Witness Name: Sir Andrew Goddard
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF SIR ANDREW GODDARD, PAST PRESIDENT OF THE ROYAL COLLEGE OF PHYSICIANS

I, Sir Andrew Goddard, will say as follows: -

1. I was president of the Royal College of Physicians from September 2018 until September 2022. I worked as a consultant physician at the Royal Derby Hospital before, during and after the pandemic, and continue to do so. I directly cared for patients with COVID-19 on my ward, and continue to do so, as well as managing non-COVID patients in out- and in-patient settings.

2. The Royal College of Physicians (RCP) is a professional membership association for physicians, who cared for 90-95% of hospitalised patients during the pandemic. Membership of the RCP is not required to practice as a doctor. The majority of our members are in the UK, but we are a worldwide organisation. There are 30 physician specialties and six faculties of the RCP. These are independent organisations that we work closely with.

3. The RCP was established by Royal Charter but does not have a statutory role in healthcare. We seek to influence policy and practice in England, Wales and Northern Ireland. We hold and develop relationships with UK governments, the NHS, Health Education England, Health Education and Improvement Wales, General Medical Council, Care Quality Commission, Healthcare Safety Investigation Branch, other Royal Colleges and our umbrella body the Academy of Medical Royal Colleges, NHS representative organisations, think tanks, and charities such as the Health Foundation, Nuffield Trust and the King's Fund.

4. The Federation of the Royal Colleges of Physicians is a collaboration between us, the Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow. The Federation delivers examinations, training and CPD on our behalf.

5. The Federations sets and maintains standards for UK medical training via the Joint Royal Colleges of Physicians Training Board (JRCPTB). Its services include curriculum design and implementation, certification of trainees, gathering and providing evidence to the GMC to enable it to award a certificate of completion of training (CCT), and approving overseas training programmes.

6. The RCP informs its work by listening to its members through an extensive system of committees, at events, through surveys, by producing journals, via social media and other one-to-one communications. Our committees include joint specialty committees, new consultants' and trainees' committees, and the patient safety committee. The latter brings together medical specialities, other professions and the NHS with the aim of improving patient safety.

7. The RCP offers an invited services review (ISR) service to healthcare organisations that require independent and external advice. It is a consultancy service that healthcare organisations can request when they feel the practice of clinical medicine is compromised and there are potential concerns over patient safety.

8. The RCP provides advice and guidance on the design and delivery of healthcare. For example, we provide quality improvement resources and guidelines on diagnosis. We also developed and maintain the National Early Warning Score (NEWS2) that is used in hospitals across the country, designed to standardise the assessment of and response to acute illness.

9. The RCP is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government to deliver

    a. the Falls and Fragility Fractures Audit Programme
    b. the National Asthma and COPD Audit Programme.

10. The RCP has accreditation programmes in a number of clinical services, including:

    a. Joint Advisory Group on gastrointestinal endoscopy (JAG)
    b. Quality in Primary Immunodeficiency Services accreditation scheme (QPIDS)
    c. Improving Quality in Allergy Services (IQAS)
    d. Improving Quality in Liver Services (IQILS)
    e. Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS)
    f. Diabetes Care Accreditation Programme (DCAP).

11. The RCP provides education beyond that required to register with the GMC. It includes online courses, credentials, accreditation and a masters programme. Some of these courses are delivered in partnership with other educational bodies. Some of our courses are funded by the NHS or government departments.

12. The RCP conducts an annual census of physicians and publishes the data. The years of data give an up-to-date picture of the workforce and enable us to identify trends to inform planning.

13. The RCP hosts a large number of events, from conferences to online debates. They include our 'Update in medicine' series, which help attendees stay abreast of clinical advancements in medicine, develop professional skills and network with colleagues.

14. The RCP seeks to influence government policy in Westminster and Cardiff. We produce policy reports, briefings for Parliamentarians, responses to select committee enquiries and similar.

15. During the COVID-19 pandemic we

a. were asked by the Department for Health and Social Care, particularly the chief medical officer's office, to help identify patients who were described as 'clinically extremely vulnerable' (CEV) and advised to shield

    i. We did this by convening the medical specialty societies. There are 30 different physician specialties, which range in size and scope from geriatric medicine (providing holistic care for older patients) through to nuclear medicine (using radioactive materials to aid diagnosis and treatment of disease). Their role, in general, is to bring together, support and represent those working in that particular field of medicine and research, including developing clinical advice and guidance. The specialty societies used their clinical judgement to provide guidance to their members to help them identify relevant patients on the basis of their clinical profile. Co-ordination between specialties was often required to ensure consistency of approach, for example ensuring patients on the same immune suppressing drugs for different conditions had the same guidance. The details of the identified patients were passed to NHS England so they could be contacted. Societies also worked with charities and other organisations to help people self-identify as CEV and contact their GP or specialist.

b. helped co-ordinate and co-chaired regular meetings with the Secretary of State for Health and Social Care and his team and other Royal medical colleges in the first year, at which Royal College presidents and chairs focused on informing the SoS what their members were telling them about access to PPE, the ability to deliver care and similar issues

c. contributed to the weekly 'National Escalations Pressures Panel' meeting with NHSE/I and other Royal Colleges

d. attended and contributed to meetings of the 'Medical Risk Panel' – an NHSE/I group advising on out-of-hospital NHS issues - during the first wave of the pandemic to discuss and manage day-to-day issues affecting the delivery of care to patients by the NHS (in the peak of the first wave these were happening every 2-3 days)

e. attended various meetings - with health ministers and Chief Medical Officers in England, Wales, Scotland and Northern Ireland; Public Health England and the equivalent bodies in Wales, Scotland and Northern Ireland; NHS England and its equivalent bodies in Wales, Scotland and Northern Ireland; National Institute for Health and Care Excellence ("NICE") about pandemic related matters – including a regular teleconference on workforce, education and training issues called by HEE; HEE's Medical Education and Training Forum; the GMC's Education Advisory Forum; the Welsh government COVID vaccines engagement group

f. provided weekly or fortnightly updates to our members on COVID-19 and the pandemic response via newsletters (AG/1 – **INQ000226564)**), our website, RCP Player (video) and RCP Medicine (podcast) allowing dissemination of key information on both clinical aspects of COVID and national policy

g. hosted in-person and virtual teaching and discussion events to help members understand the clinical and service delivery aspects of COVID-19 and the pandemic, with contributors including Professor Chris Whitty, Chief Medical Officer, and Professor Steven Powis, NHS England National Medical Director

h. regularly surveyed our clinically active members in the UK (who account for around two thirds of all our members) about the impact of COVID-19 and the pandemic response - from access to PPE and having the right equipment to deliver video consultations, to access to diagnostics and their morale – and published the results (AG/2 – INQ000226565)

i. produced advice and guidance for our members and the wider healthcare workforce on clinical and ethical dimensions of the pandemic

j. produced briefings and reports about our thoughts on the impact of the pandemic on services and what needed to happen as a result, contributing to reports such as the National Audit Office report on PPE supply 'The supply of personal protective equipment (PPE) during the COVID-19 pandemic' (AG/30 – **INQ000145895).** . The report examined responsibilities for PPE supply in England; the emergency response to PPE shortages, focusing on the performance of national bodies in obtaining and distributing PPE to local organisations; the experience of health and social care providers and their workforce; and the Department of Health & Social Care's new PPE strategy. It concluded that, "The Department and its partners deserve some credit for building at pace a new international supply chain and distribution network. But there are important aspects that could and should have been done much better in supplying PPE… neither the stockpiles nor the usual PPE-buying and distribution arrangements could cope with the extraordinary demand created by the COVID-19 pandemic. As a result, government's structures were overwhelmed in March 2020. Once government recognised the gravity of the situation it created a parallel supply chain to buy and distribute PPE. However, it took a long time for it to receive the large volumes of PPE ordered, particularly from the new suppliers, which created significant risks. There were further difficulties with distribution to providers and many front-line workers reported experiencing shortages of PPE as a result. The initial focus on the NHS meant adult social care providers felt particularly unsupported. Government has budgeted an unprecedented £15 billion of taxpayers' money to buy PPE for England during 2020-21. It has paid very high prices given the very unusual market conditions, and hundreds of millions of pounds-worth of PPE will not be used for the original intended purpose."

k. re-organised training and exams for trainee physicians to allow on-going progression of the NHS workforce

l. conducted virtual hospital visits to support physicians working and training in those hospitals during the pandemic

m. developed a 'COVID-19 rapid response' article type for both our journals, with a rapid peer review and production process to fast-track these articles through to online publication and created a COVID-19 subject collection to gather all published content in one easily accessible place for readers.

