positive or suspected positive patients without proper protection, wearing inadequate FRSMs with patients coughing repeatedly in their faces as they sought to assess them or undertake investigations such as blood tests.

329. The BMA engaged frequently and at a high level with the UK Governments in raising the concerns of our membership, drawing from their experiences of what failing to supply adequate PPE meant to those who desperately needed it. The BMA raised concerns about PPE directly with the Prime Minister, the SoS, DHSC Ministers, the CMO for England, PHE, NHS England, the HSE and via media interventions (see section C). We also raised concerns locally with trusts, where members raised these with us through the BMA's First Point of Contact services and dedicated out of hours PPE hotline (see section C).

A lack of PPE and inadequate PPE put doctors at risk as they worked tirelessly to care for patients

330. Early in the pandemic, shortages of PPE were so severe that at the time the BMA had to produce guidance for staff detailing their rights as well as moral obligations if they did not feel adequately protected (PB/098 - INQ000117758).

331. Worryingly, many respondents to our call for evidence, particularly those working in hospitals, reported feeling pressured to work without adequate protection and described the worry and anxiety this caused. As a Consultant in England wrote: *'I was put under pressure to carry on regardless and 'support my colleagues'.'*

332. The BMA is not aware of specific examples from doctors of care not being provided, or being limited, because of a lack of or simply inadequate PPE. This is starkly revealing of the profound care and sense of duty members of the medical profession have to patients, many of whom during the pandemic presented with urgent medical needs.

333. However, doctors and other healthcare workers should not have been exposed to COVID-19 hazards so unnecessarily, because of inadequate PPE and significant shortages and it is likely that this increased the number of COVID-19 infections among

[64] BMA Covid Tracker survey (England and Wales), 09 July 2020.

staff, cases of long COVID and deaths. The BMA warned about this at the start of the pandemic when, dissatisfied with UK Government assurances about supplies of PPE and receiving reports from members of inadequate PPE in their workplace, on 25 March 2020, the BMA warned that doctors and patients were at risk of illness and death due to a lack of protection (PB/477 - INQ000397240).

334. The BMA does not wish for doctors and other healthcare colleagues to be lionised for putting themselves in harm's way, and neither do they. What we and they do want, however, is for the lack of availability of functioning, effective and properly fitting PPE, appropriate for the hazards they were asked to face, to be recognised so that such lessons truly are learned, and the same failings are not repeated.

PPE fit and availability of fit testing was a further factor which limited the protection of doctors and particularly impacted specific groups, such as women, ethnic minorities and disabled people

335. A lack of PPE was not the only barrier to healthcare workers being properly protected from COVID-19. For PPE, especially RPE such as FFP2/FFP3 masks, to work effectively they must be properly fitted and be tight fitting. Poor availability of fit testing to ensure properly fitted masks was a frequent problem cited by respondents in our 2021 call for evidence. Moreover, where fit testing did occur, it was often useless as shortages meant only poor-fitting masks were available.

    a. *'It was really poor; little or no fit testing and even if you had been fit tested, the chance of finding the right mask was very remote.'* (Consultant, England)

    b. '*Haphazard availability, multiple fit testing due to masks going out of stock.'* (Consultant, Northern Ireland)

336. Women particularly struggled to find well-fitting masks. There is a gender bias within PPE – which is largely manufactured to suit white male faces and physiques – meaning PPE was less likely to fit women, despite making up around 77% of the healthcare workforce (PB/478 - INQ000397278). This was a problem that emerged at the start of the pandemic and persisted throughout. Respondents to our 2021 call for evidence survey set it out well:

    a. *'I didn't feel fully protected at all and in particular being female and small and failing fit testing several times with several masks I was left feeling quite vulnerable from this.'* (Consultant, England, female)

Similarly, access to well-fitting PPE was also raised as a problem by some ethnic minority respondents:

b. *'Using FFP3 with black hair is easier with a hair cover. The elastic snags. PPE posters do not routinely show or normalise the reasonable adjustments necessary for non-religious and religious reasons for covered hair.'* (Consultant, Scotland, Black/Black British)

337. Across a range of BMA tracker surveys, female respondents consistently reported slightly higher rates of failing a fit test, compared to males.[65] Other non-BMA research also suggests that failure rates for fit testing are higher in staff from ethnic minority backgrounds compared with staff of White ethnicity (PB/479 - INQ000397300).

338. The BMA consistently raised the disproportionate impact of PPE decisions on women and some staff from ethnic minority backgrounds and certain religious groups (such as those who wear a beard or hair covering for religious reasons), who faced greater difficulties in finding well-fitting masks. The BMA raised these concerns with NHS England, DHSC and the British Safety Industry Federation (PB/072 - INQ000097864, PB/075 - INQ000097948, PB/076 - INQ000097874)

a. The BMA wrote to the Chief Executive of NHS England on 9 April 2020 (PB/072 - INQ000097864) on a range of issues affecting some doctors with differing needs, including the need to ensure there is sufficient supply of effective PPE for those who wear beards for religious reasons.

b. The BMA, jointly with the RCN, wrote to the British Safety Industry Federation on 28 May 2020 (PB/075 - INQ000097948) expressing concern that specialist FFP3 masks disproportionately do not securely fit smaller, often female face shapes. This led to many female nurses and doctors failing fit testing. While recognising the primary obligation to provide suitable and sufficient PPE rests with the employer, in the context of the pandemic the BMA and RCN asked the industry to review the design of PPE, including masks.

---

[65] BMA Covid Tracker Surveys, 30 April 2020 – 18 June 2020 (responses from hospital doctors working in England and Wales only)

c. Later, on 13 January 2021, the BMA wrote to Jo Churchill MP, Parliamentary Under Secretary of State (DHSC Minister for Prevention, Public Health and Primary Care) highlighting ongoing concerns about female doctors still, one year into the pandemic, struggling to find respirator masks that pass fit testing and called for appropriate PPE to urgently be made available to meet the diverse needs of the healthcare workforce (PB/076 - INQ000097874).

339. One of the key recommendations from the first report of the BMA's COVID-19 Review (*How well protected was the medical profession?*) was that a diverse medical workforce must have PPE that is suitable to different face and body shapes, varying hair textures, head coverings, and facial hair so all workers can access adequate protection. This should be reflected in design, testing and procurement. During the Module 1 hearings of the Inquiry, Clara Swinson, Director General at the DHSC, accepted that these issues were not adequately considered as part of pandemic planning prior to COVID-19 as borne out by the experience of doctors and other healthcare workers[66].

340. In addition to these challenges, the universal need for masks and respirators in clinical settings caused difficulties for Deaf healthcare workers who relied on lipreading for communication. While steps were eventually taken to mitigate such issues, such as the development of clear face masks, progress was painfully slow.

341. On 15 December 2020, NHS England held a stakeholder meeting to discuss the lack of clear face masks for Deaf healthcare workers, which the BMA attended. At that point, NHS England said they would undertake a pilot of different types of masks. It was not until April 2022 that three clear medical masks were approved that conformed to health, safety and environmental protection standards. These were, however, not available on the NHS supply chain and had to be purchased by NHS trusts directly from suppliers.

<u>Guidance for healthcare workers on the use of PPE was often inadequate</u>

342. We also received testimony in our 2021 call for evidence about the quality of guidance on how to safely use PPE in healthcare settings. Practices like safe donning and doffing play a key role in ensuring the safety of the wearer and ensuring that hazardous PPE is safely disposed of.

[66] UK Covid Inquiry transcript of Module 1 Public Hearing on 19 June 2023 (pages 187-188).

343. There was a large degree of variation among respondents in how well trained they were in using PPE, but also in safely removing it. Some respondents reported receiving effective doffing and donning training and they emphasised that this was usually locally organised and in contrast to centrally administered guidance. Others reported receiving little to no training and being expected to instinctively know what procedures to implement.

    a. *'The IPC team dashed around saying follow droplet precautions without actually ensuring practical training to frontline doctors and nurses, never mind the poor porters, domestics, etc. There were no donning & doffing posters, no SOPs [Standard Operating Procedures] for how to get items (equipment, food, drink) in & out of an infectious room. There were huge assumptions made by off-ward staff that front-line staff would just know how to do these things, so no attention was paid to these details.'* (Consultant, England)

344. The BMA believes that PPE should be provided with centrally coordinated guidance and practical training on how to fit test, use, and dispose of it safely. This would go much further to ensuring doctors are better protected in future.

H. Healthcare provision and treatment

345. The impact of the pandemic on the delivery of health services was unprecedented in the history of the NHS. The clear failures to adequately invest in the UK's health workforce, infrastructure and services in the decades preceding the pandemic and to properly plan for the surge capacity that would be required in the event of a pandemic, such as COVID-19, meant that health services were more severely disrupted than they might otherwise have been.

346. This section sets out the views of BMA members and the BMA's involvement on a range of issues about how healthcare provision and treatment were impacted during the pandemic. These include:

    a. shortages of key equipment and supplies;

    b. the ability of doctors to deliver the right care at the right time;

    c. concerns about the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders;

    d. the impact on treatment of patients with non-COVID-19 conditions.

347. The information the BMA holds on these specific issues is set out in this section, along with further detail about access to healthcare for undocumented migrants; and the impact on care delivery in private practice. Generally speaking, the impact of the pandemic on non-COVID-19 care delivery was significant for both staff and patients – many of whom could not access (elective) treatment or whose treatment was significantly impacted (such as in maternity care where strict IPC rules meant partners were unable to attend scans or visit women admitted with pregnancy complications in many hospitals).

Shortages of equipment during the pandemic

The UK had too few ventilators and last-minute efforts to improve stocks were costly

348. The UK started out on the backfoot in relation to the supply of intensive care ventilators. This is because the recommendations set out in Exercise Cygnus were largely overlooked, despite concerns around ICU ventilator capacity. The failure to action the recommendations meant that, at the pandemic's onset, there was already a serious risk of the UK running out of ventilators.

349. In late February and early March 2020, the UK Government conducted a survey of NHS Trusts in England to determine ventilator capacity. The results showed that the NHS in England had an absolute maximum of around 7,400 mechanical ventilators – a number deemed insufficient based on modelling from NHS England, which estimated a need for up to 90,000 ventilators. Efforts were therefore made to boost capacity, and by mid-April (the peak of the first COVID-19 wave) 1,800 new ventilators had been acquired (PB/480 - INQ000087456).

350. Similarly, the Scottish Government ordered 300 new ventilators, doubling their ventilator capacity by March.[67]

351. According to a Cabinet Statement from the Welsh Government (dated 6 April 2020), NHS Wales had 415 ventilators in Welsh hospitals, capable of invasive ventilation. Additionally, they had 349 anaesthetic machines with ventilator capacity, and 207 non-invasive ventilators. The statement mentions that a further 1,035 ventilators were being procured by NHS Wales Shared Services Partnership and through UK arrangements (PB/586 - INQ000433856).

[67] The Times, *Scottish NHS orders 300 new ventilators to double capacity,* 16 March 2020.

352. In Northern Ireland, health minister Robin Swann said on 16 March 2020 that only 139 ventilators were available. He also sought help, asking if anyone could produce more ventilators by 'reprofiling' their manufacturing equipment. At the time of Swann's statement, 40 new ventilators had been ordered, due for delivery by the end of the month (PB/569 - INQ000433860).

