

DOCTORS' ASSOCIATION UK

THE VOICE OF FRONTLINE DOCTORS

Rt Hon Layla Moran MP
Chair
All Party Parliamentary Group on Coronavirus
18th July 2020

Dear Ms Moran,

Thank you for Chairing the All Party Parliamentary Group on Coronavirus and for starting the process of collating evidence to inform recommendations made to the UK government. The Doctors' Association UK has been at the forefront of representing the views of frontline doctors during COVID-19 pandemic. Raising concerns about pandemic preparedness, the provision of Personal Protective Equipment (PPE), gagging of whistleblowers and the challenges we face in the months ahead. Our *Protect the Frontline* campaign, launched early during the pandemic sought to address some of these key issues affecting frontline healthcare workers across the country.

We have lobbied for a timely independent judge-led public inquiry into COVID-19 to examine all aspects of how we have dealt with the pandemic enabling us to learn the vital lessons required before subsequent waves. We firmly believe that this is vital to saving lives in the future, both of patients and healthcare workers alike.

Our submission draws on our experiences as frontline doctors in the NHS, those of our members who have written to us throughout the pandemic and surveys of the wider profession. Our most recent survey found that doctors were most concerned about the impact of a subsequent second wave and the consequences of delayed diagnoses and treatment for thousands of patients who have had their care disrupted. The mental health effects of the pandemic on patients and healthcare workers must also not be underestimated and will also lead to significant morbidity in the months and years to come.

I hope that our submission is helpful in expressing the views and experiences of the frontline doctors and medical students who stepped up to help during the first wave of the pandemic. I am very happy to discuss our submission and give oral evidence.

Yours sincerely,



Dr Rinesh Parmar
Chair, Doctors' Association UK



Management of COVID-19

Evidence from the Doctors' Association UK to All Party Parliamentary Group on Coronavirus

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Introduction

As a professional association for UK doctors and medical students our members have been at the forefront of the nation's response to SARS-COV-2. From late February we have been hearing from our members by email and across our various communications platforms about their concerns about the UK preparedness for a pandemic. Despite previous influenza pandemic planning in the aftermath of the 2009 Swine flu outbreak, to many members, the country seemed underprepared. Learning and recommendations from the 2016 Exercise Cygnus pandemic planning exercise had not been published and it quickly became evident that we did not have sufficient personal protective equipment for the NHS.

The Doctors' Association UK surveyed frontline doctor members in late February about NHS preparedness for a pandemic. Only 8 out of 1618 NHS doctors felt that the NHS is well prepared for Coronavirus¹. As we emerge from the first wave of the pandemic and our attention turns towards preparing for the winter and a potential subsequent wave, we must examine and learn the lessons to guide future decisions. The Doctors' Association UK welcome the opportunity to present our evidence, engage with the All Party Parliamentary Group and contribute our experience to your inquiry as the voice of frontline doctors

¹ <https://www.theguardian.com/society/2020/mar/02/coronavirus-just-eight-out-of-1600-doctors-in-poll-say-nhs-is-ready>

Provision of Personal Protective Equipment (PPE)

In February the executive committee of the Doctors' Association UK (DAUK) decided that all our resources would be redirected to support and represent the medical profession through the developing COVID-19 crisis. By March we had repurposed our various online fora to serve as lines of communication between our members (frontline doctors of all grades from across the United Kingdom) and the DAUK executive committee. In addition, we commissioned surveys on a range of issues relating to COVID-19. We launched our #ProtectTheFrontline campaign calling for 6 key asks from the Government².

It became clear through these fora that doctors across the UK were faced with an unprecedented and wholesale change to their working lives. Annual leave and study leave were suspended; elective, locum and private work was quickly halted; emergency rotas were implemented within weeks (in some cases overnight); most non-consultant doctors were transitioned to intensive 13-hour day and night shift only rotas. All post-graduate training activity was suspended.

The most remarkable thing - in our view - is how doctors rose to these challenges and changes without much - if any - complaint. Indeed, in many places doctors led, designed and implemented these rota changes themselves, to surge acute and critical care capacity across NHS hospitals, and of course to bolster emergency and urgent provision in the community. We were very proud to see how well our profession - as well as our nursing and other NHS colleagues - rose to the challenge. In the end it wasn't these transgressions against our working lives and contracts that concerned doctors. The medical profession was fully cognisant of the potential scale of the task before it and took the required changes to their working lives in their stride. Ultimately, the central issue of contention was to become personal protective equipment (PPE) – and the guidance relating to it, as well as the procurement and distribution of it.

² <https://www.dauk.org/protectthefrontline>

Despite WHO, European CDC and US CDC clinical guidelines and standards being published outlining minimum standards of full-length disposable gowns, PHE released guidance which differed from the international consensus.

Within weeks of UK case numbers accelerating, and admissions climbing in UK hospitals, doctors started to tell us of PPE shortages. We were told of examples of doctors having to source their own PPE from hardware shops and nurses who were told to 'hold their breath' to save PPE. After obtaining 8,000 signatures from UK doctors, we wrote to government pleading that PPE be procured and delivered to NHS hospitals and GP surgeries, the letter was published in the Sunday Times as it approached 4000 signatories³. In an interview with Andrew Marr, our Chair, Dr Rinesh Parmar pleaded with the Prime Minister to Protect the Frontline by ensuring adequate PPE. He outlined the harrowing messages we had been receiving from frontline doctors who felt as if they were "cannon fodder" and "lambs to the slaughter" without adequate PPE.

We highlighted a number of stories from hospitals and GP practices across the country of doctors having to purchase their own PPE from DIY stores⁴. Nurses, without adequate PPE were forced to wear bin bags and later tested positive for COVID-19⁵.

Speaking to Sophy Ridge our Chair, Dr Rinesh Parmar said:

"Doctors have said that they're having to re-use masks that should be single use only. They're talking to nurses doing some of these high-risk procedures are holding their breath as they're unsure and unaware of whether the mask they have been provided is going to offer them adequate protection. We have seen in certain centres that supplies are getting to the frontline, but we're hearing every day of more and more cases

³ <https://www.thetimes.co.uk/article/coronavirus-letter-to-the-editor-without-protection-nhs-staff-are-cannon-fodder-tsw0nmbxs>

⁴ <https://www.dauk.org/news/channel4newsjennyvaughanppe>

⁵ <https://www.independent.co.uk/news/health/coronavirus-nurses-bin-bags-ppe-shortage-positive-covid-19-symptoms-a9457231.html>

particularly with General Practitioners who simply don't have the eye protection and basic equipment they need...We've seen doctors resorting to accepting donations from local schools, of using science goggles that children would normally be using in their labs and repurposing them for use in their surgeries. We've seen a tremendous effort from the local community to try and get personal protective equipment to doctors"

In conjunction with Messly, the Doctors' Association UK created an online application where frontline doctors could report real-time shortages of PPE. In total we received 1396 distinct reports from 269 practices and hospital settings. It revealed a shocking lack of PPE and a situation that did not improve for many weeks. The application revealed that doctors faced PPE shortages for many weeks at a time when the UK government was repeatedly stating that the problems had been resolved.

