MEMORANDUM OF EVIDENCE FROM THE BRITISH MEDICAL ASSOCIATION TO THE ALL-PARTY PARLIAMENTARY GROUP ON CORONAVIRUS INQUIRY ON THE UK’S HANDLING OF THE CORONAVIRUS OUTBREAK.

About the BMA
The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

This response to the All-Party Parliamentary Group on Coronavirus’ inquiry on the UK’s handling of the coronavirus outbreak seeks to provide an overview of the key areas and themes which we believe the group should consider as part of its wider inquiry. The BMA hopes, as the APPG announces individual evidence sessions that we will be able to contribute further to those specific topics.

Summary of key areas
- Planning, stockpiling, and distribution of Personal Protective Equipment
- Supporting the healthcare workforce to meet patient need
- What worked: Reducing bureaucracy and improving technology to meet patient need
- The role of testing, guidance and data
- Preparedness for restarting non-COVID-19 care
- Learning from the COVID-19 pandemic

Introduction
While we have seen positive learning, particularly regarding the use of technology emerge during the pandemic, the BMA believes that the Government’s initial response was marked by a failure to adequately prepare. Widespread shortages of personal protective equipment, unclear guidance and delays to providing comprehensive population testing and tracing, including priority testing for healthcare workers and care homes, caused significant issues and impeded attempts to slow transmission rates.

COVID-19 has also exposed structural weaknesses in terms of the size of the healthcare workforce, NHS resourcing and inequalities for BAME healthcare workers, that persist throughout the UK. We believe that action must be taken to better support the healthcare workforce and resource the NHS. There is also an immediate need to improve the reach of health services to BAME communities and to address socioeconomic inequalities, so that existing health inequalities are not widened.

Overview of key areas
1. Planning, stockpiling, and distribution of Personal Protective Equipment (PPE)
1.1 Failure to stockpile enough PPE at the outset of the pandemic was a crucial issue for healthcare workers. This was further exacerbated through significant delays to procuring additional PPE, with reports of some batches sent into the NHS being faulty or past its expiry date. There were missed opportunities regarding the potential to join the EU scheme to procure PPE, which the Government ruled out applying for, even though the UK was still entitled to participate¹.

1.2 The lack of appropriate PPE was clearly demonstrated by a BMA survey, in April 2020, of over 6,000 doctors showing that around half of doctors working in high risk areas said there were shortages or no supply at all of long-sleeved disposable gowns and disposable goggles, while 56% said the same for full-face visors. In general practice, more than a third of GPs said they had no eye protection, with a further third saying there were shortages.

1.3 Equalities considerations must be built into the commissioning and supply of PPE. The BMA has heard cases of doctors who wear beards for religious reasons such as Sikh, Muslim and Jewish doctors being told there are no alternatives available to FFP3 masks and they must abandon their religious practise and shave, even though the HSE recognises that suitable alternatives like PAPR hoods should be provided. There are also instances of women and those of different ethnicities struggling to find face masks that fit, and doctors who are deaf and reliant on lip-reading have highlighted the need for transparent face masks to be developed.

1.4 The Government now needs to provide a detailed plan for how it will ensure sufficient PPE supply is in place to adequately cope with any second wave of COVID-19 cases. A recent statement from Government indicated that it has ordered 28 billion items of PPE, but gave no breakdown of when these would be in place and which specific items have been ordered. Assurances are also needed that lessons have been learnt from the initial wave in how PPE is distributed to healthcare settings, given the government’s previous statements that some of the problems were logistical rather than due to lack of supply. Given the fragmentation of the NHS supply chain, there also needs to be accountable and coordinated leadership instead of a disconnected web of private providers who have acted independently and with ineffective oversight.

1.5 We consider PPE to be a crucial area for the APPG to consider as part of its inquiry. Healthcare workers should never again be placed in a situation where they are being pressured to put themselves at risk by working without adequate or appropriate PPE made available to them.

2. **Supporting the healthcare workforce to meet patient need**

2.1 Latest national statistics show that the equivalent of 88,347 full-time vacancies persist across secondary care in the NHS. Staffing shortages exist across both medical specialities (8,338 doctors) and nursing (36,083). We also lost the equivalent of 334 full-time qualified GPs between December 2019 and March 2020, which is a decline of 1,418 GPs since September 2015. These shortages undoubtably contributed to pressure faced by the NHS workforce during the pandemic.