353. The UK Government *had* been invited to participate in a pan-EU effort to procure ventilators, but this deadline was (ostensibly) missed – marking the first of several key failures around equipment. Instead, the UK Government contracted private companies to build up ventilator capacity in the UK's health services. Many of the companies had no prior appropriate experience or expertise in the manufacturing of ventilators, bringing the rationale behind the awarded contracts into question.

354. Had the UK Government jointly purchased ventilators with other EU countries, they could have likely secured better value for money. This is because pooling country requests improves bargaining power, thereby reducing the cost of equipment. Instead, by August 2020, DHSC and the Cabinet Office's emergency procurement of 26,000 ventilators UK-wide had cost the taxpayer £569 million. Ultimately, demand for ventilators was not high enough for this to cost lives – of the 26,000 ventilators, only approximately 10% were used[68] - but demand *could* have outstripped supply.

355. Part of this large sum can be attributed to the very expensive purchase of Chinese ventilators, costing £50,000 per unit. The price of the ventilators was significantly inflated, relative to earlier prices for the same device. Additionally, the Chinese ventilators were unfamiliar to UK healthcare staff, and therefore not always intuitive to use. This added to the pressure staff were under, in an already high-stress environment. Indeed, the BMA's evidence submission to the National Audit Office (NAO) in May 2020 (PB/180 - INQ000117896) notes that the Shangrila 510 ventilators imported from China arrived 'dangerous and unfit for hospital use'.

356. As well as availability and cost, the *distribution* of ventilators was also found to be an issue. Reports from BMA members describe using anaesthesia machines instead, which are not designed for long-term ventilatory support and usually require supervision by staff trained to use them. This occurred particularly in London, despite there being many unused, fully functional invasive ventilators available elsewhere in the UK. This suggests

[68] House of Commons Public Accounts Committee report: 'Covid-19: Supply of ventilators', 25 November 2020. Page 9, paragraph 4.

that the distribution of ventilator stock may have been poorly planned in line with demand. Overall, in its submission to NAO, the BMA described the government's response to potential foreseeable issues in relation to ventilators as 'arguably late, muddled, and inefficient'.

Oxygen never 'officially' ran out, but there were challenges with getting high-flow oxygen into outdated buildings, and BMA members also reported shortages

357. Health services estates were underprepared for responding to a large-scale respiratory pandemic, necessitating the delivery of high flow oxygen to large numbers of people.

358. In his testimony for Module 1, Nigel Edwards (CEO of the Nuffield Trust) explained that high flow oxygen was not anticipated as a method of treating COVID-19, and that – in many cases – the hospital pipework of oxygen supply was inadequate (especially relative to the scale of the pandemic). Some hospitals therefore had to make major engineering and structural changes at pace in order to ensure high flow oxygen supply.

359. In the interim, this meant staff had to adapt. In my oral evidence in Module 1, I discussed how intensive care consultants had to perform physics calculations of oxygen flow through pipes to determine whether more oxygen could be delivered around the hospital I work in. During this time, staff reported feeling so unprepared, they feared they faced death and readied themselves for this possibility.

360. In addition to this, we got dangerously close to running out of oxygen. Throughout the pandemic, there were moments when members reported shortages. These included:

    a. Our COVID-19 tracker survey from 16 April 2020 found that 33% of respondents (out of 4,652) experienced shortages of medicines, medical gases or other therapeutics (such as ventilators) most or some of the time. Of these, almost a fifth (19% out of 2,682) reported a shortage in oxygen supplies. One consultant in our 2021 call for evidence wrote that there was *"shortage of ventilator capacity initially",* but that the *"main threat was the integrity of the oxygen supply".*

    b. Notes from 23 April 2020, from one of the regular internal '08:30am calls' established by the BMA during the pandemic, show that "*oxygen rationing [was] becoming an increasing problem*". This included doctors adjusting flow rates below recommended standards, effectively reducing the amount given to patients to avoid running out of oxygen and spread limited supplies between a larger number of patients where necessary. Such 'anticipatory rationing' was

described by one consultant from England in our 2021 call for evidence survey who spoke about the "*rationalisation of oxygen [...] by lowering the thresholds for oxygen treatment*" and described "*everyone pretending it was ok*".

361. Similarly, supply issues impacted the supply of oxygen. A Guardian article from 30 December 2022 chronicles how ambulance crews in some parts of England were urged to conserve oxygen by their Trusts (PB/481 - INQ000397251). This is because, due to increased demand, suppliers were unable to refill their tanks, placing patients in a potentially unsafe position. Some suppliers claimed that demand for oxygen cylinders was even higher than during the first wave of the pandemic, due to the 'twindemic' of COVID-19 and the flu that winter.

362. While ultimately we did not run out of oxygen at a national level, one Junior Doctor from England wrote in the BMA's 2021 call for evidence survey *"it was mostly luck that our oxygen supplies didn't fail in various hospitals'.*

363. Overall, almost 40% of 4,273 respondents to the BMAs COVID-19 tracker survey of 16 April 2020 felt that shortages of medicines, including medical gases such as oxygen forced them to provide less effective care to patients than they normally would either frequently or occasionally.

364. Due to these issues, as well as wider fears of the healthcare system being overwhelmed, the BMA issued ethics guidance on 16 March 2020. This covered resource allocation, warning that restrictions in the availability of mechanical ventilation may become severe. The guidance states that doctors would be obliged to make decisions that mean "*some patients may be denied intensive forms of treatment that they would have received outside a pandemic*" (PB/143 - INQ000117773).

<u>Weaknesses in supply chains meant blood tests had to be rationed</u>

365. The pandemic also exacerbated other risks within NHS supply chains. This is illustrated by the example of Becton Dickinson (BD), set out below:

    a. BD at the time was the primary provider of blood test tubes in the UK, which in itself presented risks, alongside the failure to at least ameliorate this risk by having any kind of reserve supply.

    b. BD alerted the NHS Supply Chain to supply shortages on 30 July 2021.

    c. On 13 August 2021 in a meeting with NHS England, the BMA was informed that 1.7 million test tubes are used in England every week, and that action must be

taken immediately to reduce their usage (i.e. rationing). England, Wales and Scotland were all affected by the blood bottles shortage due to an over-reliance on this one manufacturer (BD). Northern Ireland was largely unaffected as they relied on a different supplier.

d. On 26 August 2021 during a phone call with NHS England, the BMA was informed that the shortage impacted most main BD blood tubes to varying degrees. NHS England then shared in a letter that alternative products were being sought, and that labs would switch to the alternatives once samples had been sent for testing and validation. The letter cautioned that it would take time to import and deliver these products to NHS services in volume. Doctors were therefore advised to suspend blood tests that were not listed as clinically urgent until 17 September 2021.

e. Following this, the BMA issued a press release on 28 August 2021 stating that "*doctors will have to make very difficult choices about which patients get blood tests*" due to the shortage of test tubes worsening. The press release warned that even the most clinically important blood tests may be at risk if the NHS does not reduce the amount of test tubes being used (PB/565 - INQ000442325).

f. By the end of August 2021, hospitals had already cut their total number of blood tests by 25%. However, due to the suspension of non-essential blood tests, NHS England guidance warned that vitamin D deficiency testing, allergy testing, routine fertility testing and pre-diabetes testing, among others, would be impacted. This meant that health professionals were having to make difficult choices about how to best use the available stock, and judge who was eligible for a test. It also contributed to an increase in the backlog of diagnostic care.

g. BMA members expressed their concerns plainly, chief amongst them: implications for patient safety, and anger that the shortage had been allowed to happen in the first place. In particular, GP practices were put in a position where they had to assess which already scheduled tests could be cancelled. This took time away from frontline patient care. In addition to this, cancelling tests made patients anxious and – more concerningly – could result in delayed treatment or a missed diagnosis.

h. On 3 September 2021, the BMA sent a letter to Sajid Javid, then Secretary of State for Health (PB/482 - INQ000400492). The letter expressed concern over

the lack of national planning for the event that there was an issue with the UK's one blood tube manufacturer. The letter also expressed worry over the lack of public-facing communications from NHS England or the government. It called for a nationally coordinated patient education campaign, explaining that the blood bottles shortage was a national pan-NHS situation and was not the fault of individual clinicians. This aimed to minimise further criticism from the media and patients. (At the time, doctors were bearing the brunt of frustrations brought about by access issues completely outside their control.)

Ability of doctors to deliver the right care at the right time during the pandemic

366. Even before the pandemic, rationing of care as a result of under-resourcing was commonplace, as illustrated in growing waiting lists, high bed occupancy and increasing 'corridor care'.

367. During the pandemic this situation was exacerbated as a result of limited resources, a lack of adequate staffing (see also section B) which was made worse as staff became ill and had to isolate, and the need to respond to growing numbers of COVID-19 patients. It is therefore not surprising that most respondents to our COVID-19 tracker survey[69] (92%) said they had been unable to provide patients with the right care at the right time at some point during the pandemic.

368. We do not hold further information about this question and did not ask a free text question on the issue in this survey. However, we believe this result reflects the situation the UK's health services were in going into and during the pandemic, as set out in this witness statement, alongside the role played by the necessities of providing treatment during the pandemic. In obstetrics and gynaecology, for example, strict IPC measures meant that pregnant people having an ultrasound were unable to be accompanied, and that partners were also only allowed to join labour wards and birthing suites during 'active' labour. Both were less than ideal ways of caring for patients.

[69] BMA Covid Tracker survey (England, Northern Ireland and Wales), 17 December 2020. 6,567 respondents answered this question.

369. We also have additional evidence from a further survey the BMA undertook for work on moral distress[70] and moral injury[71] (PB/385 - INQ000397269). The survey showed:

a. Those who saw only COVID-19 patients reported highly alarming levels of moral distress – 97% stated they had experienced moral distress (as opposed to 85% of those who saw non-COVID-19 patients and 88% of those who saw both COVID-19 and non-COVID-19 patients) in relation to their own ability to provide care during the pandemic.

b. 88% of those who only saw COVID-19 patients indicated they had experienced moral distress in relation to a colleague's ability to provide care (compared to 66% of those working with non-COVID-19 patients and 74% of those working with both COVID-19 and non-COVID-19 patients).

c. The extent of moral distress in those working with COVID-19 patients is significant and could demonstrate a lack of support given to those working in environments like ICUs, as well as the UK's general lack of preparedness for the pandemic, which has been well-documented.

370. The causes of moral distress in medical staff are varied but they are often consistent across countries. Doctors can experience moral distress due to a range of factors, including: lack of agency to make the best decisions for patients; insufficient resources or non-existent resources to provide care to suitable professional standards; witnessing poor standards of care; practical experience of medical care clashing with ethical standards taught at medical school and doctors' own personal ethical standards; fear or making the wrong decision when working under extreme pressure; and doctors involvement in end-of-life care decisions.