1. 38% of respondents reported no access to any eye protection
2. 23% of respondents reported no access to eye protection during the most high-risk aerosol generating procedures (AGPs)
3. 70% of doctors had no access to FFP3 respirator masks. This was at a time when the UK Resuscitation Council deemed Cardiopulmonary Resuscitation to be an AGP.
4. 38% of respondents reported no access to FFP3 respirator masks whilst doing aerosol generating procedures (AGPs)
5. 75% of respondents reported no access to long sleeve gowns
6. 47% of respondents reported no access to long sleeve gowns whilst performing an aerosol generating procedure.
7. 60% of respondents reported that they had not had mask fit testing, as recommended by the Health and Safety Executive (HSE)⁶.

We have worked with charity partners Med Supply Drive, MedShr and the Scrub and Facial Protection Hub to supply doctors who reported severe shortages with PPE meeting WHO standards across the country with multiple deliveries made during the last few months.

⁶ <https://www.hse.gov.uk/pubns/indg479.pdf>

Our concerns were initially dismissed by the Secretary of State for Health and Social Care, stating that the problems were simply issues with 'distribution'. In the immediate aftermath of our open letter to the Prime Minister, an NHS England statement said that there is "currently an adequate national supply of vital protective equipment if used in line with PHE's recommendations."⁷ A few weeks later, the Secretary of State for Housing, Communities and Local Government confirmed once again that UK stocks were insufficient and announced that an order of 400,000 surgical gowns from Turkey had been placed. Despite delays, the gowns did arrive in the UK only to realise that none of them met UK standards and so were useless to frontline healthcare staff⁸.

We raised concerns again in April 2020 as it emerged that there was rationing of personal protective equipment. Doctors had reported to us that they were wiping down and re-using PPE items which were designed for single use.⁹

A DAUK snapshot survey of 900 frontline doctors¹⁰ revealed that a fifth of doctors have been issued with unusable personal protective equipment amid concerns that faulty facemasks and surgical gowns are being delivered to hospitals. A senior nurse's FFP3 respirator mask failed whilst present for an intubation, it was later discovered to be out of date. Doctors have complained of PPE smelling of mould and being visibly degraded.

It has also emerged that re-dated masks which were said to be safe to use have actually been found to pose a risk to wearers. The recall notice in June 2020 comes many months after the masks were used by frontline healthcare staff¹¹. The risk arises from the

⁷ <https://www.england.nhs.uk/2020/03/hospitals-get-ramped-up-for-delivery-of-protective-kit-to-staff-fighting-coronavirus/>

⁸ <https://www.theguardian.com/world/2020/may/07/all-400000-gowns-flown-from-turkey-for-nhs-fail-uk-standards>

⁹ <https://www.thetimes.co.uk/article/coronavirus-terrified-frontline-medics-fear-recycled-gowns-are-spreading-disease-rsdb65nz>

¹⁰ <https://www.thetimes.co.uk/article/fifth-of-frontline-doctors-complain-of-unusable-coronavirus-ppe-wxf09gbb3>

¹¹ <https://news.sky.com/story/coronavirus-faulty-masks-sent-to-care-homes-and-gps-recalled-12018520>

degradation of materials, fitting with concerns being reported to the Doctors' Association UK by our members in April 2020.

Our members have consistently written to us with their concerns throughout the pandemic, either by email or via our NHSppe Application.

“No gowns available overnight Sunday. Masks in short supply and being hoarded by different departments. Being asked to reuse visors and gowns. Becoming more in short supply.”

A hospital doctor in the West Midlands

“Turned away from my shift in the intensive care unit due to lack of masks and gowns”

A hospital doctor in the East of England

“Caesarean sections were cancelled today due to non-availability of long sleeve surgical gowns. There are only limited long sleeve gowns available for emergency surgeries.”

Obstetrician and Gynaecologist from the South East

“I am working on a COVID ward with confirmed cases. Initially we were given FFP3 masks along with surgical gowns and visors. From today we have been asked to go back to using surgical masks and flimsy aprons because of new Public Health England advice. Lots of apprehension amongst the medical and nursing staff on our ward”

A hospital doctor in Wales

“Reusing gowns and visors now. FFP3 in short supply in all sizes. Surgical masks and now running low and are being rationed”

A hospital doctor in Birmingham

Key Recommendations

We have a wide-ranging set of recommendations in this area. Whilst the vast majority relate to investigation, fact finding and learning the lessons through an independent public inquiry,

we have also set out some key steps which we feel are essential before a potential second phase in the winter months.

1. Independent judge-led public inquiry with wide terms of reference that specifically include:
 - a. Pandemic planning including evaluation of recommendations from Exercise Cygnus
 - b. Stockpile contents and maintenance of in-date Personal Protective Equipment
 - c. Management of stockpile by Movianto
 - d. Replenishing out-of-date PPE stock
 - e. Actions taken to act upon NERVTAG recommendation to add gowns to pandemic stockpile in June 2019¹²
 - f. Steps taken by UK government to release stockpile items to NHS trusts and timeline of when this took place
 - g. Difficulties with distribution and delivery of PPE
 - h. Procedure of re-labelling PPE (often multiple times), were these items ever re-tested to ascertain the risk they posed to staff?
 - i. Procurement of Personal Protective Equipment internationally and domestically – efforts made to procure from local stockists who contacted the UK Government.
 - j. Decision to not join the EU PPE procurement programme, the rationale and justification for not doing so.
 - k. Investigation into the deaths of health and social care workers as a result of inadequate PPE provision
2. Replenish UK stockpile of Personal Protective Equipment in line with WHO PPE recommendations, including FFP3 masks, Visors, long-sleeve fluid repellent gowns and gloves.
3. Procurement should be from both domestic and international sources. An over-reliance on international production meant that we were unable to respond

¹² <https://app.box.com/s/3lkcbxepqixkg4mv640dpvvg978ixjtf/file/576265864905>

effectively during the first phase of the pandemic. Similar errors should not be made in subsequent waves. A national database of UK stockists and manufacturers should be compiled.

