UK Covid-19 Inquiry: Module 3

Closing Submission of the Academy of Medical Royal Colleges

Introduction

1. The Academy of Medical Royal Colleges ('The Academy') is the membership body for medical royal colleges and faculties in the UK and in Ireland providing a professional voice for the medical profession as a whole. The Academy considers itself part of the medical leadership voice in the UK.
2. The Academy operates on a UK-wide basis and, as far as possible, seeks to devise policy on cross-specialty issues, that is applicable across the four nations. Unless obviously only related to issues in one administration, it should be assumed that this submission is relevant on a UK basis.
3. In its written statement and opening statement for this Module, the Academy sought to avoid retrospective judgments on decisions made in good faith on the evidence available at the time when knowledge and evidence was changing rapidly. As in many crises, the reality is that some decisions could, in retrospect, have been different to what they were. In addition, we believe that in many cases the choice was not between a right and wrong decision but judging the various risks involved what was the least worst decision.
4. The Academy has already put forward recommendations for the Inquiry to consider, in relation to assisting the UK in the management of any future pandemic. We believe that most valuable task the Inquiry can fulfil is in providing practical lessons on how the UK can prepare for and manage a future pandemic because we know that it is inevitable we will face another pandemic. We do not believe that harm or risk can be eliminated but it can be minimised. In this submission, the Academy aims to add further context, in light of the evidence now disclosed in Module 3, to those proposed recommendations.

Summary of Key Academy Findings

5. It is a tragedy that there were 229,150 deaths that listed COVID-19 as one of the causes of death on their death certificate (as of August 2023). In addition to this, there was a far higher number of people who suffered or continue to suffer in varying degrees from COVID-19. Our sympathies go out to all those who suffered or were bereaved.

Management of the pandemic and Impact on services

6. As we have heard during the Module 3 oral hearings, whilst services came close, they did not collapse during the pandemic. They were however overwhelmed on occasions

at many sites. The pressures on ICU and acute care and their staff was enormous, but it did not completely breakdown, owing to the incredible response of staff in the face of unprecedented pressure, sickness rates and lack of PPE. This selfless response saved thousands of lives and very much was 'the needs of the many outweigh the needs of the few'.

7. The cancellation of elective care and 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 to this day. 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.
8. The cancellation of elective care and outpatient appointments 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"* (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.
9. The Inquiry has heard in Module 3 about the decline in the willingness of the public to seek treatment or care during the pandemic, either for not wanting to be an apparent burden on services, or for fear contracting COVID-19. This was an area of 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 (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 Inquiry has heard how 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.

10. The impact 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. Whether it is delayed presentation or screening for cancer, early signs of a mental health condition not being detected, 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.

Long COVID and continuing impact

11. The Inquiry has heard powerful and moving testimony on how individuals, the NHS and the country are all living with the long-term impact of the pandemic. For those who suffered the loss of a relative, there are the lasting consequences of bereavement.
12. 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, 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.
13. Whilst you have detailed written evidence from the Royal College of Paediatrics and Child Health ('RCPCH') on this subject, it is worth noting that for children and young people, the impacts of the pandemic were different. The Academy recognises that while 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.
14. Unfortunately, the impact of pandemic on the NHS continues to this day. Whilst the increase in elective and outpatient waiting lists was happening before the pandemic, the pandemic has certainly exacerbated the issues.
15. In addition, the pandemic had a profound effect on mental health across the population and in particular on people with mental illnesses, intellectual disabilities and neurodevelopment conditions. Mental health services are still managing the consequences to this day and will be for some significant time to come. 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.

Impact on staff

16. Staff across disciplines and locations were under extraordinary pressure throughout the pandemic. The Office of National Statistics report 2,129 deaths involving COVID-19 of health and care staff in England and Wales between March 2020 and February 2022. The BMA has recorded the deaths from COVID-19 of 53 doctors working in the NHS from the start of the pandemic to February 2022. Many more suffered from the virus.
17. Workload pressures and stress of healthcare staff was already too high, pre-pandemic. The pandemic pushed staff beyond what was acceptable, and as the Inquiry has heard, the workload and the psychological impact of the pandemic caused widespread exhaustion and burnout. For many, this is still the case.

