Witness Name: Alastair Henderson
Statement No.:
Exhibits: AH/1 (INQ000369621) to AH/36 (INQ000369650)
Dated: 5 January 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ALASTAIR HENDERSON

I, Alastair Henderson, will say as follows: -

1. I was the Chief Executive Officer of the Academy of Medial Royal Colleges ('the Academy' or 'AoMRC') from 2010 to the 31st March 2023. During the period of Inquiry's time frame (1 March 2020 - 28 June 2022) I worked alongside the Chairs of the Academy Council, Professor Dame Carrie MacEwen (1st March – 22nd July 2020) and Professor Dame Helen Stokes-Lampard (July 22nd 2020 - 28 June 2023) leading the organisation's response to the pandemic.

The Academy of Medical Royal Colleges (role, function, aims)

2. The Academy of Medical Royal Colleges ('The Academy') is the membership body for medical royal colleges and faculties in the UK and in Ireland. It was established in 1996 from the previous Conference of Medical Royal Colleges. The organisation is a registered charity and a company limited by guarantee.

3. The Academy seeks to speak on behalf of its members on standards of care and medical education across the UK. By bringing together the expertise of the medical Royal Colleges and Faculties it drives improvement in health and patient care through education, training, and quality standards.

4. The Academy's policy and position on healthcare issues is determined by its Council which comprises the presidents or equivalent leaders of all the member

organisations as well as representatives of patients, trainee, and specialty and specialist ('SAS') doctors.

5. As a rule, the Academy speaks on cross-specialty issues that impact on a number or all colleges. Unless requested by an individual member organisation, the Academy does not comment on specialty specific issues, nor will it give a clinical opinion on specialty matters. However, if requested by a member, the Academy will raise a specialty issue provided it has the support of other members. In that case it can be assumed that the issue does represent the view and policy of the Academy.

6. The Academy operates on a UK-wide basis and, as far as possible, seeks to devise policy that is applicable across the four nations. Unless obviously only related to issues in one administration, it should be assumed that Academy statements are relevant on a UK basis.

7. There is a Scottish Academy of Medical Royal Colleges which is a separate organisation albeit with corresponding membership. The Scottish and UK Academy work closely together and have a Memorandum of Understanding covering their activities. There is a Wales Academy which is not a separate body but operates as a committee of the UK Academy. In Northern Ireland there is a network of college members supported by the UK Academy.

8. In practical terms, the Scottish, Welsh, and Northern Irish groups will liaise directly with their administrations on detailed issues relating to healthcare in their countries. The UK Academy therefore tends to focus its work with health service bodies in England and the UK government.

9. In terms of the national COVID-19 Inquiries, the Scottish Academy will be submitting evidence on behalf of colleges to the Scottish Inquiry. However, this evidence from the UK Academy should be assumed to be applicable on a UK wide basis unless otherwise stated, although, inevitably, there is a focus on activities and engagement in England.

10. This submission has been agreed and signed-off by all member organisations and the Chair of the Academy Trainee Doctors Group. Some individual member

colleges and faculties have had their own Rule 9 requests or made their own separate submissions to the Inquiry which give their specialty perspective and experience and provide more detail on specific issues.

11. We hope this submission addresses the issues raised by the Inquiry in their Rule 9 Request. There were a number of areas where we have not made any response. This is because we do not have relevant knowledge or expertise, and/or the issue was not raised with us as a concern. Issues identified by the Inquiry we have not covered are: -

a. Details of any concerns the AoMRC was made aware of during the relevant period in relation to discharge of patients from hospital.
b. Details of any concerns the AoMRC was made aware of during the relevant period in relation to palliative care of patients with Covid-19.
c. Whether the AoMRC was made aware of any concerns about the impact on the following areas of healthcare during the relevant period:
    a. care and treatment for ischaemic (coronary) heart disease; (*Royal College of Physicians, Royal College Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow)*
    b. care and treatment for colorectal cancer; (*Royal College of Radiologists; Royal College of Surgeons of England, Royal College of Surgeons of Edinburgh, Royal College of Physicians and Surgeons of Glasgow)*
    c. hip replacements; (*Royal College Surgeons of England, Royal College of Surgeons of Edinburgh, Royal College of Physicians and Surgeons of Glasgow)*

    Information relating to these specific conditions might be obtained from the appropriate College, as set out above.

- A summary of any concerns or issues reported to the AoMRC by its member organisations about levels of ventilation within healthcare settings.

12. In producing our statement, the Academy has been very conscious of the danger of retrospective judgement. Knowledge and evidence changed rapidly during the pandemic. As in any crisis, the reality is that some decisions might, in retrospect, have been different to what they were. As we acknowledged during the pandemic, in many cases it was a case of choosing the least worst option. It was rarely a

case of a right or wrong decision. In our interaction, we felt that decisions were made in good faith based on the evidence available at the time.

Cooperation with other stakeholders

13. By the nature of its activities, the Academy seeks to engage with and influence a wide range of stakeholders in health and social care. This includes governments, politicians, civil servants, arm's length bodies, employers, regulators, and other professional bodies. During the pandemic, those links were, in general, strengthened with closer working arrangements, greater collaboration and pooling of knowledge when information was sparse. In broad terms the Academy felt it was appropriately consulted by Government in relation to decision making affecting its member organisations although on occasions, perhaps sometimes inevitably, timescales were so tight as to make meaningful consultation impossible.

14. During the pandemic, the Academy's key links were with the Chief Medical Officer ('CMO') in England, and to a lesser extent the CMOs in the devolved administrations, NHS England, particularly through the NHS England Medical Director, Health Education England and the General Medical Council ('GMC'). The Chief Scientific Advisor role at DHSC was also a very useful interface to other taskforces within government.

15. From 30 January 2020, the Academy was meeting on a weekly basis with the CMO in England, Professor Sir Chris Whitty. In June 2020, the meetings became fortnightly, and attendance restricted to college presidents only. The purpose of the meetings was for colleges to seek information and understand latest developments directly from the CMO, for colleges to provide intelligence on activity at local level and to provide clinical advice and views to the CMO and team as appropriate. The Academy and Colleges found the meetings extremely valuable and welcomed the opportunity for regular direct input to the CMO. It is our understanding that the CMO also found the meetings valuable. The meetings continued throughout the period of the pandemic and are indeed continuing now on a monthly basis.

16. The Academy and colleges also met with NHS England National Medical Director, Professor Sir Steve Powis, and colleagues on a weekly basis from March 2020 and then fortnightly from autumn 2020 throughout the pandemic. These meetings were not solely for Academy members but for wider clinical representatives. The meetings provided an important regular briefing for stakeholders with NHS England and included updates from the relevant NHS or Public Health England (PHE) leads on the epidemiological and service position, forthcoming advice and guidance, vaccination, Infection Prevention and Control (IPC) etc. These meetings also provided an opportunity to ask questions of NHSE. The Academy also held additional regular meetings with the NHS National Medical Director.

17. In March 2020, the Academy was asked by the NHS National Medical Director to organise and manage the Out-of-Hospital Clinical Risk Panel. This group, chaired by Professor Edward Baker, then Chief Inspector of Hospitals at the Care Quality Commission ('CQC'), was established to advise the National Medical Director on changes proposed to the out of hospital phase of care introduced in response to the COVID-19 crisis. Issues considered included Ambulance service and NHS digital 111 abbreviated pathways triage options; proposed change to NHS England Improvement ('NHSEI') guidance on ambulance service conveyancing to hospital; proposed change to NHS 111 telephone breathlessness assessment. All conclusions/recommendations went to the NHS Medical Director for his consideration. Information on the outcome of such consideration should be obtained from NHSE. The Academy Chair of Council was a standing member of the Group, as were the heads of the Colleges of Physicians, Emergency Care and General Practitioners. Academy staff provided the secretariat for the meetings.

18. The Academy Chair of Council was a member of the NHSE National Escalations Pressures Panel (NEPP) which was originally established in 2017 to advise NHSE's Director for Urgent and Emergency Care on pressures and clinical risk alongside the presidents/Chair of the Royal College of Physicians, Royal College of Surgeons (England), Royal College of General Practitioners, Royal College of Emergency Medicine. Its judgements informed national actions to be taken at times of significant pressure.

19. The other major engagement was with Health Education England (now part of NHSE). The Academy had regular contact with the HEE Medical Director, Professor Wendy Reid, and Deputy Medical Director Professor Sheona MacLeod. The Academy co-hosted regular meetings with HEE for all colleges to discuss issues relating to the impact of COVID 19 on medical education and training including the delivery of exams.