4. Planning with local domestic manufacturers to ascertain capacity for PPE production and barriers to production
5. Refining distribution processes in the event of a second wave to enable hospitals, GP practices, hospices and care homes to receive stock in a timely way so that they do not run out
6. Fit testing of all staff with mask types available in the UK

Whistleblowing and speaking up about COVID-19 concerns

Our NHS desperately needs to adopt a culture in which every staff member is able and empowered to speak out about their concerns. The ability to speak up and share experiences has never been more important than during a pandemic. However, the Doctors' Association UK has grown increasingly concerned that frontline doctors have been discouraged from speaking up. Our recent questionnaire suggested that almost half of all respondents had been told not to raise concerns about COVID-19 or Personal Protective Equipment. It is deeply troubling to hear stories of dedicated doctors who have raised concerns through official channels being subsequently reprimanded for speaking out when their concerns have fallen on deaf ears. Our survey was featured in an exclusive report with Mary Robinson MP and Georgina Halford-Hall (WBUK CEO) in May 2020.¹³

DAUK has been working with NHS England to ensure doctors are encouraged to speak up during the pandemic. We welcome the recent intervention by Prerana Issar, the Chief People Officer in direct response to our lobbying which clarifies that all NHS staff members can freely speak out in a personal, trade union or professional body capacity without prior clearances from their employer. Only with an NHS culture where we can share experiences of learning without blaming, fear or intimidation can improve patient and staff safety.

There have been major concerns during the COVID-19 pandemic about the ability of healthcare worker (HCWs) to speak out about their concerns. Everyone accepts that these are challenging times and that this is essentially an issue relating to transparency, rather than a political issue. The Doctors' Association UK is extremely concerned about the findings of our Whistleblowing survey. The survey aimed to improve our understanding of this crucial issue. The results have helped to inform our campaign to highlight and tackle ongoing PPE shortages and our work to improve protections for whistleblowers in healthcare.

¹³ <https://www.bbc.co.uk/news/uk-52671814> BBC News Article

This was an in-depth questionnaire which was published across our social media platforms as well as by NMC watch, Protect and Whistleblowers UK. The survey received 234 detailed responses which was the level and depth aimed for.

It was a self-selecting survey however 50% of respondents had not been discouraged from speaking up, this reassured us that this was a balanced survey, given the self-selecting nature of its audience and respondents. The vast majority of respondents were doctors (25% Consultants, 22% General Practitioners and 36% junior doctors, 9.6% of respondents were from a nursing background). There were a smaller number of responses from allied healthcare professionals including midwives, physiotherapists, paramedics, Operating department practitioners, radiographers and speech and language therapists as well as porters and security staff.

Our survey results showed:

- 75.2% of respondents stated that they had concerns about not having access to PPE
- 58.6% of respondents stated that they had raised concerns about the lack of access to PPE
- 46.9% of respondents stated that they had been told not to raised concerns about COVID-19 or PPE via social media
- 47.6% of respondents stated that they had been told not to speak to the press about COVID-19 or PPE
- 15.2% of respondents who had offered opinions on social media stated that they had been challenged or disciplined
- 32% of respondents stated that they had experienced bullying around the issues of raising concerns about PPE

There was evidence of some good practice by some hospitals and community organisations. Sadly, in others we heard evidence of bullying and suppression of those trying to speak up. It is vital that staff are free to speak up, in particular in respect to PPE. Many of those who raised concerns were attempting to secure donations of PPE or source PPE through an

alternative method for their workspace. The main parties who told our sample not to raise concerns were trust management and senior colleagues.

DAUK has raised these concerns directly with the National Medical Director for NHS England as it became apparent that doctors were being threatened and bullied into silence. As a direct response to our work and lobbying, we are pleased to read the blog post from Prerana Issar, the Chief People Officer at NHS England and NHS Improvement¹⁴ and the letter to Trust Chief Executives by NHS Chief Executive Sir Simon Stevens¹⁵. We are already aware of the work of Sir Robert Francis QC in this area in his Freedom to Speak Up review¹⁶. This policy contributes to the need to develop a more open and supportive culture that encourages staff to raise any issues of patient care, quality or safety.

Key Recommendations

In November 2018 we also launched a patient and staff safety campaign 'Learn Not Blame' which we believe is fundamental to future improvements in this area. The event was kindly hosted and chaired by Dr Philippa Whitford MP and was attended by cross party MPs and the Secretary of State for Health and Social Care. Donald Berwick has personally endorsed this and it relies on a resilient and transparent process for whistleblowers. We noted the work and importance of the National Freedom to Speak Up Guardian and her office, in addition to Whistleblowers UK and Protect. We would support reform of the Public Interest Disclosure Act such as creation of an independent body to protect whistleblowers. This body would need to have sufficient powers to enforce standards. It should in the first instance promote an open and just culture and measures that prevent the need to blow the whistle. In the event of a public interest disclosure it should act to protect the whistleblower and finally act to redress any detriment suffered.

¹⁴ <https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/>
<https://www.england.nhs.uk/blog/the-right-of-nhs-staff-to-speak-up-and-effective-communication-during-the-covid-19-pandemic/>

¹⁵ <https://www.england.nhs.uk/coronavirus/publication/second-phase-of-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/>

¹⁶ <https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review>

Investigating the deaths of healthcare workers

As outlined in our submissions on PPE, the Doctors' Association UK has widely shared concerns about failures to protect healthcare workers throughout the COVID-19 crisis. We are committed to advocating for the families of colleagues who have lost their lives as a result of contracting coronavirus while working during the pandemic. Many worked in conditions that were manifestly unsafe, and we feel that the circumstances of their deaths require thorough and proper scrutiny. The lack of a meaningful government commitment on this to date is distressing to bereaved families, leaving them without the opportunity to have their questions about the circumstances of these deaths answered.

The current provision for such investigations appears to be piecemeal and varies according to region/employer. Structures currently available for investigation of these deaths include:

1. Investigations by individual NHS trusts with serious incident investigations
2. Evaluation by Medical Examiners who are often employed by the same NHS Trust
3. Reporting under RIDDOR to HSE
4. The opening of inquests by coroners into deaths of individual healthcare workers when these are reported. All deaths in which the certifying practitioner "suspects that the person's death was due to...an injury or disease attributable to any employment held during the person's lifetime" should be referred to the coroner, who exercises their discretion in whether or not to open an inquest.

The Chief Coroner issued guidance covering this topic on 28th April 2020¹⁷:

"In the usual way, it is a matter of judgment for the individual coroner to decide on the scope of each investigation. The coroner must consider the question of scope in the context of providing evidence to answer the four statutory questions. Coroners are reminded that an inquest is not the right forum for addressing concerns about high level government or public policy"

¹⁷ <https://www.judiciary.uk/wp-content/uploads/2020/04/Chief-Coroners-Guidance-No-37-28.04.20.pdf>

We wrote to the Chief Coroner on 30th April expressing our concerns about this guidance¹⁸, and maintaining that inquests should be opened into the deaths of *all* health and social care workers who may have contracted COVID-19 at work. Without inquests, it is not possible to understand fully how these deaths occurred, whether healthcare workers are likely to have contracted the disease in the course of their work, and the local circumstances and availability of personal protective equipment.

