UK COVID-19 PUBLIC INQUIRY

Sixth Witness Statement of Professor Philip Banfield

I, Professor Philip Banfield, of the British Medical Association (the BMA or the Association), will say as follows:

1. I am chair of the BMA's UK council, chair of the BMA's board of directors and a member of the chief officer team of the BMA. I am a Consultant Obstetrician and Gynaecologist based in North Wales and I am honorary professor in the Cardiff University School of Medicine. Before being appointed as chair of council, I spent several years as a representative of BMA Cymru Wales, as chair of both Welsh council and the Welsh consultants committee. I have sat on the UK council since 2012.

2. I provide this statement in response to a request for evidence made on 28 June 2024 by the UK Covid-19 Public Inquiry (the Inquiry) under Rule 9 of the Inquiry Rules 2006 in connection with Module 5 of the Inquiry.

3. The headings used in this statement reflect the topics and questions set out in the Inquiry's Rule 9 request.

4. I took on the role of chair of council of the BMA in July 2022, after the period identified by the Inquiry as having particular relevance to the Rule 9 request (namely, 01 January 2020 to 28 June 2022). In providing this corporate statement to the Inquiry, I have therefore sought input and assistance from colleagues in BMA Northern Ireland, BMA Scotland and BMA Cymru Wales, as well as from relevant policy, communications and operational UK teams across the Association. The information contained within this statement is true to the best of my knowledge and belief.

Contents

A. The British Medical Association's role, function and responsibilities

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

Senior elected leadership

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

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

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

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

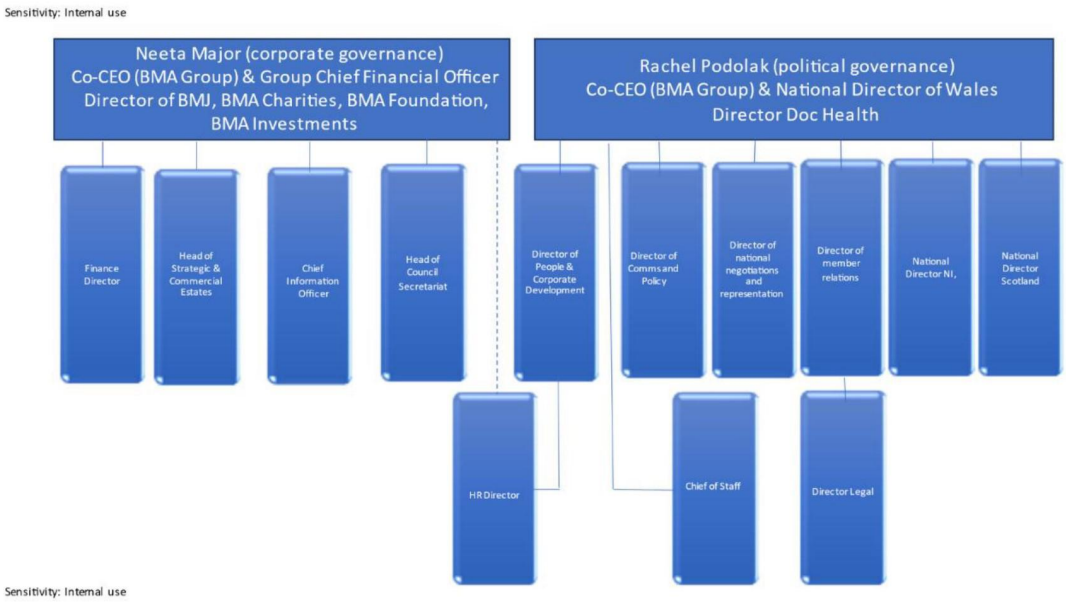
    c. The treasurer is responsible for the good stewardship of the Association's financial and property assets, and chairs key governance committees including the finance committee. The treasurer is a member of the BMA council and is deputy chair of the BMA board.

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

non-voting member on all committees, including the UK council (with the exception of the organisation committee).

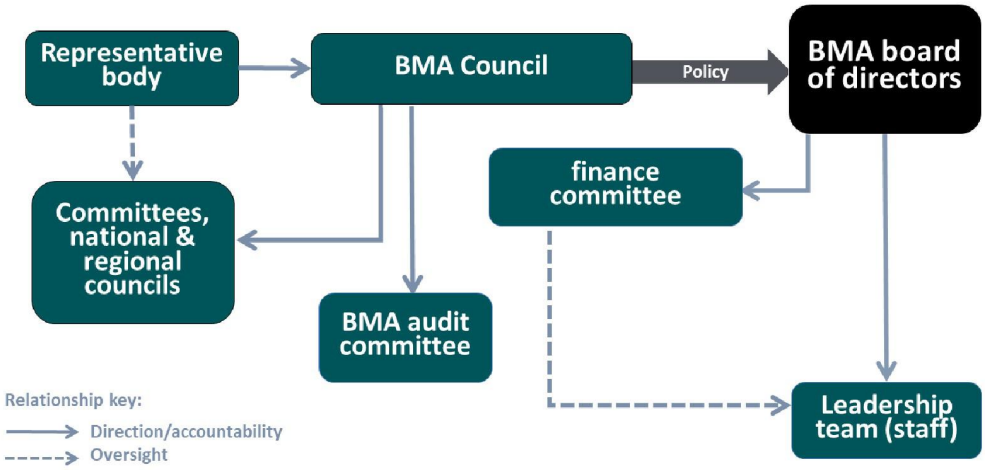
Senior staff leadership team

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



Governance

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



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

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

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

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

i. the council chair (chair of the board);

ii. the representative body chair;

iii. the treasurer (deputy chair of the board);

iv. the deputy chair of council;

v. three medical persons as may be elected and/or replaced by council from time to time;

vi. the chief executive officer(s);

vii. the group chief finance officer;

viii. one lay (non-medical) person experienced in business and commerce to be elected and/or replaced by council from time to time;

ix. the BMJ chair.

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

d. **Branch of practice committees:** Reporting to the UK council, there are 12 UK branch of practice committees that represent doctors in different areas of medical practice, for example, GPs, consultants, junior doctors and public health. Branch of practice committees have delegated authority to negotiate terms and conditions of service.

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

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

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

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

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

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

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

The BMA's role, function and aims

14. As a trade union, the BMA is formally recognised for collective bargaining purposes at a UK, national and local level. It represents, supports and negotiates on behalf of all doctors and medical students in the UK and has a membership of just over 194,000 (over half of practising doctors).

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

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

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

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

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

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

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

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

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

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

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

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

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

BMA Northern Ireland, BMA Scotland and BMA Cymru Wales

18. In each devolved nation, a national director leads a team of staff who work closely with their national chair of council, branch of practice chairs and committees in delivering the policies and priorities of the membership in that nation, as well as delivering employment support and advice for members working around the UK.

19. On an operational level, the national directors of each nation sit on the BMA's senior staff leadership team (see paragraph 9 above).

20. The BMA's Northern Ireland, Scottish and Welsh councils have full delegated authority to consider matters of specific relevance to the medical profession and healthcare in their nations. They determine policy and action where the application is exclusive to that nation (see above).

21. The chair of each national council provides political leadership for the BMA in their respective nation and is a focal point for engagement with the devolved government in that nation and associated organisations and agencies.

22. National branch of practice committees in the devolved nations have full delegated authority to negotiate on devolved matters with their respective employers and governments. They report into their respective UK wide branch of practice committees

and to their national council with branch of practice committee chairs sitting on their national council.

23. The Northern Ireland council has 24 directly elected members covering all branches of practice, the four BMA divisions in Northern Ireland and the five Health and Social Care Trusts. Members of council are elected every three years, and the current constituted Northern Ireland council runs from 2024 to 2027.

24. The Scottish council has 35 voting seats, each assigned to a particular grade and/or region of Scotland: consultants, GPs, specialist, associate specialist and specialty doctors, resident doctors, students, medical academics, retired members, and other branches of practice not otherwise represented. The voting members are elected for a three-year term of office. The current term of office runs from July 2023 to July 2026.

25. The Welsh council includes the chairs of all Welsh branch of practice committees as voting members. This includes the Welsh Consultants Committee, the General Practitioners Committee (GPC) Wales, Welsh Staff Grades & Associate Specialists Committee, Welsh Junior Doctors Committee, Welsh Medical Students Committee, the Welsh Committee of Public Health Medicine, and the Forum of Welsh Local Negotiating Committees. There are also 15 directly elected members with voting rights, who are elected for three sessions (a session runs for 12 months between ARMs). Ex-officio members of the Welsh Council include the BMA chief officers, the president of the BMA, and any UK council member with a registered address in Wales. The chair of the Welsh Council is elected triennially for a maximum of six sessions, whereas the deputy chair is elected annually and is eligible for re-election.

How the BMA operated during the pandemic

26. Given the wide-ranging impact of the pandemic on the BMA's membership and on so much of the BMA's work, a large number of elected members and staff were involved in the BMA's response to the pandemic.

27. At a UK level, this work was overseen by the BMA's chair of council at the time, Dr Chaand Nagpaul. The chair made decisions in close consultation with the following:

    a. The BMA's chief officers.

    b. Senior staff, such as the CEO and the Directors of Communication and Policy.

c. Staff with expertise in policy, communications, member support and the negotiation of terms and conditions.

d. Senior elected members, such as the chairs and other representatives of BMA committees.

28. Within the devolved nations, the BMA's pandemic response was headed by the chairs of the relevant national council, supported by the national directors, national committee chairs and other relevant BMA staff.

29. Decision making across the BMA was supported more broadly by a wide group of members who shared their expertise and experience, primarily through the meetings described in the next paragraph, as well as through direct engagement with staff on specific issues.

30. From late March 2020, daily virtual meetings were established, referred to internally within the BMA as '08:30am calls', to ensure that the leadership was well informed of the latest developments, key emerging evidence and the Government response. These meetings also allowed members and staff to share insight and concerns that were emerging from the frontline of the NHS and from public health (including from the BMA's own member relations teams across the nations, which are responsible for closely supporting members in their place of work). The daily calls were attended by the CEO, chief officers of the BMA, chairs of the branch of practice and other key committees (such as Ethics and Occupational Medicine and national councils), and senior staff from across the organisation, including the Directors of the BMA Northern Ireland, Scotland and Wales Cymru offices.

31. These meetings reduced in frequency over time but continued on at least a weekly basis until the end of 2021 and then on at least a monthly basis, until the summer of 2022. Outside of the meetings, members of this group were updated via a dedicated email channel (known within the BMA as a 'listserver'), with many cascading that information to their respective constituencies.

32. To the best of my knowledge, no elected member of the BMA was a member of any official public health committee or scientific body with responsibility for advising or reporting to governments in the UK or devolved nations about the response to Covid-19, including SAGE.

B. Survey Data Collection

Member surveys were the main way the BMA gathered data and experiences from members during the pandemic

33. Throughout the pandemic the main way the BMA gathered data and experiences was through the BMA's regular surveys of the membership to help us to understand the different experiences of doctors working in frontline health services during the pandemic (these were initially called Covid tracker surveys, later renamed the BMA's Viewpoint surveys to enquire among members about a broader range of topics).

34. During the pandemic, most surveys were conducted on a UK wide basis and distributed to all BMA members. The surveys included demographic questions to support more detailed analysis, which was especially important in the early stages of the pandemic when less was known about the virus. Members who were not working in the pandemic, such as those who were permanently retired, were not required to respond to any or all questions (dependent on the survey content) and could be filtered out as appropriate.

35. Surveys were distributed using email with reminders to participate occasionally sent via SMS messaging. Survey samples were therefore self-selecting. Surveys were generally open for at least 2 to 4 days early in the pandemic, with priority given to rapid gathering, analysing and reporting information on an urgent basis, which was felt to be especially critical in the first Covid wave when there were acute PPE shortages.

36. Although the length of time a survey remained open varied, we believe that this was unlikely to have systematically impacted the quality of information. For our self-selecting surveys which were dependent on a limited number of reminders or follow up communications to encourage participation, the great majority of respondents tended to reply near the beginning of the data collection period.

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

38. Although our surveys were referred to as 'trackers' in the acute phase of the pandemic, during 2020 especially, because the samples were self-selecting and varied for each survey, they did not track individual experiences longitudinally through the pandemic. This would have required a systematically identified cohort sample, something that was

impractical in the circumstances of the acute pandemic. However, by virtue of their relatively large sample size, typically of several thousand respondents per survey, they provided a picture of the overall situation impacting doctors with reasonably high confidence when referenced with the whole 'population' of the wider BMA membership.

39. As with any survey, even those of several thousand respondents, the margins of confidence associated with highly granular subsets of data meant that such information was not always appropriate for publication or wider commentary.

40. Surveys were not conducted at pre-arranged times but in response to the evolving situation. At the start of the pandemic in 2020, surveys were undertaken fortnightly between 06 April and 18 June 2020, before moving to monthly and then bi-monthly.

41. The survey content was developed through joint working between research and policy staff with input from senior elected members and the BMA's network of elected committees. It considered anecdotal information referred from the wider membership as well as evolving media reports during the pandemic on issues acutely impacting healthcare settings, such as PPE or other equipment shortages.

42. Throughout our tracker surveys, we did not systematically undertake analysis of findings by nation. The surveys were set up to collect responses that were proportionate and broadly representative on a UK-wide basis. Consequently, the number of responses would often have been insufficient for comparison for smaller nations (Northern Ireland and Wales especially). At the time of our tracker surveys, our initial concern was to get a UK wide view on relevant issues, such the UK-wide supply of PPE, procurement and distribution which was coordinated by the UK Government. Findings were subject to simple visual inspection and if there had been intuitive evidence indicating potential systematic variances between UK countries, then a different approach may have been adopted.

43. Our tracker surveys were also not intended to produce findings that supported granular regional level analysis. As described above, our surveys were set up to collect responses that were proportionate and broadly representative on a UK-wide basis, thereby giving a robust overall picture. In an NHS context, it is also unclear which regional level of granularity might have given insight to the adequacy of PPE supply and distribution. In England alone, the NHS consists of individual trusts/hospitals, GP practices and other providers of NHS services contained within other defined organisations/regions, such as

Integrated Care Systems (ICSs) and NHS regions. The survey methodology was not designed to have attracted sufficient responses to an individual healthcare setting (e.g. a trust/hospital) to have robustly identified the source of a specific supply or distribution failure.

44. In addition to regular surveys, the BMA also conducted a Call for Evidence to inform the BMA's own Covid-19 Review, discussed in more detail in section H (paragraph 405 onwards).

Survey findings were used to inform engagement with governments and public statements on key issues

45. The BMA did not have a formal process for sharing the information from these surveys with governments. However, our surveys formed a key plank of the evidence gathering that was used to understand the experience of doctors on the front line, to brief elected BMA officers, including the Chair of Council, ahead of meetings or media interviews, and to inform the BMA's communication with government officials. Press releases launching the surveys' findings and more detailed results were frequently published on the BMA website.

46. On occasion, BMA staff shared survey results directly with Government ministers or officials. For example, BMA Scotland shared the BMA's Covid-19 Tracker survey results with the Scottish Government via email in April 2020 and May 2020 (PB/343 - INQ000117023, PB/344 - INQ000400408, PB/540 - INQ00400409). Survey findings were also shared via the UK Social Partnership Forum Wider Group on several occasions, set out later in this statement, and with the UK Parliamentary Under-Secretary of State for Mental Health, Suicide Prevention and Patient Safety in October 2020 (PB/386 - INQ000097859). Selected survey findings were also regularly used in letters and meetings with the UK Secretary of State for Health. On issues relevant to Module 5, this included the BMA sharing member reports related to the lack of testing availability in a letter to the Secretary of State (PB/231 - INQ000118110) on 9 September 2020. A reply was received on 14 October 2020, in which the SoS stated that testing capacity was expanding (PB/267 – INQ000466405)

C. Personal Protective Equipment (PPE)

Summary of key issues relating to PPE during the pandemic

47. The supply of PPE to staff across the health and care sectors during the pandemic was woefully inadequate. This was a result of a number of issues, namely: failure in pre-pandemic planning and stockpiles, levels and type of stock and distribution issues during the pandemic, issues with fit testing; and IPC guidance that consistently failed to properly acknowledge airborne transmission of Covid-19 and recommending PPE that left healthcare workers exposed to a risk of infection from Covid-19.

48. The drastic shortages of PPE in many parts of the NHS and social care, particularly but not exclusively in the first waves of the pandemic were caused by the lack of a sufficient and correct stockpile and delays in procuring further PPE, compounded by the NHS's procurement system being based on a "just-in-time" business model. The Government struggled to procure PPE from across the globe at short notice, and the drastic shortages led individual organisations to source PPE made by schools or bought from hardware stores or to fashion items such as gowns from bin bags.

49. Staff had to go without PPE, reuse single-use items, use items that were out of date with multiple expiry stickers visibly layered on top of each other, or use homemade/donated items. Throughout the pandemic there were also reports of faulty PPE reaching staff at the frontline.

50. Even where PPE was available, there was commonly poor availability of fit testing (required for Respiratory Protective Equipment including Filtering Facepiece (FFP) Respirators and respirator hoods to ensure a tight seal). On other occasions, staff were fit-tested, but the RPE that was a good fit for them at the time was subsequently not available, due to supply issues. There was also a large degree of variation in the training that staff received to safely don and doff PPE.

51. Issues related to the supply and adequacy of PPE impacted some staff groups more than others:

    a. **Ethnic minority doctors** more commonly experienced PPE shortages, had higher rates of failing a fit test, felt pressure to work in environments without sufficient PPE and felt fearful about speaking out about safety issues they were concerned about.

b. **Doctors with a disability/long-term health condition (LTC)** also more commonly felt fearful about speaking out about issues they were concerned about. Deaf staff who relied on lipreading faced additional challenges as the development of clear masks was painfully slow.

c. **Female doctors** particularly struggled to find well-fitting masks due to the gender bias in PPE design and reported slightly higher rates of failing a fit test.

52. The PPE that healthcare staff had access to was – beyond supply issues – primarily dictated by the 'Covid-19 Infection, Prevention and Control (IPC)' guidance for healthcare settings that was developed by a four nation IPC cell and published by Public Health England (PHE) and, later the UK Health Security Agency (UKHSA) (covered in detail in section D). While it was possible for employers to provide higher grade PPE than that recommended in the IPC guidance, the BMA's surveys suggest that the majority of employers followed the guidance in place at any given time.

53. Initially, the IPC guidance in January 2020 recommended full PPE (including FFP3 respirators or respirator hoods) for all staff caring for patients with suspected or confirmed Covid-19. However, this recommendation was downgraded by the UK Government in March 2020 (after Covid-19 was downgraded from being categorised as a High Consequence Infectious Disease (HCID)), with Fluid Resistant Surgical Masks (FRSMs) recommended for staff outside of so-called Aerosol Generating Procedure (AGP) areas.

54. This effectively meant that staff who were not working in Intensive Care Units or otherwise carrying out one of the limited procedures on the AGP list (which was developed before and not for the pandemic), were not protected by RPE from a respiratory virus which it was known, from the start of the pandemic, had the potential to spread by the airborne route and, for which evidence emerged throughout the pandemic that it did in fact spread via aerosols to a significant degree. The deficiencies in the IPC guidance are discussed in detail in section D.

Impact of PPE issues on doctors and other healthcare workers

55. Being exposed to a potentially deadly virus while treating patients without appropriate PPE has had a profound impact on the mental and physical health of the medical workforce. Many doctors caught Covid-19 at work and over fifty doctors are known to have died from the virus (PB/238 - INQ000397279).

56. Experiences of burnout, trauma, moral distress, isolation and poor psychological safety were commonplace and, while this has a number of reasons, IPC guidance that recommended (and to this day continues to recommend) inadequate respiratory protection was, and remains in the BMA's view, a significant contributory factor. A large number of doctors acquired Long Covid and are still limited in their ability to work or train.

57. In BMA surveys and in response to the BMA's call for evidence as part of its own Covid-19 review, staff described how exposed, poorly protected and incredibly let down they felt. Others described the lengths to which they and others went to source PPE (e.g. schools 3D printing visors, purchasing from DIY stores, patients making visors and/or scrubs for staff). Others described the heightened anxiety of feeling pressured to work without adequate protection.

58. The downgrading of the recommended protection in the IPC guidance in March 2020, following the declassification of Covid-19 as a High Consequence Infectious Disease (HCID) caused huge concern amongst healthcare workers, particularly for those not working in ICUs and other settings where RPE was recommended. This is clearly articulated by one of the respondents to the BMA's Call for Evidence who said:

> *I was redeployed to ICU [Intensive Care Unit] part way through from AMU [Acute Medicine Unit]. The difference in protection was stark. In ICU we had full PPE for anyone suspected and were told by consultants to take our own PPE to any ward patients to protect ourselves […] On the AMU side, even though there is an undifferentiated take, self bought masks were not permitted (as they would frighten patients!) until a while after the CDC [Centres for Disease Control and Prevention] and WHO [World Health Organisation] recommendations were made. It was clear that ICU was prioritised and wards were having other 'guidance' to protect PPE levels. This is not equity, and judging by the level of staff COVID sickness in wards compared to ICU, and patient breakouts, there are indicators that staff and patients came to harm during this time due to these differences.' (Locally employed/trust grade doctor, Wales)*

Issues relating to PPE were regularly covered in BMA member surveys

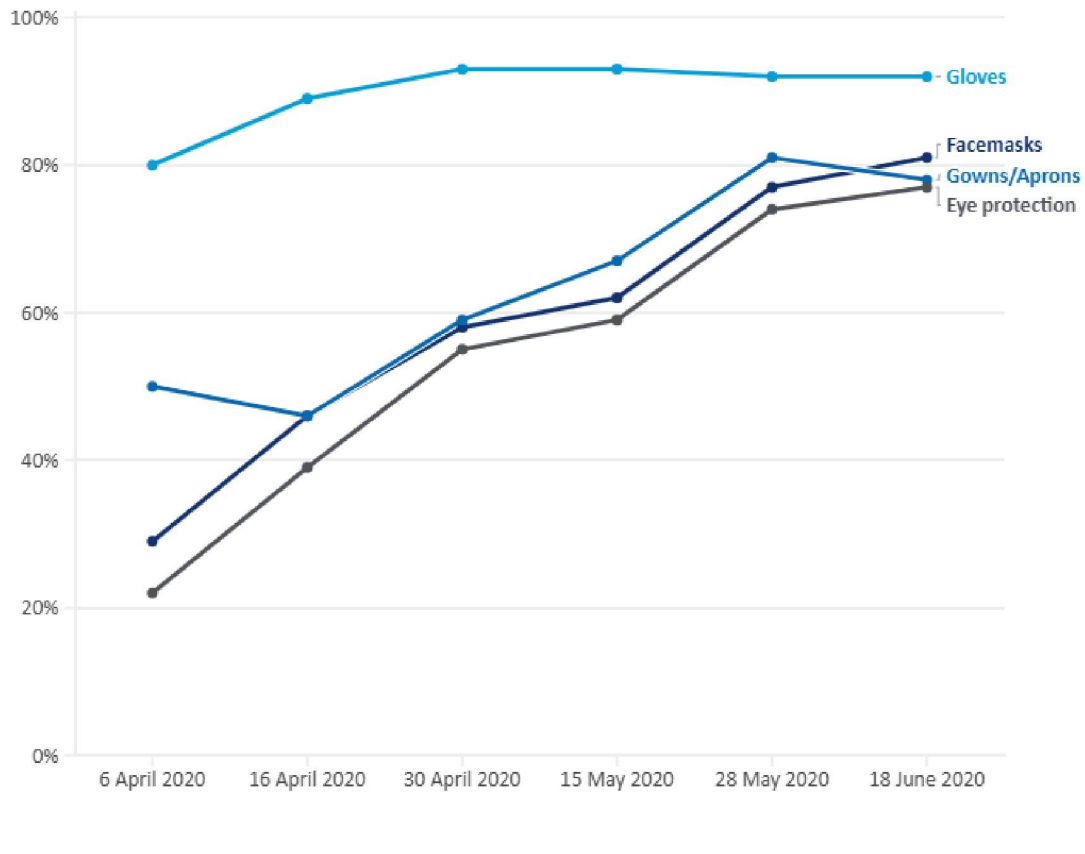
Survey results show significant shortages of PPE, particularly in the first wave of the pandemic

59. The BMA asked members participating in our Covid Tracker surveys a range of questions on access to PPE. Between some survey waves, the form these questions took was altered slightly to ease completion and collation of data. Where there are caveats to the interpretation of time-series data, this is stated.

60. At the outset of the pandemic in 2020, our tracker surveys asked members about their access to PPE and RPE in the context of their clinical setting, including whether they were working in defined AGP areas or not, following the model set by IPC guidance in place at the time.

61. Survey responses between 06 April and 18 June 2020, show that although some items of PPE such as gloves were in relatively adequate supply (though still not all respondents reported having access to them), masks providing respiratory protection, such as FFP3 respirators (indicated as 'facemasks' in figure 1) for respondents working with aerosol generating procedures or AGPs (circumstances in which the Governments' IPC guidance recommended their use) were in severe shortage early in the first Covid wave (for example, just 29% had adequate supplies at 6 April) although our surveys suggested these acute shortages had somewhat eased by mid-June. However, by 18 June 2020 still about 1 in 5 doctors reported not having access to adequate supplies of RPE in an AGP area.

Figure 1 – The proportion of respondents to BMA Covid Tracker surveys reporting having access to adequate supplies of PPE when working in an AGP area in the last week

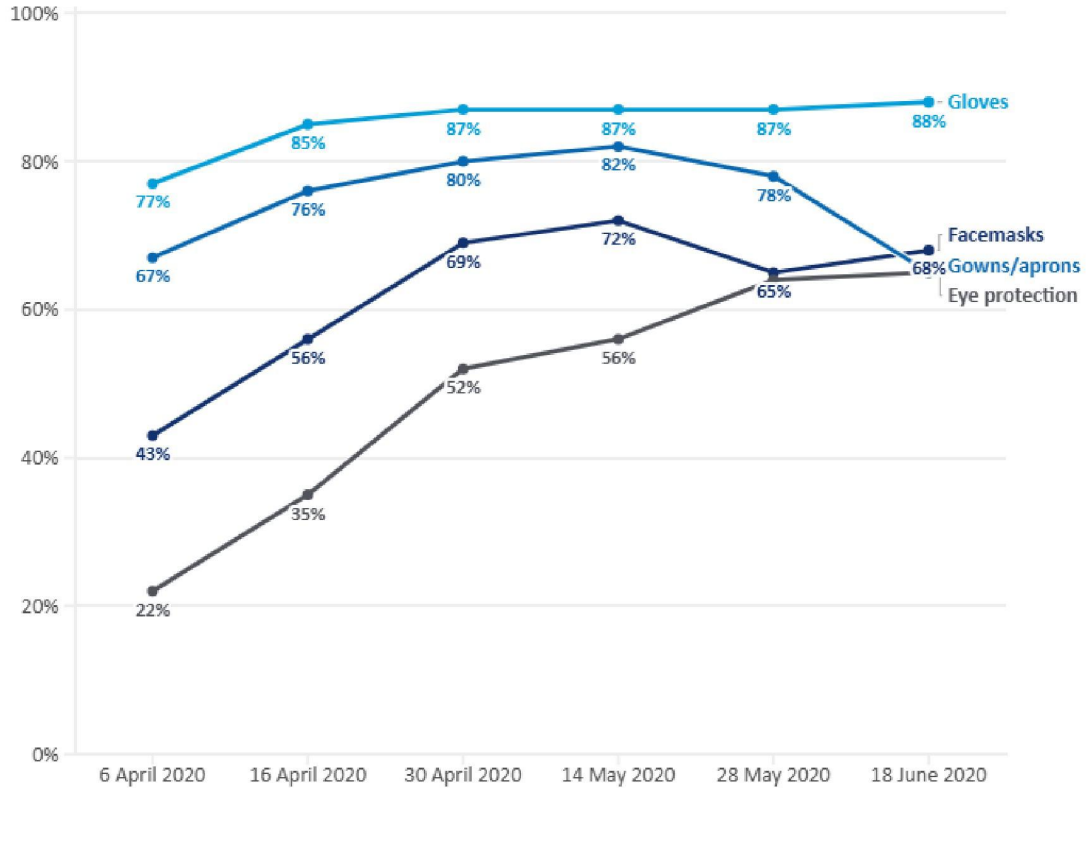


Note: From the survey of 28 May 2020, different groupings for facemasks and gowns/aprons were used in questions which asked about different types of PPE, so results are not directly comparable with earlier surveys. Question asked: Over the last week, have you had adequate supplies or shortages of the following PPE when working in an AGP area? In the context of aerosol generating procedures in this question, 'facemasks' described respiratory protective equipment such as FFP3 respirators.

62. Responses to our tracker surveys showed some similarities in the PPE available to doctors working in 'non-AGP' contexts, in that supplies of all items of equipment were inadequate early in the first Covid wave but improved as the wave progressed. Our data suggested facemasks that were recommended in the IPC guidance for working in 'non-AGP' settings (i.e. Fluid Resistant Surgical Masks (FRSMs) (also sometimes called Fluid Repellent Surgical Masks) appeared to be in less acute shortage than for respiratory protection (increasing from 43% of respondents saying these were in adequate supply at 06 April to 72% at 14 May), though supplies of these nevertheless remained in shortage

throughout the first wave. See section D for BMA position on the inadequacy of IPC guidance.

Figure 2 - The proportion of respondents to BMA Covid Tracker surveys reporting having access to adequate supplies of PPE when working in a non-AGP area in the last week

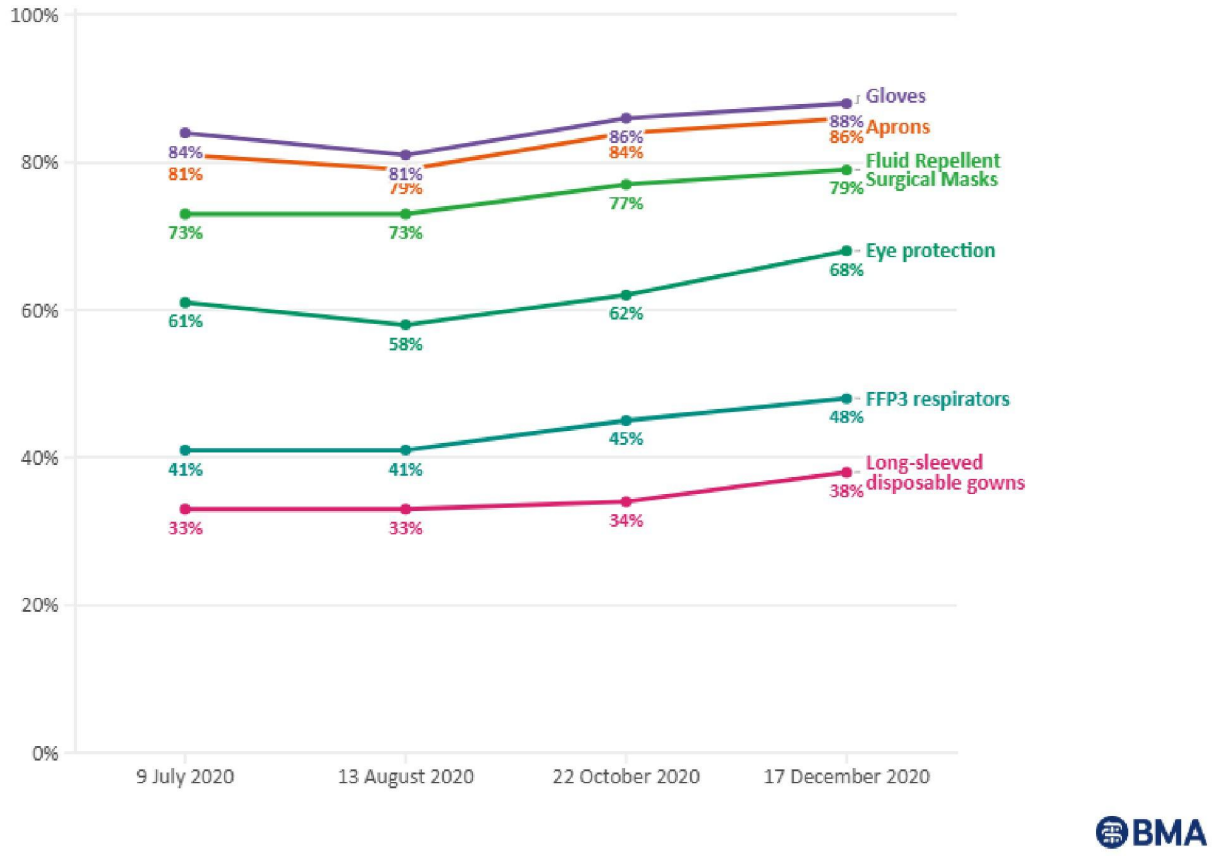


Note: From the survey of 28 May 2020, different groupings for facemasks and gowns/aprons were used in questions which asked about different types of PPE, so results are not directly comparable with earlier waves. In this question, 'facemasks' described FRSMs. Question asked: We next want to ask about PPE in other (non-AGP) settings to be used by healthcare workers who are in contact with patients with possible or confirmed Covid-19. Over the last week, have you had adequate supplies or shortages of the following PPE?