The work of the Academy during the pandemic

20. The work of the Academy during the pandemic can be broken down as follows:
    a) Co-ordinating collective engagement between medical royal colleges and DHSC, NHSE and other national bodies e.g., meetings with CMO
    b) Keeping members informed of developments and sharing information e.g., e-mails and our Weekly Update to members.
    c) Seeking and collating views of medical royal colleges in response to requests for clinical input from national bodies e.g., on Infection Prevention Control (IPC) guidance, shielding groups.
    d) Producing position statements and policy papers for public release reflecting the consensus college view on specific issues e.g., on extending vaccination, preparation for further waves of COVID
    e) Media work as required.

21. A list of the material we published and the information we circulated to our members is attached to this submission as Annex A (schedule of documents) (AH/1 - INQ000369621), Annex B (Academy Weekly Update emails) (AH/2 - INQ000369632), and Annex C (Academy emails on Covid) (AH/3 – INQ000369643).

22. As stated earlier, the Academy does not produce detailed clinical guidance on specialty specific conditions and issues directly related to these; that is the responsibility of individual colleges, faculties or specialist societies who have expertise in those areas. Colleges and faculties all produced valuable guidance and advice for their members on specialty related and sometimes wider issues.

23. However, as detailed in Annex C, the Academy did officially coordinate and collate input from colleges in response to specific requests from NHS England and the CMO on the following issues: -

a)	Advice on high-risk groups to CMO	19 March 2020
b)	Identifying patients at risk (shielding)	24 March
c)	PPE guidance	27 March
d)	Outstanding issues on PPE guidance for CMO	2 April
e)	Guidance on cancer surgery during COVID	3 April
f)	Unintended harm gap analysis	3 April
g)	Restoration of service – unintended consequences	9 April
h)	Use of coverall as alternative to gowns	10 April
i)	Testing	14 April
j)	Staff risk reduction tool	4 May
k)	Capturing beneficial clinical changes	28 May
l)	Cancer diagnostics guidance	6 June
m)	Examples of good and poor practice	29 June
n)	IPC guidance	7 July
o)	Patient Initiated Follow up initial guidance	14 July
p)	Facemasks in primary care	22 July
q)	PHE self-isolation guidance	23 July
r)	Curriculum derogations	21 August
s)	Beneficial changes from COVID	29 September
t)	Virtual wards	10 October
u)	Diagnostic validation framework	20 October
v)	NICE guidelines on long term effects of COVID	24 November
w)	Discharge to virtual wards	4 January 2021
x)	Workforce recovery	4 March
y)	COVID certification status medical exemptions	18 August
z)	Acute Respiratory Infection assessment hubs and virtual wards	22 October
aa)	JCVI letter on vaccination 11–15-year-olds	14 Jan 2022
bb)	CMO Technical review of COVID	18 Jan

Note: The dates referred to above are in general when the Academy contacted its members seeking their views. Any coordinated response would have been submitted shortly after that date.

24. In addition, the Academy and member organisations provided advice and views on an informal basis regularly in meetings with the CMO, NHSE or others. Issues which the Academy considered and raised are set out in Sections 52-120 below.

The impact of the pandemic on healthcare provision

25. The impact of COVID on healthcare provision was, of course, massive. It can be seen as: -
    a) Pressures on the service in managing patients with COVID-19 – the impact on ICU, primary care, acute care and mental health.
    b) The impact on other services – primarily due to cancellation of services, including pauses in screening and other public health and community services and redeployment of staff.
    c) The consequences of patients not presenting
    d) The challenge of restoration of services
    e) The impact on the nation's mental health and need for mental health services.
    f) Primary care
    g) The impact on research and stopping of many clinical trials.
    h) Technology

Managing and treating COVID-19

26. With 229,150 deaths of people whose death certificate mentioned COVID-19 as one of the causes as at August 2023 (UK Government statistics) and a far higher number suffering to varying degrees from the infection, some to a chronic degree, managing and treating COVID-19 was, rightly, the primary healthcare priority.

27. In terms of the actual management of COVID itself, the Academy believes that services and staff responded extraordinarily well. Despite fears as to what might happen, services did not collapse or become overwhelmed. The pressures on ICU

and acute care and their staff were enormous but we are not aware of any cases of complete breakdown in care.

28. Clinical research into the disease and effective treatment was crucial to managing the pandemic. There were positives from the National Institute for Health and Care Research ('NIHR') coordination of research, but also the missed opportunities. Information coming from clinical research studies might, in some cases, have been used earlier. For example, we learned from studies that many patients hospitalised could recover (reduce their World Health Organisation ('WHO') scoring level) within relatively few days (2-3) with appropriate oxygen supplementation from the start (Intensive care national audit & research centre [ICNARC] report 2023, 22nd June pg. 82.). Early understanding and spread of this information could have avoided potentially harmful treatments applied too early and may have helped clinical staff. Although much was shared through clinical societies such as the British Thoracic Society and European Respiratory Society, perhaps better, more coordinated, transparent of communication could be considered for critical areas.

29. Examples of better collaboration and transparency could include: -
    a. Transparency about what research/innovation is required (at a sufficiently granular level to enable research groups in industry and academia to define research protocols). This should include target product profiles, including consideration of underserved groups. It should be noted that the research/innovation needs will evolve over time as a pandemic unfolds, and this should also be transparent.
    b. Transparency about who is working on what already to enable collaboration and avoid duplication.
    c. Transparency about funding processes - what are the criteria for funding, the requirements for delivery (quality and timeframes) and the process of selecting funding recipients? Best practices and due diligence should be adhered to in the selection and oversight of providers.
    d. Transparency of results, including lay summaries for the public and journalists.

30. While many of these elements exist already, there would be huge value in having an end-to-end integrated approach (e.g., a single online platform) as a go-to place for funders, researchers, and clinical leaders.

31. We would commend the role of NICE and the royal colleges in their rapid reviews of treatment of COVID-19. These cut through the early results and provided clear guidance on use of new therapies. Examples included: -
    a. NICE COVID-19 rapid guideline [NG159]: critical care in adults March 2020
    b. NICE COVID-19 rapid guideline [NG188] COVID-19 rapid guideline: managing the long-term effects of COVID-19 18 December 2020
    c. NICE COVID-19 rapid guideline: [NG 191] managing COVID-19 March 2021

Cancellation of services

32. The cancellation of elective care including outpatient appointments from 15 April 2020 at the latest was a matter of real concern, but its necessity was broadly recognised. However, whilst the extent of elective care cancellation varied across the country the overall impact has been huge and continues to be felt. As of June 2023, the number of patients referred for but awaiting treatment was 7.6 million with 416,790 children on the paediatric elective waiting list. (NHSE consultant-led referral to treatment waiting times data). Four million fewer patients completed elective care treatment pathways in England in 2020 than in 2019. It is important to recognise that there were very considerable pressures on elective care and staffing prior to the pandemic and factors other than just COVID impact on waiting lists.

33. Cancellation impacted not just secondary elective care but across community, mental health, and primary care services for all groups of patients. The Academy produced a paper in May 2020 for members and government stakeholders entitled *"Effects on health from non-COVID-19 conditions and moving towards delivery of healthcare for all"* (AH/4 - INQ000369651) which set out the challenges and potential short-, medium- and long-term solutions. This covered the risk of not treating or delaying treatment of specific conditions; engagement with clinicians, patients, and the public; alternative pathways and provision; Infection, prevention

and control; workforce and training. More detailed examples were given in relation to radiology and pathology. Fuller details are available in the exhibit.

Public willingness to seek treatment

34. The willingness of the public to seek treatment or care during the pandemic was a real concern to the Academy and its member colleges and was shared by NHS England and the CMOs. Early messaging of "*Stay at home, protect the NHS, save lives"* whilst understandable and contemporaneously necessary, perhaps inevitably had some adverse consequences. In April 2020, the Academy released a statement urging the public to seek medical help for serious conditions during the pandemic (AH/5 – INQ000369652). It said that "*during this COVID-19 pandemic it is vitally important that patients and the public recognise that they must continue to seek medical assistance if they have symptoms which cause concern, or they already are being treated for a serious health condition."* The Royal College of General Practitioners ran a similar specific "*General Practice is Open"* campaign. Additionally, the Royal College of Paediatrics and Child Heath (RCPCH), Royal College of General Practitioners and the Royal College of Psychiatrists joined forces to produce advice to help young people worried about their health during the pandemic.

35. Understandably, patients were anxious about attending healthcare delivery environments whether in hospital, primary, community or mental health settings because of the risk of catching COVID-19. In addition, there were also people who felt it was their responsibility not to burden the NHS. Achieving the right balance between discouraging attendance at primary or secondary care for minor ailments and ensuring that people with serious conditions did present was undoubtedly hard. The "collateral damage" of delayed presentations is a recognised feature of pandemics and there is little doubt we are suffering the consequences of this now in many areas. Failure to treat conditions at the right time leads to mortality or increased morbidity. Examples are set out in the Academy document *"Effects on health from non-COVID-19 conditions and moving towards delivery of healthcare for all* " (See paragraph 33). Whether it is delayed presentation or screening for cancer, lack of routine monitoring of long-term

conditions or childhood immunisation, the result overall is a less healthy population with fewer people being cured (reduced survival rates), more treatment related toxicity (long term morbidity which impacts economic participation), more co-morbidities which means treatment is more debilitating and costly and increased impact on mental health.

