About the BMA

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

This response to the Health and Social Care Committee and the Science and Technology Committee outlines the experiences and views of the BMA and its members in relation to lessons to be learned from the COVID-19 pandemic. We understand that both committees will be considering previous submissions made by the BMA to their earlier COVID-19 inquiries. Subsequently this submission seeks to address issues outside of those we have already raised in previous submissions.

Overview

- The BMA believes that the Government’s initial response to the pandemic was marked by a failure to adequately prepare for a major pandemic and lessons must be learned for the future.
- The UK did not implement NPISs (non pharmaceutical interventions) quickly enough, and once they were established, the country was then arguably re-opened too quickly. Had this not been the case there is a higher likelihood that transmission rates could have been slowed and outcomes improved.
- The effectiveness of Government messaging waned over the course of the epidemic and through several iterations of restrictions, causing initially high public ‘buy in’ to wane as the pandemic progressed.
- Widespread shortages of personal protective equipment demonstrated a systematic failure to adequately protect healthcare workers and patients.
- There were repeated delays to providing comprehensive population testing and tracing, including priority testing for healthcare workers and care homes, which caused significant issues and further impeded attempts to slow transmission rates.
- COVID-19 has exposed structural weaknesses in the NHS following a decade of underinvestment, including chronic workforce shortages and inadequate infrastructure in terms of beds, IT, estates and diagnostic equipment. This underinvestment must be reversed if the NHS is to recover from the pandemic and develop future resilience to public health threats.
- The decision to discharge all hospital in patients who were medically fit, many of whom to social care settings, without any testing was a major failure, putting vulnerable people at a heightened risk of infection.
- The pandemic also brought into the spotlight health inequalities which persist across the UK. There is an immediate need to improve the reach of health services to BAME communities and to address socioeconomic inequalities, so that existing health inequalities are not widened.
- Within the healthcare workforce, 61% of 200 healthcare workers who have died from Covid-19 have come from BAME backgrounds and over 90% of those doctors who have died from COVID-19 have also been from a BAME background, more than double the proportion in the
medical workforce as a whole. This is clearly significant and must be addressed to ensure lessons are learnt for the future to prevent such high fatalities occurring again.

- The BMA has significant concerns that outsourcing to private companies throughout the pandemic has not been effective and has not followed established standards. This has resulted in huge costs which often delivered substandard results particularly in the cases of PPE procurement and NHS Test and Trace.

1. Deployment of non-pharmaceutical interventions

1.1 The UK has recorded over 1.7 million coronavirus cases and the death count stands at 64,000. The figures for excess deaths during the first peak are even more alarming - between February and the end of May the UK recorded the highest per 100,000 rate of excess deaths in Europe. It is widely regarded that the UK did not implement NPIs (non pharmaceutical interventions) quickly enough. Countries that introduced lockdown style policies in a shorter timeframe after recording their first case tended to have a lower excess mortality.

1.2 The Government and SAGE initially appeared reluctant to implement the kind of policies that we were seeing across Europe such as a ban on mass gatherings and the closure of non-essential business. It was only after data from Imperial College London showed the impact uncontrolled spread would have on the health service and the potential mortality rate that the Government relented and imposed national restrictions. A more immediate reaction from the Government in the period between the UK recording our first case and the implementation of NPIs would have been live saving. The UK Government was also slow to advocate mask wearing as a population wide intervention, which other EU countries with a comparable infection rate did much earlier.

1.3 Once restrictions were implemented, data shows that public adherence was high and there was widespread public buy-in in for stay at home orders. The clear messaging produced by the Government at that point appeared to resonate with the public. This is in stark contrast to more recent figures produced by SAGE which estimate that only around 20% of people who report symptoms also report being fully compliant with isolation orders and staying at home. This demonstrates that the effectiveness of Government messaging waned over the course of the epidemic and through several iterations of restrictions. High profile figures breaking rules, different confusing iterations of restrictions and mixed messaging from the Government all contributed to the erosion of confidence and trust that individuals had in the Government and the willingness therefore to comply with restrictions.