63. After revisions to survey questions, from July to December 2020, respondents were asked about the adequacy of supply of items of equipment in a more general way without relating to existing IPC guidance and reference to AGPs, with respondents specifically asked about supply of FFP3s and FRSMs, separately. It is likely that the lower proportion of

respondents reporting they had access to adequate supply of FFP3s is at least partly explained by respondents working across a range of settings, including some settings for which FFP3s were not recommended in IPC guidance. Although this period shows a slight but general improvement in supply of PPE, items remained in significant shortage, including FRSMs.

Figure 3 - The proportion of respondents to BMA Covid Tracker surveys reporting having access to adequate supplies of PPE in the last two weeks (new tracker question used between July and December 2020)

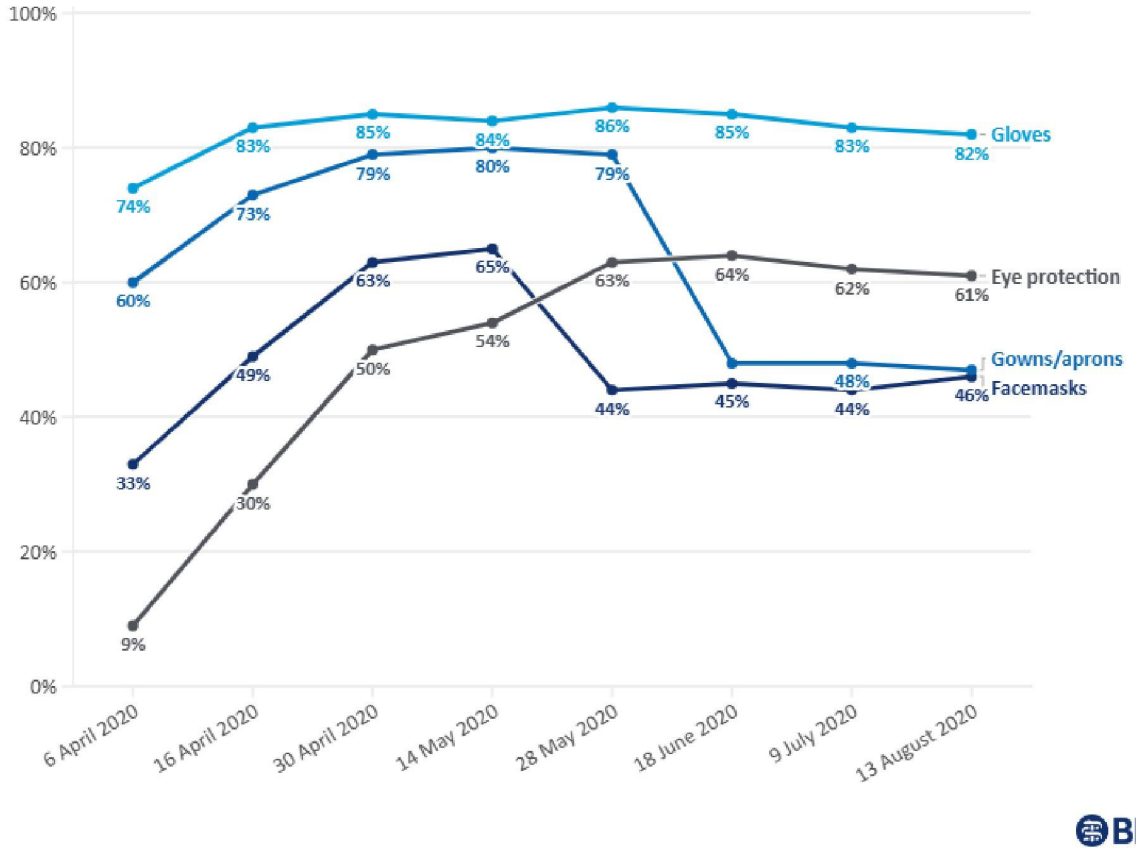


Question asked: Over the last two weeks, have you had adequate NHS supplies or shortages of the following PPE? (July to Dec 2020)

64. For GPs specifically, there were acute shortages of FRSMs early in the first Covid wave along with a lack of eye protection, though it should be noted all PPE items were in shortage. As with other clinical settings, items such as gloves were in comparatively better supply. Caution in interpretation is required when comparing percentages from the survey

of 28 May 2020 onwards, due to changes in methodology.

Figure 4 – The proportion of GP respondents to BMA Covid Tracker surveys reporting having access to adequate supplies of PPE in the last week.



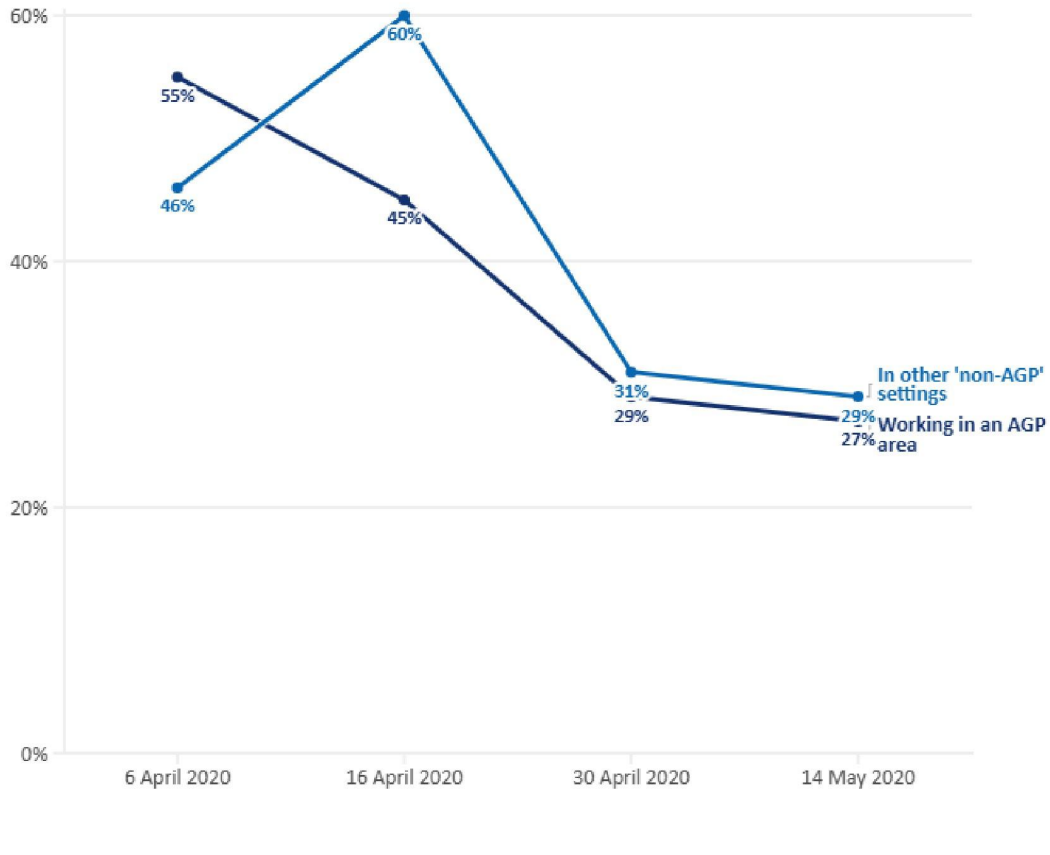
Note: From the survey of 28 May 2020, different groupings for facemasks and gowns/aprons were used in questions, so results are not directly comparable with earlier waves. Question asked: We want to ask about PPE to be used by GPs who are in contact with patients with possible or confirmed Covid-19. Over the last week, have you had adequate NHS supplies or shortages of the following PPE?

65. In summary, overall, while our surveys show a picture of improving availability of PPE since the beginning of the first wave, with some items becoming more available from a very low base (e.g., eye protection), multiple critical PPE items remained in shortage throughout the acute pandemic in the experience of our members.

Doctors also reported feeling pressured to work without adequate protection

66. In addition to repeat questions on adequacy of supply of PPE, we also asked members if they had experienced feeling pressured to work without adequate protection. Regardless of whether working in an AGP or other context, around a half of all respondents reported feeling pressured to work without adequate protection at the start of the first wave and this figure remained at approximately more than one quarter of respondents towards the end of the first wave (figure 5). These data loosely correlate with the easing of shortages as the first Covid wave progressed but demonstrate the enormous pressure felt by doctors and the severe risks to which many were exposed.

Figure 5 – The proportion of respondents to BMA Covid Tracker surveys reporting (sometimes or often) feeling pressured to work in 'AGP' and 'non-AGP' settings

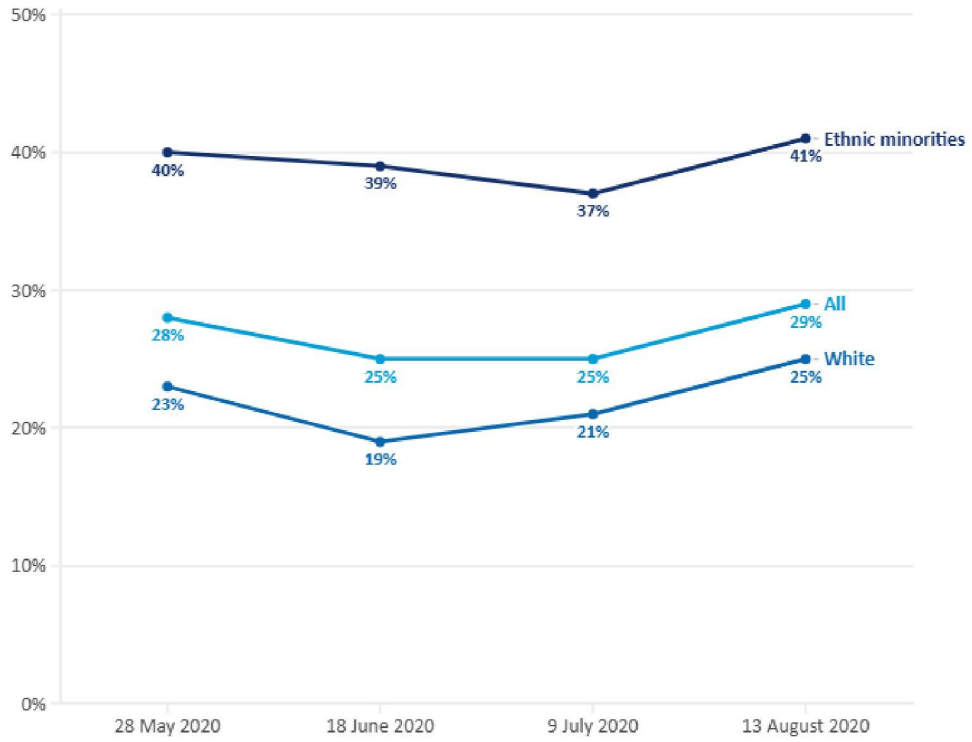


Question asked: Have you ever felt pressured when working in an AGP area / in other (non-AGP) settings to see a patient without adequate protection?

67. As I stated in my witness statement to Module 3 (INQ000477304), many respondents to the BMA's call for evidence, particularly those working in hospitals, reported feeling pressured to work without adequate protection and described the worry and anxiety this caused. As a Consultant in England wrote: *'I was put under pressure to carry on regardless and 'support my colleagues'.* Our 2021 call for evidence also showed that twice as many ethnic minority doctors as White doctors reported feeling pressured to work in high-risk settings without adequate PPE and a greater fear of raising concerns (for fear of impacting one's career or being judged negatively by colleagues). This needs to be seen in the context of an NHS which still faces a significant degree of institutional racism.

68. BMA tracker surveys at the time demonstrated a similar pattern of experience during the first Covid wave in 2020, with ethnic minority doctors up to approximately twice as likely as their White colleagues to report feeling pressured to see patients without adequate protection (figure 6).

Figure 6 – The proportion of respondents to BMA Covid Tracker surveys reporting (sometimes or often) feeling pressured to see a patient without adequate protection



Question asked: Have you ever felt pressured to see a patient without adequate protection?

Poor availability of fit testing was an issue particularly for female and ethnic minority doctors

69. While the severe shortages experienced in the first wave of the pandemic gradually improved, access to PPE was not the only barrier to healthcare workers being properly protected from Covid-19. The fit of a mask also matters.

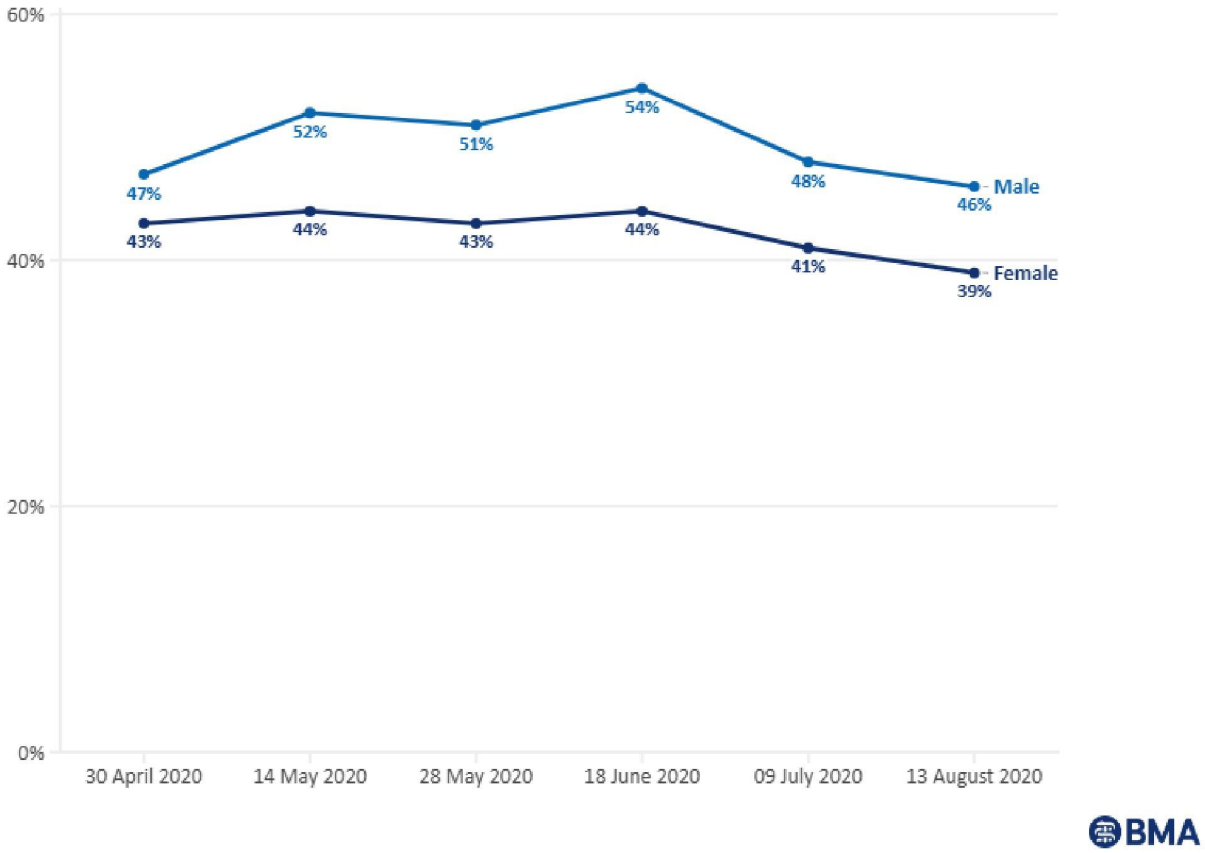
70. For RPE, such as FFP2/FFP3 respirators, to work effectively they must be properly fitted and be tight fitting. Fit testing should be done during initial selection of RPE, before the respirator mask is worn in a hazardous environment, and whenever there is a change to the type or model of mask, or a change in circumstances of the wearer that could alter the fit of the mask.

71. **Women** were more likely to have difficulty in finding well-fitting masks. There is a gender bias within PPE – which is largely manufactured to suit white male faces and physiques – meaning PPE was less likely to fit women, despite making up around 77% of the healthcare workforce (PB/478 - INQ000397278). This was a problem that emerged at the start of the pandemic and persisted throughout.

72. BMA surveys included questions on access to, and the success of fit testing. Across a range of BMA tracker surveys, female respondents consistently reported slightly higher rates of failing a fit test, compared to males (figure 7).[1]

Figure 7 – The proportion of male and female respondents reporting passing a fit test first time between 30 April and 13 August 2020

[1] BMA Covid Tracker Surveys, 30 April 2020 – 18 June 2020 (responses from hospital doctors working in England and Wales only)



Question asked: If you have been fit tested for a mask/respirator, which of the following best describes your experience?

73. Respondents to our 2021 call for evidence survey set out the impact of this well:

> *'I didn't feel fully protected at all and in particular being female and small and failing fit testing several times with several masks I was left feeling quite vulnerable from this.'* (Consultant, England, female)

74. Similarly, access to well-fitting PPE was also raised as a problem by some **ethnic minority respondents**:

> '*Using FFP3 with black hair is easier with a hair cover. The elastic snags. PPE posters do not routinely show or normalise the reasonable adjustments necessary for non-religious and religious reasons for covered hair.'* (Consultant, Scotland, Black/Black British)

75. These experiences are backed up by other, non-BMA research, which suggests that failure rates for fit testing are higher in staff from ethnic minority backgrounds compared with staff of White ethnicity (PB/479 - INQ000397300).

76. Poor availability of fit testing to ensure properly fitted masks was a frequent problem cited by respondents in our 2021 call for evidence. Moreover, where fit testing did occur, for some of these doctors it was often useless as shortages meant that masks proven to fit were unavailable.

> *'It was really poor; little or no fit testing and even if you had been fit tested, the chance of finding the right mask was very remote.'* (Consultant, England)

> '*Haphazard availability, multiple fit testing due to masks going out of stock.'* (Consultant, Northern Ireland)

PPE issues were relevant to the work of a wide range of teams and Committees at the BMA

77. Access to, the quality and adequacy of PPE were all major concerns for **BMA members** across the different branches of practice throughout the pandemic. PPE issues came up frequently in discussion among members. This included PPE being discussed at branch of practice committee meetings, UK and national Councils. Often these were discussions about the action the BMA was taking to raise concerns about PPE issues with governments or through the media or reporting back on meetings that a representative of their committees had attended where PPE was discussed. PPE was also regularly discussed in the BMA's daily meetings (described in section A, above). The representatives in attendance at these meetings brought a range of perspectives on PPE from their respective committees and personal experience that together informed the BMA's positions taken during the pandemic, alongside the BMA's member surveys and (emerging) scientific evidence.

78. Staff across the BMA's policy directorate, and staff in the devolved nations actively considered issues relating to supply, access, quality and adequacy of PPE, working with colleagues in our member relations, communications and public affairs teams to elevate issues and concerns in the press and to government ministers and officials. In addition,

our first point of contact call centre fielded queries and concerns directly from members and regional staff dealt with these issues at a Trust or local system level.

Issues relating to PPE were regularly raised with government ministers and officials in a range of ways

79. Issues and concerns about PPE – as with other pandemic-related issues - were raised with Government through the BMA's spokespeople, predominantly the BMA's UK Chair of Council, the BMA's Deputy Chair of UK Council as well as the Chairs of each of the Devolved Nation Councils (Chair of BMA Scotland, Chair of BMA Wales, Chair of BMA Northern Ireland) in letters, meetings or through interventions in the media. In addition to this, PPE as an issue came up in meetings that Chairs of Branch of Practice Committees had, such as the regular meetings the Chair of UK Consultants Committee had with NHSE's Medical Director (see below). On some occasions the Chairs of Branch of Practice Committees also wrote directly to relevant ministers or officials.

80. The BMA's chair of UK council had regular (approximately monthly meetings) with Matt Hancock when he was **Secretary of State for Health and Social Care (SoS)**. The chair of UK council and senior staff also had regular meetings with **Minister of State** Ed Agar MP, and Minister of State Helen Whately MP, both on a 1:1 basis and as part of the SPF Wider Group. PPE provision was discussed on multiple occasions.

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

82. These meetings allowed the BMA to raise issues of concern to the BMA and its membership and to set out how the BMA thought the Government should respond on certain issues relating both to the wider public health response to the pandemic, including non-pharmaceutical interventions (NPIs), but also on other matters directly affecting doctors and other healthcare workers (such as access to PPE or the impact of the pandemic on staff from an ethnic minority background). However, this engagement did not

always lead to government decisions and actions that the BMA felt were appropriate. In these instances, the BMA was proactive in publicly criticising government actions or inactions that:

a. it considered put the wider population and healthcare workers (including doctors) at risk;

b. that were likely to lead to greater transmission of the virus; or

c. that were likely to increase pressure on healthcare services.

83. Throughout this statement, I have indicated where possible whether the response to a particular intervention addressed the BMA's concerns or led to a change or improvement. Overall, however, it is the BMA's view that on some key issues, notably the IPC guidance issues discussed in section D, the BMA's concerns were not addressed adequately, or in some cases at all.

84. While the BMA did not have regular recurring meetings with the **CMO for England**, the CMO made himself available to meet at the Association's request to discuss issues of concern. This was primarily with the BMA's chair of UK council, often with senior staff from the BMA's Public Affairs team in attendance. Occasionally other elected members of the BMA also attended, e.g., the BMA branch of practice committee chairs. These meetings were held to discuss a range of issues during the pandemic, including availability and adequacy of PPE for healthcare staff and lack of access to testing.

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

86. The BMA did not have regularly recurring meetings with representatives of **PHE/ the UKHSA**, however occasional meetings took place on topics such as PPE guidance, PPE adequacy, Covid-19 testing and the impact of Covid-19 on ethnic minority communities.

The BMA also received updates from PHE/the UKHSA through the SPF Covid-19 Engagement Forum.

87. The BMA received updates on issues of relevance from **senior civil servants and DHSC representatives** through stakeholder calls, as well as the Social Partnership Forum (SPF).[2] The SPF Wider Group is the most senior SPF Group and is chaired by a health minister although during the pandemic, chairing duties were often delegated to a senior civil servant. A BMA member of staff attended these meetings. During the relevant period, the SPF had a number of sub-groups both ongoing and set up for particular issues. Of relevance to matters in scope in Module 5 was the SPF Covid-19 Engagement Forum which was an important way the BMA engaged with relevant officials including DHSC representatives, senior civil servants, PHE/UKHSA, Test and Trace and NHS England. This Engagement Forum was specifically set up during the pandemic to deal with Covid issues. The group met weekly from 31 March 2020 until 21 July 2020, after which the meetings were fortnightly (and they stopped at the end of 2021). While these were not decision-making meetings, this was a forum for the BMA to provide feedback and gather information on the Government's developing response to Covid-19. Topics of discussion included, among others, PPE and staff testing (PB/205 - INQ000117813).

88. In addition, staff members from the BMA's Medical Ethics team attended meetings of the **Moral and Ethical Advisory Group (MEAG)**, set up by DHSC, which the CMO for England also sometimes attended. While this group was established before the pandemic (being established for a three-year period from October 2019), once Covid-19 emerged, the meetings of the group were focused on ethical issues in the government and healthcare response to the pandemic. The first meeting of MEAG that focused on Covid-19 was on 20 March 2020. The attending BMA staff member contributed to discussion on most of the items on the agenda. PPE was not a major feature of these discussions, although it arose in relation to ethical considerations, such as the adequacy of the fit of PPE for healthcare workers unable to shave their beards for religious reasons.

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

BMA Staff and members in the devolved nations also regularly engaged with their governments regarding PPE issues

89. BMA **Northern Ireland** had a constructive relationship with the Minister for Health in Northern Ireland and engaged regularly, with nine meetings occurring between April 2020 and January 2022. PPE was one of the issues regularly discussed. These calls were attended by the Northern Ireland council chair, Northern Ireland national director and Northern Ireland senior public affairs advisor. One meeting was attended by the Northern Ireland consultant committee chair and another by the chair of GPC Northern Ireland. The BMA team in Northern Ireland also engaged (albeit less frequently) with the Chair of the Northern Ireland Assembly Health Committee, Colm Gildernew MLA (Sinn Féin).

90. In addition to the regular calls with Minister Swann, there were other established regular meetings in Northern Ireland which were not specifically about the Covid-19 response, but which inevitably featured Covid-19 issues, particularly during 2020 and 2021. These meetings included discussions on PPE for medical staff.

91. BMA Northern Ireland and the Department of Health Northern Ireland met to specifically discuss workforce issues at HR Engagement Forum meetings, which began prior to the pandemic. Forums that are within the scope of Module 5 took place on 14 May 2020, 30 September 2020, 06 May 2021 and 05 May 2022. These forums discussed a wide range of issues including PPE. These meetings were attended by Departmental officials and the Deputy Chief Medical Officer, Dr Naresh Chada.

92. BMA **Scotland** had a good working relationship with the Scottish Government, CMO, Cabinet Secretary for Health and senior civil servants throughout the period in question, with regular telephone discussions, scheduled meetings and email exchanges between the BMA Scotland national director and her team, and relevant officials and civil servants. An offer from the Cabinet Secretary, Jeane Freeman, to raise immediate problems directly with her office should BMA members become aware of any led to occasional meetings between the BMA Scotland chair of council and national director with the Cabinet Secretary for Health. There were also weekly/fortnightly meetings between the Scottish Government Primary Care Directorate and the BMA Scottish GP Committee in 2020 and 2021 on various issues including PPE provision.

93. The majority of BMA Scotland's engagement with Scottish Government Ministers, senior civil servants and the CMO throughout the specified period were through established

meetings between BMA staff and Government officials. This included daily meetings of the Scottish Government's Workforce Senior Leadership Group. These reduced in frequency to two or three meetings a week between April and August 2020, and then moved to weekly or fortnightly following August 2020. Amongst a range of issues, regular agenda items included IPC guidance and availability/supply of PPE. There were also joint meetings between the Cabinet Secretary for Health, BMA Scotland and the RCN where discussions included PPE concerns and interpretation of IPC guidance.

94. BMA **Cymru Wales** maintains ongoing, working relationships with relevant ministers, Welsh Government officials and NHS organisations across Wales, and this was also the case throughout the relevant period. Well established forums in which the BMA participates, and which continued during the pandemic, include the Welsh Partnership Forum[3] and Joint Oversight Meetings[4], at which officials and the Deputy CMO for Wales were often present.

95. BMA Cymru Wales engaged with the CMO for Wales intermittently throughout the period and in a number of ways. Primarily, letters were exchanged outlining member views on responses to the pandemic. There were also occasional direct meetings, participation in wider meetings (e.g., alongside the Academy of Medical Royal Colleges in Wales), and invitations to the CMO to address BMA committees directly (e.g., in October 2021). Government officials established regular technical briefings for trade unions and other representative bodies on topics such as testing and PPE, and the Deputy CMO would on occasion address these briefings directly.

96. BMA Cymru Wales participated in a number of Ministerial groups, as well as specific individual meetings with the Minister for Health and Social Services to express member views on the Welsh Government response to the pandemic. These included attendance at the regular technical briefings as set out above. At these meetings, the representatives of the NHS Wales Shared Services Partnership (NWSSP) provided updates to BMA and other trade union representatives on national PPE stock levels.

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[3] The Welsh Partnership Forum is a tripartite group sponsored by the Welsh Government with representatives from the recognised healthcare trade unions for NHS Wales, senior management for NHS Wales and the Welsh Government. The main purpose is the development, support and delivery of workforce policies at a national, regional and local level. More information about the Welsh Partnership Forum can be found here: https://www.nhsconfed.org/wales/nhs-wales-employers/welsh-partnership-forum

[4] Joint Oversight Meetings were regular (usually quarterly) meetings between the NHS Wales Director General and the chairs of the BMA branch of practice committees.

97. Where appropriate, BMA Cymru Wales council / committee chairs wrote to the Minister in relation to specific topics, details of which are included in relevant sections of this statement.

98. BMA Cymru Wales, primarily via staff rather than elected members, maintained contact with Welsh Government civil servants and officials via emails and telephone calls as a means of communication between the Welsh Government and the wider medical workforce. Staff also attended weekly formal meetings where BMA, NHS Employers Wales representatives and Welsh Government officials were present (the NHS workforce planning cell). Welsh Government officials often led the regularly held technical briefings on testing and PPE (for example M2B/PB/057 - INQ000118555).

Specific engagement with governments and arms-length bodies regarding PPE

99. The BMA at a UK level and in each of the Devolved Nations had extensive engagement on PPE issues with a wide range of individuals from the Prime Minister, First Ministers in each of the Devolved Nations, other senior ministers and with senior civil servants in government departments, arms-length bodies and relevant regulatory and other external organisations. Often there were specific PPE issues that were the key focus of a letter or specific meeting; however, on other occasions PPE would have been one of a number of issues being discussed as part of routine meetings or engagement related to the pandemic response.

100. A summary of how the BMA across the UK worked with governments and key officials across the four nations is set out above. Throughout this section, we have set out the key issues related to the supply and quality of PPE, including how the BMA raised these issues with relevant individuals or agencies. Key letters and documents relating to PPE and other matters within the scope of Module 5 are detailed below and exhibited to this statement, and this includes specific documents about which the Inquiry has asked for details. Questions of the adequacy of PPE are largely linked to the deficiencies in the IPC guidance and are, therefore, covered in Section D.

101. However given the pace at which work happened during the pandemic and the fast-moving external environment, the BMA does not always hold detailed records of meetings or discussions, although we have included these where we do have them, based

on extensive email and document searches. Where we have a record of a response to a specific letter or issue, we have included this in the statement.