We recognise that such investigations raise wider issues of policy which coroners conducting individual investigations are not equipped to answer in the context of a single inquest. Coroners could, in appropriate cases, pause their individual investigations to allow the rights and wrongs of wide-ranging policy decisions to be examined in a more appropriate forum. To this end we have called for a full and timely public inquiry whose scope includes PPE provision and the deaths of healthcare workers. We are concerned that if inquests are not opened the appropriate evidence to understand these deaths will not be preserved.

The Chief Coroner's response dated 1st May highlighted what we feel is an unacceptable level of local variation in the access of bereaved families to coronial inquests.

“Coroners are independent judges...they exercise their judicial duty and discretion in relation to any death, including that of a healthcare worker, which is reported to them.”

Our understanding from families who have contacted the Doctors' Association UK is that there are cases in which inquests have not been opened. In his response the Chief Coroner reiterated the purpose of an inquest, namely

“to answer the four questions (who, where, when and how the person died)”.

¹⁸ <https://www.dauk.org/news/2020/4/30/dauk-writes-to-chief-coroner-with-concerns-over-guidance-on-healthcare-worker-inquests>

We maintain that answering this forth question is not possible without an inquest in every case. Deborah Coles, director of the legal charity INQUEST, wrote to the Chief Coroner on 13th May, outlining similar concerns about the guidance, which INQUEST feels is wrong, and

“likely to stymie, limit and frustrate the investigations into the deaths of frontline workers from COVID-19”.¹⁹

Key Recommendations

We owe it to our colleagues to ensure that the circumstances of healthcare workers’ deaths are properly investigated and understood, and that lessons are learned from them to prevent further deaths. Bereaved families should have access to inquests committed to understanding how these deaths occurred. We feel that there is not currently an adequate framework to ensure that this is the case, and that a commitment is urgently needed on this front.

We seek legislative changes mandating the opening (and adjournment if required) of coronial inquests in each and every health and social care worker COVID-19 death. A full, independent judge-led public inquiry to examine wider policy issues such as the procurement of personal protective equipment and the links to healthcare worker deaths.

¹⁹ <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=de257e84-e63f-47ff-be50-171c31a8e048>

Impact of COVID-19 on Black, Asian and Minority Ethnic Patients and Healthcare Workers

The impact COVID-19 crisis is not uniform across ethnic groups and clustering different minority groups together potentially overlooks important differences. Understanding why these differences exist is crucial for assessing the role of policy in addressing inequalities. Health and social care workers from a Black, Asian and Minority Ethnic (BAME) background have been particularly affected by the COVID-19 crisis. Occupational exposure can only partially explain the disproportionate deaths for these groups. This is where we need to note that the pandemic exposed and exacerbated longstanding inequalities affecting BAME groups in the UK.

Excess mortality due to COVID-19 is higher in BAME populations. Those of South Asian descent more likely to have higher disease severity on admission to hospital and more likely to need ICU support.²⁰ In addition, the Public Health England report, 'Disparities in the risk and outcomes of COVID-19'²¹, identified that individuals of Black African or Black Caribbean ethnicity are of highest increased risk. The same report also found that the mixed and Indian, Pakistani, and Bangladeshi ethnic groups are also at significantly increased risk of death from COVID-19. According to this report, all-cause mortality from COVID-19 compared to the general population is:

- 4 times higher for Black males
- 3 times higher for Asian males

The BAME communities have a number of risk factors putting them at higher risk of COVID related complications. These include living in urban areas, increased numbers living in overcrowded households, living in deprived areas and working in higher risk occupations.

²⁰ Sapey E, Gallier S, Mainey C, Nightingale P, McNulty D, Crothers H, et al. Ethnicity and risk of death in patients hospitalised for COVID-19 infection: an observational cohort study in an urban catchment area. medRxiv. 2020:2020.05.05.20092296.

²¹ Public Health England 'Disparities in the risk and outcomes of COVID-19'

The disproportionate mortality rate can be understood by the following:

1. The UK population has 15% people from BAME backgrounds. However, 33% of the population dying of COVID-19 belonged to BAME communities. Previous research had already forecasted that a flu type pandemic infection would especially impact on BAME communities. Early data confirmed a disproportionate number of BAME people dying as a result of COVID-19.²²
2. 20% of the NHS workforce are of BAME heritage. By late April it was known that 63% of NHS staff who died from COVID-19 were from BAME background. 71% of the nurses and midwives, 94% of doctors and dentists, 56% of healthcare support staff and 29% of other staff who died were BAME.
3. There are a number of modifiable risk factors including cardiovascular disease, diabetes, high blood pressure and chronic kidney disease where public health initiatives and primary care can play a key role. Primary prevention of transmission of COVID-19 remains key but requires a concerted effort for to be culturally competent. This includes multi-lingual resources for health promotion and public health initiatives.
4. Implicit in the ONS report and PHE reports have been extra factors, independent of these modifiable risk factors which have been shown not to fully account for the increased to those of a BAME background. These extra factors have been identified in previous work as being linked with social deprivation, as shown by the Marmot Report²³ and with the negative health effects associated with the Hostile Environment Immigration Policy. The latter has led to a large number of BAME patients having a fear of accessing NHS care due to concerns unjustified immigration detention.²⁴
5. The Institute for Fiscal Studies report identifies that those of Indian ethnicity make up over 14% of doctors.²⁵ Black Africans account for 7% of nurses. Indian and Black

²² Hutchin et al. Protection of Racial/Ethnic Minority Populations During an Influenza Pandemic

²³ Fair Society, Healthy Lives (The Marmot Review)

²⁴ Weller et al. The negative health effects of hostile environment policies on migrants: A cross sectional service evaluation of humanitarian healthcare provision in the UK

²⁵ Are some ethnic groups more vulnerable to COVID-19 than others? IFS Deaton Review

African men are 150% and 310% more likely to work in health and social care compared to white British men. All are at much higher risk of COVID-19 related complications. The first 10 doctors to die from COVID-19 were of BAME origin. Actions to protect BAME healthcare workers during this crisis have not been taken promptly, even after the relationship to mortality and morbidity in this population was known. Crucially, healthcare institutions are yet to risk assess all of their BAME staff. Where risk assessments have taken place, DAUK has been told by frontline doctors again and again that nothing has been put in place to modify the personal risk to them as BAME frontline healthcare workers.

According to the latest workforce race equality data for the NHS²⁶ 29% of BAME staff reported being bullied or abused by other NHS workers, up from 27% in 2016. At over 147 NHS Trusts BAME staff remained more likely to face disciplinary action than their white colleagues.