Restoration of services

36. One of the challenges of the pandemic for the NHS was when and at what pace services could and should be restored. In May 2020, so, in hindsight, relatively early in the pandemic the Academy published six principles for reintroducing healthcare services (AH/6 – INQ000369653). These were:
    a) There should be clear messaging to the public stressing the need to seek medical help for serious conditions whilst encouraging appropriate self-care.
    b) Patients should be offered virtual or remote care where safe and appropriate.
    c) Through a shared decision-making process, patients should be offered evidence based alternative management options, where practical.
    d) Patients must feel safe and be protected when they need to access direct healthcare in all settings.
    e) Staff should be enabled, safe and protected to deliver equitable and clinically prioritised care.
    f) Staff should be supported and provided with training and education that will ensure adequate preparation of current and future staff to deliver services that meet the needs of the population.

37. The intention was to provide guidance for new pathways that would be required to reduce the risk of spread of coronavirus infection while Covid-19 was endemic and improve patient confidence in the NHS, followed by elaboration of what will be required generically within each one. It is worth noting that even at this stage colleges recognised that different ways of working would be required not only to take into account endemic coronavirus, but also to reflect positive changes in practice learned during the epidemic.

38. The Academy also produced additional guidance on restoration of services including more detailed papers:
    a. "Effects on health from non-COVID-19 conditions and moving towards delivery of healthcare for all (May 2020)" (**AH/4** – **INQ000369651**)
    b. Preparing for Covid-19 surges winter (July 2020) (AH/8 – INQ000369655) as well as contributing to NHS publications on
    c. Patient Initiated Follow Ups as part of the COVID recovery programme (July 2020) (AH/9 – **INQ000051407**)
    d. Draft cancer diagnostics guidance (June 2020) (AH/10 - INQ000369622)
    e. NHS England validation and clinical prioritisation programme (October 2020). It is worth noting that this programme incorporated several of the Academy's principles for reintroducing healthcare services.
    f. Early discharge to virtual COVID wards (January 2021) (AH/11 – **INQ000193212**

Several of these publications are referred to in more detail elsewhere in this statement and full detail can be found in the above referenced exhibits.

39. A key feature of the recovery process was the NHSE 'Delivery plan for tackling the COVID-19 backlog of elective care' published in February 2022 (Full details in NHSE document) (AH/12 - INQ000369624) The Academy and some Colleges were involved in the development of the plan and its publication was publicly welcomed by the Academy Chair of Council and several other college leaders albeit this is an NHSE document and NHSE would be better placed to speak to its genesis and content.

40. The restoration of medical education and training was a key issue for the Academy, and this is considered in more detail in paragraphs 121-138.

Long term impact of the pandemic

41. Individuals, the NHS and the country are all living with the long-term impact of the pandemic.

42. For individuals who suffered the loss of a relative, there are the lasting consequences of bereavement. Whilst most people fully recovered from infection, particularly following vaccination, for a substantial number of patients the effects of Long COVID were substantial and long lasting and, for some, continuing. In addition, as mentioned in paragraph 33, there are patients whose illnesses have progressed more than they should have done because of delayed presentation or treatment during the pandemic. For some the consequences have been or will be fatal.

43. For children and young people the impacts were different. We recognise children and young people were generally less seriously affected by COVID-19 than adults in direct terms, they are more at risk from the negative longer-term consequences of the current pandemic. The RCPCH flagged the following as particular issues with regards to longer term impacts of the pandemic:
    a. Children and young people's mental health.
    b. Safeguarding and child protection especially of vulnerable children.
    c. The widening of child health inequalities.
    d. Redeployment of the child health workforce and facilities to adult services.
    e. The interruption of routine child health appointments including in the community and the disruption of wider childhood vaccination programmes.

44. The impact on the NHS continues. The increase in elective and outpatient waiting lists was happening before the pandemic and has been affected by issues not related to the pandemic, but the pandemic continues to be a key factor. The pandemic had a profound effect on mental health across the population. Mental health services are still managing the consequences and will be for some significant time to come.

45. There has also been a psychological impact on NHS staff. Burnout and exhaustion were commonly felt by NHS staff, and we are still living with those consequences in terms of staff leaving the service and continued low staff morale.

46. Finally, the economic and wider social impact on the country continues to be felt. The Faculty of Pharmaceutical Medicine ('FPM') reported as part of the Academy's call for evidence that the UK has been slower in getting back to conducting trials in non-COVID conditions than other countries. As time goes on,

the impact lessens and other factors play their part but the full cost of the pandemic has probably not been calculated.

Technology

47. There is absolutely no doubt that the pandemic was a huge catalyst for technological change in the delivery of healthcare, particularly with "remote consultation". It proved a turning point from which, in broad terms, there is no going back.

48. The Academy and Colleges have supported the increased use of technology within healthcare and for consultations. Colleges have produced guidance on remote consultation (Royal College of General Practitioners guidance on remote consultation and triaging and Royal College of Physicians guidance on effective remote consultations.). The use of remote consultation was hugely beneficial, particularly in general practice during the pandemic, accelerating a trend that was already being encouraged by DHSC. There were some downsides with clinicians unable to pick up non-verbal cues from telephone calls as well as in a face-to-face consultation, limitations for those who are hard of hearing or with other sensory impairment and the potential inability of those living within abusive relationships to have a "private" consultation with a doctor.

49. The Academy and Colleges are clear that it is not simply a binary decision between a remote or in person consultation. Some of the media and political comments during the pandemic were not particularly insightful and helpful, and attacks on GPs were uninformed and unfair. There is a need for both types of consultation and what is most suitable will depend on the circumstances and individuals concerned. The decision on whether remote or in person consultations are most appropriate should be a shared decision between patient and clinician - a point set out in a blog by the chair of the Academy Patient Lay Group, Ros Levenson, in May 2022 (AH/13 – INQ000369625).

50. Examples of innovative and beneficial uses of technology can be found across specialties. A good example would be the huge positive impact telemedicine for early medical abortion had on services. The subsequent decision by Parliament

in May 2022 (See House of Commons Library briefing CBP 9496 Nov 2022) that this should continue and not be stopped as proposed by the Government was extremely welcome. Another example is the use of clinicians to support other services such as NHS 111. The Royal College of Paediatrics and Child Health ('RCPCH') supported NHS England to recruit retired or shielding paediatricians to work in NHS 111 call centres to improve paediatric advice during the pandemic. This trial was evaluated and published promising results around quality of advice given, and divergence away from primary and acute care settings. Initial data indicated that calls taken by paediatric clinicians were more likely to result in a self-care disposition compared to those taken in the non-paediatric specialist professional groups thus diverting patients away from ambulances and primary care (AH/14 - INQ000369626).

51. Going forward, we expect continued and increased use of technology within healthcare systems. However, in doing so it must: -
    a. Be appropriate clinically.
    b. Suit the wishes of the patient and clinician
    c. Be user friendly and not create additional burdens or barriers to patients or clinicians.
    d. Be adaptable to continued or forced future changes in another pandemic.

Concerns brought to the attention of the Academy

52. Throughout the pandemic, member organisations, and indeed others, brought issues and concerns to the Academy. These would then be the subject of discussion within the Academy and amongst members (via e-mail or in virtual meetings). Where appropriate, the Academy raised these issues with the relevant national bodies, whether NHS England, Public Health England ('PHE'), the CMO, Health Education England ('HEE') or the GMC. In addition, the Academy would produce a public statement or guidance if members felt this was required.

53. For ease of reference, we have divided the issues between medical issues relating to COVID-19 and care delivery, and concerns relating to staff.

Medical/care delivery issues

Public health messaging

54. At various times throughout the pandemic, Academy members were concerned to ensure that public messaging continued about the risks from COVID-19 and the need to continue with particular protective measures whilst ensuring the public continued to seek medical attention when required. This view was discussed with the England CMO and NHS Medical Director who shared the concerns. It was also recognised that there was added value in these messages not coming just from Government and seen independently from the medical profession but being complementary and aligned in content.