---

[70] Moral distress refers to the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action. Even without an understanding of the morally correct action, moral distress can arise from the sense of a moral transgression. More simply, it is the feeling of unease stemming from situations where institutionally required behaviour does not align with moral principles. This can be as a result of a lack of power or agency, or structural limitations, such as insufficient staff, resources, training or time. The individual suffering from moral distress need not be the one who has acted or failed to act; moral distress can be caused by witnessing moral transgressions by others.

[71] Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm. Moral injury can produce profound guilt and shame, and in some cases also a sense of betrayal, anger and profound 'moral disorientation'. It has also been linked to severe mental health issues.

There were concerns about the blanket issuing of DNACPR notices

371. While the BMA is not aware of members raising concerns about the blanket issuing of Do Not Attempt Cardiopulmonary Resuscitation notices (DNACPR notices) at the time, we were aware of the issue reasonably early in the pandemic through media reports. In our COVID-19 call for evidence in November 2021, a small number of respondents voiced concerns about this issue. For example, a consultant from England wrote: "*I am not confident that the elderly were allowed access to critical [care] in an equitable way. The action to put (a) DNAR order on and limit access to secondary care without adequate assessment and consultation with the patient was unacceptable*".

372. Towards the end of March 2020, the CQC approached the BMA requesting that we sign a joint statement with them and other organisations highlighting the importance of advance care planning for older people, those who were frail or living with other serious conditions and making clear that any decisions about whether or not to complete a Do Not Attempt Resuscitation (DNAR) Form[72] must be made on an individual basis and not applied to groups of people. This approach followed reports that some GP practices had been sending blank DNACPR forms to patients over 65 or to patients with a disability. The joint statement, which made clear that it was unacceptable for advance care plans, with or without DNAR forms, to be applied to groups of people, was published on 1 April 2020 and sent to all GP practices (PB/313 - INQ000400508).

373. Following this, the BMA published a set of principles for Advance Care Planning which were shared via the BMA's GPC newsletter to members and with Local Medical Committees, the local representative committees of NHS GPs. These principles were based on the BMA ethics team's existing, well-established principles of advance care planning and were intended to provide further guidance to GPs when faced with difficult discussions and decisions in a highly pressured environment.

374. In June 2020, the BMA ethics team then, with input from the BMA's GPC, developed a leaflet for patients about advance care planning, including an explanation of DNACPR decisions and how they could be made (PB/483 - INQ000397262). This was intended for GPs to aid their discussions with patients and families and to give to patients, so they could consider their advance care planning wishes and discuss them with their families.

[72] DNAR is often used interchangeably with DNACPR which is the BMA's preferred term as it more accurately reflects the decision being made.

375. In October 2020, the CQC announced they had been commissioned by the DHSC to undertake a review of DNACPR decision making during the pandemic, issuing an interim report in December 2020 and a final report in March 2021. Following the launch of the final report, the BMA issued a statement from the Chair of the BMA's Ethics Committee reiterating that DNACPR decisions should never be made on the basis of a blanket approach applied to all (PB/484 - INQ000397247).

376. The report recommended the establishment of a ministerial oversight group tasked with reviewing the state of play and making recommendations. The BMA's Community Care Committee established an advance care planning working group, including members from primary and secondary care as well as the BMA's Patient Liaison Group with a view to influencing this process. The Chair of the BMA's Medical Ethics Committee was also invited to sit on the Ministerial Oversight Group (MOG) established by the DHSC and a member of the BMA's ethics team attended a separate working group that sat under the MOG. The BMA also responded to the DHSC consultation on a set of universal principles for advance care planning, which included DNACPR decisions in May 2021 (PB/485 - INQ000400461). BMA Northern Ireland responded to a separate consultation from the Department of Health Northern Ireland on their guidance on Advance Care Planning in February 2022 (PB/486 - INQ000400496).

Joint guidance was issued by the BMA, the RCN and the Resuscitation Council on CPR

377. The UK Government did not issue specific DNACPR guidance during the pandemic. Instead, they signposted to the joint guidance issued by the Resuscitation Council (UK), the BMA and the RCN titled *Decisions relating to cardiopulmonary resuscitation* (PB/487 - INQ000331016). This guidance was originally published in 2001 and was last updated in 2016. It is the BMA's view that the existing guidance was appropriate for use in the COVID-19 pandemic, and it was not necessary for central government guidance to be issued. The issue, as outlined above, was not with the adequacy of the guidance but related to its implementation. In terms of learning lessons, it would be helpful for future pandemics to identify in advance, which protocols can lawfully and ethically be modified – and how they should be modified – in the face of out-of-the-ordinary demands on health and care services and staff.

378. The preface to the 2016 guidance provides a history of the guidance and the rationale for key updates. This provides a rationale for the development of guidance for healthcare

professionals and sets out the reasons for different updates to the guidance over the years, since the first joint guidance was published in 2001:

> "*Healthcare professionals are aware that decisions about whether or not CPR will be attempted raise very sensitive and potentially distressing issues for patients and those emotionally close to them. As a consequence there has been stand-alone professional guidance on CPR decision making since the 1990s and guidance published jointly by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing since 2001 (sometimes referred to as the 'Joint Statement').*
>
> *The guidance underwent substantial revision in 2007 in order to ensure compliance with the Mental Capacity Act 2005, to respond to feedback on practical aspects of implementing the 2001 guidance and to recognise the increasing importance of multidisciplinary working (for example by acknowledging the role of suitably experienced nurses in the CPR decision-making process in some nurse-led settings). These changes reflected emerging developments in healthcare professionals' roles and the way health care is delivered today. As part of the 2007 revision there was extensive consultation with key stakeholders including professional bodies, patient groups, regulators and charities.*
>
> *The high-level ethical principles that were embedded in the second (2007) edition underpin the guidance in this revised third edition. Recent revisions of the guidance place even greater emphasis on ensuring high-quality communication, decision-making and recording in relation to decisions about CPR. This is in response to public and professional debate about CPR decisions, to feedback from individual healthcare professionals and professional bodies, and to recent legal judgments*".

379. We are not aware of the specific circumstances leading up to the decision to develop and publish joint guidance in 2001. However, we expect it was because the three organisations had similar concerns about the need for clear and consistent guidance for health and care professionals to enable them to have these often difficult but vital conversations with patients. Given the multidisciplinary nature of healthcare, including end of life care, it made sense for a joint approach and shared guidance that crossed professional roles and boundaries.

380. It is our understanding that the joint guidance was developed collaboratively with the Resuscitation Council (UK) and the RCN via a working group. Different staff members, including staff from the BMA's ethics team, were involved in drafting sections and commenting on sections drafted by other people. The draft guidance (for each of its editions) would have been reviewed and considered by the BMA's Medical Ethics Committee (MEC). Staff from the ethics team who were most closely involved in the development of the joint guidance and the subsequent revisions are no longer employed by the BMA; therefore, this statement is based on the recollection of other staff and a search of relevant files, including MEC minutes.

Issues in the treatment of patients with non-COVID-19 conditions

381. Non-COVID-19 care was significantly impacted during the pandemic. At the start of the pandemic large chunks of non-COVID-19 care was paused and staff from these settings were often redeployed to help respond to the pandemic (as set out earlier in this statement). Later in the pandemic, staff were expected both to look after COVID-19 patients and to deliver close to normal levels of non-COVID-19 care. The delivery of care was also impacted by IPC measures which – while crucially important – reduced throughput significantly.

382. This meant that elective waiting lists and waiting times for outpatient appointments – which had been rising before the pandemic – rose even more sharply. This caused significant issues for General Practice in particular, which has found itself managing patients awaiting secondary care beyond the capacity they are resourced for by a considerable margin. This is set out in more detail in the BMA's third COVID-19 Review report which looks at the impact of the pandemic on healthcare delivery (PB/015 - INQ000185355).

383. The issues staff in non-COVID-19 care settings faced in treating patients included a lack of staff, a lack of resources and reduced productivity as a result of IPC measures, such as the requirement to thoroughly disinfect areas between patients or procedures and adhere to strict social distancing in settings that would not normally need such enhanced IPC measures. The BMA argued in July 2020 (PB/488 - INQ000397340) that the extent of the pandemic's adverse impact on services was, in part, due to political decisions made to not expand the capacity of healthcare services, in respect of bed numbers, critical care facilities, or workforce, in order for it to meet growing demand.

384. A wider implication of the pandemic on the treatment of non-COVID-19 conditions was a reluctance on the part of some patients to present at Emergency Departments and urgent care facilities due to fear of the virus, despite having symptoms of major ill-health. In May 2020, the BMA strongly emphasised the need for patients to be encouraged to continue to seek urgent and emergency care if they needed it, and not to be deterred by fear of COVID-19 or of 'burdening' the NHS (PB/384 - INQ000397312). This was a particular issue regarding patients experiencing suspected heart attacks. Research from July 2020 suggested that, at that time, as many as 5,000 people had missed out on life saving treatment for heart attacks as a consequence of the pandemic, with many not seeking care due to fear of COVID-19 transmission (PB/489 - INQ000397256).

Treatment of patients with specific clinical conditions

385. Cancer care was prioritised, but care was affected, and performance targets were and continue to be missed

386. There was a conscious effort made during the pandemic to prioritise the protection and restoration of cancer care services (PB/490 - INQ000397305). Nevertheless, cancer care was impacted, especially in England, with significant drops in both urgent cancer referrals and first cancer treatments in the first months of the pandemic. Some cancer screening (e.g. breast and cervical screening) was also paused or significantly reduced in the early stages of the pandemic.

387. As the BMA set out in July 2020 (PB/488 - INQ000397340, PB/491 - INQ000397343), in England when compared to 2018 and 2019, it was estimated that across April, May, and June 2020 there were:

    a. between 274,000 and 286,000 fewer urgent cancer referrals

    b. between 20,800 and 25,900 fewer patients starting first cancer treatments following a decision to treat

    c. between 12,000 and 15,000 fewer patients starting first cancer treatments following an urgent GP referral.

388. The first months of the pandemic also impacted cancer services across Northern Ireland, Scotland and Wales, though to varying degrees, some of which may be a result of how Nightingale hospitals/the Louisa Jordan in Scotland was used (see below). It is important to note that the data collections vary between all four nations, making direct

comparison challenging, but examples of the immediate impact of COVID-19 on cancer services include:

a. In **Northern Ireland**, the percentage of patients seen within 14 days of an urgent referral for breast cancer saw a drop from 97% in the quarter up to December 2019 to 79.6% in the quarter ending March 2020. Performance then stabilised briefly, before declining significantly to 59.4% in the quarter ending December 2020, to 47.4% in the quarter ending March 2021, and to 47.4% in the quarter ending June 2021[73]. The BMA is not aware of any specific examples of cancer care being delivered at Northern Ireland's Nightingale hospital, but The Irish Times reported on 10 March 2021 that it was to be transformed into a centre for cancer operations (PB/563 - INQ000442323).

b. **Scotland** saw an early decline in the number of cancer patients receiving treatment, before a gradual return to more typical demand. While 6,466 patients received their first treatment for cancer following a decision to treat in the quarter ending March 2020, this dropped to 5,052 and then 4,985 in the following two quarters, before gradually returning to pre-pandemic levels by mid-2021. Notably, performance against the 31-day standard for first treatment following decision to treat remained above the 95% target during this period – indicating that demand fluctuated more than performance[74]. A 27 April 2021 press release from NHS Lanarkshire talks about the additional capacity the NHS Louisa Jordan provided to its radiology department, enabling them to see "*over seven thousand CT scan patients and 760 breast clinic patients at the temporary hospital from September 2020 until the end of March 2021*" (PB/564 - INQ000442324).

c. The immediate impact of the pandemic on cancer services in **Wales** was less apparent and March 2020 actually saw an increase in the numbers of patients starting their first definitive treatments, up to 1,692 from 1,381 in February 2020. This was, however, followed by a decline in numbers treated in successive months, to 1,240 in April and then 1,172 in June 2020, though the numbers of patients seen stabilised in the following months. Performance against the target for patients to receive their first definitive treatment within 62 days of first being

[73] Northern Ireland waiting time statistics: cancer waiting times. Statistics by HSC Trust and 14 Day Wait. Northern Ireland Statistics and Research Agency (NISRA).

