

The UK Covid-19 Inquiry Module 3

Written closing statement of the British Medical Association (BMA)

Introduction

1. It is the BMA's firm belief that, while a pandemic or health emergency is always likely to put enormous strain on healthcare systems and the people who work within them, the *severity* of the impact was not inevitable.
2. The overall state of healthcare systems across the UK in the years leading up to the pandemic played a major role in the inability of these systems to cope when Covid-19 arrived. It exacerbated the severe disruption to healthcare delivery, with major consequences for staff and patients, and continues to impact health services today. Moreover, the measures in place to protect staff and patients from harm were inadequate, as is the support for those who have experienced Long Covid, burnout, trauma, stress and poor psychological safety.
3. This written statement draws on the evidence before the Inquiry in Module 3 and sets out the key areas that the BMA urges the Inquiry to consider as it develops its report and recommendations. It focuses on the following areas which have fundamental consequences for staff and patients:
 - A. The continued lack of capacity for day-to-day and emergency care in all settings.
 - B. The lack of adequate protections from harm.
 - C. The significant and ongoing impacts on staff and patients, with some groups disproportionately affected.
4. The statement makes specific recommendations for the Inquiry to consider. In broad terms, there is an urgent need for this module of the Inquiry to publish recommendations that will:
 - a. Lead to better-resourced healthcare systems which improve patient care by having sufficient capacity for both day-to-day and emergency situations, and which support staff physical and mental health. This includes recommendations that will address the endemic staff shortages, high vacancy rates, unsafe bed occupancy levels, the maintenance and modernisation of estates and improvements in digital infrastructure.
 - b. Reduce the impact of a future pandemic or health emergency on healthcare staff in all settings. This includes ensuring staff are adequately protected, for example through effective and responsive Infection, Prevention and Control (IPC) guidance, adequate Personal Protective Equipment (PPE), risk assessments and arrangements regarding redeployment and returning to service that are supportive. It also includes ensuring that, where unequal impacts exist, these are swiftly identified and mitigated.

A. There was, and continues to be, a lack of capacity for day-to-day and emergency care in both primary and secondary care

In 2020 the UK's health systems had insufficient capacity for day-to-day care, let alone an emergency

5. As already highlighted in the Inquiry's Module 1 report, health and social care *"were running close to, if not beyond, capacity in normal times"*, with severe staff shortages, infrastructure that was not fit for purpose and an NHS that 'runs hot' every winter¹.
6. It is vital that, when the next emergency occurs, all parts of the UK's health systems start from a far more resilient baseline. Improvements in both baseline *and* surge capacity need to be central to the Inquiry's recommendations and will take time and significant investment, because, as described by Professor Summers, you *"can't just magic up"* the resources you need².
7. The Inquiry has received demonstrably clear evidence about the lack of capacity within the UK's health systems. This inescapable reality has been reinforced by almost every witness, including the Inquiry's experts, all four Chief Medical Officers (CMOs) and Chief Nursing Officers (CNOs), the heads of all four health services and the political leaders of all four governments.
 - a. As the Inquiry is aware, capacity is not simply about *"furniture or bits of kit"*, it is the ability to staff beds and to undertake interventions safely³. As described by Dr Catherine McDonnell, *"the workforce is the baseline from which we launch ourselves into the pandemic"*⁴. Yet the UK entered the pandemic with healthcare systems that had chronic staff shortages and high vacancy rates. As emphasised by multiple witnesses, proper workforce planning is needed because it takes years to train specialist staff⁵; redeployment alone is not sufficient to fill these gaps⁶. In the words of a Consultant from a BMA survey, *"What I needed most during the pandemic were the colleagues I was already missing"*.
 - b. Insufficient capital investment meant that, across the UK, infrastructure and estates were inadequate in both primary and secondary care. The maintenance backlog was growing year on year, and by 2019/20 it stood at £9bn in England alone⁷. Patient and staff safety were being compromised by buildings that were not fit for purpose⁸; as described by Amanda Pritchard, *"the age and design of the NHS estate means a certain lack of flexibility into any*

¹ UK Covid-19 Inquiry Module 1 report 'The resilience and preparedness of the United Kingdom', p. 2 and p.122.

² 02.10.2024/59:19-20.

³ 02.10.2024/49:2-6.

⁴ 30.09.2024/180:24-25.

⁵ 02.10.2024/59:19-20 and 18.09.2024/14:6-24.

⁶ 02.10.2024/59:8-25 and 02.10.2024/61:11-21.

⁷ INQ00040925/69.

⁸ INQ000477304/31. 23.09.2024/191:5-11.

*surge response is baked in*⁹. Moreover, there was a need to improve the IT infrastructure across health systems¹⁰.

8. As a result of the above, the Inquiry heard that the quality and safety of patient care was already being impacted prior to the pandemic:
 - a. Operations were already being cancelled for non-clinical reasons¹¹ and waiting lists were at record highs, standing at approximately 5.6 million UK-wide in March 2020¹². Bed occupancy levels often exceeded the recommended 85% occupancy safety threshold, which is the rate at which hospital-acquired infections are known to increase¹³. As described by witnesses such as Professor Sir Chris Whitty, it is a common occurrence during winter for the NHS to be unable to escalate all patients to the next level of care¹⁴.
 - b. In primary care there was a steady trend of an increasing number of patients per GP, alongside higher GP workloads and increased patient complexity¹⁵. This was made worse by the pandemic, with GPs having to 'hold' a lot of the demand that secondary care did not have capacity for.
9. Despite the serious capacity constraints, some witnesses have suggested that the NHS was never overwhelmed¹⁶. It is undoubtedly the case that huge amounts of healthcare could not be delivered and that patients who would normally have received treatment outside of a pandemic did not. Healthcare workers were overwhelmed, physically and emotionally, and they still bear the scars of these injuries today. To continue to maintain, whether intentionally or not, that the NHS was never overwhelmed – even after hearing the powerful testimony of Professor Fong and many frontline healthcare workers – is fundamentally disrespectful to the staff who experienced this reality every single day.
10. As highlighted by Professor Sir Chris Whitty, NHS resource and configuration is a choice: *“You can have more capacity... That's a political choice. It's system configuration choice, but it is a choice”*¹⁷. Yet, as a result of NHS resource decisions, a large number of patients and healthcare staff suffered avoidable harms and will do so again in the next emergency unless urgent action is taken to improve capacity.

⁹ INQ000409250/70.

¹⁰ 23.09.2024/130:16 - 23.09.2024/131:9 and INQ000477304/32.

¹¹ INQ000177805/81.

¹² INQ000477304/20.

¹³ INQ000477304/27.

¹⁴ 26.09.2024/67:6-11.

¹⁵ 23.09.2024/50:17-22.

¹⁶ 21.11.2024/25:12 - 21.11.2024/28:22.

¹⁷ 26.09.2024/68:10-14.

Five years on, the UK's health systems are in a worse position to cope than they were in 2020

11. The Inquiry received clear evidence that, almost five years on from the start of the Covid-19 pandemic, the UK's health systems are in an even worse position to deliver day-to-day care, let alone cope with a future pandemic or health emergency.
12. The physical and digital infrastructure remains inadequate:
 - a. The number of beds is too low, with analysis by the Royal College of Emergency Medicine finding that the UK needs an additional 13,000 extra beds to meet day-to-day demand¹⁸. The BMA agrees with the recommendation by Professor Summers and Dr Suntharalingam that there needs to be a systematic UK-wide review of baseline ICU capacity which includes consideration of local population health needs¹⁹.
 - b. The UK-wide maintenance backlog for NHS estates currently stands at an astounding £17.3bn²⁰. In England, the cost of eradicating the maintenance backlog now exceeds the in-year cost of running the estate²¹. A recent report by the Health Service Journal (HSJ) found that infrastructure failings have led to over 1,000 operations being cancelled in the past two years at 14 Trusts alone²².
 - c. IT infrastructure across health services must be improved. Millions of working hours are lost yearly due to inadequate IT²³. A UK-wide survey conducted by the BMA in February 2022 found that almost a third of primary and secondary care respondents thought their IT software was either 'rarely' or 'not at all' adequate for their job role²⁴.
13. Health services are in the midst of a chronic workforce crisis:
 - a. There are severe staff shortages across all settings. NHS England predict these will increase to over a quarter of a million by 2036/37²⁵. In addition, staff sickness absence rates have risen

¹⁸ Royal College of Emergency Medicine 'Beds in the NHS', May 2022. Available at: <https://res.cloudinary.com/studio-republic/images/v1653920684/RCEM-Acute-Insight-Series-Beds-1/RCEM-Acute-Insight-Series-Beds-1.pdf>

¹⁹ INQ000474255/85.

²⁰ £17.4bn in real terms (2024/25) prices. BMA analysis of information from NHS England, Audit Scotland, Audit Wales and Department of Health Northern Ireland.

²¹ For 2023/24 the maintenance backlog in England was £13.8bn and the cost of running the NHS estate was £13.6bn. NHS England 'Estates Returns Information Collection', available at: <https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/management-information---provisional-summary-figures-for-2023-24>

²² Health Service Journal – 'Revealed: the ongoing impact of delays to 'new hospital' schemes', November 2024. Available at: <https://www.hsj.co.uk/finance-and-efficiency/revealed-the-ongoing-impact-of-delays-to-new-hospital-schemes/7038060.article>

²³ BMA report - 'Building the Future: Getting IT Right', December 2022. Available at: <https://www.bma.org.uk/media/6578/bma-infrastructure-2-report-getting-it-right-dec-2022.pdf>

²⁴ BMA report - 'Building the Future: Getting IT Right', December 2022. Available at: <https://www.bma.org.uk/media/6578/bma-infrastructure-2-report-getting-it-right-dec-2022.pdf>

²⁵ NHS Long Term Workforce Plan, June 2023. Available at: <https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/>

and currently remain higher than pre-pandemic²⁶. Alongside an increase in baseline levels of staff, pandemic planning must involve streamlined programmes for bringing in additional staff during emergencies. Staff should be able to take up roles with ease and flexibility, with processes in place for training and oversight.

- b. Staff mental health and morale remains poor, with high levels of burnout, stress and trauma. As described by Professor Summers, health and social care workers *“won't ever be the same. There is no going back to how we were before; that is not possible, we can't unsee things, but there is a huge, huge burden of care that is still needed...so there is no chance to pause and reflect and stop and repair”*²⁷. The BMA agrees with Professor Fong's recommendation that the *“wellbeing of the workforce should be a central strategic priority for the NHS, whether it is a pandemic or not, and it needs better resourcing”*²⁸. This must include, as Professor Edwards pointed out, interventions to improve the wellbeing of all staff, including GPs²⁹. While all four nations implemented positive initiatives to support staff mental health during the pandemic, some of this was only short-term and funding has since been reduced or withdrawn, as seen in the example of staff wellbeing hubs in England.
- c. Across the UK, the occupational health workforce does not have anywhere near enough resources to meet demand³⁰, meaning that access and quality varies drastically. As described by Dr Shin, the under-resourcing of occupational health services prior to the pandemic impacted their ability to provide staff with adequate support such as risk assessments³¹. Health services need good occupational health systems that can act quickly to protect staff, both during and outside of health emergencies.
- d. Health services cannot afford to lose their existing staff, so measures to improve retention and ensure staff are valued are crucial. It is also vital that healthcare workers are well supported to return to work following absence, including absence related to the pandemic such as Long Covid, stress and trauma. The expert report of Professor Brightling and Dr Evans highlighted the need for people living with Long Covid to have flexible, individualised support to return to work³², yet a BMA survey found that around 3 in 10 doctors with Long Covid had not been provided with support and adjustments to help them return to work³³.
- e. Workloads drastically increased during the pandemic and remained high. Professor Edwards, for example, described how the total activity in primary care now exceeds the level of activity

²⁶ NHS England, 'NHS Sickness Absence Rates', July 2024. Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/july-2024>

²⁷ 09.10.2024/114:1-18.

²⁸ 26.09.2024/48:14-16.

²⁹ 23.09.2024/57:8 - 23.09.2024/58:5.

³⁰ INQ000118475/34.

³¹ 19.09.2024/132:21-25.

³² INQ000421758/42.

³³ INQ000477304/111.

prior to the pandemic³⁴. The enormous waiting lists in secondary care continue to cause increased workloads for GPs who manage patients in the interim³⁵.

14. The severe consequences are being felt by patients and the wider population:

- a. Waiting lists across the UK currently stand at approximately 9.4m - an increase of nearly 4m since March 2020³⁶. Importantly, waiting lists are not experienced equally, with some parts of the UK³⁷, people living in more deprived areas³⁸ and people from certain ethnic minority backgrounds³⁹ disproportionately affected.
- b. There is an urgent need to address growing health inequalities and protect population health. As acknowledged in the Inquiry's Module 1 report, resilience to a pandemic involves having a resilient population⁴⁰. Yet population health and inequalities have worsened. The amount of time that people spend in poor health has increased⁴¹, the gap in healthy life expectancy between the most and least deprived areas is now almost 20 years⁴², and the number of working-age people out of work due to ill-health has skyrocketed⁴³.
- c. In addition to this, the latest ONS data estimated that in March 2023 over 1.8 million people in the UK were experiencing Long Covid⁴⁴. This condition is still limiting the ability of many patients and staff to work, train and undertake day-to-day activities, which, as noted by Professor Sir Stephen Powis, will have consequences for their mental health⁴⁵.

