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Tavistock Square
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BMA

Rt Hon Jeremy Hunt MP
Chair, Health and Social Care Select Committee
House of Commons
London
SW1A 0AA

12 March 2020

Dear Jeremy,

Re: Preparations for COVID-19

I write regarding the Health and Social Care Select Committee's ongoing inquiry into COVID-19 and your upcoming evidence session with NHS England.

The BMA has engaged with NHS England throughout the emergence of COVID-19 regarding preparedness and planning. We consider this communication to have been vital and it has allowed us to facilitate communication regarding guidance and planning with our members on the ground. We are also encouraged by the Government's assurance that the NHS will get the support it needs to deal with COVID-19 and specifically the announcement of investment in the NHS, including the initial £5bn emergency response fund, targeted at reacting to this virus.

However, in terms of preparedness, as the situation continues to develop there are some areas where clarity and action are still urgently needed. I have outlined these below.

Bringing doctors out of retirement
The Government has suggested asking recently retired doctors to come back to the NHS to help the system cope with the pressures of Covid-19. Recently retired doctors have a wealth of knowledge and expertise, and some may well be able and willing to contribute their skills during emergencies. However, we have concerns that the Government has not provided clarity on a number of issues, such as GMC registration, and scope of practice, indemnity, death in service benefit, any impact on returning doctor's pensions and how they will be trained and integrated back into the workplace.

In addition, many retired healthcare workers are of an age, or have conditions, that makes them more likely to suffer a more serious illness should they contract Covid-19. We must consider their wellbeing and whether they would be putting themselves at risk by returning to work. Where retired doctors do return to work it must be ensured that those in at risk groups are protected from becoming infected including by allowing them to work remotely. For such an approach to be viable, and to give confidence to doctors considering returning from retirement these issues will need to be addressed.

Medical students

It has also been widely suggested that final-year medical students may be drafted in to support medical colleagues. We do not support students acting outside of their competency, and any medical student taking on this responsibility would require additional supervision compared to other clinicians and extra protections to ensure they and patients are not at risk. This may include scenarios where medical students are asked to fill 'non medically-qualified' roles, for example as healthcare assistance or 111 operators, without prior experience.

We plan to communicate to our medical student members that any medical student involvement must be based on that individual student's own decision, and that whole cohorts must not be conscripted without their consent.

We also expect that medical students working to support their colleagues must be remunerated for the work undertaken, in a way that reflects the responsibilities and in line with what is offered to current foundation doctors. They must be offered contracts that reflect all the working hours protections, pay arrangements, and hospital inductions that are provided to new FY1 doctors. Any clarity which your committee could help to secure on the expected role of medical students would be appreciated by those students, who may be considering how they can offer their support.

NHS Capacity

Before Covid-19 began circulating in the UK, our health system was already under intense pressure with A&E and 12 hour trolley waiting times at a record high, GP waiting times reaching three weeks, and an understaffed healthcare workforce. It is more crucial now than ever, as Covid-19 has been classified as a pandemic, that we have greater capacity, more beds and more staff, as more and more patients will require treatment and support.

We are also clear that there must be measures, such as cross-cover between providers, put in place for those struck with NHS staff shortages due to illness. In general practice given the relatively small staff numbers, if even one or two healthcare staff are unable to work due to ill health, this may render the practice unable to deliver normal services and some may need to close. It may be worth exploring options such as the use of 'locum banks' to allow GPs to move around and support practices with low staffing levels. There is currently no clear plan about how these types of processes will be managed, and it is vital that this is developed, alongside ensuring that providers are not pressurised into unsafe practice through breach notice threats.

As the number of Covid-19 cases continues to rise, intensive care unit (ICU) capacity has become a real concern among doctors. We already have one of the lowest provisions of ICU beds per head of population across western health economies; investment in improving the provision of ICU beds is urgently needed to meet the potential future demands caused by Covid-19. As well as the urgent need to rapidly increase bed capacity, which will require additional staff, additional space within hospitals, the rapid development of systems of care for anticipated large numbers of patients and a large rise in the availability of suitable equipment. The ability of ICUs to help reduce overall mortality depends, in part, on the effective mobilisation of sufficient staff to support the care of large numbers of patients but also on the provision of appropriate facilities to deliver that care together with the rapid identification of those patients deemed most likely to benefit from ICU care. If the Government can effectively manage the spread of the virus across the population over a longer time period, this may prevent a concentrated peak in demand, which would help ease pressures.

