



APPG Coronavirus

The Royal College of Physicians (RCP) welcomes the APPG's inquiry coronavirus, which aims to ensure that lessons are learned from the UK's handling of the COVID-19 outbreak so that the UK's response and preparedness may be improved in future.

Summary

As part of our work to track the impact of COVID-19 on the workforce, to date, we have conducted five surveys on members and fellows [1-2 April](#), [22-23 April](#), [13-14 May](#) [3-4 June](#), and our most recent in July (to be published soon). The findings from the surveys include a sample size of responses from members and fellows in England ranging from 900 - 2000 respondents.

The surveys revealed several challenges and findings around access to personal protective equipment (PPE) and testing, time taken off due to COVID-19 symptoms, and changes to working patterns. The surveys also asked questions on issues such as resumption of services and concerns about doctors' health.

We used these findings to develop and inform our [Priorities for future COVID-19 wave planning briefing](#), which outlines six priorities that the government ought to consider when planning for the very real possibility of a second peak and future localised outbreaks of COVID-19 infection.

Key survey findings

- **Health concerns**

Our surveys asked members a range of questions in order to monitor changes in wellbeing as a result increased pressures and changes to working patterns. We also know that clinicians have worked incredibly flexibly during COVID-19. Our second survey during the peak of the pandemic (22-23 April), found that 29% of respondents were working in a clinical area different from their normal practice. However, it said they **only 59% said they had access to psychological/emotional support** and 51.5% received mentoring.

Our third survey (13-14 May) asked respondents whether they were concerned for their health or that of a household member. Overall, 48% of respondents said they were either concerned or very concerned about their health. 76% of those from BAME backgrounds reported that they were concerned or very concerned about their health. **Employers must therefore be supported to prioritise risk assessments, particularly for those who are vulnerable.**

- **Personal protective equipment**

While access to personal protective equipment (PPE) has improved since the beginning of lockdown but remains an issue (appendix 1). In our second survey (22-23 April) we asked respondents if, based on the Public Health England (PHE) guidance available at the time, whether they were able to access specific pieces of PPE in different settings. Just under a third of respondents said they were working in an aerosol generating procedure (AGP) area. Of them, 31% report being able unable to always access long sleeved disposable gowns, and 37% unable to always access full-face visors (appendix 2). Similar



concerns were expressed by clinicians working in non-AGP areas with confirmed or possible cases of COVID-19.

These responses add to the growing body of evidence that staff have not always been adequately protected in the frontline response to COVID-19. The supply of PPE must be urgently increased and stabilised so all healthcare workers have adequate access. Our latest survey (21-22 July), revealed that 10% of doctors said they were working in a clinical area that is different from their normal practice of which, 20% were working on a COVID-19 ward. To ensure their safety, it is crucial that **adequate PPE training is provided**, particularly for staff working in high risk COVID-19 settings involving AGP.

- **Testing**

Whilst access to polymerase chain reaction (PCR) testing improved between the period of April and June (appendix 3), our latest survey in July (21-22) reveals challenges with routine testing - with **only 13% of respondents saying they were tested in the past two weeks, of which 18% were showing symptoms**. The government must ensure that all NHS staff whether symptomatic or not are tested regularly. The need for this is further supported by findings which show that of the 79% of respondents who have had an antibody test, 25% have had a positive result.

Despite improvements in access to testing for NHS staff, there has been **slower progress on turnaround times for results which must be improved** in order to provide clarity and enable staff to return to the frontline as quickly as possible. Our third survey during the peak of the pandemic (13-14 May), asked people whether they had been tested and how quickly they got their results back. Of the 12% who reported having had a test in the past 2 weeks, only 17% reported receiving the results within 24 hours. Our latest survey (21-22 July) f

This must be addressed in order to avoid exacerbating pre-existing challenges with workforce shortages and capacity in the NHS, which will also be further impacted by necessary infection prevention and control (IPC) measures.