[74] Cancer Waiting Times (Table 4). December 2019 - September 2023, Public Health Scotland.

suspected of cancer was also largely stable, sitting at around 62% in March, April, and May 2020, before increasing to 69% that June – this was, however, below the 75% target for this standard[75]. The BMA is not aware of any specific examples in Wales that Nightingale hospitals were used to provide cancer care.

389. The knock-on impact of the pandemic on cancer treatment in the longer term also varies, but can still broadly be seen across the UK today, with waiting lists for cancer treatment rising and performance targets being missed consistently:

    a. The performance target for 93% of patients to have their first consultant appointment within two weeks of an urgent GP referral in **England** has now not been met since May 2020. In June 2023, it stood at 80.5%[76].

    b. The percentage of patients receiving their first treatment within two months of attending a screening service in **England** dropped dramatically during the initial few months of the pandemic, with only 13.3% seen within the target time in June 2020. Performance against the target remains poor. In England, 62.2% of patients had their first treatment within two months of attending a screening service in June 2023, well below the operational standard of 90%[77].

    c. In **Northern Ireland**, the proportion of patients starting treatment within 62 days of an urgent GP referral for suspected cancer has been declining continually, following a trend beginning prior to the pandemic. In March 2023, only 34.8% of patients started treatment within 62 days – a record low[78].

    d. In **Scotland**, performance against the 62-day standard for first treatment following urgent referral continues to worsen: in the quarter ending December 2022, only 72% of eligible people received treatment within this target, compared to 84% in December 2019. In contrast, performance against the 31-day standard

[75] Suspected cancer pathway (closed pathways). StatsWales, December 2023 (last update).

[76] Cancer Waiting Times – National Time Series Oct 2009 – Jan 2024 with Revisions (XLSX), NHS England.

[77] Cancer Waiting Times – National Time Series Oct 2009 – Jan 2024 with Revisions (XLSX), NHS England.

[78] Northern Ireland waiting time statistics: cancer waiting times. Statistics by HSC Trust and 14 Day Wait. Northern Ireland Statistics and Research Agency (NISRA).

for first treatment following urgent referral remains fairly strong and, as of December 2022, sat at around 94%, just below the 95% target[79].

e. In **Wales**, the number of patients starting treatment within 62 days after first suspicion of cancer stood at just over 58% in March 2023. This is well below the 75% compliance target – and even further below the 80% target set for 2026 in the Planned Care Recovery Plan (PB/492 - INQ000270477)[80].

390. Critically, this fall in activity and subsequent backlog has impacted both diagnosis and treatment – meaning that not only have fewer patients received cancer care, but many patients have also sought or received diagnoses later than would have otherwise been the case. Equally, some people avoided healthcare settings as they were worried about COVID-19 infections, which may have delayed them seeking care and a potential diagnosis. As these people have sought care, this has further impacted the waiting list. Consequently, the impact of the pandemic on cancer services will continue to be felt for years.

391. Beyond these impacts on cancer care more generally set out here, we do not hold specific information on the treatment of patients with colorectal cancer.

Hip replacements were delayed

392. The BMA is not able to provide details on the impact of the pandemic on hip replacements specifically, primarily because relevant publicly available data are typically not granular enough to allow specific treatments to be pinpointed.

393. That being said, elective care was heavily impacted by the need to prioritise COVID-19 care during the pandemic. This meant that fewer elective operations, including hip replacements, took place during the pandemic.

394. Patients undergoing hip replacement surgery are typically older and have more co-morbidities, so were protected from catching COVID-19 in hospital by such action. However, as people who delayed seeking treatment during the pandemic have since come forward, elective waiting lists have continued to grow, exacerbated by widespread insufficient elective capacity, especially in orthopaedics, across the four nations.

[79] Cancer Waiting Times (Table 4). December 2019 - September 2023, Public Health Scotland.

[80] Suspected cancer pathway (closed pathways). StatsWales, December 2023 (last update).

Children's and young people's access to mental health services

395. This was not an area in which BMA members raised specific concerns, but we did raise concerns about the general population's access to mental health services considering the pandemic's impact on population mental health.

396. The BMA expressed concerns about the impact of the pandemic on children and young people's mental health, such as the removal of opportunities to socialise, the impact on those who faced abuse at home and were no longer able to escape it due to school closures, or the longer-term impacts of disrupted education. We called for research to be done to further explore these impacts on children's mental health, which would provide a better idea of how services should be resourced to ensure access (PB/493 - INQ000397275).

397. Prior to the pandemic, the BMA had already expressed concerns that mental health services were not resourced to the degree that they were able to meet current, let alone any increase, in demand. For example, our report *Beyond Parity of Esteem* was published in January 2020 and sets out recommendations to improve population mental health in England (PB/494 - INQ000397314).

398. In October 2022 the BMA began to regularly publish data analysis about mental health services using data from NHS England. This data illustrates the way in which even before COVID-19, demand for mental health services was outstripping supply. For example, for Child and Adolescent Mental Health Services (CAMHS) in England, the number of children and young people in contact with these services has expanded at over three and a half times the pace of the CAMHS psychiatry workforce since 2016 (PB/558 - INQ000433871). As of January 2024, there has been a 27% increase in children and young people in contact with mental health services within the past two years alone (PB/558 - INQ000433871).

399. As demand goes up, pressure is felt not only on mental health services but on general practice which is often the first point of call for those with ill mental health, at a time when GPs continue to face the wide-ranging impacts of the pandemic.

Those without an official immigration status faced additional barriers to accessing healthcare

400. COVID-19 was included on the list of conditions exempt from charges for those not ordinarily resident in the UK, which was a welcome move in trying to ensure that

everyone, regardless of their immigration status, felt safe coming forward for timely screening and treatment.

401. However, this did not mean all migrants sought the care they needed, even when entitled to it. Wider charging regimes for 'oversees visitors' accessing non-COVID-19 care remained in place in all four nations. Moreover, in some nations, data sharing policies between health services and the Home Office have created a legacy of fear and, although these policies did not apply to COVID-19 care, they continued to apply to non-COVID-19 care. As such, people were reluctant to access care for fear that they would incur charges related to any non-exempt comorbidities, or that interaction with the UK's health services could lead to them being targeted by immigration services. A poll by the Joint Council for the Welfare of Immigrants (PB/495 - INQ000142281) showed that almost half of the migrants surveyed (43%) were scared to access healthcare during this pandemic. Indeed, some people were reluctant to seek care even for 'exempt' conditions such as COVID-19, with reports of people dying at home as a result (PB/496 - INQ000215521).

402. On 13 April 2020 the BMA, along with a coalition of other organisations including the UK Faculty of Public Health, the British Red Cross and many of the Royal Colleges, wrote a letter to the Secretaries of State at DHSC and the Home Office raising concerns that the UK Government's hostile environment policies would constrain public health efforts by deterring migrants from accessing healthcare even if they were entitled to it (PB/279 - INQ000235275).

Impact on care delivery in the private sector

403. At the height of the pandemic, the UK Government decided to block book independent sector providers to support overstretched NHS services in England, spending an estimated £2 billion on reserving capacity in case it was needed without clearly defined targets or transparency on the contracting arrangements (PB/497 - INQ000397277). The BMA strongly suggests that the Inquiry looks further into these arrangements as part of its investigation in Module 5.

404. Ultimately, much of this capacity was unused – partly due to the fact that many staff who work in the private sector are also employed in and by the NHS. This meant the UK Government paid for facilities without the staff to operate them, as doctors worked extra shifts in the NHS to help with the pandemic effort. This is evidenced by the underutilisation of beds and the negotiated revisions to the COVID-19 contracts – a

focus of which was to ensure value for taxpayers' money by securing surge capacity only if it was needed.

405. In Scotland, the health service spent more than £20.8 million on access to the private sector during the first wave of the pandemic, primarily to ensure that cancer provision continued. This was especially notable in Lanarkshire, where more than 4,900 outpatient activities were carried out on behalf of NHS Lanarkshire (PB/498 - INQ000397332).

406. In Northern Ireland, private hospitals were also contracted to continue treatment for urgent elective cancer patients while trust hospital sites concentrated on COVID-19 patients. An FOI request shows that private hospitals were paid £27 million to treat over 40,000 patients in an initial three-month agreement (PB/499 - INQ000397255).

407. The BMA does not hold any information about private sector contracting during the pandemic in Wales. Wales has a relatively small private healthcare sector compared to other UK nations. We recommend the Inquiry engages with Welsh Government about whether any such arrangements were put in place.

408. As in England, deals struck with the private sector in the devolved nations were also marked by a lack of transparency. Because of this, it is difficult to determine whether those deals ultimately delivered good value for taxpayer money.

409. An often-overlooked aspect of these arrangements was the impact these arrangements had on doctors working exclusively in the private sector and their patients. Many of these doctors are self-employed, effectively renting space from private hospitals and suddenly found themselves unable to do so due to the block booking arrangements – on which they had not been consulted. This effectively meant while private sector facilities stood empty, private sector waiting lists grew, often impacting patients who had sought such care precisely because of the already long waiting times for NHS or HSC care before the pandemic. This also impacted doctors working in the private sector financially, with many suddenly finding themselves without any income through no fault of their own, while worrying about the deteriorating condition of their patients.

410. Later in the pandemic, contracts with the private sector in England were revised, with NHS regions encouraged to make their own arrangements with private sector providers to boost capacity.

411. The BMA raised the issues set out in this section a number of times, including in our July 2020 report, *The role of private outsourcing in the COVID-19 response,* and our

2022 reports, *Outsourced: the role of the independent sector in the NHS* and our third COVID-19 Review report, *Delivery of healthcare during the pandemic* (PB/500 - INQ000397344, PB/501 - INQ000397270, PB/015 - INQ000185355). The concerns highlighted in these reports included the lack of transparency of many deals with the independent sector, the rationale for outsourcing certain contracts and aspects of the pandemic response to private firms, and the value-for-money of these agreements. The BMA also raised these issues in a meeting with the SoS in April 2021, and in letters to NHS England on 16 March 2021 and 14 January 2022 (PB/502 - INQ000400453, PB/294 - INQ000400468).