15. While the Government has prioritised the NHS in its recent budget, significant sustained investment is required to address historic underfunding. There need to be sustained real terms increases to

³⁴ 23.09.2024/29:20-25.

³⁵ 23.09.2024/176:15-23.

³⁶ BMA analysis of data from NHS England, Northern Ireland Statistics and Research Agency, Public Health Scotland and Stats Wales.

³⁷ 24.09.2024/41:2-10.

³⁸ Kings Fund – 'Tackling the elective backlog – exploring the relationship between deprivation and waiting times', September 2021. Available at: <https://www.kingsfund.org.uk/insight-and-analysis/blogs/elective-backlog-deprivation-waiting-times>

³⁹ INQ000249831.

⁴⁰ UK Covid-19 Inquiry Module 1 report 'The resilience and preparedness of the United Kingdom', p. 70.

⁴¹ ONS – 'Health state life expectancies in England, Northern Ireland and Wales: between 2011 to 2013 and 2020 to 2022', published March 2024. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/between2011to2013and2020to2022>

⁴² ONS – 'Health state life expectancies by national deprivation deciles, England: 2018 to 2020', published April 2022. Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2018to2020>

⁴³ Health Foundation – '300,000 people leave the workforce and report ill health annually'. Available at: <https://www.health.org.uk/news-and-comment/news/300000-people-leave-the-workforce-and-report-ill-health-annually>

⁴⁴ ONS – 'Prevalence of ongoing symptoms following coronavirus (Covid-19) infection in the UK' (30 March 2023). Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/30march2023>

⁴⁵ INQ000485652/288.

both resource and capital budgets, including long-term investment to address the maintenance backlog (on top of the £1.5bn that was allocated in the most recent budget). Workforce plans need to be properly funded to achieve safe staffing levels (in England, for example, the Long-Term Workforce Plan has not been funded beyond the first phase).

16. Against this background, the task of this Inquiry has never been more urgent and critical. It is vital that the Inquiry makes recommendations to improve the capacity of health systems to provide day-to-day care so that we can start from a more resilient position, rather than solely focusing on surge capacity. As stated by Sir Christopher Wormald, *“a key lesson learned was that workforce resilience and deployment of surge capacity initially lies with existing staff in the NHS”*⁴⁶. Solely focusing on surge capacity will not be enough for health services to weather the storm of a future pandemic and sets them up to repeat the failings that they experienced with Covid-19.

The BMA specifically proposes for the Inquiry to recommend that decision-makers:

- Invest money to ensure healthcare systems are adequately resourced for both day-to-day and emergency situations, including staff, physical infrastructure and digital infrastructure.
- Conduct regular independent assessments of both workforce and bed stock to meet the demands of day-to-day and emergency situations. These assessments must be credible and the full modelling that underpins them must be transparent and publicly available. A commitment to review these assessments at least every two years, to ensure they remain up to date, must be enshrined in legislation to ensure it remains a continued commitment for future governments. Moreover, successful delivery of these assessments is contingent on sustained and adequate funding.
- Ensure programmes are in place in all four nations to bring additional staff into healthcare services quickly during emergencies (e.g. redeployment, returners and reservists schemes). There should be streamlined processes for staff to take up roles with greater ease and flexibility, and disruption to training must be minimised.

B. Healthcare workers were not adequately protected from harm

17. In addition to healthcare systems' severe lack of capacity, there were clear failings in the protections which should have been put in place to protect staff from mental and physical harm.

The Health & Safety Executive (HSE) abrogated its responsibility to protect staff

18. As confirmed by witnesses including Professor Sir Chris Whitty and Dr Warne, healthcare workers were at higher risk of infection from Covid-19 compared to the general population⁴⁷. Evidence in Module 2 showed that during the first wave they were six times more likely to be infected than the general population⁴⁸. Indeed, in November 2020, a shocking 24% of staff at one Health Board in

⁴⁶ INQ000473872/18.

⁴⁷ INQ000410237/55 and 19.09.2024/154:1-20.

⁴⁸ Published by the Inquiry in Module 2 as INQ000271363.

Wales had Covid-19 despite community prevalence being only 1%⁴⁹. Further, the Inquiry heard that around the same time some midwifery services were running with 40% of their staff off sick⁵⁰. As summarised by Professor Sir Chris Whitty, *“healthcare workers were at an increased risk of catching Covid-19 as a result of their proximity to infected people as well as the frequency in which they will have come into contact with the virus”*⁵¹.

19. However, despite this increased risk, the HSE abrogated its responsibility to protect staff by failing to challenge the adequacy of the IPC guidance and act on concerns raised by organisations such as the BMA and the Royal College of Nursing (RCN).
20. The HSE failed to take a proactive approach in ensuring that employers complied with existing health and safety legislation, including the legal duty to undertake risk assessments. As described by Rosemary Gallagher of the RCN, the IPC guidance, not helped by the HSE’s lack of visibility, was interpreted as unchallengeable despite its failure to emphasise the need for risk assessments and its failure to reference health and safety requirements under Control of Substances Hazardous to Health (COSHH)⁵².
21. Further, the HSE actively supported the IPC guidance instead of challenging it in accordance with their statutory duty, evidenced in the response of HSE in January 2021 to concerns raised by the BMA and RCN⁵³, as follows: *“if an employer is following the updated guidance for controlling exposure to Covid-19, they will be taking, under health and safety legislation, reasonably practicable precautions to control the risk...HSE will not be undertaking a review, as this has already been done by those responsible for the guidance”*⁵⁴. This response is even more surprising given that the HSE’s Chief Scientific Advisor knew that Covid-19 was airborne⁵⁵ and that Fluid Resistant Surgical Masks (FRSMs), as recommended by the IPC guidance, did not adequately protect against aerosol transmission. Nevertheless, with the HSE’s position that guidance equated to *“reasonably practicable precautions”*, it is no surprise that IPC guidance, although flawed, was likely seen by many employers as a de-facto mandate.
22. Despite it being a legal requirement to report a disease attributed to an occupational exposure to a biological agent (in this case Covid-19) via RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations), HSE’s guidance set an unnecessarily high threshold which discouraged the reporting of infections by setting. Instead of an infection being reportable if there is reasonable grounds or reasonable evidence (which the BMA believes is the appropriate test based on the legislation) that it can be attributed to occupational exposure, HSE set a higher threshold of reporting only where it was considered ‘more likely than not’ (alternatively expressed as on the

⁴⁹ INQ000396261.

⁵⁰ 07.10.2024/98:19-20.

⁵¹ INQ000410237/55.

⁵² INQ000475580/17-20.

⁵³ INQ000097909/1.

⁵⁴ INQ000417574/2.

⁵⁵ 12.09.2024/108:19-24.

'balance of probabilities') that the person's work activity was the source of exposure to coronavirus. This put the onus on the employer to decide where the infection was acquired. The HSE guidance also stated that it was most likely that a case of Covid-19 would have been contracted in the community rather than the workplace, even in healthcare settings⁵⁶. This is illogical given the significantly higher rates of infection which healthcare workers experienced, especially given the restrictions on community mixing imposed by lockdowns and Non-Pharmaceutical Interventions.

23. As highlighted by Kevin Rowan of the Trades Union Congress (TUC) and Professor Philip Banfield of the BMA, this higher threshold is very likely to have discouraged reporting⁵⁷:

- a. In the first two years of the pandemic, Medical Examiners found 357 cases of healthcare worker deaths from workplace exposure in England alone⁵⁸, compared to 170 reported to RIDDOR in England, Wales and Scotland combined⁵⁹.
- b. Analysis of the number of healthcare worker deaths reported to RIDDOR compared to the number of deaths recorded by the ONS suggests that healthcare worker deaths may be almost five times higher than the number reported to RIDDOR. In the 24 months between 09 March 2020 and 28 February 2022, ONS data indicates that there were 839 healthcare worker deaths in England and Wales⁶⁰. However, in a very similar 24-month period from 10 April 2020 to 31 March 2022, there were 170 deaths reported to RIDDOR in England, Wales and Scotland in the industry categorised as 'human health activities'⁶¹. Not only is this figure almost five times smaller than the ONS data, it covers a larger geographical area.

24. There is also evidence that, when reporting did occur, the HSE failed to appropriately investigate a robust sample of the staff infections and deaths that were reported⁶². Accurate reporting is vital because it enables an understanding of infection patterns, including prevalence in healthcare as a sector as well as infection differences between occupational groups of healthcare workers⁶³. It also ensures workplace safety, properly recognises the sacrifice of those who died and assists staff with Long Covid in seeking access to compensation.

- a. This is supported by Dr Warne who said, *"to be able to understand infection prevention and control we need to understand the numbers, the surveillance, the numbers of hospital-acquired infections, the interventions which may be used to reduce them...that needs a*

⁵⁶ INQ000475580/51.

⁵⁷ 16.09.2024/11:17-19 and INQ000477304/128.

⁵⁸ INQ000412890/231.

⁵⁹ INQ000347822/41.

⁶⁰ ONS data - Deaths involving coronavirus (COVID-19) among health and social care workers (those aged 20 to 64 years), England and Wales, deaths registered, 9 March 2020 to 28 February 2022. Table 1. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14379deaths-involvingcoronaviruscovid19amonghealthandsocialcareworkersthoseaged20to64yearsenglandandwalesdeathsregistered9march2020to28february2022>

⁶¹ INQ000347822/41.

⁶² INQ000477304/131.

⁶³ 16.09.2024/9:10-21, 16.09.2024/16:4-20 and 16.09.2024/19:10-24.

*consistent unified process...to ensure that that guidance is consistent and the best quality that we can provide*⁶⁴. This is why Dr Shin, Professor Gould and Dr Warne recommend a single UK-wide organisation or process with oversight of healthcare-associated infection⁶⁵.

- b. Ultimately, if you do not have data about the extent to which staff are not being adequately protected, then you are less able to fulfil your responsibilities as a regulator by identifying where this protection needs to be improved or your legal responsibility as an employer to protect your staff. As described by Kevin Rowan, *“the most safe approach would be to gather as much data as possible and to share that data as early as possible”*⁶⁶.

25. It appears that there was no central data collection system to accurately record the number of healthcare worker infections and deaths, greatly limiting understanding of the pandemic’s impact on staff in health and care settings⁶⁷. The appalling nature of this failure is illustrated by the tribute of the British Medical Journal on 7 September 2023⁶⁸ to doctors who had died of Covid-19 in the line of duty, which acknowledged that the list of doctors mentioned may not be complete and invited the reporting of any individuals not mentioned.

26. The BMA agrees with witnesses such as Professor Susan Hopkins and Professor Sir Chris Whitty who highlighted the need for improved reporting of healthcare worker deaths in the event of a future pandemic⁶⁹. Richard Brunt stated that RIDDOR was never intended to be used in a pandemic involving thousands of infections, and that it was instead designed to capture single one-off unexpected incidents⁷⁰. This limited and restrictive interpretation is not accepted by the BMA, and immediate action is required (see below).

The BMA specifically proposes for the Inquiry to recommend that decision-makers:

- Urgently update the IPC guidance across all four nations to reflect the evidence that the Inquiry has heard about aerosol transmission by recommending FFP3 or equivalent protection for the routine care of patients with or suspected to have Covid-19. **Given the current and ongoing operational relevance of IPC guidance, both to staff and patient safety, the BMA urges the Inquiry to publish this as an urgent interim recommendation prior to the publication of the full Module 3 report, and thus enable staff and patients to benefit from the greater protection that respiratory protection provides.**
- Require the HSE to act in accordance with its legal powers and responsibilities and without delay in producing comprehensive guidance whenever there is a risk to the health, safety or welfare of workers, and specifically for the protection of healthcare workers from Covid-19.

⁶⁴ 19.09.2024/171:15 - 19.09.2024/172:2.

⁶⁵ INQ000474282/143.

⁶⁶ 16.09.2024/13:10-15.

⁶⁷ INQ000457580/50.

⁶⁸ INQ000397279.

⁶⁹ 18.09.2024/192:8-16 and 26.09.2024/187:13-17.

⁷⁰ 12.09.2024/88:21 - 12.09.2024/89:4.

- Enforce the RIDDOR reporting of infectious illness and deaths for which a reasonable judgement of occupational causation can be made. Require that the HSE produce clear and adequate guidance, investigate RIDDOR reports thoroughly, enforce compliance with the law and produce and disseminate timely analyses of their findings in order to gain an accurate understanding of transmission and infection levels and patterns within healthcare settings. These requirements must have independent oversight to ensure accountability.
- Ensure workplace risk assessments are undertaken, recorded and regularly reviewed (as per COSHH and Management of Health & Safety at Work regulations). In a future pandemic or health emergency, staff need to receive timely risk assessments and have confidence that the recommendations will be implemented. This must pay particular attention to characteristics such as ethnicity, disability and age.