- **Time off**

Findings revealed that people taking time off work continued to fall throughout the pandemic - with 5% reporting taking time off work in June. Of those, 9% report having confirmed COVID-19 with a further 7% suspecting that they have COVID-19. This compares to 18% of respondents reporting taking time off in our first survey in April (1-2), of which 33% suspected having COVID-19 at the time.

As antibody testing begins to be rolled out, there should be a focus on testing healthcare professionals who meet the criteria to allow staff to understand whether they have had COVID-19. This will be a helpful indicator of past infection and possible immunity to future infection.



- **Working patterns and practices**

During the pandemic, 59% of respondents reported working on an emergency rota. We also asked respondents to tell us the status of these rotas: 27% said that the rotas had been discontinued, 44% that de-escalation had started, 14% that de-escalation plans had been made but not started and 15% that no plans had yet been made. **The government must support trusts to develop and implement de-escalation plans as COVID-19 data allows.** It is also crucial that as services begin to resume 'as normal' that staff health, safety, and wellbeing of staff remain priority.

- **Preparedness for second wave and winter**

Our most recent survey (21-22 July) found only 36% of respondents had been involved in conversations about preparing for a second wave of COVID-19. Of those, 64% were preparing on the assumption that a second wave is likely. Meanwhile, only 53% felt their organisations were 'somewhat prepared' for the potential second wave. We also asked respondents to rank in order of importance, measures to prepare for a second wave of COVID-19 where 1 is the most important and 8 the least. Findings revealed that PPE (3.12), enough staff (3.19) and bed capacity (3.46) were considered as the most important.

The survey also revealed that 23% of respondents feel 'not at all prepared'. Given the high degree of uncertainty over how the coronavirus pandemic will play out this winter, it is crucial that the **government ensures that clinicians and staff are engaged with plans and preparation for a second wave**, with a view that it may overlap with winter.

Priorities for future COVID-19 wave planning

In our [new briefing](#), we have outlined key priorities for future COVID-19 wave planning, in line with our COVID-19 survey findings and additional information provided from our membership and engagement. It is crucial that we learn the lessons from the past 3 months, as well as considering the additional challenges that future waves may bring if they coincide with winter flu.

1. Estate

The NHS estate is a finite resource which has been flexed as far as possible during the first wave of COVID-19. As pressure recedes, local systems and NHS regional teams will be considering how they might manage further waves. They will also be trying to increase the number of nonCOVID-19 services.

- The UK government and devolved governments should ensure that providers are able to access additional capital funding to implement these plans
- The additional bed capacity created by the Nightingale hospitals during the first wave should be maintained. How this bed capacity is provided should be decided following a review of the Nightingale model. Additional capacity must be fully staffed and adequately resourced
- The NHS should work with local authorities to identify estate and facilities that may be appropriate to deliver services if needed.



2. Flu vaccine

COVID-19 is likely to remain in the community for the foreseeable future. To further support the expanded flu vaccination programme announced by the government and help build resilience in both the NHS and social care workforces, and in the general public:

- If the evidence of potential benefit supports it, the UK government and devolved governments should seek to secure additional batches of flu vaccine to maximise availability
- In the event that a COVID-19 vaccine becomes available around the same time as the annual flu vaccine programmes begin, it is key that the two programmes work together to effectively cover the population need.

3. Workforce

Staff across the NHS and social care have gone above and beyond throughout the pandemic. We must use the time available to us now to consider how we can bolster the NHS and social care workforces for future waves.

- The UK government must support the NHS to rapidly develop a 'reservist' workforce model. It should establish a group of people who can be deployed quickly to support the service. Individuals who sign up to the reservist workforce should be able to quickly access CPD opportunities and contractual issues should be dealt with in advance so that they can be deployed at speed. The reservist clinical workforce may include those who have recently retired, those who are taking a career break, clinical academics, and those who work outside of the NHS. They need to be recognised as valued additions to the NHS
- The UK government must also develop a plan to ensure staff are able to access a risk assessment framework and be deployed appropriately.