16. Recommendations the RCP would make to improve conditions within healthcare settings in the event of a future pandemic are:

    a. ensure clear communication and consistent messaging from government

    b. ensure staffing levels and therefore care capacity within the health and social care system is adequate to both deliver routine care and respond to an emergency

    c. ensure that adequate stocks of PPE and the logistics are in place to distribute them

    d. ensure clarity over the appropriate levels of protection in different healthcare settings

    e. ensure the system is prepared to protect healthcare professionals by providing adequate rapid testing, individualised risk assessments and flexible working conditions

    f. ensure better levels of UK population health by investing more in preventative healthcare and other measures.

17. One of the key learnings from the pandemic was that poor and worsening levels of UK population health contributed to higher levels of mortality from COVID-19 and health inequality that existed before the pandemic was exacerbated by it. In March 2021, in response to a World Obesity Federation's report showing obesity had been linked to a higher risk of severe COVID-19 and death from the disease, we said that the link between high levels of obesity and deaths from COVID-19 in the UK was indisputable.

18. We urged the government to implement a cross-government strategy to address health inequalities, the main call of the Inequalities in Health Alliance that we founded in 2020. We first did this in February 2020 when we wrote to the Prime Minister to ask to accept the recommendations *of Health Equity in England: The Marmot Review 10 years on* (**AG/32** – **INQ000319648**), including a national strategy for action on the social determinants of health, and tell him we intended to establish the IHA. Other signatories to the letter (AG/32 – INQ000319648) were the Royal Colleges of Surgeons of England, Emergency Medicine, Nursing, General Practitioners, Paediatrics and Child Health, Ophthalmologists, Midwives, Pathologists, Physicians of Edinburgh, Radiologists, Surgeons of Edinburgh, Obstetricians and Gynaecologists, Physicians and Surgeons of Glasgow; and the Faculties of Public Health, Dental Surgery, Intensive Care Medicine, Sport and Exercise Medicine, Sexual and Reproductive Healthcare, Pharmaceutical Science; and the Academy of Medical Royal Colleges. We then wrote again as the IHA in October 2020 to ask the prime minster to develop a cross-government strategy to reduce health inequalities, use the socio-economic duty, section 1 of the Equality Act 2010, to address health inequalities, and to adopt a 'child health in all policies' approach. We followed that with a letter in September 2021 with 92 signatories (AG/33 - INQ000319649). The IHA is a campaigning initiative led by the RCP that is primarily concerned with the health inequality that arises from the social determinants of health, which is why we campaign for a cross-government strategy. It does not campaign specifically about inequalities in access to and outcomes from healthcare. While we had planned to establish the IHA by early 2020, our plans were simultaneously hindered by our need to support the response to the pandemic and made more urgent by its impact. In IHA campaigning we have explained the fact that people subject to health inequality and inequality in general were worse affected by the pandemic and that COVID-19 exacerbated those inequalities.

19. In April 2021, as part of one of our regular COVID-19 impact surveys of our members, we asked about the impact of deprivation on health. 9% said they had seen cases of conditions, diseases or disorders that they might not expect to see in 2021, such as TB or rickets. A similar proportion saw high rates of asthma or respiratory conditions with patients complaining of damp housing or living in areas with high concentrations of air pollution. 31% saw patients with obesity, or complications from early stages of malnutrition or nutrient deficiency, as a result of being unable to afford to eat healthily. The RCP believes that a key factor in preparing for future pandemics and similar is improving general levels of health among the population.

20. At the start of the pandemic, the main issues were people being off work due to illness or self isolation, access to testing and access to PPE. As the pandemic proceeded, these problems eased, but were replaced by problems accessing diagnostics and treating non-COVID-19 patients.

21. Something that was raised by members throughout the pandemic was concern about levels of ventilation in hospitals, although we did not collect evidence on this systematically. Those that wrote to us were concerned that ventilation systems, or lack thereof, were facilitating the transmission of COVID-19.

22. By January 2021, when the second wave hit, one of the main issues was fatigue among our members and their colleagues. At that time we reminded our members that, according to government data and as widely reported, on 12 April 2020 (at the peak of the first wave) there were 21,684 patients in hospital with COVID-19, 15% of whom were ventilated (3,301 patients). In comparison, according to the Intensive Care National Audit and Research Centre, on 15 January 2021, 10% of the 37,475 patients in hospital with COVID-19 were on ventilation (3,789 patients). That represented a 73% increase in the number of patients with COVID-19 being treated by the wider medical team beyond Intensive Treatment Units (ITU).

23. Improvements in treatment for COVID-19 meant that in the second wave a much smaller proportion of hospitalised COVID-19 patients required ventilation on Intensive Treatment Units (ITU). However, their conditions were still severe enough to require inpatient hospital treatment on a general COVID-19 ward. This placed huge pressure on the wider medical team in all specialties, particularly respiratory medicine. 56% of respondents to our COVID-19 impact survey (sent to approximately 25,500 RCP members in the UK, with 1,890 respondents) were very concerned about the impact of rising COVID-19 admissions on their organisation's capacity to deliver safe and effective care. Only 3% were not concerned at all. Of the 97% who were at least somewhat concerned, over half (52%) were more concerned for their non-COVID patients.

24. A large proportion of staff had to move from working in their usual area in order to care for patients with COVID-19. In April 2020, 29% of respondents (sent to approximately 25,000 RCP members in the UK, with 2,129 respondents) reported working in a clinical area different from their normal practice. Over half (53%) of respondents who were working in a clinical area different from their normal practice were working on acute medicine wards and 14% were working on a COVID-19 ward. The majority of members had been supported with the transition: 73.5% had access to training, 59% access to psychological/emotional support and 51.5% received mentoring. By June, 22% were working in a different area; 40% of that 22% of them were working on a COVID-19 ward. Previously, 59% of respondents reported working on an emergency rota and we asked respondents to tell us the status of these rotas: 27% said that the rotas had been discontinued, 44% that de-escalation had started, 14% that de-escalation plans had been made but not started and 15% that no plans had yet been made. By August only 10% were working in a different clinical area to usual, with 74% saying rotas had returned to normal.

25. In July 2020 (sent to approximately 25,500 RCP members in the UK, with 829 respondents) and September 2020 (sent to approximately 25,500 RCP members in the UK, with 898 respondents), we asked about preparedness for a second wave of COVID-19. In July, only 5% felt their organisation was 'fully prepared' and 10% said their organisation was 'not at all prepared'. The majority (54%) felt their organisation was 'somewhat prepared', while 31% said 'quite prepared'. By September, just under half (47%) had been involved in a conversation in their organisation about preparing for a second wave, compared to 36% in July. 10% said their organisation was not at all prepared for a second wave, but the majority (50%) felt it was somewhat prepared. 95% said their organisation was preparing on the basis that a second wave was likely (23%) or extremely likely (72%). When asked about measures to prepare for a second wave, sufficient PPE and staffing levels were identified as the single most important factors. But respondents felt a full package of measures was needed, including ensuring enough bed capacity, access to testing and working closely with social care.

26. In January 2021 (sent to approximately 25,500 RCP members in the UK, with 1,890 respondents) we reported on the impact of the second wave on how people were feeling. Almost a fifth (19%) of physicians reported that they had had informal mental health support and 10% had received formal mental health support from either their employer, GP or external services. A large proportion (64%) felt tired or exhausted, and many felt worried (48%). It was welcome to see that over a third felt supported (35%) and that feelings of determination (37%) continue despite the challenges faced.

27. At that time, half of respondents (49%) said they believed that their organisation had enough medical staff to safely manage daily demand before the pandemic, although not during winter and summer peaks. A quarter (23%) felt that they had enough staff to both safely manage daily demand throughout the year and manage the pandemic.

28. In January 2021 we were also sad to announce that the RCP registrar, Professor Donal O'Donoghue, had died from COVID-19. At the RCP Donal's responsibilities included clinical and professional affairs and he took a lead role in matters relating to membership, governance, regional activity, global programmes and relationships with the NHS. In that role, and as a member of the senior officer team, Donal made a huge contribution to our pandemic response, particularly in making sure that we were providing our members with the clinical and ethical advice and guidance they needed. Donal was unfortunately only one of several RCP members who died of COVID-19, and the list of all doctors who died was much longer. We have paid tribute to our members in a digital publication (AG/3 – INQ000226566).

29. In February 2021 (sent to approximately 25,000 RCP members in the UK, with 1,426 respondents), a large proportion (63%) still felt tired or exhausted, 28% worried and 27% demoralised, although 48% were worried the previous month. 27% reported feelings of determination, down from 37% in January, although 18% did feel optimistic – a small increase from January. As in January, around a third (32%) felt supported. Only 51% reported getting the amount of sleep they needed all or most of the time in the previous four weeks. Respondents in London were the worst affected – only 42% got the amount of sleep they needed all or most of the time, and 11% said they never got the amount of sleep they needed, compared to 8% for all respondents. 63% said there had been no discussion in their organisation about timetabled time off to recuperate, and a further 25% just didn't know. 12% said they hadn't arranged to have any time off and didn't feel they needed it, but almost a quarter (24%) simply said they hadn't arranged it.