Staff experienced widespread PPE shortages and problems with quality and fit

27. Some witnesses have stated that the UK never ran out of PPE, and that the problems were with the distribution rather than the overall quantity of the national stockpile⁷¹. It is the BMA's firm belief that, if a healthcare worker who needs PPE does not have it readily available, then this is a PPE shortage, regardless of whether the problem relates to distribution or stock quantity. There is a stark contrast between claims such as these and the experiences of staff as outlined below.
28. The Inquiry heard striking evidence about the lengths to which healthcare workers were forced to go to source PPE. This includes staff wearing makeshift items out of bin bags, ski-masks, swimming goggles or cagoules, while others purchased it from DIY stores⁷². In an example provided to the BMA by a GP in England, *"We had no PPE. Our first delivery was a box of 20 masks... This was for a surgery of 22,000 patients and 50+ staff. We made our own face shields with acetate overhead sheets and the use of a 3D printer loaned to us... We made aprons from bin liners"*.
29. In BMA surveys, staff regularly described how exposed, poorly protected and let down they felt⁷³. The RCN received similar testimonies, with nurses describing *"feeling like 'lambs to the slaughter' or 'cannon fodder' and that they were 'scared' and were left feeling 'let down and frustrated'"*⁷⁴.
30. PPE shortages were so severe that the UK Government had to produce shortages guidance, and the BMA produced guidance on rights and moral obligations if staff did not feel adequately protected⁷⁵. Professor Susan Hopkins described that in April 2020 supplies *"were down to days"*⁷⁶ with Matt Hancock stating that at one point the UK was *"within 6 or 7 hours of running out"*⁷⁷. This is reflected in a BMA survey in April 2020 which found that, among those working in settings where

⁷¹ INQ000421858/33, 17.09.2024/127:6-10 and 30.09.2024/118:8-24.

⁷² INQ000399526/10, INQ000475580/7, 26.09.2024/38:12, 26.09.2024/41:3-6 and 28.10.2024/118:5.

⁷³ INQ000477304/139.

⁷⁴ INQ000475580/8.

⁷⁵ INQ000477304/140.

⁷⁶ 18.09.2024/124:24.

⁷⁷ 21.11.24/124:8-9.

Aerosol Generating Procedures (AGPs) are carried out, there were considerable shortages or no supply at all of items including FFP3 respirators⁷⁸.

31. Further, an RCN survey in April and May 2020 found that around half of respondents working with Covid-19 patients in high-risk areas were asked to reuse single-use items of PPE⁷⁹. As noted by Rosemary Gallagher, *“reuse of single-use PPE, as suggested by PHE, was deemed unacceptable...this was a significant risk to health and care workers and to their patients”*⁸⁰.
32. There is also evidence that, when PPE was received, it was not always of sufficient quality. This includes PPE that had been stored in damp and leaky warehouses, visors that would fall apart, masks with faulty ear loops, aprons that ripped easily and contamination concerns including a cockroach found inside sterile packaging⁸¹. A secondary care doctor in England told the BMA in a survey that, *“the elastic straps on FFP3 masks had perished and would unpredictably snap during the working day thereby exposing the wearer”*.
33. Moreover, there were a number of issues with PPE fit testing during the pandemic. For FFP2 and FFP3 to give the right level of protection, they need to have a good fit and a good seal with the skin of the wearer⁸². However, as outlined by Richard Brunt of the HSE, there was a lack of testing machines, a lack of testing fluids and a lack of trained staff⁸³. The Inquiry received evidence that, in some instances, staff were asked to ‘fit check’ their PPE instead of fit test (which is a legal requirement) due to fit testing equipment not being available⁸⁴, placing staff at increased risk.
34. PPE shortages and fit-testing difficulties did not impact staff equally, as the Inquiry has heard. For example:
 - a. JS Bamrah of the Federation of Ethnic Minority Healthcare Organisations (FEMHO) highlighted the lower fit test pass rates experienced by ethnic minority staff due to respirators having been conventionally developed for the white male population. He also described how Sikh, Jewish and Muslim men were asked to remove their beards in order to pass the fit test for a FFP3 respirator, and how *“many did so under duress and out of fear for their job security”*⁸⁵. Evidence from an RCN survey in April 2020 found that ethnic minority staff working in AGP areas were significantly less likely to have been fit tested for their PPE compared to their white British colleagues⁸⁶.
 - b. Outsourced healthcare staff experienced greater delays in receiving PPE compared to directly employed staff and had their safety concerns dismissed by their employers, leaving them

⁷⁸ INQ000477304/138.

⁷⁹ INQ000475580/8.

⁸⁰ INQ000475580/24.

⁸¹ 01.10.2024/20:17-21, INQ000474039/41 and INQ000477593/28.

⁸² 12.09.2024/82:8-25.

⁸³ 12.09.2024/85:1-4.

⁸⁴ INQ000475580/7.

⁸⁵ INQ000399526/9-11.

⁸⁶ INQ000475580/9.

disproportionately exposed to infection⁸⁷. As described by the Frontline Migrant Health Workers Group, this *“led to staff with different employment statuses working closely together with varying levels of protection”*⁸⁸.

- c. Female healthcare staff reported disproportionate difficulties in finding well-fitting PPE because FFP3 respirators were not designed to fit smaller, often female face shapes⁸⁹. This is despite 89% of the UK nursing workforce and 48% of doctors being female⁹⁰.

35. Not only did the failure to prepare result in staff experiencing severe PPE shortages, but it also played a role in the inadequate protection recommended by the IPC guidance (see paragraphs 49-52 below).

The BMA specifically proposes for the Inquiry to recommend that decision-makers:

- Ensure that pandemic preparations include plans for rapidly scaling up the use of PPE, especially Respiratory Protective Equipment (RPE) and its fit testing, across a range of settings. Make preparations to ensure prior fit testing of staff with the best fitting RPE recorded in staff records and used to inform procurement decisions.
- Ensure a PPE stockpile suitable for a diverse range of face and body shapes, with sufficient stocks of PPE and especially RPE. This stockpile needs to be properly funded, easy to distribute in an emergency, and have adequate quality control processes in place.

There is irrefutable evidence that Covid-19 is transmitted via aerosol

36. The Inquiry heard a significant amount of evidence about the airborne transmission of Covid-19, including how the weight of this evidence amassed during the pandemic. The airborne transmission of Covid-19 is now clearly irrefutable. This was confirmed by multiple witnesses including the Inquiry’s experts, Professor Sir Chris Whitty, Professor Susan Hopkins, Professor Catherine Noakes, Dr Barry Jones and in the 2022 technical report published by the CMOs and DCMOs.

At the start of the pandemic, it was known that airborne transmission was likely, and the weight of evidence only increased

37. Despite Covid-19 being a novel virus, it was known prior to the pandemic that coronaviruses are transmissible through aerosols (not solely droplets). SARS-CoV-1, which is closely related to SARS-CoV-2 with 80% genomic similarity, was known to transmit by aerosol⁹¹.

38. It was also well established prior to the pandemic that RPE provides far greater protection against an airborne virus than a FRSM⁹², something confirmed during the oral evidence of Richard Brunt of the HSE⁹³. As highlighted in the expert report of Dr Shin, Professor Gould and Dr Warne, a paper

⁸⁷ INQ000477577/13-14.

⁸⁸ INQ000477577/15.

⁸⁹ INQ000477304/141.

⁹⁰ INQ000475580/62.

⁹¹ INQ000177534/23 and INQ000177534/48.

⁹² See for example INQ000145893 or INQ000130561.

⁹³ 12.09.2024/79:3-25.

co-authored in 2013 by, among others, Dr Lisa Ritchie and Professor Sir Jonathan Van-Tam recommended FFP3 for routine treatment of SARS-CoV-1⁹⁴.

39. As a result of this prior knowledge, decision-makers in the UK were aware from the very early months of the pandemic that Covid-19 could be transmitted via aerosol. For example:

- a. On 10 January 2020, the Four Nations High Consequence Infectious Disease (HCID) Definition and List Group stated that *“we recommend that the disease caused by Wuhan Novel coronavirus is classified as an Airborne HCID”*. It further stated that *“It is reasonable to assume airborne transmission (droplets and aerosols) is possible, consistent with what we know about transmission routes for other coronaviruses”*⁹⁵.
- b. A precautionary approach to PPE was initially in place until the declassification of Covid-19 as a HCID on 19 March 2020, following which PPE was de-escalated without a proper scientific basis. As confirmed in the expert report of Dr Shin, Professor Gould and Dr Warne, *“the two issues are separate...it was entirely possible to declassify Covid-19 as a HCID and retain the need for enhanced PPE measures”*⁹⁶.
- c. Professor Sir Chris Whitty observed that, in late March 2020, *“the question whether there was any airborne transmission struck us as ‘well of course there is going to be some’”*⁹⁷.
- d. The CMOs in Scotland and Wales also gave evidence that they were aware early in the pandemic that airborne transmission was a possibility. For example, Professor Sir Gregor Smith stated that there were early observational studies, particularly one from China, which suggested that there was at least some contribution from aerosol spread⁹⁸, while Sir Frank Atherton confirmed that his understanding in early March 2020 was that airborne transmission was a possibility⁹⁹.
- e. As referred to in the oral evidence of Dr Barry Jones, the Environmental Modelling Group (EMG) presented a paper to SAGE on 14 April 2020¹⁰⁰ which stated that *“the potential for viral aerosol formation [of Covid-19] due to breathing and coughing airflows therefore remains”*. The paper provided SAGE with seven studies of Covid-19 air sampling within hospitals, six of which found positive samples of the virus. This is supported by evidence from local infection control teams, such as Glasgow Royal Infirmary, who in April 2020 were seeing infection patterns *“which were indicative of airborne spread”*, including patients who were becoming infected without close contact with other infected patients¹⁰¹.

⁹⁴ INQ000130561 and INQ000474282/65.

⁹⁵ INQ000223380.

⁹⁶ INQ000474282/64.

⁹⁷ 26.09.2024/82:9-11 and 26.09.2024/138:1-6.

⁹⁸ 15.09.2024/39:21-24 and 15.09.2024/35:19-24.

⁹⁹ 30.09.2024/34:20-25.

¹⁰⁰ INQ000189678.

¹⁰¹ 14.11.2024/9:2-18.

- f. Another paper provided by the EMG to SAGE on 14 May 2020 stated that *“there is weak evidence that aerosol transmission may play a role under some conditions such as in poorly ventilated crowded environments”*¹⁰². This paper was shared with decision-makers beyond SAGE, for example, it was received by Sir Frank Atherton in a Technical Advisory Cell briefing on 05 June 2020¹⁰³.
40. As such, decision-makers should have taken a precautionary approach from the outset of the pandemic to protect the lives of staff and patients by recommending the use of RPE for all staff working with patients with, or suspected to have, Covid-19. As succinctly summarised by Sir Gregor Smith, *“it was also important to ensure that absence of evidence was not interpreted as evidence of absence, and that important transmission routes to which there were potential countermeasures were not ignored”*¹⁰⁴.
41. This view reflects the advice provided by SAGE in April 2021 which describes the precautionary principle, as defined by the United Nations Conference on the Environment and Development (UNCED) as, *“Where there are threats of serious or irreversible environmental damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent degradation”*¹⁰⁵. SAGE concludes that *“the precautionary principle in this context describes an approach that should be adopted for addressing hazards subject to high scientific uncertainty, and rules out lack of scientific certainty as a reason for not taking preventive action”*¹⁰⁶.
42. As the SAGE paper makes clear, *“Although invoking the precautionary principle means taking action when scientific uncertainty rules out sufficient information for risk assessment, it does not mean that a risk based approach is abandoned”*¹⁰⁷. The BMA has been surprised at the attempts made by some witnesses to explain away the precautionary principle in favour of a risk-based approach. First, as is made clear by SAGE, the precautionary principle is risk-based, and second, on any risk-based analysis, the emergence of Covid-19 as a deadly airborne virus that disproportionately infected healthcare workers who were required to work in poorly ventilated spaces in close proximity to infected patients, demands the protection of RPE. Instead, RPE, such as FFP3 respirators, was restricted to intensive care and AGPs.
43. As highlighted by Professor Clive Beggs, decision-makers set a higher bar of proof for airborne transmission compared to some other routes of transmission¹⁰⁸. This failure is summarised in the question to Professor Susan Hopkins from Counsel to the Inquiry, *“why doesn’t guidance say at the start: we think it’s droplet and contact, we can’t exclude aerosol, and therefore at the moment we are recommending the highest level of protection until we know more about the route of*

¹⁰² INQ000069689/2.

¹⁰³ 30.09.2024/35:20-24.

¹⁰⁴ INQ000484783/9.

¹⁰⁵ INQ000075022/5.

¹⁰⁶ INQ000075022/5.

¹⁰⁷ INQ000075022/5.

¹⁰⁸ 11.09.2024/121:11-22.

*transmission?*¹⁰⁹. To have no answer to this question is astounding given the thousands of staff and patients who acquired Covid-19 in healthcare settings and who died or are continuing to experience the effects of Long Covid.