55. To this end, the Academy made a series of statements aimed at the media and public during the pandemic on the necessary clinical response to COVID: -
    a) Seek medical help for serious conditions during the pandemic – 7 April 2020 **AH/5** – **INQ000369652**
    b) Health protection public and professional responsibilities - 11 June 2020 (AH/16 – INQ000369628)
    c) Wearing of facemask – 14 July 2020 (AH/17 – INQ000369629)
    d) Follow the guidance or we will go back to square one - 7 October 2020 (AH/18 – INQ000369630)
    e) COVID vaccine – 10 November 2020 (AH/19 – INQ000369631)
    f) Vaccination second doses and maintaining protection. – 11 January 2021 **AH/19** – **INQ000369631**)
    g) COVID is not over - 9 July 2021 (AH/21 – INQ000369634)
    h) Vaccination of 12–15-year-olds- 13 September 2021 (AH/22 – INQ000369635)
    i) Acting responsibly – 21 September 2021 (AH/23 – INQ000369636)
    j) Omicron variant 15 - December 2021 (AH/24 – INQ000369637)

    The key messages of these statements were: -

    - The need for patients to continue to seek help for serious conditions (a)
    - The need to follow guidance and act responsibly ((b), (c), (d), (g), (i), (j)
    - The value of vaccination ((e), (f), (h)

(N.B. The Academy made other public statements on issues not directly related to the clinical response to COVID.)

56. The Academy believes that there was a good degree of alignment on messaging on clinical issues between the medical profession, UK Governments and NHS England/Public Heath England. That was hugely important in providing consistency and assurance to both the public and the clinical community.

57. Where there was misalignment or variation between clinical advice from different governmental, professional, or patient groups it was clearly unhelpful as were some media contributions from various individual commentators. Rewriting or providing additional interpretation to guidance can potentially lead to misunderstanding. Clearly there must be space for differing conclusions, provided they are evidence based. But one of the lessons for the future is the need to work hard to ensure consistency in advice produced by any organisation on a specific topic, whether for clinical or non-clinical issues.

58. Indeed, one of the major concerns of the Academy was apparent variation of approach and advice between the UK governments on various issues. As stated, we believe that on directly clinical issues there was generally good alignment, and we understand that the four CMOs worked well together, and they were consistent and complementary in what they said. However, beyond healthcare on the wider policy and political approach to the pandemic, the differing policy approaches, sometimes perhaps more perceived and presentational than real, were hard for the public to understand and created difficulties for clinicians in providing clear advice for patients. Areas of divergence generally related to the timing, duration, and stringency of responses. Examples included Stay at Home orders, school closures, use of face coverings in shops and public places, "circuit breakers," internal movement, presence at births/deaths. We recognise the political complexities of managing the pandemic across four different political administrations, but what seemed at times like difference for the sake of difference was not helpful.

Health inequalities

59. As the pandemic spread its impact on health inequalities became increasingly apparent. The differential impact of COVID-19 on different ethnic groups both in the public at large and amongst health and care workers was the subject of much concern and discussion. The interrelational impact of an individual's ethnicity, morbidity, socio-economic status and personal living circumstances was not clear-cut and has to be the subject of detailed academic study. Front-line clinicians had simply to deal with the patients presenting to them but the wider impact of both the virus itself and long-term implications of the pandemic were a major concern for colleges and the subject of discussion with the CMO.

60. Within the NHS the risk assessment exercise initiated by NHSE (see paragraphs 109-112) was designed to identify and mitigate differential risks between different staff groups and backgrounds.

Ethical guidance

61. The professional expectation was that clinicians should continue to use their normal ethical decision-making processes in the pandemic and this was stressed by the Faculty of Intensive Care Medicine and was at the core of Royal College of Physicians *Ethical dimensions of COVID-19 for frontline staff* **AH/24a - INQ000361986** which was endorsed by several colleges and the Royal College of General Practitioners Ethical Guidance on COVID-19 and Primary Care. There was conjecture as to whether the Moral and Ethical Advisory Group (MEAG) might produce guidance for use in a situation of demand significantly exceeding supply but this did not occur and was not required. (MEAG was established by DHSC to provide independent advice to the UK Government on moral, ethical and faith considerations on health and social care issues as they occurred. The advice was intended to inform management of health-related incidents including but not limited to pandemic flu. It was used during the COVID 19-Pandemic. The group was closed in October 2022.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

62. From the beginning of the COVID-19 pandemic, there were concerns that 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions were being made without involving people, or their families and/or carers if so wished, and were being applied to groups of people, rather than taking into account each person's individual circumstances. Colleges were clear that patients have to be at the heart of care planning and DNACPR decisions and these can only be made for individuals not groups of patients. However, Academy member organisations did not request the Academy to make a statement on the issue. Several colleges did welcome the recommendations of the CQC report *"Protect, respect and connect-decisions about living and dying well during COVID-19"* published on 18 March 2021 **AH/24b - INQ000235492**

Shielding – Clinically and Extremely Clinically Vulnerable

63. The Academy was involved in early discussion in March 2020 over the four governments' plans for identifying high risk groups (shielded patients) and then helped facilitate colleges and specialist societies in the complex task of identifying and then contacting at-risk patients within the identified groups by informing and clarifying what was required, raising queries with DHSC and making links to appropriate officials. This was a major task for colleges, specialist societies and individual doctors, especially physicians and GPs. Professional organisations responded to the challenge swiftly and efficiently, and this is a good example of the active role played by colleges and other professional bodies in supporting and delivering the right COVID care.

64. Colleges supported the concept of identifying high risk groups and ensuring they received additional protection. There were, unsurprisingly, calls for other groups to be included or put in one or other category in March and April 2020 (e.g., the Royal College of Physicians of Edinburgh highlighted older people with frailty, RCPCH with clinically extremely vulnerable children, the Royal College of General Practitioners called for BAME communities to be considered a high-risk group for priority vaccination. and the Royal College of Psychiatrists highlighted those with severe eating disorders and severe dementia). Final decisions on who was designated as clinically vulnerable or extremely clinically vulnerable were made by Government on a UK-wide basis. Anecdotally, College Presidents with direct

experience reported that the co-ordination with local authority services who contacted shielded patients worked effectively. As the pandemic continued there were difficulties identified in terms of the isolation of shielded patients and some lack of clarity around arrangements for individuals and indeed groups coming out of high-risk status. However, we believe that the initiative was effective and of significant overall benefit because it provided protection for many people who otherwise would have been at considerable risk.

ICU and bed capacity

65. During the most intense phases of the pandemic there were concerns about both ICU and overall bed capacity from all Academy members but especially the physician colleges and Faculty of Intensive Care Medicine. This was a regular topic of conversation at the meetings with NHSE Medical Director and the England CMO. The Nightingale Hospital programme was a remarkable example of logistics and planning despite much negative media comment and those involved deserve to be commended. As stated earlier, thankfully, NHS provision was not overrun despite the huge pressures felt in many local areas and by many staff. At the end of the day, the Nightingale capacity was not fully required. However, should it have been needed there would have been a major problem with staffing capacity. The same - limited - number of staff would have been available for Nightingales and existing facilities. The utilisation of Nightingales would have required redeployment of staff from existing facilities which would not have been possible at any great scale. Additional physical capacity without the additional staffing resource would not have provided a solution.

Shortage of medicines

66. The Royal College of Anaesthetists (RCoA) and the Faculty of Intensive Care Medicine (FICM) raised concerns on potential drug shortages. The RCoA have issued Guidance on potential changes to anaesthetic drug usage and administration during pandemic emergency pressures (April 2020). and the FICM Guidance on adaptations to standard UK critical care medication prescribing and administration practices during pandemic emergency pressures (April 2020).

67. The MHRA has always monitored drug supply across the UK and issue every month which medicines are currently in short supply and detail what alternative treatments are available to replace the medicines in question. This monitoring continued throughout the pandemic as usual and played an important part in the assurance that medicines or alternatives were available. Also, with the preparations for Brexit and the concern that medicines would be in short supply when the UK left the EU, systems and procedures were put in place jointly by the DHSC and the pharmaceutical industry to stockpile key medicines to safeguard against shortages. These measures were still in place at the start of the pandemic, which to an extent alleviated concerns about the shortage of medicines.

Visiting

68. For the public, the restriction on visiting patients in hospitals was one of the most distressing aspects of the pandemic. Not being able to see dying relatives was hugely painful and has had a lasting impact on many people. It is important to recognise the impact of the visitors' ban for non-COVID patients. Maternity services were an obvious example where birth partners were restricted and poor experiences were reported. Similarly, cancer patients who received a diagnosis had to attend their treatment sessions alone as relatives could not accompany them. This also had a significant impact on longer stay patients across mental health services (including dementia, forensic, severe mental illness, autistic spectrum disorder settings) for whom restricted access to family support is particularly problematic.

69. The Academy and Colleges fully recognised the rationale for barring visitors and accepted that restrictions were required. However, there seemed to be little flexibility in approach, and in variance in when the ban on visiting was lifted. It has been suggested that fuller availability of PPE for staff and visitors on a precautionary basis would have enabled minimising or reducing the restrictions on visiting which undoubtedly caused distress.