30. Also in February 2021, 10% of those taking time off were doing so as they had long COVID, up from 7% in January and more than the proportion who were off due to acute COVID-19 (7%). Among those who had a positive PCR test result, symptoms persisted for a week or less for 30%. For 18% they persisted for two weeks, for 25% up to six weeks, and between 6 weeks and 6 months for 12%. The most common symptom was fatigue, reported by 85%. That was followed by pain (32%) and breathlessness (29%). 18% reported cognition problems and 9% limb weakness. 56% reported other symptoms, including persistent anosmia, headache, dizziness, myalgia and a cough.

31. In March 2021 we published *Recover, rebuild, renew* (AG/4 – INQ000226567), which looked at the effect of the pandemic on the medical workforce in Wales. We said it was an opportunity to embed new ways of working into the way the NHS cares for its patients and staff. We said that around 90% of all hospital in-patients with COVID-19 were cared for by physicians, and the past 12 months had put immense strain on these doctors. Thousands of clinicians and care workers were exhausted; some would be close to burnout. A survey of RCP members found that almost one-third had sought mental health support during the pandemic. The report included extensive quotes and case studies from doctors about their experiences of working during the pandemic. We made 54 recommendations under three headings:

    a. The next Welsh government must support clinicians to develop innovative solutions as we rebuild the post-pandemic NHS. A renewed focus should be placed on enabling health and social care systems to work more closely together, thus allowing key workers to provide seamless care and improve the experience of patients with complex needs.

    b. The next Welsh government must support doctors to deliver the best care possible by investing in training, education, and career development. Physician associate regulation must be fast-tracked, medical school places should be increased and there should be more flexible working. Perhaps most importantly, all clinicians must be allowed time and space to rest and recuperate.

c. The next Welsh government must show national leadership on public health by supporting people to live healthier lives, reducing avoidable illness, and helping to keep people out of hospital. This includes effective action to tackle obesity, air pollution, smoking and alcohol abuse.

32. In its June 2021 contribution (AG/5 – INQ000226568) to the Academy of Medical Sciences report *Preparing for a challenging winter 2021/22*, the British Thoracic Society (BTS) said that the pandemic had a "significant impact on respiratory specialty in relation to workforce and the delivery of routine services. Respiratory professionals continue to be involved at all levels in the care of COVID-19 patients (acute, recovery, Long-COVID-19) and at the same time are expected to restore and maintain the full range of non-COVID-19 respiratory services… In November 2020, the BTS conducted a survey of respiratory departments across the UK in which 71% of respondents reported that their respiratory teams did not have sufficient bed space to cope with the number of patients they had in their care, suggesting an ongoing issue with inadequate ward facilities to accommodate patients during winter surges… The NHS has an inadequate number of skilled respiratory staff of all skill sets (medical, nursing, allied health professions, clinical scientists) to deal with the growing care demands of the UK population." In July 2021 the BTS provided a detailed account of the impact of the pandemic in its submission to the APPG for Respiratory Health's inquiry on COVID-19 (AG/6 – INQ000226569). It said that "the single most important lesson to be learnt from the past few months was that the NHS must have a level of staff and resources that allows it to accommodate and adapt to surges in demand without impacting day to day services. Respiratory medicine continues to respond to all the challenges of COVID-19 without any increase in staffing. The pandemic hit the respiratory specialty from a position of relative weakness in terms of year on year understaffing."

33. In August 2021 we published findings of the largest study to date of the quality of care given to patients in the UK with COVID-19 to identify learnings from the pandemic, *Caring for hospital patients with COVID-19* (AG/7 – **INQ000239713).** Using data from patient records provided by reviewers from a large and representative sample of NHS trusts in England and a modified version of an established and validated structured judgement review process already used by many clinicians in the retrospective case record analysis of acute hospital death, the study concluded that overall care delivered was judged to have been adequate, good or excellent for 96.5% of patients (good or excellent for 77.4%).

34. The study looked at significant variations between hospitals when it came to end-of-life care experiences, assessment, documentation and communication, senior review, do not attempt resuscitation decisions and discharge planning. This revealed both excellent care and care that could have been improved.

35. Care judged to be poor overall was very uncommon and occurred in only 3.5% of the total sample (18 of 510 cases). We said that when it did occur, the commonest causes were end-of-life care issues, nosocomial infections (those acquired in hospital), delays in assessment, escalation decisions, and the two linked issues of poor communication and poor documentation. We also said that none of the cases where care was scored poorly affected the outcomes for the patients.

36. A subset of 216 patient case reviews supplied allowed more detailed comparison of the care quality scores across four scenarios: patients who received critical care and survived, patients who received critical care and died, patients who didn't receive critical care and survived, and patients who didn't receive critical care and died. There was no evidence for differential quality of care delivery between any of the four subgroups, but those patients who died and were not escalated to critical care had poorer care scores across the phases of care. This may be due to a combination of hindsight bias and the absence of negative factors in the survivors who did not, for example, experience poor end-of life care.

37. Returning to our COVID-19 impact surveys, we reported on the findings of the final one in January 2022 (sent to approximately 25,000 RCP members in the UK, with 1,218 respondents). We asked respondents whether they had felt overwhelmed at work during the past three weeks and 69% said they had. The situation was worst in Northern Ireland, with 62% saying that had felt overwhelmed either once or twice a week or every day. In England outside of London it was 43%, in London and Wales 37.5% and in Scotland 22%.

38. We also asked respondents whether they had been asked to fill a rota gap at short notice in the past three weeks. 55% said they had. 15% of respondents had been asked to fill a rota gap at short notice on 5 or more occasions. Almost a quarter (24%) had been asked to do this at least once while on annual leave. Trainees, locally employed and specialty and associate specialist (SAS) doctors were most likely to have been asked to cover rota gaps at short notice, with two thirds (62.5%) of those respondents saying they had been. 53.5% of consultants had been asked. Just 11% of consultants had been asked to cover a rota gap on 5 or more occasions, compared to 29% of trainees, locally employed and SAS doctors.

39. For clarity, SAS doctors are a diverse group of doctors. They range from doctors having 4 years' experience (trainee-like) to senior doctors practising independently (consultant-like). They are registered with the GMC like all doctors but are not on the specialist register. According to the GMC in its *Spotlight on SAS doctors and LE doctors: analysis of Barometer survey 2022 results* (AG/34 – INQ000316263) 65% gained their primary medical qualification in a country other than the UK.

Engaging with and supporting our members

40. Facilitating engagement with and support for our members was necessarily affected by the pandemic. If it were not for the fact that we had established digital methods of communication before the pandemic, we would have struggled to achieve this.

41. Across UK regional networks, local new consultants' forums were moved online, reaching a much wider audience. The monthly forums were organised by new consultant committee regional representatives and covered topics such as 'Human factors in healthcare'.

42. Regular virtual fora for the College Tutors (CTs) and Associate College Tutors (ACTs) – who are our local links within individual hospitals - resulted in greater engagement across networks, forming a supportive response to recovering training during the pandemic. There was a positive result in Annual Review of Competence Progression (ARCP) outcomes and continuing high recruitment into physicianly specialty posts. We converted the annual CT and ACT conference to virtual in 2020.

43. To increase support for trainees, we held the first virtual 'Call the Med Reg' conference in July 2021, aimed at preparing IMT3 and ST3 trainees for the transition into the medical registrar role. Topics included how to manage the acute medical take safely, when to call the consultant and the importance of registrar wellbeing, as well as focusing on specialty top-tips in the acute setting.

44. We provided further support for trainees through a programme of 14 regional virtual poster competitions. Open to trainees at all levels as well as physician associates and physician associate students, the success of the scheme was overwhelming with more than 500 entries across all regions and nations. Organised with the medical student and foundation doctor network, we held our first Specialty Careers Showcase in October 2021.

45. Through our global networks, we strengthened our relationships with our international advisers, with quarterly events held for them across each of the college's global regions (Americas, Asia Pacific, Middle East & North Africa, South Asia & Sub-Saharan Africa) since September 2020. These provided a great opportunity to engage with and support international advisers and the RCP's international membership.

46. Our first global member network was created in Iraq and its inaugural meeting was held in February 2021. It was attended by 56 members and fellows from Iraq, representing a third of the country's membership and ranged from medical students and junior doctors to consultants and senior fellows. Between then and September 2021 we saw an eight-fold increase in RCP membership in the country.

47. Some international members and fellows were particularly hard hit during the pandemic. The monthly RCP Global Newsletter provided support to international members by signposting global activities, information and events during COVID-19 surges. We curated best practice guidance around COVID management, links to wider support and wellbeing support for members in India and Sri Lanka.