Shortages of PPE were a persistent and regular issue on which the BMA sought to raise concerns with governments and senior officials

102. It has been stated by a number of government ministers and officials that the UK never ran out of PPE. Yet at the same time, the BMA received numerous reports and responses to our regular surveys (see section B) that staff often went without PPE, had to reuse items, use homemade and donated items and often received PPE with multiple expiry stickers layered over each other.

103. Access to PPE varied across settings and locations but in the early weeks and months of the pandemic, we have no doubt that shortages were widespread and acute. While supply issues largely improved over time, they persisted in some areas, notably in general practice.

104. Given the scale and extent of this issue, it is unsurprising that it was a key area of focus in the BMA's communication with government ministers (including on at least one occasion the Prime Minister), senior government officials, arms-length bodies and other organisations. Some of the key interventions made by the BMA related to PPE shortages are set out below.

UK Government

105. The BMA regularly raised concerns about shortages of PPE for healthcare staff with the UK Government. The period leading up to and over Easter 2020 was particularly challenging with widespread concern that health and care settings would run out of certain items of PPE.

106. On 01 April 2020, the BMA shared with NHSE via email (PB/866 - INQ000522166, PB/197 - INQ000117819) a collation of feedback from BMA regional staff and networks across England about PPE availability in different NHS Trusts.

107. The BMA continued to receive reports from members about acute shortages in different parts of the country and sought to raise these issues with the Secretary of State and others.

108. The BMA wrote to the Secretary of State for Business, Energy and Industrial Strategy on 03 April 2020 (PB/067 - INQ000097847) regarding the unacceptable shortage of PPE, and stated that, despite the government having stated that there was an adequate stockpile of supplies, the BMA believed that this would not be sufficient in the face of a likely prolonged pandemic, and that domestic production of PPE needed to be increased. The BMA stated that the association had therefore joined with fellow trade unions and industry federations ADS Group and the British Printing Industries Federation to call on the government to take the necessary action to enable underutilised UK manufacturing capacity to produce PPE.

109. On 6 April 2020 (PB/065 - INQ000097854) the BMA chair of UK council wrote to the Secretary of State for Health and Social Care. This followed a conversation between the BMA Council Chair and the SoS, during which the Chair highlighted that it was imperative the government pursue every avenue available in the procurement of PPE, testing and tools needed by doctors to effectively fight against Covid-19. The BMA heard from multiple organisations with access to PPE testing kits and ventilators who claimed to have attempted to make their supplies available to DHSC to no avail. The BMA sent details of these organisations to DHSC and urged the SoS to ensure that these offers were explored urgently. The BMA also called for ramping up UK production of PPE, having joined with Unite, Unison and the RCN, with various trade organisations, to call on the government to take all necessary actions to unlock underutilised UK manufacturing capacity to enable production of PPE.

110. On 10 April 2020, the BMA received an invitation from the Department of Health and Social Care to attend a briefing ahead of an announcement by the Secretary of State for Health and Social Care on PPE that afternoon. This briefing was attended by the Chair of BMA UK Council and a member of BMA staff (PB/867 – INQ000522163).

111. The BMA also wrote to Lord Deighton (Government lead for PPE procurement) on 21 April 2020 (PB/068 - INQ000097911) bringing his attention to a BMA survey of over 6,000 doctors which found that half of all doctors working in high-risk areas reported shortages or no supply of long sleeved disposable gowns, and that 45% said they felt pressure often or sometimes to work without adequate protection. The letter also draws attention to the government PPE guidance relating to the reduced need for gowns that had been issued on 17 April 2020, without consultation with the profession. The BMA was concerned that this change had been driven by PPE shortages instead of the best

evidence and protection of staff. Lord Deighton replied on 06 May 2020 in agreement with the points in our letter and stating that in his role, he was prioritising the utilisation of existing UK manufacturing capacity to address the issue (PB/809 - INQ000522168).

112. Subsequently, in an SPF meeting attended by Lord Deighton on 20 May 2020, BMA staff asked questions directly of him in relation to PPE, including about human rights due diligence in the NHS supply chain, which Lord Deighton confirmed was being done. He was also asked about the continuing issue of women and ethnic minority staff more commonly failing PPE fit testing, which Lord Deighton said was being factored into decision making when developing PPE. Further topics of discussion with Lord Deighton included diverting UK plastic bag manufacturers to produce aprons, finalising a series of deals on eye protection, and the focus on suppliers in China who provide 80% of supply as opposed to smaller suppliers (PB/215 - INQ000215040).

113. In addition to the above written interventions with senior ministers, the BMA consistently raised PPE shortages and wider PPE issues with Government ministers and officials in meetings and calls, including:

a. The UK council chair and chair of the BMA's representative body raised BMA concerns about PPE and testing in a meeting with the CMO for England (26 March 2020) (PB/204 - INQ000117801).

b. The BMA also gave feedback through the SPF meetings (22 April 2020, 20 May 2020, 30 June 2020, 4 November 2020 - PB/214 - INQ000215039, PB/215 - INQ000215040, PB/216 - INQ000118021, PB/218 - INQ000215042).

c. PPE shortages were also discussed with the SoS on a number of occasions including 18 March 2020 (PB/200 – INQ000117760) and 28 October 2020 (PB/206 – INQ000118179).

Devolved Nations

Wales

114. Communications from the Welsh Government around the availability of PPE was poor early on, something BMA Cymru Wales highlighted. In response to the BMA's representations the Welsh Government rapidly engaged to improve co-ordination of procurement and provide regular updates on availability of stock, so that BMA members could be reassured.

115. Direct meetings with the CMO or Deputy CMO for Wales were held on:

a. 25 March 2020 – The Chair of Welsh Council met with the DCMO to discuss concerns about PPE guidance, the adequacy of recommended PPE, and the particular impact of PPE supply for GPs having face-to-face appointments (when the arrangements for PPE provision to primary care from NHS stocks were unclear). An internal note was prepared after the discussion (M2B/PB/115 - INQ000355786).

b. 06 May 2020 – In my role as Chair of the BMA Welsh Consultants Committee I met with the DCMO and CEO of NHS Wales to discuss PPE and staff safety in hospitals. BMA Cymru Wales does not have any notes from this meeting, but the topics of discussion can be found in email communication (M2B/PB/116 - INQ000355805).

116. A number of meetings also took place with Simon Dean, Deputy CEO of NHS Wales, with topics discussed including PPE and testing, among others. These meetings took place on 05 June 2020 (the NHS Wales Chief Executive was also in attendance), 30 September 2020, 24 November 2020, 05 March 2021 and 20 July 2021 (by 2021 the PPE discussion likely related to the need to extend FFP3 use in light of evidence of aerosol transmission, discussed in more detail later in this statement) (M2B/PB/139 - INQ000356005).

117. BMA's Welsh Council also met with the Minister for Health and Social Services on a number of occasions to raise specific concerns. This included a meeting on 17 September 2020 to discuss PPE supplies among other issues (M2B/PB/097 - INQ000118619).

118. On at least 2 occasions early in the pandemic (13 and 20 March 2020) BMA Cymru Wales policy staff and the Chair of Welsh Council raised concerns with the Director of Primary Care and the Health Emergency Planning Adviser [Welsh Government] about the PPE being distributed to general practice. This communication sought reassurance that the PPE being distributed would provide adequate protection and that supply levels were sufficient (M2B/PB/141 - INQ000118520, M2B/PB/142 - INQ000118517, M2B/PB/143 - INQ000118518, M2B/PB/144 - INQ000118525).

119. BMA Cymru Wales also made a number of media statements throughout March and April raising concerns about PPE shortages and the impact on staff.

Scotland

120. BMA Scotland engaged with the Scottish Government on a range of PPE issues throughout the pandemic, including raising concerns about PPE shortages. These communications included the Cabinet Secretary; the CMO for Scotland; the Chief Nursing Officer Directorate (CNOD); the CEO of NHS Scotland; senior leaders within the Health Workforce Directorate; and the HCAI/AMR (Healthcare Associated Infections and Antimicrobial Resistance) Policy Unit. Key interventions included:

a. The Chair of BMA Scotland's GP Committee (SGPC) wrote to the CMO on 14 February 2020: to highlight that GP practices *"have been promised PPE masks – however, these have not arrived in many areas which is a delay of several weeks"* (PB/810 - INQ000522185). In response the SGPC Chair was told to suggest GPs contact their local health board.

b. BMA Scotland's National Director emailed the CMO for Scotland on PPE shortages on 07 April 2020, sharing the findings of a BMA tracker survey, as discussed above in paragraph 46 (PB/343 - INQ000117023).

c. BMA Scotland's National Director raised issues of concern particularly relating to ongoing PPE access issues with the Scottish Government via email, between the 17 February 2022 and 01 April 2022. These emails included discussion regarding messaging to management and senior leadership to challenge other management who were not supporting junior staff to undertake self-assessments and obtain the PPE they needed, and an example of a staff member who experienced ongoing PPE access issues (PB/342 - INQ000117309).

Northern Ireland

121. As outlined previously, BMA Northern Ireland had regular communication with the Minister for Health as well as other forums and meetings in which issues related to the pandemic response, including PPE and PPE shortages, were discussed. BMA Northern Ireland also wrote to the CMO for Northern Ireland, on a number of occasions, including:

a. 02 March 2020, calling for PPE to be made available in all clinical areas, especially primary care, so that staff were protected (PB/002 - INQ000116865).

b. 17 April 2020, again flagging the shortage of PPE equipment such as eye protection and goggles (PB/320 - INQ000116866).

Issues and concerns relating to PPE were included in a number of external publications

122. Access to PPE, the quality and the adequacy of PPE were key issues for the BMA and our members throughout the pandemic. As a result, the BMA's concerns about these issues were commonly included in range of published outputs. This includes, but is not limited to, press releases, recommendations in BMA briefings and reports about easing lockdown restrictions safely, submissions and evidence in response to parliamentary committee inquiries and letters to ministers and senior civil servants that the BMA chose to make public. Often the issues of PPE were included in publications addressing wider issues relating to the pandemic.

123. There were several reasons for the BMA to publish these documents. In some cases, it was to provide direct guidance to our members about relevant PPE issues, particularly where there was concern or confusion from members about their rights and obligations, such as in the case of severe PPE shortages. In other cases, information was put into the public domain to raise awareness of the BMA's concerns, particularly where governments appeared not to be listening to, or acting, on these concerns. Finally, the BMA submitted evidence to a number of parliamentary inquiries seeking to understand what had happened during the pandemic and to make recommendations for the future. As the Inquiry is aware the BMA also published its own Covid review reports setting out recommendations for change.

124. The following section highlights the main points that the BMA raised about access, quality and adequacy of PPE for doctors and other healthcare workers and key publications in which these issues and points were set out. This does not include letters and other direct interventions with the UK and devolved nations governments or press statements on these issues, which are set out in other relevant sections of this statement.

Reports

Guidance on easing restrictions

125. On 02 June 2020, the BMA published a paper titled 'Easing the lockdown: principles and priorities' in which the BMA identified principles and actions to safely and effectively ease lockdown restrictions. The report included a recommendation that the

easing of restrictions should be underpinned by assured supplies of appropriate PPE for health and social care workers and other key workers, and that public communication and education should emphasise messaging on the importance of wearing face coverings (PB/010 - INQ000117966). Guided by these principles, the specific priority actions relating to PPE included the need to urgently address the PPE stock shortfall and guarantee supplies, highlighting the need for an adequate stockpile and sufficient ongoing supply of appropriate PPE for health, social care and other key workers, as well as the need for a guaranteed means of supply and distribution for the future across all essential services, including domestic production.

126. The report also highlighted the need for mitigating actions to protect the public from Covid-19 while carrying out essential duties. Whilst PPE shortages were ongoing, the report was clear that medical grade masks must be prioritised for healthcare workers and that other key workers who were unable to socially distance should also be provided with suitable face protection.

127. In November 2020 the BMA also published a report titled 'Exiting the lockdown – a strategy for sustainably controlling the transmission of Covid-19 in England'. The report called for greater support for vulnerable groups and action to address health inequalities. In relation to PPE it stated that the BMA supported calls for the provision of PPE for visitors, rather than simply face coverings, to reduce the risk of infection. The document also called for clear advice within healthcare settings on the continued use of PPE.

128. In response to the government's 'Living with Covid' strategy published in February 2022, the BMA produced a briefing in March 2022 (PB/512 - INQ000397267), which provided an overview and analysis of the government's plans, including what they would mean in terms of patient safety, public health, and the medical profession. Particularly in relation to PPE, the BMA expressed concern that the strategy lacked reassurance that the IPC guidance would not be relaxed when it was due to be updated on 01 April 2022, including mandatory mask wearing and access to adequate PPE in healthcare settings.

129. While recognising the importance of pharmaceutical interventions as well as the need to learn to adapt to Covid-19, the BMA had repeatedly stated that relying solely on vaccinations to protect the country was not sufficient, and emphasised the importance of access to adequate, free PPE and effective IPC guidance, both for the safety of healthcare workers and patients.

Guidance

Risk Assessment guidance

130. As part of his academic professional work, the chair of the Medical Academic Staff Committee led a research group during the first Covid wave examining the relative risk of mortality and hospitalisation from Covid-19 against key demographic variables, using emerging data. This research used data for the general population (where the weight of available evidence was far greater than for healthcare staff alone) to produce a user-friendly risk stratification tool that was made freely available to download through the BMA website, UK-wide, in addition to the BMA's other guidance for the profession. This research has subsequently been published by peer review (PB/055 - INQ000116842).

Covid-19 toolkit for GPs and GP practices

131. The BMA produced guidance in 2020, updated in 2022, to provide information about Covid-19 related risk assessments in general practice, including the professional and legal requirements, and a step-by-step guide for GP employers and practice manages on how to undertake it (PB/060 - INQ000117990). At the time, IPC guidance stated that "employers must ensure that Covid-19 is included in risk assessments for any health and care staff who come into contact with Covid-19 due to their work activity", including health and social care workers caring for infected patients, as set out in HSE guidance on risk assessments. The BMA found that this was inconsistent with the governments 'Living with Covid-19' response, which stated that "the health and safety requirement for every employer to explicitly consider Covid-19 in their risk assessments" was removed on 01 April 2022, and that as this could leave practices vulnerable to risk, therefore saw a need to produce its own guidance (PB/474 - INQ000397249). This guidance included a specific section on RPE, setting out the appropriate RPE for different levels of risk, i.e. an FFP2 for high-risk scenarios, and FFP3s for very high risk. The guidance stipulated that if the risk in a practice was high or very high, that staff should make reasonable efforts to source FFPs with fit testing, for example by contacting their local commissioner. The guidance also highlighted that although FRSMs had been shown to lower the risk of spreading Covid-19, they do not fulfil the standard or legal definition of RPE.

BMA guidance for refusing to treat where PPE is inadequate

132. Early in the pandemic, shortages of PPE were so severe that at the time the BMA had to produce guidance for staff detailing their rights as well as moral obligations if they

did not feel adequately protected (PB/098 - INQ000117758). This guidance was issued on 22 April 2020, setting out processes for doctors to follow to identify whether PPE was adequate, and what could be done if it was not. It was stipulated that staff should not face a disciplinary process if exercising their right to decline to treat patients when their PPE was inadequate, if they were at high risk of infection and if there was no other way of delivering the care required. The guidance also included a section for situations where alternative PPE was being offered or where PPE was being reused. In the instance of a shortage, trusts were required to have an agreed action plan to support the implementation of IPC guidance published on 17 April 2020, to cover the reuse of PPE and alternatives to fluid resistant gowns in high-risk areas.

Further guidance

133. The BMA also produced online guidance for doctors who wore beards for religious reasons and therefore had issues with the fit of FFP2/FFP3 respirators. This guidance is described in paragraph 177.

134. Further, the BMA produced guidance for 'Reducing infection risk in healthcare settings' (PB/100 - INQ000118397), which is summarised in detail in paragraph 336.

Parliamentary briefings

135. The BMA produced a parliamentary briefing on 23 March 2020 (PB/811 - INQ000117784) in order to seek clarification on several topics within the UK government's 'Emergency Covid-19 Bill', including within the 'Protecting and supporting people' section specifically relating to PPE. The BMA asked whether the government intended to confirm the measures it would be taking to tackle the current insufficient supply and adequacy of PPE for frontline healthcare workers, and what routes there were for escalating urgent issues regarding lack of supplies of PPE and raising concerns.

136. It was highlighted in this briefing that doctors need adequate PPE if they are entering situations in which they are treating patients either with Covid-19 or with suspected Covid-19, and that the BMA had heard widespread reports of staff having to buy their own masks from DIY stores or online retailers. The BMA urged the government to review the guidance regarding levels of PPE for different situations, and to find a reliable way to substantially increase the production and distribution of PPE.

137. The BMA produced a response to the call for evidence from the Women and Equalities Select Committee and Joint Committee on Human Rights in May 2020, within

which it was highlighted that our BMA Covid-19 tracker survey had found that ethnic minority doctors were much more likely than White doctors to say they felt pressured to see patients without adequate PPE (PB/524 – INQ000117887). The submission also called for assurances that as well as improving the supply of PPE to healthcare workers, it must be ensured that differing needs are taken into account, for example in relation to gender, disability and religion.

138. The BMA also provided a memorandum of evidence to the House of Lords Select Committee on public services inquiry on lessons from coronavirus in June 2020 (PB/041 - INQ000118011), within which the BMA outlined key failings in the government's approach to managing Covid-19. In relation to PPE, the BMA stated that there were significant issues with stockpiling, procurement and distribution of PPE. The failure to stockpile at the outset of the pandemic was a significant issue for healthcare workers and was further exacerbated by significant delays in procuring additional PPE. Additionally, there was frustration with the Government's daily briefings referring to there being sufficient PPE, when this was not the lived experience of our members, as evidenced in the April 2020 BMA surveys which found that around half of the 6,000 doctors surveyed who were working in high-risk areas did not have the PPE they needed. The BMA had received reports of the PPE supply chain being inefficient, for example GP practices receiving PPE packages that were either short of the number of PPE units requested or missing key items.

139. In July 2020 the BMA submitted evidence to the APPG on Coronavirus' inquiry on the UK's handling of the coronavirus outbreak, highlighting the widespread shortages of PPE, caused by failure to stock enough PPE at the outset of the pandemic and significant delays in procuring additional PPE. It also outlined issues with poor quality or faulty PPE being distributed to the NHS. In our submission we called for a detailed plan of how the Government would ensure there would be sufficient PPE in place to cope with the predictable second wave of Covid cases.

140. The BMA submitted evidence to the PAC inquiry on Government procurement and contracts for PPE in December 2020, stating that the Government's inability to respond in an agile way to the demand for PPE leads to delays and drastic shortages in many parts of the NHS (PB/185 - INQ000118235). In the submission we argued that this was due to delegating large parts of the management of procurement processes and supply chains to external companies, which is outlined in more detail in the section 'Procurement and

outsourcing in the pandemic' later on in this statement. We outlined that the Government's strategy to address these problems was ineffective and slow, with reports of some batches of PPE sent into the NHS being faulty or past the original expiry date.

The BMA's approach to FFP2, FFP3 and FRSM

141. The BMA's overriding consideration in all of our work on PPE during the pandemic was ensuring that our members, and the wider health and care workforce, were adequately protected from the risks of Covid-19. Throughout the pandemic, the BMA consistently called for better access to PPE for healthcare staff. The focus of the BMA's calls reflected the concerns raised by BMA members and in response to our regular surveys (outlined in section B, above).

142. The BMA was also concerned about the adequacy of the PPE frontline staff were provided with, as a result of the IPC guidance issued by the four nation IPC cell. This covered a range of different concerns, set out in detail in section D.

143. In the early weeks and months of the pandemic, a lot of the BMA's focus was on the dire shortages of all types of PPE. The BMA also raised concerns about reports of frontline staff being provided with PPE that had multiple expiry date stickers layered on top of each other, and there were also reports of significant defects and faults in a range of products. These reports undermined staff trust in the personal protection that they were ostensibly being provided with

144. RPE is a class of PPE that provides the greatest levels of protection against respiratory viruses, particularly those spread by the airborne route. They include FFP2 and FFP3 respirators and equivalents such as powered air purifying respirators (PAPR) (commonly known as respirator hoods). FFP3 respirators are the most commonly used respirator in healthcare settings in the UK although the BMA understands FFP2 respirators were also in use during the pandemic, often due to supply issues with FFP3 products.

145. The understanding and dissemination of the knowledge of the significance of airborne routes of transmission of Covid-19 evolved over the pandemic. What has been known for a long time though is that respiratory protective equipment, such as FFP3 respirators provide significantly greater protection for healthcare staff compared to FRSMs for an airborne virus. This was included in a 2008 report prepared for the HSE which found that where there is a respiratory risk of infection, the use of FFP3 devices represents best

practice, and where these are not available then FFP2 may be an acceptable, pragmatic compromise (PB/451 - INQ000145893). The report also explains that filtering facepiece respirators are classified as FFP1, FFP2, and FFP3 according to the level of protection they afford, with FFP3 offering the most protection (99% filter efficiency and an assigned protection factor of 20), with FFP2 (94% filter efficiency and an assigned protection factor of 20), and FFP1 (80% filter efficiency and an assigned protection factor of 4) providing correspondingly less protection. The greater protection offered by FFP3 respirators compared with FRSM against Covid-19 was demonstrated by an observational research study undertaken at Addenbrooke's Hospital, a tertiary NHS hospital in Cambridge, during the pandemic (PB/455 - INQ000408843).

146. The BMA usually referred to FFP2 and FFP3 respirators together when comparing them to FRSM and did not generally differentiate but was always clear in our communications that FFP3 provided the highest level of protection. However, in the face of the severe shortages of PPE experienced at the start of the pandemic, in particular, the BMA accepted that the use of FFP2 may be a pragmatic compromise and offered significantly higher protection than FRSM which are not RPE and do not provide effective protection against an airborne virus.

147. The BMA's calls for greater use of FFP2/FFP3 intensified as the pandemic progressed and more evidence emerged on the significance of aerosol transmission of Covid-19. For example, in the BMA's report, 'Reducing infection risk in healthcare settings' (see paragraph 336), the BMA highlighted deficiencies in the Covid-19 IPC guidance for healthcare settings and stated that "As a precautionary step, employers should ensure that all healthcare professionals providing care for confirmed or suspected Covid-19 patients are provided with FFP3 respirators or equivalent, such as elastomeric reusable respirators" (PB/099 - INQ000118214). The report also called for the same protection to be offered to ancillary staff such as cleaners who were in close contact to Covid-19 patients, often in poorly ventilated spaces.

148. The BMA did not routinely monitor the approach of other countries as to the use of FFP2 and FFP3 respirators in healthcare settings, although we were aware that different approaches were taken in different countries to the use of these products. It is notable that other countries with previous experience of Coronaviruses made different choices in protecting their populations. We believe, for example, that South Korea recommended the use of FFP2 masks for their population and subsidized their provision (PB/812 - INQ

000520245), while in the UK healthcare workers were and continue to be asked to treat patients with Covid with FRSM masks only. Equally the CDC (Centre for Disease Control and Prevention) and EDC (European Centre for Disease Control and Prevention) both recommended the use of FFP2 for healthcare workers (PB/813 - INQ000520236).

Engagement with key regulatory bodies and other organisations on the need for respirators to protect healthcare staff

149. The BMA's interventions which aimed to increase the number of healthcare workers who were provided with FFP2/FFP3 respirators broadly covered two separate issues:

a. The overall shortage of PPE which included respirators and calling on Government to increase the stocks of all types of PPE. These issues are covered in relation to PPE shortages in paragraphs 102-104.

b. Concern about the risk of aerosol transmission of Covid-19 and the deficiencies in the IPC guidance for healthcare settings in not recommending RPE for the care of patients with confirmed or suspected Covid-19, outside a limited range of settings and procedures. These issues and the actions the BMA took to get this rectified are set out in detail in section D.

150. This section sets out details of the BMA's correspondence with HSE on this issue not covered elsewhere in the statement.

Health and Safety Executive

151. The BMA wrote to the Health and Safety Executive (HSE) on several occasions during the pandemic, including on the topic of respirators:

a. The BMA UK Council Chair and Chief Executive & General Secretary of the Royal College of Nursing (RCN) sent a joint letter to Sarah Albon, Chief Executive, HSE, on 21 January 2021. The letter highlighted BMA and RCN members' concerns around the protection from aerosols with the use of FRSM and requested the HSE undertake an urgent review of IPC guidance for health and care to reduce transmission of Covid-19, particularly in relation to the appropriateness of the recommended PPE. The BMA also called for a review of the guidance with regards to the provision of ventilation across the health and care estate, given the

emergence of new variants (PB/090 - INQ000097909). HSE replied (letter dated 29 January 2021). In their reply HSE stated that DHSC and PHE were responsible for leading the development of the IPC guidance and declined to review the IPC guidance as a clinical and scientific review had been done prior to its publication (PB/815 - INQ000417574).

b. The Chair of the BMA's Occupational Medicine Committee wrote again to Steve Forman, Principle Medical Advisor, HSE, on 24 March 2021 requesting clarification of HSE guidance around the reporting of Covid-19 cases and HSE's duty to determine the correct level of RPE (PB/463 - INQ000400480). In their reply, dated 28 April 2021, the HSE stated that it is the employer's duty to determine the correct level of RPE (PB/439 - INQ000400457).

c. The deputy chair of the BMA's Occupational Medicine Committee co-signed a joint letter to Sarah Newton, HSE Chair, dated 25 November 2021. Other signatories included representatives from the Royal College of Nursing, the British Occupational Hygiene Society, FreshAirNHS, and the Covid Airborne Protection Alliance. The letter called on HSE to act urgently to protect NHS healthcare workers from the risk of Covid-19. In particular, the letter called on HSE to undertake an urgent review of the IPC guidelines on respiratory infection risk to determine their appropriateness and compatibility with Health and Safety law (PB/109 - INQ000118441). In her reply, dated 15 December 2021, Sarah Newton set out HSE's position that 'All employers, including those in the NHS, are expected to assess the risks to their workers created by their work activity and to implement appropriate measures to control these risks". She also stated that HSE would not be undertaking a review of this guidance as this has already been done by DHSC, UKHSA and the Devolved Administrations which they regarded as 'competent bodies', and that they had already undertaken investigations and enforcement actions at employer level or given verbal advice (PB/110 - INQ000118447). The BMA found this approach particularly concerning given the HSE's commissioned research on respiratory protection prior to the pandemic, which recommended that FRSM should not be used in situations where close exposure to infectious aerosols is likely, as they did not provide adequate protection against exposure via this route of transmission.

Issues with the quality of FFP3 and other PPE supplied to frontline healthcare staff

152. Several specific examples of faulty or defective PPE were brought to the BMA's attention and led to public interventions to get the government to act and provide reassurance that staff were not being provided with faulty PPE putting them, their families and loved ones, and patients at risk of infection.

Faulty Cardinal Health FRSM and FFP3

153. On 30 June 2020, the BMA issued a comment to the press from the Chair of GPC England about the issue of faulty Cardinal Health fluid resistant surgical masks after the Medicines and Healthcare products Regulatory Agency (MHRA) issued an alert and advised that these products should be disposed of locally (PB/816 - INQ000522188). These faulty masks carried a risk to the wearer due to the possibility that the foam strip could disintegrate, and particles could enter the airway or mouth.

154. Dr Chaand Nagpaul, UK BMA Council Chair, wrote to Simon Stevens on 06 July 2020 about the issue of faulty and out-of-date Cardinal Health masks (consisting of FRSM and FFP3 products) remaining in circulation despite reports that these were faulty and out of date (PB/194 INQ000097855). In particular there were issues about out-of-date and faulty Cardinal Health **FRSM** reaching health and social care staff. This is despite NHSE providing assurances in March 2020 that any PPE products which "may appear" to have an out-of-date expiration date will have passed stringent tests to demonstrate their safety. Separately, we also raised concerns that Cardinal Health **FFP3** products were continuing to be distributed despite a decision reportedly being made by the Department of Health and Social Care, also in March 2020, not to further distribute these products in light of evidence that they were failing to achieve successful fit testing. The letter noted that as late as June 2020, the BMA had attempted to flag issues to NHS England about incidents of Cardinal Health FFP3 masks yielding 100% failure rates in fit testing. The BMA sought urgent clarity and reassurance on a range of matters relating to the Cardinal Health FRSM and FFP3 respirators as well as wider PPE products. This included:

a. whether all batches of the faulty, re-dated FRSMs had been withdrawn from frontline health and community care settings, and clarification of how many providers had been affected and what action was being taken to follow up with those impacted

b. confirmation that all batches of the substandard Cardinal Health FFP3 masks had been withdrawn. Further, if the decision to cease distribution of these respirators applied to all products and why these items continued to be in circulation, as per reports from BMA members

c. whether other items of PPE – whatever make or model – that had out-of-date expiration dates but had been tested and deemed safe, would now be re-tested or recalled.

155. The BMA received a response to this letter from Dr Emily Lawson, Chief Commercial Officer of NHSE on 30 July 2020 (PB/435 - INQ000400421) which briefly addressed the issues relating to both Cardinal Health IIR and FFP3 products but did not fully allay the BMA's concerns. In particular, the letter failed to provide clarity on the numbers of providers impacted or what steps would be taken to ensure lessons were learned and this situation didn't happen again. Nor did NHSE provide specific reassurance on wider PPE products that were out-of-date but still in use.

156. In relation to the Cardinal IIR masks, the reply stated that these products were from the DHSC pandemic stockpile and queries about the stockpile - including how stockpile products were tested - should be directed to the DHSC and PHE. In relation to the concerns raised about the products themselves, Dr Lawson stated that since the problem with foam strips in the masks was identified, the DHSC issued an alert based on advice from the MHRA, who recommended all products were disposed of locally and stated that this alert was sent to NHS Trusts via a number of routes.

157. In relation to the Cardinal Health FFP3 respirators, the reply stated that a decision was taken by the government to pause nationwide distribution and pilot the Cardinal respirators with some Trusts, with their agreement.

Counterfeit FFP3 respirators – Fan Tian

158. On 18 February 2021, the DHSC issued an alert about Fang Tian FT-045A FFP3 masks not meeting the required technical specification. It advised health and care providers to check stocks and stop using these products pending further investigation. This was subsequently reported in the media, with the masks described as counterfeit with a forged CE mark. The news reports said that there were an estimated 1.2 million of these products in use or hospital stores in the NHS. The BMA issued a statement from the Chair

of the BMA Consultant's Committee (England) in response to this news story (PB/817 - INQ000099249).

159. The BMA commented on this issue again in January 2022, when media reported that a report into the issue of the Fang Tian masks found that concerns about these products had been dismissed both before they entered circulation in the NHS and afterwards (PB/818 - INQ000522164).

Faulty PPE in the Devolved Nations

160. BMA **Northern Ireland** became aware of concerns from members about a particular brand of FRSMs (Tiger IIR) circulating in healthcare settings, particularly hospitals. The concerns were that the masks in question had elastic ear loops, and no anti-fog strip and staff reported that the masks ride down their face while they speak. The BMA raised this issue with a number of organisations.