Testing

70. There were many commendable aspects to the arrangements and management for COVID testing across the UK. The rapid development of near universal testing capacity was a remarkable logistical achievement. However, colleges expressed a number of operational and scientific concerns over arrangements for COVID testing, and these were discussed at various national meetings with NHSE and the England CMO. The concerns were: -

a) Insufficient public health and workforce capacity for testing prior to the pandemic
b) In the initial period of testing (prior to Lateral Flow Antigen tests being available to all) a ministerial concentration on the total number of tests as an end in itself, as opposed to a clear strategy on the purpose, benefit and delivery of testing.
c) Supply and ordering problems with PCR tests
d) Logistical problems with PCR test booking e.g., tests allocated at a huge distance from people's homes.
e) The delay in receiving results of PCR test for inpatient admissions, (and discharge) and staff raised many issues including how to manage the wait for results and utilise staff.
f) Sensitivity of rapid antigen tests

The concerns were recognised by the CMO and NHSE who sought to address the logistical problems.

71. The Academy supported and endorsed the Royal College of Pathologists National Testing Strategy published in June 2020 (AH/25 – INQ000369638). Whilst not solely concerned with COVID-19 or pandemic virus testing, this document set out a vision for a future strategy around which clinical, scientific, policy and patient stakeholders can align and forms an important basis for future preparedness. Having a clear strategy for testing where testing is matched to purpose and pathways and there is the right workforce and structure with capacity for rapid expansion of testing facilities, is one of the Academy's recommendations for future preparedness.

Vaccination

72. The Academy would place on record its view that the development of COVID-19 vaccines and subsequent successful roll-out was an extraordinary achievement by all of those involved and enabled the country to move on from the pandemic in a way that would not otherwise have been possible.

73. The Academy was kept well informed on proposals for rollout and progress by the England CMO and Dr Jonathan Leach, NHSE Vaccination Programme Lead. The Academy supported the Joint Committee on Vaccination and Immunisation ('JCVI') recommendations adopted by Governments on the prioritisation of roll-out although we were aware that some colleges (e.g. Royal College of Psychiatrists) made separate representations to JCVI calling for amendments to be made. There were some problems reported of vaccine availability in primary care on occasions but on the whole the roll-out was managed very effectively within primary care and vaccination hubs.

74. Other Academy members also had important input into decisions around vaccination strategy. The Royal College of Obstetricians and Gynaecologists presented evidence to the JCVI on the safety of vaccination of pregnant women, and worked closely with UK Government and NHS bodies to encourage uptake of the vaccine amongst the pregnant population.

75. In September 2021, representatives from the Academy, the Scottish Academy, the Royal College of General Practitioners, Royal College of Paediatric and Child Health, the Royal College of Psychiatrists and Faculty of Public Health were invited by the four UK CMOs to advise them, as part of their process for making a final decision and recommendation to their respective Governments, on whether to extend COVID-19 vaccination to healthy 12–15-year-olds. This followed the suggestion from JCVI, agreed by health ministers, that the Government might wish to take further advice, including on educational impacts, from the Chief Medical Officers of the four nations.

76. In providing their advice, colleges were acutely aware how complex an issue this is and of the range of views on the topic. However, the general consensus from the college representatives was that there were wider benefits in vaccinating people in the 12–15-year-old age group which augment the marginal health

benefit to individuals identified by JCVI. Medical royal colleges supported the four CMOs' final recommendation to ministers that 12–15-year-olds were vaccinated.

Impact on staff

77. Staff across disciplines and locations were under extraordinary pressure throughout the pandemic. The Office of National Statistics report 2129 deaths involving COVID-19 of health and care staff in England and Wales between March 2020 and February 2022 (NHS 839, Social Care 1290 *(ONS "Deaths involving Coronavirus among health and social care workers (aged 20-64) deaths registered 9 March 2020- 28 February 2022- Reference 14379*). The BMA has recorded the deaths from COVID of 53 doctors working in the NHS from the start of the pandemic to February 2022 *(British Medical Journal March 2022*). Many more suffered from the virus. The workload and the psychological impact of the pandemic caused widespread exhaustion and burnout. For example, in January 2021 an RCP survey reported that 64% of respondents felt tired or exhausted and 19% had sought informal mental health support. The annual census of consultant physicians and higher specialty trainees which collects data on the physician workforce conducted by the RCP for the Federation of Physician Colleges of the UK for 2020, 2021 and 2022 show this was a continuing issue. In a survey conducted between November 2020 and February 2021, RCPCH noted the paediatric workforce had been under a huge amount of pressure, with over 15% of services reporting absence due to stress and 45% of clinical leads reporting concerns about future absences. Other colleges report similar results from their members and the recent GMC Annual Training Surveys of trainees and trainers carried out every year have shown increased burnout or risk of burn-out.

78. Workload pressure and stress on healthcare staff is to be expected in coping with a pandemic. However, the Academy and Colleges identified a number of specific areas of concern which contributed to the negative impact on staff.

Staffing levels

79. The staffing shortages in the NHS prior to the pandemic undoubtedly exacerbated the pressures on medical and other staff during the pandemic. The shortage of medical and other healthcare staff had been the key concern of the Academy prior to the pandemic (and continues to be so). Colleges have consistently called for increases in medical workforce numbers across specialties and for greater attention to be paid to staff well-being. The relentless increase in workload over recent years, staff shortages and a strong sense of being undervalued meant the NHS and medical workforce was not in a healthy state at the outset of the pandemic. There was without doubt a positive sense of commitment, camaraderie and determination to overcome the pandemic but in overall terms the pandemic only worsened the state of the NHS workforce.

80. During the pandemic itself, staffing pressures were increased with staff being absent having tested positive for COVID. The redeployment of staff from other areas was able to assist but had its own challenges. The efforts to bring in retired or ex-staff were positive but too often too slow, hampered by red tape and ineffectual. The Academy does not hold detailed information on the numbers of staff brought back or rejoining the register, but these should be obtainable through NHSE and the GMC.

81. In July 2020, the Academy produced a joint statement with the BMA, RCN, UNISON, NHS Confederation and NHS Providers on 'Supporting the workforce' (AH/26 - INQ000369639). This unprecedented alliance called for recognition of the efforts of staff, increased staff numbers, well-being, training and leadership. There was no official response to the statement, but the issues fed into the NHS Long Term Workforce Plan.

82. Staffing is still the key concern for colleges, but the Academy welcomed the publication of the Government's Long-term Workforce Plan in June 2023. If followed through, the proposals should address many of the staffing concerns in the longer term. However immediate pressures remain with a pressing need to retain staff.

83. One of the strong recommendations from the Academy in terms of future preparedness is ensuring there is an adequate baseline of workforce supply. This

applies not just to those needed to manage a future pandemic – GPs, ED, acute medical, ICU, anaesthetists, pathologists, occupational health physicians' psychiatrists – but across the medical and wider workforce.

Deployment of staff

84. Colleges and the Academy recognised from the outset of the pandemic that to be able to provide the best care for patients and ensure effective working for staff, clinicians would need to be flexible in how they worked, and that this required some planning. As the Academy, four CMOs and NHS England and GMC medical directors set out in their letter to doctors in March 2020 (AH/30 – **INQ000049584**), this might entail doctors working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients and the population as a whole. Staff might also have to work outside their usual hierarchies with working practices and structures, being skills- and experience-based, as opposed to seniority-based.

85. The Academy strongly welcomed the statement that clinicians must be supported in this, and employers be flexible in their approach and expectations. Healthcare regulators stated they would take into account factors relevant to the environment in which the professional is working, including relevant information about resources, guidelines or protocols in place at the time. An Academy statement on deployment of staff (27 March 2020) supported the approach of the four CMOs, NHS Medical Director and GMC (AH/27 - INQ000369640).

86. The Academy worked closely with NHS England on the development of guidance on staff deployment including a Standard Operating Procedure for staffing in critical care. Whilst this is ultimately an NHSE document and NHSE is better placed to speak to it, the purpose of the document was help employers determine how best to manage critical care staffing

87. Redeployment was a particular concern for trainee doctors. There were generic concerns about competencies when working outside one's area of expertise, especially for trainees originally in non-patient facing services and some trainees reported through the Academy Trainee Doctors Group poor or minimal

training/induction in new roles. Trainees also had understandable specific concerns about the potential impact of redeployment (and the pandemic more generally) on their training programmes and development of their consultant skills.

88. The Academy Trainee Doctors Group made a statement on redeployment on 26 March 2020 (AH/28 – INQ000369641). Importantly, trainees recognised the need to be supportive, adaptive and reactive in the difficult and evolving environment of the COVID-19 pandemic, but stressed the view that, wherever possible, trainees should be working within their existing specialty/skill set; when working in any setting outside documented competencies or recognised roles appropriate standardised training must be delivered and supervision clarified, and that not all skills/competencies were transferable or up-skillable.