1.4 The Government also arguably re-opened the country too quickly and did not use the respite to properly establish a functioning test, trace and isolate system. There are many lessons to be taken away from the UK’s public health response:

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3. BMJ, 'The UK's Public Health response to COVID', 2020: https://www.bmj.com/content/369/bmj.m1932
- The Government acted too slowly to the situation and was unprepared to deal with the scale of the pandemic.
- Government messaging, whilst robust at the beginning of the pandemic, was diluted and its credibility damaged by external events.
- National restrictions were too quickly lifted and there was no clear plan on how to keep infection levels down after exiting the first lockdown or manage a second wave.

2. NHS workforce preparedness
2.1 The pandemic shone a spotlight on longstanding healthcare workforce shortages, including across the medical specialties. While the Government effectively managed to re-engage retired healthcare workers to return and increase capacity by putting final year medical students onto contracts, it should not have come to this. Had the UK addressed these workforce shortages previously it would not have had to resort to these last-minute measures. The equivalent of 87,237 full-time vacancies persist across secondary care settings in the NHS. Staffing shortages exist across both medical specialities (7,502 doctors) and nursing (37,821). There are also 334 fewer FTE (full-time equivalent) fully qualified GPs between September 2019 and September 2020. In September 2020 there were 1422 fewer FTE fully qualified GPs than there were in September 2015.

2.2 These shortages undoubtably contributed to the pressure faced by the NHS workforce during the COVID-19 pandemic. It is vital that learning here is not lost and the Government explores how it may retain some of those returning healthcare workers. Improved and increased recruitment and retention of NHS staff must now take place to meet the needs of patients across the NHS. This includes at least a doubling of medical school places from the current figure of around 7,500 by the middle of the 2020s. Further information on NHS workforce shortages and its impact is available in the BMA submissions to the Health and Social Care Committee’s inquiry into NHS workforce burnout and resilience and the Comprehensive Spending Review.

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

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

3.3 Equalities considerations must be built into the commissioning and supply of PPE. The BMA has heard cases of doctors who wear beards for religious reasons being told there are no alternatives available to FFP3 masks and they must abandon their religious practice and shave, even though the HSE recognises that suitable alternatives like PAPR hoods should be provided.

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9 https://committees.parliament.uk/writtenevidence/11201/pdf/
There are also instances of women and those of different ethnicities struggling to find face masks that fit, and doctors who are deaf and reliant on lip-reading have highlighted the need for transparent face masks to be developed.

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

4. **The impact on the social care sector**

4.1 COVID-19 has placed enormous strain on health and social care services. In order to address increased demand, the Government announced actions to be put in place to redirect NHS staff and resources. These included urgently discharging all hospital in-patients who were medically fit to leave. This approach increased pressure on an already-stretched community and adult social care system. The situation was made even more worrying as many of these patients were sent back to care homes without a mandatory process being implemented for them to be tested for COVID-19 – thus potentially exposing many more vulnerable people to infection.

4.2 During March and April, discharges from hospitals to residential care homes were 75% of the historical average, while discharges from hospitals to nursing homes increased to 120% of the historical average. These decisions to discharge patients were made in an urgent and uncertain context but played a role in transferring risk to a poorly supported social care system\(^\text{13}\). One in five directors of adult social services believed that in general people were not discharged to the right place during the period of rapid discharge from hospital in the initial stages of the pandemic. This may have left some people without, for example, the reablement services that might help them regain their independence\(^\text{14}\).

4.3 Vulnerable older people and the workers caring for them, should never again be so exposed to infection as they have been in this pandemic. At least 40% of COVID-19 deaths in England and Wales occurred in care homes. Lessons must be learned from this; in future, it is essential that care homes are provided with appropriate and sufficient amounts of PPE. Patients should also not be discharged from hospital without ensuring that they have not tested positive for COVID-19.