44. The Inquiry heard that the evidence of aerosol transmission had significantly strengthened by the summer and autumn of 2020. For example:

- a. The oral evidence of Sir Gregor Smith referred to a statement issued by the WHO on 08 July 2020 which said that airborne transmission could not be ruled out in crowded, enclosed or poorly ventilated spaces. This statement was referred to in a Scottish cabinet meeting on the same day¹¹⁰. He also stated that the possibility of aerosol transmission was built into the Scottish Government response during summer 2020, for example through emphasising that it was safer to be outdoors or in well-ventilated spaces¹¹¹.
- b. On 04 August 2020, a ministerial submission to the Scottish Government specifically acknowledged aerosol as a possible route of transmission, stating that *“there is evolving evidence that aerosol transmission may play a role in some conditions such as in poorly ventilated and crowded environments”*¹¹².
- c. The expert report of Professor Beggs refers to the example of the March 2020 Skagit Valley Chorale in the United States, in which 87% of the choir caught Covid-19 and two people died. This incident was analysed in a report published in September 2020 in which the authors concluded that the transmission was aerosol¹¹³. In oral evidence, Professor Beggs highlighted that *“by the end of September 2020 there was enough moderate certainty evidence to strongly suggest that [Covid-19] could be transmitted via the airborne route”*¹¹⁴.
- d. Professor Susan Hopkins stated that, by 2021, PHE were clear that some transmission was happening through the air¹¹⁵. PHE convened a Respiratory Evidence Panel in Spring 2021 at which there was a consensus that Covid-19 had an airborne component¹¹⁶. As seen in the examples outlined above, this is not a timely acknowledgement.

45. However, even at this point, the IPC cell refused to update the guidance to provide staff with appropriate respiratory protection placing them at significant risk of infection, death and Long Covid.

¹⁰⁹ 18.09.2024/90:9-13.

¹¹⁰ 25.09.2024/41:5 - 25.09.2024/42:23.

¹¹¹ 25.09.2024/58/14 - 25.09.2024/59:12.

¹¹² INQ000380368/2.

¹¹³ INQ000474276/51.

¹¹⁴ 11.09.2024/111:3-6.

¹¹⁵ 18.09.2024/80:18-20.

¹¹⁶ 18.09.2024/81:17 - 18.09.2024/82:15.

The IPC cell failed to properly consider the growing evidence of aerosol transmission

46. Despite the increasingly strong evidence of aerosol transmission, the IPC cell failed to properly acknowledge it in IPC guidance. As described by Rosemary Gallagher, *“the guidance was so wedded to being predicated on droplets that it didn’t change”*¹¹⁷.

Substantial concerns were raised but these were ignored by the IPC cell

47. From at least October 2020, concerns were being raised, both internally within the IPC cell and externally by other organisations, about the adequacy of the guidance. This includes:

- a. October 2020: A Scottish Covid-19 IPC addendum is first published, containing guidance from ARHAI which states that *“where staff have concerns about potential exposure to themselves, they may choose to wear an FFP3 respirator rather than a FRSM when performing an AGP on a patient in the low-risk pathway”*, with the stated rationale of minimising staff anxieties¹¹⁸. As confirmed in the witness statement of Caroline Lamb, this published addendum was guidance from ARHAI, rather than Scottish Government policy¹¹⁹.
- b. 23 November 2020: The RCN emailed Dr Lisa Ritchie questioning the effectiveness of FRSMs in non-AGP settings. The email highlights a *“recent publication on the gov.uk website of the need for ventilation in homes...[which] talks of infective particles remaining in the air for long periods. This infers airborne transmission”*¹²⁰.
- c. 24 November 2020: An RCN email to PHE which questioned the conflict of advice between the IPC guidance failing to recommend RPE for healthcare workers in all settings and the UK Government video about ventilation in homes¹²¹.
- d. 01 December 2020: A BMA letter to the HSE¹²², calling for FFP3s or N95s to be recommended when providing routine care to Covid-19 patients. This contrasts with Dame Ruth May stating that in December 2020 no one was calling for FFP3 use in routine care¹²³.
- e. 22 December 2020: IPC cell minutes show that Colin Brown from PHE stated that *“Our understanding of aerosol transmission has changed. A precautionary approach to move to FFP3 masks whilst we are awaiting evidence should be advised”*¹²⁴.
- f. 23 December 2020: IPC cell minutes show that *“PHE are recommending [for the IPC cell to recommend] FFP3 masks in all medium/high risk pathways (irrespective of AGPs) as there could be increased airborne transmission in these pathways”*. In the same meeting, another

¹¹⁷ 04.11.2024/100:22.

¹¹⁸ INQ000485979/162.

¹¹⁹ INQ000485979/162.

¹²⁰ INQ000417625/2.

¹²¹ INQ000417639/1.

¹²² INQ000118222.

¹²³ 17.09.2024/52:7-13.

¹²⁴ INQ000398244.

member of the cell highlighted that *“There may be a risk of increased aerosol transmission following evidence re singing, shouting and enclosed spaces”*¹²⁵.

- g. 23 December 2020: A joint BMA and RCN letter to Sir Patrick Vallance, the CNOs of all four nations, the HSE and HSE NI, and PHE¹²⁶. This called for a precautionary approach, including RPE for all those working with Covid-19 patients.
 - h. 13 January 2021: A joint BMA and RCN letter to Professor Sir Chris Whitty calling for RPE for staff in all settings working with Covid-19 patients, highlighting poor ventilation and asking why a precautionary principle has not been applied in the interim¹²⁷.
 - i. 13 January 2021: A BMA letter to PHE and the Parliamentary Under Secretary of State requesting that PHE urgently reviews the adequacy of the IPC guidance and calling for a precautionary approach which recommends the wider use of RPE outside of AGPs¹²⁸.
 - j. 15 January 2021: An RCN letter to PHE requesting an urgent review of the evidence underpinning the IPC guidance given concerns about aerosol transmission¹²⁹.
 - k. 21 January 2021: A joint BMA and RCN letter to the HSE highlighting the ineffective protection provided by FRSMs against aerosols and asking HSE to urgently review the IPC guidance in respect to aerosol transmission from actions such as coughing and talking¹³⁰.
 - l. 18 February 2021: A joint letter from 21 healthcare organisations to the Prime Minister and the Health Ministers in all four nations¹³¹. This highlighted the evidence of aerosol transmission outside of AGPs and called for RPE for all staff working with Covid-19 patients.
 - m. 28 February 2021: An Independent Review published by the RCN found that the literature reviews informing the IPC guidance paid insufficient consideration to evidence of airborne transmission, ventilation of healthcare premises and aerosols generated by coughing and speaking, despite research being conducted into these matters during the relevant period¹³².
48. Yet, despite these concerns, for the majority of the pandemic the IPC guidance continued to put staff at risk by stating that those providing routine care to Covid-19 patients outside of AGPs did not require access to RPE. On 17 January 2022 there was a brief change in the IPC guidance which acknowledged that *“airborne particles can be released when a person coughs or sneezes”* and stated that *“an FFP3 respirator (or equivalent), must be worn by staff when caring for patients with a suspected or confirmed infection spread by the airborne route (during the infectious period)”*¹³³.

¹²⁵ INQ000398242.

¹²⁶ INQ000417588.

¹²⁷ INQ000417643.

¹²⁸ INQ000097875.

¹²⁹ INQ000114315.

¹³⁰ INQ000097909.

¹³¹ INQ000118291.

¹³² INQ000475580/32-33.

¹³³ INQ000300389/17 and INQ000300389/10.

However, this guidance was revised on 15 March 2022, adding the word “*predominantly*” before “*spread by the airborne route*” which the guidance stated was to “*clarify*” that the same PPE recommendations applied, namely that FRSMs were recommended for the care of patients with suspected or confirmed Covid-19¹³⁴.

Other factors influenced the IPC guidance, leaving staff unprotected

49. While some witnesses have claimed that the development of the IPC guidance was based purely on the scientific evidence¹³⁵, evidence before the Inquiry shows that other factors did appear to trump the IPC cell’s proper consideration of the evidence. This includes considerations related to PPE supplies and capacity for fit testing. For example:

- a. The inadequate stock of FFP3 respirators at the outset of the pandemic is confirmed in an email of Professor Van-Tam dated 23 January 2020 that raises concerns about the potential shortages of FFP3 in the circumstances of a pandemic surge¹³⁶. Professor Van-Tam stated that, if the volume of Covid-19 infections resulted in patients being admitted to “*standard ward settings*”, the UK “*would need to draw down pandemic PPE stockpiles. These are configured for influenza and largely depend on SFMs [Surgical Face Masks] for most healthcare, and FFP3 respirators (requiring fit-testing) for ICUs and specific AGPs in non-ICU settings. The historical HSE statutory position is that maximum level RPE is required. This was neither affordable nor practical for pandemic stockpiling. The difference between PH/clinicians and HSE’s statutory viewpoint have to my knowledge never been resolved [emphasis added]. Whilst I recognise surge is a long way off and I very much hope we never get there, but I think this needs very careful handling*”.
- b. 22 January 2020: An email from Dr Lisa Ritchie to Sir Gregor Smith stated that “*the option for FFP3 respirators is not one [that] can be easily and quickly implemented in general practice nor effectively sustained – specifically, given the need for fit testing*”¹³⁷. Sir Gregor Smith confirmed in oral evidence that it is an example of when scientific considerations were overridden by the difficulty of implementation¹³⁸.
- c. 01 February 2020: An email from Dr Lisa Ritchie to NHS Scotland, which states that RPE would initially be used, but if Covid-19 led to sustained community transmission then FFP3s would be reserved for ICUs and AGPs, and FRSMs would be used for normal ward settings. In the same email chain, James Miller from NHS Scotland states that “*there is little point in guidance for a product that the country can’t access*”¹³⁹.

¹³⁴ INQ000348420/14 and INQ000348420/5.

¹³⁵ 16.09.2024/118:10 - 16.09.2024/119:3 and 18.09.2024/104:7-12.

¹³⁶ INQ000151353.

¹³⁷ INQ000492302/1.

¹³⁸ 25.09.2024/85:7 - 25.09.2024/87:24.

¹³⁹ INQ000291635.

- d. 04 March 2020: Minutes from the IPC cell, in relation to an update on the PPE supply chain, include comments that a *“pragmatic approach [to the use of FFP3] may differ. For HCW looking after patients who are confirmed, they should be the priority for wearing FFP3 rather than those in minimal/short contact with patients”*¹⁴⁰
 - e. 20 March 2020: An email from Professor Van-Tam, calling for, *“a proportional plan for sensible prioritised use of what PPE we have and can get. In other words, given the science, given the reality of stocks, how can this be prioritised in the most sensible, risk-stratified way.”*¹⁴¹
 - f. 29 May 2020: In response to draft PPE guidance for hospital visitors, Professor Dame Jenny Harries highlighted that PPE supply chains for healthcare workers were still fragile, the impact of which needed to be factored into the content of the guidance¹⁴².
 - g. 22 December 2020: IPC cell minutes include the comment *“if we increase the use of FFP3 masks we need to consider stock availability, as this could put additional pressure on Trusts”* and *“How do we manage staff expectations across hospitals and all other care settings if a FFP3 precautionary approach is taken?”*¹⁴³.
 - h. 23 December 2020: IPC cell minutes include comments of *“If it was changed [to FFP3] there would be significant implications with roll out in care homes”* and *“There are concerns regarding the use of FFP3 masks, due to availability and capacity for fit testing”*¹⁴⁴.
 - i. An April 2021 paper from SAGE¹⁴⁵ discusses considerations for implementing the use of FFP3, stating that *“extending the use of FFP3 across care areas has operational implications...it would require sufficient supplies of FFP3 to maintain stock and not compromise supplies for HCWs undertaking AGPs who are at recognised increased risk.”*
50. In contrast to Dr Lisa Ritchie and Professor Susan Hopkins, the role played by limited FFP3 availability in the development of the IPC guidance was confirmed by Laura Imrie, a member of the IPC cell, who gave oral evidence that *“If we wrote guidance as a precautionary principle to put everybody into FFP3 then not only would they have had a large amount of the workforce that couldn't comply with the guidance, and therefore couldn't come to work, we would also have had high risk areas...that might have been left without the FFP3s...there was at the beginning of the pandemic a very quick and a rapid stocktake of what stock we held and what was required, and from my understanding that would have made it really difficult to supply the FFP3s to ITU units and other areas we deemed high risk”*¹⁴⁶. Matt Hancock also confirmed that this was his understanding when he told the Inquiry *“the availability of the higher-end masks was extremely tight at the start of*

¹⁴⁰ INQ000398198/2.

¹⁴¹ INQ000381179/1.

¹⁴² INQ000410237/73.

¹⁴³ INQ000398242/3.

¹⁴⁴ INQ000398242/2-3.

¹⁴⁵ INQ000075022/9.

¹⁴⁶ 05.11.2024/149:17 – 05.11.2024/150:8.