161. On 03 June 2020, the Chair of NI BMA Council and BMA staff had a call with the Chief Executive and colleagues from the Health and Safety Executive Northern Ireland which was then followed up by letter from the Chair to the HSENI Chief Executive on 05 June 2020, asking him to look into this issue with the MHRA and to consider how the risks to healthcare workers from these products was being mitigated (PB/819 - INQ000116870). The CE of HSENI replied in a letter dated 23 June 2020 (PB/820 - INQ000116873). HSENI advised that they had written to all Health and Social Care Trusts on 10 June 2020 asking if they had or were using these products and, if so, whether guidance had been given to staff on how to achieve a secure fit. The letter advised that all Trusts had confirmed that they had used these products to varying degrees, and all had provided guidance on their use to achieve a secure and comfortable fit. The also stated that the Department of Health had advised HSENI that they were in discussions with the MHRA (who were responsible for ensuring compliance of medical devices, including FRSM, with relevant regulations) and that the MHRA had confirmed they were in the process of considering the various issues raised about the quality and safety of the current stock of fluid shield masks (which the BMA understood to mean FRSM).

162. On 24 June 2020, the Chair of BMA NI Council wrote to the Interim Chief Executive of the MHRA on the same issue (PB/821 - INQ000522187). A reply was received from the MHRA dated 07 July 2020 (PB/822 - INQ000522186). In reply, the MHRA stated that when they became aware of issues with the fit of these products, they

took immediate action to liaise with colleagues in Northern Ireland. They confirmed that a large number of ear loop FRSM products had entered the supply chain and that currently there was no significant trend across the UK relating to fit issues. They confirmed that the Tiger products about which the BMA had raised concerns complied with relevant safety and performance requirements, but they acknowledged that not one size will fit all in terms of the range of medical face masks in the supply chain and that the careful choice of masks is important to ensure the desired level of protection. The MHRA advised that they had also advised the NHS PPE central supply channel of the issue and were aware that the IPC cell and some manufacturers had recommended minor adjustments to improve the fit of the products. They advised that they would continue to monitor all reports and take further action if appropriate.

163. The Chair of the BMA NI Council wrote to the CMO of Northern Ireland regarding this issue on 20 July 2020 (PB/321 - INQ000116876). The letter outlined the issue with the Tiger IIR masks and reported that there was at least one trust that had implemented modification with ties but asked that this issue is resolved before a second surge of the virus. The BMA asked if it would be helpful to convene a teleconference of relevant bodies with a small number of expert doctors from the BMA to try to find a solution that would help increase confidence in the profession.

164. BMA **Scotland** contacted the Scottish CMO and Director of Workforce on 11 November 2020 following reports on social media of concerns around the provision of PPE gowns which appeared to be of inferior quality and not fit for purpose to GPs in particular. In reply, the Scottish government advised that there appeared to be two issues in relation to aprons which had been conflated in social media reports. Firstly, there was an issue with some aprons being mislabelled as polythene bin bags but they had received assurances by National Services Scotland (NSS) that these items were 'smock style aprons' and NSS were investigating how the mislabelling happened but assured the BMA the products were compliant with all regulations and had passed rigorous quality assurance. The second issue was that as part of primary care allocations some health boards were sent smock style aprons instead of other types of disposable aprons but again assured the BMA that all styles of aprons had passed the quality assurance requirements. They outlined the process for staff who wanted a different style of apron to follow to request this. They confirmed that a communication was issued to boards the previous month advising them that they may have received different styles of aprons to

previous shipments and NSS would be sending a further communication the next day to reinforce this message (PB/865 – INQ000522184).

Female, ethnic minority and religious staff faced particular issues in relation to PPE

Lack of available FFP3 respirators to fit a variety of face types impacted ethnic minority and female staff

165. The impacts of the pandemic were not felt equally for all frontline healthcare staff. It became evident, from as early as April 2020, that doctors from ethnic minority backgrounds were more likely to be infected with Covid-19, have higher rates of severe illness and admission to critical care, as well as mortality from Covid-19. The first ten doctors in the UK who died from Covid-19 were from ethnic minority backgrounds, and by May 2020, more than 90% of the doctors who died were from ethnic minority backgrounds.

166. The BMA was one of the first organisations to call for an urgent national review into the disproportionate impact of Covid-19 on ethnic minority doctors and communities. The BMA UK council chair sent a letter dated 09 April 2020 to the Chief Executive of NHS England regarding the 'Impact of Covid-19 on BAME communities and the doctor workforce' in which the BMA raised concerns that a disproportionate number of patients critically ill with Covid-19 are from ethnic minority backgrounds and that this would translate to a higher death rate among ethnic minorities. Further, the doctors who had died from Covid-19 were disproportionately from ethnic minority backgrounds. The BMA asked that NHS England urgently investigate whether patterns were emerging in the hospital admission or death of healthcare workers. Having heard that doctors wearing beards for religious reasons were facing difficulties in getting alternative respirators where FFP3 masks could not be fitted, the BMA emphasised that it was imperative that adequate and effective PPE be provided to the NHS workforce, in line with WHO recommendations at a minimum (PB/072 – INQ000097864).

167. Issues that ethnic minority doctors faced in getting access to well-fitting PPE are also reflected in the BMA's survey data (see section B). These surveys show that many staff from ethnic minority backgrounds had issues with the fit of FFP2/FFP3 respirators and as a result failed their PPE fit testing. Our survey data also indicated that these issues

were compounded by ethnic minority doctors feeling worried or fearful about speaking out, and the fact they felt risk assessments had been ineffective, which put them further at risk of Covid-19.

168. Data from BMA surveys also indicated that female doctors were struggling with poorly fitting PPE, which left them more exposed to Covid-19. This was due to gender bias within PPE design, which meant that specialist FFP3 masks disproportionately did not securely fit smaller, including female, face shapes.

169. The BMA consistently raised concerns about the disproportionate impact of PPE decisions on certain frontline staff, and of the lack of face coverings to fit a diverse range of face shapes and sizes, as well as a lack of face transparent coverings to support deaf staff relying on lip reading. For example, in a BMA news article "BAME doctors hit worse by lack of PPE" on 24 April 2020, we highlighted that doctors from ethnic minority backgrounds were being disproportionately affected by PPE shortages (PB/872 - INQ000553499). The BMA published a blog "The NHS 'make-do' culture is not safe" on 06 May 2020, which drew attention to the fact that doctors from ethnic minority backgrounds can be less confident in raising concerns, including about PPE, more fearful of being blamed if something goes wrong, and are more likely to experience bullying and harassment in the workplace (PB/873 – INQ000553500).

170. In April 2020, the BMA made a submission to the Women & Equalities Committee inquiry on Covid-19 on the impact of Coronavirus on people with protected characteristics (PB/524 - INQ000117887), which stated that the BMA had raised with PHE the need to ensure diversity of PPE so that differing needs were considered. Our submission summarised that we had heard from: women doctors who struggled to access smaller sizes of FFP3 masks, the most highly protective masks; Sikh, Muslim and Jewish doctors who wore beards for religious reasons and would have liked HSE-recommended alternatives (like PAPR hoods) to be made available so that they did not have to abandon their religious practice; and deaf doctors and medical students who called for transparent face masks so they could lip-read and communicate easily with colleagues (only prototypes of transparent masks were available which had not been approved for safe use in the Covid-19 pandemic). This issue was also discussed at a briefing by NHSE in December 2020 which a BMA staff member attended (PB/201 - INQ000118248).

171. The BMA also reiterated concerns about the lack of protection of ethnic minority healthcare workers from Covid-19 in the workplace in a submission to the PHE Review

into the disparities and outcomes of Covid-19, dated 24 May 2020. This included concerns about workers not being adequately risk assessed, being more likely to be deployed or feel under pressure to work in high-risk areas and not having access to adequate, well-fitting PPE (PB/079 – INQ000117943).

172. On 28 May 2020, the BMA, jointly with the RCN, wrote to the British Safety Industry Federation (PB/075 - INQ000097948) expressing concern that specialist FFP3 masks disproportionately did not securely fit smaller, often female face shapes, which led to many female nurses and doctors failing fit testing. While recognising the primary obligation to provide suitable and sufficient PPE rests with the employer, in the context of the pandemic the BMA and RCN asked the industry to review the design of PPE, including masks.

173. In an undated reply, the British Safety Industry Federation confirmed that the size mix of FFP masks had been led by industry, although several manufactures had a range of sizes to fit smaller face sizes, and that the disruption to supply chains caused by the pandemic led to limited product availability, further limiting available sizes and models of FFP masks (PB/823 - INQ000417570).

174. On 29 May 2020, during a regular meeting with Stephen Powis, National Medical Director NHSE, the chair of the BMA Consultants Committee raised the issue of PPE in relation to gender as well as security of PPE supply (PB/200 - INQ000117760).

175. In January 2021 the issues around correctly fitting PPE for a diverse healthcare workforce were still ongoing. The BMA council chair sent a letter dated 13 January 2021 to Jo Churchill, Parliamentary Under Secretary of State (Minister for Prevention, Public Health and Primary Care) regarding the failure of PPE in meeting the diverse needs of the medical workforce. In this letter the BMA highlighted persistent concerns from members regarding inadequate, ill-fitting PPE for healthcare workers, and in particular female doctors reporting their difficulties in finding masks that fit. We requested urgent provision of appropriate PPE to meet the diverse needs of the workforce (PB/076 - INQ000097874). This letter was referenced in a separate letter to PHE sent by the BMA also on 13 January 2021 about access to RPE for healthcare staff (PB/089 - INQ000097875). The issue was also discussed in a meeting between BMA staff and officials from DHSC. In the meeting the officials from the department recognised that there were problems with ensuring PPE fitted individuals, especially in relation to FFP3 respirators. The officials also stressed that the concerns the BMA expressed were being heard and that the department would continue to monitor and perfect the situation. The BMA asked the department to continue

to promote the diversity of the PPE available and the importance of fit testing and emphasised that PPE shouldn't be dictated by manufacturers but should be available for the needs of the workforce (PB/869 – INQ000522172).

Doctors who wore beards for religious reasons had particular issues with the fit of FFP2/FFP3 respirators

176. One of the first equalities issues raised with the BMA related to the fact that a number of ethnic minority doctors faced particular difficulties with ill-fitting PPE due to wearing a beard for religious reasons, as facial hair may affect the fit of FFP2 and FFP3 respirators.

177. In relation to this issue in particular, the BMA provided online guidance to doctors who have beards (the BMA does not have the precise publication date but believe it was between 13 March and 05 May 2020 (PB/824 - INQ000522182)). The guidance outlined the implications of a policy that required staff to shave their beards when using FFP3 masks due to Covid-19 safety measures, which may have disproportionately affected doctors with religious obligations. It stated that, under the Equality Act 2010, such policies must be justified by legitimate health and safety needs. It stated that employers are encouraged to consider the psychological impact of this requirement and explore alternative PPE options, like powered air-purifying respirators (PAPR), that do not require beard removal. It also advised doctors that they should ask their employer whether, due to their religious obligations they could be exempted from tasks that required the highest-level PPE.

178. Staff from the BMA's Ethics and Equality, Inclusion and Culture teams wrote an article which was published on the BMJ opinion page on the 12 March 2020 examining the legal and ethical considerations of this issue in further detail (PB/825 - INQ000520237).

179. The BMA continued to hear instances of doctors experiencing ongoing difficulties in accessing PPE that allowed them to wear a beard or hijab, including not being provided with alternatives to FFP2/3 respirators such as PAPR hoods. We also heard from some doctors who did shave their beards early in the pandemic who were concerned about how long it would be before they could wear a beard again, particularly if alternative PPE was not more widely available.

Recommendations made by the BMA in relation to ill-fitting PPE

180. The BMA made a number of recommendations around the issue of ill-fitting PPE for staff such as female doctors and those from ethnic minority backgrounds.

181. In the first report of the BMA's Covid-19 Review, the BMA called for the UK Government to maintain an adequate rotating stockpile of PPE and have plans to quickly scale up procurement and manufacturing if required. Because the medical workforce is diverse, we stated that the PPE we procure needs to be suitable to different face and body shapes, varying hair textures, head coverings, and facial hair so all workers can access adequate protection. We said that PPE should be provided with centrally coordinated guidance and practical training on how to fit test, use, and dispose of it safely. Similarly, in our submission to the Women's and Equality Committee referenced above, we said that PHE must improve the supply of PPE to healthcare workers, and must take differing needs into account, including gender, disability and religion.

182. In the second report of the BMA's Covid-19 review, we recommended that to mitigate inequity in the future, mechanisms must be introduced to make the experience of working in the NHS less variable by background or protected characteristic.

183. In our response to the PHE Review into the disparities and outcomes of Covid-19, we said that the Review should ensure it has properly considered the cultural, occupational and workplace risk factors that could lead to disproportionate impacts on ethnic minority staff or other vulnerable staff and what more can be done to control or mitigate them effectively (PB/826 - INQ000117851).

184. The BMA also wrote to Sir Simon Stevens on 28 April 2020 (PB/056 - INQ000097947) calling for a national risk profiling framework to be developed for NHS staff. We were pleased that NHSE/I heeded our calls and instructed all NHS providers to ensure risk assessments were carried out on a precautionary basis (albeit it did not provide a risk profiling framework, leading the BMA to produce its own as mentioned above). Following this, 'ethnicity' was included as a risk factor in the various updated risk assessment frameworks and guidance, adding that BAME populations appear to be associated with increased risks. At the same time, the National Director of BMA Scotland contacted the Director General of Health and Social Care (PB/063 - INQ000117069) about the same issue, while in Wales the Chair of Welsh Council and the National Director of BMA Wales contacted the Director of Workforce and Organisational Development (PB/360

- INQ000118541, PB/471 - INQ000118548). The BMA received a letter from Stephen Powis, NHS England's Medical Director dated 12 October 2020 stating it was intended to "close the loop" on a number of letters from the BMA on risk assessments, including the 28 April letter to Simon Stevens. This reiterated the action taken by NHS England to improve risk assessments, including for ethnic minority staff as well as addressing issues related to the procurement of PPE, noting that PPE shortages had significantly improved in recent months but also acknowledging the need for the supply of PPE to align with the different types of PPE required in different situations (PB/438 – INQ000400425).

D. Infection, Prevention and Control Guidance

Summary of key issues relating to the IPC guidance

185. Throughout the pandemic there were significant shortcomings in how staff working in healthcare settings were protected from the virus. Infection Prevention and Control guidance on Covid-19 in healthcare settings, which was intended to keep staff and patients safe, is a prime example of this. It has been, and continues to be, inadequate, putting both staff and patients at risk. The BMA was vocal in calling for improved protections for healthcare workers through the IPC guidance throughout the pandemic, calling for a precautionary approach.

186. Early in the pandemic, there were concerns about UK IPC guidance not recommending the same level of protection as guidance from the WHO, the European Centre for Prevention and Disease Control (ECDC) and the US Center for Disease Control and Prevention (CDC), particularly around the use of long-sleeved gowns and eye protection.

187. The BMA also raised concerns about decisions not to classify CPR (including chest compressions) as an Aerosol-Generating Procedure (AGP), which impacted on the provision of PPE to staff. Another issue we raised concerns about was revisions to the guidance in the summer of 2020 which downgraded the PPE for use in designated 'low risk' settings, including removing airborne protections (i.e. access to FFP3 respirators) for AGPs in this setting.

188. As the pandemic developed, the BMA increasingly highlighted the relevance and consequences of aerosol transmission for Covid-19 and called for the IPC guidance to be

updated to recommend FFP2/3 respirators when treating patients with suspected or confirmed Covid-19, in line with the BMA's precautionary approach to the protection of healthcare workers. For example, in a meeting between BMA staff and officials from the Department of Health and Social Care on 22 January 2021 (PB/869 – INQ000522172), the BMA expressed concern that the IPC guidance still only recommended FFP3 in AGP areas and concerns remained about aerosol spread outside those areas and called for this precautionary approach. In the same meeting the BMA also questioned how much supply was a limiting factor in the recommendations about the use of FFP3. The Department official stated that supply wasn't a limiting factor. Officials further suggested that the BMA be involved in a proper debate with the authors of the IPC guidance about our concerns; the ways in which the BMA sought to do this are set out extensively in this statement

189. The updates to IPC guidance were often published late on Fridays, which made it difficult for the BMA to engage with the final guidance (even in instances where consultation on draft guidance or proposed changes had occurred prior to this) and even more difficult for healthcare professionals and leaders on the ground who were required to implement it, given it usually came into force with immediate effect or with only a few days' notice.

190. Throughout the pandemic, the BMA made representations to individuals, departments and agencies either responsible for, or with the ability to influence, decision making to correct what we believe were and are major failings in IPC guidance. In particular, the BMA was and remains concerned about the failure to recognise the growing significance of airborne transmission and reflect this in IPC guidance by recommending staff dealing with suspected or confirmed Covid-19 cases wear RPE, including FFP3 respirators.

Impact of deficient IPC guidance on healthcare workers

191. The deficiencies in the IPC guidance had profound impacts for the physical and mental health of doctors and other frontline healthcare workers. Trust in the IPC guidance – and the protections that flowed from it – was essential for the psychological safety of staff. It was clear to the BMA that staff lost trust in the IPC guidance.

192. As a result of this lack of trust, staff worried even more that they were at risk of infection and that they could be inadvertently putting their families, friends and loved ones at increased risk as they were not adequately protected at work. Many staff went to extraordinary lengths to protect their loved ones, often moving out of their own home or segregating in different areas of their homes, where this was possible.

193. The concerns of doctors, particularly about the failure of the IPC guidance to recommend RPE for the routine care of Covid-19 patients was particularly apparent in the comments of many respondents to our Call for Evidence in 2021:

> *'No PPE availability. Failure to acknowledge that speaking singing coughing etc [sic] are all aerosol generating procedures, that healthcare staff cannot assess patients without getting close. Therefore, ALL categories of staff should be provided with PPE'. (GP trainee, England)*
>
> *'The fact we still use FRSM masks now is a joke given that we know it's an airborne virus'. (GP contractor/principal, Wales)*
>
> *'We were advised full PPE for Covid positive patients ONLY if they were 'aerosol generating'. Covid positive patients were constantly coughing. In my opinion, coughing is aerosol generating too. But apparently, getting ourselves exposed to [a] Covid positive patient's cough is OK and only [a] flimsy plastic apron and blue mask are enough to protect one'. (Consultant, England).*

194. While we may be through the acute Covid-19 pandemic, UK IPC guidance and consequent RPE provision is not an academic matter. Covid-19 continues to circulate meaning staff not offered adequate protection continue to be put at risk of catching the virus at work and being either ill themselves or transmitting the virus to clinically extremely vulnerable patients or relatives. In addition, our survey of doctors with post-acute complications of Covid-19 (e.g. long Covid) showed that only a minority of these doctors (26%) were supplied with an item of RPE, such as a FFP2 or FFP3 respirator, around the time they acquired Covid-19, with the great majority also believing they contracted Covid-19 at work. These findings indicate that inadequate respiratory protection could have contributed to occupational disease acquisition, with Covid-19 being contracted in the workplace. A failure to provide PPE in the beginning of the pandemic has also been directly implicated in the death of at least one doctor, with evidence of requests for equipment being declined (PB/458 - INQ000397294).

The BMA had limited direct consultation on the IPC guidance

195. The BMA has records of direct feedback on the IPC guidance being sought from the BMA in relation to three drafts of IPC guidance:

a. An update to the main Covid-19 guidance for healthcare settings which was published on 02 April 2020

b. Specific guidance on IPC related to the remobilisation of essential services published on 21 August 2020.

c. Guidance for seasonal respiratory infections in health and care settings for Autumn/Winter 2021-2022.

196. On each occasion, the BMA (and other stakeholders) had limited time to submit comments ahead of the guidance being published and had significant concerns about the guidance that was ultimately published.

April 2 IPC guidance

197. PHE sought feedback from various stakeholders, including the BMA, on the revised version of the UK IPC guidance for different clinical scenarios and settings, which was ultimately published on 02 April 2020. This version of the IPC guidance included four tables detailing the:

a. Recommended PPE for HCWs by secondary care inpatient clinical setting, in the NHS and independent sector.

b. Recommended PPE for primary, outpatient and community care by setting, in the NHS and independent sector.

c. Recommended PPE for ambulance staff, paramedics, first responders, other patient transport services and pharmacy staff.

d. Additional considerations, in addition to standard IPC precautions.

198. The BMA gave feedback via the consultation form provided by PHE for version 1 of the guidance relating to primary and community care (table 2 – PB/827 - INQ000269654) on the 30 March 2020 and provided the following input (PB/828 - INQ000117805):

a. The BMA questioned the distinction in the guidance between “suspected cases” and other patients and said that all patient care within primary care (and in other

settings including in secondary care) should be treated as 'suspected cases' for the protection of frontline healthcare workers and in the absence of widespread testing.

b. Table two recommended that eye/face protection be worn in some circumstances whilst providing direct patient care, but in other cases to only do so if a risk assessment had been completed. In other circumstances (such as working in a communal area with possible or confirmed cases where a 2m distance was not possible) the guidance did not recommend the use of eye protection at all. In relation to this section and the wider document, the BMA expressed the clear view that eye protection (including visors) and disposable gowns must be made available for all direct patient care in any setting due to the risk of droplet production and the possible viral load of patients and should not be worn only following a risk assessment.

199. Following this submission, the BMA participated in a stakeholder call with PHE on 01 April 2020 and provided further written feedback on the PHE guidance on PPE via email on 01 April 2020 (PB/826 - INQ000117851, PB/829 - INQ000117816). The BMA outlined its concerns regarding the deviation between PHE guidance and WHO guidance, specifically in relation to the use of disposable gowns versus the use of aprons. The BMA sought clarification and asked for this issue to be specifically addressed, requesting that PHE clearly communicate its reasoning to frontline healthcare professionals. The email further outlines feedback on a number of points in the guidance, including on use of PPE (for example it was not clear how long FFP3 masks can be worn), donning and doffing PPE, social distancing, and a number of equality and inclusion issues, such as issues with FFP3 masks being available in a range of sizes. The BMA was also invited to a briefing the following day with Professor Stephen Powis to discuss the guidance and its application on the frontline (PB/199 - INQ000117821).

200. The BMA further emailed PHE colleagues on 07 April 2020 (PB/826 - INQ000117851), following publication of the revised guidance, highlighting areas that were raised in the consultation but not reflected in the new guidance. This included a range of issues about available protections, guidance on donning and doffing, the need for full PPE in ITU settings as well as flagging a range of equality and inclusion issues. The BMA also raised the evidence review of AGPs commissioned by PHE, and asked when this would likely be published, particularly given the BMA had received enquiries on whether

CPR is an AGP. Susan Hopkins, then Deputy Director, National Infection Service at PHE, replied on the same day. In some cases, she indicated that she believed the issues had been addressed and, in others, deferred to local decision making and implementation. In relation to the AGP review she advised she was waiting for further discussions with NERVTAG and was engaging with the UK Resuscitation Council on the issue of CPR.

21 August - Guidance for Remobilisation of Essential Services within Healthcare Infection Prevention and Control Recommendations

201. The UK IPC cell produced draft IPC recommendations in July 2020 to support the remobilisation of essential healthcare services (after many of these had been paused to deliver Covid care) and sought feedback from the BMA and other stakeholders on this guidance via email on 09 July 2020, with a deadline for comments of 16 July 2020.

202. The BMA provided feedback on the draft guidance on 16 July 2020 to the IPC cell via the evaluation tool provided (PB/579 - INQ000433858, PB/581- INQ000433859). The BMA provided comments on a number of sections in the guidance:

a. Section 3: 'COVID-19 care pathways': This section suggested that staff should try to work in one area throughout their shift. The BMA highlighted that this would be difficult for many staff (for example higher medical/surgical trainees) who are often required to move around the hospital to review patients. In relation to patients on a non-covid pathway admission requiring a Covid-19 test less than 72 hours prior to admission, the BMA asked for information on who would perform these tests and how they would be commissioned and funded. It was also fed back that it would be useful to have a clear procedure set out for occasions where patients refused to wear a mask.

b. Section 5: Transmission based precautions: The BMA reiterated its previous calls (alongside RCUK and others) that chest compressions as part of CPR should be included in the list of AGPs. It was also noted that although it was positive to see a clear statement that all staff required to wear an FFP3 must be fit tested, this could be elaborated on to include 'if this is not possible, they should be removed to non-exposed areas.' The BMA also emphasised that different size FFP3 masks should be available for women and those who fail fit testing on standard size FFP3 respirators.

c. Appendix 2: The BMA provided feedback that it may not be appropriate to use a new surgical mask after each patient contact in the medium and low risk pathways (referring to the table in the appendix). This should be sessional use at the discretion of the infection control team. It was stated that there is little risk to the patient from the sessional wearing of a surgical mask between patients if hand hygiene is performed, but there is increasing risk to healthcare workers with changing their masks.

203. The BMA (including some members of staff as well as the consultants committee chair and the GP committee chair) met with NHSE/I for a briefing on 10 August 2020 regarding the near final version of the IPC guidance, which was planned to be published imminently after the meeting. Following the briefing, the BMA emailed NHSE/I expressing concern about some aspects of the guidance (PB/198 - INQ000118065) and suggested delaying its publication so that these concerns could be addressed. The BMA's main feedback included:

a. The need to reassure staff. Initially in the outbreak, staff confidence was lost due to a lack of adequate supply of PPE. The BMA highlighted that care must be taken to make sure that does not happen again calling for a "reassurance narrative" throughout the document to reassure staff that their safety will not be prejudiced in order to deliver increased NHS throughput.

b. Concerns about the 'low-risk pathway' which were extremely contentious. One of the key issues was the removal of airborne precautions for AGPs happening in this pathway. This would be happening as shielding was coming to an end and high-risk individuals would be returning to the workforce. The BMA called for clear guidance on how this new PPE guidance sat alongside guidance on risk assessment and mitigations for individuals at high risk.

c. Linked to the above, the BMA had concerns about false negative results for Covid testing, especially given that testing would be used for entry into the low-risk pathway. While appreciating that in many areas where community transmission is low this would present a relatively low risk, there needed to be accessible real-time information on local levels of transmission to support decision making on PPE. The guidance lacked some consistency regarding 3 vs 14 days of pre-procedure self-isolation; 3 days was advised for low-risk pathways, but the advice suggested that patients at risk of severe consequence from covid infection should self-isolate for

14 days, implying that 14 days is safer for patients than 3 days in self-isolation. The BMA also highlighted that when the guidance is implemented locally it would be useful for the terms 'high', 'medium' and 'low' to be used consistently (rather than a variable selection of colour codes). The BMA suggested that there should be consultation with ethnic minority medical organisations before publication.

d. Finally, the BMA asked for clarity on the PPE requirement for immunisations.

204. NHSE/I's Deputy National Strategic Incident Director responded to the BMA's email on this guidance on 14 August 2020, saying that it was essential that the BMA and NHS England continued to work together (PB/830 - INQ000522170). They responded to the BMA's concerns as follows:

a. **Staff confidence:** NHSE/I said they had tried to enhance the communications plan and address this key issue, and that the BMA's support on this would be welcome. They emphasised that there is no change to the PPE used in the high and medium-risk pathways, which they knew "from the rates of nosocomial infection, that this is safe and effective". In relation to the low-risk pathway, it was stated that staff can be confident that the tests used on patients before admission are sensitive, so the chance of a false negative is very low. They said that they are working with PHE to try to ensure that staff have easy access to data on the local prevalence so that staff can be aware of the local risk in their hospital or surgery.

b. **Low risk pathways, high-risk individuals and removal of airborne precautions for AGPs:** The email stated that the recommendation for removing the airborne precautions during AGPs in this pathway was consistent with WHO guidance, and that this applies to other infectious disease management. The email stated that concerns of shielding staff and staff from an ethnic minority background were understandable, but that the IPC guidance was designed to be safe for everyone, irrespective of their risk factors. It was stated that it's impossible to cover every individual variable within national guidelines, but that all NHS staff in an at-risk or shielding group must have a risk assessment undertaken and that the resource section in the guidance links to all assessments referred to.

c. **Self-isolation:** The email stated that NICE had reviewed the available evidence and recommended that patients self-isolate from the time of their test until hospital admission, which is usually three days. From a practical perspective, patients had

been struggling to self-isolate for 14 days and patients breaking this rule could potentially put more staff at risk. Clinicians may recommend that a small number of patients, such as those having a transplant, would need to self-isolate for more than 3 days.

d. **Consistent use of terms 'high', 'medium', 'low':** NHSEI agreed with this point, however said that organisations may choose to use colour coding which is outside of their control.

e. **Consultation with BAME medical organisations:** NHSE/I said that this had been arranged for the following week (of 17 August 2020).

f. **Clarity on PPE requirement for immunisations:** NHSE/I recorded that this was complete, given wording agreed with the Chair of the BMA's GPC England committee.

IPC guidance for seasonal respiratory infections in health and care settings including SARS-CoV-2 for Autumn/Winter 2021-2022

205. On 22 September 2021, the BMA received, via the SPF, an email from the UK Covid-19 IPC Cell (PB/831 - INQ000522179) seeking the views of stakeholders across the four nations on revised guidance for seasonal respiratory infections in health and care settings, which superseded the UK IPC 'Guidance for maintaining services within health and care settings IPC recommendations'. The stakeholder engagement period ran from 22 September 2021 until 06 October 2021.

206. The BMA fed into this revised guidance including feedback from BMA members via the consultation form provided, dated 04 October 2021 (PB/832 - INQ000522181), setting out the following:

a. **Section 2 'About this guidance'**: the BMA stated that the guidance should make clear that while it aims to set out clinical best practice for reducing transmission in healthcare settings, it does not supersede existing legislation for employers to keep their staff safe. Employers have legal responsibilities – promulgated in both The Management of Health and Safety at Work Regulations (1999) and Control of Substances Hazardous to Health Regulations (COSHH) to protect the safety and well-being of their employees at work. These responsibilities precede and remain paramount despite any central guidance on infection prevention and control.

b. **Section 3 'Key messages':** The BMA expressed concern about the proposed system of transmission-based precautions (TBPs) particularly that the document listed droplet precautions for protection from Covid-19, given the BMA had previously highlighted the increasing evidence regarding aerosol transmission outside of AGPs. The feedback also expressed concern regarding the approach remaining based on 'AGP' vs 'non-AGP' environments and argued that given evidence of aerosol transmission outside of AGPs, that precautions should be in place for any individuals providing direct care for covid positive patients.

c. **Section 7 'PPE':** The guidance stated that face coverings may not be required in non-clinical settings and deferred to country specific policy on face coverings in public spaces. The BMA fed back that it would like to see a recommendation to wear face coverings extended to certain non-clinical spaces as appropriate, such as if these spaces see significant interaction between patients and staff. The BMA's submission was clear that surgical masks offer very little protection against viral aerosols. While the use of FRSMs would remain important in a healthcare setting for many scenarios, further advice should have been offered in this section on the important role of proper fitted RPE in situations where aerosol transmission is a known and relevant pathway for transmission. The BMA again highlighted the importance of aerosol transmission and cited the WHO's formal acknowledgement of this.

The BMA regularly raised concerns about the IPC guidance with government departments, arms-length and regulatory bodies

207. In addition to the few occasions where the BMA's direct input on IPC guidance was sought, the BMA regularly and consistently raised concerns about the various issues with the IPC guidance, outlined above.

208. This section sets out the key interventions the BMA made to try and get the deficiencies in the guidance corrected and to ensure the proper protection of doctors and other healthcare workers. This includes letters and interventions solely from the BMA as well as the occasions where we sent joint letters with other organisations who shared our concerns, including the RCN and CAPA (Covid Airborne Protection Alliance).

Public Health England/UKHSA

209. While the IPC guidance was developed by a four nation IPC-cell, it was published on behalf of the group by PHE and, once PHE was disbanded by the Government mid-pandemic, by the newly established UKHSA. Therefore, many of the letters the BMA wrote were to PHE and UKHSA on the range of issues already set out in this statement.