4. Personal protective equipment (PPE)

PPE has been one of the workforce's biggest concerns during the first wave of COVID-19. There must be no repeat of PPE shortages that have plagued the NHS and social care.

- The UK government, working with the devolved governments, must rebuild the stock depleted by the pandemic, providing regular updates on stock levels. > The UK government, working with devolved governments, must ensure that the NHS and social care can procure PPE kit rapidly when needed
- The UK government, working with the devolved governments, must ensure that the logistical challenges faced during the first pandemic are fully resolved and stress tested
- As the evidence around PPE and COVID-19 infection control develops, PPE advice from PHE should be reviewed in partnership with the professions.

5. Partnership working

To effectively plan for a second wave of COVID-19, the UK government must truly recognise that the NHS and social care are inextricably linked, with decisions in one affecting the other. Now is the time

for local systems and providers in both the NHS and social care to come together to develop local plans for future waves based on national guidance. This should include local government partners.

- Each local system should develop plans for future waves that aid good communication between providers, escalation plans and a clearer understanding of the roles and responsibilities of different stakeholders.
- Social care must be given the resources it needs to effectively manage during future COVID-19 outbreaks and waves. From PPE to testing, and staffing to funding, it is key that social care is placed on a sustainable footing.

6. Testing

Like PPE, access to testing hasn't always been as readily available as we would have liked. The Royal College of Pathologists (RCPATH) recently published [COVID-19 testing: a national strategy](#), which sets out a clear way forward to ensure that clinicians, patients and the public have the testing we'll need in the event of future outbreaks and waves.

- The UK government and the devolved governments should implement the RCPATH national strategy, ensuring that all necessary resources are made available to provide timely, accurate and reliable testing.

Impact of COVID-19 on trainee workforce

There has been some beneficial effects of the COVID-19 pandemic in terms of acquisition of generic competencies such as management experience, service design and risk management. However, COVID-19 has caused interruption to the normal rhythm of trainee doctor progression and wellbeing.

The RCP asked our trainees committee to outline the key challenges they have faced as a result of COVID-19 both directly and indirectly. These must be recognised by the UK government within their plans for future waves. There may be a need for the government to allocate additional funding to ensure that trainees can progress when COVID-19 allows.

Clinical training and progression

- Some trainees have not been able to meet certain training requirements during the pandemic, and such opportunities will remain limited for many in the months to come. These include professional exams, courses, procedural training, sub-specialty experience, and outpatient working. Short term solutions to some issues have been found – allowing temporary progression without certain non-essential requirements. However, these need to be obtained later in 2020/early 2021, and whilst exams are restarting, courses are re-opening and some training opportunities are coming back, there is no certainty that these difficulties may not persist given the significant risk of a 'second wave' limiting opportunities again.
- During the pandemic, training of physicians has naturally been disrupted with the pivot to exclusive COVID-19 care at the expense of internal medicine and specialist training and is now further compromised by capacity constraints linked to Infection Prevention and Control (IPC). This has had a



disproportionate impact on respiratory medicine in particular, which has played a unique role in COVID-19. For respiratory medicine the lack of lung function testing and the reticence in recommencing this area of investigation at the present time does also have an impact for these trainees. For those training in gastroenterology, cardiology and other craft specialities, the reduction in number of procedures that can be undertaken because of the need for IPC measures has impacted their training opportunities. They are likely to need extended time before acquiring the necessary competencies for CCT.

- Those 'shielding' have been particularly affected and there remains marked uncertainty about the impact on this group going forward as more than any other group their training has significantly changed.
- The move away from face-to-face appointments during the initial COVID-19 outbreak and significant increase in virtual clinics is likely to have long-term positive implications for how healthcare is delivered. In order to keep up with ambitions for digital transformation the government must invest in innovations and technology to better support and transform both delivery of care and how training is delivered.

Wellbeing

- It remains unclear what impact the last few months will have on healthcare professionals' mental wellbeing and health long term. Training programmes are hard, and the challenges of the last few months, combined with the worry and uncertainty of what is to come, will take their toll on trainees' wellbeing and psychological reserves.