*the pandemic and had we, for instance, specified FFP3 masks right from the get-go, there would have been a risk that in extremely high-risk settings there would not have been the availability of those masks had they been used across the board when the lower-grade masks were available more widely.*¹⁴⁷

51. In addition to PPE supplies, concerns about staff confidence also seem to have impacted the level of protection afforded to staff. For example:

- a. 9 September 2020: Minutes from the IPC cell include the comment of: *“if you change the guidance itself, it would need to be a very careful narrative as it would be easy to give the impression that we got it wrong the first time, when it is something we collectively signed off and submitted to our CNOs”*¹⁴⁸.
- b. 22 December 2020: Minutes from the IPC cell include the comment of *“There will be pressure from organisations and bodies for more precautionary measures. The confidence of staff in high intensity units is being lost”*¹⁴⁹.
- c. 23 December 2020: Minutes from the IPC cell include the comment of *“colleagues might think that they have not been appropriately protected with what has been previously recommended”*¹⁵⁰.

52. Healthcare workers should not have to bear the consequences of poor pre-pandemic planning, nor should their protection have been compromised in an effort to retain their confidence. Given the realities of widespread PPE shortages, the IPC guidance should have been honest and transparent with staff. An example of such an approach can be seen in the most recent guidance from the European Centre for Disease Prevention and Control (ECDC), published in February 2021, which includes advice for situations where there are shortages of the recommended PPE, including respirators¹⁵¹.

The IPC guidance contains numerous contradictions about aerosol transmission

53. Although the IPC cell continued to deny the role of aerosol transmission, draft IPC guidance recognised the importance of ventilation systems to control exposure at source as early as March 2020¹⁵² with SAGE also noting around the same time that *“Ventilation in buildings is an important consideration, particularly for nosocomial transmission”*¹⁵³. As described by Professor Beggs:

¹⁴⁷ 22.11.2024/33:24 - 22.11.2024/34:6.

¹⁴⁸ INQ000398144.

¹⁴⁹ INQ000398242/3.

¹⁵⁰ INQ000398242/2.

¹⁵¹ ECDC, ‘Infection prevention and control and preparedness for COVID-19 in healthcare settings’ (page 7).

Available at: https://www.ecdc.europa.eu/sites/default/files/documents/Infection-prevention-and-control-in-healthcare-settings-COVID-19_6th_update_9_Feb_2021.pdf

¹⁵² INQ000088334/5.

¹⁵³ Published by the Inquiry in Module 2 as INQ000089720/158.

“There is an inherent inconsistency with arguing in saying that room ventilation is important while simultaneously arguing that airborne transmission does not occur”¹⁵⁴.

54. In November 2020, the UK Government published a video on ventilation in homes. As described by Rosemary Gallagher of the RCN, *“the video talked of infective particles remaining in the air for long periods...The UK IPC guidance and policy still did not support any mention of airborne transmission: there seemed to be conflicting and contradictory language and advice”¹⁵⁵.*
55. In 2022, IPC guidance sought to draw a confusing distinction between a virus spread ‘wholly or partly by the airborne route’ and one spread ‘wholly or partly by the airborne or droplet route’.
- This distinction inexplicably results in the requirement to consider a FFP respirator for use by staff for patients with diseases spread ‘wholly or partly by the airborne route’, but not for a disease spread ‘wholly or partly by the airborne or droplet route’¹⁵⁶.
 - As noted in the expert report of Professor Beggs, the language used *“is rather ambiguous and confusing, making implementation of the guidelines difficult, as the meaning of “spread wholly or partly” is not clear...there appears to be inconsistencies between the approach taken to these two “airborne” diseases [of measles and Covid-19]”¹⁵⁷.*
 - This distinction is neither scientifically or practically coherent as it effectively directs use of FFP3 for some unspecified airborne respiratory diseases but not for other airborne diseases and appears to be an attempt by the IPC cell to justify its position in relation to RPE and avoid accepting that they got it wrong.

The IPC cell’s reasons for failing to recommend FFP3 are flawed

56. A small number of witnesses have put forward theories about why the IPC cell failed, and continues to fail, to recommend FFP3s for staff working with Covid-19 patients. However, these theories are ‘after the event’ justifications and do not stand up to scrutiny. They will be seen by many healthcare staff as an attempt to retrospectively justify the risks to which staff (and subsequently patients) were unnecessarily exposed.
57. First, it has been claimed that it makes a difference whether Covid-19 is *predominantly* or *partly* transmitted via aerosol¹⁵⁸.
- It is the BMA’s firm belief that aerosol does not need to be the predominant route of transmission in order for staff to be protected by RPE. If aerosol is *even one* of the routes whereby a virus is transmitted, then this transmission needs to be mitigated through RPE.

¹⁵⁴ 11.09.2024/144:15-18.

¹⁵⁵ INQ000457580/64.

¹⁵⁶ INQ000300684/22.

¹⁵⁷ INQ000474276/84.

¹⁵⁸ 16.09.2024/89:16 - 16.09.2024/91:1 and 17.09.2024/53:5-7.

- b. Beyond the evidence of aerosol spread set out above, a scientific review was published by Greenhalgh et al. in May 2024 which, while primarily examining the evidence base of masks and other face coverings, analysed over 100 studies and found that *“there is strong and consistent evidence that [SARS-Cov-2 and other respiratory pathogens are] spread predominantly by the airborne route”*¹⁵⁹ .

58. Second, Dr Lisa Ritchie stated that it would require a conclusive statement about airborne transmission from international organisations such as the WHO before the IPC guidance would be changed to recommend routine use of FFP3s for healthcare workers caring for Covid-19 patients¹⁶⁰. However, as Professor Sir Chris Whitty explained, the WHO provides *“advice relevant to all countries simultaneously, with different epidemiology, population structure, healthcare system and purchasing power. Their advice therefore had to allow for local adaptation”*¹⁶¹. Statements from the WHO do not give countries the green light to only do the very minimum recommended by them. A number of witnesses confirmed the UK is not bound to follow WHO guidance, and that each country develops advice for its own circumstances¹⁶². Further, there is a danger of relying on one single body for conclusive statements. In any event, current WHO IPC guidance permits the use of a respirator when caring for suspected or confirmed Covid-19 patients¹⁶³.

59. Third, it has been claimed that there is limited real-life evidence, outside of laboratory studies, about the effectiveness of FFP3s¹⁶⁴.

- a. While in a non-pandemic situation decision-makers may have wished to have evidence from Randomised Control Trials (RCTs), this type of evidence, as acknowledged by Professor Sir Chris Whitty¹⁶⁵, is by its nature always going to be difficult to accrue in the intensity of a pandemic. Instead of refusing to act without RCT evidence, decision-makers should have taken a precautionary approach to protect lives.
- b. Moreover, there is clear evidence of FFP3 superiority. It has been the position of the HSE since at least 2008 that FFP3s offer the greatest protection from an airborne virus (with a 99% filter efficiency and an assigned protection factor of 20)¹⁶⁶. By recommending FRSMs, the IPC guidance is recommending something proven in laboratory studies to provide inadequate protection; it would be impossible for this protection to then improve in real-life scenarios.

¹⁵⁹ Greenhalgh et al. ‘Masks and respirators for prevention of respiratory infections: a state of the science review’, 22 May 2024. Available at: <https://doi.org/10.1128/cmr.00124-23>

¹⁶⁰ 16.09.2024/116:9-18.

¹⁶¹ INQ000410237/70.

¹⁶² 21.11.2024/19:23-24, 18.09.2024/63:6-12 and 26.09.2024/84:19-21.

¹⁶³ WHO ‘Infection prevention and control in the context of Covid-19: a guideline’, 21 December 2023 (page 16).

Available at: <https://iris.who.int/bitstream/handle/10665/375200/WHO-2019-nCoV-IPC-guideline-2023.4-eng.pdf>

¹⁶⁴ 18.09.2024/83:19 - 18.09.2024/84:25 and 26.09.2024/149:5-17.

¹⁶⁵ 26.09.2024/150:14-20.

¹⁶⁶ INQ000145893/12.

- c. The patterns of infections and deaths amongst healthcare staff can sadly be seen as real-life evidence in themselves. The expert report by Professor Summers and Dr Suntharalingam states that ICU staff were arguably safer than in other parts of the hospital due to recommended use of enhanced respiratory protection. They outline that when FFP3 respirators (as used in ICU from the outset) were introduced to non-critical care areas in one major hospital, ward-based infection fell to effectively zero¹⁶⁷. Similarly, the witness statement of Dr Daniele Bryden refers to an April 2020 study of 119 healthcare workers who died, of which none were intensivists or anaesthetists¹⁶⁸. Real-life evidence was also provided in a study in a hospital in Cambridge conducted by Ferris et al, which was published in November 2021¹⁶⁹, although the results were urgently made available in June 2021 given their significance.¹⁷⁰ This study found that staff using FRSMs while working on Covid-19 wards faced a 31-fold increased risk of infection, which significantly reduced when staff wore FFP3s.
 - d. Moreover, if decision-makers truly believed that FFP3 respirators do not provide protection against aerosols, then it is illogical for them to recommend FFP3s for staff performing AGPs.
60. Fourth, it has been suggested that the discomfort of FFP3 respirators is a justification for the failure to recommend their use¹⁷¹.
- a. It is important for healthcare workers to wear the most comfortable form of RPE available to them, which is measured via the fit testing process. As described by Professor Banfield of the BMA, there are a range of FFP3 respirators available, and it is up to the employer to ensure employees find the one that allows them to do their job across their shifts¹⁷².
 - b. PPE can be uncomfortable, but this is a secondary consideration to the need to protect from a deadly disease transmitted by everyday actions such as coughing, talking, and breathing. As described by Dr Barry Jones, *"it's not particularly pleasant, but the side effects quoted, apart from being uncomfortable, side effects like acne really aren't life threatening"*¹⁷³.
 - c. This justification is largely retrospective, and the IPC cell minutes do not show any evidence that this was a significant consideration. Indeed, discomfort is only mentioned on two occasions (on 07 February 2020 and 08 April 2020¹⁷⁴) out of all the IPC cell meetings.
61. Fifth, it has been suggested that FFP3 respirators lead to additional communication challenges¹⁷⁵.

¹⁶⁷ INQ000474255/81.

¹⁶⁸ INQ000389244/56.

¹⁶⁹ INQ000408843.

¹⁷⁰ Upgrading PPE for staff working on COVID-19 wards cut hospital-acquired infections dramatically. Available at: <https://www.cam.ac.uk/research/news/upgrading-ppe-for-staff-working-on-covid-19-wards-cut-hospital-acquired-infections-dramatically>

¹⁷¹ 18.09.2024/86:17-19, 18.09.2024/91:3-8 and 26.09.2024/141:2-11.

¹⁷² 28.10.2024/116:8-13.

¹⁷³ 12.09.2024/39:15-20.

¹⁷⁴ INQ000398199 and INQ000398166.

¹⁷⁵ 26.09.2024/141:12 - 26.09.2024/142:7.

- a. The use of any mask or respirator can cause difficulties for those who rely on lipreading for communication. It is important to mitigate such issues, for example by using masks and respirators with a clear panel through which the mouth is visible.
 - b. However, the same communication challenges are experienced whether a healthcare worker is wearing a FRSM or a FFP3, and, therefore, communication challenges cannot be a justification for failing to provide staff with the protection provided by FFP3 respirators.
62. Sixth, it has been claimed that staff non-compliance or the absence of training would negate the protection provided by FFP3s¹⁷⁶.
- a. There is some evidence that RPE still gives significant protection to people who have not been trained in using it. A 2018 study on the effectiveness of N95 masks found that even with no training on how to wear and fit respirators, a good level of protection was still achieved¹⁷⁷.
 - b. Any small incidents of wearing a FFP3 incorrectly would not have undermined the huge benefits of staff having access to FFP3s compared to FRSMs. Recommending something which does not provide adequate protection is not an acceptable alternative.
 - c. Further, if staff non-compliance or training were truly a concern, there are many ways in which these could be addressed without putting the lives of staff and patients at risk.
63. Seventh, it has been claimed that other elements in the hierarchy of controls are more important than PPE¹⁷⁸, and that PPE is not a silver bullet¹⁷⁹.
- a. The hierarchy of controls is important, with the most effective control being elimination of the hazard. However, in healthcare settings many elements in the hierarchy of controls cannot be properly applied, for example due to notoriously poor ventilation and estates that are inadequate for social distancing. As such, PPE is of paramount importance. As highlighted by Richard Brunt of the HSE, *“the hierarchy of controls cannot be applied while allowing a healthcare worker to carry out their job, so you fall back on PPE”*¹⁸⁰.
 - b. The importance of PPE is further strengthened by the fact that healthcare staff need to be in close contact with patients in order to provide care. As described by Dr Barry Jones of CATA, *“most healthcare occurs within 1 metre of a patient, because of course no health worker has an arm longer than 1 metre”*¹⁸¹. By claiming that other elements in the hierarchy of controls are more important than PPE, it puts an emphasis on managing the unmanageable¹⁸².

¹⁷⁶ 26.09.2024/78:1-4.

¹⁷⁷ The effectiveness of respiratory protection worn by communities to protect from volcanic ash inhalation. Part II: Total inward leakage tests. Available at: <https://doi.org/10.1016/j.ijheh.2018.03.011>

¹⁷⁸ 18.09.2024/83:3-11.