89. There were concerns from some trainees over inappropriate redeployments, especially where original services were continuing e.g., maternity care where the Royal College of Obstetricians and Gynaecologists (RCOG) made several public calls to stop redeployment from maternity services and also in mental health care.

90. There are some anecdotal reports of nursing staff choosing to leave rather than be redeployed into COVID areas. However, there were others who relished the challenge and flourished.

91. Across a number of trusts there was provision of improved facilities for staff with added rest areas and 24-hour food provision. Unfortunately, these have not all continued which impacts poorly on staff. Ensuring those support facilities for staff is a lesson for the future.

Bringing back staff

92. In March 2020, NHSE launched the "*Bringing Back Staff*" campaign to encourage retired or non-practising clinicians to return to the NHS to assist in clinical or other roles. The Academy was supportive of the initiative and liaised with NHS England on the scheme discussing details with NHSE Deputy Medical Director for Workforce, Celia Ingham-Clarke and promoting the scheme amongst member organisations. There was an enormous response to the call from across professions.

93. It is recognised that there would always be several logistical challenges in bringing back non-working staff, including ensuring safety and competence and matching available skills to local needs. However, it must be said that the experience of many who volunteered was disappointing. The Royal College of General Practitioners reported many retired GPs not hearing back from NHS bodies or practices after getting through the initial emergency registration process, and also issues with on-boarding. There was a similar experience for secondary care clinicians encountering bureaucratic hurdles, a lack of employer flexibility or simple lack of response. We also had reports of doctors volunteering to assist in the vaccination programme never having their offer followed through or even acknowledged.

94. Despite the efforts of many people involved, the Academy believes that this was a missed opportunity with many organisations not showing any great imagination on how volunteers might be deployed and opportunities for staffing Nightingale facilities fully realised. Administrative/communication arrangements need to be better in any future circumstances. NHS England subsequently launched the "NHS Reservist" scheme in March 2020 after piloting in five sites, but the Academy believes that, in terms of preparation for a future pandemic, there should be a specific plan both to utilise reservists and to be able to mobilise further volunteers easily and efficiently.

Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE)

95. Issues around infection prevention and control guidance and use of PPE were probably the greatest source of friction between colleges and other professional bodies and national government bodies.

PPE

96. The availability of the most appropriate PPE was one of the most significant concerns of doctors and other health service staff. It exercised colleges considerably and was the subject of extensive discussion with NHS England in late March/early April 2020.

97. There were major concerns from colleges and other staff organisations over the content and clarity of initial guidance on PPE in acute and mental health secondary care settings in March 2020. Following meetings with the NHSE Medical Director and PHE on 27 March, the Academy was asked to co-ordinate input from colleges and other staff organisations (RCN, RCM). This was set out in a letter to the service and colleges from Professor Steve Powis, NHS Medical Director, Professor Yvonne Doyle, Medical Director PHE and Professor Carrie MacEwen, Chair of the Academy AH/28a - INQ000130506 The Academy was a co-signatory to the letter to make clear the intention of ensuring that organisations representing clinicians were being involved in the process of clarifying the guidance.

98. PHE received over 1,000 responses by the end of March, primarily from professional organisations, on the two sets of guidance for acute and community settings. The Academy recognised that the final guidance did address most of the issues raised by colleges, although concerns remained for some groups particularly around the unknown nature of transmission and the pivotal role of defining Aerosol Generating Procedures (AGP) and the level of protection required. Difference of opinion remained between medical experts, and this played out in public. It should be noted that the Academy did not have sight of the responses made to PHE and therefore we do not know how much regard was had for the totality of responses made in the final, published guidance.

99. In overall terms (in part but not solely in relation to the initial guidance) concerns that were expressed to NHSE/PHE throughout the pandemic were:
    a) NHS England/PHE stated that there was sufficient PPE available. Whilst this may have been true in global terms, there is no doubt that the right equipment was not in the right place at the right time.
    b) Lack of understanding or acceptance by staff of officially designated levels of PPE required in specific situations.
    c) Before the precise mode of transmission was fully understood, disagreement over what constituted AGPs and therefore what the appropriate level of PPE should be (see below on CPR and PPE). This was raised early in the pandemic and during the Omicron wave in December 2021.

d) Lack of clarity about how PPE should be used in primary care.
e) Lack of clarity about how PPE should be used across mental health settings, including situations involving rapid tranquilisation and restraint as well as nasogastric tube feeding.
f) Continuing concerns about the re-use of PPE items only intended for single use.
g) Shortage of surgical gowns and advice on alternatives.
h) Lack of transparency over PPE stocks.

100. Frontline staff were understandably hugely anxious about personal protection, particularly in the early stages of the pandemic. A cautious and perhaps at times over-cautious approach to what staff wanted in terms of PPE was not surprising. This ran up against an official objective calculation of requirements. These different starting points led, on the one hand, to some staff believing that PPE was being restricted for financial reasons and, on the other hand, government bodies' lack of comprehension and frustration at how PPE was apparently being used.

101. The Academy did not see any evidence nationally of any wish to deny staff the right PPE, and individuals worked hard to ensure the distribution of supplies. There were distribution difficulties in some areas but of greater concern to colleges and other organisations was what, at times, seemed to be a lack of transparency and frankness about the position. What was seen as a political desire to make it appear that problems had been dealt with when they remained unresolved was deeply unhelpful and indeed counterproductive leading to distrust in national messages.

102. Honest and transparent communication between Government and the service and professional bodies is essential. Professional bodies understand the logistical and operational challenges in a crisis situation and are mature enough to accept them. Lack of communication or blandishments make matters worse rather than resolve them.

103. Poor communication over advice issued regarding a potential shortage of surgical gowns and possible alternatives in April 2020 was a clear example of the

problems that could be caused. (It should be noted that following this problem PHE sought to ensure that the Academy was always informed when advice was to be published. Although timescales were sometimes very short this was welcome).

Cardiopulmonary resuscitation (CPR) and Personal Protective Equipment (PPE)

104. In April 2020 there was a difference of opinion between Public Health England and the Resuscitation Council (RCUK) on whether CPR should be considered an aerosol generating procedure requiring Level 3 PPE to be worn. Based on the NERVTAG evidence review and consensus statement, PHE stated that chest compressions and defibrillation (as part of resuscitation) would not be added to the list of aerosol generating procedures (AGPs) whilst the Resuscitation Council guidance on CPR and COVID-19 stated that chest compressions should be considered as AGPs, and, in the healthcare setting (acute or nonacute), level 3 PPE should be donned before commencing either chest compressions or airway manoeuvres during resuscitation. We were also made aware by the Royal College of Psychiatrists that the initial guidance on CPR presented further confusion for those working across mental health settings as neither addressed this setting specifically leading to differential applications of guidance.

105. The Academy's physician colleges supported the RCUK position. Whilst it is obviously legitimate for two highly respected scientific groups, NERVTAG and RCUK, to draw different conclusions, it did create dilemmas for individual clinicians and healthcare organisations. It illustrates the point made earlier that obtaining consensus on clinical advice, particularly in the absence of definitive evidence, is extremely important.

106. An Academy statement (4 May 2020) did not express a preference for either the RCUK or NERVTAG positions because, with the genuine difference in opinion amongst clinical experts, we did not believe we had the expertise for us to make a definitive judgement (AH/29 – INQ000369642). Our statement suggested that organisations and clinicians should agree, as soon as possible, on the local policy regarding availability and use of PPE in resuscitation situations in order to provide appropriate protection for staff and best care of patients. It was

anticipated that they were guided by the consensus view of those clinicians likely to be involved in resuscitation and that local decisions were transparently agreed, understood, shared and adequately resourced.

Infection Prevention Control (IPC)

107. Effective prevention and control of infection entails much more than just PPE. The Academy and colleges were closely involved with Dame Ruth May, Chief Nurse at NHSE, in the publication of NHSE guidance in August 2020 on IPC measures in relation to the remobilisation of services within health and care settings and reviewed and provided comments on the draft guidance in July.

108. As the pandemic receded, there were questions as to when and if IPC measures should be relaxed with some wanting swifter relaxation of guidlelines.to support more efficient delivery of care. Requirements on spacing of patients in ED or inpatient settings was an obvious example of this tension i.e. reduce spacing requirements and enable more patients to be treated but at potential risk of infection or maintain spacing and keep greater protection but not treat additional patients. This was generally determined at local level.

Risk assessment of staff

109. The issue of adequately assessing the risk from COVID-19 to individual staff depending on their work role, their own morbidity and home personal circumstances was an important topic. This was an inequalities issue and originally arose because of concerns of increased risk to minority ethnic staff although there were other at-risk groups. NHS England commissioned an independent reference group chaired by Professor Kamlesh Khunti to consider the issue and it produced a risk reduction framework.