We are similarly aware that there may need to be change to the way care is delivered and believe more communication is required regarding plans and advice to cease non- essential work both in secondary and primary care. This would enable providers to cope not just with exponential demand but also with a workforce which may have reduced from illness itself. The reduction of non-essential work must include ceasing bureaucratic work, it should also ensure that GMP is amended during this crisis to provide reassurance to doctors who are forced to de-prioritise some patients due to increased pressures.

There will be a continuing requirement for the delivery of urgent care not related to Covid-19; investment in resources to enable remote and video consultations both in secondary and primary care may also help to facilitate the delivery of care without the risk of cross-infection. This needs a clear policy for doctors to understand what practices are being developed by NHS England to support remote working from home such as compliant IT access, so that even should doctors be forced to self-isolate, they may still be able to offer some support to colleagues, patients and the wider NHS.

Personal Protection Equipment (PPE)

It is vital that all healthcare workers are protected against Covid-19, while at work, so that they can continue to treat patients throughout this period. This can be helped by making sure we have the right equipment to deal with the outbreak and that those giving out supplies listen to doctors and other frontline staff when they say they require more equipment for their local areas. Inadequate provision of PPE both in number and design, both into secondary care where the burden of direct care for infected patients will fall, and in primary care and the community who will have to deal with large numbers of infected patients who are able to be managed at home, will rapidly deplete staff numbers. It must be recognised that staff members who succumb to Covid-19 infection may not be able to return to work during this outbreak, so preserving their good health is of paramount importance.

After pressure from the BMA, GP practices have this week received supplies of PPE, including fluid repellent masks, aprons and gloves, but plans must be in place to monitor the situation to ensure these supplies continue to be adequate. However many practitioners are concerned that but the PPE provided is not of sufficient standard for regular exposure to infected patients and comparable to that provided in secondary care. Doctors need to be confident that they have the right standard of PPE as well as being able to use clinical judgement to know how much PPE is required, and GP practices must know they have easy access to as much as is needed to protect themselves and patients.

In hospitals, where the most serious cases will be treated, staff will need access to more sophisticated equipment. For example, caring for a single critical patient would require the use of up to 24 sets of PPE per day across all staff. It is critical that this level of PPE is available, so that staff can be safeguarded. Our key concern is that while the Government says it will implement a 'distribution strategy' for equipment once we reach the mitigation stage of planning, we need to make sure these supplies are in healthcare settings *before* they are needed. This extra time is vital so that equipment can be tested, so that staff have adequate time to be fitted so to ensure that this equipment is working at its most effective, as well as familiarising themselves with its use. Our experience to date suggests that PPE provision into secondary care is patchy at best.

Staff will also need to have the confidence that they will be properly protected from work-related risks of infection, both to ensure their own safety and to ensure that they do not transmit infection to their own families.

The BMA is seeking reassurance from the Department of Health and Social Care that all front line staff will have the correct protection they need and that it is fitted and tested in a timely fashion. We would ask that the committee raises this issue as a priority as part of its inquiry.

We are also concerned that given the increased risk healthcare staff will be subject to, that Death in Service and Ill Health Retirement benefits are available for all healthcare workers across the NHS, including non permanent staff, such as locum GPs. Death in Service benefit and Ill Health Retirement, as you will know, are the "Risk Benefits" that form part of the NHS Pension provisions. You will also know that many senior doctors from both primary and secondary care have been forced to leave the NHS pension scheme by large additional Annual Allowance taxation charges. These doctors now no longer have access to important benefits that would have offered them and their dependents financial security should they be unable to continuing working or die. These essential staff must be given immediate access to these benefits so as to restore these protections and allow them the confidence to continue to work in what may well be very adverse conditions.

Doctors need to be able to feel confident regarding all stages of the planning and delivery of patient care across the NHS in respect of Covid-19. They need confidence that they will be adequately protected from the risks of work-related infection, that they will be as well-resourced as possible to meet the challenge of patient care, that regulatory systems will give proper cognizance to the very adverse nature of the circumstances in which this care will be delivered, that doctors' time will not be expended on tasks and procedures that have no place in a crisis and that their employer – the NHS – will offer them proper provision should they suffer injury as a result of their work. At present such confidence is lacking.

I hope that highlighting these priority areas is helpful ahead of your next evidence session. The BMA is keen to continue to support your inquiry and would be happy to provide further written or oral evidence.

Yours sincerely,

Dr Chaand Nagpaul CBE
BMA council chair