¹⁷⁹ 16.09.2024/125:8-9 and 16.09.2024/126:7-8.

¹⁸⁰ 12.09.2024/72:1-13.

¹⁸¹ 12.09.2024/45:17-19.

¹⁸² INQ000475580/39.

- c. In May 2021 the UK-wide senior clinical leaders group (consisting of the CMOs, CNOs, national medical directors and senior public health officials) confirmed that, if an unacceptable risk of transmission remains after the hierarchy of controls has been rigorously applied, for example if factors such as ventilation and overcrowding cannot be addressed, then it may be necessary to extend the use of RPE for patient care¹⁸³.

64. These arguments are attempts at ‘after the event’ justification and are simply a continuation of the IPC cell’s stubborn refusal to acknowledge the risks of aerosol transmission, to recognise that they got it wrong and to take appropriate remedial action in response.

There is a collective unwillingness to accept responsibility for the IPC guidance

65. The Inquiry has heard significant disagreement in relation to who was ultimately responsible for the IPC guidance. This includes:

- a. Witnesses such as Dr Lisa Ritchie, Dame Ruth May and Professor Sir Stephen Powis¹⁸⁴ stating that PHE, and later UKHSA, were the final decision makers. As described by Dr Lisa Ritchie, PHE *“could, as the lead organisation for infectious diseases in England, have trumped our [the IPC cell’s] decision”*¹⁸⁵.
- b. This contrasts to witnesses including Professor Dame Jenny Harries, Professor Sir Chris Whitty and Professor Susan Hopkins¹⁸⁶, who all claim that the IPC cell were ultimately responsible for the decisions taken. Professor Sir Chris Whitty stated that the ultimate responsibility for decision making regarding PPE and IPC guidance was unclear, with many people thinking they were partially responsible, but that, in his view, *“ultimately, the responsibility for decisions was taken by the IPC cell, which became clearer over time”*¹⁸⁷.

66. The oral evidence of Dr Lisa Ritchie confirmed that there was no formal way of reaching a consensus within the IPC cell, for example via voting. Instead, it would be up to the Chair to determine what the consensus was. According to Dr Ritchie’s evidence, if there was disagreement it would be escalated to the UK senior clinical leads in each of the four nations¹⁸⁸. However, the IPC cell minutes indicate that disagreements were not always escalated. For example, when PHE representatives raised concerns during IPC cell meetings on 22 and 23 December 2020, the conclusion drawn by Dr Ritchie at the end of the meeting did not reflect these concerns or any related escalation that would be taken¹⁸⁹.

67. Although a number of people had a role in the IPC guidance, their levels of knowledge, and therefore their ability to raise concerns, varied widely. Fiona McQueen, for example, had a role in

¹⁸³ INQ000412890/131.

¹⁸⁴ 16.09.2024/159:16-23, 17.09.2024/6:20-25, 17.09.2024/7:1 and INQ000412890/113.

¹⁸⁵ 16.09.2024/159:16-23.

¹⁸⁶ INQ000489907/29, 26.09.2024/80:20-21 and 18.09.2024/107:6-7.

¹⁸⁷ 26.09.2024/80:20-21.

¹⁸⁸ 16.09.2024/75:19 - 16.09.2024/78:1.

¹⁸⁹ INQ000398244 and INQ000130587.

approving the guidance, yet stated that she was a generalist rather than an IPC specialist and so relied on colleagues to advise her. Given this involvement, and her role as CNO for Scotland until February 2021, it is astonishing that she was at no time aware that aerosol transmission was taking place outside of AGPs that required action through the provision of FFP3¹⁹⁰.

68. Effective IPC guidance is lifesaving, and drastic improvements are needed to this process, including clarity of accountability and improvements to the culture surrounding it.

Staff still do not have access to adequate PPE

69. Importantly, Covid-19 is still circulating today and the IPC guidance in all four nations continues to recommend a FRSM for routine care of patients with Covid-19 outside of areas where AGPs are undertaken. This is despite:

- a. The Inquiry has heard evidence, including from Professor Beggs and Dr Warne, that daily actions such as breathing and coughing can produce more aerosols than so-called AGPs¹⁹¹. As described by Dr Warne, *“coughing is in itself probably an aerosol generating event”*¹⁹². The IPC guidance continues to place too much emphasis on the false dichotomy between AGPs and non-AGPs instead of providing staff with adequate protection.
- b. A number of the Inquiry’s experts, including Dr Suntharalingam¹⁹³ and Dr Warne¹⁹⁴ stated that IPC guidance should be updated to recommend FFP3 for all staff treating Covid-19 patients. The Greenhalgh et al. scientific review of over 100 studies, published in May 2024, reached the same conclusion, stating that RPE should be provided to all staff working directly with Covid-19 patients, not just those performing AGPs¹⁹⁵.
- c. The roundtable discussion on 07 January 2022 between the IPC cell, UKHSA, and others, which agreed that UKHSA would work with the IPC cell on messaging to ensure the IPC guidance is *“more ‘enabling’ of FFP3 use in appropriate settings”*¹⁹⁶.
- d. The prevalence of aerosols in daily actions such as breathing and talking, and the subsequent need for staff delivering close care to Covid-19 patients to have the highest grade of respiratory protection, was concluded in a UKHSA paper published in February 2022. This paper, which Professor Dame Jenny Harries confirmed during oral evidence that she had approved and shared with the IPC cell¹⁹⁷, states that *“There is an increasing evidence base of aerosol measurements during normal respiratory activities such as tidal breathing, breathing*

¹⁹⁰ 17.09.2024/181:4-16 and 17.09.2024/199:11 - 17.09.2024/200:3.

¹⁹¹ 11.09.2024/123:1-13 and 19.09.2024/51:13-16.

¹⁹² 19.09.2024/48:20-21.

¹⁹³ 09.10.2024/73:22-25.

¹⁹⁴ 19.09.2024/47:5-10.

¹⁹⁵ Greenhalgh et al. ‘Masks and respirators for prevention of respiratory infections: a state of the science review’, 22 May 2024. Available at: <https://doi.org/10.1128/cmr.00124-23>

¹⁹⁶ INQ000348432/2.

¹⁹⁷ 06.11.2024/179:2-21.

*during exercise, talking, shouting, and singing. Each of these activities generates measurable aerosol in a graded and proportionate way and importantly this physiological respiratory aerosol has been demonstrated to contain SARS-CoV-2 in patients with Covid-19*¹⁹⁸. Two of the conclusions in this paper are, firstly that *“in the absence of robust evidence, the precautionary principle should apply before potentially removing protection from staff and patients”*, and, secondly, *“that those delivering close care to patients with suspected or confirmed COVID-19 should be provided with the highest grade of respiratory protection”*¹⁹⁹.

- e. The statement made by Dr Soumya Swaminathan, the WHO’s chief scientist, who publicly stated upon retirement in November 2022 that her biggest regret was not acknowledging early in the pandemic that SARS-CoV-2 could be spread by aerosols²⁰⁰.
- f. The CMO’s technical report published in December 2022, which states that, *“As a respiratory virus SARS-CoV-2 carried the potential for transmission via droplets and aerosols”*, and that, *“it was important to retain an open mind as understanding evolved over the course of the pandemic. It was also important to ensure that absence of evidence was not interpreted as evidence of absence, and that important transmission routes to which there were potential countermeasures were not ignored”*²⁰¹.

70. Current guidance in Scotland and Wales states that *“Where staff have concerns, they may choose to wear an FFP3 respirator rather than a fluid resistant surgical mask (FRSM) when providing patient care, provided they are fit tested. This is a personal PPE risk assessment”*²⁰². This approach was supported by some witnesses during the Inquiry hearings²⁰³. However, it is the BMA’s firm belief that this approach is inadequate for the following reasons:

- a. The fundamental purpose of IPC guidance is to ensure staff are protected. As stated by Richard Brunt of the HSE, *“personal protective equipment has to protect, and anything that undermines that [then] you’re not satisfying your legal duty”*²⁰⁴. Having an opt-in approach does not *guarantee* that staff will be protected and leads to unacceptable local variation.
- b. An opt-in approach places the burden on the individual worker to raise concerns and ensure they have the necessary fit testing. Given evidence that some staff, including those from ethnic minority backgrounds and those with a disability or long-term health condition, feel less able to raise concerns, this position is likely to exacerbate existing staff inequalities.
- c. It cannot be expected for all staff to have enough knowledge of the transmission routes of every disease to make judgements about their own levels of risk. Many staff would not have

¹⁹⁸ INQ000348440/2.

¹⁹⁹ INQ000348440/4.

²⁰⁰ INQ000474276/46.

²⁰¹ INQ000087225/48.

²⁰² INQ000413473/6.

²⁰³ 18.09.2024/95:8-19 and 26.09.2024/144:2-22.

²⁰⁴ 12.09.2024/86:8-11.

sufficiently in-depth knowledge to know whether a higher level of PPE is needed and would therefore most likely follow the PPE recommended in the guidance. This can be seen in Professor Sir Chris Whitty stating that he would likely just use the PPE recommended in the guidance²⁰⁵, as well as Fiona McQueen stating that she relied on advice from others²⁰⁶.

The BMA specifically proposes for the Inquiry to recommend that decision-makers:

- Require that planning for, and actions in, future pandemics or health emergencies take a precautionary approach to ensure maximum protection for healthcare staff and patients, with relevant IPC guidance updated where new evidence becomes available. To rebuild trust and confidence, guidance needs to be explicit about the nature of the risks faced by staff.
- Significantly improve NHS estates, starting with a transparent and independently audited national review of the condition of primary and secondary care estates and urgent funding to make improvements. This includes ensuring there is adequate ventilation, space is improved, and the digital infrastructure is in place to support remote care where appropriate or necessary.

C. There was significant harm to both staff and patients, with some groups disproportionately affected

Impacts on staff physical and mental health

71. As well as the tragic deaths of over 800 healthcare workers in England and Wales alone²⁰⁷ (see above), healthcare staff suffered significant physical and mental health impacts.

72. Many staff continue to be severely impacted by Long Covid, leaving them unable to work, train and undertake day-to-day activities.

- a. The latest ONS data (March 2023) estimated that over 1.8m people in the UK were experiencing Long Covid, and that the prevalence is around 50% higher in those working in healthcare²⁰⁸. However, there is an absence of robust and current data on the prevalence of Long Covid, including along the lines of occupation and demographic characteristics such as ethnicity²⁰⁹.
- b. In a BMA survey of doctors with Long Covid, over half of respondents said that carrying out daily activities has become difficult or not possible, while nearly 1 in 5 said they were left

²⁰⁵ 26.09.2024/145:1-6.

²⁰⁶ 17.09.2024/181:4-16.

²⁰⁷ ONS - Deaths involving coronavirus (COVID-19) among health and social care workers (those aged 20 to 64 years), England and Wales, deaths registered, 9 March 2020 to 28 February 2022. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14379deaths-involvingcoronaviruscovid19amonghealthandsocialcareworkersthoseaged20to64yearsenglandandwalesdeathsregistered9march2020to28february2022>

²⁰⁸ ONS - 'Prevalence of ongoing symptoms following coronavirus (Covid-19) infection in the UK' (30 March 2023).

Tables 1 and 4. Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/alldatarelatingtoprevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk>

²⁰⁹ 08.10.2024/14:7-17.

unable to work²¹⁰. The ongoing consequences were described by one doctor, as follows *“my second Covid infection has left me with damage to my spinal cord. I now walk with crutches and cannot walk more than about 200m without them. I also have bladder and bowel problems and have to intermittently catheterise. There is not a day that goes by where I don’t have some form of pain”*. This echoes the testimony of other witnesses to the Inquiry who developed Long Covid after working with Covid-19 patients without the necessary RPE, such as Nicola Ritchie of Long Covid Physio²¹¹.

- c. As described by Professor Sir Chris Whitty, increased rates of infection led to increased rates of Long Covid, irrespective of anything else²¹². If healthcare staff had been better protected, the number of staff currently suffering from Long Covid would be far lower.

73. In addition to these severe impacts on physical health, powerful testimony from witnesses highlighted just how traumatic the last few years have been for staff. The severe and ongoing impacts on staff mental health cannot be underestimated. As described by Professor Sir Chris Whitty, *“the pressure on individual clinicians was immense, combining exceptionally long hours, fear for themselves or, more commonly, their families, and the psychological distress of treating so many very sick patients. Despite that the professions responded, day after day”*²¹³.

74. Evidence received by the Inquiry includes:

- a. The powerful testimony of Professor Fong, who told of healthcare workers who described themselves as *“worse than broken”* by the trauma they had experienced, including having to admit colleagues with Covid-19. Professor Fong described a member of staff telling him that it felt like *“a terrorist attack since this started and we don’t know when the attacks are going to stop”*. He also described staff in one hospital who *“were so overwhelmed that they were putting patients in body bags, lifting them from the bed, putting them on the floor, putting another patient in their bed straightaway because there wasn’t time”*²¹⁴.
- b. Because they were inadequately protected, staff feared for their lives and readied themselves for possible death, for example by taking out additional life insurance or updating their wills²¹⁵.
- c. Staff were terrified about passing infections to family members and went to extreme lengths to avoid this, including sleeping in the boot of a car for three months, immediately changing clothes in hallways, and living in temporary accommodation²¹⁶. Staff still struggle now to live with the elements of risk that they exposed family members to during the pandemic²¹⁷.