Health inequalities

18. As the pandemic proliferated, 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 Inquiry has heard powerful testimony and evidence on this subject already. We would ask the Inquiry to address the intersectional impact of an individual's ethnicity, morbidity, socio-economic status and personal living circumstances, on their health outcomes. 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.
19. We understand that the NHS the risk assessment exercise initiated by NHSE was designed to identify and mitigate differential risks between different staff groups and backgrounds. Again, it would be of value for the Inquiry to address this.

Vaccination

20. 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. 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.

Use of technology

21. One of the few silver linings of the pandemic was in facilitating the great expansion and adoption of technological change in the delivery of healthcare, particularly with "remote consultation". The use of remote consultations was hugely beneficial, particularly in general practice during the pandemic, accelerating a trend that was already being encouraged by DHSC. The Academy recognises that there are some downsides however, 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.
22. The Academy and colleges are clear that it is not simply a binary decision between a remote or in person consultation. As the Inquiry heard, 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 the needs of the patient . The decision on whether remote or in person consultations are most appropriate should be a shared decision between patient and clinician.

Academy's Proposed Recommendations

NHS and care delivery

Capacity

23. It is clear, there was insufficient workforce and infrastructure capacity during the pandemic. This was not a sudden issue but the result of growing chronic workforce shortages and infrastructure capacity throughout the healthcare system over several years. The Inquiry has heard how ICU and bed capacity in the UK is lower than most comparable countries. This had been a consistent concern of colleges and the problems were exposed during the pandemic.

> *"So we went into the pandemic with about 15%[1] too few anaesthetists. We knew we also had too few intensivists as well and that that had an impact on our ability to provide support to elective operating."*
>
> Oral evidence (Module 3) of Dr Daniele Bryden (Dean of the Faculty of Intensive Care Medicine, but also on behalf of the Royal College of Anaesthetists and the Association of Anaesthetists), 8th October 2024 [8/166/21]

[1] Note that the transcript says 50%, this is a transcription error.

24. For example, prior to the pandemic, most emergency departments (EDs') were stretched beyond the capacity they were designed and resourced to manage at any time. EDs were poorly equipped going into the pandemic, lacking essential facilities like negative pressure rooms. EDs were and still are, too small, have very few isolation rooms and are poorly ventilated. Operating in this way is not conducive to creating a resilient healthcare system that can adequately manage an outbreak.
25. In terms of workforce, it is crucial that areas such as medical pathology, mental health, public health and occupational health staff are not ignored. Of course, shortages occur across professions and these have to be addressed in other clinical professions as much as in medicine. In addition, there is also not the surge capacity to deal with a future pandemic.

> *"The NHS needs to have more capacity to deal with seasonal pressures and pandemics."*
>
> Witness Statement of Professor Neil Mortensen, ex-President of the Royal College of Surgeons of England INQ000475591

26. The 2023 NHS England Long Term Workforce Plan was a welcome recognition of the problems and it is essential that an evidence-based fully funded workforce plan is implemented.
27. ***Academy Recommendation 1:* It is essential that there is sufficient capacity in the system to be able to manage future pandemics.**

> *"Expand the general practice workforce to build resilience into the system to manage surges in the health needs of populations, during the pandemic but also in the aftermath."*
>
> Witness Statement of Dr Michael Mulholland (Honorary Secretary of the Royal College of General Practitioners) INQ000339027

> *"16b. ensure staffing levels and therefore care capacity within the health and social care system is adequate to both deliver routine care and respond to an emergency."*
>
> Witness Statement of Professor Andrew Goddard – Past President of the Royal College of Physicians (2018-2022) INQ000346095

"You can have more capacity. Taking ICU in particular, the UK has a very low ICU capacity compared to most of our peer nations in high-income countries. Now, that's a choice. That's a political choice. It's system configuration choice, but it is a choice. But, therefore, you have less reserve when a major emergency happens, even if it's short of something of the scale of Covid. So that's the first alternative. The second alternative is to do things which -- and this, in my view, is undoubtedly necessary either way that minimise the scale of the impact of the pandemic, and that of course is what the various attempts at lockdown and other NPIs were really about. But the way out of these is always going to be science in the end, as it was for this one, with vaccines."

Oral evidence (Module 3) of Professor Sir Chris Whitty (Chief Medical Officer for England), 26th September 2024 [12/68/10]

Testing

28. 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.
29. However, colleges expressed a number of operational and scientific concerns over arrangements for COVID testing. These 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) with staff raising many issues including how to manage the wait for results and utilise staff who were available.
    f. Sensitivity of rapid antigen tests
30. ***Academy Recommendation 2*****: There must be a clear national strategy for testing setting out the purpose, benefits (and limitations), and delivery of testing.** This should 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.