2.2 In order to address these significant shortages during the pandemic, the Government appealed to doctors who had left the NHS, including those who had retired, to return and provide support for a fixed period. Final year medical students were also employed on NHS contracts. While these approaches did increase capacity, they also demonstrate the severity of current understaffing.

2.3 It is vital that learning in relation to the healthcare workforce is not lost and the Government explores how it may retain some of those returning healthcare workers. Improved and increased recruitment and retention of NHS staff must now also take place to meet the needs of patients across the NHS.

2.4 Much greater action is also required to protect the health, safety and wellbeing of the workforce. BMA survey data indicates that, as recently as July 2020, 30% of doctors had still not had a risk assessment to determine if they are likely to be at increased risk from Coronavirus. There needs to be an effective system of risk assessment for all doctors, including those from a BAME (black, Asian or minority ethnic) background, and those who are pregnant, to ensure that doctors can work in a way that minimises risk to themselves and patients. We ask that the APPG consider the

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4 *General Practice Workforce - 31 March 2020*, NHS Digital (May 2020)
impact on the healthcare workforce of the pandemic and the need for increased planning and investment in the workforce, including in their health and wellbeing, in future.

3. What worked: Reducing bureaucracy and improving technology to meet patient need

3.1 When given the freedom to innovate without artificial targets and undue bureaucracy, NHS staff can achieve a huge amount. Throughout the pandemic, general practices and secondary care have adopted the use of video and telephone consultations, while enhanced access to the summary care record and greater remote working have changed the way some secondary care services are delivered. This provision of remote access to GPs has been beneficial to the many patients who would struggle to attend GP surgeries, although face-to-face contact will still be important for some consultations. Adoption amongst GPs should be further expanded in future to better join up with the care sector. Care must be when expanding this digital offer, to ensure that a digital divide does not occur, which could exacerbate existing health inequalities.

3.2 In secondary care, rules on how technology is used and approval mechanisms for funding for new equipment were lifted during the pandemic, providing more streamlined delivery of care through increasing access to needed technology. We would again support the continued use of this approach. This valuable learning from where new approaches have been taken during the pandemic and have resulted in improved delivery of care must be retained in the future, and we ask that the APPG considers this aspect of the handling of the pandemic.

4. The role of testing, guidance and data

4.1 The UK Statistics authority (UKSA) during the pandemic has raised concerns that the Government may have mislead the public over reporting of the number of tests carried out for COVID-19. The UKSA chair highlighted a lack of clarity and transparency over the number of tests carried out and the number of testing kits sent out by post. There have also been concerns raised regarding the Government’s assertions that testing centres and mobile units were turning around test results within 24 hours, with recently published data seeming to contradict these claims. We would ask that the APPG considers the reason behind this lack of transparency as part of its inquiry.

4.2 The initial Government response in relation to availability of testing and tracing fell far short of what was needed, which resulted in the infection spreading unchecked, as Government did not initially have the capacity to test more widely, and its 10,000 test a day target was delayed. This situation continues as ongoing delays to the NHS tracking app remain an area of serious concern, particularly as lockdown measures ease and we face the possibility of a second wave of the virus.

4.3 The Treasury has recently reported that £10bn was spent on the Government’s test and trace strategy. The DHSC also documented that local public health teams traced eight times more contacts compared to the national call centre run by Serco and Sitel. The BMA believes that rather than outsourcing the contact tracing service to private firms, local public health teams would have been better placed to lead this initiative had they been better resourced and sufficiently funded. We hope that the APPG will consider exploring how these contracts outsourced to private companies and whether they represented value for money given the lack of progress made to date on the test and trace programme.
4.4 The guidance produced by Government for healthcare workers was also a significant cause of concern, both in its variance from international WHO guidance but also in its seemingly constant changes. This is echoed by the ongoing situation regarding government advice to the public on the use of public face coverings. The BMA believes that the wearing of face coverings by the public in areas where they cannot socially distance is beneficial to reducing transmission and that the Government should have followed the lead of other nations is its advice on this issue.

4.5 Ensuring the availability of daily postcode level data on transmissions for local authorities, as we move into the next phase is particularly important. For this reason, we advised the Government that clear guidance, possibly in the form of a framework, which outlined “trigger points” for local lockdowns, should exist alongside the data to inform Local Authority actions in relation to data finding (ie. what trends would suggest a need to ‘lockdown’ specific areas). We are glad to see a framework was announced by the Prime Minister at his press conference on 17 July 2020 and hope it will represent a step forward.