4.4 Social care funding across the UK has not kept up with rising demand for services and costs are continuing to rise. It is crucial that substantial funding is provided to enable the sector to meet rising demand, whilst also improving services and workforce conditions, to ensure it is better prepared in future. This will cost an extra £12.2 billion in England in 2023/24\(^\text{15}\). Additional funding will be needed on top of this to ensure better access to care by providing more services free at point of need. An additional £5 billion would be needed in England, for example, to implement free personal care in 2023/24\(^\text{16}\).

4.5 It is also crucial that the social care sector expands its workforce. COVID-19 demonstrated the importance of this workforce and how they need to be valued and invested in. Workforce shortages are a major issue for the social care sector, with an estimated 122,000 vacancies in England alone\(^\text{17}\). As a low paying sector, social care staff should be provided with opportunities for salary and career progression. Ensuring social care employment terms and conditions mirror those of the NHS would help to improve the situation and improve retention and access to skilled personnel. Further detail of the current shortfall in social care resource is available in the BMA’s submission to the Health and Social Care Committee inquiry into social care funding\(^\text{18}\).

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\(^{18}\) [https://committees.parliament.uk/writtenevidence/6326/pdf/](https://committees.parliament.uk/writtenevidence/6326/pdf/)
5. Impact on BAME communities

5.1 The BMA has consistently raised concerns regarding the trend of the disproportionate impact of COVID-19 on people from Black and Asian Minority Ethnic (BAME) backgrounds. We have provided extensive evidence to both the Women and Equalities Committee and the Public Accounts Committee on the impact on the healthcare workforce and wider BAME communities, and calling for action on the interventions we know are needed to protect people now and in the future. We have also provided evidence to the Race and Ethnic Disparities Commission highlighting how the COVID-19 pandemic has emphasised ethnic disparities that have long persisted within our societies and institutions.

5.2 Within the healthcare workforce, 61% of 200 healthcare workers who have died from Covid-19 have come from BAME backgrounds. Among doctors, over 90% of those who have died from COVID-19 have been from a BAME background, more than double the proportion in the medical workforce as a whole. The BMA is concerned that differences in access to PPE, exposure to high-risk environments, and fear of raising concerns could have contributed to this disproportionate mortality. Since April, we have repeatedly called for data about healthcare worker deaths to be published, disaggregated by protected characteristic.

5.3 Urgent action is also needed to ensure that the NHS and public services generally foster a diverse and inclusive environment. We welcome goals to increase diversity in leadership within the NHS People Plan for 2020-2021. The BMA has called for the membership of NHS trusts and organisations to reflect the ethnic make-up of their workforces.

5.4 Medical education also has a role to play in helping improve health outcomes and the diversity of the healthcare workforce. It is important that the medical curriculum is diversified to reflect BAME patients and populations in clinical teaching to ensure doctors are able to deliver the best care to every patient. Such changes are also part of creating an inclusive learning environment as students and staff should be able to see themselves and their communities represented in what and how medicine is taught.

5.5 The BMA has also emphasised that the government’s Covid-19 response must engage with and gain the trust and confidence of BAME communities. It is essential that the government works with ethnic minority community leaders and organisations to disseminate public health information and improve the reach of health services to BAME communities. It is especially important that this lesson is reflected in the immediate term to encourage take-up of the vaccine, which recent research shows is lower among BAME groups.

6. Inequalities and mental health

6.1 The UK experiences severe health inequalities, with improvements in life expectancy slowing down: unlike most European and other high-income countries. Inequalities in life expectancy have also increased since 2010. As the response to COVID-19 has shown, a healthier nation is more resilient. The Government’s new obesity strategy was a good example of reactive public health, published only when it became apparent obesity was an indicator of poor health outcomes from COVID-19. The strategy had some welcome policy changes in it and included many of the asks from the BMA and other expert bodies, but it should have been enacted sooner.