Professional involvement in planning

31. As we have heard across Modules 1, 2 and 3, there was not sufficient planning or scenario testing for a non-influenza pandemic.
32. During the pandemic there was generally positive engagement of clinical professional bodies, but it was sometimes inconsistent and late in commencing, and perhaps inevitably, rushed.
33. In addition, it is important in planning, that the differing needs of patients are considered. Children and young persons have differing needs to those who are pregnant. Expanding on that, pregnant women must be considered as a specific group when planning and implementing responses to pandemics and other situations. There are 750-800,000 pregnant women in the UK at any one time, a significant number. Pregnancy can't be stopped, which means maternity is a front door specialty, and women are looked after by specially trained staff who should not be redeployed.
34. ***Academy Recommendation 3:*** **There should be greater involvement of professional clinical and public health 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.

> *"136.1. DHSC, UKHSA and NHSE should undertake new pandemic preparedness exercises. These should involve the RCPsych and other organisations representing the mental health, intellectual disability and autism services and include an assessment of the suitability of the mental health estate in the event of a future pandemic."*
>
> Witness Statement of Dr Lade Smith (President of the Royal College of Psychiatrists) INQ000417461

> *"Ensure primary care is considered and consulted at an early stage in key guidance and emergency plans. General practice carries out the majority of the consultations in the NHS and therefore must be at the core of any health emergency response to avoid unintended consequences to patients' healthcare."*

Witness Statement of Dr Michael Mulholland (Honorary Secretary of the Royal College of General Practitioners) INQ000339027

"Para 44: Management of Covid-19 correctly focused on developing new strategies for detecting, diagnosing and managing Covid-19. This included fast immunological testing, monitoring of oxygen saturation and managing respiratory problems in the most efficient way. However, the NHS could have been better prepared by learning from previous pandemics. The world has been subject to a number of pandemics over the last century, including the 1918 Influenza Pandemic. There have been Pandemics in 1957, 1968, 1977 and 2009. SARS CoV1 emerged in 2002, MERS CoV in 2012, Ebola in 2013 and Zika in 2015. Strategic planning for pandemics is therefore vital. The last exercise for an Influenza Pandemic based on a strategy of 2011 was in 2016 (Operation Cygnus and lasted three days.) As far as we are aware, there was no national strategy update since that time."

Witness Statement of Mike McKirdy (President of the Royal College of Physicians and Surgeons of Glasgow INQ000470230

Availability of PPE

35. The Inquiry has heard across Modules 1 and 3, that the availability of, and access to, PPE was one of the major anxieties of front-line staff and professional bodies and a consistent concern.
36. The system would have greatly benefited from transparency surrounding PPE levels. The messaging of 'we have enough' when it at times it was clear that there was not enough in certain places, was not helpful.
37. The case for FFP3 masks vs FSRM masks, that has been extensively argued indirectly throughout Module 3, has left many in a position of uncertainty over what should have been provided to clinicians. Clarity over that matter would be welcome. In any event, it appears there simply were not enough FFP3 masks for every clinician to wear at all times during the pandemic.
38. There were major anxieties from medical royal colleges and other staff organisations over the content and clarity of guidance on PPE. Whilst in global terms there may have been sufficient PPE there is no doubt that the right equipment was not in the right place at the right time.

"303. Shortages of staff PPE increased staff infections and reduced the functionality of ICUs. In order to ensure that adequate PPE is available in times of crisis, a central PPE stockpile should be kept for future use and, where possible, domestic production and supply systems should be built up to make the UK less reliant on imports from other nations."

Witness Statement of Dr Daniele Bryden (Royal College of Anaesthetists, the Faculty of Intensive Care Medicine, and Association of Anaesthetists) INQ000389244

"I am aware that our organisations at the time had three broad levels of concern. Early on in the pandemic it was around the provision of advice and the timeliness of the advice as to the correct PPE to wear, because we were aware that many of our members and fellows were looking to us for distillation of advice, and we were struggling to be clear as to what that advice was. We then also had concerns around the consistency of the advice in terms of the timescales and, again, what PPE individuals should wear, and then finally there were concerns, as later on in the first wave, around the availability of PPE and the appropriate PPE."