48. To support shared learning through the pandemic, we launched a 'Global Stories' webinar series. It featured topics such as the impact of the explosion in Beirut in November 2020 on local healthcare provision and the provision of palliative care services in low- and middle-income countries. It featured members and fellows sharing their local experiences of COVID-19, how it was managed in their country/region, and the wider cultural and societal impact on their communities.

Staffing

49. The results of our regular COVID-19 impact surveys of our members plus other information in the public domain made it clear that staffing levels and therefore care capacity within the health and social care system were not adequate to both deliver routine care and respond to the pandemic, which led to a significant increase in an already significant backlog of care. This additional pressure on an already inadequate workforce had a negative impact on morale and led to people leaving healthcare professions.

50. The number of people unavailable to work because they were waiting for testing had an impact. The lack of reagents, a dearth of suppliers and the prevalence of 'just-in-time' procurement suggested there was a significant lack of planning.

    a. In early April 2020 we reported that testing was available for 31% of respondents with symptoms, but there was wide geographical variation across the UK: 40.5% in London, and from 9.5% in East of England to 63% in our Northern region. But only 12.5% said testing was available for members of the household who had symptoms: 13% in London, and from 2.7% in East of England to 32% in Thames Valley.

    b. By late April and mid-May 2020 access to testing had improved, but our members were still reporting that they were not always able to access what they needed for themselves, their households and their patients. In May we also asked whether people had had a test in the past 2 weeks and how quickly they got their results back. 12% reported having had a test in the past 2 weeks. Of those, 17% reported receiving the results within 24 hours, 38% received them between 24–48 hours, 20% between 48–72 hours, 14% over 72 hours+ and 17% had not yet received their results at the time of the survey.

    c. By early June 2020, 97% of respondents reported that they were able to access PCR testing for themselves, 86% for members of their households and 97% for their patients. 9% reported having been tested in the previous 2 weeks, with 15% getting their result back within 24 hours, 47% between 24–48 hours, 12% between 48–72 hours and 13% in 72 hours+. For the first time we also asked respondents whether they had been able to access antibody testing for themselves. 26% reported having been able to access a test. We asked those respondents who had been tested to tell us the results of these tests. This was an optional question but of those who felt comfortable sharing the results, 31% had tested positive for COVID-19 antibodies and 69% negative.

d. By early August, 79% were able to access an antibody test, significant progress from the 26% who were able to in June. A quarter reported a positive test for antibody infection, with no notable differences between ethnicity, gender, grade and London and other English regions. PCR test results were being received more quickly than in June – 34% were receiving results within 24 hours (up from 15% in June) while it was taking over 48 hours for 15%, down from 25% in June.

e. In September 2020 we reported that half of respondents had had a PCR test for COVID-19 at some point. The result was negative in 83% of cases. 15% had been tested in the previous two weeks, up from 13% in July. Of them, only 80% of them were able to access the test in the first 24 hours, compared to 88% in July. 26% of those tested received their results within 24 hours, similar to July. 25% waited up to two days, down from 38% in July; 17% up to three days, compared to 21% in July; and 12% more than three days, compared to 13.5% in July. Three quarters of respondents had been able to access an antibody test for COVID-19. 5% had wanted one but been unable to access it. The result was negative in 79% of cases. Of those who had received a positive PCR test result, 12% received a negative antibody test result. By early November, the situation was broadly similar.

f. In January 2021, of those who needed it, 95% were able to get a test for themselves within 24 hours. Only one person was off work because they were self-isolating while waiting for a test for someone in their household. Of those who needed it, 87% said they were able to get a test for their household within the first 24 hours.

g. In February 2021 we found that 78% had been provided with lateral flow tests to do each week. For those who had a positive PCR test result, 30% had had a lateral flow test in the previous two days. Of these, two thirds (67%) had received a positive result. Respondents had generally (88%) been able to access an antibody test if they needed one. 27% reported a positive result, compared to 22% in November 2020 and the highest since June 2020 (31%). The highest number of positives were reported among geriatricians (17%) and respiratory physicians (13%).

h. By January 2022, when we reported on our final COVID-19 impact survey, 86% of respondents who needed it were able to access the testing they needed for themselves in the first 24 hours. 82% were able to access it for members of their household with symptoms and 95% for their patients in the same timeframe. 1% were unable to access testing for their patients despite trying. 3.5% were unable to access a test for themselves and 4.5% for members of their household with symptoms.

51. Infection prevention and control and PPE were central issues for RCP members. While stocks of PPE may or may not have been adequate, they were not in the right place at the right time. There was also confusion over the appropriate levels of protection in different healthcare settings.

a. At its March 2020 meeting, members of our Council raised concerns about whether the recommendations to wear fluid repellent masks, apron and gloves (except where an aerosol is generated, in which case the recommendation is to use a FFP3 mask, visor, gown and gloves) were adequate. We were advising that PPE be worn when treating any patient in order to fully protect healthcare workers. We also noted there was a likelihood that CPR on patients with COVID-19 would need to be performed wearing a FFP3 mask. Consequently, we felt this could negatively affect survival rates for cardiac arrest.

b. In early April 2020 we reported that 21.5% in London and 18.3% in the rest of England (RoE) were taking time off from their normal work schedule, with no significant difference between consultants and non-consultant grades. The main reason for being off work was ill with suspected COVID-19 (42% London, 30% RoE), followed by self-isolating because someone in the household showed COVID-19 symptoms (18.5% London, 25% RoE). 78% of respondents were able to access the necessary PPE (79.4% in London and from 72.7% in West Midlands to 90% in Thames Valley). From what they told us, it was clear that there were at least two distinct issues with PPE: supply, and recommendations on what to wear and when.

c. By late April 2020 many fewer doctors reported being off work: around 8% nationally, with little variation between regions, and this stayed roughly consistent for the rest of the pandemic. These averages masked a stark disparity though: 23% of locally employed doctors and 15% of SAS doctors said they were currently taking time off. Of those, 42% were ill with COVID-19 and 36% were off work due to suspected COVID-19. While the number of SAS and locally employed doctors was small (just over 5% of the total) these findings were important given a large proportion of these doctors are from black and minority ethnic backgrounds, and the disproportionate impact of COVID-19 on BAME communities.

d. Access to PPE remained an issue and looked to be worsening. 26.5% of respondents reported being unable to access the PPE they needed for managing COVID patients, compared to 22% in our first survey. It was therefore a concern that 23% said they didn't know how to raise concerns about PPE in their organisation. Just under a third of respondents said they were working in an aerosol generating procedure (AGP) area. Of them, 31% reported being unable to always access long sleeved disposable gowns, and 37% unable to always access full-face visors. 86% of respondents were working in non-AGP areas with confirmed or possible cases of COVID-19. Almost 40% were not always able to access eye protection, and 15.5% not always able to access fluid repellent face masks. Only 69% of respondents reported either having had, or being able to access, fit testing. Over a third (34.5%) said they didn't feel confident fit checking their PPE.

e. In mid-May 2020, 19% of respondents reported that they didn't feel that they currently had the PPE they needed to wear for managing patients. 16.5% agreed that they had been in a situation in the past 2 weeks where they hadn't been able to access the PPE that PHE advised. This varied across the regions, with 8% in the South West region agreeing compared with 28% in the East of England. A third reported that they had not been or were not able to get fit tested for the PPE they were using. Additionally, 37% of clinicians reported not being confident about fit checking their PPE before entering patient-facing areas. For the first time, we asked respondents to tell us whether they had had an assessment of their risk concerning COVID-19. Only 18% reported having had a formal risk assessment undertaken, with 11% reporting that this had happened informally, eg a colleague raising concerns with them. We also asked respondents whether they were concerned for their health or that of a household member. Overall, 48% of respondents said they were either concerned or very concerned about their health. 76% of those from ethnic minority backgrounds reported that they were concerned or very concerned about their health.

f. By early June 2020, only 24% of respondents reported having had a formal assessment of their risk undertaken, an increase of 6% compared to the previous survey. In response to the PHE review of the disparities in risk and outcomes of COVID-19, we called on employers to ensure that all at-risk staff have had an initial risk assessment undertaken within 2 weeks. 38% said they were concerned or very concerned about their health, a drop of 10% (down from 48%) compared with our survey in mid-May. Respondents from ethnic minority backgrounds continued to be significantly more concerned, with 59% saying they were concerned or very concerned (although this had reduced by 17% since the last survey). 17% of respondents still reported not having the PPE they felt they needed when managing patients with COVID-19. 11% reported having found themselves in a situation in the past 2 weeks unable to access the PPE that PHE advised, a drop from the 16% who reported this 3 weeks previously. 31% reported not having been or able to get fit tested. In this survey for the first time, we asked respondents to tell us whether their employers were providing them with regular updates and communications about the supply of PPE to their organisation. The majority (72%) reported that they were, but the remaining 28% reported that this wasn't happening.