6.2 Another area of concern is homelessness. The success of the ‘Everyone In’ initiative to house rough sleepers during the pandemic shows what can happen when there is the political will for

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19 Health Service Journal Deaths of NHS staff from COVID-19 analysed (April 2020)
20 This is based on information the BMA has been collecting based on media reports and our records.
21 NHSE (July 2020) We are the NHS: People Plan for 2020-21
22 Health Foundation Marmot 10 Years On (2020)
ambitious change. The impact of Government funding and urgency was remarkable, with 90% of rough sleepers reportedly offered accommodation to protect them from COVID-19. Funding from the initiative has now run out, and thousands of rough sleepers are at risk of sleeping in night shelters, unsuited for social distancing, or on the street. The BMA is calling for proper evaluation of any changes in practice or service delivery from 'Everyone In' to be sure lessons are learned and good quality data is gathered to ensure rough sleeping can be ended for good, and to meet the Government target to end rough sleeping by 2024.

6.3 Government has not properly recognised the effects of COVID-19 on mental health, sometimes referencing the issue as simply a case of increased poor mental wellbeing, as opposed to recognising the very real risk of increased mental illness, and the pressures this will place on the NHS. The relationship between physical or mental wellbeing and mental illness is significant. This is particularly the case during social distancing measures where people are perhaps unable to turn to usual coping mechanisms and support networks. Four in ten psychiatrists have reported an increase in people needing urgent and emergency mental healthcare, including new patients, in the wake of the lockdown\(^\text{23}\). Meanwhile, UK wide data from NHS Benchmarking published in October confirmed all specialties had more detained patients than in previous years as well as seeing a 19% increase in detentions under the Mental Health Act in acute beds over the summer\(^\text{24}\). The lesson here is that the Government must recognise the importance of public mental health.

6.4 A second lesson to be learned is to be taken from the evidence that some groups’ mental wellbeing and health have been more affected than others. Because those from the BAME community are at higher risk of both contracting and dying from COVID-19 than white people\(^\text{25}\), there are concerns across both the mental health and BAME charity sectors about the mental health consequences\(^\text{26}\). Worse mental health outcomes during COVID-19 could also be explained in part by the worse mental health outcomes before the pandemic; not everyone arrived at the outbreak with the same ability to ‘weather the storm’\(^\text{27}\).

6.5 The WHO has also warned that older adults, especially in isolation and those with cognitive decline or dementia, may also become more anxious, angry, stressed, agitated and withdrawn during the outbreak or while in quarantine\(^\text{28}\). What COVID-19 itself has taught us is that people’s experience of mental health support in this country is too variable.

6.6 In the short term, research must be conducted to establish which groups are at a higher risk of developing mental illness as a result of the COVID-19 outbreak. This will help to inform a public mental health approach that meets the needs of vulnerable groups. The BMA is also calling for local authorities to be given the money to double public mental health funding over the winter months.

7. Testing and contact tracing

7.1 Lack of testing capacity in the early stages of the pandemic meant we missed an opportunity to suppress the virus sooner. Testing capacity was initially slow to increase and has lagged behind other countries. In the initial stages, February and March 2020, the UK appeared to be slower in increasing its testing capacity compared to some other nations. When the Government decided in mid-March to stop local community testing and tracing, it is likely that from that point, the UK went to the back of the queues for testing kits, swabs and chemical reagents that all countries were competing to access. Problems noted during the process of increasing the UK’s testing capacity include:

\(^{23}\) Royal College of Psychiatrists press release (15.5.20) Psychiatrists see alarming rise in patients needing urgent and emergency care and forecast a ‘tsunami’ of mental illness.

\(^{24}\) https://www.hsj.co.uk/commissioning/exclusive-u-turn-on-mass-expansion-of-covid-care-units-as-no-funding-available/7028623.article


\(^{26}\) Mental Health Today (21.5.20) Coronavirus pandemic disproportionately affecting BAME people - here’s how your experiences could inform mental health care responses...

\(^{27}\) https://www.centreformentalhealth.org.uk/publications/commission-equality-mental-health-briefing-3

\(^{28}\) World Health Organisation press release (18.03.20). Mental health and psychosocial considerations during the COVID-19 outbreak.
Soon after it was launched on 2nd April, Prof John Newton, confirmed that the antibody testing kits that the UK had ordered, were not reliable enough to be distributed in the community.