Oral evidence (Module 3) of Dr Daniele Bryden (Dean of the Faculty of Intensive Care Medicine, but also on behalf of the Royal College of Anaesthetists and the Association of Anaesthetists), 8th October 2024 [18/132/11]

Academy Recommendation 4: **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.**

"16c. ensure that adequate stocks of PPE and the logistics are in place to distribute them

16d. ensure clarity over the appropriate levels of protection in different healthcare settings"

Witness Statement of Professor Andrew Goddard – Past President of the Royal College of Physicians (2018-2022) INQ000346095

Returning staff

39. The Academy was supportive of the initiatives to bring back retired or non-practicing clinicians to help in the pandemic. However, it is clear that these arrangements were generally not very satisfactory. The experience of many who volunteered was disappointing. Many volunteering clinicians reported encountering bureaucratic hurdles, a lack of employer flexibility or simple lack of response. This was a missed opportunity.

40. ***Academy Recommendation 5:* 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 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.

> *"[NHSE should be] providing that extra support to make it as easy as possible for individuals to come back into the health service."*
>
> Oral evidence (Module 3) of Professor Sir Stephen Powis, National Medical Director, NHS England, 11th November 2024 [29/17/21]

Care homes

41. Whilst the system and policy for governing care homes is beyond the area of expertise, of the Academy, it is undeniable that those in care homes were amongst the worst affected by the pandemic. It appeared that there was little coherent planning in terms of the care sector. This was a tragedy which must be addressed.

42. ***Academy Recommendation 6:* There should be a full review of plans for supporting care homes in a pandemic.**

Mental health consequences

43. The pandemic had an overwhelming negative mental health consequence on the UK, as a whole. Whilst the mental health consequences of a pandemic or disaster on the public, patients and care staff has not always been a priority in the past, it has been recognised that the pandemic itself (deaths, long-term illness) and its attendant requirements (lock-down, isolation, closure of schools, inability to visit sick/dying relatives) has had a profound impact on mental health across the population and people with mental illnesses, intellectual disabilities and neurodevelopmental conditions.

44. At the same time health and care staff themselves managing unprecedented workload levels, extremely high mortality amongst patients and colleagues were under huge stress and faced considerable mental health issues. Whilst some of these issues will have been short-term others will have very long-term effects.
45. ***Academy Recommendation 7:* 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.**

> *"151. The Government must provide investment in mental health services that is proportionate to the level of demand for mental health services, and the NHS and its ICBs need to ensure that children and young people mental health spend increases as a proportion of mental health spend, with funding reaching the frontline."*
>
> Witness Statement of Dr Elaine Lockhart, Chair of the Royal College of Psychiatrists Faulty of Child and Adolescent Psychiatry ('CAP') INQ000472876

Behavioural, relationship and communication issues

46. Whilst the Academy does not lay out specific recommendations in relation to communications, behaviour and relationships, we have set out general messages that are important to consider.

Communications

47. The Academy has heard of many examples of good local communications during the pandemic. Most of the national messaging was clear.
48. However, there were far 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.
49. For example, the process of transition from High Consequence Infectious Disease (HCID) to non-HCID was poorly communicated, at best. The focus at the start of the pandemic in hospital was around ICU risk, with not enough attention given to the risks posed in emergency departments ('EDs'). During this time, some EDs had to fight to get resuscitation rooms (where critically sick undifferentiated patients were seen) to be accepted as a 'high-risk' area.

50. In addition, at time the volume of communications to medical professionals was overwhelming.

> *[Regarding developing guidance with stakeholders] "The short answer is we did what we could but there is a trade-off between getting guidance out rapidly and doing the consultation that you would want do under normal circumstances. It's a set of lousy choices often but you have to make that judgment."*
>
> Oral evidence (Module 3) of Professor Sir Stephen Powis, National Medical Director, NHS England, 7th November 2024 [28/85/19]

> *"So I think we issued about 67 or so clinical guidance documents, often more operational than best practice, and NICE similarly issued guidance as well. As wave 1 started to -- as infections came down at the end of wave 1, we handed that particular responsibility back to NICE. But during the first wave we were producing guidance on quite a frequent basis."*
>
> Oral evidence (Module 3) of Professor Sir Stephen Powis, National Medical Director, NHS England, 7th November 2024 [28/63/18]