Alignment of early UK IPC guidance with international bodies

210. Early in the pandemic the BMA raised serious concerns that the IPC guidance on PPE for healthcare workers caring for Covid-19 positive or suspected positive patients did not align with recommendations from other organisations, including the World Health Organisation (WHO), European Centre for Prevention and Disease Control (ECDC) and the USA's Center for Disease Control and Prevention (CDC).

211. The BMA raised and sought clarification on these discrepancies in a letter to PHE on 24 March 2020 (PB/087 - INQ000097932), in which we outlined increasing concern that doctors did not consistently have access to any or appropriate PPE when treating patients with confirmed or suspected Covid-19. We sought urgent clarification regarding WHO guidance which stated that staff in all healthcare settings where Covid-19 was suspected should use gowns and eye protection, which was not reflected in PHE guidance, and emphasised that healthcare professionals should be provided with PPE in line with WHO recommendations as a minimum. The ECDC's guidance also recommended the use of gowns and eye protection in these circumstances, as well as an FFP2 or FFP3 respirator.

The limitations of the AGP list

212. The BMA first flagged its interest in an expected review of the AGP list in an email exchange with PHE on 07 April 2020. This email was sent to follow up our written feedback on the draft IPC guidance published on 02 April 2020 (PB/826 - INQ000117851), particularly given the BMA had received enquiries regarding whether CPR is an AGP, and because the existing PHE list of AGPs at this point differed from the WHO's classification of AGPs. NERVTAG had been asked to undertake an evidence review to consider whether chest compressions and defibrillation are associated with an increased risk of transmission of acute respiratory infections, and whether these procedures should be considered to be AGPs. The BMA later followed up twice regarding the evidence review of the PHE list of AGPs, on 16 and 17 April 2020. On 16 April 2020, PHE stated that

NERVTAG would be formally reviewing the list of AGPs the next day, and that the guidance would be updated with the outcome of that review. On 17 April 2020 PHE further updated the BMA that the evidence review would occur over that weekend (PB/826 - INQ000117851).

213. The BMA, a few days later, alongside the Resuscitation Council UK, Royal College of Nursing (RCN) and the Hospital Consultants and Specialists Association, called on PHE in a letter of 23 April 2020 (PB/088 - INQ000097926) to classify CPR (including chest compressions) as an AGP within IPC guidance, and as such ensure that FFP3 masks were recommended for staff undertaking these procedures. Given an absence of definitive evidence, PHE were urged to take a precautionary approach to this area of IPC guidance. This would require a change to PHE's guidance.

214. A response was received to this letter from the Chief Executive of PHE on 24 April 2020 (PB/434 – INQ000117861), the same day on which updated guidance not including chest compressions was published, stating that NERVTAG had undertaken the evidence review to consider whether chest compressions and defibrillation are associated with an increased risk of transmission of acute respiratory infections, and to give an opinion on whether these should be considered to be AGPs. NERVTAG concluded that it "does not consider that the evidence supports chest compressions or defibrillation being procedures that are associated with a significantly increased risk of transmission of acute respiratory infections". Based on this evidence review, PHE did not add chest compressions to the list of AGPs, a position which, according to the PHE response letter, was discussed and agreed with CMOs of the four nations and NHS England's medical director.

215. As no change was forthcoming, the BMA again reiterated its concerns about this issue in another letter to PHE of 01 May 2020 (PB/273 - INQ000097842), noting that although the PHE IPC guidance published on 24 April 2020 enabled healthcare providers to maximise protection for healthcare providers through the use of AGP PPE, the decision not to explicitly align with RCUK guidance on the issue of chest compressions, their continued lack of exclusion from the AGP list would not just put staff at risk, it would also continue to create confusion, and was not in line with international clinical guidance. The BMA also expressed concern regarding the decision-making process that PHE was using to designate AGP status. The BMA pointed out that NERVTAG's latest appraisal had failed to take into account the most recent data and evidence, due to its sole reliance on evidence from the literature review undertaken by Health Protection Scotland in 2019,

rather than the more recent review from the International Liaison Committee on Resuscitation from April 2020. It was also stated that the latest European Resuscitation Council guidance from 29 April 2020 corresponded with its RCUK equivalent. The BMA called for NERVTAG to engage proactively with assessing new data and evidence in this area and stated that the organisation was ready to work in partnership with PHE to develop guidance for acute settings. The BMA received a reply on 13 May 2020 (PB/877 - INQ000117907) which stated that the PHE recommendations related to chest compressions is based on NERVTAG recommendations and is regularly reviewed and updated.

Concerns that IPC guidance was based on supply rather than protection of healthcare workers

216. In a letter to PHE on 19 April 2020 the BMA raised concerns that PHE's exceptional shortage guidance published on 17 April 2020 on the use of PPE during exceptional shortages was designed to fit around the availability of supplies rather than evidence of protection (PB/459 - INQ000097902) and pointed out that the lack of consultation with the BMA prior to the publication of this guidance was disappointing.

217. This updated guidance was published late in the day on a Friday, without notifying or consulting the profession, leading to an undermining of staff confidence, which as the letter points out, is a key element in ensuring that good IPC practice is followed.

218. The letter also raised a number of specific points, including that the reuse of equipment must be demonstrably driven by science, and that detailed donning and doffing procedures and related training must be provided to staff in relation to the suggested PPE alternatives in the revised guidance.

219. A response to this letter was received from PHE on 20 April 2020, outlining that the PPE advice issued was in accordance with global evidence, and that the HSE agreed that the guidelines, given the need to optimise PPE supplies, were appropriate (PB/433 - INQ000466401). It was clarified that the guidance on use of PPE in exceptional circumstances was not intended to replace the IPC guidance issued on 02 April 2020, but rather that it was in response to urgent requests from DHSC and NHS England, given PPE stocks were becoming low. The guidance, PHE stated, was intended to be used as a last resort in extreme circumstances, and if properly followed, it should present 'no additional infection risk' to healthcare staff. In addition, PHE stated that organisations

themselves would need to consider whether they could develop and implement procedures and training for the safe re-use of PPE.

The failure of IPC guidance to adequately protect against aerosol transmission despite growing evidence

220. While the BMA had long argued for a more precautionary approach by governments in responding to the pandemic, including in relation to the protections offered to healthcare workers, the BMA became increasingly concerned about the deficiencies in the IPC guidance throughout 2020 and the fact that the guidance continued to recommend FRSM rather than FFP3 for healthcare workers caring for patients with suspected or confirmed Covid-19. This was despite the growing evidence that Covid-19 was transmitted via the airborne route and the knowledge that FFP3 provided significantly greater protection for healthcare workers from the virus. In Module 3, the expert report by Professor Summers and Dr Suntharalingam (INQ000474255) found that ICU staff were arguably safer than staff working in other areas of a hospital due to the recommended use of enhanced respiratory protection. Their expert report outlined 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 zero. The BMA ramped up our calls to key Government Ministers and civil servants and responsible agencies to address this towards the end of 2020. We have consistently continued our calls since this time.

Engagement on IPC guidance with key Individuals

221. The BMA wrote a joint letter to the Prime Minister on 18 February 2021 (alongside 20 other organisations representing health and care workers and patients, including the Royal College of Nursing and Royal Pharmaceutical Society) (PB/070 - INQ000114283) calling for amendments to the IPC guidance to recognise aerosol transmission, thereby providing staff with appropriate PPE. The letter stated that although Covid-19 is spread via the airborne route, and beyond AGPs in healthcare settings, measures to reduce airborne transmission of Covid-19 in high-risk health and care settings had, to date, been inadequate. It highlighted the importance of ventilation to prevent the spreading of Covid-19, and in the context of emerging variants of concern, called on the Prime Minister to take a range of actions to increase protection of health care workers from airborne transmission of Covid-19. These included improving ventilation in health and care settings, updating IPC guidance, and collection and publication of data and scientific evidence on airborne transmission and the contraction of Covid-19 among healthcare workers. The BMA wrote

a further letter to the Prime Minister, jointly with other organisations representing healthcare workers on 14 July 2021. This coincided with the announcement that the UK Government would be removing some of the public protections for Covid-19. The letter called on the government to ensure that protections for healthcare staff, including access to RPE and improved ventilation in healthcare settings remained in place alongside a number of practicable measures for the public including social distancing and the wearing of facemasks (PB/230 - INQ000114256).

222. The Chair of BMA UK Council wrote to the CMO on 30 March 2022, cc'ing Dame Jenny Harries, the CE of UKHSA (PB/091 - INQ000097952). In this letter, the BMA raised concerns about the 15 March 2022 update to the IPC guidance. 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)" (PB/879 - INQ000300389). 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-19 (PB/880 - INQ000348420). In our letter of 30 March 2022, we expressed our extreme concern that the guidance only recommended RPE when conducting AGPs or caring for patients with infections transmitted predominantly through the airborne route, as the continued failure to properly acknowledge the airborne pathway in the transmission of Covid puts healthcare workers at increased risk while working. We also stressed the importance of employers' legal duty to assess workplace risks, including Covid, noting that the Government's 'living with Covid' strategy could mean that risk assessments would no longer be obligatory for most healthcare workers exposed to Covid.

223. A response was received to this letter on the 19 April 2022 from the Chief Executive of UKHSA (PB/436 - INQ000118464). This letter stated that the evidence base for the guidance included a review of the latest evidence relating to IPC, and that it was consistent with WHO recommendations. It also stated that the PPE/RPE recommendations, glossary within IPC guidance, and information about aerosol transmission had not changed since the last guidance update on 17 January 2022; this meant that FRSMs continued to be recommended for the care of patients with confirmed or suspected Covid-19 outside of

AGPs. In relation to the BMA's concerns about communications to ensure employers are aware of their duty to undertake risk assessments under the Health and Safety at Work Act 1974, the Chief Executive highlighted that the guidance is of a general nature, and employers should consider the specific conditions of each individual place of work and comply with the applicable legislation and regulations. Responding to the BMA's concerns about risk assessments, the Chief Executive cited the Living with Covid plan, clarifying that the derogation from covid risk assessments did not apply to the NHS and that there was still a requirement to conduct a risk assessment for those who come into contact with the virus due to their work activity.

Public Health England/UK Health Security Agency

224. The BMA wrote to PHE on 13 January 2021 (PB/089 - INQ000097875) to request that they urgently review the adequacy of the IPC guidance for healthcare staff, specifically, the recommendations on PPE usage to enable a more precautionary approach on the provision of RPE to ensure staff are protected from aerosol transmission. We highlighted significant concerns about the role of aerosol transmission of Covid-19 in healthcare settings, and the need for wider use of RPE beyond AGPs, noting the WHO guidance on wider use of respirators, where supplies allowed, as well as evidence that wider use of RPE had beneficial impacts on staff absences due to Covid. We further highlighted the importance of appropriate and well-fitting PPE, particularly to minimise the risk for staff who have a higher vulnerability to Covid-19.

225. In a 17 February 2021 response, PHE (PB/591 - INQ000466410) stated that IPC guidance does not 'belong solely to PHE' but that it was produced by the UK-wide IPC cell and stressed that the IPC Cell had reviewed guidance in light of emerging variants and evidence on routes of transmission but recommended no changes to PPE. However, PHE said there was agreement within the IPC Cell that existing IPC practices needed to be strengthened, which was reflected in the Central Alerting System (CAS) alert issued on 24 December 2020 (PB/875 - INQ000072252), which stated, that 'all NHS organisations should ensure they are fully implementing and have systems in place to monitor adherence to the current IPC guidance', and in the updated IPC guidance which was published on 21 January 2021. Finally, PHE stated that the IPC Cell would continue to monitor the evidence and review the recommendations. In the BMA's view, this does nothing to address the BMA's and others' fundamental concern which is that the IPC guidance was flawed and inadequate.

NHS England

226. The BMA engaged frequently with NHSE on a wide range of issues, many of which are set out in other sections of this statement. On several occasions the BMA wrote directly to NHSE on the issue of the IPC guidance and lack of protection from aerosol transmission. While NHSE was not responsible for the production of the IPC guidance, the Chair of the IPC-cell for much of the pandemic was simultaneously IPC lead for NHSE.

227. Frustrated by the lack of progress on this issue from the bodies responsible for drafting the guidance, and in light of particular concerns relating to access to RPE by General Practice, the BMA wrote to the CEO of NHSE, Amanda Pritchard, on 23 December 2021 (PB/195 - INQ000097930) about the application of IPC guidance to general practice and expressing deep concern about GP staff not having access to RPE when seeing patients with suspected or confirmed Covid-19, noting it had been confirmed that the virus can be transmitted by the airborne route, and that the Omicron variant was particularly highly transmissible. The letter expressed concern that there was no system in place for general practice to access enhanced PPE and RPE, nor for fit testing. Further, it noted the statement in the latest IPC guidance that the use of respirator masks might be considered where there remained an unacceptable risk of transmission, following local risk assessment, which inherently applied to GPs as they work in small, enclosed consulting rooms.

228. The Chair of the BMA's General Practice Committee (England) followed up with a further letter to Amanda Pritchard on 30 December 2021 about the availability of RPE for general practice staff (PB/196 - INQ000097955). In particular the BMA sought action to ensure RPE was available in general practice, i.e. the immediate provision of FFP2 masks in place of surgical masks. The letter further requests increased capacity for fit testing in general practice to allow for the use of FFP3 masks, as well as further clarity on the provision of Respiratory Clinical Assessment Services, particularly the timeframe for the establishment of these services.

229. Alongside this the BMA also wrote on several occasions to the CEOs of NHS Trusts in England reminding them of their obligations under health and safety law and urging them to extend the use of RPE beyond those limited circumstances recommended by the IPC guidance.

Engagement with the Health and Safety Executive (HSE)

230. The BMA wrote to HSE regarding PHE/UKHSA decisions not to update IPC guidance in light of increasing evidence of airborne transmission of Covid-19 and new variants on several occasions.

231. The Chair of the BMA's Occupational Medicine Committee wrote to Dr Steve Forman, Principal Medical Advisor, HSE, on 01 December 2020. The letter covered a range of issues (PB/069 - INQ000118222). In relation to the IPC guidance and recommended PPE, the letter outlined that routes of aerosol transmission were not being appropriately recognised and that IPC guidance failed to recommend RPE outside of AGPs. The letter pointed out that the terminology used within IPC guidance pertaining to AGPs is misleading, as it implies that managing a patient while they are coughing, talking, or breathing is not aerosol generating, when it almost certainly is. The advice at this point from PHE (as of 21 August 2020) for PPE use in non-AGPs was the use of FRSMs, despite the Health and Safety Laboratory's own research a decade prior showing that surgical masks did not provide adequate protection against viral aerosols (PB/451 - INQ000145893). The letter further states that the recommended RPE by both PHE and HSE is insufficient, and that the advice provided by the British Occupational Hygiene Society should be followed – e.g. that FFP3 or N95 masks (equivalent to FFP2 in Europe) should be used by all staff when providing direct care to patients with suspected or confirmed Covid-19.

232. Dr Forman replied on 18 December 2020 (PB/814 – INQ000522189). On issues relevant to IPC guidance and PPE Dr Forman advised that it was not in HSE's remit to comment on the list of AGPs and that any concerns on this should be directed to the public health authorities. Dr Forman stated his view that the IPC guidance on respirators was not inconsistent with findings from earlier HSE research on effectiveness of FRSM in protecting against aerosols. This is not the BMA's view of the findings of this research, and in Module 3 oral evidence Richard Brunt of the HSE and Professor Beggs, one of the Inquiry's IPC experts, both confirmed that RPE provides far greater protection against an airborne virus than a FRSM. Finally, Dr Forman's letter referenced the interim WHO guidance on mask use in the context of Covid-19. This WHO guidance recommended use of FRSMs by staff caring for patients outside of AGPs, although stated that RPE such as FFP2/3 could be used if widely available and if cost is not an issue. In relation to ventilation,

he acknowledged it was important to minimise the risk of transmitting Covid-19 and referred recent HSE guidance for employers.

233. As set out in paragraph 151.a, the BMA wrote a joint letter with the RCN to the HSE on 21 January 2021 asking that they urgently review the IPC guidance for health and care to reduce transmission (PB/090 - INQ000097909).

234. The BMA received a response to this letter from the Chief Executive of HSE on 29 January 2021 (PB/815 - INQ000417574). In response to the BMA's concerns expressed regarding new variants, HSE stated that the DHSC and PHE were responsible for developing and publishing IPC guidance, and that a clinical and scientific review undertaken before the publication of the revised guidance had concluded that there were no necessary changes to be made to the recommendations. In relation to the point raised by the BMA relating to ventilation, the HSE pointed to its own existing guidance on ventilation.

235. As set out in paragraph 151.c, the Deputy Chair of the BMA Occupational Medicine Committee co-signed a joint letter dated 25 November 2021 to the HSE Chair calling on HSE to act urgently to protect NHS workers from the risk of Covid-19 (PB/109 - INQ000118441). The HSE chair replied in a letter dated 15 December 2021, as set out in more detail in paragraph 151.c.

Liaison regarding IPC guidance with regulatory bodies, government departments and/or arm's length bodies in the devolved nations

Wales

236. A key concern of BMA Cymru Wales in relation to PPE was the inadequacy of the IPC guidance in the face of aerosol transmission, and the type of respiratory protective equipment available to staff as a result.

237. Similar to a UK level, early concerns raised by BMA Cymru Wales, for example with the Director of Primary Care and the CEO of NHS Wales in March 2020, centred around the IPC guidance and associated PPE recommendations deviating from the recommendations of other organisations, including the WHO. This particularly related to gowns (instead of aprons) and eye protection in the form of googles or a face shield. The updated IPC guidance produced by all four UK Chief Medical Officers in early April 2020

was helpful in realigning somewhat towards WHO recommendations, including the provision of eye protection. However, concerns with the IPC guidance persisted as the pandemic developed and understanding of the significance of airborne routes of transmission evolved.

238. BMA Cymru Wales wrote to the CEO and Deputy CEO of NHS Wales via email on 22 March 2020, seeking clarity on PPE guidance for GPs and other healthcare professionals in Wales and insisting that PPE requirements should be in line with the WHO guidance and latest research. This email also shared a letter sent from the BMA's UK Chair of Council to the Prime Minister on 21 March 2020 which raised the same concerns (PB/513 - INQ000118526, PB/064 - INQ000097910).

239. There were also concerns about the application of the IPC guidance to the flu vaccination programme in primary care. On 14 August 2020 a letter from the Chair of BMA Wales GPC and the Chair of Welsh Council was sent to the CMO which sought urgent clarification on the type of PPE required to safely deliver the flu vaccination programme in primary care, calling for four-country guidance agreed by all CMOs and GPCs (M2B/PB/107 - INQ000355862). BMA Cymru Wales received a reply on 25 September 2020 (M2B/PB/108 - INQ000118622) which outlined revised IPC guidance issued on 21 August 2020 and clarified that delivery of the flu vaccination programme should use the PPE recommended within the 'medium risk pathway'. This pathway included a FRSM rather than the greater protection provided by RPE.

240. BMA Cymru Wales increasingly highlighted the relevance of aerosol transmission as the pandemic progressed. It set out the greater protection of respirator masks compared to FRSMs (PB/451 - INQ000145893) and the limited recommendation for when frontline healthcare staff should wear RPE, which the BMA believed placed doctors and other healthcare workers unnecessarily at risk.

241. On 22 January 2021, the chair of GPC Wales wrote to the Director of Primary Care and Health Science in the Welsh Government asking her to ensure that higher-grade PPE be made available to general practice staff, in light of the emergence of a new, more transmissible variant of Covid-19. The letter stated that, in the BMA's view, at a minimum FFP2/N95 masks should be supplied to general practitioners undertaking face to face patient contact (PB/362 – INQ000118679). This followed letters to Health Board and Trust Chief Executives urging them to provide higher grade PPE and to adopt a permissive approach to PPE use. Concerns about the need for higher grade PPE in light of the

emergence of the new Covid-19 variant was also discussed on a call between the National Director of BMA Wales and the Health Minister on the same day where the Minister stated that the guidance hadn't changed but they were actively reviewing the evidence. After the meeting, the Welsh Government sent through a link to the IPC guidance updated the previous day, which did not change the position in relation to FFP3 (M2B/PB/102 - INQ000118680).

242. A letter was sent from the Chair of BMA Wales Council to the Minister of Health and Social Services on 23 February 2021 highlighting the evidence of Covid-19 aerosol transmission outside of AGPs and calling for FFP2 and FFP3 respirators to be made available to all frontline healthcare staff (PB/352 - INQ000118686). BMA Cymru Wales received a reply almost two months later, on 16 April 2021, which expressed the Minister's confidence in the current IPC guidance (M2B/PB/091 - INQ000118703).

243. On 09 December 2021 I, along with the Chair of BMA Welsh Council and public affairs staff met with the Minister for Health and Social Services reiterating calls for enhanced PPE for healthcare workers, including FFP2 and FFP3 respirators. BMA Cymru Wales provided an internal briefing for the Chair of BMA Welsh Council ahead of the meeting (M2B/PB/099 - INQ000356032) and circulated internal notes afterwards (M2B/PB/100 - INQ000356031).

244. On 23 December 2021, the Chair of BMA Welsh Council then sent another letter to the Minister of Health and Social Services reiterating BMA Cymru Wales' calls to issue enhanced PPE guidance to Health Boards, including for FFP2 respirators to be available to all frontline healthcare staff, and FFP3 respirators for those working with known Covid patients (PB/053 - INQ000118727). BMA Cymru Wales received a reply on 25 January 2022, a month later, which stated that Wales was continuing to follow the UK IPC guidance and would therefore not be issuing any new PPE recommendations (PB/054 - INQ000118729). BMA Cymru Wales reiterated its calls in a press release on 31 January 2022, calling the Welsh Government's PPE position "untenable" (PB/460 - INQ000118732).

245. On 27 January 2022 a joint letter from the Chair of BMA Welsh Council and Director of the RCN Wales was sent to the Minister for Health and Social Services reiterating calls for FFP2 and FFP3 respirators to be readily available to protect all healthcare workers from infection. This letter referred to a recent update of the UK IPC guidance which appeared to acknowledge the significance of aerosol transmission, and

the consequences of this for staff access to Respiratory Protective Equipment (M2B/PB/093 - INQ000118731). Unfortunately, this brief acknowledgement of aerosol transmission of Covid-19 requiring RPE in the IPC guidance was shortly after withdrawn (see paragraph 222).

Direct meetings with the CMO or Deputy CMO for Wales

246. On 25 March 2020 the Chair of Welsh Council met with the DCMO to discuss concerns about PPE guidance, the adequacy of recommended PPE, and the particular impact of PPE supply for GPs having face-to-face appointments (when the arrangements for PPE provision to primary care from NHS stocks were unclear). An internal note was prepared after the discussion (M2B/PB/115 - INQ000355786).

247. On 14 December 2021 the Chair of the BMA Welsh Council participated in a meeting organised by the DCMO in relation to the IPC guidance and the ongoing absence of adequate protection from an airborne virus. After the meeting the Chair of the BMA Welsh Council circulated an internal note (M2B/PB/118 - INQ000356033).

Scotland

248. As elsewhere across the UK, as a result of the UK wide IPC guidance and subsequent Scottish IPC guidance published in early 2022, doctors and healthcare workers in Scotland were also not guaranteed to receive the right level of protection. IPC guidance in Scotland continues to fail to properly recognise that Covid-19 spreads via the airborne route and instead 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 places responsibility on individual healthcare workers to raise concerns about PPE and ensure they have the necessary fit testing.

249. On 17 March 2020, BMA Scotland's National Director raised concerns with the Scottish Government regarding members experiencing significant issues with acquiring PPE, either that fits, or at all. The issue of availability of PPE, and the need for guidance, was discussed at a meeting between BMA Scotland and the Scottish Government's health workforce team that same day, and in a follow up email BMA Scotland's National director highlighted that an initial response from the Scottish Government was expected that week on these issues. The Scottish Government later responded on 22 March 2020 attaching

official correspondence relating to various issues, some of which included PPE briefly, and shelf-life extension clarification for facemasks for GPs (PB/338 - INQ000116990).

250. On 21 April 2020, BMA Scotland's National Director raised issues with the Scottish Government via email relating to the inconsistent interpretation of guidance on the need for PPE whilst performing CPR. The email raised the fact that the latest PHE guidance on using PPE during CPR was at odds with RCUK's guidance. The BMA supported guidance from RCUK which defined CPR as an AGP, whereas guidance from PHE did not. BMA Scotland's National Director followed up on these concerns multiple times, including further details of these concerns (PB/334 - INQ000117062). On 23 April 2020, the Scottish Government responded saying they were awaiting a definitive view on this issue from NERVTAG. (PB/335 - INQ000117063).

251. In January 2021 BMA Scotland raised concerns about the level of protection provided by the recommended PPE and called for the Scottish Government to protect the safety of healthcare staff by reviewing the guidance and providing FFP3 respirators and eye protection in a wider range of situations. BMA Scotland shared a 13 January 2021 letter from the BMA Chair of UK Council to PHE (PB/089 - INQ000097875) on the failure to update IPC guidance to reflect the risk of aerosol transmission with Health Protection Scotland and the CMO for Scotland (PB/347 - INQ000400446) and the Scottish Government's ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) programme (PB/580 - INQ000433863) to ensure they were fully aware of the issue. ARHAI replied outlining the process for reviewing the IPC guidance (PB/833 – INQ000522183).

252. On the 09 July 2021, BMA Scotland's National Director shared a letter of 07 July 2021 sent from the Chair of BMA UK Council to NHS England Trust CEOs with the Scottish Government's Health Workforce Senior Leadership Group. The letter included a call for the wider use of RPE and reiterated the importance of trusts taking a precautionary approach, as well as drawing attention to the latest UK IPC guidance which clarified the need for NHS organisations to assess risk and provide respiratory protection where necessary (PB/339 - INQ000400458).

253. On 25 November 2021, BMA Scotland's National Director sent an email to the HAI/AMR Policy Unit and the Health Workforce Senior Leadership Group, attaching a letter that had been sent to English NHS trusts, setting out concerns about updated IPC guidance. The letter sets out concerns about aerosol transmission and the need for wider

use of RPE. It asks for the provision of FFP3 masks to all staff who treat patients with Covid-19 (PB/340 - INQ000400463).

254. On 20 January 2022, BMA Scotland's National Director emailed the Scottish Government's Health Workforce Senior Leadership group, outlining that the BMA has been raising serious concerns about supporting healthcare workers who were experiencing stress about the protection from Covid-19 they had access to. The email outlined that the most recent changes to IPC guidance supported these significant concerns, and the view of BMA Scotland was that not enough was being done to protect the workforce. The email requested an urgent response regarding actions the Scottish Government was taking to address these issues (PB/341 - INQ000400469).

Northern Ireland

255. The BMA Northern Ireland Council Chair wrote a joint letter with the Chief Executive of the Royal College of Nursing to the Health and Safety Executive for Northern Ireland on 21 January 2021 (PB/870 - INQ000400935). The letter highlighted BMA and RCN members' concerns around the protection from aerosols with the use of FRSM and requested the urgent review of IPC guidance for health and care to reduce transmission of Covid-19 and seeking guidance on the provision of ventilation.

256. On 29 July 2021, the BMA Northern Ireland Council Chair sent a letter to the CEO of each Health and Social Care Trust highlighting the aerosol transmission of Covid-19 and asking them to provide FFP3 respirators to all staff treating patients with Covid-19 (PB/328 - INQ000116913).

E. Ventilators

Definitions

257. Intensive care, critical care and intensive care units (ICU) are referred to interchangeably in this section. When referring to ventilators, unless specifically noted otherwise, I am referring to invasive ventilation machines, as described in the next paragraph.

258. There are multiple means of supporting patients' oxygen saturation through ventilation, including the following, as described in Professor Summers and Dr Suntharalingam's expert report (INQ000474255):

a. '*Continuous positive airway pressure (CPAP) — oxygen and pressure are delivered via a tight-fitting mask (or hood) whilst the patient continues to breathe for themselves*.'

b. '*Non-invasive ventilation — oxygen and pressure are delivered via a tight-fitting mask, as for CPAP. However, when the patient initiates a breath for themselves, the machine provides an increased pressure to support breathing*.'

c. '*Invasive mechanical ventilation — a patient is sedated to allow placement of a tube through the vocal cords (intubation), and a mechanical ventilator supports the patient to breathe in and out. Often, in the early stages of severe illness, patients require sedation to the extent that the ventilator undertakes almost all the work of breathing. As things improve, the patient is gradually weaned from the support provided by the ventilator by reducing the pressures used and decreasing the level of sedation to allow more work of breathing to be undertaken by the patient.*'

259. During the pandemic, anaesthetic machines which, unlike the mechanical ventilators usually used in ICU, are not designed for long-term ventilatory support but rather to be used for a few hours, were at times used in place of the ventilators usually used for invasive ventilation in ICU. These machines are notably different in their operation and usually require supervision by staff specifically trained to use them.

Summary of key issues relating to ventilators

260. Ventilator availability is an aspect of intensive care capacity; as such it must be viewed alongside considerations of intensive care staffing and bed availability, all of which were too low at the outset of the pandemic as set out in my witness statements to Module 3 of the Inquiry (INQ000477304).

261. The number of ventilators available across the UK was not known prior to the pandemic which led to an arguably rushed procurement process when modelling found

that the anticipated need for ventilators was far greater than likely available capacity. This led to unfamiliar, unsuitable and unsafe ventilators sometimes arriving at hospitals.

262. Intensive care provision was stretched across the UK during the pandemic, despite capacity being increased in a variety of ways, including using spare and new ventilator machines, altering staffing patterns, redeploying doctors from other departments and expanding into other clinical areas beyond the normal ITU footprint such as theatre recovery areas. There were, at times, localised shortages of ventilators which necessitated the transfer of patients between hospitals, and the use of anaesthetic machines in lieu of ventilators., and the use of anaesthetic machines in lieu of ventilators.

263. The government did not provide guidance to support clinicians in their decision-making in the event that the need for critical healthcare outstripped supply. As I set out in my witness statements to Module 3 of the Inquiry and below in paragraph 288, this led to the BMA publishing its own guidance for clinicians (PB/143 - INQ000117773).

Impact on members

264. Shortages of ventilators for the numbers of patients who might benefit, combined with a lack of government or NHS guidance on clinical prioritisation, put additional pressure and uncertainty on doctors during an already highly stressful period. Circumstances in which demand outstrips supply raise serious ethical and professional challenges and give rise to the potential for moral injury among those doctors responsible for making final decisions on care escalation, as well as wider concerns about the potential for discrimination in the application of criteria.

The BMA raised concerns around ventilator capacity during the relevant period

265. The BMA engaged with the DHSC and NHSE on several occasions to raise concerns about the availability of ventilators. The BMA also made public statements, published reports and submitted evidence to public investigations and inquiries on this matter. These are discussed in further detail in the paragraphs that follow.