White applicants were 1.46 times more likely to be appointed from shortlisting compared to BAME applicants. Meanwhile at a senior level, less than 6% of very senior managers fare from a BAME background despite 40% of hospital doctors and 20% of all staff being from a BAME background. 40% of London NHS trusts boards had no BAME board members at all, while the proportion of CEOs and chairs from a BAME background decreased from 5.3% in 2006 to 2.5% in 2014.

In a survey conducted by the Doctors' Association UK and reported on BBC Newsnight:

- 75.2% of surveyed doctors had concerns about not having access to adequate personal protective equipment
- 32.4% stated that they had experienced bullying around the issue of raising concerns about PPE

²⁶ Workforce Race Equality Standard data reporting – 2019

<https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-2019/>

Quotes from doctors in the survey included:

“There is a toxic culture of bullying, especially if you say something about the lack of PPE”.

“There is a shortage of almost everything, as an IMG doctor I’m worried that I’ll speak up and get deported”.

Our NHS is truly multicultural, and we proudly have a workforce consisting of many different nationalities. The health and social care sector are reliant on our overseas workforce and never has this been clearer than during this time of national crisis. Despite this international medical graduates (IMGs) and overseas healthcare workers have been poorly treated for years, with many saying they have been made to feel unwelcome in the UK due to the effect of the Hostile Environment.

Migrants, many from BAME communities have selflessly risked their lives in the service of this country and their patients. The scrapping of the Immigration Health Surcharge was the first step in recognising this sacrifice however repeated delays and confused messaging after the government’s announcement has caused considerable anxiety amongst IMGs. Whilst automatic visa extensions have been granted to frontline healthcare workers, they have yet to be granted indefinite leave to remain. DAUK believe that those that served during this national emergency have more than earned that right to call this country home.

Parallels have been drawn between the lack of action to protect ethnic minority groups from COVID-19 and the Black Lives Matter movement. The reason people have been distraught at the tragic death of George Floyd is because black and ethnic minority lives are treated as though they are second rate, or they matter less. The failure to act on evidence that has been in the public domain for a long time has led to disenfranchisement, e.g. the data from the Office of National statistics on inequalities in mortality from COVID-19 are similar to inequalities in mortality from all causes as laid out in the Marmot Review published in 2010.

Key Recommendations

DAUK feels strongly that more needs to be done to protect BAME communities, and frontline health and social care workers in this higher risk group. We also feel that migrant healthcare workers who are putting their lives at risk in service to the NHS deserve to have this sacrifice recognised. These are our policy asks which we would be grateful for your support on:

1. Extension of NHS Health Check to BAME individuals from age 25 as the modifiable risk factors tend to present earlier in this age group.
2. Culturally competent health promotion programmes linked to modifiable risk factors.
3. Ethnicity data to be recorded on death records.
4. Risk assessments are simply not enough if those identified as at risk are forced to continue to work in high risk areas. We are therefore calling for published metrics that show staff have been re-deployed once assessed to be high risk.
5. End to the policy of extending the Hostile Environment to NHS care.
6. Indefinite Leave to Remain for frontline NHS staff serving during the pandemic.

Private sector involvement in aiding post-pandemic elective waiting list relief

The COVID-19 pandemic caused by Novel Coronavirus SARS-COV-2 has had a marked impact on the provision of NHS services. Emergency attendances and admissions fell dramatically during the lockdown²⁷, but in addition, the number of patients waiting under Referral to Treatment (RTT) for consultant-led care and those waiting for elective procedures has markedly increased. This section considers the possible mechanisms by which the UK Government and the NHS can hope to reduce the burden of elective operative and non-operative cases as lockdown measures are eased, specifically regarding the role of the private sector.

To maximise capacity, hospitals were instructed by NHS England on 17th March 2020 to cease elective working and re-structure from at least April 15th for a minimum three-month period.²⁸ This was to cope with the increased influx of COVID-19 patients, which peaked at around 19,000 a day during the month of April.²⁹ The health minister of Wales issued a similar statement on 13th March 2020 in preparation for the crisis and suspended all non-urgent appointments and procedures and relaxed targets across the healthcare system in Wales.³⁰

As COVID-19 caseloads and admissions continue to fall, and the three-month window draws to a close, the numbers are beginning to reveal the extent of the elective backlog that would require clearing.

²⁷ England.nhs.uk. 2020 <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/05/Statistical-commentary-April-2-020-jf8hj.pdf>

²⁸ England.nhs.uk. 2020. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf>

²⁹ Hsj.co.uk. 2020. https://www.hsj.co.uk/download?ac=3045627&utm_medium=Social&utm_source=t.co&utm_campaign=newsfeed

³⁰ GOV.WALES. 2020. Written Statement: Coronavirus (COVID-19) | GOV.WALES. <https://gov.wales/written-statement-coronavirus-covid-19-2>

The statistics in England, comparing May 2019 to May 2020, make for stark reading:

RTT waiting list figures have actually fallen during the pandemic, from 4.4 million to 3.8 million patients in the latest published data.³¹

Routine testing (such as for suspected cancer and heart function) has dropped by 37.5% from 1.2 million to 870,000

Elective operations in England fell by 80% from 296,000 to 55,000³²

The number of people in Wales on the other hand, waiting for more than 36 weeks for surgery increased from 28,000 at the end of March to around 45,000 at the end of April 2020³³.

Following lockdown measures, it is also clear that from March 2020 to May 2020, median and 92nd percentiles waiting times have increased markedly (8.9 to 15.3 weeks and 26.5 to 34.3 weeks respectively)^{31,32}. Perhaps most starkly, over that 2-month period, the number of patients waiting more than 52 weeks for treatment rose from 3097 to 26029, a staggering increase of 840%.

To cope with the anticipated surge in demand, the private sector had elements ring-fenced by NHS England, including its 8482 beds, 5000 nurses and 700 doctors^{34,35}. This is an expansion on the 1140 beds that would normally be ring-fenced by the NHS, as per

³¹ England.nhs.uk. 2020 <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/07/May20-RTT-SPN-publication-version.pdf>

³² England.nhs.uk. 2020. <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/05/Mar20-RTT-SPN-publication-version.pdf>

³³ Wightwick, A., 2020. *45,000 In Wales Have Waited More Than 36 Weeks For An Operation*. walesonline. <https://www.walesonline.co.uk/news/health/hospitals-surgery-wales-operations-coronavirus-18412257>

³⁴ Illman, J., 2020. *NHS Block Books Almost All Private Hospital Sector Capacity To Fight Covid-19*. Health Service Journal. <https://www.hsj.co.uk/policy-and-regulation/nhs-block-books-almost-all-private-hospital-sector-capacity-to-fight-covid-19/7027196.article>

³⁵ Ft.com. 2020. *Private Sector Resources Bring Welcome Relief For NHS*. <https://www.ft.com/content/b6e48ee8-6c26-11ea-9bca-bf503995cd6f>

documentation in the King's Fund and independent analysts LaingBuisson³⁶. Year upon year, the private sector has undergone increases in national funding, with the latest figures from 2018 showing £34.5 billion worth of sector investment³⁷. Many of these centres prioritise day-case surgery, which has understandably been de-prioritised thanks to the pandemic.