Study leave, teaching sessions, and out of programme activities

- Teaching programmes, conferences, and study leave have been cancelled during the epidemic.
- Out of programme activities, for instance in research, education, and leadership, are of great value to trainees, and to the future consultant NHS workforce. Almost all out of programme trainees have returned to full time clinical work.

Recruitment

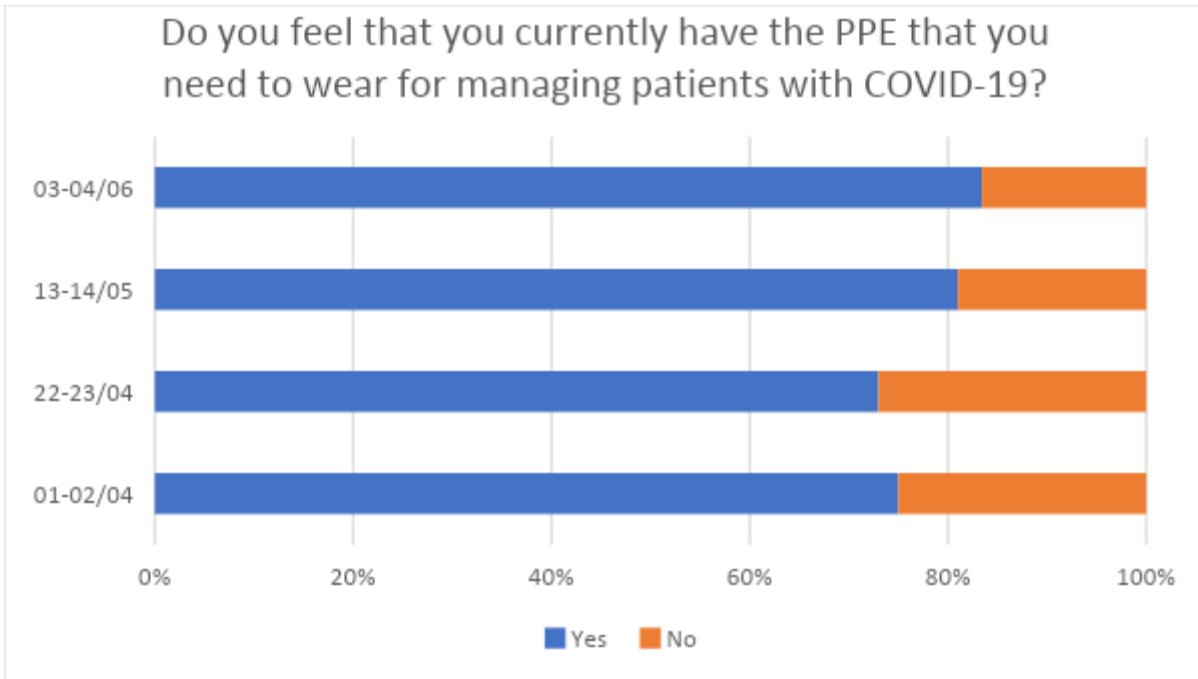
- Changes to recruitment processes were made earlier this year by Health Education England and the four nation Medical and Dental Recruitment and Selection team. These changes, including the removal of interviews and changes to which criteria were used to rank individuals, led to considerable dissatisfaction from many trainees, particularly those in the most competitive specialties, who feel that the goalposts have been moved mid-game.