266. Key communications with the UK government, DHSC and NHSE included:

a. A letter from the BMA UK council chair to Professor Keith Willett, Director for Acute Care, NHSE, dated 27 March 2020, requesting support in urging the government to procure ventilators and PPE through the EU's Civil Protection Mechanism and the EU's Joint Procurement Agreement (PB/193 - INQ000097943).

b. An email from a member of BMA staff to a member of staff at the Department of Health and Social Care regarding offers the BMA had been approached with from industry to supply the NHS or help with the procurement of ventilators, PPE and testing, dated 27 March 2020 (PB/531 - INQ000117800).

c. A letter from the BMA UK council chair to Matt Hancock, Secretary of State, Department of Health and Social Care, regarding the procurement of PPE, testing, and ventilators required for doctors to combat the Covid-19 pandemic, dated 6 April 2020 (PB/065 - INQ000097854) (see paragraph 108).

d. A phone call with Stephen Powis, Medical Director NHSE on 23 March 2020 regarding ethics guidance for triage of care should need for intensive care outstrip capacity (PB/582 – INQ000117789).

e. A letter from the BMA UK council chair to Chris Whitty, Chief Medical Officer in England, requesting national guidance from the government should demand for intensive care resources outstrip supply, dated 14 April 2020 (PB/270 - INQ000400347)

Public investigations and inquiries

267. An evidence submission to the National Audit Office, dated 01 May 2020 on 'Readying the NHS and social care for the Covid-19 peak' (PB/180 - INQ000117896). The submission included a section on 'preparing for, and responding to, large numbers of inpatients requiring respiratory support' which highlighted the BMA's concerns regarding the inefficiencies of the 'Ventilator Challenge'[5] and the government's efforts to procure ventilators from abroad (see paragraph 280).

268. A memorandum of evidence submitted by the BMA to the House of Lords Select Committee inquiry on 'Public Services: Lessons from Coronavirus', dated 29 June 2020

[5] The 'Ventilator Challenge' was a procurement and production exercise for ventilators, including expanding production of existing ventilators, and requesting design and manufacture of new ventilator designs, launched on 16 March 2020 and run by the Cabinet Office.

which noted the issue of ICU capacity not being available locally where it was needed, and anaesthetic machines being used in place of ventilators (PB/041 - INQ000118011).

BMA reports and guidance

269. A Covid-19 ethical issues guidance note and frequently asked questions published by the BMA (PB/143 - INQ000117773, PB/144 - INQ000433852 and PB/145 - INQ000117787) (see paragraph 288).

270. A report published by the BMA titled 'In the balance: Ten principles for how the NHS should approach restarting 'non-Covid care', which highlighted the need to co-ordinate ICU around the country to make best use of ICU staff and ventilator capacity (PB/384 - INQ000397312).

271. The BMA's third Covid review report, published 26 June 2022, covers ventilators and oxygen (PB/015 - INQ000185355), stating that total UK ventilator stock was not known at the outset of the pandemic, and the UK Government's procurement process for ventilators made use of manufacturers with no prior experience of ventilators, and did not secure best value for money.

BMA press releases

272. A statement from myself, in my then role as the BMA Cymru Wales Consultants Committee Chair regarding capacity at Intensive Care Units in Wales, dated 18 March 2020, which highlighted the shortage of ventilators in ICUs (PB/834 - INQ000118507).

273. A press release titled 'BMA publishes ethics guidance for doctors making difficult Covid-19 decisions on the front line', produced in response to the risk that the pandemic will overwhelm intensive care beds, ventilators and ECMO life-support, dated 01 April 2020 (PB/835 - INQ000522162).

The UK entered the pandemic without enough ventilators

274. As I have previously described in my witness statement for Module 3 of the Inquiry (INQ000477304), the UK started out on the backfoot in relation to the supply of intensive care ventilator beds, having failed to sufficiently consider ventilation capacity as part of pre-pandemic planning and preparedness. This is because the recommendations set out in Exercise Cygnus were largely overlooked, despite concerns around ICU ventilator capacity then (PB/836 - INQ000520238). The failure to action the recommendations

meant that, at the pandemic's onset, the UK was already at serious risk of running out of ventilators, with all 4 UK governments noting a very significant shortage of ventilators compared to estimated potential need. Indeed, the UK entered the pandemic without enough ventilators and ICU beds for normal levels of emergency and elective care; the lack of a staffed ICU bed was (and remains) a frustratingly common reason for the cancellation of major surgical procedures.

275. Notably, the total number of ventilators in England was not known prior to the pandemic, and it was not until late February and early March 2020, that the UK Government conducted a survey of NHS Trusts in England to determine ventilator capacity. The results showed that the NHS in England had an absolute maximum of around 7,400 mechanical ventilators – a number deemed insufficient based on modelling from NHS England which estimated a need for up to 90,000 ventilators. Efforts were therefore made to boost capacity, and by mid-April (the peak of the first Covid-19 wave) 1,800 new ventilators had been acquired (PB/480 - INQ000087456).

276. Similarly, the **Scottish Government** had to order 300 new ventilators, doubling their ventilator capacity by March 2020 (PB/837 - INQ000520239).

277. According to a Cabinet Statement from the **Welsh Government** (dated 06 April 2020), NHS Wales had 415 ventilators in Welsh hospitals, capable of invasive ventilation. Additionally, they had 349 anaesthetic machines with ventilator capacity, and 207 non-invasive ventilators. The statement mentions that a further 1,035 ventilators were being procured by the NHS Wales Shared Services Partnership and through UK arrangements (PB/586 - INQ000433856).

278. In **Northern Ireland**, health minister Robin Swann said on 16 March 2020 that only 139 ventilators were available. He also sought help, asking if anyone could produce more ventilators by 'reprofiling' their manufacturing equipment. At the time of Swann's statement, 40 new ventilators had been ordered, due for delivery by the end of the month (PB/569 - INQ000433860).

The BMA had concerns about the process of the procurement of ventilators

279. Early in the pandemic when modelling showed a very significant shortage of available ventilators compared to predicted need, the UK Government was invited to participate in a pan-EU effort to procure ventilators, but this deadline was (ostensibly)

missed – marking the first of several key failures around equipment during the pandemic. The BMA expressed its concerns that the UK did not join EU procurement schemes for purchasing ventilators on several occasions. Firstly, the BMA UK council chair sent a letter to Professor Keith Willett, Director for Acute Care NHSE, dated 27 March 2020, requesting Professor Willet's support in urging the government to procure ventilators and PPE through the EU's Civil Protection Mechanism and the EU's Joint Procurement Agreement (PB/193 - INQ000097943). Professor Willet responded on 07 April 2020, stating that he would forward our letter to DHSC, as these issues around EU procurement were a matter for them (PB/868 – INQ000117826). This letter and the request that the government work collaboratively with EU partners in procurement of equipment was then echoed in a letter from the BMA UK council chair to Matt Hancock, Secretary of State, Department of Health and Social Care regarding the procurement of PPE, testing, and ventilators dated 06 April 2020 (PB/065 - INQ000097854).

280. Instead of listening to the BMA's calls, the UK Government contracted private companies to build up ventilator capacity in the UK's health services as part of the 'Ventilator Challenge', a procurement and production exercise for ventilators (including expanding production of existing ventilators and requesting design and manufacture of new ventilator designs) run by the Cabinet Office and launched on 16 March 2020. The BMA believed that it may have been both cost- and time-inefficient as multiple non-specialist firms began designing new ventilator prototypes despite the existence of ventilator designs which were already approved, particularly given that the call for new ventilator designs was made on 16 March 2020. This led to an increased burden on the MHRA which had to consider these and whether they could be approved for use, and reports from industry also suggested it would have been more efficient to scale up production of existing designs. Many of these companies had no prior appropriate experience or expertise in the manufacturing of ventilators, bringing the rationale behind the awarded contracts into question as they risked being unusable on the frontline. Ultimately, the Cabinet Office never ordered ventilators in any of the new designs which were part of the 'Ventilator Challenge' programme (PB/480 - INQ000087456). Doctors raised concerns with the BMA regarding the lack of transparency in contracting arrangements with the private sector and the money wasted as a result (see section H).

281. In its submission to the National Audit Office, the BMA also highlighted reports that the specification for ventilators provided by the government to manufacturers was not in

line with medical requirements for treating Covid-19 patients, as stated by Dr Alison Pittard, Dean of the Faculty of Intensive Care Medicine, who was reported as having said that the government's request was for ventilators that would stabilise patients for a matter of hours, contrary to clinicians' advice on minimum specifications for ICU ventilators (PB/180 - INQ000117896, PB/838 - INQ000520243).

282. Had the UK Government jointly purchased ventilators with other EU countries, they could have likely secured better value for money through collective bargaining. Instead, DHSC and the Cabinet Office's emergency procurement of 26,000 ventilators UK-wide cost the taxpayer £569 million (PB/480 - INQ000087456). The BMA heard from various external organisations offering to support the NHS through the production or procurement of PPE primarily, but also ventilators, who indicated that they had attempted to engage with and make their supplies and services available to the DHSC to no avail (PB/065 - INQ000097854). The BMA shared this information with DHSC (PB/531 - INQ000117800).

283. Part of the large sum spent on emergency procurement of ventilators can be attributed to the very expensive purchase of Chinese ventilators costing £50,000 per unit (PB/480 - INQ000087456). The price of the ventilators was significantly inflated relative to earlier prices for the same device. Additionally, the Chinese ventilators were unfamiliar to UK healthcare staff, and therefore not always intuitive to use. This added to the pressure staff were under in an already high-stress environment. It was widely reported that, as well as being unfamiliar to staff and designed for ambulance rather than hospital use, the Shangrila 510 ventilators imported from China were dangerous, risking patient harm or death. Issues reported included a 'variable and unreliable' oxygen supply, and the ventilators arrived with a 'non-EU' oxygen connection hose (PB/839 - INQ000520244). The BMA raised these issues in an evidence submission to the National Audit Office (NAO) in May 2020 (PB/180 - INQ000117896). Overall, in its submission to the NAO, the BMA described the government's response to potential foreseeable issues in relation to ventilators as 'arguably late, muddled, and inefficient'.

There were localised shortages of ventilators

284. Although capacity was stretched across the board, there were particularly acute instances of intensive care capacity not being available in the place where it was needed, most often in London. In March 2020, a hospital in north London declared a critical incident

when it had no further critical care capacity available and needed to transfer patients to neighbouring trusts. There were also reports of anaesthetic machines being used, which, as discussed in paragraph 259, are not designed for long-term ventilatory support and usually require supervision by staff specifically trained to use them. This occurred particularly in London, despite there being many unused, fully functional invasive ventilators available elsewhere in the UK. These incidents were included in the BMA's submissions to the NAO and the House of Lords Select Committee on public services inquiry in May and June 2020 respectively (PB/180 - INQ000117896, PB/041 - INQ000118011).

Ventilator capacity also requires the availability of specialist staff and beds

285. Ventilator capacity does not solely depend on the availability of the ventilator machines. Patients on ventilation support, particularly those who are undergoing invasive mechanical ventilation, require constant care by highly trained healthcare workers. The availability of the ventilators cannot be separated from the consideration of specialist ICU staff capacity. According to the National Critical Care Nursing Workforce Survey carried out by the Critical Care Network – National Nurse Leads Forum across England, Wales and Northern Ireland in December 2019, there was a band 7-9 critical care nurse vacancy rate of 8.9%, with significant variation across England (no breakdown of data for Wales or Northern Ireland are available) (PB/840 - INQ000520247). This shortfall of ICU workforce compared to patient need resulted in the considerable stretching of ICU nurse to patient ratios during the pandemic. During the first peak of the pandemic, these ratios were diluted from the usual 1:1 care for level 3 critical care patients to up to 1:6 (as described in the expert report by Professor Summers and Dr Suntharalingam, INQ00047425). Staff are also trained to work with specific models of ventilators, which had implications for the efficacy of rapid ventilator procurement processes.

286. Ventilator capacity also requires the availability of specialist intensive care beds. ICU bed numbers and occupancy increased dramatically during the pandemic, further demonstrating the huge pressure on intensive care provision during this time. Data from the Intensive Care Society show that there were an additional 2,023 ICU beds occupied in England in January 2021 compared to January 2020, 84 more ICU beds occupied in Wales in January 2021 compared to January 2020, 44 more ICU beds occupied in

Northern Ireland in January 2021 compared to January 2020, and 100 more ICU beds occupied in Scotland in January 2021 compared to January 2019 (the data set does not include January 2020 data for Scotland) (PB/841 - INQ000395297). However, as these statistics are nation-wide, they obscure the particular pressures and bed-shortages that some hospitals faced and which led to the transfers of critical care patients between hospitals described above.

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

287. As I stated in my Module 3 witness statement (INQ000477304), no government guidance or prioritisation protocols were issued setting out the criteria and policies for determining which patients would be admitted into intensive care units within hospitals or be treated with specific interventions, such as mechanical ventilation, in the event that demand outstripped already limited resources or services were overwhelmed. The BMA considers this a key failure, given that the lack of capacity in the health service pre-pandemic was largely due to years of underinvestment by successive governments. The BMA raised the issue of the need for guidance for such circumstances on numerous occasions, including through the Moral and Ethical Advisory Group (MEAG) set up by the DHSC. The chair of the BMA's Medical Ethics Committee also discussed this during a phone call with Stephen Powis, NHSE's Medical Director, on 23 March 2020 (PB/582 – INQ000117789), and the BMA UK council chair wrote to Chris Whitty, Chief Medical Officer for England, on 14 April 2020 requesting national guidance from the government (PB/270 - INQ000400347). Pan-profession guidance was commissioned by the four UK CMOs, and a small group within MEAG was tasked with producing draft guidance. At this stage, the BMA shared the draft guidance being developed by the BMA with the Chair of MEAG. Draft guidance was produced by the group and was discussed at a MEAG meeting on 25 March 2020 (PB/225 - INQ000117797, PB/374 - INQ000117794). However, by 30 March 2020 the UK Government decided not to issue this guidance in order to avoid raising public anxiety unnecessarily as they felt that resources would not be exhausted (PB/125 - INQ000117806).

288. As a result of the UK Government's decision not to issue guidance or any protocols for prioritising care, the BMA issued its own ethics guidance for the profession. This

covered resource allocation, warning that restrictions in the availability of mechanical ventilation may become severe. The guidance states that doctors would be obliged to make decisions that mean "some patients may be denied intensive forms of treatment that they would have received outside a pandemic" (PB/143 - INQ000117773). The BMA also published a set of Frequently Asked Questions (PB/144 - INQ000433852 and PB/145 - INQ000117787). A number of other organisations also published their own guidance. However, having multiple sets of guidance, instead of a central source, created the risk of different interpretations and a lack of clarity for staff.

289. While the BMA did not directly receive evidence that the need for a threshold for admission to intensive care or for use of scarce intensive treatments ever arose during the pandemic in any part of the United Kingdom, the expert report by Professor Summers and Dr Suntharalingam (INQ000474255) states that *'[…] it is likely that in practice, ICU capacity was overwhelmed in some locations at certain times and that the criteria for ICU admission changed via local informed processes (conscious or unconscious alterations in decision-making by individual clinicians rather than due to policies or guidelines being issued) when capacity was stretched, meaning those who might usually be admitted to ICU were not'*. In the BMA's view, an understanding of the UK's usual and surge ventilator capacity, at a local as well as national level, and ensuring alignment between staff training and available ventilators, as well as increasing overall staffing numbers, would ensure the right ventilator capacity in the right place at the right time during a future pandemic or health emergency.

F. Oxygen

Summary of key issues relating to Oxygen

290. The pandemic put unprecedented strain on hospital oxygen delivery systems due to the number of patients requiring high-flow oxygen. Although oxygen never officially 'ran out', BMA members reported shortages and there were challenges in ensuring high flow rates of oxygen around hospital buildings. This led to the rationing of oxygen to patients (patient oxygen saturation levels deemed appropriate were lowered) to reduce the risk of a sudden loss of oxygen pressure with hospital oxygen delivery systems. There were also concerns of fires breaking out on wards due to the high concentration of oxygen in the air.

291. Although NHS England issued multiple estates and facilities alerts about oxygen management during the relevant period, the government did not provide guidance to support clinicians in their decision-making in the event that need for critical healthcare outstripped supply as I have set out above in paragraph 287.

Impact on members

292. BMA members described the threat of insufficient oxygen supplies and their distress at having to limit oxygen provision to patients in our 2021 call for evidence.

293. As described above, circumstances in which healthcare need outstrips supply raise serious ethical and professional challenges and can lead to moral injury among doctors responsible for making final decisions on care escalation. In such circumstances, wider concerns about the potential for discrimination in the application of criteria may also arise.

Oxygen supply systems were put under unprecedented strain during the pandemic

294. Prior to the pandemic, the BMA was not aware of oxygen supply or flow issues. However, hospital oxygen systems had only very rarely, if ever previously been under the pressure they were during the peaks of admissions due to Covid-19 in 2020 and 2021. Furthermore, before the onset of the pandemic, a much lower proportion of patients required oxygen therapy and generally lower rates of flow of oxygen were needed to support these patients.

295. During the pandemic, there was significantly increased use of both invasive and non-invasive ventilation, and particularly CPAP ventilation, which requires a high oxygen flow rate. This placed abnormally high demand on hospitals' piped oxygen supply systems. Increased requirements for high-flow oxygen present a significant risk of failure of oxygen delivery systems throughout hospitals. If overall oxygen demand through wall outlets exceeds the maximum capacity of oxygen delivery systems, there is a risk of a sudden drop in oxygen pressure which would mean that patients receiving oxygen through face masks, CPAP, ventilators, and in operating theatres would simultaneously stop receiving oxygen, which would be highly dangerous for patients and potentially fatal.

296. In England NHSE/I Estates and Facilities Alerts were issued to hospitals on 31 March 2020 and 6 April 2020 about high use of oxygen and the risk of sudden loss of oxygen pressure and flow, and on 18 November 2020 about the risk of sudden loss of pressure and also regarding the elevated risk of fire due to high ambient oxygen levels (PB/842 - INQ000443868, PB/843 - INQ000269929 and PB/844 - INQ000376956). The 31 March 2020 alert gave a number of urgent actions, including to 'calculate the maximum number of patients who can be treated with high flow devices such as wall CPAP and communication of this to the relevant clinical teams'.

297. That this alert and its instructions for action came so late, and indeed, as an urgent alert for immediate action, suggests a lack of anticipation of and planning for such high use of oxygen, and that hospitals had not been able to prepare adequately. In his testimony for Module 1, Nigel Edwards (CEO of the Nuffield Trust) explained that high flow oxygen was not anticipated as a method of treating Covid-19, and that – in many cases – the hospital pipework of oxygen supply was inadequate (especially relative to the scale of the pandemic). Some hospitals therefore had to make major engineering and structural changes at pace in order to ensure high flow oxygen supply. Older hospital oxygen flow systems can produce as little as half the maximum flow rate of modern oxygen systems (PB/842 - INQ000443868).

298. In its submission to the NAO in May 2020 (PB/180 - INQ000117896), the BMA referenced media reports describing how poor access to the engineering support needed to safely expand oxygenated bed supply hampered efforts of many trusts to provide more patients with high flow oxygen - a senior leader at a trust outside London reported trying to access engineering support for more than a week (PB/845 - INQ000520242). Investment in NHS estates, including upgrading oxygen systems, is needed to better protect delivery of patient care in the event of a future pandemic.

Oxygen was rationed and there were supply and flow issues

299. Although oxygen never 'officially' ran out, BMA members reported shortages and there were challenges in ensuring high flow rates of oxygen around older hospital buildings as set out above. The BMA is also aware of pre-emptive actions, such as the rationing of oxygen, being taken to reduce the risk of a sudden loss of oxygen pressure. Doctors told the BMA that the need to ration oxygen impacted on the care they could provide to patients.

In my oral evidence in Module 1, I discussed how intensive care consultants had to perform physics calculations of oxygen flow through pipes to determine whether more oxygen could be delivered around the hospital I work in.

300. Examples of how oxygen flow and shortage issues affected doctors and patient care include:

a. Our Covid-19 tracker survey from 16 April 2020 found that 33% of all respondents experienced shortages of medicines, medical gases or other therapeutics (such as ventilators) most or some of the time. Of those who experienced shortages, almost a fifth (19%) reported a shortage in oxygen supplies. Overall, almost 40% of respondents felt that shortages of medicines, including medical gases such as oxygen forced them to provide less effective care to patients than they normally would, either frequently or occasionally.

b. Notes from 23 April 2020 of one of the regular internal daily virtual meetings established by the BMA during the pandemic (described in further detail above in paragraph 30 of this statement), show that "oxygen rationing [was] becoming an increasing problem". Such 'anticipatory rationing' was also recounted by one consultant from England in our 2021 call for evidence survey who spoke about the *"rationalisation of oxygen […] by lowering the thresholds for oxygen treatment"* and described *"everyone pretending it was ok"*. Oxygen rationing included doctors adjusting flow rates below recommended standards, effectively reducing the amount given to patients to avoid running out of oxygen and to spread limited supplies between a larger number of patients where necessary. This was done in the context of NHSE urging trusts to lower target oxygen saturation levels from the normal 94%-98% to 92%-96% in the first instance. NHSE also advised that a 'target range of 90%-94% may be considered if clinically appropriate by hospitals according to prevailing oxygen flow demands' (PB/846 - INQ000522167).

c. A consultant in our 2021 call for evidence wrote that there was *"shortage of ventilator capacity initially"*, but that the *"main threat was the integrity of the oxygen supply"*. A resident doctor from England wrote that *"it was mostly luck that our oxygen supplies didn't fail in various hospitals"*.

d. Another consultant doctor stated in our 2021 call for evidence that they had *'huge anxiety'* that a fire would break out as a result of the high levels of oxygen and amounts of flammable materials such as PPE packaging.

301. The BMA is aware of multiple incidents relating to oxygen flow and supply. Some of these issues were raised by BMA members to the BMA directly (see also above), and the BMA also became aware of these and other issues through media reports. Issues included, but were not limited to, the following:

a. Late March 2020: A major London teaching hospital almost ran out of oxygen due to the high number of patients being treated with oxygen there (PB/847 - INQ000520240)

b. 04 April 2020: West Hertfordshire Teaching Hospitals NHS Trust declared a critical incident and asked the public not to attend Watford General's A&E due to a technical issue with its oxygen equipment. An undisclosed, 'small' number of patients were transferred to other hospitals in the area (PB/848 - INQ000520241).

302. In addition to the specific incidents above, a report by the Health Services Safety Investigations Body (HSSIB, formerly the Healthcare Safety Investigation Branch) published on 24 June 2021 states that the HSSIB was aware, through various sources including national media and NHS reporting, of 'at least a dozen NHS trusts' where concerns around oxygen flow were raised in the context of the Covid-19 pandemic and the increased demand for oxygen flow around hospitals (PB/849 - INQ000270026). This report covers an investigation undertaken by the HSSIB in response to a 'reference event', a major incident involving disruption to oxygen flow in an acute trust in autumn 2020. The report considers medical gas pipeline systems (MGPS) and their safety across the NHS.

303. Among the investigation's key findings are that the relevant NHSE health technical memorandum (HTM) guidance on MGPS does not reflect developments in oxygen therapy and current challenges in managing MGPS. It found that there is a lack of shared ownership and knowledge of MGPS among hospital-based multidisciplinary teams, but that where a multidisciplinary approach to oxygen and MGPS management was taken during the pandemic this enabled hospitals to respond to demand better. It also found that historic underinvestment in MGPS caused difficulties for hospitals in responding to the Covid-19 pandemic. The HSSIB made a number of safety recommendations including that NHSEI 'completes ongoing work to review, revise and reissue the health technical

memorandum (HTM)' for MGPS and that NHSEI 'review and further specify the key roles, responsibilities and competencies' of individuals identified in the HTM for MGPS.

G. Access to Covid-19 testing in healthcare settings

Summary of key issues related to testing

304. The BMA's primary focus in relation to testing was ensuring staff and patients had access to timely testing for Covid-19 to reduce the transmission of the virus, protect staff and patients from infection and ensure staff were not self-isolating unnecessarily, reducing staffing at such a critical time.

305. In the UK, the first tests available were PCR (polymerase chain reaction) tests, which needed to be sent to a laboratory for analysis. In all four nations, eligibility for a test was first made available to a small cohort (those with a medical need and some critical workers), before gradually being expanded to a wider group over time. By the end of August 2020, everyone in the UK with symptoms was eligible for a test.

306. Initially, there was a lack of any testing in the community and in healthcare settings due to supply issues, which became more critical as the virus began circulating more widely. As a result, the Government committed to prioritising testing for healthcare settings, something the BMA called for, but this did not always lead to sufficient tests being available.

307. Doctors reported issues accessing testing, requiring them to self-isolate even if it later transpired that they did not have Covid-19. This reduced the number of staff available at a critical time.

308. Testing for patients was also impacted due to supply issues, with tests being reserved for patients entering intensive care, which left little capacity for other patients in hospital, for example. In the early weeks, there were also strict criteria for testing patients, linked for example, to recent travel to specified countries.

309. While access to testing for staff and patients initially improved as the pandemic progressed, there were issues that arose at different times, particularly at times of high community prevalence or when there was an easing of restrictions leading to increased social mixing, such as the reopening of schools, and therefore higher levels of infection or contact with infected persons, requiring testing.

Impact on members due to testing issues

310. The lack of testing impacted doctors and the wider health service in a number of ways.

311. Doctors told the BMA that they were unable to test incoming patients, which meant that doctors were often coming into contact with symptomatic and asymptomatic Covid-positive patients without the recommended PPE. Given the shortage of available tests for medical professionals during the early stages of the pandemic, this meant that Covid was inevitably transmitted unwittingly to other patients and colleagues.

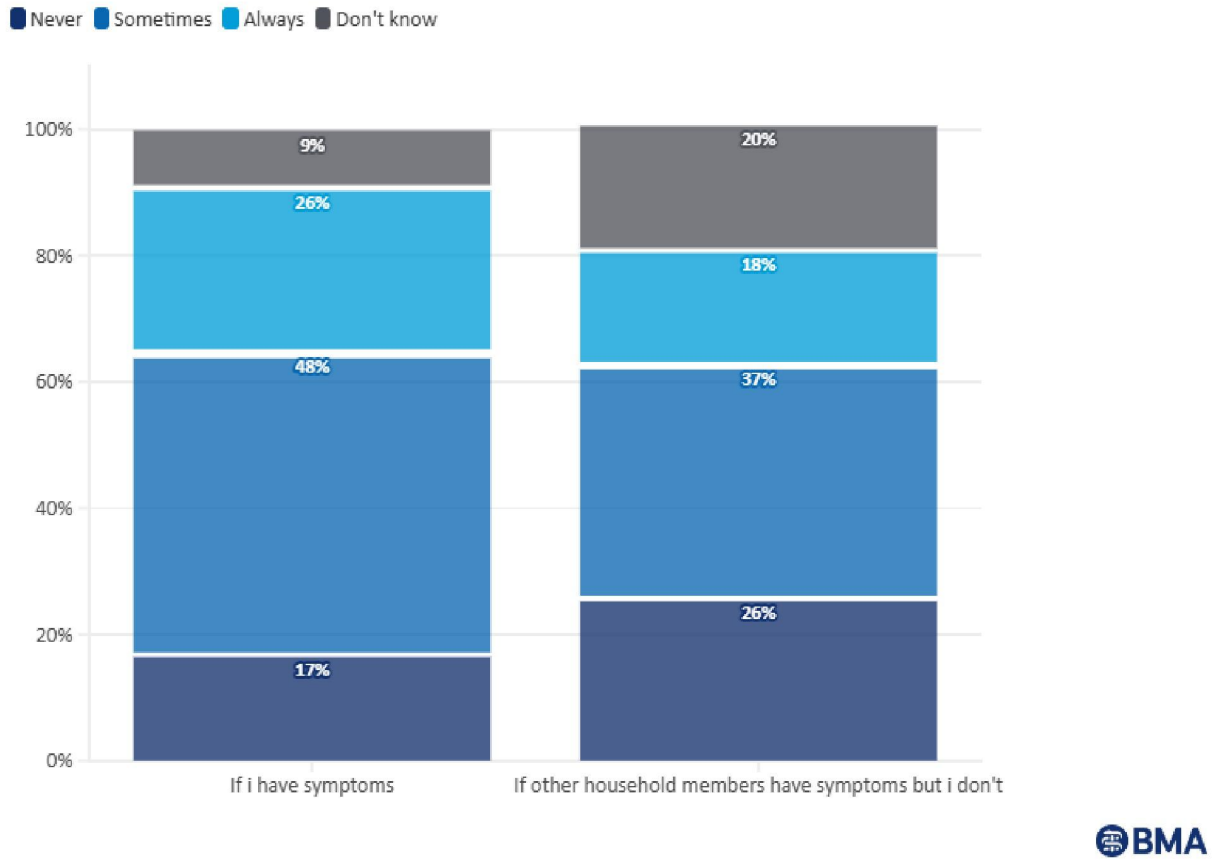
312. Delays to accessing tests and receiving results also meant that many healthcare staff were required to self-isolate, often meaning they could not work, further reducing the number of staff available which impacted on both patients and staff.

The BMA asked members about access to PCR testing and Lateral Flow tests at different times of the pandemic

313. We enquired among our members about access to PCR testing at different stages in the pandemic and lateral flow tests (LFTs) during the Omicron wave. In our first Covid tracker survey on 06 April 2020, just 13% of hospital doctors and 9% of GPs, respectively, said that testing was always available for those self-isolating with symptoms. These figures were lower still in circumstances where the working doctor was not symptomatic, but members of the household were, requiring the doctor to self-isolate: 8% and 5% for hospital doctors and GPs, respectively.

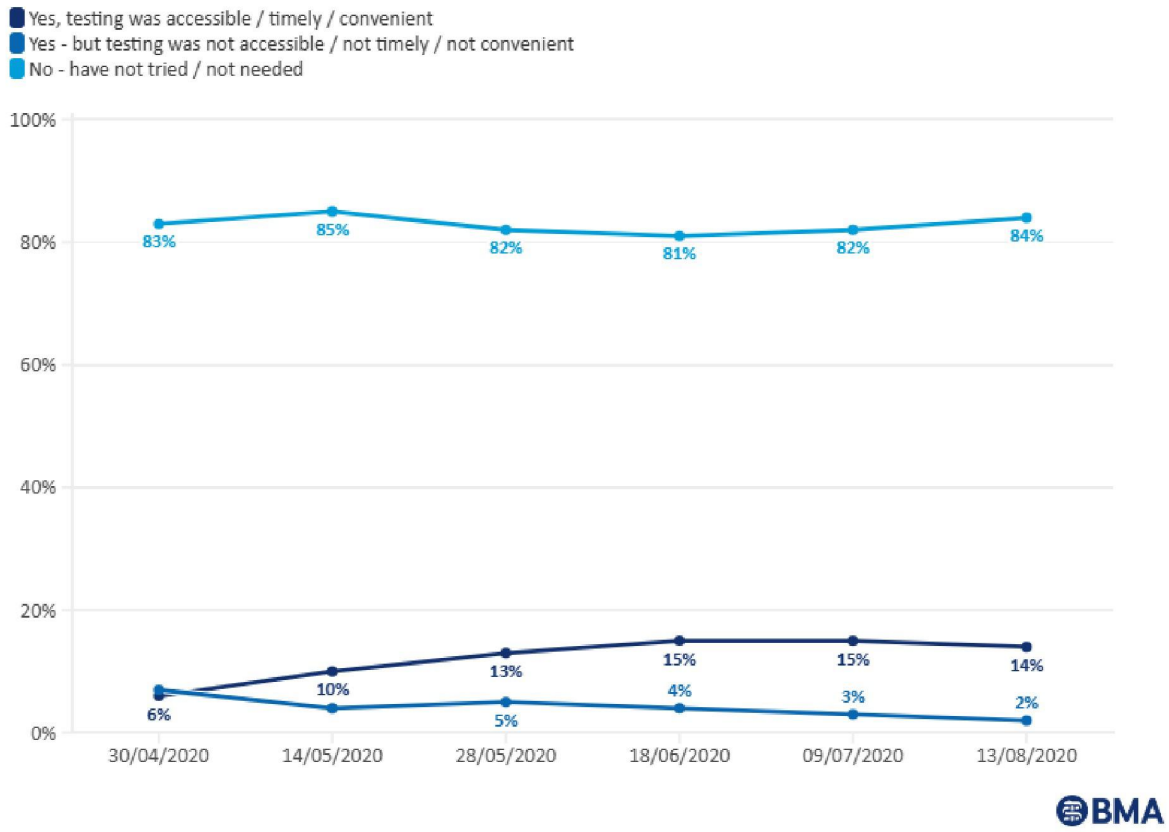
314. By the time of our second Covid tracker survey on 16 April 2020, there were signs of an improvement in the availability of testing for symptomatic doctors with 26% of doctors reporting that testing was always available in their place of work or local NHS, compared to just 18% if they had to self-isolate because household members had symptoms but they personally did not (figure 8).