To compare with Wales, many essential services across many Health boards had been relocated partly to the local private hospitals³⁸. The relationship between the NHS and the private sector has changed dramatically during the course of the pandemic and is definitely worth reflecting upon. Both sectors have had to adapt to new ways of working in the course of this partnership. With normal services resuming, an important question remains as to whether the private sector can use its capacity to assist in the reduction of these waiting times.

Given the rapidly evolving nature of the pandemic, and since much of the latest cumulative publicly available data only extends to May 2020, it is difficult to truly grasp the scale of the impending elective crisis. Expert analysis has been carried out by waiting time tsar Rob Findlay up until 10 July 2020, analysis which shows a variable national picture with some trusts performing markedly worse than others over the relevant metrics³⁹. This may reflect variations in consultant availability and population demography amongst other factors.

To add to this, even with the various practical alterations that have been in place, essential services - those deemed to be lifesaving or life-impacting - should have been maintained at

³⁶ The King's Fund. 2020. *NHS Hospital Bed Numbers*. https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers#footnoteref6_5nql84k

³⁷ Statista. 2020. *Private Healthcare Expenditure In The UK 1997-2018* | Statista. <https://www.statista.com/statistics/317868/private-healthcare-expenditure-in-the-united-kingdom-by-sector/>

³⁸ BBC News. 2020. *NHS To Take 'Cautious' Steps Towards Normality*. <https://www.bbc.co.uk/news/uk-wales-52904408>

³⁹ Public.tableau.com. 2020. *Tableau Public* <https://public.tableau.com/profile/rob.findlay8209#!/vizhome/RTTwaitingtimesinEnglandwithaveragewaits/Dashboard>

all times throughout the pandemic. However, the response to COVID-19 may have led to backlogs due to staff re-allocation, re-tooling of existing hospital premises to support COVID-19 patients and the subsequent reliance on virtual clinics. This backlog, especially in the realm of cancer care, is one that needs to be urgently addressed and, moving forward, carefully considered⁴⁰.

What should be realised however is that even if the private sector were to take work on, there would be limitations. There will be a major capacity constraint even after services are resumed to “normal” due to enhanced infection control arrangements which will reduce the volume of patients that can be treated. In addition, since COVID-19 has marked perioperative impacts, surgery on positive patients can often incur significant morbidity, with the literature suggesting non-urgent surgery be avoided wherever possible in such patients⁴¹.

In terms of logistic practicality, many private hospitals are designed to support day-case procedures. While use of private services could clear day-cases that have accumulated on the NHS, the crossover of complex cases with prolonged subsequent inpatient stays would require a more thorough resource assessment in order to determine practical utility. Moreover, many of the consultants working in private healthcare already work for the NHS, meaning there is limited extra consultant-led capacity, especially when it comes to surgical practice. Given that the government ring-fencing only managed to procure 700 extra doctors from the private sector, the grades and specialties of whom are unclear, it is difficult to determine how much work exactly the private sector could take on. Improved and transparent communication between the two would need to escalate beyond that which already exists to cope with the eventual demand.

⁴⁰ Gov.wales. 2020. https://gov.wales/sites/default/files/publications/2020-06/nhs-wales-covid-19-operating-framework-quarter-1_1.pdf

⁴¹ Archer JE, Odeh A, Ereidge S, Salem HK, Jones GP, Gardner A, et al. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. *Lancet*. 2020

Key Recommendations

1. COVID-19 free sites: Where possible, there should be a physical separation between COVID-19 positive and COVID-19 negative patients. There is a need for clear 'green zones' to minimise the risks to the patients in the perioperative period, given both the risks of mortality and other complications. These can be created at designated private hospitals. Patients should be asymptomatic and isolate for 14 days where feasible. This should be supplemented with a pre-admission test COVID-RT-PCR (maximum 72 hours in advance). Staff would need to be tested at regular intervals to minimise the risk of nosocomial transmission of COVID-19.
2. Provisions of appropriate PPE to staff and patients in addition to testing and quarantine measures will need to be agreed on a larger scale than have already been proposed. Hand and respiratory hygiene, social distancing, reducing surface contact transmission should be implemented and monitored in a rigorous manner. Infection, prevention and control policies should be managed in an open and transparent manner to reassure staff and patients alike.
3. Staff engagement: There is a need to revise and reassign clinician job plans and existing contracts. Clinical staff inclusive of consultants should be flexible wherever possible to ensure cross site cover between NHS hospital and private sites. Remuneration for this additional flexibility and inconvenience should be provided following negotiation.
4. The effect of utilising the private sector on the training of junior surgeons and anaesthetists, as well as allied health professionals. These environments are not usually equipped for effective teaching and infection control precautions that must be taken in the current climate further reduce the time available for learning. As part of the mid to long term plan, mitigation for these changes should be considered and a solution sought that is not detrimental to doctors in training.

5. There will be some cases which during the very complex nature of the procedure or due to patient suitability cannot be carried out in the private sector. NHS beds and theatre space should be reserved for these procedures and patients.

6. The private sector will resist tariff basis. The buying capacity could be purchasing diagnostics and theatre sessions. These negotiations should be left to the NHS England or the respective health boards who should have accountability and receive scrutiny throughout.

7. Both the NHS and the private sector work in different ways. Both need to reflect, adapt and work with one another to ensure that each can provide care in the safe manner which patients deserve. Shared learning exercises should be routinely scheduled.

COVID-19 and mental health

It is widely recognised that there are higher rates of mental illness in healthcare workers including anxiety, depression, substance use and burnout. The Covid-19 pandemic is very likely to worsen this⁴², and the Doctors' Association UK (DAUK) feel it is imperative that this risk is acknowledged and that measures are put in place to protect the mental health of NHS workers.

Studies on the psychological impact of the 2003 SARS epidemic in China support these concerns. A study by Wu in 2009⁴³ found that 10% of hospital staff had symptoms of post-traumatic stress during the epidemic and a study by Nickell et al⁴⁴ found 45% of nursing staff showed probable emotional distress. It is also known that there are higher rates of anxiety, depression and PTSD in people admitted to critical care with Adult Respiratory Distress Syndrome⁴⁵ and that a significant proportion of these will be healthcare workers⁴⁶.