Lack of consistency in response

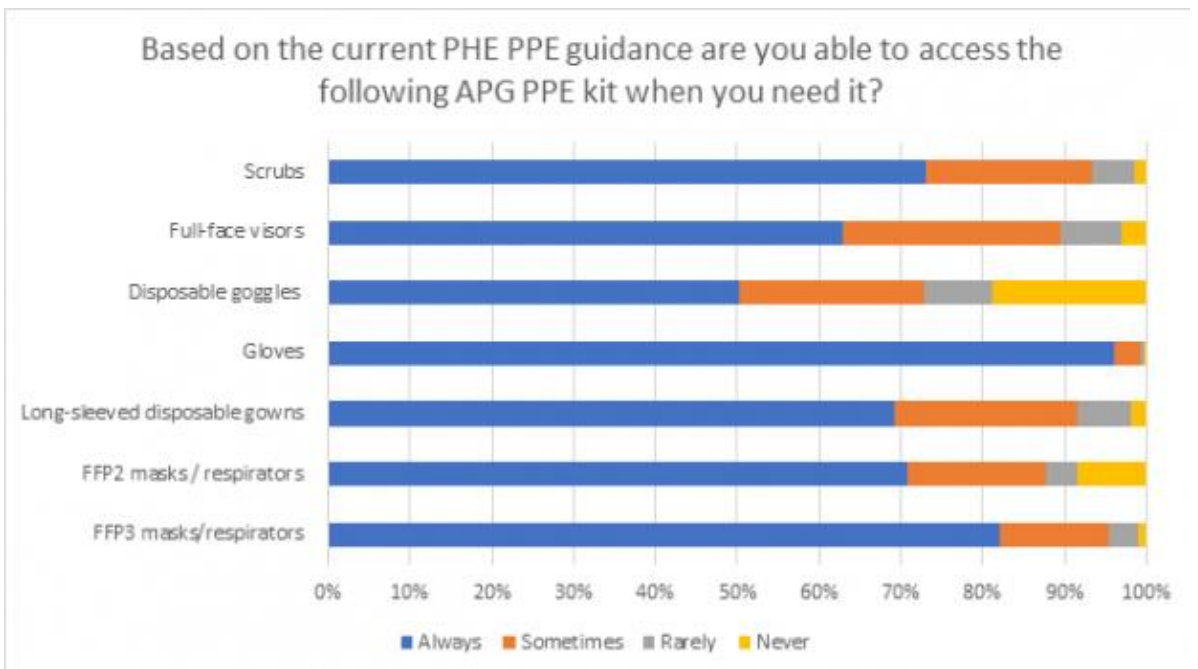
- Hospitals throughout the country have responded in very different ways and at different times to the pandemic – some pre-empting the initial wave significantly and some responding seemingly very late. Some responding with marked changes and others making much less significant ones especially with regards to rostering. Some maintaining changes well after things have resolved locally and others rapidly de-escalating. Some places have involved trainees in changes and some haven't. This doesn't appear to have any link to intensity of the pandemic but appears to be due to local decision making. This has created considerable inequity with trainees seeing marked differences to colleagues in other trusts despite similar impacts of COVID-19.