Figure 8 – Does your place of work or local NHS offer testing for Covid-19? (tracker survey 16/04/2020)



315. In our surveys undertaken between 30 April 2020 and 13 August 2020, a different form of question was used for all participants. Responses suggested that for those who needed it, the proportion able to access testing for Covid-19 in a timely and convenient way, increased steadily to approximately 15% of survey respondents, while approximately 80% self-reported having not tried or needed to test. However, up to approximately 5% of respondents said they found testing was not accessible, timely or convenient (figure 9).

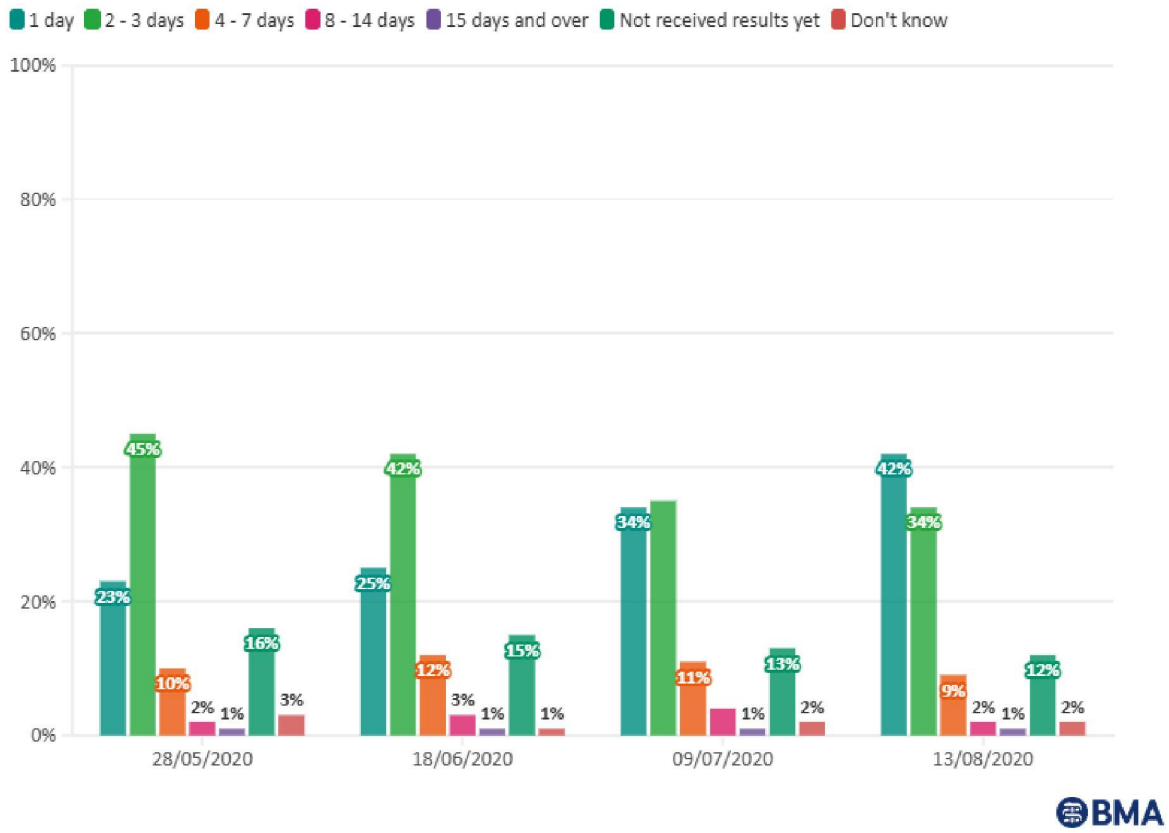
Figure 9 - Within the last two weeks, have you, or a member of your household, tried to access testing for Coronavirus (in your place of work, local NHS, or online)? (tracker surveys 30 April2 020 to 13 August 2020)



Note: 'Prefer not to say' responses are not shown (<1%).

316. Between May and August 2020, participants in our tracker surveys were asked how long they had to wait to receive the results of their test for Covid-19. Responses suggested a gradual increase in those receiving their results in 1 day (from 23% on 30 April 2020 to 42% on 13 August 2020) and an associated decrease in the proportion waiting 2-3 days. However, even by 13 August 2020, our survey suggests approximately one quarter of respondents reported waiting 4 or more days to receive their result (figure 10).

Figure 10 – How long after your test did it take to get the results? (14 May 2020 to 13 August 2020)

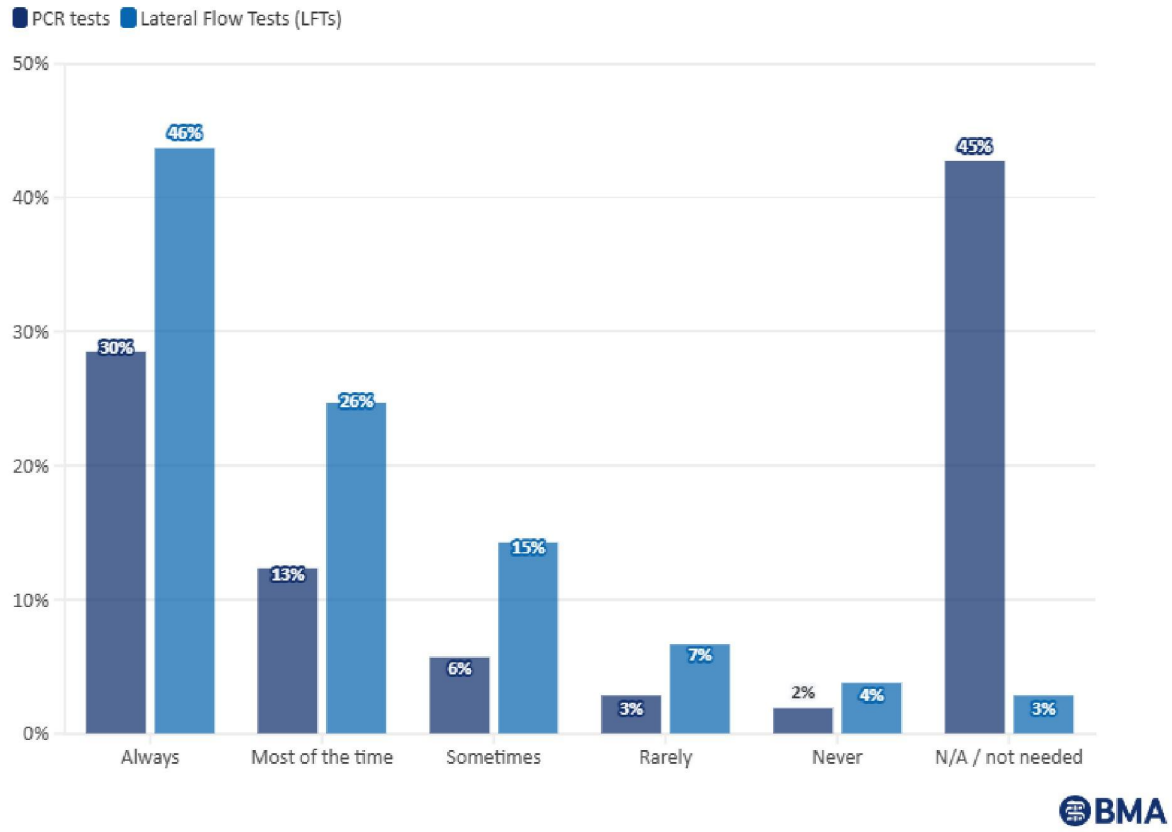


Note: Surveys undertaken on 09/07/2020 and 13/08/2020 were England and Wales only.

317. Later in the pandemic, we asked our members about access to routine asymptomatic testing. The results are not directly comparable due to differences between questions and sampling. In December 2020, 49% of respondents said they had access to routine asymptomatic testing (survey excluded Scotland), compared with 75% of respondents to our survey in February 2021 (UK wide).

318. We revisited some of these issues later in the pandemic during the spread of the Omicron variant in January 2022. 43% and 72% of respondents said in the last three weeks they always or most of the time had access to PCR and LFTs, respectively (figure 11). 13% of respondents said access to PCR or LFTs had affected their ability to work in the last three weeks, while 83% said it had not affected them at all.

Figure 11 – Within the last three weeks, have you been able to access PCR tests / Lateral Flow Tests (LFTs) when needed?



The BMA took action to raise awareness of the shortages of Covid-19 tests for healthcare staff

There were significant shortages of tests at the outset of the pandemic and issues continued throughout

319. Throughout the pandemic the BMA sought to raise concerns with Ministers and senior officials about the shortage of testing. As shown by the BMA survey data above, staff reported difficulties accessing tests were particularly acute in the first wave of the pandemic and there were further concerns when the Omicron variant emerged.

320. So concerned was the BMA about access to testing by healthcare staff, the Chair of BMA UK Council wrote to the then Prime Minister Boris Johnson on 21 March 2020 emphasising the need to prioritise testing for healthcare workers and their families to

address the growing shortages and protect both staff and patients (PB/064 - INQ000097910).

321. Around the same time, we also raised issues relating to testing with the SoS for Health and Social Care and the CMO, including in a meeting on 18 March 2020. On 26 March 2020, the BMA wrote to the SoS calling for healthcare workers, and their household members, to be tested for suspected Covid-19 as an urgent priority (PB/007 – INQ000097941). The letter outlined that testing for healthcare staff was being implemented to varying levels in Wales, Scotland and Northern Ireland, but stated that there were particular concerns about the system in England with BMA members reporting only a few isolated tests being available, and threats that even the limited existing services may be withdrawn. The letter emphasised that the lack of testing was impacting on staffing at a critical time and that urgent clarity was needed about the timeframe for healthcare staff being prioritised for testing.

322. This letter dated 26 March 2020 resulted in a phone call between the Chair of Council and the SoS (also on 26 March 2020) (PB/204 – INQ000117801) in which the SoS told the BMA that more tests would be available soon but that it may be two weeks before healthcare workers saw a significant roll out of testing. The Chair of Council advised the SoS to be honest publicly about the supply issues. It was also agreed that the BMA should send through the offers it had received from companies to supply tests directly to the SoS's office which I have mentioned elsewhere in this statement, which the BMA did later the same day (PB/531 - INQ000117800).

323. There was a meeting with Helen Whately MP, Minister for Care, on 27 March 2020 which included discussions on testing shortages in which the BMA emphasised the importance of honesty if there are testing shortages, the need to prioritise healthcare workers and the role testing plays in allowing doctors to return to work (if they receive a negative test result) rather than having to isolate for 14 days.

324. The BMA UK Council Chair again wrote to the SoS on 06 April regarding testing required for doctors to combat the Covid-19 pandemic (PB/065 - INQ000097854) (see paragraph 108). Testing and contact tracing was also discussed with the SoS on 28 April 2020.

325. On 22 April 2020, the BMA issued press releases urging for an expansion of testing sites to ensure more healthcare workers could be tested (PB/381 - INQ000397242). At that time, only 6,000 to 7,000 tests were being conducted per day for NHS staff and their family members, which the BMA deemed insufficient for allowing healthcare workers to return to work. The press release stated that an estimated 100,000 NHS staff and family members were self-isolating across England, Scotland, and Wales, unable to continue their jobs due to insufficient testing sites and sites being inaccessible. In addition, healthcare workers at the time relied on their employers to facilitate the testing process, as they required permission to be tested and could not go on their own, which further delayed the process. In the release, the BMA stated that around 70 doctors had been in contact with the BMA in that week to express their frustration.

326. The BMA issued a news article on 13 May 2020, expressing concerns about the risks of false negative test results for healthcare workers, as well as a lack of testing in general practice and the community (PB/874 - INQ00474863).

327. The BMA raised further significant concerns about testing availability, particularly for healthcare staff and patients in September 2020.

328. The BMA published a news article: Outsourced and undermined: the Covid-19 windfall for private providers (PB/852 - INQ000493396) on 08 September 2020, highlighting that the outsourcing of testing resulted in significant adverse effects such as delays in test results (PB/852 - INQ000493396).

329. On 08 September, the BMA issued a press release urging the UK Government to get a grip on testing services at a critical time in the fight against Covid-19 (PB/850 - INQ000099104). This was in response to the admission from the National Director of Test and Trace that people were not able to get a Covid-19 test due to labs reaching capacity.

330. The following day (09 September 2020) the Chair of UK Council wrote to the Secretary of State for Health about this issue and sought assurances that it would be addressed urgently. The letter described what the BMA saw as a significant breakdown in the Covid-19 testing service affecting healthcare staff and patients. Problems included difficulties in booking tests, long travel times to testing sites, and delays in receiving results, largely due to limited laboratory capacity. The letter noted that these challenges disproportionately affected vulnerable groups, such as low-income individuals, the elderly, and those with mobility issues. The BMA emphasised the urgency of improving testing

capacity to control the rising infection rates and prevent a major second wave, seeking an update on government plans to address these problems (PB/231 - INQ000118110).

331. A response to this letter was received on 14 October 2020 from the Secretary of State, following a discussion with the BMA (PB/267 - INQ000466405). Regarding the BMA's concerns about testing capacity (particularly due to low laboratory capacity), the SoS said that the government had expanded testing capability, increased capacity of labs and had set up new testing sites. They pledged to increase testing capacity to 500,000 a day and increase test site numbers to 500 by the end of October. Further, the SoS stated that more walk-in testing sites would be opened, and in conjunction with piloting new testing technology this would ensure faster results.

332. Similar issues were discussed with Baroness Dido Harding in a call with the BMA on 21 September 2020 (PB/208 - INQ000118118). In the meeting, the BMA sought further information on the steps being taken to improve lab capacity and when these issues would be resolved. Concerns about the performance of the private sector labs and the extent to which further capacity would be reliant on the private sector were also discussed. The BMA also asked what steps were being taken to ensure healthcare workers could access tests particularly as demand increases heading into winter, when other non-SARS-CoV-2 respiratory viruses would be more prevalent too. The BMA advised Baroness Harding that there were increasing reports of healthcare workers having to isolate when they may not have had Covid and being taken out of the workforce because they cannot access tests.

333. These issues continued throughout the pandemic. On 30 December 2021, the BMA issued a press release stating that the system for prioritising healthcare staff for lateral flow and PCR tests was not working and that this was putting NHS services under severe threat (PB/878 - INQ000553502). The release reports that, at the time, over 18,000 staff were absent from acute hospital trusts in England due to Covid-19 or self-isolating, averaging about 465 absences per trust. This issue was compounded by difficulties in accessing tests, which hampered the ability of healthcare workers to return to work. In the press release the BMA Chair of UK Council urged the government to prioritise key workers for testing supplies, especially with the rapid spread of the Omicron variant increasing demand. He was clear that ensuring access to tests was crucial to avoid further disruptions in patient care, particularly during winter pressures and staff shortages.

While there were initial concerns about the sensitivity of lateral flow tests, as the technology improved, the BMA called for wider rollout to health and social care staff

334. Once Lateral Flow tests (which staff could self-administer and did not need lab processing) became available, the BMA sought information on government intentions to roll out routine testing for healthcare staff. This was particularly in response to growing concerns about the extent of asymptomatic transmission of Covid-19 and the implications for staff and patients of nosocomial infection if staff and patients were infectious but not showing symptoms.

335. For example, in one of his regular meetings with Stephen Powis on 10 July 2020, the Chair of the BMA's Consultant's Committee asked about regular or routine testing of staff. Stephen Powis advised that this would likely be reviewed around winter or if community prevalence increases but said that the current focus was on targeted surveillance in areas with infection spikes rather than workforce-wide routine testing.

336. The BMA published a report, 'Reducing infection risk in healthcare settings' in November 2020 (updated in August 2021) (PB/099 - INQ000118214, PB/100 - INQ000118397) which set out actions government and employers should take to protect staff. In relation to testing, the report emphasised the importance of health and social care workers (both symptomatic and asymptomatic) having access to priority testing for Covid-19. It noted that, given concerns about the asymptomatic spread of the virus in healthcare settings, it was crucial that capacity for regular asymptomatic testing of staff was expanded as soon as possible. However, it also noted that some concerns had been expressed about the sensitivity of new lateral flow tests (i.e. that the test was falsely negative when the test subject was actually infectious) and noted that it is therefore important that healthcare workers can continue to be guided by their symptoms, as well as having access to repeat testing. The guide was clear that alongside this there must be clear plans in place setting out the consequence of positive tests among healthcare workers, including managing isolation of staff testing positive and their contacts.

337. Widespread routine testing for NHS staff using lateral flow tests was eventually rolled out in November 2020 and continued until 2022 when it was phased out by the summer.

338. On 28 March 2022, the chair of BMA UK council, sent a letter to Amanda Pritchard, CEO of NHS England requesting reassurance that regular free Covid-19 testing for NHS

staff would continue beyond 01 April 2022 (PB/203 - INQ000097946). The letter emphasises the importance of government maintaining testing to protect healthcare workers and patients, especially considering concerns regarding funding among healthcare providers and the potential for an increase in infections. Dr Nagpaul warns that any reduction in routine testing could worsen staffing absences and increase pressure on the NHS, which is already managing a significant backlog of care. He also mentions ongoing discussions with the Treasury about funding for these measures and raises concerns about the government's broader testing policies, which could place further strain on the health service.

BMA offices in the devolved nations also raised concerns about access to testing

BMA Cymru Wales

339. BMA Cymru Wales raised a number of concerns about testing during the course of the pandemic, which mostly related to testing requirements for health and care staff as non-Covid services tentatively began to restart during late Spring-Summer 2020. BMA Cymru Wales sought to raise awareness of issues related to testing primarily where it concerned NHS staff directly, or where deficiencies of the testing regime would have a significant impact on the delivery of healthcare services.

340. Regular Welsh Government technical briefings were instituted to aid information sharing on a number of topics, including in relation to testing. These briefings offered the opportunity to raise questions of civil servants as testing regimes developed. The briefings were often led by Welsh Government officials but on occasion featuring staff from the NHS Wales Shared Services Partnership or Public Health Wales. These briefings were held for trade union staff representatives, with BMA Cymru Wales invited as a member of the Welsh Partnership Forum. The primary purpose of these briefings was for the Welsh Government to share information with trade union staff representatives and for attendees to have an opportunity to ask questions. These briefings were not decision-making forums and had no agendas or papers.

341. BMA Cymru Wales wrote to the Chief Scientific Adviser for Wales on 16 April 2020 seeking his view on data that had recently been published in the JAMA (The Journal of the American Medical Association) which suggested that isolated throat swabbing had

only a 30-40% positive pick-up rate, and 60% with nasal swabbing. The letter also stated that advice from communicable disease specialists was that guidance suggested combined throat and nasal swabs with a repeat test two days later, although this was not happening in Wales. The letter also sought the Chief Scientific Advisor's views on whether there was a need for standardising testing methods across Wales, and on how much reliance could be placed on tests (PB/356 - INQ000118538). BMA Cymru Wales also wrote to the Minister for Health and Social Services on 08 July 2020 to highlight the emerging evidence on asymptomatic spread, the likelihood of increased pressure on the health service and the need for regular staff testing (PB/350 - INQ000118581).

342. In a submission to the Health and Social Care Committee Inquiry in May 2020 BMA Cymru Wales also called for clearer messaging to the public around testing, and better alignment in testing regimes in the nations to minimise confusion (PB/181 - INQ000118549).

343. The Chair of BMA Wales Council sent a letter to the CEO of NHS Wales on 02 July 2020 providing comments on the Q2 Operating Framework Guidance, which was published by NHS Wales during the 2020/21 financial year, setting out its priorities for the coming quarter. BMA Cymru Wales' comments included the importance of regular asymptomatic staff testing, the need for improved IT provision, and the importance of risk assessment tools being used consistently (PB/369 - INQ000118574).

344. In a BMA Cymru Wales media release on 03 July 2020, BMA Cymru Wales advocated for regular testing of all NHS frontline workers for Covid-19, regardless of symptoms, to ensure patient and healthcare worker safety as services resumed. Leading doctors emphasised the importance of frequent testing to prevent the spread of the virus, particularly among asymptomatic staff. In my role as the Chair of BMA Wales' Consultants Committee I highlighted the need for timely test results and antibody testing, urging measures to ensure doctors can safely care for patients while minimising transmission risks. I also called for transparent data on testing to boost public confidence in NHS safety.

345. On 08 July 2020 a letter was sent from the Chair of BMA Wales Council raising concerns about the possibility of false negative Covid-19 antigen tests, and the consequences of this for staff potentially transmitting the virus to vulnerable patients. In this letter BMA Cymru Wales again called for regular testing of frontline healthcare staff (PB/350 - INQ000118581).

346. In August 2020, following up on member concerns, the Chair of GPC Wales wrote to the NHS Wales Informatics Service (NWIS) to clarify BMA Cymru Wales' calls for patients' Covid-19 test results to feature on GP clinical systems in a timely and accessible manner, for information purposes with no further action required by the practice (M2B/PB/008 - INQ000355863). This change was subsequently made.

347. In September 2020, following the announcement of a local lockdown in Caerphilly County and in light of significant issues with test availability, BMA Cymru Wales raised a number of concerns, including in the press, about severe testing shortages being experienced by the public (M2B/PB/009 - INQ000355864, M2B/PB/010 - INQ000355865). At the regular technical briefings, Government reported these shortages being due to significant pressures upon both the UK Government 'Lighthouse' laboratories and the Public Health Wales laboratories, with the latter being prioritised for NHS Wales services and staff. BMA Cymru Wales continued to call for routine asymptomatic staff testing in November 2020 (M2B/PB/153 - INQ000118640, M2B/PB/154 - INQ000118641, M2B/PB/155 - INQ000118642, M2B/PB/156 - INQ000118643, M2B/PB/157 - INQ000118644, M2B/PB/158 – INQ000118648). In addition to this, the National Director of BMA Wales met with the Acting Deputy Director of Workforce and Organisational Development on 03 November 2020 to discuss asymptomatic staff testing.

348. BMA Wales also called for improvements in a news article on 13 September 2020 to Test and Trace so people did not have to travel many miles to access testing (see for example PB/051 - INQ000118611).

349. In late 2020 and early 2021, the pace of the rollout of lateral flow testing devices across NHS Wales was uneven. At the time, BMA Cymru Wales raised concerns regarding a lack of progress in rolling out lateral flow testing to GP practice staff (M2B/PB/011 - INQ000355944, PB/357 - INQ000118653). The lack of availability of testing devices to GPs and their staff made it difficult for some GPs to maintain visits to the care homes in their area, given the policy requiring all health professionals visiting care homes to have a negative lateral flow test (M2B/PB/012 - INQ000355918). Widespread routine testing for staff in Wales using lateral flow tests was required from 14 December 2020, despite issues with supply which continued for several months.

350. BMA Cymru Wales had a range of other engagement in relation to testing for healthcare staff, including:

a. 27 May 2020 – Briefing by BMA Cymru Wales on the Welsh Government's framework for the resumption of some NHS services. The briefing set out BMA Cymru Wales' belief that the framework for the reintroduction of additional services was too fast and could have negative consequences, which was confirmed in a letter to the Welsh Government. It included recommendations of the steps the Welsh Government should put in place to gradually ease the lockdown and resume routine services, including recommendations related to testing and contact tracing (M2B/PB/171 - INQ000118552).

b. 03 July 2020 – Sharing a press release with Members of the Senedd calling for the routine testing of all NHS frontline workers (M2B/PB/172 - INQ000118576, M2B/PB/173 - INQ000118575).

c. 30 September 2020 – A meeting with the Deputy CEO of NHS Wales to provide feedback on the Welsh Government's Winter Protection Plan. Feedback from members collated ahead of the meeting included the need for improved communications to the public about testing (M2B/PB/132 - INQ000355866).

d. 04 November 2020 – Following a meeting with the Acting Deputy Director of Workforce and Organisational Development the previous day, the National Director of BMA Wales shared external research with them which had been published in the BMJ about asymptomatic transmission and called for routine asymptomatic staff testing (M2B/PB/153 - INQ000118640, M2B/PB/154 - INQ000118641, M2B/PB/155 - INQ000118642, M2B/PB/156 - INQ000118643, M2B/PB/157 - INQ000118644, M2B/PB/158 – INQ000118648).

Scotland

351. Regular testing was crucial for protecting staff and patients and is something BMA Scotland called strongly for. BMA Scotland raised this with the Director General of Health and Social Care and CMO for Scotland via email on 21 March 2020 (PB/577 - INQ000433847), while also highlighting that effective testing strategies would, in the longer term, likely reduce staff absence by reducing the spread of the virus.

352. Covid-19 testing was an agenda item in the daily meetings that were held by the Health Workforce Senior Leadership Group, which was established by the Scottish Government in response to the pandemic.

353. Widespread routine testing for some staff, such as frontline staff in secondary care and ambulance services, started in late November 2020. It was later rolled out to primary care staff on 15 February 2020.

354. BMA Scotland also participated in the Care Home Rapid Action Group. Set up in April 2020, this group was led by the Scottish Government's Directorate for Community Health and Social Care. It discussed issues affecting care homes during the pandemic including Covid-19 testing and infections.

355. The BMA Scotland National Director raised concerns regarding clarity of knowledge amongst the public in relation to testing via email on 12 March 2020 with the Health Workforce Leadership and Service Reform Directorate within Scottish Government.

356. On 17 and 20 March 2020, the BMA Scotland National Director held a meeting with the Directorate for Community Health and Social Care in Scottish Government, within which they discussed testing for healthcare staff.

357. Free Covid-19 testing ended in Scotland on 18 April 2022, followed shortly after by the end of the Scottish Government's Covid Highest Risk List (previously 'the shielding list') on 31 May 2022. The ending of regular testing of both staff and the public had a particular impact on those previously shielding, especially those immunosuppressed for whom vaccinations are often less effective.

Northern Ireland

358. In Northern Ireland, testing for healthcare staff by appointment started on 04 April 2020. The Council Chair of BMA Northern Ireland welcomed the opening of Northern Ireland's first Covid-19 testing centre for healthcare workers on 04 April 2020 via a press release (PB/871 – INQ000553503).

H. Procurement and outsourcing during the pandemic

359. The BMA's view is that procurement processes and outsourcing to private sector organisations during the pandemic were flawed. Contracts lacked transparency and did not provide good value for money. These contracts covered a range of issues, including testing centres, laboratories and PPE procurement. Private sector hospital capacity was also contracted during the pandemic and was underutilised. As a result, there was a significant amount of wasted resource.

360. The BMA consistently raised concerns about this going back to the first wave. Prior to the pandemic the BMA had also been raising concerns about the level of outsourcing of NHS services to private providers and the value for money of such arrangements. The BMA raised concerns about procurement directly with NHSE and DHSC as well as in the media. The BMA also highlighted its concerns in a series of published policy reports, a webinar and submissions to Parliamentary inquiries and NHS England consultations. These concerns also formed the basis for some of the BMA's lobbying activities around the 2022 Health and Care Act as referenced below in paragraphs 393-396.

Millions of pounds were spent on contracts with private hospitals without adequate scrutiny

361. As a result of the lack of capacity within the English health service in March 2020 NHS England signed a contract with the private hospital sector whereby in return for the NHS covering all their operating costs, a large number of private hospital companies would agree to make 100% of their facilities available to the NHS. Much of the financial information about this agreement is still not available, but in practice very few Covid-19 patients were treated in private hospitals, and it is likely that this was not a good use of public money. One of the reasons for this is that many staff who work in the private sector also work in the NHS, meaning the UK Government's deal often simply secured access to hospital buildings and equipment but without the staff to run them. It is also worth noting that the agreement meant many private sector hospitals stood empty while private sector waiting lists were growing and doctors working exclusively in the private sector had their ability to work temporarily restricted (PB/015 - INQ000185355).

362. Similarly, there was a lack of transparency of the contracting arrangements in the devolved nations. In Scotland, the health service spent more than £20.8 million on access to the private sector during the first wave of the pandemic. While arrangements of this deal and its value for money remain unclear, this helped to ensure that cancer provision continued (PB/015 - INQ000185355).

363. In Northern Ireland, private hospitals were also contracted to continue treatment for urgent elective cancer patients while Trust hospital sites concentrated on Covid-19 patients. An FOI request issued to Trusts shows that private hospitals were paid £27 million to treat over 40,000 patients in the initial three-month agreement. This figure is

likely to be an underestimation given that not all trusts provided up-to-date data. It is important to note that this lack of transparency means that it is difficult to determine whether good value for taxpayer money was ascertained through these deals (PB/015 - INQ000185355).

364. The sections that follow deal with issues that were most acute in the NHS in England, although not exclusively.

The BMA raised concerns about procurement in the media

365. The BMA issued press releases and published news stories on the BMA website. These include:

366. 23 July 2020 BMA news article: Covid-19 conceals deepening privatisation of the NHS (PB/851 – INQ000520246). The article written by Dr David Wrigley, then the BMA's deputy chair of UK council, argued that the Government's Covid-19 response had accelerated private outsourcing – and the race toward a disastrously fragmented health system. This was published in conjunction with the BMA's July 2020 report on this topic (see paragraphs 375-376 below).

367. 08 September 2020 BMA news article: Outsourced and undermined: the Covid-19 windfall for private providers (PB/852 - INQ000493396). The article points out that the contingency measures that were put in place during the pandemic circumvented normal tendering processes. The article sets out the UK Government's dependence on private firms during the pandemic, which followed a decade of health system reorganisation and marketisation combined with severe funding cuts to public services and local authorities in England. This resulted in weakened and fragmented NHS and public health services – with the country's ability to respond to Covid-19 hampered.

368. Speaking to The Doctor (the BMA's member magazine), in June 2020, the former health secretary and former chair of the Commons health and social care select committee Jeremy Hunt admitted mistakes had been made under his tenure. He said: 'The main mistake was that we focused our preparation on pandemic flu rather than a SARS-like virus, all our thinking was geared to the way flu-type viruses behave – that there was no need to increase PPE stocks or testing capacity.'

369. The Doctor article highlights the various problems that were experienced during the pandemic as a result of the procurement processes in place at the time. This includes failings procuring PPE, testing capacity, delays getting test results and wasted money.

370. It noted that the BMA had consistently called for a publicly funded, publicly provided and publicly accountable NHS. It was clear that the best chance of a speedy and comprehensive response to a pandemic is a properly resourced health and care system. The result of an over-reliance on outsourcing carries a risk of removing crucial elements of major incident management – such as the ability to command and control.