51. The fragmentation of responsibilities amongst national organisations in England added to the problem.

> *"I think that -- and I think this is a recommendation I think the Inquiry might -- I would invite the Inquiry to consider. I think that the messaging near the beginning of this was quite confused. And I think the reason that it was confused was it was not entirely clear who it was who was ultimately responsible for making decisions in this fast-moving situation."*
>
> Oral evidence (Module 3) of Professor Sir Chris Whitty (Chief Medical Officer for England), 26th September 2024 [12/79/12]

52. The communication between the leaders of medical royal colleges and senior national medical leaders was effective but there were too many occasions where organisational communication was late or insufficient (particularly relating to ethical guidance and clear escalation policies)

> *Constant two-way communication between the leaders of the medical profession was essential. The Presidents of the Royal Colleges as the senior*

clinicians for their professional groups, the NHSE National Medical Director and the OCMO among others hugely benefitted from regular contact.

Witness Statement of Professor Sir Chris Whitty INQ000410237

"Clearer communications planning with the public, including tailored information to children and young people, at a much earlier stage and with medical Royal Colleges and others fully brought into those discussions so that ambiguity can be avoided."

Witness Statement of Dr Camila Kingdon (Past-President of RCPCH) INQ000411507

"311. The pandemic has also demonstrated the value of collaboration between national organisations. Royal Colleges have worked successfully with regulators and NHS leaders to co-ordinate guidance and responses as situations arose. This level of alignment should endure to ensure that clear messaging and strong leadership remain a critical component of the response to future surges."

Witness Statement of Dr Daniele Bryden (Royal College of Anaesthetists, the Faculty of Intensive Care Medicine, and Association of Anaesthetists) INQ000389244

53. Royal colleges would benefit from receiving advanced notice announcements regarding vulnerable groups in any future pandemic, to avoid confusion and so we can work with Government to provide expertise and support the development of any necessary patient and clinician resources/groups/communications.

Political consistency

54. Consistency of political approaches across the four nations is hugely important. Differing messaging can cause confusion and can often make the task for professionals managing the pandemic, harder.
55. Areas of divergence across the four nations 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. The Academy does 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.

"16a. ensure clear communication and consistent messaging from government."

Witness Statement of Professor Andrew Goddard – Past President of the Royal College of Physicians (2018-2022) INQ000346095

Consistency of clinical advice

56. Whilst there was some political inconsistency across the four nations, there was a good degree of alignment on messaging on clinical issues nationally 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. The Academy welcomes this consistency and notes that is should apply equally to all clinical advice and guidance.

"As a general principle, and I think the Chief Medical Officer may have given this in previous evidence, we would want to align clinically between the four nations as much as possible, and I think from the senior clinicians in those four nations that was the aim. Of course, we have to recognise that they are four different political systems and health is devolved, and therefore there is that context. But as much as possible, we were trying to align clinically."

Oral evidence (Module 3) of Professor Sir Stephen Powis, National Medical Director, NHS England, 7th November 2024 [28/66/12]

58. 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.

"Section three: collaborating with other regulators and system partners across all four countries of the UK to ensure clear and consistent advice, guidance and messaging for doctors, other healthcare professionals and patients in uniquely challenging circumstances."

Witness Statement of Charles Massey (CEO of the GMC) INQ000410862

Transparency and honesty

59. As a general overarching matter, the Academy believes that transparency, honesty and engagement must be at the heart of any Government's management of future pandemics.
60. 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.
61. Such a perceived approach to the public and professionals may have fostered suspicion and resentment, making it harder to achieve the jointly held objectives of saving lives, treating patients and overcoming a pandemic.

Medical education and training

62. The Academy wishes to stress the need to support medical and other clinical education and training during a pandemic. In medicine, the training of doctors is the life blood of the future healthcare system.
63. Inevitably, training was negatively impacted during the pandemic. Trainee doctors were redeployed to support COVID-19 care, exams and training courses were cancelled, and progression was stalled.
64. Whilst some impact on training is inevitable during a pandemic, it is essential that the importance of maintaining education and training both for the health system itself and for individual doctors in training must be recognised and accepted at all levels. We would urge the Inquiry to ensure that is made clear in its final Module 3 report.

Conclusion

65. As stated at the outset we believe the Inquiry provides a real opportunity to learn lessons from the handling of the pandemic and therefore to better prepare and manage a future pandemic. We believe that if these recommendations are adopted by the Inquiry and crucially then implemented by Government and other relevant organisations, harm from a future pandemic can be minimised. The Academy looks forward to receiving the Module 3 report and will endeavour to implement the relevant recommendations.