g. By August 2020, risk assessment had improved but slowly, with just 56% having had a formal risk assessment (up from 24% in June). 10% reported using the risk reduction framework hosted on the Faculty of Occupational Medicine website, while 4% had had informal risk assessments.

h. By September 2020, 65% of respondents had had a formal risk assessment. 11% reported using the Risk Reduction Framework for NHS staff at risk of COVID-19 infection (AG/35 – **INQ000223041)** hosted on the Faculty of Occupational Medicine (FOM) website, while 5% had had informal risk assessments. Of the 26% who hadn't been assessed at all, only 16% were from an ethnic minority background, although they made up 26% of all respondents. By early November, only 8% of respondents from an ethnic minority background had not had a risk assessment, compared to 24% of white respondents. FOM is a faculty of the RCP. Its President, Anne de Bono, was a member of the expert working group, led by Professor Kamlesh Khunti, that produced the risk reduction framework, a consensus document with the aim of better protecting the workforce and maximising the ability of the NHS to deal with the pressures.

i. In November 2020 the National Audit Office published *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*. It said, "Member surveys by the British Medical Association, the Royal College of Nursing, the Royal College of Physicians and Unison in April and May 2020 showed that a significant proportion (at least 30%) of participating care workers, doctors and nurses reported having insufficient PPE, even in high-risk settings. From this survey evidence we cannot know how representative these experiences are of the whole workforce, but occurrence of shortages is supported by other qualitative evidence."

j. In January 2021, many fewer doctors were off work compared to April 2020. 6% in London and 7% in the rest of England were off, compared to 21.5% and 18.3% the previous year. But of those who were off, the top reason (24%) was confirmed COVID-19, compared to 7% in April 2020. 4% were off work in relation to COVID-19. 21% said they felt they did not have the PPE they needed to wear for managing patients with COVID-19, around the same as in April 2020. Many of the comments on PPE provided via the survey were concerned with the PPE guidance for non-ITU settings. 80% said they had been, or were able to be, fit-tested for the PPE they were using, compared to 69% the previous year. 77% said they were confident fit checking their PPE, compared to 65% the previous year.

k. In February 2021, 60% of respondents said they were fairly or completely confident that their organisation's infection prevention and control (IPC) measures were effective. 16% were not at all confident. As in previous surveys around a quarter (24%) reported having neither a formal nor informal assessment. 18% felt they did not have the PPE they needed for managing COVID-19 patients, down from 21% in January. 4% said they hadn't been able to access the PPE that PHE advise in the previous two weeks. 18% had not been or were not able to be fit tested for the PPE they were using. 21% said they weren't confident fit checking their PPE before entering patient facing areas.

52. The availability of a vaccine obviously had an impact on the number of staff available to work. In November 2021, when it was announced that COVID-19 vaccines will be mandatory for NHS frontline staff, we knew from our surveys and NHS data that 98-99% of physicians had been vaccinated. In early 2021 we had supported the decision to delay the second dose of vaccination to prioritise first doses. We agreed that it would maximise the impact of the vaccine programme in its primary aims of reducing mortality and hospitalisations and protecting the NHS and equivalent health services.

Access to diagnostics, medicines and devices

53. From the beginning of our survey series, we asked if our members were able to access what they needed to provide care. In April 2020 we asked about access to medicines, oxygen and consumables. We asked them whether these shortages were new (since COVID-19) or pre-existing. 24.5% reported shortages in consumables since COVID-19, compared to 3% before its onset. New shortages in medicines were also reported in both inpatients (17% compared to 9%) and outpatients (12% compared to 11.5%).

54. On 14 April 2020, in my bulletin to members I talked about oxygen supply and renal support issues and will quote from that bulletin:

    a. Following last week's alert on oxygen supply I've been learning more about the engineering constraints of NHS oxygen supply. Our oxygen is supplied in the main by BOC and getting it to hospitals is not the problem, it is getting it from hospital stores to the patients. If there is excess demand the liquid oxygen in the vacuum insulated evaporator (VIE) (see last week's Facebook Live) leaks out and causes damage. Not good and not a quick fix. CPAP apparently needs high flow-rates – sometimes up to 40–80 L/min. Thus we need to plan the number of patients we can support through CPAP carefully so that demand does not exceed supply. I'm keenly awaiting the results from the CPAP trials in London. Renal support may also be an issue supply-wise. Large numbers of critically ill patients are in need of renal support and we have a limited number of the continuous veno-venous haemofiltration (CVVHF) machines most usually used in critical care. Experience is suggesting that CVVHF in COVID- 19 patients can fail due to clots in the machine making this an increased challenge. I know that people are addressing this issue in NHSE and among the ITU and renal communities.

55. Concerns regarding oxygen supplies were addressed, but renal support remained an issue until the first wave passed.

56. In August 2020, we reported that 60% were worried that patients in their care had suffered harm or complications following diagnosis or treatment delays during the pandemic. The overwhelming majority (94%) were concerned about the indirect impacts of COVID-19 on their patients. Delays to diagnosis or treatment, as a result of lack of capacity due to people working to manage COVID-19, was the most common concern, cited by 58%. 86% reported that their hospital had restarted diagnostic procedures, but of these a third (34%) said only a very small number of procedures had restarted. London appeared to face greater challenges than the rest of England – 46% reported only a small number of procedures restarting, compared to 30% in the rest of England. Delays accessing diagnostic testing were compounding these problems. Endoscopy testing was particularly affected: only 8% reported no delays for outpatients, and over a third (36%) were experiencing long delays. For inpatients, 72% were experiencing delays. Delays to clinical physiology testing were seeing similar delays – 75% for inpatients and 90% for outpatients. Delays to elective surgery were also anticipated for some time yet. Only 13% thought the NHS would recover its 18 week referral to treatment target within a year. 40% believed the target would be met again within two years, but almost half (47%) thought it would take up to five years or 'not within the foreseeable future'.

57. In November 2020 we said delays to diagnostic testing for both inpatient and outpatient services remained a problem. Endoscopy and clinical physiology services were the worst affected, with 82% reporting delays in endoscopy tests for outpatients. 83% reported delays for clinical physiology testing for outpatients, including 36% experiencing long delays.

Ethical guidance

58. The lack of clear ethical guidance from the government's Moral and Ethical Advisory Group (MEAG) – which was created specifically to provide independent advice to the UK government on moral, ethical and faith considerations on health and social care related issues during the pandemic - during the first wave made decision-making more stressful for staff in the frontline than it could have been. This lack of MEAG level advice was apparently due to delays in publication and eventual non-publication rather than MEAG not being able to agree.

59. We therefore supported our members to manage the fact that care capacity was inadequate by producing, with the help of our Committee on Ethical Issues in Medicine, our own ethical guidance. In *Ethical dimensions of COVID-19 for frontline staff* (AG/8 – **INQ000361986)** we reminded them that while so much had changed during the pandemic, they still needed to ensure that care was provided in a fair and equitable way.

60. The principal values that informed this guidance were that any guidance should be

    a. accountable: Measures are needed to ensure that ethical decision-making is sustained throughout the crisis, ideally nationally.

    b. inclusive: Decisions should be taken with stakeholders and their views in mind.

    c. transparent: Decisions should be publicly defensible.

    d. reasonable: Decisions should be based on evidence, principles and values that stakeholders can agree are relevant to health needs, and these decisions should be made by credible and accountable members of staff.

    e. responsive: Flexibility in a pandemic is key. There should be opportunities to revisit and revise decisions as new information emerges throughout the crisis, as well as mechanisms to address disputes and complaints.