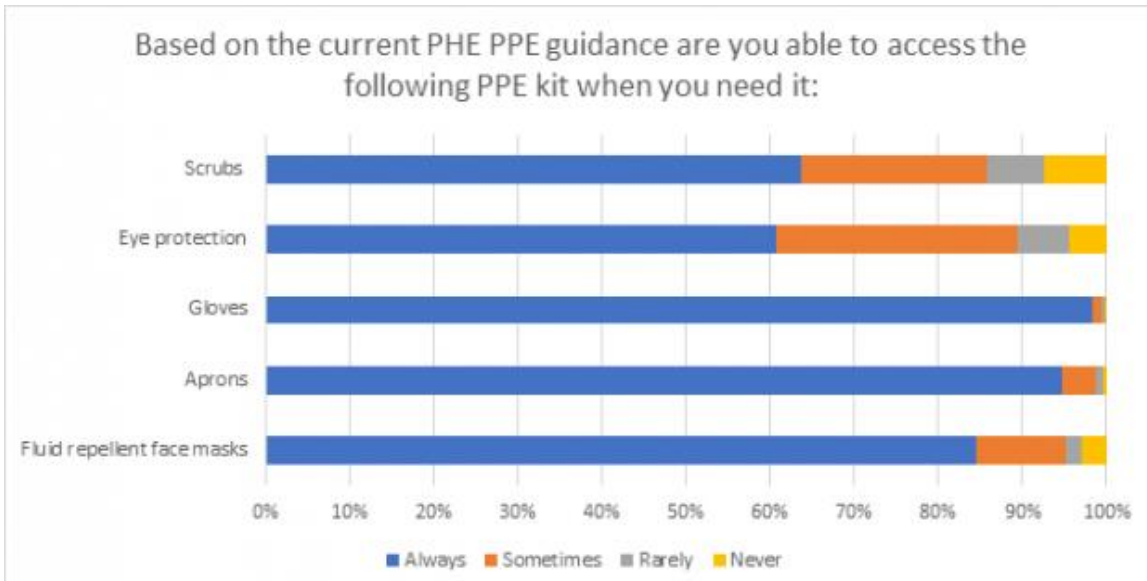


Appendix 1: Breakdown of key questions and answers (PPE)

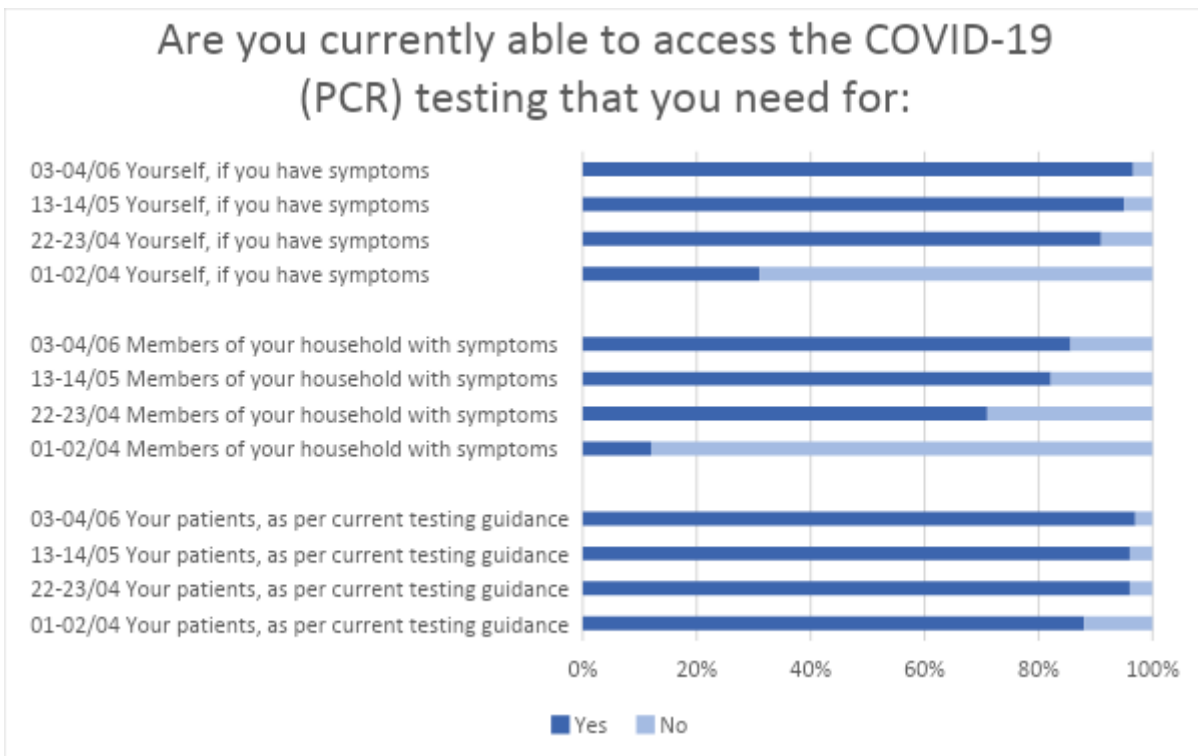


Appendix 2: PHE guidance and specific PPE availability (survey 2 - 22-23 April)





Appendix 3: Breakdown of key questions and answers (access to testing)





**Royal College
of Physicians**

Submission

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About the RCP

The RCP plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the UK and overseas with education, training and support throughout their careers. As an independent body representing over 38,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high-quality care for patients.