

Written evidence submitted by the British Medical Association (DEL0205)

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 inquiry sets out the BMA's views on what principles should be followed to ensure that the return to delivery of core NHS and care services which had been paused in response to the outbreak of COVID-19, is carried out in the best possible conditions for both NHS patients and staff as well as the wider community.

Overview

- The BMA is broadly supportive of restarting most core non- COVID-19 related care services at this time. This includes promoting both childhood and adult immunisations and reopening secondary care referral pathways. Government should urgently provide clarity on how referral pathways from GP surgeries into secondary care will be effectively reopened.
- The Government must put in place a credible strategy on testing. This should include, but not be limited to, increasing national testing capacity with the ability to test potential asymptomatic carriers where evidence suggests there are pockets of infection.
- Extensive rapid pre-operative COVID-19 testing of patients coming for elective surgery should be encouraged to help reduce need for PPE by allowing some theatre lists to be carried out with fewer precautions than an unscreened list.
- As core services are reintroduced it is important to ensure resource is still maintained for NHS acute and critical care, retaining the ability to scale up critical care capacity again should a second wave of the virus lead to a sudden spike in demand.
- It is likely that an increasing number of people will need mental health support due to a combination of factors including prolonged social isolation, increased rates of domestic violence, the impact of economic hardship and those coping with losing loved ones during the pandemic. A plan for resourcing this additional support should be part of the Government's next phase planning.
- Doctors and other healthcare workers have gone above and beyond to ensure the NHS can cope with the pandemic, working in intense and stressful environments for many weeks.
- To meet the wellbeing needs of healthcare workers employers need to ensure that staff are able to take time off, or if they would like to work flexibly are supported to do so.
- Healthcare workers should also be empowered to consider their own and colleagues wellbeing, with clear routes offered to access mental health support.

1. Introduction

- 1.1 On 29th April the Chief Executive of NHS England, Simon Stevens, wrote to NHS bodies in England setting out plans for the "second phase" of the NHS's response to COVID-19. This letter asked NHS bodies to step up non-COVID-19 urgent services and to make judgements on whether they have further capacity to restart at least some routine non-urgent elective care.
- 1.2 The BMA is broadly supportive of the aim of restarting core NHS and care services given the potential harm to patients if this is neglected for a prolonged period of time. However, caution is also needed – the NHS is still dealing with the incredibly difficult task of responding to COVID-19-related demand, and there will be risks and challenges in pivoting back to more routine care. We

must be realistic about how much “spare” capacity the NHS has, given that services have been stretched thinly in many areas to deal with COVID-19. Doctors and other healthcare workers have been going above and beyond to ensure the NHS can cope with the pandemic, and this means they have been working in intense and stressful environments for many weeks. It is vital therefore that steps are taken to safeguard the wellbeing of healthcare workers as part of this phase of the NHS’s response.

2. How to achieve an appropriate balance between coronavirus and ordinary health and care demand

- 2.1 The coming months will require the NHS to maintain a difficult balance between continuing to provide care for patients with COVID-19 whilst ensuring that as far as possible, services stopped or delayed due to the outbreak can begin again. This will be challenging due to the scale of the changes that have been required to ensure the NHS can cope with the pandemic, and there are a number of risks and challenges that will need to be carefully navigated.
- 2.2 Firstly, services must be careful to ensure they do not underestimate the ongoing need for critical care capacity, both for COVID-19 and non-COVID-19 patients. Prior to the pandemic, there was insufficient NHS acute and critical care capacity to cope with small increases in demand. The current ‘surge’ in critical care capacity was achieved through an unprecedented resource shift towards critical care at the expense of other parts of the NHS. Any return to elective treatment and other types of care will require this resource shift to be reversed.
- 2.3 Requirements for PPE and additional cleaning have markedly slowed down operating theatres. Extensive rapid pre-operative COVID-19 testing of patients coming for elective surgery may help to slightly reduce this by allowing some theatre lists to be carried out with fewer precautions than an unscreened list. There will, however, still be additional precautions required that will slow things down even once all theatres and recovery spaces are returned from surge critical care to normal surgical use.
- 2.4 Planning will need to be robust to protect against critical units being overwhelmed, as their capacity is reduced but elective and urgent care demand increases. This planning phase will require evidence based prioritisation to rank interventions,
- 2.5 The creation of separate, dedicated critical care facilities for COVID-19 patients to reduce hospital transmission presents obvious difficulties. These non-COVID-19 critical care patients will clearly need to be kept physically separate from those with the disease, so separate zones or even sites (each with their own staff) will be needed, further stretching limited resources.
- 2.6 In shifting some focus back to “ordinary” NHS care it is important that we retain the ability to scale up critical care capacity again should a second wave of the virus lead to a sudden spike in demand. Large temporary hospitals, such as NHS Nightingale London will reportedly be used for COVID-19 critical care in the event of a second surge in demand. However, it is unclear how these facilities will be properly staffed and equipped given reports of London hospitals being unable to transfer patients to NHS Nightingale due to the facility having insufficient critical care nurses over past weeks. It is also unclear how these facilities will provide critical care for COVID-19 patients with high frailty scores or co-morbidities, given that most of these temporary hospitals have been set up to provide step-down care or critical care to fitter patients.
- 2.7 Capacity was also created by discharging large numbers of patients back into the community, and there will need to be careful consideration of how general practice, social care and other community services will be supported as part of this phase of the Government’s response. Clarity is needed on how referral pathways from general practice into secondary care will now work, given that they have been significantly disrupted by the changes made to deal with COVID-19. GPs should be able to refer patients where they feel this is clinically appropriate, with triage taking place in secondary care to decide whether adequate capacity exists to take on the referral.