The Government’s ‘super labs’ initially experienced both supply and logistical issues due to shortages of swabs and chemical reagents.

In May 50,000 coronavirus tests were admittedly sent to the US following operational issues in UK laboratories.

7.2 Outsourcing the coordination of testing to accountancy firms rather than people with knowledge of clinical operations also resulted in adverse effects: delays in delivering test results have been compounded by reports of lost test samples, leaking test vials and incorrectly labelled samples at testing sites. Hospital trusts have raised concerns over the logistical management of these privately run sites, and some have actively discouraged their staff from testing there.

7.3 Professor John Newton also attributed drawbacks to “data quality issues”, with Deloitte missing key information on the individual’s occupation and ethnic background, vital in establishing whether they were health workers or from BAME groups who have disproportionately burdened the disease. The lags in sharing data also made it difficult to understand local disease clusters. In addition to these concerning logistical hurdles, unions such as the BMA, Royal College of Nursing and Unison have all stressed that the discrepancy observed between testing capacity and numbers tested for the virus has largely been the result of rigid eligibility criteria and difficulties accessing the testing sites.

7.4 The accessibility of the 29 drive-through, appointment only, testing sites was widely reported as being problematic. Over the summer some people had to make round trips of hundreds of miles to reach their nearest centre. This journey is a challenge for those suffering from Covid-19 symptoms who are unable to use public transport and unable to ask anyone outside of their household to accompany them. In addition, the Government launched an online portal to allow key workers to self-refer to order home-testing kits for members of their household and themselves. However, the online portal failed at first to accommodate the demand for testing kits and therefore did very little to ease access to testing for key workers.

7.5 Earlier this year, the BMA published a report ‘the role of private outsourcing in the Covid-19 response’ that raised concerns about the level of outsourcing to the private sector to support the Government’s pandemic response strategy. The Government’s reliance on private outsourcing to deliver increased testing capacity and conduct contact tracing reflects a lack of investment in local public health services over the last decade. As a matter of urgency and because of the public health risk associated with COVID-19, many of these contracts were awarded under emergency procedures bypassing competitive tender, public scrutiny or demonstrating value for money. The underperforming test and trace system is just one example why serious questions need to be asked about how these contracts were set up and how this money was used. Contract arrangements with private providers do not require the company to share detailed information with PHE or local authorities. Rather, this information is held in central Government. Consequently, GPs and local authorities were reportedly unable to receive timely, detailed information on tests carried out in privately-run sites, despite Pillar 2 commitments that required companies to share data with patient medical records.

7.6 The current contact tracing system in England has also been falling short of the Government’s set targets. The NHS test and trace (NHSTT) system was introduced at the end of May 2020 with the objective to replace the national lockdown with localised responses to outbreaks of infection and considered a crucial component to the Government’s COVID-19 recovery strategy. The NHSTT programme has faced criticism for failing to reach set targets. Its performance appears

29 https://www.bbc.co.uk/news/uk-52603566
32 https://www.ft.com/content/a9d74c93-48a2-44a6-bf73-a4103c9101dd
stark in contrast with the success of local public health teams which are proving much more efficient at tracing contacts of positive cases. Challenges in the NHSTT appear to stem from the Government’s decision to develop a parallel, centralised system focused on private sector expertise. The Government has now recognised the need to integrate the national outsourced NHSTT programme with local systems. In August, it announced a major shift in its approach to COVID-19 contact tracing in England, by giving local council public health teams more responsibility and shrinking the national Test and Trace scheme. The BMA is calling for:
- Contact tracing to be led by well-resourced local public health teams
- Greater support for businesses and individuals to support adherence to self-isolation (at least living wage)