The Doctors' Association UK conducted a survey of 350 healthcare workers⁴⁷ which found that 57% of respondents have felt so stressed that they have been overwhelmed or unable to cope because of pressure at work during the last month.

The anonymous survey also found that 11% of responders had felt suicidal and 3% had self-harmed in the past month, as a result of stress due to increased pressure at work. They

⁴² Douglas P, Douglas D, Harrigan D & Douglas K (2009) Preparing for Pandemic Influenza and its Aftermath: Mental Health Issues Considered. *International Journal of Emergency Mental Health*, 11(3):137-44

⁴³ Wu P, Fang Y, Guan Z, Fan B, King J, Yao Z, Lui X, Fuller C, Susser E, Lu J & Hoven C (2009) The Psychological Impact of the SARS Epidemic on Hospital Employees in China: Exposure, Risk Perception, and Altruistic Acceptance of Risk, *Canadian Journal of Psychiatry*. 54(5):302–311.

⁴⁴ Nickell, L. A., Crighton, E. J., Tracy, C. S., Al-Enazy, H., Bolaji, Y., Hanjrah, S., ... & Upshur, R. E. (2004). Psychosocial effects of SARS on hospital staff: survey of a large tertiary care institution. *Cmaj*, 170(5), 793-798.

⁴⁵ Sim K & Chua H (2004) The psychological impact of SARS: a matter of heart and mind. *Canadian Medical Association Journal*. 170 (5)

⁴⁶ Thomas, C., and Quilter-Pinner, H. (2020) Care fit for carers: ensuring the safety and welfare of NHS and social care workers during and after COVID-19. London: IPPR.

⁴⁷ <https://www.dauk.org/news/2020/4/27/dauk-and-itv-news-look-at-the-impact-of-covid-19-on-the-mental-wellbeing-of-nhs-staff>

were then asked whether they had been offered adequate support from their employer for their mental wellbeing. Almost 48% of the 350 staff who completed the survey said that they did not feel the support had been adequate.

Many of the respondents commented that the lack of personal protective equipment and the conflicting and changing advice on what PPE should be worn and in which circumstances, has led to increasing levels of anxiety and stress.

Key Recommendations

We have seen an increase in support offered for NHS staff including helplines and access to psychological therapy. However, it is vital that we also look at prevention rather than just treatment and that a proactive approach is taken. As we begin to tackle the backlog of demand for services put on hold whilst also preventing a second wave of Covid-19, we must remember that we cannot spread services too thinly. The same staff who worked on the frontlines during the pandemic are the same staff manning the routine services. We cannot place insurmountable pressure on staff who are suffering from psychological distress, at high risk of mental illness and expect them to cope. Adequate resourcing and funding must be provided, and the wellbeing of staff must be a priority. Prolonged breaks from working, adequate rest on shift and appropriate remuneration for their work are essential.

Without the above, and without also achieving parity of esteem for mental health services, we risk not having a workforce in the event of a second wave of Covid-19.

1. The helplines created for health and social care staff should not be a temporary sticking plaster but should be continued and funded indefinitely
2. Creation of specialist services such as the Practitioner Health Programme in Wales, Northern Ireland and Scotland and expansion of the funding and remit to cover all NHS clinical staff groups.
3. Funding of awareness campaigns within primary and secondary care settings so that healthcare staff know about symptoms and how to access help locally

Preventing the inpatient or nosocomial spread of COVID-19

Although efforts have been made to prevent the spread of COVID-19 within our hospitals, this still took place during the first wave of the pandemic. Evaluating reasons for this spread and implementing strategies for future waves to prevent further transmission is key to saving lives.

Investigators have identified both special and temporal links between positive cases within hospital wards, with evidence of patient to patient as well as patient to staff transmission. These findings highlight both the importance of good hygiene practices as well as adequate personal protective equipment to keep both patients and staff safe.

Public Health England has estimated the rate of nosocomial COVID-19 infections to be in the range 10-22%⁴⁸. A meta-analysis of Chinese hospital data purported the rate to be closer to 44%⁴⁹. The availability for adequate staffing is a major concern in the NHS. With nearly 10,000 doctors and 40,000 nurses short even prior to the pandemic the NHS struggles to both recruit and retain its clinical workforce. In specialist ward based settings, where nurses are specially trained to care for patients with certain pathologies, patients with suspected or confirmed COVID-19 were cared for in side-rooms. As a result of the specialist care these patients require, nurses are often tasked with caring for these patients with suspected COVID-19 and those without COVID-19 symptoms. The ideal scenario of creating 'hot' COVID positive or suspected areas and 'cold' COVID negative areas may not always be feasible. You would also need to create separate rest areas and no mixing of teams, something difficult to practically achieve in the NHS today.

The attendance of visiting teams or medical emergency teams to review clinically unwell patients increases the risk further of nosocomial infection. The movement of patients with

⁴⁸ <https://www.theguardian.com/world/2020/may/17/hospital-patients-england-coronavirus-covid-19>

⁴⁹ Zhou, Q., Gao, Y., Wang, X., Liu, R., Du, P., Wang, X., ... & Li, W. (2020). Nosocomial Infections Among Patients with COVID-19, SARS and MERS: A Rapid Review and Meta-Analysis. *medRxiv*.

proven or suspected COVID-19 from one bed to another, from one ward to another multiple times also increases the risk of hospital transmission to other patients and staff. Staff testing was made available a few weeks into the first wave of the pandemic, although positive results initially carried a stigma, most staff with symptoms now are being tested and self-isolating.

Key Recommendations

1. Provision of adequate Personal Protective Equipment is vital to protecting both patients and staff from nosocomial transmission
2. Implement strategies to reduce the movement of patients, reducing to only those moves that are absolutely clinically necessary
3. Isolating vulnerable patients such as tracheostomy patients who are susceptible to contracting the virus and also spreading it to surrounding patients
4. All healthcare professionals should continue to use full level 3 personal protective equipment when carrying out tracheostomy care.
5. All healthcare providers should publish their COVID-19 rates. These are likely to vary significantly depending on the patient population and care environment.
6. Those testing positive or having symptoms of COVID-19 should continue to quarantine for 14 days, including healthcare staff working in high risk areas.

Concerns about the second wave as we head into the winter

The first peak of the coronavirus pandemic has passed, but the NHS has not returned to normal. As the country begins its long path to recovery, the NHS is expected to restore its functioning capacity whilst also rising to the inevitable further challenges of COVID-19. This task is compounded by the unprecedented amount of physical and mental stress afforded to the workforce. At the Doctors' Association UK (DAUK), we have heard from hundreds of frontline workers across the NHS and have identified a number of major concerns going forward into the winter.