61. The issues we addressed within the guidance were:

    a. Ensuring fair and equitable care: Any system used to assess patients for escalation or de-escalation of care should not disadvantage any one group disproportionately. Treatment should be provided, irrespective of the individual's background (eg disability), where it is considered that it will help the patient survive and not harm their long-term health and wellbeing.

b. Caring for COVID-19 vs non-COVID-19 patients: The presence or absence of COVID-19 should not be a limiting factor in treatment decisions. Care should be based on national guidance. Efforts must be made to ensure that the public understand the purpose of any treatment guidelines being used.

c. Making difficult decisions: It is advisable that assessment and prioritisation decisions are carried out by more than one clinician colleague, where feasible, for reasons of practical and moral support. Decisions to escalate care to Intensive Treatment Units (ITU) should have the input of ITU doctors. Decisions in ITU should involve the multidisciplinary team where appropriate, particularly if a decision is taken to withdraw treatment from existing patients in critical care, and must be made with the patient and, if appropriate, their carers.

d. Accountability for decision making: All accountability for decisions still holds during a pandemic. Decisions, regardless of whether they are COVID-19 related, should be made according to protocol and justified where required, as per good clinical practice. Documentation of the decision-making process is very important and should be in writing as far as possible.

e. Support with difficult decisions: Medical ethicists can help with difficult decisions and hospitals may wish to engage them or form clinical ethics committees. Teamwork and mutual support across the whole healthcare team are essential to making difficult decisions.

f. Discussing care wishes with patients: We strongly encouraged all frontline staff to have discussions with patients for whom an advance care plan was appropriate, so as to be clear in advance the wishes of their patients should their condition deteriorate during the pandemic.

g. Prioritising ITU beds and resources: All hospital beds and resources should continue to be allocated based on appropriate assessment methods. Assessment should be continual to ensure patients in most need are prioritised and cared for.

h. Working outside of specialty: Doctors are bound by their duty of care and during a pandemic this means doctors need to be flexible and may need to work in locations or clinical areas outside their usual practice. They should be prepared and supported to do that, but not obligated to work outside their competency. There should be overt support of the clinicians – preferably by the government, but at the very least by the trusts/health boards employing the clinicians. Doctors working out of remit should be provided with appropriate training and personal protective equipment (PPE) to work competently in their new role.

i. Doctors with pre-existing conditions or over the age of 70: An extension of a doctor's duty to protect the public from harm is the right to protect themselves from harm so they can continue to care effectively. In this respect, it was ethical for those doctors who would be harmed by contracting the virus to refrain from treating patients with (or suspected) COVID-19. Doctors with care responsibilities for vulnerable family members should also be given the option of stepping back from frontline care of patients with COVID-19, as part of their duty of care to that family.

j. PPE for frontline staff: We said all frontline staff should have constant access to PPE during the pandemic as per Public Health England guidance. We said doctors should immediately report being asked to care without appropriate PPE to the relevant director of the clinical service

62. We added appendices on *Receiving the COVID-19 vaccine (*AG/9 – INQ000226572), in which we said that when deciding whether to accept a COVID-19 vaccine, healthcare staff should consider the ethical and professional obligations to their practice, their patients and themselves; *Ethical dilemma scenarios for ambulance-based clinical assessments during COVID-19* (AG/10 – INQ000226573), to reflect the fact that, with the NHS weathering the second, considerably larger wave of COVID-19, patients were unfortunately needing clinical assessment by hospital staff in waiting ambulances.

63. We also published *Conversations for ethically complex care* (AG/11 – INQ000226574) which provided a framework for ethical discussions to support decision making and documentation in clinical practice. It outlined a structured, patient-focused approach suitable for use by all professional groups, specialties and in all care settings. It was intended to be disease- or diagnosis-agnostic and to ensure fair and equitable care for all, without causing harm to their long-term health and wellbeing.

    a. We proposed six guiding principles for ethical decision making which left room for judgement to be applied appropriately in specific circumstances: respect for patients, duty of care, equity of care, accountability and transparency, inclusivity and reasonableness

    b. We outlined a four question approach to facilitate and support conversations and decision making for ethically complex care, influenced by the four quadrant approach of Jonsen, Siegler and Winslade. The questions were:

        i. What specific clinical decision is being discussed, and what are the possible outcomes? This is to make sure the nature of the decision is clearly stated and potential outcomes defined as best as can be offered. This question sets the clinical context in which the subsequent three decisions are answered.

        ii. What are the patient's values and preferences? This includes considering previously made decisions and plans, the patient's mental capacity, the patient's wishes, the views of the clinical team and any other relevant information.

        iii. What are the anticipated effects on the patient's quality of life? This includes the patient's views on the effects of the decision, the views of the clinical teams on the likely effects of the decision, the consideration given to other health conditions and level of dependency where appropriate, and the influence of any discerning features such as a prognostic score or performance measure.

iv. What contextual factors, if any, have an impact on the decision or outcome? This may include (although not exclusively) religious, cultural, legal or resource-related factors. The key feature of this question is whether or not the contextual factor has any material impact on the decision being considered or its outcome. There may be no contextual factors.

Clinical guidance

64. Throughout the pandemic we supported and communicated to our members the guidance of the Resuscitation Council UK as it amended it in light of what we learnt about COVID-19 and its transmission. This included the guidance that cardiopulmonary resuscitation (CPR) was an aerosol generating procedure (AGP). This was in opposition to the guidance of Public Health England that CPR was not an AGP. CPR is generally accepted to be an AGP and it remains the position of the RCP.

65. That guidance also covered the use of Do Not attempt Cardio-Pulmonary Resuscitation Notices ("DNACPRs"), specifically to ensure that they were well documented and communicated. Our members did not raise concerns regarding use of DNACPR notices. Nobody reported to us that blanket issuing of DNACPR notices was encouraged or taking place in relation to groups of patients due to characteristics such as old age, disability or neurodivergence. The RCP did not issue its own guidance on the use of DNACPRs.

66. An early review article by ClinMed editorial board member Alex Lake, published in March 2020, gathered what was currently known about the virus and disease and summarised it for readers. It remains ClinMed's top-cited paper.

67. In April 2020 we issued guidance to our members about the National Early Warning Score 2 (NEWS2) and deterioration in COVID-19:

    a. National Early Warning Score 2 (NEWS2) should be used when managing patients with COVID-19 to supplement clinical judgement in assessing the patient's condition. We said it would ensure that patients who were deteriorating, or at risk of deteriorating, would have a timely initial assessment by a competent clinical decision maker.

b. The NEWS2 scoring system for oxygen supplementation is binary (yes/no). We said that in patients with COVID-19 infection, once hospitalised and treated with oxygen, their oxygen requirement might increase rapidly if their respiratory function deteriorates but this may not result in any additional significant increase in the NEWS2 score. Therefore, in patients with COVID-19, all staff should be aware that ANY increase in oxygen requirements should trigger an escalation call to a competent clinical decision maker. This should be accompanied by an initial increase in observations to at least hourly until a clinical review happens, if this has not already happened as a result of NEWS2.

c. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced by the RCP in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness. It is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

    - respiration rate
    - oxygen saturation
    - systolic blood pressure
    - pulse rate
    - level of consciousness or new confusion*
    - temperature.

    A score is allocated to each parameter as they are measured, with the magnitude of the score reflecting how extremely the parameter varies from the norm. The score is then aggregated and uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation. This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, recorded on a standardised clinical chart – the NEWS2 chart.

68. In my 27 April 2020 bulletin to members I talked about why COVID-19 affects BAME doctors. I said it was staggering that more than 94% of the doctors who have died from COVID-19 were from a BAME background and were male. I said the reasons were complex and unknown. I said a risk factor being put forward by some as an explanation was vitamin D deficiency, which I said was a plausible hypothesis although I was unconvinced it was the whole story. In June 2020 Rhodes et al published *COVID-19 mortality increases with northerly latitude after adjustment for age suggesting a link with ultraviolet and vitamin D* (AG/36 – INQ000316265). They said, "There are exceptions, but COVID-19 mortality correlates with reported vitamin D levels across Europe, and in sunnier Brazil, where mortality is rising, 28% prevalence of vitamin D deficiency is reported. An association between vitamin D insufficiency and COVID-19 severity is supported by substantial evidence of its impact on cytokine response to pathogens. A direct effect of ultraviolet light on the environmental survival of severe acute respiratory syndrome coronavirus is also possible but would not explain the association between mortality and ethnicity, whereas people with dark skin need more ultraviolet exposure for equivalent vitamin D synthesis." In November 2020 I said that several studies had shown an association of vitamin D levels and severity of COVID-19 (including in hospital staff). In February 2021 I said that there a reasonable hypothesis why vitamin D supplementation should work, it is not overly expensive and should be amenable to testing in large RCTs, but we still had no published RCT evidence of benefit, and preprints of studies with potential serious methodological flaws kept appearing. Since then there have been studies that show vitamin D reduces the severity of COVID-19 and that it may protect against contracting it, particularly in some ethnic groups, but it is still not conclusive, which is probably why it has not become standard practice yet.

69. A reduction in bureaucracy in many cases led to rapid change to meet local needs by enabling clinical leadership and partnerships with management at the local level. We collated and promoted advice from specialty societies solely on aspects of clinical care and treatment during the COVID-19 epidemic.

70. The RCP brought together many national health bodies to produce an online resource supporting the implementation of the NICE COVID-19 rapid guideline: critical care in adults (NG159), which we supported throughout the relevant period. The website aimed to provide information for patients, relatives, carers and professionals to support good practice in the critical care of patients with COVID-19. The RCP was one of the organisations that reviewed the rapid guideline for NICE, which recommended use of the clinical frailty scale (CFS) where appropriate. The CFS is a tool for assessing frailty that was originally published in 2005. In my bulletin to members on 30 March I said:

    a. Lastly, the clinical frailty score is not applicable in all patients. The algorithm [one of the resources mentioned above] states this but it bears repeating. The score does not apply in younger people, those with stable long-term disabilities, learning disabilities, autism or cerebral palsy. If someone needs a stick to walk because of a birth injury it doesn't make them frail. We must also be wary of not widening health inequality in this area. Our unconscious biases can play a strong part in decision making when we are tired and stressed. Again, common sense and care is needed.