4.6 Finally, the initial and ongoing government response in relation to availability of testing and tracing fell far short of what was needed. This resulted in the infection spreading unchecked through a policy of self-isolation, as Government did not initially have the capacity to test more widely, and its 10,000 test a day target was delayed. This situation continues as ongoing delays to the NHS tracking app remain an area of serious concern, particularly as we face the possibility of a second wave of the virus.

5. Preparedness for restarting non-COVID-19 care

5.1 As we emerge from the worst aspects of the first wave of the pandemic, workload intensity will increase above pre-COVID levels as the NHS resumes all services and deals with the three-month backlog of non-COVID patient need. This is why the NHS must continue to get “whatever resources it needs” both now and in the future, particularly in light of the continuing need for staff to follow strict safety, hygiene and infection control protocols, to ensure all patients can receive the care they need in a timely and safe fashion for both themselves and the NHS staff who care for them.

5.2 As the Academy of Medical Sciences recently warned in a report commissioned by the Government, the NHS faces a number of potential challenges this winter, including the risk of a second wave of COVID-19 cases, a significant flu outbreak and a growing backlog of work (for example, it has been estimated that waiting lists for elective care could rise as high as 10 million by the end of the year).

5.3 The unprecedented resource shift towards critical care to prepare for the COVID-19 outbreak came at the expense of other parts of the NHS. This included postponing all non-urgent elective operations, urgently discharging hospital inpatients medically fit to leave, and block-buying capacity in independent hospitals. There was also a large shift in workforce and technical capacity from other clinical areas towards critical care. This has had far-reaching effects on both patients and the health and social care workforce. In a recent BMA survey, 40% of respondents said that the longer-term impact of the pandemic on patient clinical demand was their top concern. We would again ask that the APPG includes within its inquiry planning and preparedness for restarting non-COVID care.

8 BBC, 17 July 2020, https://www.bbc.co.uk/news/uk-53441912
6. Learning

6.1 The COVID-19 pandemic has brought to the fore longstanding structural inequalities that persist within the UK and our public services. However, it has also exposed where action is needed to address these. Recommendations within the PHE’s report on the impact of COVID-19 on BAME communities must be urgently implemented and an action plan published that clearly sets out roles and responsibilities for taking these recommendations forward.

6.2 The Equality and Human Rights Commission recently announced that it is suspending its compliance work to enforce the specific duties that support the Public Sector Equality Duty (PSED) and require public bodies to annually report equality information about their workforce and among service users during the COVID-19 pandemic. We believe this may have caused confusion about the status and priority to be given to equality at present. Public bodies must be clear that the PSED remains in force through the current crisis and must continue to gather data and assess the impact on equality of their policies and practices. Equality monitoring should continue throughout the pandemic and steps taken to identify and mitigate health inequalities and disparities of experiences and outcomes as they arise.

6.3 More broadly, we believe that the pandemic has demonstrated the need to empower doctors, as local clinical leaders. During the pandemic we have seen greater collaboration between hospitals, such as the leadership shown by clinicians setting up the Nightingale hospitals and a shift from ‘payment by results’ type practices, as well as increased support from CQC as it moves away from undertaking appraisals and inspections.

6.4 During the pandemic GP practices have not received additional funding despite the fact that primary care has been playing a vital role in the response and will continue to do so given the scale of the backlog of care that now exists. We believe that this must urgently be delivered through the COVID-19 fund promised by the Government at the outset of the pandemic.

6.5 The Government has also yet to clarify what funding the NHS will receive beyond 2020/21 and must do so urgently. It is not feasible to return to previous spending plans given the scale of the ongoing crisis, the Government should commit to at least repeating the emergency uplift in funding due to COVID-19 for 2021/22 and should ideally set out ambitious plans for annual real terms increases in total health spending by at least 4.1% going forward.

6.6 By focussing on learning, and planning, the BMA believes that we will put the country in the best possible position not only to tackle a future pandemic, or second wave, but also to improve wider delivery of care. This can be achieved by implementing learning from reducing bureaucracy, investing in NHS facilities and supporting the healthcare workforce to delivering care in the best way in the most appropriate setting. We look forward to the next steps of the APPG’s inquiry and contributing further to that process.