412. In addition, the BMA raised concerns about the ability of private patients to access COVID-19 vaccinations, particularly the lack of clarity about whether patients would be able to access the vaccine without having an NHS number. The BMA raised these concerns in a letter to the NHS England vaccination coordination team on 22 January 2021 and received a reply from Ed Waller, Director of Primary Care, on 25 February 2021 (PB/503 - INQ000400450, PB/504 - INQ000400452). This reply provided advice on the steps that private patients and practices needed to take, in order for private patients to receive a vaccination invite and for this vaccination to be recorded.

413. The BMA also wrote to Jo Churchill, Parliamentary Under-Secretary of State for Primary Care and Public Health, on 09 February 2021 to raise concerns about the financial barriers introduced by the CQC for private practice GPs to administer COVID-19 testing swabs (PB/399 - INQ000097861). These financial barriers arose from changes to the CQC's scope to practice in December 2020, with the UK Accreditation Service (UKAS) advising that private practices would instead need to register with them for a significant fee, in order to continue to provide PCR tests for patients.

I. Discharge and movement of patients

414. This section sets out the BMA's views on guidance issued about the discharge of patients from hospitals as well as any concerns raised by the BMA or its members about the guidance about, and criteria for, the discharge of patients from hospital and the discharge and movement of COVID-19 and non-COVID-19 patients to free up inpatient and critical care capacity for COVID-19 patients.

There was an understandable push to speed up hospital discharge to free up capacity for COVID-19 patients

415. At the outset of the pandemic, health systems across the UK understandably sought to maximise the capacity of their hospitals to meet newly increased demand, particularly for acute care facilities such as ventilated and ICU beds.

416. On 17 March 2020, hospitals in England were asked to urgently discharge all hospital in-patients who were medically fit to leave (PB/505 - INQ000087317). It is likely that health services in Scotland, Northern Ireland and Wales issued similar directions to hospitals, but the BMA does not hold any information about these other than what is described below.

417. The BMA does not hold information about hospital discharge criteria prior to 1 March 2020. COVID-19 Hospital Discharge Service Requirements were published for English hospitals on 19 March 2020 (PB/506 **- INQ000087450)**, however the BMA was not consulted, nor did it comment on this guidance or the clinical/assessment criteria underpinning it. The guidance did state that "*NHS CHC (continuing healthcare) assessments for individuals on the acute hospital discharge pathway and in community settings will not be required until the end of the COVID-19 emergency period*" and this was supported by legislative change as part of the COVID-19 Bill. NHS England and regulating bodies in the devolved nations will be best placed to clarify changes to hospital discharge policies.

418. However, what is important to note is that in so doing, the guidance prioritised the rapid discharge of older patients into care homes without adequate testing for COVID-19. Testing for COVID-19 was not widely available at this stage, meaning there was widespread discharge of many hospital patients without being tested – and into environments with people more at risk of severe outcomes from infection with the virus. The risk was further compounded by the possibility of asymptomatic transmission.

Significant numbers of older or vulnerable patients were discharged without testing

419. Evidence gathered via FOI requests for Wales suggests that in May 2020, 2,355 people were discharged from Welsh hospitals into care homes, but only approximately 700 (30%) were tested for COVID-19 (PB/507 - INQ000397348). The BMA received informal reports from public health doctors in Wales that they were asked to reassure care homes concerned about taking in those discharged from hospital, presenting serious ethical dilemmas for them. This was due to concerns about risk to staff and

residents because of potential COVID-19 positive patients being discharged into care home environments (which have more vulnerable people in them), as well as issues with the availability and/or adequacy of PPE and testing in these settings (PB/015 - INQ000185355).

420. Despite directing hospitals in England to discharge patients urgently on 17 March, it took until 15 April 2020 for a policy of testing those being discharged to be introduced. It is estimated that around 25,000 people were discharged into care homes between 17 March and 15 April 2020. Many of these individuals would not have been tested for COVID-19 due to the policy at the time prioritising those with respiratory illness or flu-like symptoms.

421. In Scotland, there were 3,599 discharges from hospitals into care homes between 1 March and 21 April 2020 but, due to clinical guidance at the time, only 18% were tested for COVID-19. In contrast, following the issuing of new guidance, 93% of patients discharged from Scottish hospitals to care homes between 22 April and 31 May 2020 were tested for COVID-19 (PB/508 - INQ000397329).

422. In Northern Ireland, testing of all patients discharged from hospital into a care home was introduced on 19 April 2020, but tests were not needed if the care home was the patient's previous residence. There was also reportedly pressure on care homes to ensure testing did not hold up timely discharge (PB/509 - INQ000256510).

423. When testing did occur, positive results also did not always prevent discharge. For example, care homes in Northern Ireland and England were told in April 2020 to accept COVID-19 positive patients if isolation was possible (PB/509 - INQ000256510, PB/510 - INQ000325315). Care homes accepting patients from hospital were also not always notified of test results or did not receive them in a timely manner (PB/509 - INQ000256510). Many care homes also struggled to access whole-home testing for all residents and staff (PB/511 - INQ000397331). This all, alongside challenges care homes faced accessing PPE at the onset of the pandemic, likely played a major part in increased deaths in care home settings.

424. Ultimately, 20,000 care home residents died during the first wave of COVID-19.

The BMA called for assurances that patients were able to be discharged safely

425. At various stages throughout the pandemic, the BMA raised concerns about the state of social care, the need for stronger support for the sector (including access to PPE and

regular testing for social care staff) and called for discharge to care homes not to happen without people being properly tested for COVID-19 (PB/158 - INQ000118442).

426. In written evidence to the National Audit Office in May 2020, the BMA raised the challenges of care homes receiving large volumes of patients who were apparently not prioritised for testing or PPE, with the result that these patients were not adequately shielded from the virus (PB/180 - INQ000117896).

427. In *Rest, recover, restore: Getting UK health services back in track* (2021), the BMA called for all UK governments to ensure care plans were in place to enable patients to be discharged safely from hospital without undue delays to free up space in hospitals, including the provision of funding for this (PB/156 - INQ000118308).

428. In written evidence to the House of Commons Public Accounts Committee in 2021, the BMA argued that the urgent and rapid discharge of COVID-19 patients into social care served to transfer risk to a poorly supported social care system, and that patients should not be discharged from hospital without ensuring that they have tested negative for COVID-19 (PB/191 - INQ000118350).

429. The BMA's report, *Weathering the Storm* (2021) argued that all UK governments must ensure social care was properly supported financially, to ensure it was able to provide safe care to those who need it, while also helping to reduce pressure on hospital and GP services, as well as to ensure timely discharge from hospital (PB/158 - INQ000118442).

430. When the UK Government published its Living with COVID-19 strategy in February 2022, the BMA expressed concerns about the absence of free testing for patients discharged into social care (PB/512 - INQ000397267).

J. Shielding

431. This section of the statement sets out details of the BMA's involvement in the development and dissemination of shielding guidance, as well as the impact of the shielding advice on doctors and medical students who were designated as clinically extremely vulnerable (CEV), and those who had family members who were designated CEV and advised to shield.

432. Shielding advice was issued by PHE on 21 March 2020. Similar guidance was issued in Wales on 24 March 2020, in Scotland on 26 March 2020, and in Northern Ireland on

27 March 2020. People who were deemed to be CEV, which meant they were at very high risk of severe illness from COVID-19, were advised to shield for at least 12 weeks by staying at home as much as possible (except for attending essential medical appointments or for exercise) and avoiding face-to-face contact with people outside of their household.

433. Shielding advice was broadly the same across the UK. However, there were slight differences in the periods during which CEV people were asked to shield – for instance, in England and Scotland shielding initially ran until 1 August 2020; in Northern Ireland, until 31 July 2020; and in Wales, until 16 August 2020.

The identification of patients who were CEV was marked by confusion and changing guidance

434. After the Government introduced UK-wide shielding in late March 2020, GPs in England were expected to put together 'shielding lists'. However, this period was marked by confusion and continually changing guidance from Government and NHS England. This added to the already considerable stress experienced by GPs, who had had to shift to a completely different model of care delivery (having been asked to move to largely virtual appointments), and it created anxiety for patients too.

435. On 21 March 2020, Professors Chris Whitty (CMO for England) and Stephen Powis (National Medical Director for NHS England) sent a letter to all practices in England, asking them to identify the patients at highest clinical risk from COVID-19 (PB/082 - INQ000048588). The guidance covered methods to identify vulnerable groups, and how to care for people at highest risk (for example, how to ensure medicine supplies and providing support with daily living).

436. Those considered at highest risk included: people aged 70 or older; people under 70 with an underlying health condition(s); and those who were pregnant, among others. The letter stated that this group was identified based on 'expert consensus', agreed to by all the UK CMOs. Annex 1 of the 21 March 2020 letter outlined the specific methodology for identifying people who were CEV, setting out how emerging clinical data at the time indicated that the COVID-19 death rate would be high for people with particular chronic diseases. That said, GPs were still encouraged to exercise their clinical judgements, "*given the difficulties of identifying those most vulnerable*". For example, the letter recognises that GPs may have had knowledge of specific additional patients that they considered high risk.

437. At this time, the BMA was not directly involved in the decision making that led to the development of shielding lists in England or Northern Ireland. In Scotland, however, BMA Scotland was invited to comment on the Scottish Government's communications to GPs in relation to identifying this group of patients (PB/329 - INQ000117010, PB/330 - INQ000400391, PB/557 - INQ000117042, PB/331 - INQ000117085, PB/332 - INQ000400414, PB/556 - INQ000400415, PB/333 - INQ000117184). Similarly, BMA Wales was approached for comment on the Welsh CMO's letter to GPs (albeit the day before dissemination). We offered feedback, such as our support for the list of high-risk groups being proposed, and the recommendation to add hyperlinks to RCGP guidance (PB/513 - INQ000118526).

438. Changing guidance caused confusion and added to GP workload. On 3 April 2020, NHS England advised general practices in England to disregard the advice contained within the 21 March 2020 letter (PB/514 - INQ000397241). GPs were instead referred to its "*update on the Government shielding policy and implications for general practice*". However, less than a week later, on 9 April 2020, this was again updated, with a CAS (Central Alerting System) message from NHS England and NHS Digital that outlined the specific tasks that practices should undertake in order to shield high-risk individuals – all by 14 April 2020, just five days later (PB/514 - INQ000397241). These tasks involved reviewing individuals identified using a clinical algorithm within national data sets and flagging those who may have been misidentified as high risk. GPs were also required to review CEV classifications made by secondary care providers, as well as those who self-identified as clinically vulnerable – creating a mammoth task for GPs, under tight time constraints and already challenging conditions.

439. According to a Pulse survey from 17-21 April 2020, GP practices in England spent an average of 26 hours per week reviewing whether patients should be shielding during the pandemic (PB/515 - INQ000397298). A Sheffield-based GP who took part in the survey described how patients were ringing the practice with questions about why they had or had not received the shielding letter, leading to a surge in workload. Dr Richard Vautrey, then chair of the BMA's GPC England, was also quoted in the Pulse article, warning NHS England that it was vital that they factored in the time needed for GPs to undertake these vital patient assessments so as not to add to the additional workload burden placed on the profession at this time.