71. We worked with our members to inform NHS England's reset of outpatient and elective services. In July 2020, in partnership with RCGP, we published *Rebuilding the NHS - Resetting outpatient services for the 21st century in the context of COVID-19* (AG/12 – INQ000226575).We recommended that NHSE

    a. made sure that all relevant organisations, patients and carers were involved in the production and implementation of reset plans
    b. systematically considered the impact of their reset plans on inequality
    c. worked towards a system in which patient records were available to everyone involved in decision making and provision of care
    d. designed new clinical processes to maximise the benefit of new technology to patients, carers and clinicians
    e. made sure that everyone involved had access to the education, training and support they needed to adapt to and use new systems.

72. Physicians define a patient as ready for discharge on a clinical basis in line with current guidance. From October 2020 we produced a summary of guidance on discharging COVID-19 patients to care homes. We identified the key points from the UK governments, NHS and elsewhere, saying the main points were:

    a. Patients should be discharged as soon as they are fit, whether they were COVID-19 positive or not.
    b. COVID-19-positive patients being discharged into a care home setting could only be discharged into care homes that had been designated safe by the relevant regulatory body. If their own care home was not COVID-19-safe, they needed to be discharged into alternative accommodation.
    c. It was the responsibility of the local authority to find alternative accommodation.

73. On 22 October the RCP published *Advice and guidance on discharging COVID-19 positive patients to care homes* (AG/37 – INQ000316266). We said that much advice and guidance about discharging patients to care homes had been issued in a short space of time. We produced the summary to help our members and their hospitals assist their patients and care services. The main points were that:

    a. Patients should be discharged as soon as they are fit, whether they are COVID-19 positive or not.

    b. COVID-19-positive patients being discharged into a care home setting can only be discharged into care homes that have been designated safe by the relevant regulatory body. If their own care home is not COVID-19-safe, they need to be discharged into alternative accommodation.

    c. It is the responsibility of the local authority to find alternative accommodation.

74. In January 2021 we published the article *Discharge criteria for patients with COVID-19 to long-term care facilities requires modification* (AG/38 – INQ000316267) by Wakana Teranaka and Daniel Pan in our Clinical Medicine journal. It concluded that "a 'positive/negative' PCR test prior to discharge to a LTCF is not appropriate because it does not relate to infectivity. A negative test may be a false negative with rates up to 30%; a positive test does not mean that

the patient is infectious and shedding active virus. Until more reliable markers of infectivity are found, we recommend modifying the discharge criteria to state that patients who have recovered from COVID-19 can be discharged to a LTCF if it is 10 days after their first positive swab or 10 days after clear symptom onset; with exceptions being those who are heavily immunosuppressed (transplant patients or those with severe genetic immunodeficiencies) as shown in Table 1. This is simple and more in line with the UK's self-isolation guidance for those who test positive for COVID-19 in the community, as well as the most recent World Health Organization guidance and should be continuously updated."

75. The British Geriatrics Society (BGS) first issued *Managing the COVID-19 pandemic in care homes* in March 2020 (AG/13 – **INQ000336345).** It updated it in April 2020 (AG/14 – INQ000226577) and June 2020 (AG/15 – **INQ000299408).** The aim of the guidance was to help care home staff and NHS staff who worked with them to support residents through the pandemic. The key recommendations were focused on having standard operating procedures, making sure staff had the right training and knowledge, infection control for visitors, advance care planning and working with the NHS to help manage the flow of patients. The BGS was concerned about the discharge of older patients from hospital during the pandemic. Older people were vulnerable to contracting the virus in hospital, despite the best precautions to minimise the risk of contamination. It is well-established that prolonged hospital stays bring the risk of deconditioning for older people, and they said that efforts needed to be made to discharge older people safely for post-acute care and rehabilitation.

76. From early 2020 the Faculty of Forensic and Legal Medicine developed new or adopted existing guidance. This included a position statement on the management of suspected COVID-19 cases in police custody (v1 March 2020 – v11 December 2020) and COVID-19 Pandemic and Sexual Assault referral Centres (SARCs) (22 May 2020).

77. The Association for Palliative Medicine provided guidance on COVID-19 and Palliative and End of Life in Secondary Care, issuing version 6 in January 2021 (AG/16 – **INQ000239705)** In February 2021 we provided new guidance on *End-of-life care in the acute care setting* (AG/17 – **INQ000239709)** and an addendum

on *Care of the dying patient with COVID-19* (AG/18 – **INQ000239718)**. We said these should be used in conjunction with our *Talking about dying* report (AG/19 – INQ000226582), which we then updated in May 2021 (AG/20 – INQ000226583). In the addendum we said

a. severe COVID-19 infection typically causes respiratory failure that is associated with breathlessness, delirium or agitation, and anxiety

b. those dying from COVID-19 and respiratory failure outside ICU tend to have a rapid decline

c. anecdotal evidence suggests that patients dying from COVID-19 also have a higher symptom burden than patients dying from all causes in hospital

d. use of anticipatory strong opioids and benzodiazepines may need to be supplemented more often by continuous subcutaneous syringe pumps to ensure excellent symptom control

e. the increased incidence of microemboli with COVID-19 infection increases the incidence of severe renal impairment, and alternatives to morphine such as alfentanil may be needed more often

f. agitation is a key symptom in those dying from respiratory failure secondary to COVID-19, as such benzodiazepines or antipsychotics may be required more frequently and need to be escalated to higher doses than in patients not dying from COVID-19

g. fans should be avoided for COVID-19-infected patients, as they run the risk of disseminating the virus

h. due to necessary visiting restrictions for those important to the patient, it is more important than ever to ensure proactive, sensitive and regular telephone communication to the next of kin about the patient's condition - supporting virtual visits through tablets and the patient's mobile phone have also been valued, but must be done safely and securely

i. some hospitals are allowing limited visiting at the bedside of a dying patient, but visitors must be counselled about their own risk, be supplied with and helped to wear appropriate PPE, and may need to be advised to self-isolate afterwards

j. there are hospitalised patients with severe COVID-19 infection for whom the outlook is uncertain. The ceiling of treatment may be non-invasive ventilation (NIV), but they may be struggling to tolerate it. For these patients, low-dose strong opioids and/or benzodiazepines orally may provide good symptom control, which in some cases can allow NIV to be continued until the lungs start to recover. These patients benefit from both active and palliative management at the same time, in an approach that can be seen as treating for the best outcome, but also planning in case the worst occurs.

78. In 2021 the Expert Haematology Panel produced guidance focused on Vaccine Induced Thrombosis and Thrombocytopenia (VITT). The panel was in regular communication with the regulators, other UK medical and surgical societies, multidisciplinary groups and international haematology colleagues focussed on the condition. In the guidance it said that VITT was a "rare life-threatening immunological reaction to covid-19 vaccination", that "primarily the Oxford-AstraZeneca vaccine triggers the production of anti-platelet factor 4 (PF4) antibodies, which cause platelet activation with thrombocytopenia and thrombosis" and there was "no clear signal of risk factors other than young age. Patients with prior thrombosis or prothrombotic disorders including antiphospholipid syndrome are no more at risk than the general population."

79. The RCP did not issue any guidance in relation to the treatment of ischemic (coronary) heart disease, colorectal cancer, hip replacements, or child and adolescent mental health conditions.

80. RCP members did not raise concerns regarding providing respiratory support or proning patients. Although in the first and (more so) the second wave the capacity for CPAP was a constant worry, especially with respect to oxygen supply. In my bulletin to members of 30 March 2020 I said:

a. Non-invasive ventilation (NIV) holds much promise with experience of continuous positive airway pressure (CPAP) in Italy demonstrating a significant reduction in the need for intubation and ITU-based ventilation. NHSE&I have produced a very helpful set of guidance on this which the RCP fully supports. These recommendations are the current RCP position on NIV, superseding any previous guidance. CPAP should be used for hypoxaemic respiratory failure and BiPAP (bilevel positive airway pressure) for hypercapnic acute on chronic respiratory failure. NIV in this setting can be used to avoid intubation, to facilitate extubation and as a ceiling of treatment for some patients.

b. In July 2020 we published two articles regarding proning patients in our Clinical Medicine journal. *Research in brief: Prone positioning in COVID-19: What's the evidence* (AG/39 - INQ000316268) was by Rajan S Pooni. It concluded that prone positioning (PP) "is an achievable and relatively safe intervention that has been shown to improve oxygenation in a proportion of conscious ward-based patients; can be trialled on suitable patients on the wards if respiratory deterioration is observed. It is not a substitute for invasive mechanical ventilation (IMV) but may defer the need for IMV (further study is needed); 'Prone teams' can facilitate in the identification and proning of suitable patients. This is particularly important in the significant cohort of obese patients observed with COVID-19." *Prone positioning in conscious patients on medical wards: A review of the evidence and its relevance to patients with COVID-19 infection* (AG/40 - INQ000316269) was by Thomas Chad and Caroline Sampson. It concluded that as evidence for conscious prone positioning in both acute respiratory failure (ARF) and acute respiratory distress syndrome (ARDS) was of low quality, it "limited the ability to draw firm inferences about the potential benefit of prone positioning as the sole intervention in patients with ARF secondary to COVID-19". But it went on to say that "short term improvements in oxygenation are seen, which may reflect the intervention acting simply as a 'recruitment manoeuvre'" that there was "certainly a physiological rationale for investigating this intervention further" and that "The intervention is achievable on medical wards and appears safe."