110. The Academy welcomed the initiative and commented on the draft framework in particular suggesting that the originally proposed "traffic lighting" was unhelpful and, indeed, it was subsequently dropped. Carrying out risk assessments at local level was slower than might have been hoped and NHSE had to write a letter to trusts on 25 June 2020 from Amanda Pritchard, the NHSE

COO, Prerena Issar, NHSE Chief People Officer and Dr Nikki Kanani, NHSE Medical Director for Primary Care to ask them to ensure that assessments for all at-risk staff were completed in the following four weeks. NHSE was keen to ensure that staff heard this message and the Academy encouraged colleges to inform their members.

111. The RCOG and the Royal College of Midwives also developed guidance for pregnant healthcare workers on occupational health, based on the decision to include pregnant women in the 'clinically vulnerable' category. Both Colleges felt this should not have been their responsibility, and called for this to be the responsibility of Public Health England or Government departments.

112. It is important to highlight the important role played by NHS Occupational Health Services and staff during the pandemic. They played a crucial role in advising about risk assessment and safe working for healthcare staff. However, the spread of OH services across the NHS is patchy and has declined over recent years. In terms of future preparedness, the Academy believes that Occupational Health Services across the NHS need to be strengthened through increased staffing, including additional occupational health trainees and consultants and wider availability of occupational health services across NHS organisations.

Vaccination as a Condition of Deployment (VCOD)

113. The extensive work around VCOD with a public consultation (the results of which were ignored), the Government decision to proceed, legislation, NHS implementation work, the Government decision then to revoke the proposal, the subsequent consultation and legislation, was an unnecessary and avoidable distraction. The difficulties were compounded by the fact of there being different policies across the four nations with VCOD only proposed in England.

114. The issue of vaccination in general and specifically VCOD generated considerable discussion. The Academy had publicly stated its support for vaccination in general and Academy members felt that we should make our position on VCOD clear. The Academy publicly stated its belief that health and care staff should choose to be vaccinated. For doctors, the GMC '*Duties of a*

Doctor' makes it clear that protecting oneself against infectious diseases is good for doctors and patients. The Academy did recognise the Government's argument for VCOD. However, historically, the Academy's position has been to not support mandatory vaccination for NHS staff believing it to be unnecessary and even counter-productive. That had been the case for flu vaccination and was for COVID-19. The Academy Council endorsed this view at its meeting on 22 July 2021 in response to the Government proposal for VCOD.

115. Our rationale for not supporting VCOD was practical and pragmatic as much as a matter of principle. By July 2021 over 90% of NHS staff had been vaccinated. We believed that mandatory vaccinations would cause real difficulties with unnecessary disputes and arguments at local and national level. Increased risk of transmission due to unvaccinated staff was likely to be outweighed by the adverse effects on staffing levels and morale. The danger was that individual arguments and "vaccine martyrs" would become a distraction from the core issues of getting as many of the population vaccinated as possible. The decision to drop the proposal in January 2022 was welcomed.

Support for staff

116. As has been recognised, healthcare staff were under enormous pressure throughout the pandemic. Supporting those staff as much as possible, both in practical terms but also in terms of public messaging, was crucial. In terms of practical support, most of what could be done had to happen at a local level.

117. However, national bodies could play a role. Aside from detailed clinical advice and guidance, NHSE and many colleges and professional bodies invested in mental health support for their members either through on-line resources or support lines. The NHSE "Supporting our people Health and Wellbeing programmes" and the "Staff mental health and wellbeing hubs" (available on the NHS website) which provided national support and signposted other resources were welcomed.

118. The Academy itself is not able to provide support to individual doctors, although the Support for doctors section of our website does signpost to a range

of support resources. However, acting as the representative body for colleges and, as such, a voice for the profession, the Academy did seek to provide recognition and messages and appreciation to medical staff for their work during the pandemic.

119. Most importantly from the Academy's perspective were three letters to the profession from the Academy, the four UK CMOs, NHS England and the GMC. These were: -

a) First CMOs letter to the profession March 2020 (AH/30 – INQ000369644)

b) Supporting doctors through the second COVID wave November 2020 (AH/31 – **INQ000071564**

c) Joint letter to the profession 12 January 2021 (AH/32 – INQ000369646)

Flowing from this there was a further letter in May 2022 on

d) Appropriate release of medical colleagues for the purposes for carrying out work for the wider health system – May 2022 (AH/33 – INQ000369647)

120. The Academy was the catalyst for these letters but appreciated the willingness of four CMOs, NHSE and GMC to engage with the initiative. The original letters had two main purposes. Firstly, to acknowledge the huge work of medical staff and thank them for their efforts and, secondly, to seek to reassure doctors that if they had to work in unfamiliar circumstances they should be supported by their employers and their Regulator. It is obviously not possible to assess what impact or benefit, if any, such letters have for staff. However, showing that the work of the profession was appreciated was felt to be important.

Education, training and assessment

121. Education, training and assessment are at the heart of the work of medical royal colleges and faculties and thus are also at the core of the Academy's work as their membership body. Colleges and faculties write the curricula for all the GMC-approved postgraduate CCT (Certificate of Completion of Training) programmes and devise, manage and deliver the exams required in the curricula.

122. The Academy itself writes the curriculum for the Foundation Programme on the basis that it is, by definition, cross-specialty. The Academy has no direct involvement in the running of any exams. The Academy runs a series of committees comprising members from all Academy member organisations and other stakeholders which cover most aspects of postgraduate medical education. The role of the committees is to share information and good practice across colleges, develop consistency of approach as well as cross-specialty guidance or templates where helpful and liaise collective with other postgraduate medical education bodies.

123. The committees are: -

a) The Assessment Committee for all issues relating to exams and assessment.
b) The Joint Academy Training Forum for issues relating to CCT programmes.
c) The Professional Development Committee for issues relating to post CCT training and development.
d) The Foundation Committee for issues relating to the Foundation programme and oversight of the Foundation curriculum.
e) An Education Strategy Committee to co-ordinate all education activity.

The Academy also has a Trainee Doctors' Group and a Specialty and Associate Specialists' Committee which have a strong interest in education issues although are not exclusively education focused.

124. The pandemic had a profound impact on medical education and training. Formal training was suspended in most specialties for reasons of service necessity and COVID safety requirements, with trainee rotations halted from May to July 2020. Many trainees were redeployed to other areas of work. The impact can be categorised as: -

a) The impact on trainee doctors themselves in terms of their education and career progression.
b) Arrangements for managing and restoring training.
c) The impact on colleges, particularly the process of delivering exams.

125. It should be put on record that the Academy worked closely and effectively with the four NHS Statutory Education Bodies (SEBs) and the GMC as the education regulator to support doctors in training during the pandemic, to resolve problems with training and to restore training as the pandemic subsided. We shared a common wish to support and maintain education and training as far as possible during the height of pandemic disruption and ensure it was not overlooked in the process of restoring services. The Academy Chair of Council and Professor Sheona MacLeod from HEE co-chaired regular meetings with the SEBs for colleges on COVID education issues throughout the pandemic. The SEBs, Academy and GMC released a joint statement on exams in March 2020 which sought to assure doctors and employers that trainees would not be disadvantaged by the cancellation of exams and wrote in June 2020 on the need to support training restoration alongside the restoration of services The Academy Trainee Group (ATDG) provided active mutual support and positive engagement with the Academy and the statutory education bodies.

Impact on trainees

126. Apart from the pressures of delivering care in a COVID-19 environment, doctors in training had additional anxiety over the impact on their training. Doctors' career progression, and indeed the opportunity to move to consultant level posts, depends on the successful completion of their training programmes. Disruption to training potentially threatened their ability to progress, both through cancellation of exams and, of potentially more concern, inability to gain the experience and competencies required to progress. This was a particular problem in practical craft and other specialties where experience and completing of hands-on procedures was integral to the training experience and progression.

127. As seen in the statement of 26 March from the Academy Trainee Doctors' Group, trainees recognised the need to be supportive, flexible and adaptive during the pandemic but were legitimately concerned about their training **AH/28** – **INQ000369641**. The Trainee Group also published principles for the reestablishment of medical training in June 2020 (AH/35 – INQ000369649). This recognised that it would take time to reestablish training stepwise over a period of

time, but that this should also be seen as an opportunity to further develop training as opposed to simply reinstating it.

128. The halting of clinical rotations in April 2020 was a concern for many trainees who felt they would be losing out on experience. Trainees were worried that they would not be able to fulfil the requirements of their Annual Review of Competency Progression (ARCP) through circumstances beyond their control, and therefore be unable to progress. With the use of the additional ARCP Outcomes 10.1 and 10.2 introduced by the SEBs and GMC (see below para 129), and individual training support, the number of trainees unable to progress was not as great as originally feared. However, while judged competent, some trainees have lacked confidence to progress and be ready for the next stage of their training.