440. The multiple – and successive – changes to guidance in England, as highlighted above, caused a number of issues for general practice. The BMA's GPC England

therefore published its own guidance on 16 April 2020 (PB/514 - INQ000397241), setting out the actions that practices should take on the list of shielded patients, as well as for those that had self-identified using the Government website. For instance, this included how to review and communicate with individuals that had self-identified, and how to help identify both "false positives" and "false negatives".

441. Patients were also impacted by the Government's poor communication, particularly those who were considered CEV. Firstly, not all CEV individuals were initially identified. For example, 870,000 people were identified centrally as CEV on 22 March 2020 - but three weeks later, a further 420,000 CEV people were identified and contacted. By 4 May 2020, yet another 900,000 people were found to be eligible for support to help them shield. The delays with identifying CEV people can be largely attributed to two factors: firstly, confusion over the expectations placed on GPs to identify and assess relevant data that would ultimately be used to flag CEV people; and secondly, the inherent IT architecture for flowing data out of general practice, which has evolved to include a substantive range of checks and balances in order to best protect patient data for unauthorised or unwarranted onward dissemination. While important for data protection purposes, it meant that identification did not always happen quickly.

442. As there was no single, agreed-upon mechanism for identifying CEV patients who needed to shield at the start of the pandemic, each UK nation used a combination of datasets from multiple data sources, some of which contained inaccurate or out-of-date information. This hindered GPs' ability to identify and contact all CEV people.

443. In Wales, a significant number of CEV people did not receive a shielding letter in early April. The BBC reported that 13,000 letters had been issued to the wrong address (PB/516 - INQ000397236). Not only did this result in a data breach, putting confidential patient information at risk, CEV people faced delays in accessing important shielding guidance and support.

444. Challenges with identifying CEV people also arose in Scotland, whereby some individuals had not been centrally identified for shielding. As a result, GP practices were asked by the Scottish Government to play a more active role (PB/543 - INQ000400375), much like in England. For example, GPs in Scotland identified patients in the highest risk groups, provided their Community Health Index (CHI) number to local Health Board teams, added codes to the patient record, and sent CMO advice letters to any additional patients identified. This too considerably increased workload for GPs.

The BMA was involved in later work to improve the identification of CEV patients

445. Several months later, the BMA's GPC England was involved in the development of a risk tool by NHS England to identify people on GP patient lists who were vulnerable to severe illness from COVID-19. Members of the GPC England Executive met with NHS England on 5 October 2020 to discuss the issue. This tool ultimately helped to identify a wider group of people for inclusion within the shielding list (see below).

446. BMA Cymru Wales received reports from practices and members that they had been contacted by members of the public who believed they should have received shielding letters but had not (e.g., renal patients, transplant recipients). BMA Cymru Wales wrote to Welsh Government officials to raise these concerns, and also issued a briefing to Assembly Members to raise awareness of the situation. Members of BMA Cymru Wales GPC engaged with the CMO for Wales to agree an improved process. A letter was issued on 3 April 2020 by the Welsh CMO that clarified that GPs could view the central shielding list on a secure portal, and if they determined that a patient, due to their particular vulnerability, should have received a shielding letter (but had not) then they could issue one directly from the practice and a particular clinical code was added to the patient record so that the person would be added to the list of vulnerable groups (PB/517 - INQ000400376, with attachments PB/082 - INQ000048588, PB/546 - INQ000048579, PB/547 - INQ000048580, PB/548 - INQ000048581, PB/549 - INQ000080900, PB/550 - INQ000048583, PB/551 - INQ000048584, PB/552 - INQ000395540, PB/553 - INQ000048587, PB/554 - INQ000048586).

There was further confusion when shielding advice was relaxed in summer 2020

447. As the initial 12-week advice to shield came to an end in the summer of 2020, poor communication again resulted in confusion – for patients and doctors alike. Dr Richard Vautrey, then chair of the BMA's GPC England, called attention to the issue in the media, highlighting the need for clear information from the Government to the public, and timely information to GP practices. He warned that, in the absence of clear guidance, patient safety would be put at risk and lead to a spike in practice workload.

448. Specifically, on 31 May 2020, Dr Vautrey expressed his concerns in a Guardian article (PB/518 - INQ000397339): as the Government announced that CEV people would be allowed outside from 1 June, he said it remained unclear whether shielding people were allowed to visit GP surgeries for routine medical treatment. He also confirmed that the BMA had not been directly informed about the new guidance, and that it conflicted with

prior guidance (i.e. that patients should receive all of their healthcare in their home setting wherever possible).

449. COVID-19 cases began to rise again after the lifting of lockdown in summer 2020, and on 13 October 2020, CEV people in England received new guidance. This was tailored to the COVID-19 risk level of their local area, but even so, people were not advised to shield.

450. During this period, advice varied significantly across the devolved nations. For example, on 22 October 2020 the CMO for Wales wrote to CEV people about taking extra precautions to protect their health but not advising them to shield (PB/519 - INQ000397245). Then on 22 December 2020, CEV people were advised to no longer attend work or school outside the home (PB/520 - INQ000397246). Going outside for exercise and to attend medical appointments was still permitted. In Scotland, a series of local restrictions came into force on 1 September 2020 in Glasgow, East Renfrewshire and West Dunbartonshire following an increase in COVID-19 cases. People living in those areas who were previously shielding were asked to be particularly vigilant. Then in November 2020 Scotland's COVID-19 strategic framework was introduced which created different levels of protection that could be applied locally or nationally to reduce transmission and keep people safe (PB/521 - INQ000397333). This included extra protection advice for people at the highest risk from COVID-19 and introduced four shielding levels. Northern Ireland shifted focus to public health advice as shielding was paused in July 2020 (PB/522 - INQ000279620), with Dr Tom Black (chair of the BMA council in Northern Ireland) calling on employers to protect workers, particularly those vulnerable to COVID-19, and ensuring that infection hotspots are quickly identified (PB/562 - INQ000442321).

451. On 16 February 2021, 1.7 million more people were added to the England shielding list, granting them early access to coronavirus vaccines. These individuals were identified using a new algorithm developed by Oxford University that considered additional, non-clinical factors, such as age, ethnicity and postcode (the latter being a proxy for deprivation) – the tool that GPC England had been consulted upon in October the previous year. The 1.7 million newly identified people, along with those previously classified as CEV, were advised to shield until 31 March 2021.

452. This caused some confusion among those added to shielding lists. Disability charities, such as the MS Society, highlighted how the sudden announcement 11 months into the

pandemic would "*come as a huge shock*" to some, and that the government must prioritise clear communication and comprehensive support (PB/536 - INQ000397316). This chimes with the findings from a Guardian article dated 19 February 2021 (PB/537 - INQ000397338), which explores the experiences of those who were added to England's shielding list. For example, an individual with a rare blood disorder expressed feeling panic and immediately contacting his GP for further clarification. Similarly, a woman who had a high BMI, described feeling "*quite angry*" and "*kind of wobbly*", particularly as her high BMI "*would have been a risk factor a year ago*".

453. The UK's shielding guidance was paused on 1 April 2021, and the programme officially came to an end on 15 September 2021. This decision was made largely due to the protection offered by widespread vaccination coverage. However, questions and anxieties remain to this day. Whilst vaccines limit the worst impacts of the virus, they do not prevent all infections – a significant concern for CEV people. There are also some people, such as those taking immunosuppressants, who remain at higher risk of infection and hospitalisation from COVID-19 after vaccination, relative to the wider vaccinated population (PB/523 - INQ000397276). Additionally, the end of free testing on 1 April 2022 in England, 18 April 2022 in Scotland, and 31 July 2022 in Northern Ireland and Wales left many high-risk individuals feeling worried and confused. The dismantling of testing infrastructure and the end of free testing weakened our ability to safeguard the most clinically vulnerable in our society.

Doctors who were clinically extremely vulnerable faced challenges at work

454. Some doctors told us their CEV status was not taken into account at their place of work. For example, a consultant in England wrote: '*As my trust created their own risk table which missed out any question of shielding or immunosuppression I was told I was not able to shield. I had to refuse this risk assessment and fight hard to be allowed to shield even after I had received my shielding letter and sent it in. It was extremely stressful and unfair*'. A GP from Scotland wrote: '*I was a locum at the time. I had no risk assessment and was ordered to go and work in a Covid hub despite being sent a shielding letter*'. Some doctors also felt pressured to come into work, despite shielding. In our call for evidence, a salaried GP from England wrote: '*I felt constant stress from my workplace applying pressure for me to return to face to face work despite shielded advice to continue to work from home…I had loss of self esteem and feelings of guilt from being a WFH shielder, aggravated by colleague resentment of my shielder status…I was discriminated against (as was my other shielding colleague) which made*

me feel angry. The anger I felt towards my workplace took its toll and I have gone through a grief process of realising there is no place for me in General Practice'.

455. Given the lack of workplace adjustments, some doctors and healthcare workers felt unable to safely return to work. In our July 2020 COVID-19 tracker survey, almost a fifth (17%) of respondents who said they were CEV had either worked less, or stopped working altogether, to reduce their risk of COVID-19 infection.

There was a lack of advice and clarity for doctors who were clinically extremely vulnerable

456. Early in the pandemic, the BMA identified the need to provide specific guidance for doctors who were shielding, as well as doctors not on the shielding list but at heightened risk due to their individual characteristics (e.g. age, ethnicity etc.). This need was particularly pressing due to the lack of clear, profession-specific guidance from the Government and NHS England at the time.

457. The BMA provided such guidance titled "*COVID-19: doctors isolating and those in vulnerable groups*" (PB/421 - INQ000118051). This guidance covered areas such as:

    a. Individual risk assessments, and how to initiate a follow-up discussion if there were outstanding questions/issues. This was particularly important as there were delays in establishing effective risk assessment processes (as set out in section G), which could have protected vulnerable groups, and also delays in pulling together the shielding list (as set out above, some clinically vulnerable people were not identified until as late as February 2021).

    b. Differing views between staff and their employer over the outcome of the risk assessment.

    c. Support with remote working.

    d. How to hold conversations with employers prior to returning to work, including how to make the workplace "COVID-secure".

    e. Vaccination status and returning to work.

458. In addition to this, on 18 May 2020, the BMA sent a letter to all Trust CEOs in England calling for the introduction of a 'risk scoring tool' across their respective organisations to protect medical staff who were at increased risk of death from COVID-19 infection (PB/101 - INQ000117919). Similar action took place in Northern Ireland, whereby BMA Northern Ireland sent a letter to Martin McBride (CMO for Northern Ireland) on 29 May

2020 (PB/062 - INQ000116868) highlighting the need for clear guidance on risk assessments for healthcare workers. This was followed by a meeting with Robert Swann (Minister for Health) on 11 June 2020, calling for a regional, consistent approach to risk assessments. BMA Cymru Wales also sent a letter to Welsh government ministers on 28 April 2020 to raise concerns around risk assessments (particularly for vulnerable healthcare workers) and to request a 'risk profile framework' (PB/360 - INQ000118541).