²¹⁰ INQ000477304/108.

²¹¹ 29.10.2024/60:4 - 29.10.2024/61:9.

²¹² 26.09.2024/104:5-10.

²¹³ INQ000410237/94.

²¹⁴ 26.09.2024/40:12-13, 26.09.2024/7:16-17 and 26.09.2024/22:3-7.

²¹⁵ INQ000477304/91.

²¹⁶ 26.09.2024/38:9-11, 01.10.2024/27:14-18, 01.10.2024/122/7-15 and INQ000399526/5.

²¹⁷ 01.10.2024/27:8-25.

- d. Staff were also far more exposed to death and critical illness than they had ever been before. Redeployed staff, not usually exposed to patients deteriorating and dying, were suddenly required to provide care for large numbers of critically ill people with significant numbers of patient deaths²¹⁸. Some staff supported those at the end of life whilst mourning themselves²¹⁹.
 - e. Redeployed staff working in new clinical environments worried about making mistakes, and being held liable for decisions made in extremely difficult circumstances. In their expert report, Professor Summers and Dr Suntharalingam acknowledged that *“significant harm”* was associated with working under such conditions, *“both to redeployed staff and those tasked with supervising and taking responsibility for them”*²²⁰.
 - f. The trauma of trying to ensure that no one died alone, acting as a *“bridge of comfort”* between families and their loved ones when families were not allowed to be present²²¹.
 - g. The unprecedented number of hospitals operating at CRITCON Level 3 during the pandemic²²². Professor Summers and Dr Suntharalingam emphasised that Level 3 *“wasn’t okay”* and that, as a result, they do not know a single ICU clinician *“who does not carry the scars of the last five years”*²²³. Moreover, the Inquiry heard that up to nine ICUs declared CRITCON Level 4²²⁴, the level defined as ‘emergency’, with ‘resources overwhelmed’²²⁵.
 - h. The moral injury suffered by staff when they were not able to deliver the care they wished. This includes not being able to give patients the right care at the right time, not being able to provide safe care and, as described by Professor Fong, not being able to pay sufficient attention to detail when delivering care²²⁶. Concerns were so severe that they were raised with the General Medical Council and the Nursing and Midwifery Council²²⁷, among others.
 - i. The loss of dignity for staff who, as described by Professor Fong, had to resort to wearing *“adult diapers because there was literally no one to give them a toilet break and take over their nursing duties”*²²⁸.
75. Distress to staff was also caused by the lack of centrally agreed guidance on decision-making in the event that demand outstripped already limited resources. This is something the BMA and other medical organisations called on the UK Government to provide, in light of the very real fears

²¹⁸ 02.10.2024/57:3 - 02.10.2024/58:20.

²¹⁹ INQ000412890/183.

²²⁰ INQ000474255/83.

²²¹ INQ000412890/183.

²²² INQ000226890/27.

²²³ 09.10.2024/72:17-18 and 09.10.2024/71:3-10.

²²⁴ INQ000497473/4.

²²⁵ INQ000409921/1.

²²⁶ 26.09.2024/20:13 - 26.09.2024/21:2 and INQ000477304/150.

²²⁷ 30.09.2024/166:21-25.

²²⁸ 26.09.2024/27:5-7.

amongst decision-makers and healthcare workers that services would be overwhelmed, and demand might outstrip supply²²⁹.

76. In circumstances of extreme uncertainty, the lack of guidance created anxiety amongst staff who feared that they would be called upon to make ethically and legally challenging decisions without a framework to guide them. Had workable central guidance been available, this would have gone a considerable way to addressing staff concerns, ensuring consistency across the country, managing moral distress and helping to build confidence among the profession during a time of unprecedented challenge. Other organisations felt similarly, for example Dr Bryden from the Faculty of Intensive Care Medicine stressed the importance of a central organisation taking ownership and leadership of this matter²³⁰.
77. To be clear, the BMA was not calling for a tool or algorithm which overrode clinical judgement. Instead, the BMA wanted the UK Government to publish a nationally agreed ethical framework to inform clinical judgement and to support staff to make decisions about how to allocate resources when there were not enough for everyone. A clear example of this would be a situation where there were two patients with potential to benefit from a ventilator but only one ventilator was available. In those circumstances, there may be ethical principles such as the ability to benefit most quickly, which might help clinicians reach a decision. Even if this extreme situation was not reached, it was certainly a possibility many clinicians were acutely aware of and were understandably seeking clarity on how to make such decisions, should the need arise. As described by Dr Catherine McDonnell, the Medical Director of Western Health and Social Care Trust in Northern Ireland, *“clinicians worked in a pervasive climate of fear of scarcity...should a decision be influenced by a need to ration, the decision makers needed additional support”*²³¹.
78. Some witnesses advised against the development of such guidance in the middle of a pandemic. Professor Sir Stephen Powis, for example, suggested this was better left to *“normal times”*, where there is space to consult with others and take in a broader set of views²³². The BMA agrees that this would ideally be the case. However, staff were in the midst of an emergency and could not afford to wait; if such situations arose, staff would have no option but to make a decision.
79. As a result of the UK Government’s decision not to issue an ethical framework, a number of organisations, including the BMA, issued their own guidance for the profession²³³. However, having multiple sets of guidance, instead of a central source, created the risk of different interpretations and a lack of clarity for staff. Ahead of the next pandemic, the BMA is calling for the development of comprehensive guidelines that encompass both practical and ethical considerations. The provision

²²⁹ INQ000477304/58-59.

²³⁰ 08.10.2024/153:4 - 08.10.2024/154:4.

²³¹ INQ000477593/40.

²³² 07.11.2024/91:6-21.

²³³ INQ000477304/60.

of such guidance would support staff with ethical decision-making, mitigate moral distress, ensure equitable care delivery and give staff more protection than guidance from professional bodies.

80. It is clear that the traumas experienced by staff continued throughout the pandemic and are still ongoing today. As described by FEMHO, the pandemic has left *“scars of depression, stress, which are written on them for a very long time”*²³⁴. For example:
- a. As described by witnesses such as Professor Sir Chris Whitty and Professor Fong, the second wave was particularly harrowing and in some ways was even harder for staff due to an increase in infections and a reduction in public support²³⁵.
 - b. The Inquiry’s intensive care experts reported data from late 2020 that 50% of ICU staff met or exceeded the criteria for a mental health disorder²³⁶. In Professor Fong’s January 2021 survey of more than 6,000 respondents working in ICUs in England, almost half reported symptoms consistent with severe depression (52%), severe anxiety (44%) and probably post-traumatic stress disorder (47%). Moreover, throughout the winter of 2020/2021, between 12-15% of respondents expressed suicidal ideation or thoughts of self-harm²³⁷.
 - c. The legacy of the pandemic means that staff have been working continuously, pushing more and more without a break while trying to reduce historic waiting lists; they are exhausted.
81. This points to a mental health crisis within the NHS workforce that is continuing. Over three in four NHS staff are currently struggling with their mental health and two in three report that morale is the lowest they have ever experienced²³⁸. This chimes with the oral evidence of Dr Tilna Tilakkumar, who shared that working in general practice post-pandemic has resulted in burnout, two episodes of depression and a general lack of job satisfaction²³⁹. Staff absence rates remain persistently high due to mental health problems, burnout, stress and a range of other conditions related to the pandemic²⁴⁰. As noted by Professor Sir Stephen Powis, the 2022 NHS staff survey indicated that over a third of staff often or always felt burnt-out because of their work²⁴¹. Data from NHS England showed that over a quarter of all staff sickness days in 2023 were due to stress-related illnesses²⁴².
82. Health bodies must take more of a leadership role to improve NHS culture and working environments, hold employers to account when they do not maintain standards or provide adequate

²³⁴ 08.10.2024/54:22-24.

²³⁵ 26.09.2024/58:11-18 and 26.09.2024/18:9-17.

²³⁶ INQ000474255/55.

²³⁷ INQ000474327/23.

²³⁸ NHS Charities Together – ‘Three in four NHS staff struggled with their mental health in the past year’, 17 April 2024). Available at: <https://nhscharitiestogether.co.uk/three-in-four-nhs-staff-struggled-with-their-mental-health-in-the-past-year/>

²³⁹ 01.10.2024/127:7-17.

²⁴⁰ 19.09.2024/155:6-15.

²⁴¹ INQ000485652/545.

²⁴² The British Psychological Society – ‘Investment in NHS staff mental health services urgently needed, says BPS’, 26 April 2024. Available at: <https://www.bps.org.uk/news/investment-nhs-staff-mental-health-services-urgently-needed-says-bps>

health and wellbeing support for their employees, and take steps to ensure support services are available and fully resourced to meet the needs of the workforce. Simply delegating these responsibilities to individual providers only guarantees unequal treatment of staff.

83. Those working in general practice came under mounting pressure.

- a. GPs faced increased demand and rising workloads, including as a result of care backlogs and a transfer of some of the secondary care workload to general practice. Alongside this, GPs juggled additional responsibilities such as reviewing shielding lists²⁴³ and delivering Covid-19 vaccinations.
- b. The pandemic saw a rapid shift to remote appointments which, as highlighted by Professor Sir Stephen Powis, was introduced as a directive from Governments in all four nations²⁴⁴ to reduce the spread of infection and maximise a limited workforce by enabling isolating staff to work remotely if well enough²⁴⁵. Healthcare staff, particularly those in primary care, experienced an increase in abuse from frustrated patients during later months of the pandemic as they sought to keep their patients and themselves safe; a BMA survey in July 2021 found that half of GP respondents reported receiving verbal abuse in the past month²⁴⁶.

84. The Inquiry has received evidence which clearly demonstrates that the experiences of healthcare staff were far from equal. It is essential for the Inquiry to make clear recommendations to address these disparities. Fundamental change is needed to the culture of the NHS because, as stated by FEMHO, *“we should not have to accept that there is always a baseline disproportionate impact”*²⁴⁷. Differences related to a number of issues and occurred along lines of occupational and demographic characteristics. This includes:

- a. Staff from ethnic minority backgrounds experienced disparities in relation to a range of factors including deaths during the first wave; rates of infection; deployment to high-risk areas; PPE shortages; pressure to work in environments without sufficient PPE; and risk assessments they felt had been ineffective²⁴⁸.
- b. Migrant and outsourced workers were disproportionately forced to work without adequate PPE and were more likely to be allocated to higher risk working environments²⁴⁹.
- c. As outlined in paragraph 34c, the gender bias within PPE design meant that female staff often struggled with poorly fitting PPE that left them exposed, while BMA surveys showed that

²⁴³ INQ000485652/551.

²⁴⁴ See for example INQ000000039.

²⁴⁵ INQ000485652/90 and INQ000477304/181.

²⁴⁶ INQ000477304/112.

²⁴⁷ 09.09.2024/187:1-3.

²⁴⁸ INQ000251650, INQ000315604/6, INQ000399526/14-15, INQ000477304/90, INQ000477304/134 and INQ000477304/137.

²⁴⁹ INQ000477577/7.

female respondents more commonly reported a decline in good mental health and reported higher levels of stress and burnout²⁵⁰.

- d. Staff with a disability or long-term health condition (LTC) more commonly felt unprotected during the first wave compared to their peers without a disability or LTC²⁵¹. They also lacked access to adequate, well-fitting PPE (e.g. clear masks to enable deaf staff to lipread) and were more likely to report worsening mental health²⁵².

85. Moreover, many of those who experienced inequality felt less able to speak up and voice their concerns, including staff from ethnic minority backgrounds, staff with a disability or long-term health condition, migrant staff and outsourced workers²⁵³. It is important that *all* staff feel able to express concerns as this fosters a culture of openness and transparency, which is essential to patient safety. Not only does this support staff wellbeing, it ensures that any risks to patient care are promptly managed, leading to improved care quality.

Impacts on patients

86. The rapid shift to remote appointments was a significant change for patients as well as staff. For some patients it was a difficult adjustment causing uncertainty, fear and frustration. This was compounded by unclear messaging from the UK Government about why the guidance on remote care needed to remain in place during later months of the pandemic²⁵⁴.

- a. As noted by NHS England, *“the offer of a digital appointment is attractive to a lot of people wanting to see a GP, and creates additional capacity for general practices”*²⁵⁵. However, they do not work well for everyone, including those who are digitally excluded, who have lower levels of education or who lack the space to take a private call²⁵⁶. As referred to by Professor Edwards, GPs continued to provide face-to-face appointments when clinically necessary, and maintained a focus on older patients, shielding patients and those with poor mental health²⁵⁷.
- b. In order to minimise the impact of a future pandemic, improvements need to be made to the digital infrastructure across the UK’s health systems.

87. Ageing estates meant that infection control measures could not always be fully implemented, particularly in relation to ventilation and the ability to provide socially distanced care.