129. However, the latest GMC National Training Survey data shows that some specialties remain badly affected by the cancellation of elective and outpatient services, particularly where independent sector provision of NHS care has increased but has not increased the number of training opportunities. For example, in 2019 just 12% of ophthalmologists had undertaken fewer than 51 cataract procedures by end of ST2, by 2022 this increased to 35% and remains high in 2023 at 32%. Trainees in all elective specialties where services were cancelled would have been affected similarly. Other trainees may also have been impacted where training opportunities were restricted because of COVID restrictions or the redeployment of the trainee.

130. Finally, many trainees would probably acknowledge that though their formal training was disrupted, the experience of working and learning through the pandemic, though exhausting and stressful, provided them with unique experiential learning which will be invaluable in their future careers. We hope that greater flexibility and better engagement with supervisors about individual training needs are an on-going legacy from the pandemic.

Arrangements for managing and restoring training

131. The disruption of training has an impact on the NHS and ultimately on patients. Lack of progression of doctors through their training pathway and ultimately to successful completion of training creates bottlenecks. Trainees unable to progress to the next level would mean that there were no slots for progression of trainees at earlier stages. The inability to achieve CCT would reduce the number of new consultants coming into the NHS to replace retirees at a time when the main need is to increase the available workforce.

132. This impact of delayed progression for both the service and individual trainees was recognised by the SEBs and GMC. Postgraduate Deans were asked to make individual assessments of the needs of their trainees. Two new ARCP Outcomes (10.1 and 10.2) were introduced in April 2020 in time for the summer 2020 ARCPs which recognised that the acquisition of required capabilities had been delayed by external factors but that either progression could still continue (10.1) or that more training was required (10.2). Whist there were some anxieties about how these new Outcomes might operate, it was recognised that they were a constructive intervention. As stated above, it appears that the extent of lack of progression was less than originally feared.

133. The Academy and colleges shared the concerns of the SEBs and GMC that education and training requirements, always under pressure in the NHS, would be squeezed further locally in the face of pressure to restore services as soon as possible. The Academy was clear that sustaining and fully restoring education and training was essential if services were to be maintained in the medium and longer term. Short-term neglect will only lead to long-term damage.

134. Alongside moving to on-line exams (see paragraphs 136-138 below) changes had to be made to recruitment process into different stages of specialty training with recruitment being carried out virtually. There have been a range of views on the advantages and disadvantages of this approach and it will have to seen how recruitment adapts and develops particularly if trainee numbers increase significantly.

135. It is probably not yet possible to assess the long-term impact that COVID-19 has had on training for the cohort of junior doctors working through the

pandemic. However, the Academy believes that those involved in the postgraduate medical education process, whether in the SEBs, GMC, colleges or local organisations, as well, of course, as trainees themselves, did all they could to support and protect education and training.

The impact on colleges particularly in relation to exams

136. The pandemic had a huge impact on all the work of colleges but particularly in relation to education and training and exams. As well as exams, which are part of recognised training programmes, most colleges run a wide range of training events and courses - both in person and online. In March 2020 colleges cancelled all planned exams because of service requirements and COVID-19 safety restrictions. The Academy made a joint statement with the four Statutory Education Bodies and the GMC in March 2020 seeking to provide assurance to trainees that they would not be disadvantaged by cancellation of exams and that progression would not automatically be halted. The key concern for colleges and education authorities was that trainees would not be disadvantaged by the cancelation of exams either in terms of their career progression or financially with fees rolled over or refunded.

137. Colleges then rapidly embarked on the task of converting their face-to-face exams to a format that could be undertaken remotely. The size and complexity of this undertaking should not be underestimated. Whilst there were, unsurprisingly, some technical and teething problems, in overall terms this was a highly successful exercise, and colleges and faculties should be commended. As restrictions were withdrawn, colleges were faced with the question of whether to revert to face-to-face exams or continue with the new remote format. Opinions varied amongst both trainees and examiners as to benefits and disadvantages. As in many areas, the answer was not binary, and the final outcome is likely to be a blend of face-to-face and remote examinations.

138. It should be noted that many colleges set up a series of on-line webinars and events for their members throughout the pandemic, often, but not exclusively, on COVID-19 issues. These generally proved hugely successful with high

attendance. This, alongside the holding of committee meetings on-line is one of the lasting changes occasioned by the pandemic.

Lessons learnt and recommendations

139. There are of course many lessons to be learnt from the pandemic and its management, both within healthcare and more widely. It is important to recognise that the structure of the UK centralised health service with essentially a single system in each of the four administrations was of great benefit. In a crisis, centralised planning will be required and having a single system makes that far easier. Delivery of the vaccination and testing programmes are clear examples of this.

140. As stated in paragraph 12 at the outset of this submission, we are keen not to apply retrospective judgments to decisions made in good faith on the evidence available at the time. Rather we want to look forward to recommendations to assist the UK in preparedness and management of any future pandemic.

141. The Academy's conclusions/recommendations have been split into practical issues relating to the NHS and healthcare delivery and wider behavioural, relationship and communication issues, particularly at national level. Our July 2020 document Preparing for COVID-19 surges and winter contained a set of recommendations for managing future COVID-19 surges (**AH/8** – **INQ000369655**). On review, these remain relevant, and we would draw the Inquiry's attention to the document. The key points are included in the list below.

NHS and care delivery

142. ***Capacity.*** It is essential that there is sufficient capacity in the system to be able to manage future pandemics. Aside from ICU and bed capacity, this particularly means workforce in terms of medical and other staff. It is crucial that areas such as pathology, public health and occupational health staff are not ignored.

143. ***Testing.*** There must be a clear national strategy for testing. This should include, although not solely focus on, the requirements of a pandemic. The plan should address how testing capacity can be rapidly expanded and spread in the event of a pandemic whilst maintaining necessary quality assurance.

144. ***Professional involvement in planning.*** There should be greater involvement of professional clinical bodies in pandemic planning and running scenarios. Transparency and clinical buy-in to likely plans at the earliest stage will be invaluable. This should include planning for mental health, elective and outpatient services, including how they might be delivered safely in non-acute settings and use of the independent sector (including training provision) during a pandemic. Occupational health physician advice should be part of that process to ensure that staff health and welfare is considered from the outset.

145. ***Availability of PPE.*** Stocks of PPE must be sufficient and available at the right time and place with clear agreement and consistent messaging regarding what is appropriate equipment and usage.

146. ***Returning staff.*** A reserve NHS workforce is required across the UK. Arrangements for rapidly bringing staff back into the health sector on a temporary basis need to be drawn up and implementation be carried through. The current NHSE NHS Reservists scheme (details available on the NHS Careers website) which offers paid work and training for 32 days per year may be the basis of any arrangement but detailed plans for rapid expansion and operationalisation with effective administrative and communication strategies should be developed.

147. ***Care homes.*** There should be a full review of plans for supporting care homes in a pandemic. This submission has not specifically addressed issues in care homes as it is not our area of expertise. But those in care were amongst the worst affected by the pandemic. There seemed to be little coherent planning in terms of the care sector and so support lagged for the care sector. That must be addressed.

148. ***Mental health consequences.*** There should be proactive consideration and planning for the mental health consequences of pandemic/disasters in

advance given the increased risk to the nation as a whole as well as to health professionals (including staff who died by suicide and those experiencing moral injury).

Behavioural, relationship and communication issues

149. ***Communications.*** Whilst there were many examples of good local communications, and a lot of the national messaging was clear, there were too many examples of confused and sometimes seemingly contradictory messages at national level. This was both in terms of communication to the public and patients and to the service and clinicians. The fragmentation of responsibilities amongst national organisations added to the problem. The communication between medical royal colleges and senior national medical leaders was effective but there were too many occasions where organisational communication was late or insufficient.

150. ***Political consistency.*** Beyond healthcare, consistency of political approach between different administrations is crucial. Different messaging confuses the public and often makes the task of professionals managing the pandemic harder.

151. ***Consistency of clinical advice.*** That consistency applies equally to clinical advice and guidance. The Academy recognises that professional and third sector bodies have a responsibility to ensure that any guidance they put out aligns with and complements nationally agreed generic guidance, and that they liaise with other relevant organisation in formulating advice. This is not to say there cannot be differences of view, if evidence based, but where this happens, this needs to be explicit, and the differences explained and justified.

152. ***Transparency and honesty.*** Finally, and perhaps most crucially, transparency, honesty and engagement must be at the heart of any Government's management of future pandemics. The Academy's engagement with individual national officials was broadly very positive and productive but a perception, whether just or not, that the default position of government seemed to be to retain

rather than share information, to tell rather than to consult, gloss rather than candour was a problem. Such a perceived approach to the public and professionals only engendered suspicion and resentment. It made it harder to achieve the jointly held objectives of saving lives, treating patients and overcoming a pandemic.

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: 5th January **2024**