8. Government communications and public health messaging
8.1 Earlier this year, the BMA published principles for restarting non-COVID care, which reflected our assessment of the initial response to the pandemic and our views on what that response should look like in the future. While we recognise the challenges posed by the changing nature of the pandemic, we believe that Government communications and messaging have, in too many instances, lacked clarity, both in terms of what is expected of patients and about what NHS services they should still continue to seek. For example, patients need to be reassured that it is safe and appropriate for them seek emergency care from the NHS if they need it. Many appeared to be staying away due to concerns about contracting or spreading the virus, or even not wanting to “burden the NHS”. Sharing more information with the public about steps being taken to keep them safe, if and when they need to use the NHS, such as the use of different zones to keep patients who have or potentially have COVID separate from those who don’t, may in future help provide reassurance.
8.2 In some cases, communications from national bodies have even openly and actively undermined doctors and NHS staff battling the pandemic on its frontline, as with NHS England’s press release ‘reminding’ GP practices that they should be providing face-to-face appointments, despite the fact that GPs have been providing them throughout the entire pandemic wherever safe and needed.
8.3 Looking to the future, the vaccine roll out is undoubtedly positive. However, it is essential that communications regarding the vaccine are careful and manage expectations regarding its impact on transmission and its availability, to ensure that necessary public health measures are properly adhered to until such a time as a vaccine can be rolled out in full, and potentially beyond.
8.4 Equally, it is also important that the public understand that the recovery of NHS services will occur over a very extended time period, given the extent of the growing backlog in elective care. The NHS will need to become adept in providing clear information to clinicians and patients alike on the scope of services available and a timeline for restoration of further services and routes to access them, noting that this will be subject to ongoing change.

9. The UK’s prior preparedness for a pandemic
9.1 The UK’s ability to respond to the COVID-19 pandemic was severely hampered by the systemic underfunding and austerity imposed on the public health system in the years preceding the pandemic. The local authority public health grant has seen a real terms decrease of 22% since 2015/16. The BMA and others have now for some time called for an increase of at least £1 billion pounds to the public health grant to return funding to 2015/16 levels. In addition to this, it is crucial that health protection functions are adequately resourced. The health protection function of PHE only received between 20-22% of Public Health England’s operational budget in the year preceding the pandemic.

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35 https://www.bma.org.uk/media/2487/ten-principles.pdf
36 The Health Foundation (2019) Urgent call for £1bn a year to reverse cuts to public health funding.
9.2 Directors of public health and local public health teams should have been more involved in decision making both at the early stages and throughout the pandemic response. The result of this lack of involvement was poor data and expertise sharing between central Government and local Government and a lack of joined up decision making.\textsuperscript{37}

9.3 In August it was announced that PHE would be abolished and replaced with the National Institute for Health Protection (NIHP). While it remains to be seen whether the NIHP will make the health protection agenda more robust and better prepare the UK to deal with infectious disease in the future, the decision to abolish PHE during a global pandemic has raised serious concerns. There are also concerns at the lack of attention being paid to the health promotion and healthcare public health agenda, increasing general population health is by far the most cost effective and efficient way of increasing life expectancy and ensuring the reduction of non-communicable disease.

10. The development of treatments and vaccines.

10.1 Unlike the inadequate public health policy response, the UK’s biomedical response has been positive. The Recovery trial supporting the use of Dexamethasone, a corticosteroid that drastically cuts mortality in the most severely ill patients, was conducted by Oxford University and facilitated by the scale of the NHS allowing for the kind of large scale randomised control trial called for by the WHO and the EU medicine agency.\textsuperscript{38}

10.2 Equally the progress of the Oxford Vaccine, a joint project between Oxford University and the drug company AstraZeneca, has been very positive and is it is hoped that the vaccine will be rolled out alongside the Pfizer vaccine. The UK was also the first country to approve the Pfizer vaccine and to begin its roll out. While there will likely be some lessons to be learned as the roll out progresses, Government is working closely with healthcare providers in both secondary and primary care to facilitate a speedy rollout, focussing on the most vulnerable and health and social care workers as a priority.

\textit{(October 2021)}

\textsuperscript{37} FT, ‘Covid-19 unmasks weaknesses of English public health agency’, 2020: \url{https://www.ft.com/content/e149101a-1c93-4b0a-bc12-14ca8bf11b0e}