- a. Witnesses described the difficulties of working in unsuitable spaces, with large open bays, an inability to distance between beds, a lack of side room capacity to isolate patients, and

²⁵⁰ INQ000477304/93 and INQ000477304/177.

²⁵¹ INQ000477304/6.

²⁵² INQ000477304/143 and INQ000477304/93.

²⁵³ INQ000477304/138 and INQ000477577/8.

²⁵⁴ INQ000477304/112.

²⁵⁵ INQ000485652/147.

²⁵⁶ INQ000474283/41.

²⁵⁷ INQ000474283/36.

windows that were painted shut²⁵⁸. As described by Professor Beggs, many older wards fail to achieve the recommended number of air changes per hour²⁵⁹. Dr Warne concluded that these factors contributed to patients acquiring infections within hospitals²⁶⁰. Michael McBride stated that there is “*no doubt*” that the fabric of hospital estates increased the risk of nosocomial infections²⁶¹. Over 9,000 deaths are attributable to nosocomial infection in England alone²⁶², and the Inquiry has heard stories from those whose loved ones were admitted to hospital in circumstances unconnected to Covid-19, only to become infected and tragically die.

- b. Primary care estates faced similar challenges in separating Covid and non-Covid patients within their buildings, particularly for the practices whose buildings are not purpose-built health centres²⁶³.

88. Evidence heard by the Inquiry demonstrated that the lack of capacity in the UK’s health systems undeniably impacted the quality of patient care. As described by Professor Summers, “*What we had, we had, and we had to stretch further and further to provide. So of course that impacted on the care that could be provided*”²⁶⁴.

89. The lack of capacity within hospitals meant that, at the outset of the pandemic, Government guidance directed hospitals to urgently discharge all patients who were medically fit to leave. A lack of testing capacity at the time resulted in the widespread discharge of many hospital patients into care homes and the community without being tested. Many of these patients were discharged into care homes, where other residents were more at risk of severe outcomes from infection with the virus. This policy, alongside challenges care homes faced accessing PPE at the onset of the pandemic, likely played a major part in increased deaths in care home settings²⁶⁵.

90. Lack of capacity was the sole reason that large amounts of non-Covid care had to be paused.

- a. At the start of the pandemic many elective procedures, diagnostic tests and routine outpatient services were suspended, and staff were redeployed to help with critical and emergency care²⁶⁶. Professor Kathryn Rowan estimated that across the pandemic there was about 9-12 months of cancelled elective work²⁶⁷. As a result, waiting times rose sharply, as did pressure on General Practice holding this additional demand.
- b. Delays in elective care and screening appointments had consequences for patients receiving care later than they otherwise would have, with significant impacts on their quality of life. The

²⁵⁸ INQ000409250/70, INQ000280647/22, 19.09.2024/159:23 - 19.09.2024/160:5 and 08.10.2024/106:23 - 08.10.2024/107:3.

²⁵⁹ 11.09.2024/154:8-25.

²⁶⁰ 19.09.2024/157:24 - 19.09.2024/160:5.

²⁶¹ 24.09.2024/167:10-14.

²⁶² 21.11.2024/132:12-22.

²⁶³ 23.09.2024/191:1 - 23.09.2024/193:4.

²⁶⁴ 02.10.2024/59:23-25.

²⁶⁵ IN0000477304/165.

²⁶⁶ INQ000473872/2 and INQ000477304/5.

²⁶⁷ 01.10.2024/145:21-25.

Inquiry's experts, Professor Metcalfe and Chloe Scott, found that the suspension and delayed restarting of elective hip replacement surgery led to *"a silent, unseen group of people suffering with severe pain and disability, and much reduced quality of life"*²⁶⁸. Similarly, the expert report of Professor Bhangu and Dr Nepogodiev found a reduction in the number of patients diagnosed with bowel cancer during the first wave of the pandemic, and a parallel small increase in the proportion of patients with advanced bowel cancer²⁶⁹.

- c. In primary care increased demand meant that GPs had to focus on providing acute care for those who needed immediate help and had less capacity to undertake follow-up work for patients with long-term conditions²⁷⁰.

91. Staff shortages meant that staffing ratios had to be stretched to unsafe levels.

- a. The Inquiry has heard ample evidence about the importance of 1:1 staffing ratios in ICU, including for example from Professor Summers and Dr Suntharalingam who were clear that when ICU ratios are stretched, there are inevitably consequences for patient care²⁷¹.
- b. Yet during the pandemic ICU ratios were stretched further, seeming to reach 1:4 as a regular occurrence and on occasion reaching 1:6²⁷². These extreme staff shortages can be seen in Professor Charlotte McArdle reaching the desperate point in October 2020 of asking the CNOs in England, Wales, Scotland and the Republic of Ireland if they could provide Northern Ireland with extra staff, but nobody was able to help²⁷³. Similarly, Professor Summers and Dr Suntharalingam outlined how a consultant in ICU would usually care for 12 patients, but that in January 2021 this jumped to as many as 33²⁷⁴.
- c. Dame Ruth May acknowledged these decisions about staff ratios would not have been needed if there had been fewer staff shortages before the pandemic²⁷⁵.
- d. Diluted staff ratios impacted on the care that patients received and also impacted on healthcare staff²⁷⁶. As described by Professor Fong, critical care is all about detail; without the correct staffing ratios staff cannot give patients the level of detailed care that they need and are instead *"putting out fires"*²⁷⁷.

92. Lack of capacity affected the quality of patient care in numerous other ways. For example:

²⁶⁸ INQ000474262/8.

²⁶⁹ INQ000474244/22 and INQ000474244/42.

²⁷⁰ 23.09.2024/153:22 - 23.09.2024/154:4.

²⁷¹ 02.10.2024/59:8-25.

²⁷² 17.09.2024/43:47, 26.09.2024/9:4-7 and 02.10.2024/63:22 - 02.10.2024/64:1.

²⁷³ 18.09.2024/45:23 - 18.09.2024/46:5.

²⁷⁴ INQ000474255/60.

²⁷⁵ 17.09.2024/20:3-10.

²⁷⁶ 17.09.2024/43:9 - 17.09.2024/44:15.

²⁷⁷ 26.09.2024/10:2.

- a. Research commissioned by the Inquiry found that during the first and second waves over half of respondents reported that some patients could not be escalated to the next level of care due to a lack of resources, most commonly due to a lack of beds²⁷⁸.
 - b. There was a large increase in the number of transfers between critical care units for capacity reasons. Although Matt Hancock described there being *“some individual hospitals where intensive care capacity was exceeded, and patients needed to be transferred elsewhere”*²⁷⁹, the Inquiry heard evidence that transfers increased up to fourfold during the first two waves²⁸⁰. While a transfer can be done safely, it comes with the risk of moving a critically ill patient, it takes additional resources and staff capacity and is distressing for the patient and their family for them to be moved sometimes hundreds of miles away²⁸¹.
 - c. Patients also experienced *“absolutely horrific”* difficulties accessing an ambulance²⁸². As described by Tracy Nicholls of the Royal College of Paramedics, ambulance delays worsened significantly. Vehicles were tied up at emergency departments which meant that crews coming onto a shift did not have an ambulance to use²⁸³.
 - d. The Inquiry heard evidence that the type and quality of care available to patients was in some cases severely limited. This includes staff shortages limiting the birthing options available to pregnant people²⁸⁴ and causing delays in patients being assessed after alerting a midwife to a problem during/after labour, in patients receiving pain relief during labour, and in staff noticing or acting on signs that a patient had (or might have had) a serious health problem²⁸⁵.
 - e. Redeployment also affected the quality of patient care by placing strain on the staff left behind. Matt Stringer, for example, told the Inquiry that the redeployment of specialist learning disability staff into other specialties led to reduced care for people with disabilities²⁸⁶. As noted by Professor Summers and Dr Suntharalingham, redeployed staff brought in to assist with critical care had a different skill mix to those familiar with working in ICU²⁸⁷.
93. There is no doubt that the pandemic has exacerbated existing inequalities within the wider population as well as created new ones. This can be seen in the disproportionate death rates of people from ethnic minority backgrounds; those with a disability or serious mental health illness;

²⁷⁸ INQ000499523/15.

²⁷⁹ INQ000421858/19.

²⁸⁰ 01.10.2024:151:16-21.

²⁸¹ 02.10.2024/80:16 - 02.10.2024/82:9.

²⁸² 23.09.2024/73:24.

²⁸³ 23.09.2024:74:2-12.

²⁸⁴ 17.09.2024/65:11-24.

²⁸⁵ INQ000408656/25.

²⁸⁶ 10.10.2024/100:6 - 10.10.2024/101:23.

²⁸⁷ 02.10.2024/61:16-21.

those in more deprived areas; those categorised as CEV and those living in care homes²⁸⁸. It can also be seen in the slow speed at which barriers such as language, cultural sensitivity, visual impairment and hearing loss were recognised by decision-makers²⁸⁹. Some of those categorised as CEV continue to shield today, and feel unsafe accessing work, healthcare and leisure activities²⁹⁰.

94. As highlighted by Professor Edwards, pandemic planning needs to examine what the experience would be like for a variety of patient groups, including older people, ethnic minorities, those who are digitally excluded, people with lower educational attainment and people with disabilities²⁹¹.

95. As highlighted in the expert report of Professors Bambra and Marmot, health inequalities are caused by the everyday conditions in which we grow, live, work and age²⁹². For the UK to stand a chance in a future pandemic, it is vital that action is taken now to reduce inequalities and address the social determinants of health.

The BMA specifically proposes for the Inquiry to recommend that decision-makers:

- Ensure that consistent and sustainable occupational and psychological support is available to all staff in order to improve their health now and in the future. Adequate mental health services need to be in place for staff in a future pandemic. Strong direction and leadership from the top is required to address this.
- Improve Long Covid support services to ensure they take a multi-disciplinary approach with less geographical variation. Properly support those suffering from Long Covid to return to work where possible, and support those who cannot by providing financial compensation. The UK needs to collect ongoing data on the prevalence of Long Covid, including patterns relating to protected characteristics and occupation.
- Implement the recommendation from the 2022 Industrial Injuries Advisory Council Command Paper for the 'prescription' of five serious post Covid complications as an occupational disease for health and social care workers.
- Address the culture of the NHS to ensure working experiences are less variable by background or protected characteristic, and all feel able to speak out and raise concerns.
- Ensure healthcare systems can quickly identify at-risk groups in a future pandemic/health emergency, with data systems that record sufficient information to allow targeted communications and interventions.
- Ensure that pandemic planning factors in the risk of future novel infectious diseases having long-term impacts beyond the initial infection and take swift action to identify and mitigate this.

²⁸⁸ INQ000410237/46-49, INQ000485652/34, INQ000185357/17 and a report from the Health Foundation, 'Assessing the impact of COVID-19 on the clinically extremely vulnerable population', available at: <https://www.health.org.uk/publications/reports/assessing-the-impact-of-covid-19-on-the-clinically-extremely-vulnerable-population>

²⁸⁹ 26.09.2024/166:17 - 26.09.2024/167:18, 08.10.2024/4:8-25, 08.10.2024/46:5 - 08.10.2024/47:19, 10.10.2024/88:1 - 10.10.2024/90:2.

²⁹⁰ 28.10.2024/159:22 - 28.10.2024/160:9.

²⁹¹ 23.09.2024/38:16-25.

²⁹² Published by the Inquiry in Module 2 as INQ000195843/29.

Conclusion

96. As this statement makes demonstrably clear, there is a continued lack of capacity across all healthcare settings to cope with day-to-day care, let alone a pandemic or other health emergency. As we approach the five-year anniversary of the start of the pandemic, this stark reality cannot be emphasised strongly enough. Not only have many of the pre-existing issues that put healthcare systems on the back foot in 2020 still not been addressed, but staff, patients and systems continue to experience the ongoing consequences of the Covid-19 pandemic. To cope with a future emergency, healthcare systems first need to have adequate capacity for day-to-day care; staff need to recover from the trauma they have experienced; and systems must be put in place to better protect staff and patients. As already identified by the Inquiry in its Module 1 report, *“there must be radical reform. Never again can a disease be allowed to lead to so many deaths and so much suffering”*²⁹³.
97. In accordance with the Terms of Reference, the Inquiry is required to examine the initial capacity of the healthcare sector, the ability to increase this capacity, and the sector’s resilience, identifying lessons learned in this respect to inform preparations for future pandemics across the UK²⁹⁴. In discharging this obligation, the BMA urges the Inquiry to reflect the overwhelming evidence of acute staff, bed, and equipment shortages, as well as the inadequate physical and digital infrastructure within the NHS, and to once again call for radical reform and improvement. This is central to pandemic preparedness, and therefore firmly in scope, and the BMA respectfully submits that this must be the foundation on which the Inquiry’s other recommendations rest. Without bold recommendations, the traumatic and devastating experiences of the pandemic are destined to be repeated.

20 December 2024

²⁹³ UK Covid-19 Inquiry Module 1 report ‘The resilience and preparedness of the United Kingdom’, p. ix.

²⁹⁴ Covid-19 Inquiry Terms of Reference – paragraph 1b(i), and paragraph 2.