459. On 10 July 2020, the BMA published a briefing on supporting staff who were shielding to return to work (PB/420 - INQ000117206). This was published just as the first period of shielding was drawing to a close in England and Northern Ireland on 01 August 2020. Around this time, CEV people were advised that they could return to 'COVID-secure' workplaces (without much clarity what such workplaces looked like). This led to confusion as the pandemic had not gone away nor the virus become less dangerous, and many people – including doctors – continued to shield due to the lack of clear government guidance, and the fear that such a return would not be safe. The BMA's COVID-19 tracker survey results from July 2020 highlighted this, showing that doctors who had been shielding were concerned about returning to work.

460. The BMA's briefing stated that "*national guidance [was] limited*" around CEV healthcare staff returning to work safely. This lack of clear guidance had a number of effects on doctors and medical students including:

    a. Disruption to training and career development

    b. Isolation from peers

    c. Job insecurity

    d. Practical challenges around remote working.

461. It is worth noting that all of the above impacts, as well as shielding itself, adversely impacted doctors' emotional wellbeing, with many experiencing guilt, anxiety, loneliness and frustration (as captured by our June 2020 COVID-19 tracker survey).

462. Following the announcement that shielding would be paused, the BMA published an external briefing in July 2020 that called on Government and arms-length bodies (ALBs) to issue clear guidance and protocols on how workplaces can be made safe for staff who have been shielding. The BMA also called on ALBs, regulators and training bodies to provide guidance and support to those who may be shielding in the long-term, seeking

clarity on issues such as training, career progression and pay protection (PB/420 - INQ000117206).

463. On 10 September 2020, the BMA published an opinion piece featuring an anaesthetics clinical fellow who was classified as CEV (PB/468 - INQ000397244). In the piece, the clinical fellow discusses doctors who were emerging from shielding being pressured into working in non-COVID-19 safe on-call environments. This is supported by testimonials gathered through the BMA's call for evidence. A Consultant in England described feeling "*bullied by line managers to try…to come into work despite NHS Employers guidance stating otherwise*".

K. The impact of changes to the model of working on doctors with protected characteristics

464. Care delivery during the pandemic changed significantly. This included the (physical) separation of COVID-19 and non-COVID-19 care; the move to delivering as much care as possible virtually, especially in General Practice; changes to ways of working (e.g. rotas, T&Cs, place of work); and changes as a result of IPC measures (e.g. the need to wear a mask or socially distance).

465. Some of these changes had particular impacts for people with protected characteristics, which are set out in the following sections.

Changes to how care was delivered impacted disabled doctors and those with long term conditions

466. Shifts to remote working, while of benefit to some, also introduced new issues for groups of disabled doctors. For example, there were reports of equipment supplied for remote working not having the necessary adaptations for some disabled people.

467. Some respondents to our call for evidence with disabilities or long term conditions (LTCs) also told us they were not allowed to work remotely:

a. *'My line manager told me I had to work in the office even though I could do my job as effectively from home. This put my health at risk.'* (Public health consultant, Scotland, has a disability/LTC)

b. *'[Risk assessment] was not automatically initiated, when pushed to get assessed, was initially taken as trying to get out of work. As a BAME, >45 yrs, [Diabetes] and*

Asthma, I was expected to continue doing home visit[s].' (Salaried GP, England, has a Disability/LTC, Indian)

468. The experiences of these doctors must be recognised and gaps in occupational health provision tackled as a priority. The pandemic necessitated the implementation of wide-ranging changes to working practices, often at considerable speed, but these happened without adequate assessment of the impact of these changes on disabled staff or those with LTCs.

Doctors from ethnic minority backgrounds were at particular risk when redeployed to high-risk areas

469. The pandemic had a profound impact on ethnic minority groups with people from these groups more at risk from severe outcomes, including death, if infected with COVID-19. This disproportionate impact on ethnic minority groups, including doctors, has been well documented and the BMA was among the first to call it out, pushing for a rapid review into the issue, which PHE undertook.

470. As set out earlier in this witness statement, the UK's health services rely heavily on staff from ethnic minority backgrounds, including IMGs, who have been instrumental to, and are a core part of, the NHS since its inception.

471. With large numbers of staff redeployed at the start of the pandemic, many such staff were redeployed to other - even higher risk areas - to help the pandemic effort. As noted in relation to IMGs (see section E), doctors from ethnic minority backgrounds often reported feeling more exposed in the workplace, reporting ineffective risk assessments, less access to appropriate PPE (including RPE) and/or being asked to work in higher risk areas compared to their White counterparts – while at the same time feeling less able to raise concerns.

472. How far all of this impacted on the significant harm and large number of deaths among ethnic minority healthcare staff, including doctors, especially at the start of the pandemic, is difficult to judge. However, these impacts need to be considered in the context of institutional racism in the UK, including in health services.

Changes to healthcare delivery models which resulted in doctors having to work longer hours and less flexibly impacted those with caring responsibilities.

473. Women were another group which the BMA's tracker survey of April 2021 showed faced higher levels of stress and burnout. Our survey found higher than normal levels of exhaustion were more common among women (61%) than men (52%).

474. The gender discrepancy may have been partly due to additional commitments outside work, such as childcare or other caring responsibilities, a duty still largely borne by women. Some respondents to our 2021 call for evidence also noted that women were particularly affected by the pandemic.

    a. *'There has been a significant toll amongst the women Consultants in our Department. It is of note, we all have children of school age and at some point have been in tears after meetings with our Clinical Lead and Management when requesting a bit of flexibility. In a department where we used to pride equality, our opinion is that we were treated differently during the pandemic because we couldn't always toe the line with regards to extra workload owing to childcare.' (Consultant, Scotland)*

    b. *'Women NHS workers have suffered hugely due to the added responsibility of childcare that typically falls at our feet.' (Consultant, England)*

475. While schools and some childcare settings remained open for children of key workers, many BMA members reported finding it difficult to access suitable childcare. As the BMA noted in a submission to the Women and Equalities Select Committee and Joint Committee on Human Rights in May 2020 (PB/524 - INQ000117887), due to a lack of funding, 46% of childcare settings had reportedly closed by 17 April 2020, often leaving doctors to try and find alternative places which were often more expensive. This was at a time when family support was often not available due to restrictions on household mixing and a lack of wraparound care provision. The BMA raised these issues with NHS Employers on 07 April 2020 (PB/525 - INQ000400388) and in a letter to the Secretary of State for Education, Gavin Williamson MP, on 12 March 2020 (PB/526 - INQ000400344). In this letter, the BMA enclosed a briefing on COVID-19 and childcare (PB/527 - INQ000397286), calling for additional financial and logistical support for nurseries and childcare providers to prevent closures, the reimbursement of additional childcare costs for doctors, consistency across local policy arrangements around carers' leave, and collaboration between local authorities, NHS bodies and childcare providers.

The BMA received a reply to this letter from Vicky Ford, Parliamentary Under-Secretary of State for Children and Families, on 20 May 2020 which outlined some of the financial arrangements available to childcare providers (PB/528 - INQ000400499). These issues were also raised by staff side unions in the Partnership Forum in Wales, for example on 31 March 2020 (PB/529 - INQ000400371, PB/545 - INQ000400372).

Pregnant doctors' working lives were also affected

476. Due to uncertainties about the risk the virus would pose to pregnant staff, the BMA recommended that all people who are pregnant be regarded as high risk and offered the option to shield (PB/061 - INQ000355841). Some were able to work remotely, but not all were able to do so.

477. Pregnant staff who were shielding or unable to work remotely experienced significant uncertainty about the impact on both their immediate health and their ongoing training and career progression, at least partly due to the lack of availability of risk assessments, especially early in the pandemic.

478. The BMA included a section on pregnant doctors within wider webpage guidance for the profession.

L. Other concerns or issues

479. In this final section of my witness statement, I set out a number of concerns that doctors raised with the BMA that have not already been outlined. These relate to: the impact of the pandemic on postgraduate training/progression, undergraduate medical education and doctors' income; a lack of transparency in contracting arrangements with the private sector; the pursuit of data programmes by NHS England; and a lack of political support for general practice. This section also discusses a number of areas that went well in how healthcare systems responded to the pandemic, where I have not previously outlined these. Lastly, it sets out four broad recommendations from the BMA to improve the conditions for doctors and medical students in the event of a future pandemic.

Other concerns relating to the impact of the pandemic on doctors not mentioned elsewhere

480. Throughout this witness statement, I have set out the concerns that doctors had throughout the pandemic regarding their physical and mental safety, that of their

families, concerns about the safety of care they were delivering to patients, and concerns about working conditions.

481. In addition, doctors raised concerns with the BMA about the following issues:

a. The **impact of the pandemic on postgraduate training/progression** - Staff redeployment and a reduction in non-COVID-19 care significantly disrupted the ability of doctors to gain experience in certain training placements necessary for career progression within their speciality. In our COVID-19 tracker survey in April 2021, 40% of doctors in training told us they were unable to gain enough experience in non-urgent and scheduled care to fulfil the competencies required for progression in their career, and nearly 30% said the same about urgent and unscheduled care.

b. The **impact of the pandemic on undergraduate medical education** - In our COVID-19 Review call for evidence respondents told us that classes, conferences and exams were often cancelled and at times mandatory courses were difficult to access or even unavailable. On 04 June 2020, the BMA published a *Statement of expectations: Medical student wellbeing support during COVID-19* (PB/530 - INQ000397272) which called on universities and NHS employing organisations to undertake specific actions to support medical students whose education was disrupted or who were taking up contracts in the NHS to support the pandemic response. These included providing access to tutors, ensuring clear processes were in place to follow up with vulnerable students virtually, ensuring disabled students were able to continue to access support and adjustments, and communicating information regarding changes to any aspect of a student's medical degree, such as exams or assessments, with notice of four weeks or longer. However, even in light of these challenges, it could be argued that the widespread shift to online learning has revolutionised education and work.

c. The **impact of the pandemic on their income** - I mentioned briefly the impact that block booking arrangements with the private sector had on private practitioners. Another group whose income was often impacted by the pandemic were locums, who were affected by redeployment and other measures taken to boost the workforce. In addition, lockdowns and restrictions on taking leave meant that fewer doctors took leave, reducing the need for cover arrangements.

d. The **lack of transparency in contracting arrangements with the private sector and the money wasted** as a result. This includes both the arrangements with private hospitals, but equally the arrangements made to source PPE, ventilators and other equipment. During the pandemic, the BMA was contacted by suppliers keen and able to deliver PPE to the NHS but unable to get through official hotlines, while those with contacts in government (but not necessarily experience in producing PPE or other equipment) were fast tracked. The BMA collated these approaches and passed them onto the DHSC (PB/531 - INQ000117800).

e. The **pursuit of data programmes by NHS England that were clinician time away from the frontline.** An example of this is the GPDPR programme (General Practice Data for Planning and Research) and Accelerated Access to Patient Records. The pursuit of these programmes by national bodies at a time when frontline clinicians and their representative bodies had little to no spare capacity was puzzling, with doctors anxious about the impact of these schemes on patient care. Ultimately interventions by the BMA led to a delay in these programmes, however this required time and resource. In addition, there could have been better consultation with the profession. The implementation of the COVID-19 vaccination clinical system for example was challenging for GPs, as it used an unfamiliar pharmacy IT system.

f. **Lack of political support for General Practice** – earlier in my witness statement I mention a rise in abuse and violence that staff experienced. A significant concern for staff was the way in which the UK Government let GPs take the blame for reduced access and the move to remote delivery of care, which in turn led to an increase in violence and abuse of staff, in particular GPs. Staff were simply following NHS England's own guidance as well as doing their best to look after an increasing backlog of care held in general practice, at the same time as delivering the vaccination programme – and all of that with declining numbers of staff.