Education and training

81. The pandemic had an unavoidable impact on education and training, as the majority of it happens within the service. On 18 March 2020, I informed our Council that all examinations had been cancelled until September. We deferred the 2020 Practical Assessment of Clinical Examination Skills (PACES) to 2021. By May 2020 we were already forecasting a budget deficit of £6m.

82. In April 2020 we published *Never too busy to learn – a pandemic response* (AG/21 – INQ000226584). We highlighted ways that teams could continue to learn and grow together, acknowledging the exceptionally challenging context that they faced. The tips and guidance were designed to support their delivery of vital teaching and learning during the COVID-19 pandemic. We adapted our 2018 Never too busy to learn resource to provide more specific and focused ways to support learning in this evolving healthcare emergency by learning with (and from) each other and patients.

83. In March 2020 JRCPTB made a statement on COVID-19 and Recognition of Trainee Progression in 2020 (AG22 – INQ000226585).It said the pandemic would lead to changes in learning opportunities for trainees in Core Medical, Internal Medicine and Medical Specialty training both in terms of experiences and in assessments. Their ability to complete rotations in specific elements of training may be compromised and, at a time when clinical teams are likely to be stretched significantly, opportunities for specific formalised learning assessments may be limited. It was already clear that opportunities in the relevant professional examinations were also going to be affected. The statement set out mitigations to minimize any disadvantage in training.

84. In June 2020 we issued a statement on *CPD requirements and the impact of COVID-19 for Physicians* (AG/23 – INQ000226586). We were aware that some physicians would have had their continuing professional development (CPD) activity cancelled or postponed due to the developing COVID-19 situation as we reached the end of the 2019/20 CPD year. In addition, the situation for the next CPD year, 2020/21, was looking uncertain. We emphasised that the requirements were recommendations and that if there was a shortfall in one year

it could normally be addressed in other years as long as the 5 year recommendations were met. But in the circumstances, we waived all numerical CPD targets. For that and the following CPD year we supported a flexible approach to CPD requirements. We said that evidence of engagement with the CPD process and with reflection was of greater importance than the number of credits obtained.

85. In November 2020 we used Twitter to debate the HEE decision to halt rotations for May, June and July of that year. The discussion was informed by two trainee-led and trainee-delivered surveys that reported the impact of halting rotations (AG/24 – INQ000226587and AG/25 – INQ000226588). The starkest finding from the surveys was the significant regional variation in the approach to halting rotations, ranging between 7% and 58% of trainees who had their rotation in April 2020 halted. Significantly, even in areas of low disruption to the rotation, as many as 55% felt they had lost opportunities for progression and 40% felt their training had been adversely affected. Three key themes emerged from the debate:

    a. There was a sense that trainees and supervisors felt devolved from the decision-making process and that rapid and responsive communication with decision makers was needed.

    b. There was a variation in how teaching opportunities were maintained during the initial phase of the pandemic. There was a rapid utilisation of digital platforms and exemplars of outstanding teaching programmes across various institutions and disciplines, including the specialty, trainee and COVID response series on RCP player However, from one survey, only 27% felt that they received training during this period

86. The loss of valuable experience in specialties such as psychiatry, primary care and emergency medicine, where it is difficult to access standalone posts without prior experience. There was significant investment in early exposure and recruitment to these specialties, and it was felt that the loss of these rotations had a burden on the career trajectories of trainees, but also on wider workforce needs.

87. Also in November 2020, the clinical leadership of the Federation published *Restarting training and examinations in the era of COVID-19* (AG/26 – INQ000226589). They said that COVID-19 had proven to be a potent disruptor of postgraduate training, assessment and learning and a potent catalyst that had driven innovation. They discussed the response of the Federation to the challenges presented by the pandemic, including that they demonstrated the need to have a workforce that is more broadly trained in general specialty areas and that is therefore more flexible.

88. Also at the end of 2020, we reported in our members magazine, *Commentary*, that:

    a. The Part 1 and Part 2 Written MRCP(UK) Exams were delivered with, for the first time ever, an online option for each. The Part 1 exam was delivered on 15 September with a total of 5,044 candidates sitting, the largest ever diet. Of these 2,341 were UK candidates and 386 completed the exam online, with similar performance between the pencil and paper format and the online. We also delivered a contingency online exam for those who experienced difficulties during the online exam or at centres – but the number was small, 41.

    b. The Part 2 Written Exam was delivered on 27 October. There were 3,207 candidates, again the largest ever diet. Of these, 1,729 were UK candidates and 1,693 elected to sit it online as COVID-19 lockdowns were closing in. There were only 21 candidates who had technical problems online.

    c. Perhaps the greatest challenge was the Practical Assessment of Clinical Examination Skills (PACES). In the UK this is delivered by the three colleges' exams teams via their network of centres. Many of the centres could not stage the exam, reducing the number available from 45 to 25. This meant we could only examine approximately 500 candidates and so we had to develop a prioritisation model to allocate places. As for the written exams, we introduced enhanced infection control and social distancing measures, supported by centre, candidate, examiner and patient risk assessment tools and processes. We had only one patient per

station in the physical examination stations and changed stations 2 and 4 to a new delivery model, whereby the candidate interacted with a computer screen in the centre and the examiners and surrogates were remote. The altered model meant we could only examine 12 candidates per day, reducing capacity further. Unfortunately, towards the end of the diet, with COVID-19 spiking a second wave and lockdown looming, four centres could not go ahead and we lost 108 places. Nevertheless, we did examine 480 candidates.

89. In April 2021 JRCPTB held a webinar on *Training progression in the age of COVID-19*. It covered the modifications we made to the Annual Review of Competence Progression (ARCP) decision aid, what the trainees and trainer should do in preparation for the ARCP, guidance for ARCP panels, and a look forward in training after the ARCP. The main points were:

    a. the pandemic had a big impact on both trainees and trainers, but it was variable, particularly on a geographic basis, with those in London most affected

    b. the personal effects included illness, exhaustion and a negative impact on mental health, plus compromised access to training and assessment opportunities

    c. all training programme directors (TPD) had been asked to indicate the proportion of trainees who might require extensions, but the real indicator would be the outcomes of annual review of competency progression (ARCP)

    d. JRCPTB had made changes to assessment tools and decision aids to make the process clearer and more flexible and had informed the GMC of these

    e. JRCPTB sought derogations to the internal medicine curriculum from the GMC so that trainees could progress to the next stage of training, but they would still need to achieve the same level of competency by the completion of internal medicine training – similar arrangements were made for some specialties

f. JRCPTB had recognised that the requirement for experience in critical care and elderly care in internal medicine training could be obtained on COVID wards

g. a particular issue was achieving the required number of outpatient clinics in a year, so JRCPTB introduced the outpatient care assessment tool to ensure trainees were still getting some experience and the expected number of clinics was adjusted.

90. At the same time we issued *Temporary derogations to curriculum requirements to support 2021 ARCPs* (AG/27 – INQ000226591). There were no changes to the 2020 requirements for 17 specialties, minor changes to 5 specialties and changes to the other 8 specialties.

91. In May 2021, in *Frequently asked questions on trainee progression during the COVID-19 pandemic* (AG/28 – INQ000226592), we said that we believed that even with the disruption of training during Covid, most trainees would have had a different but no less adequate experience and training and - with assessment, support and filling of any "gaps" following appropriate analysis - they would be every bit as effective and safe in the registrar role. They will be well equipped to progress into higher specialist training.

92. In October 2021, in *Training Recovery after COVID-19* (AG/29 – INQ000226593), we laid out what trainees, consultants/SAS doctors/senior trainees, clinical and educational supervisors, and training programme directors needed to consider. We said that although the effects of the COVID-19 pandemic were still apparent and were likely to be around for some time, the need to ensure that trainees in the medical specialties were being given adequate opportunities to re-engage with training was of critical importance.

Statement of Truth

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

Signed: Personal Data

Dated: 14th November 2023