371. 10 February 2021 BMA news article: Supply of PPE inadequate, finds report (PB/853 – INQ000520251). The article was published after the release of a Public Accounts Committee report into the Government's procurement and supply of PPE during the first wave of the Covid-19 pandemic, which revealed the Government's plan and stockpile supply of PPE was inadequate and that staff in health and social care experienced shortages and were forced to reuse single-use items with stocks running 'perilously low'. BMA council chair Chaand Nagpaul said: "Within the pages of this report is the appalling and awful truth about health and social care staff having to care for people with Covid-19 or suspected Covid-19 without any or enough PPE to protect themselves from infection. This should never have happened and lives should not have been put at risk because of it."

372. 11 February 2021 BMA press release: Clinicians must be front and centre in plans for NHS reform, says BMA (PB/854 – INQ000520253). The press release was issued ahead of publication of the Health and Care White Paper (discussed below in paragraphs 403-404). It noted that the BMA has previously expressed concerns about awarding contracts without sufficient scrutiny to outsourced providers at huge expense to the taxpayer. It highlighted the devastating impact of this with both PPE and NHS Test and Trace. It stated the BMA's position that the NHS should always be the preferred provider for NHS services.

373. 22 April 2021 BMA press release: BMA responds to Transparency International's report on procurement during Covid-19 pandemic (PB/855 – INQ000099323). Responding to the publication by Transparency International of *Track and Trace: identifying corruption risks in UK public procurement for the Covid-19 pandemic*, Dr Chaand Nagpaul, then the BMA's chair of UK council, highlighted the problems the BMA's members were experiencing with PPE and called for greater transparency around private sector spending.

The BMA raised concerns about procurement and outsourcing through research and policy reports

374. Between 2020 and 2021 the BMA published several reports that addressed outsourcing during the pandemic. The BMA's research highlights how years of underinvestment in NHS services led to a reliance on private sector organisations to deliver services and that these contracting arrangements have been neither transparent nor provided good value for the NHS or for patients.

375. The BMA published a report in July 2020 **"Public Services Private Profit: The role of private outsourcing in the Covid-19 response"** (PB/500 - INQ000397344) which centred on the Government's use of outsourcing in response to the Covid-19 pandemic. The report specifically examined logistical support for PPE, the running of testing centres and labs, procurement of logistical and IT support for the test and trace strategy, and recruitment of returning doctors and nurses. The report concluded that:

a. Public resources were being wasted on unnecessary private outsourcing. Generous sums of money paid to companies with no relevant public health experience also represent a missed opportunity to restore and resource the UK's public health system.

b. Outsourcing was being used to fill gaps created by underinvestment. There is no doubt that sustained underfunding of public health and the NHS as a whole left the UK more reliant on outsourcing to private companies in its response to the pandemic.

c. Outsourcing caused fragmentation of services disabling a coordinated response. 'Pillar two' of the government test and trace strategy (testing of the wider population), for example, stated that test results from privately run centres would be made accessible through patient medical records. Yet GPs reported absent and delayed test results. These lags in data sharing in turn made it difficult to understand local disease clusters and prevented healthcare workers from returning to work.

d. In addition, fragmentation of the NHS supply chain has severely impacted the distribution of PPE supplies. Delegating large parts of the management of procurement processes and supply chains to a complex web of external

companies arguably left the UK Government less able to respond in an agile and rapid way to the dramatic increase in demand for PPE caused by the pandemic.

e. There were legitimate concerns over transparency and the robustness of procurement processes. The contracts awarded to private providers under special pandemic powers bypassed normal tendering processes. The contracts that covered issues including testing centres, laboratories and PPE procurement were agreed without competition or public scrutiny making it difficult to demonstrate value for money. Emergency procurement is said to have enabled a rapid response to the crisis but had reduced transparency around the contracts signed with private firms.

376. The report recommended the following:

a. In any public inquiry into the UK government's handling of the Coronavirus outbreak the role of outsourcing must be scrutinised, including PPE shortages and delayed test results

b. The UK government must be more transparent about private sector outsourcing that has taken place during the pandemic and publish details of contractual arrangements with private companies where taxpayer's money is being used (as is normally the case for any public procurement, despite the government commonly citing commercial confidentiality to keep these deals removed from public scrutiny).

c. A much more robust governance system under NHS control that has oversight of the management and coordination of procurement in England or at a UK-wide level must be introduced.

d. Government must significantly strengthen NHS and local public health capacity and expertise through a substantial and sustained increase in funding for the NHS and local public health departments, including clarity on funding beyond 2020/21.

e. A publicly funded, publicly provided and publicly accountable NHS.

377. The BMA published a further report in March 2022 **"Outsourced: the role of the independent sector in the NHS"** (PB/501 – INQ000397270). This report centred on the role of independent sector providers (ISPs) in providing NHS funded services in the

context of the Government's elective recovery plans. In doing so, it examined the role ISPs played in the pandemic response. The report concluded that:

378. Years of NHS under-resourcing meant that the pandemic necessitated unprecedented arrangements with the independent sector to bolster capacity. ISPs (independent sector providers) were swiftly handed key public health duties in important areas, for example Test and Trace. Critically, ISPs were also contracted to continue routine elective care and provide additional capacity to support the pandemic response.

379. At the height of pandemic, enlisting ISPs to support overstretched NHS services was needed to safeguard patient care, however, this should have been done transparently with clearly defined targets. Independent sector contracting fell short when it came to delivering NHS patient care. This is evidenced by the underutilisation of beds and the negotiated revisions to the Covid contracts with private sector hospitals to ensure better value for taxpayers' money.

380. There were questions to be asked about how much 'additional' capacity can be provided given that private hospitals across the UK largely rely on NHS consultants who carry out additional work in their free time. This was made all too clear in the first round of Covid contracts, which saw the NHS largely gain facilities rather than the workforce to run them.

381. NHS block-funded activity carried out by ISPs was further constrained by the backlog of private patients who were unable to access treatment during these 2020 arrangements. A BMA survey (September 2021) of doctors engaged in private practice found that under these arrangements, 60% of private practice respondents were unable to provide care to their private patients at the time. Approximately 25% reported private patients presented later than they should have – citing NHS bed reservation and subsequent limited capacity as the reason.

382. Spend on ISPs was £2 billion higher in 2020-21 compared to the previous year, where spend was £11.8 billion. The significant increase in ISP spending during the pandemic reflects the historic lack of NHS funding which led the Government to contract with ISPs to bolster NHS capacity.

383. While the BMA recognised the need to utilise all available capacity to tackle elective care waiting lists, it had serious concerns about the increasing reliance on the independent sector to deliver NHS-funded elective care. The priority must be to increase

investment in long term NHS infrastructure and capacity to prevent further backlogs of care in the future, not to direct that taxpayer-funded investment into the independent sector and ultimately shareholders' pockets.

384. The Government's elective recovery plan also risked embedding ISP provision of elective NHS care in the longer-term and potentially beyond the 2025 target for elective recovery. This threatened to undermine NHS planning, finances, and staff training if certain surgeries – namely high volume, low complexity procedures – are no longer performed in the NHS.

385. The lack of detail regarding the terms of ISP involvement in elective recovery was concerning, particularly in relation to possible incentives to increase activity, transparency of contracts, and how the value for money of ISP provision of NHS care would be assessed.

386. The report recommended the following:

a. NHS capacity must be increased in the medium to long-term. Recommendations here included growing the NHS workforce and publishing a long-term workforce strategy; and increasing bed capacity.

b. A viable exit strategy is needed from Government to reduce the role of ISPs in the delivery of NHS-funded services. Where outsourcing is likely to occur, ISPs must contribute towards the education and training of the current and future NHS workforce (this does not currently take place). Patient safety standards must be safeguarded in ISP settings. Outsourcing arrangements must not widen health inequalities and ISP contracts and public spending on ISPs must be transparent.

c. The [2022] Health and Care Bill must be amended to safeguard the NHS from further outsourcing (see paragraphs 393-396 below). This includes making the NHS the default provider for NHS contracts, ruling out independent sector companies from wielding influencing over commissioning decisions, and enshrining Government accountability for ensuring adequate staffing levels in the NHS.

387. Subsequently, in March 2021, the BMA published a report **"Rest, recover, restore: Getting UK health services back on track"** (PB/156 - INQ000118308). This report set out recommendations to safeguard patient safety and the wellbeing of healthcare staff, as well as how this would help tackle backlogs of care and support health service recovery. In it, the BMA acknowledged that there may be a case for using private

sector capacity to support the NHS in bringing down waiting lists, despite the private sector having its own backlog to tackle. The report recommended:

a. Transparency around what contracts have been agreed and what capacity is being purchased.

b. An acknowledgement of the fact that many of the doctors doing work in private hospitals are also full-time NHS doctors and that they need to work reasonable hours as well as recuperate from the pandemic.

c. Clear expectations and KPIs be set out, so that private companies can be held to account for any poor performance or failure to deliver what has been agreed.

d. A guarantee of value for money for the NHS, with no repeat of the issues seen in the initial stages of the pandemic where funding was used to block-book private capacity which was then not used.

e. A clear exit plan to ensure that the NHS can return to not relying on private sector capacity as swiftly as possible, and the private sector can return to normality too.

The People's COVID Inquiry explored procurement and outsourcing

388. In February 2021, The People's Covid Inquiry, Learn Lessons – Save Lives opened. The Inquiry was chaired by Michael Mansfield KC and a panel of experts including Dr Jacky Davis who is a BMA council member. It is important to note that whilst Dr Davis was a panel member, this was not a BMA-led Inquiry and Dr Davis took on this role in a personal capacity. The Inquiry was organised by campaign organisation Keep Our NHS Public. Witnesses included Dr Latifa Patel who was then the deputy chair of the BMA's representative body and Dr David Wrigley, who was then the deputy chair of the BMA's UK council. The witness list included other BMA members who gave evidence in their personal capacity as doctors and not as BMA representatives.

389. The Inquiry held a range of evidence sessions covering topics including NHS preparedness, the Government's response, the impact of the pandemic on the population, the impact of the pandemic on frontline staff and keyworkers (including issues around PPE provision), inequalities and discrimination and profiteering from the public's health (this session included issues around PPE procurement, the NHS supply chain, testing capacity, use of private outsourcing and transparency around private sector contracts).

Dr Patel's evidence

390. Dr Patel gave evidence on 05 May 2021 in Session 6: Inequalities and Discrimination. Her witness statement (PB/856 - INQ000522174) makes reference to the lack of PPE provision, highlighting that:

a. The BMA's Covid tracker survey from February 2021 had shown that:

- only 36% of ethnic minority doctors said they felt adequate PPE was provided in non-AGP areas to make them feel protected, compared with 43% of white doctors.
- Only 23% of ethnic minority doctors felt fully protected, compared with 30% of white doctors. Ethnic minority doctors were twice as likely (12%) to say they didn't feel at all protected, as white doctors (6%).

Dr Wrigley's evidence

391. Dr Wrigley gave evidence on 19 May 2021 in Session 7: Privatisation of the People's Health. His witness statement (PB/857 - INQ000522175) covered a range of issues relevant to the scope of Module 5 including that:

a. BMA members were growing seriously concerned by the level and nature of the contracts handed out to large firms in important areas of the Government's response, such as Test and Trace and PPE logistics.

b. The government failed to deliver a Test and Trace system which was well enough integrated with the NHS and our nation's public health infrastructure to function properly; considerable amounts of testing data going missing; the delivery of vital PPE to the frontlines of our health service being mismanaged; and as a result the government's ability to mount a co-ordinated and swift response to the most significant health emergency in a century being constrained.

c. The BMA had grown increasingly concerned by reports over the last year about procurement made outside of normal rules and with little transparency. At a time when frontline healthcare staff had been so focused on the pandemic and the huge pressures it had created it had been particularly concerning to see public money leaving the NHS in this way.

d. Public procurement of goods and services was subject to a number of rules and regulations. While the procurement rules allowed for special procedures in the

event of an emergency, the guiding features of the process, namely transparency and the delivery of value for money, should always be adhered to.

e. At the onset of the pandemic, the government enacted contingency measures with the stated intention of expediting procurement and enabling a rapid response to counter the crisis. While guidelines stated that departments must publish the details of awarded contracts within 30 days of agreement to enable public scrutiny, billions of pounds spent on private Covid-19 contracts remained unaccounted for. Proper and timely scrutiny of contracts are no less important during a pandemic, where transparency and openness have been undermined by emergency decrees, often leading to poor value for money.

f. The BMA's evidence to the PAC inquiry (PB/185 - INQ000118235) on Procurement and PPE highlighted that public scrutiny limits the risk of fraud and is crucial for demonstrating value for money. Indeed, the National Audit Office and Public Accounts Committee have both indicated a lack of transparency and sufficient documentation in the way in which the government managed billions of pounds worth of procurement goods and services, and that emergency decrees opened up substantial procurement risks.

g. The BMA received a number of offers of help from PPE suppliers, some of whom said they hadn't received responses when they contacted Government even as some hospitals were reporting that they were on the verge of running out of essential equipment. The BMA sent these over to the Department of Health and Social Care. We did this in order to help them obtain desperately needed PPE at a time when many doctors were reporting feeling anxious and unprotected.

h. In its submission to the PAC inquiry on procurement, the BMA had set out a number of ways to mitigate against such risks in the future (such as a PPE strategy that ensures speedy access to high quality PPE for healthcare workers, private outsourcing to be scrutinised in any future public inquiry on the Government's handling of Covid-19, transparency of private contractual agreements, a more robust NHS governance system with oversight of management and coordination of procurement), and to ensure the Government is not in a position where it has to depend so heavily on new private procurement in emergency situations.

i. The drastic shortages of PPE in many parts of the NHS and social care were caused by the lack of a sufficient and correct stockpile and delays in procuring PPE. The statement also made clear that the BMA also raised concerns during the first wave that PPE being supplied fell short of the requirements by the World Health Organisation (WHO), potentially putting healthcare staff at risk.

j. To ensure such mistakes aren't repeated, the statement was clear that the BMA had called for a PPE strategy that ensures health and social care professionals have speedy access to the high-quality PPE they need in future. This must include equalities considerations and the latest scientific evidence.

k. It is crucial that government learns valid lessons from the issues experienced to ensure diverse, high-quality PPE is made available to health and care staff going forward. This means moving away from the current NHS procurement system's basis of a "just-in-time" business model to ensure our healthcare system is better prepared to cope with future pandemics.

l. Another key lesson is that we must reform procurement arrangements to ensure there is greater in-house expertise in managing complex procurement systems. Fragmentation of the NHS supply chain has severely impacted the distribution of PPE supplies, demonstrating the importance of accountable and coordinated leadership instead of a disconnected web of private providers who act independently and with ineffective oversight.

The BMA held a webinar on outsourcing during the pandemic

392. The BMA held a webinar in November 2020 which centred on the relationship between the Covid-19 pandemic and outsourcing. Speakers included Dr David Wrigley, then deputy chair of the BMA's UK council, David Rowland, director of the Centre for Health and the Public Interest, Polly Toynbee of The Guardian, and Anthony Costello of Independent SAGE. Speakers highlighted the big reduction in the funding going to the NHS, in capital infrastructure, the resources available for public health and a big increase in the use of the private sector to deliver NHS services and that `the scale of contracting out in the name of the pandemic suggests real danger that this becomes endemic in future NHS procurement' (PB/607 - INQ000479073).

The BMA called for changes to NHS competition and procurement rules in England

2022 Health and Care Act (England)

393. The Health and Care Act received Royal Assent on 28 April 2022. Prior to its passage, the BMA actively lobbied to amend the bill to address a number of concerns including on NHS procurement and outsourcing. The Act repealed Section 75 of the Health and Social Care Act 2012, meaning NHS commissioners will no longer be compelled to put services out to competitive tender – something the BMA had long called for to safeguard a publicly provided NHS. However, the BMA had raised concerns that the proposed legislation did not go far enough to safeguard against NHS contracts being awarded to the private sector without adequate scrutiny.

394. The BMA lobbied for the bill to establish the NHS as the default option for contracts to avoid unnecessary outsourcing and the destabilisation and fragmentation this can bring. Amendments the BMA lobbied for would have also guaranteed that contracts would not be awarded to corporate providers without proper scrutiny or transparency (PB/858 - INQ000522176, PB/859 - INQ000522177).

395. Ultimately the Bill became law without the additional safeguards the BMA had called for i.e. making the NHS the preferred provider of services. In May 2022, the BMA published a member briefing on the Health and Care Act (PB/860 - INQ000522178). In it, the BMA expressed disappointment that the Bill that was presented to Parliament risked further private sector inference in the NHS by failing to rule out corporate healthcare providers from sitting on NHS-decision making boards or safeguarding against NHS contracts being awarded to the private sector without adequate scrutiny.

396. In addition to lobbying to amend the Bill, the BMA responded to several related consultations and a Parliamentary inquiry in the lead up to the Bill becoming law. These are set out in the paragraphs that follow.

NHSE consultation on integration and legislative reforms

397. On 08 January 2021, the BMA responded to “Integrating care: Next steps to building strong and effective integrated care systems across England”. This was NHSE’s consultation on health service reforms to promote better system integration and recommended changes to legislation to enable better working. This was necessary,

according to NHSE, as the existing legislation (the National Health Service Act 2006 and the Health and Social Care Act 2012) did not present a "sufficiently firm foundation for system working" (PB/861 - INQ000520250). The legislative reform proposals included establishing ICSs (Integrated Care Systems) as statutory bodies; balancing competition between NHS organisations, for example, by reducing the Competition and Markets Authority's role in the NHS; and simplifying procurement rules by scrapping section 75 of the 2012 Act which made competitive tendering a requirement.

398. The BMA's response was sent via a letter to Ian Dodge, NHSE's National Director, Strategy and Innovation (PB/862 - INQ000522171). In its response, the BMA welcomed the proposed changes to competition rules but emphasised that this needed to be reinforced by making the NHS the preferred provider of services. The letter stated that as seen in the Government's response to Covid-19, many high value contracts were handed to private companies with little oversight and on the basis of relationships between those companies and the commissioners involved. The BMA argued that NHS services should not be subcontracted to private providers and that simply removing competitive tendering rules would not be sufficient to deliver this (and indeed may lead to NHS contracts being handed to private providers without due diligence). Eliminating present tendering rules without establishing a clear replacement could ultimately lead to the use of other, equally undesirable approaches to the contracting of NHS services.

NHS Provider Selection Regime consultation (NHSE)

399. While not detailed in the Health and Care Act itself, commissioning and service procurement is governed by NHS England's Provider Selection Regime. The regime was subject to a consultation (PB/863 – INQ000520252) in February 2021 (which the BMA responded to), and gave commissioners three options:

a. renew an existing contract without competitive tender

b. award a new contract, or an existing contract to a new provider, without competitive tender

c. hold a competitive tendering process, if necessary.

400. NHSE's stated aim was to provide more flexibility than before to make decisions about arranging care in a streamlined way, including without competitive tendering, where this could be shown to be in the best interests of patients, taxpayers and the population.

401. The BMA's response was sent via a letter to Ian Dodge, NHSE's National Director, Strategy and Innovation (PB/864 - INQ000522173). In its response, the BMA broadly welcomed the central proposals for the new NHS Provider Selection Regime – namely the removal of Section 75 and the move towards a more holistic model of commissioning. However, this change also has the potential to lock in existing levels of privatisation and, without proper safeguards, could reduce the transparency of the contracting process – especially where contracts are awarded to ISPs.

402. The BMA argued that to avoid the pitfalls seen during the current pandemic, the NHS should be established as the preferred provider of NHS services. The BMA's response noted that a number of high-profile Government contracts were handed to ISPs throughout the pandemic, and that a lack of oversight and transparency can lead to poor outcomes – in respect of finances, quality, and public confidence. The BMA said that it was essential that the replacement for Section 75 comes with the necessary safeguards to ensure that NHS and public health services are arranged appropriately, transparently, and with accountability.

Health and Social Care Committee inquiry on the Health and Care White Paper

403. In May 2021, the BMA submitted evidence to the Health and Social Care Committee's inquiry on the Health and Care White Paper (PB/189 - INQ000145892). In it, the BMA welcomed that the White Paper removed Section 75 of the Health and Social Care Act 2012 which required automatic competitive tendering as this would reduce the costly disruption caused by the present procurement process. However, we argued again that whilst this was a step in the right direction, the proposed legislation should be tightened to establish the NHS as the preferred provider of services to protect the NHS from instability and prevent further privatisation.

404. The BMA said that it was vital that the new provider regime NHSE was consulting on (as described above in paragraph 399) established sufficient scrutiny and transparency over the tendering and awarding of contracts. The BMA noted the shortcomings of a lack of scrutiny for the public purse during the Covid-19 pandemic. Specifically, that many high value contracts were handed to private companies with little oversight and on the basis of relationships between those companies and the commissioners involved. The impact of this led to performance issues, for example tests being lost or vital data not shared, problems in the delivery of high-quality PPE to frontline workers, and a lack of mechanisms through which to hold companies to account for their handling of these contracts. The BMA

warned that a failure to establish clear and robust commissioning rules could lead to similar mistakes being made in future.

The BMA's Covid-19 Review highlighted issues with procurement and outsourcing during the pandemic

405. The BMA published five 'Covid Review' reports between 19 May 2022 and 28 July 2022, ahead of the Inquiry's public hearings. The review drew on the regular BMA surveys conducted throughout the pandemic, as described earlier in this statement. Specifically to inform the BMA Covid-19 Review, the BMA conducted an additional and wide-ranging call for evidence from members, encouraging them to pause and reflect on their experience during the pandemic. The call for evidence was held online between 10 November and 17 December 2021 and received 2,484 responses from across the profession. The Association used BMA communications channels, including social media, the website, email and newsletters to ensure that the call for evidence achieved a wide reach and encouraged both members and non-members to take part. The call for evidence combined a range of quantitative and qualitative questions, providing doctors with an opportunity to describe the impact of Covid-19 in their own words. As part of the review, the BMA also held two roundtables with external stakeholders and drew on a wide range of external analysis and resources. The review covered topics such as the impact of the pandemic on healthcare delivery, population health and (health) inequalities, as well as how the medical profession was protected from Covid-19, and the impact of the pandemic on doctors.

406. The **first report**, published 19 May 2022, assessed how well the medical profession was protected against Covid-19 – including PPE (PB/013 - INQ000118474). This report highlighted that PPE supplies were insufficient, and processes for training and ensuring safe fit were inadequate. Key findings and recommendations relevant to Module 5 included:

a. As early as the beginning of March 2020, it was apparent that there was an unparalleled global demand for PPE, which led to severe shortages and a lack of supply worldwide. The UK Government initially made the mistake of believing that its existing supplies would be sufficient. NHS England, for example, gave assurances to the Health and Social Care Select Committee that the England

stockpile would be enough to manage the whole of the pandemic, whereas it barely lasted two weeks. This meant that as late as mid-March the UK Government was more focussed on ensuring delivery of existing stock than on increasing its procurement. So, when the UK Government scrambled to secure more supplies in late March and April 2020 – as demand began vastly outstripping what they thought would be sufficient supply – they entered a crowded marketplace.

b. This created significant problems because the procurement process was more prone to risk than would normally be the case. It led to well-documented cases of PPE being procured from organisations with no experience of producing PPE and of PPE being delivered that was unsuitable for use on the front line. While the UK Government worked quickly to address this problem, their process was often flawed. For example, organisations with relevant PPE knowledge were unable to recommend leads to the high-priority lane for contracts, while leads from Ministers and Lords were more actively pursued. There was also a general lack of transparency surrounding the deals struck to source PPE. The report was clear that the lack of the UK's domestic capacity to manufacture PPE was an added difficulty and something the BMA highlighted to the UK Government at the time.

c. Importantly, the delays in procurement and subsequent errors meant that medical professionals on the frontline often had to go without PPE, reuse single-use items or use homemade or donated items. The BMA repeatedly highlighted that medical professionals were not being provided with the PPE they needed throughout the pandemic, and our surveys show that there were acute shortages

d. Going without PPE put doctors in the extremely difficult position of having to continue to treat patients knowing they were not being as well protected as they should have been. Respondents reported that they often had to reuse items or use items that were out of date, with multiple expiry stickers visibly layered on top of each other. The situation was so severe, that at the time the BMA had to produce guidance for staff detailing their rights and moral obligations to continue working if they did not feel adequately protected. Worryingly, many respondents to our call for evidence, particularly those working in hospitals and ethnic minority staff, reported feeling pressured to work without adequate protection and described the worry and anxiety this caused. Some respondents told us they felt unable to challenge management in this context.

e. While generally PPE supplies improved in AGP settings from April 2020 into May 2020 and the acute shortages seen at the beginning of the pandemic subsided – the BMA was still receiving reports about PPE shortages as late as August 2020. Other issues with PPE also persisted, due to the problems with the IPC guidance, as outlined earlier in this statement. This means that some healthcare workers were – and still are – working with an unsuitable level of PPE. Our call for evidence showed this caused an understandable level of anger among healthcare workers.

f. PPE fit and availability of fit testing were an issue, especially for certain groups, as previously outlined and were an additional barrier to healthcare workers being properly protected.

g. Guidance on using PPE and on donning and doffing safely was often inadequate. Practices like safe donning and doffing play a key role in ensuring the safety of the wearer and ensuring that hazardous PPE is safely disposed of. There was a large degree of variation regarding how well-trained staff were in using PPE, but also in safely taking it off.

h. Testing was a well-documented problem at the beginning of the pandemic, both in the community and in health and social care settings. The UK Government drastically overestimated the UK's capacity to perform Covid-19 tests at the pace and in the volumes required. The lack of capacity was one of the reasons the UK Government abandoned contact tracing so early during the pandemic and later had to separately set up Test and Trace, at a significant cost to the UK taxpayer.

i. This initial lack of capacity meant that even though testing was reserved for health and social care settings, there were not enough tests for all patients who needed one. This lack of testing capacity became a serious issue as Covid-19 began widely circulating in the community.

j. The report made a number of recommendations, including

    i. The UK Government needs to maintain an adequate rotating stockpile of PPE and have plans to quickly scale up procurement and manufacturing if required.

    ii. PPE needs to be suitable to different face and body shapes, varying hair textures, head coverings, and facial hair so all workers can access adequate protection.

iii. PPE should be provided with centrally coordinated guidance and practical training on how to fit test, use, and dispose of it safely.

iv. Public health systems should be resourced and funded to have adequate contact tracing capacity and be able to rapidly scale up testing for future variants or pandemics.

407. The **second Covid Review report** was published on 19 May 2022 and centred on the impact of the pandemic on the medical profession (PB/014 - INQ000118475). In relation to the scope of Module 5, this covered some of the same issues relating to PPE outlined in the first report but focused on the impact on the profession. Additional key findings and recommendations included:

a. Had the UK been better able to protect staff (as set out in the first report of the BMA Covid-19 review) we may have seen fewer long-term absences due to Covid and Long Covid and consequently, less capacity lost to health services across the UK.

b. During the pandemic, more than 50 doctors tragically lost their lives caring for others. As the first report of the BMA's Covid-19 review concluded, medical professionals were too often left unprotected and exposed, suggesting these deaths were not inevitable.

c. The report noted that ethnic minority doctors were much more likely than white doctors to report feeling pressured to work in settings with inadequate PPE, exposing them to risk of infection. It also highlighted inequalities faced by other doctors, including disabled doctors. The report called for mechanisms to make the experience of working in the NHS less variable by background or protected characteristic and posed some questions for future Inquiries into the pandemic to answer including: what can be learned from the experiences of ethnic minority doctors, disabled doctors, and other protected groups during the pandemic; and how can we mitigate inequality in future crises faced by the UK's health services?

408. The **third Covid Review report**, published on 26 June 2022, centred on healthcare delivery during the pandemic (PB/015 - INQ000185355). In relation to the scope of Module 5, this report covered use of private sector hospitals to boost capacity during the pandemic, oxygen and ventilators. Key findings and recommendations related to these issues included:

a. Given the impact of the virus there was an immediate need to ensure that the UK's health services had sufficient ventilator capacity. Jointly purchasing ventilators with other EU countries could have secured better value for money on the basis that pooling requests could reduce the cost of equipment through improved bargaining power.

b. On oxygen shortages the report was clear that there were points during the first wave where the lack of sufficient planning to maintain oxygen supply left some organisations on the precipice of running out of oxygen and having to give suboptimal oxygen therapy to some patients.

c. Private hospitals in England, Scotland and Northern Ireland were contracted to provide additional surge capacity (much of which went unused in England) and to ensure some critical services e.g. cancer continued (see paragraphs 262-263 above). Millions of pounds were spent on these contracts and the lack of transparency meant that it was difficult to determine whether good value for money was ascertained through these deals.

409. The report recommended that:

i. Governments across the UK must develop a credible plan to meaningfully increase hospital capacity and ensure that the UK's health services are not reliant on private sector capacity in the long-term.

ii. Action must be taken to ensure that the core bed stock grows to reach a level that will cope with year-round demand – this must include the re-opening of acute beds closed during the pandemic and a sufficient workforce to staff them safely.

iii. UK health services' estates must be improved – this includes expanding physical space, implementing improved ventilation and infection control measures and addressing the backlog of maintenance costs.

410. The **fourth report**, published 28 July 2022, focused on the effectiveness of the UK's public health response to Covid-19 (PB/016 - INQ000185356). While this primarily focused on Government decisions in relation to non-pharmaceutical interventions, in relation to Module 5, it looked at the availability of covid testing for the public but also in healthcare settings. Key findings related to these issues included:

a. To minimise transmission, testing must be readily available to those who need it, tests processed promptly, and test results made available quickly.

b. Test eligibility is not the same as test availability. In England, there was a critical failure to ensure sufficient laboratory capacity to meet the demand for testing, which became a significant issue in September 2020, with the public left unable to arrange tests or being offered appointments 100 miles away from their homes.

c. This shortfall in testing capacity has been partly ascribed – including by the BMA – to the failure to utilise the 44 pre-existing NHS laboratories and an overreliance on both the private sector and the seven Lighthouse Laboratories created by the UK Government to provide additional capacity.

d. The expense and effort of using these alternative laboratories, which operate independently of public health and NHS infrastructures and use different software and systems, was seemingly unnecessary and created unhelpful fragmentation. Covid tests in Scotland, Wales and Northern Ireland were processed by a combination of Lighthouse Laboratories, NHS-run laboratories and, in some cases, private laboratories. In Wales, for example, 50% of the Covid tests conducted between April and September 2020 were processed by Lighthouse Laboratories. This use of UK-wide infrastructure meant that Lighthouse Laboratory delays impacted testing capacity in all four UK nations. As a result, from September 2020 Wales chose to shift capacity towards laboratories run by Public Health Wales instead.

e. The report concluded that in the future all UK governments should take steps to ensure that the staffing, tools, and facilities needed to address any future pandemic can be scaled up quickly if necessary. The report also posed a number of questions for future Inquiries into the covid pandemic to consider, including:

    i. How are UK governments maintaining or disposing of their pandemic assets (such as extra lab capacity or funding) and does this risk undermining any future pandemic response?

    ii. Why did the UK Government opt not to use existing public capacity for testing and whether better value for money and effectiveness could have been achieved by using existing public sector laboratories?

411. The **fifth and final report** of the BMA's Covid-19 Review, published on 28 July 2022, examined the impact of the pandemic on the UK population's health (PB/017 - INQ000185357). This report did not cover issues within the scope of Module 5 in any detail.

Statement of Truth

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

Signature: **Personal Data**

Name: Philip Banfield

Date: 31 January 2025