A major concern shared across the country is the prospect of a second peak of infection. The NHS has withstood immense challenges over the past few months, however the costs on its workforce are only starting to come to the fore. At the Doctors' Association UK, we have heard from frontline doctors who say they are so stressed recently they have been unable to cope.

A DAUK snapshot survey with 1431 respondents revealed that 57% were most worried about a second wave of COVID-19 as we head into the winter. 40% stated that they were most worried about secondary harm to patients as a result of delays in diagnosis and treatment due to COVID-19. The remainder were concerned about the impact of COVID-19 on the mental health of patients.

A significant component of this stress has been the challenges surrounding PPE guidance and supply. A priority for the NHS going forward must be adequate protection of its staff. The recent outbreak has identified a number of shortcomings in the provision of adequate PPE and protection of healthcare workers. We must learn from these challenges and ensure that a proactive approach is taken in preparation for potential future peaks. These strategies must include:

1. Ensuring in-date, suitable quality PPE is distributed and stockpiled in all trusts around the country. This process must be started immediately, with locally produced UK products and high-quality products from abroad. Reliance on either imports or UK

produce alone is not a viable option and carries significant risk to healthcare workers.

2. PPE guidance must be consistent with international best standards from the World Health Organisation and in line with international consensus. This should not be downgraded due to issues with PPE supply.
3. Transparent reporting of concerns without detriment as well as timely dissemination of information from the NHS, to Trusts and to all clinicians.
4. Rapid testing of staff and patients must be available as the elective functions of the NHS begin to reopen. Procedures should only be booked if adequate PPE is available. We would advocate for the regular testing of all staff members on a weekly or twice weekly basis.
5. Effective means to communicate and resolve equipment shortages as the PPE helpline did not work. Many doctors reported having to source their own PPE despite contacting the PPE helpline set up by the Secretary of State for Health and Social Care.
6. BAME and vulnerable staff are risk assessed and adequately protected from high risk environments as soon as possible. No healthcare worker deemed to be high risk should be expected to continue in their current working environment. A change of duties in this situation is paramount.
7. The safeguarding of the NHS for the future. Outsourcing data handling and video consultation outside of the UK not only risks vital patient data being traded but opens the NHS up to further private sector reliance. Utilisation of in-house expertise within the UK and within NHSX will ensure that patient data will not be shared with other external companies. Video consultations have limited utility as clinicians are unable to adequately examine patients. Using US based applications or private sector providers enables these firms to exert a greater influence in the NHS and day to day service delivery.
8. There must be checks and balances to the use of the private healthcare sector in the UK. It is important that NHS investment does not suffer as a result of funds being diverted to the private sector. Further privatisation of the NHS would not ultimately benefit patients.

In preparing for a second peak, we must also respond to the stress and exhaustion experienced in the workforce. Doctors will need time to reflect and recover and should be supported in taking time out from the workplace where needed. Adequate resources should be available in all trusts to support the wellbeing of staff, including rest facilities and access to confidential support. Despite recent improvements, many hospitals have not restored rest facilities for doctors and retain a culture where resting is frowned upon. There must also be transparent lines of communication between management and staff, with forums that encourage speaking up about concerns.

Suspended procedures and outpatient appointments have led to an unprecedented backlog of cases. The NHS confederation estimate that the number of patients waiting for an elective procedure could double to over 10 million by the end of 2020⁵⁰. Moreover, an estimated 2.4 million people in the UK are still waiting for screening, treatment or tests for potential cancer. This creates pressure for both the elective and emergency operations of the NHS, as protracted will inevitably lead to acute admissions.

Whilst it is essential elective services resume, safety must take priority over service provision. It is imperative that robust procedures are in place for protecting patients and staff during elective operations, including pre-operative screening and testing, adequate PPE and ensuring appropriate resources are available for adverse events. Moreover, staffing levels must be carefully regulated to ensure the workforce is not spread too thin in an effort to increase operating capacity. Staff testing is absolutely vital to being able to accommodate the backlog of patient awaiting procedures. We would advocate the weekly or twice weekly testing of all staff who have patient-facing roles.

Workforce redistribution has been a vital component of adapting the NHS during this pandemic. However, this has come at the expense of training and career progression for the majority of the workforce. It is essential that as the NHS begins to resume normal

⁵⁰ BBC News: NHS waiting list 'could hit 10 million this year'. (2020)

<https://www.bbc.co.uk/news/health-52984742>

operations, doctors are engaged in their normal training activities and supported to achieve required competencies. These goals can be realised through:

1. Additional dedicated time set aside for informed meetings with educational and clinical supervisors on how to catch up with competencies
2. Flexible rostering to allow greater exposure to clinical areas where competencies are lacking
3. Allowing additional study leave, when educational activities are identified

As part of the NHS reset initiative⁵¹, it is highly likely that external sites will be used to increase routine operating capacity. We have heard from a number of doctors that this redistribution of elective work has already prevented junior staff from accessing adequate learning opportunities, as external sites have restricted clinical training. These barriers must be urgently addressed by senior clinical staff, education bodies and NHS England.

Working Practice

Flexible working practice introduced during the pandemic must not become a permanent feature. Rosters must be compliant with the junior doctors' contracts and support the training requirements of that stage. Moreover, there must be proper remuneration for work done out of hours and beyond the contracted hours. Healthcare staff who have endured the most horrific conditions must not now be forced to pay again for COVID-19 through reductions in salary or public sector pay freezes. Nurses and doctors have already suffered some of the worst pay freezes in the public sector of the last decade, with further pay restraint effectively decimating the small amount of morale that remained pre-COVID.

Key Recommendations

⁵¹ NHS Confederation. (2020). NHS Reset: Reforming health and care post COVID-19
<https://www.nhsconfed.org/supporting-members/nhs-reset>

The Prime Minister has announced an extra £3billion for the NHS in England to prepare for COVID-19 this winter. We are yet to hear of funding arrangements for Wales, Scotland and Northern Ireland. Once funding is appropriately allocated it is imperative to have a strategy about:

1. How funds are to be allocated to NHS Trusts and health boards
2. Prioritisation of additional funds to hospitals dealing with surges in COVID-19 cases
3. Designation of local hospitals as COVID-free centres where other treatments, surgery and procedures can continue throughout the winter (hot and cold sites).
4. Processes to ensure that treatments for cancer and urgent procedures continue throughout a subsequent wave
5. Prioritise the provision of personal protective equipment for healthcare workers
6. Re-deployment of healthcare workers deemed to be at high risk
7. Provision of adequate rest facilities for healthcare workers who are working 12 – 13 hour shifts
8. Wellbeing and psychological support for health and social care workers through existing services such as the Practitioner Health Programme and the commissioning of similar services in Wales, Scotland and Northern Ireland.