What went well in how healthcare systems responded to the pandemic

482. In the BMA's view, there were several areas which went well in how healthcare systems responded to the pandemic, although not all of these positive developments

have been fully maintained. This section outlines the positive developments which I have not already discussed earlier in this statement.

Medical professionals experienced an initial sense of improved morale

483. At the beginning of the pandemic, the medical profession felt a sense of camaraderie, satisfaction from helping in a national emergency, and a sense of achievement from making radical changes to care delivery in a short amount of time. In May 2020, 65% of respondents to our COVID-19 tracker survey agreed that there was a greater sense of teamworking, 45% agreed they felt more valued as a doctor, and 47% agreed they felt less burdened by bureaucracy. As described in our 2021 call for evidence: "*Was a positive experience of working with colleagues, the patient population (so many willing volunteers and helpers) and the wider practice staff. We all pulled together, and it has been in that sense a positive experience*". (GP contractor/principal, England)

484. However, initial feelings of positivity and high morale amongst staff tended to wear off after the first wave. Longitudinal data from our surveys show that doctors' experiences of increased team spirit, recognition, and sense of autonomy decreased during the pandemic. This downward trend was also reflected in our 2021 call for evidence, for example: "*Initially a very positive mutually supportive atmosphere in the practice but difficult to maintain this given the duration of the pandemic and the increasing workload. In the first wave all we were dealing with was the pandemic since then it has been on top of normal workload so more stressful and tiring*". (GP contractor/principal, England)

Rapid shift to remote working within general practice

485. The shift to remote working, particularly in general practice took place rapidly. This change was considered essential to stop the spread of COVID-19, helped to maximise a limited workforce and allowed those who had to isolate to work remotely if well enough. GPs continued to provide face-to-face appointments when clinically necessary, and maintained a focus on older patients, shielding patients and patients with poor mental health (PB/532 - INQ000397310).

486. In England, the BMA engaged with NHS England regularly during the early stages of the pandemic to relay challenges from frontline staff and to facilitate the distribution of over 20,000 laptops and 30,000 VPN tokens to GPs to support remote working.

487. The shift to remote working was not as effective in secondary care due to the reasons set out in section B.

Greater autonomy and reduced bureaucracy in general practice

488. During the pandemic GPs experienced greater autonomy, flexibility and freedom to act in the best interests of their patients, with a reduction in many of the regulatory and contractual requirements that had previously been placed on them. A significant theme from the BMA tracker surveys and other feedback from frontline GPs and Local Medical Committees has been the positive impact of the reduction in some levels of 'micromanagement' within general practice including repeated 'improvement' initiatives, performance management targets and oversight meetings.

489. It is important to capitalise on this greater autonomy and incorporate the positive learning into new ways of working. Whilst some form of oversight and regulation is necessary within any health system this should be light-touch, facilitative and supportive, not constrictive. In the past some expert groups and other bodies have set inappropriate and/or unevidenced standards for general practice settings that have not been fully costed or are unrealistic for implementation. To avoid this DHSC ministers should work with key general practice and primary care stakeholders to set appropriate and achievable clinical standards for general practice. Reducing the burden on general practice is essential if GPs are to continue to provide safe, high-quality care, to their patients.

Improved access to abortion services

490. In some areas, the pandemic improved access to healthcare. A key example is access to abortion. The introduction of telemedical abortion in England, Wales and Scotland removed an important barrier to access by allowing women to be counselled and receive pills for early medical abortion without attending a hospital. These changes to early telemedical abortion were made permanent in Wales (February 2022) and England (March 2022) and have been extended in Scotland since May 2022.

491. The situation in Northern Ireland was different as abortion had only been decriminalised in October 2019 and the pandemic began before the framework for commissioning and delivery of abortion services in Northern Ireland was implemented. Access to early medical abortion via post became available for those in the first 10 weeks of their pregnancy, something BMA Northern Ireland had called for in a letter to the CMO expressing concerns about the lack of access for women in Northern Ireland to a safe abortion service (PB/322 - INQ000400342). However, it was not until October 2022 that

the Northern Ireland Secretary of State issued instructions to commission abortion services in Northern Ireland. While all health trusts in Northern Ireland now provide early medical abortions, there is still not a full telemedicine service, unlike in the other nations of the UK.

Changes to appraisal processes

492. In March 2020, appraisals were paused across the UK to allow clinicians to focus on meeting frontline pressures.

493. When appraisals resumed in most of the UK from Autumn 2020, they took a new approach that was streamlined and had a greater emphasis on wellbeing, although revalidation requirements remained the same. There was a focus on how appraisees could meet revalidation requirements while stripping back extra and unnecessary facets of appraisal that had been added over the years.

494. The pandemic provided a much-needed opportunity to rethink appraisals and consider how the requirements of revalidation could be met in a way that better supports doctors' professional development and wellbeing.

The vaccination programme

495. The vaccination rollout is widely regarded as an unprecedented success. Vaccinations were delivered remarkably quickly in comparison to other nations, and the UK government hit its ambitious target of offering the vaccine to all adults by July 2021.

496. General practice did an exceptional job at spearheading the programme and delivered a large portion of the vaccines. For instance, in England by the end of October 2021, 71% of vaccines had been administered by GPs and community pharmacies compared with 21% by vaccination centres (PB/533 - INQ000065228). A report by the National Audit Office also highlights the 'goodwill, flexibility, and dedication' that had been required to set up and run vaccination sites at such pace and scale (PB/533 - INQ000065228).

497. This achievement is all the more remarkable considering that the vaccination rollout was delivered in addition to standard GP workload, not instead of it. Demand on general practice - which was understaffed even before the pandemic - has been consistently high throughout the pandemic and increased further due to the backlog of unmet need. The vaccination programme increased this workload further. As described by two respondents in the BMA's 2021 call for evidence:

a. *"We have been stretched so thin covering COVID centres and also delivering vaccine programmes this has had a huge impact on our staff".* (GP Contractor/Principal, Northern Ireland)

b. *"We worked all weekends delivering vaccine with volunteers, clinicians and patients and friends. Part time doctors became full time. Retired doctors revalidated and manned 119 etc, 5 receptionists resigned, unable to cope".* (Medical Academic GP, England)

498. The BMA recognises that the Inquiry will focus on the vaccination rollout within Module 4. While the BMA believes the rapid development and delivery of the COVID-19 vaccines was a success, in Module 4 it will also be important for the Inquiry to consider those aspects that were less successful or where there is learning for the future, including mixed messages received by pregnant people, or examining the reasons for lower vaccine uptake and vaccine hesitancy in some groups, particularly ethnic minority communities and in more socio-economically deprived areas of the United Kingdom.

Government COVID-19 data sharing

499. In the course of the pandemic, the scope of data sharing quickly accelerated to support activities in three key areas: COVID-19 care; vaccination and health service planning; and vaccination and treatment research. To facilitate this, a significantly larger set of patient data was drawn from general practice via a number of different mechanisms, with this data subsequently being made available to government bodies, other healthcare providers and research organisations.

a. **Direct care:**

i. With the support of the BMA, NHS England provided additional information in the Summary Care Record (SCR) with a greater and more relevant range of information extracted from the GP record to be made available to secondary care clinical staff via the SCR. In theory, this was designed to reduce time spent requesting information and to facilitate quicker and more targeted care. In practice, it is unclear whether it had a substantial impact on the delivery of care, however it was a very low effort intervention with little to no risk or workload implications.

ii. The flow of COVID-19 test results to and from the GP record was also seen as a critical step towards improving the support provided to patients, with positive test results logged in the GP record used as a trigger for remote monitoring and care of vulnerable patients. This took the form of provision of pulse oximeters to be used by patients at home to monitor oxygen saturation levels for 14 days after a positive test. A system to automatically alert GPs in Wales of patients' COVID-19 test results was rolled out in September 2020 following lobbying by BMA Wales.

b. **Planning & Research**

i. While the use of data for direct care saw a modest increase, the extraction of GP data for research and planning was significantly greater in scope and scale. The BMA and RCGP worked with NHS England, NHS Digital and DHSC to support the introduction of a tactical GPES (GP Extraction Service) to facilitate the use of patient data in the context of the pandemic. This utilised the existing framework for flowing patient data out of general practice to create a comprehensive dataset that was used for a wide range of programmes including: COVID-19 risk stratification, vaccination delivery planning, pandemic health service planning, and vaccine research and development.

Any recommendations the BMA would make to improve conditions for doctors and medical students in the event of a future pandemic

500. Throughout this witness statement I have highlighted areas where we believe improvements can be made to ensure a future pandemic has less of an impact on doctors and medical students. Detailed recommendations are also set out in the BMA's five COVID-19 Review reports (PB/013 - INQ000118474, PB/014 - INQ000118475, PB/015 - INQ000185355, PB/016 - INQ000185356 and PB/017 - INQ000185357).

501. Broadly speaking the BMA's recommendations fall into four key areas:

a. **Better resourcing of health, care and public health services** to improve care delivery for patients and reduce pressures on staff both during 'normal' times and during health crises such as pandemics. This includes having minimum safe staffing levels underpinned by legislation in all UK nations. It also includes the

need for transparent and regular workforce planning and, as clear from the Module 1 evidence to the Inquiry, planning for and ensuring sufficient surge capacity within the system. Planning for, and building in, appropriate surge capacity would enable the waiting list backlog to be tackled more rapidly during periods of less acute need.

b. **Improved protection for staff and patients at work** – this ranges from having better equipped estates (with adequate ventilation in clinical and non-clinical areas, plus the ability to distance infectious patients from non-infectious patients), to having a range of PPE suitable for a diverse range of face and body shapes, regular fit testing, risk assessments, access to occupational health services and sufficient stocks of PPE. This also includes taking a precautionary approach in the event of future pandemics that allows for novel and unknown biological threats to be mitigated via agile risk assessment and adequately emphasised health and safety advice that protects staff and the public. The need for wider use of RPE still needs to be urgently addressed.

c. **Greater attention on those most vulnerable to a future threat** – including ensuring that pandemic planning includes full consideration of inequalities, with tangible systems in place to mitigate disparities and detailed plans for how those most vulnerable can be protected quickly. Likewise, cross-government strategies to improve population health and reduce health inequalities would improve the UK's resilience to future pandemics and thereby help to mitigate some of the impacts on both staff and patients.

d. **Better safeguards for staff** – including plans for the continued delivery of training during the next pandemic, as well as better rotas and T&Cs, including better protections for those putting their lives on the line and their families. It is unconscionable that doctors who put their lives on the line in the course of duty and as a result got long COVID are not receiving the financial and wider support they deserve.

Statement of Truth

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

Signature:

Personal Data

Name: Philip Banfield

Date: 03.05.2024