2.8 Finally, where private capacity has been block booked to support the NHS, clarity is needed on how this capacity will be effectively used, and consideration should be given to whether contracts need to now be extended to ensure the NHS can continue to use private capacity.

3. Measures must be taken to safeguard staff wellbeing

- 3.1 Following intensive levels of high workload, employers need to ensure that staff are able to take time off, or if they would like to work flexibly are supported to do so. A consistent and fair policy for staff using annual leave entitlement is needed which ensures that those who have worked for an extended period during the pandemic are able to take a break when they need it most. Staffing rosters must have cover for annual and sick leave built in to prevent unrealistic expectations of service capacity being built up.
- 3.2 More broadly, healthcare workers need clarity on their future contractual status and working arrangements. Many doctors and other healthcare workers have had to change their working patterns as part of the NHS's response to COVID-19. Some of these changes – because they were in response to a true emergency – have been extraordinary, including prolonged periods of duty, short notice changes without any predictability and involving extended periods away from home life, and most junior doctors having their training effectively put on hold. Where contractually agreed elements of doctors' roles have been temporarily suspended due to the pandemic – including vital elements of education and training, academic research, study leave, and professional development – these should be reinstated.
- 3.3 Where there is any suggestion that some employers might want to retain some of the changed work patterns that should inform part of a future negotiation where the presumed starting point is the pre-emergency arrangement. Alongside this, clarity is needed on how and when training programmes and timely career progression will continue, not just to give certainty to affected doctors in training, but also to ensure ongoing sustainable service delivery. In particular, we need early reassurance that the summer rotation will happen, and how. A new cohort of FY1s need to be accommodated and trained, and their predecessors need to move on to free physical and training capacity, as well as to continue their own careers.

4. Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak

- 4.1 According to NHS England figures, there was a 29% drop in numbers of people attending A&E departments in hospitals in March 2020. About 1.5 million patients attended, compared to nearly 2.2 million in March 2019. Emergency admissions were also down, falling by 23% on last March, to nearly 428,000. Data from the [Emergency Department Syndromic Surveillance System](#) reveal that daily attendances fluctuated between 16,000 and 20,000 in April 2019, whereas in April 2020 daily attendances dropped below 10,000.
- 4.2 In general practice, the total number of appointments recorded in GP practice systems has declined in March, from 6,026,140 in the first seven days of the month to 4,225,502 in the last seven days – a reduction of almost 30%. There was 1.66 million less appointments in March 2020 than there were in March 2019 (only a 6% decrease as the daily decrease in appointment numbers due to COVID-19 slowly happened throughout March 2020, most of the decrease happening at the end).
- 4.3 Depending on how quickly levels of demand return, we may see rising pressure in both primary and secondary care in the coming months. Services may also feel under pressure to make progress on reducing backlogs of work where these have built up in recent weeks but may not realistically have capacity to do this without putting healthcare workers under unsustainable levels of pressure.

- 4.4 Government need to develop a clear and effective communication strategy to inform the public about how and when to access services as they are restored. Any public facing information and guidance should be developed with patients input to ensure effectiveness and relevance to all population groups and reduce the risk of increasing health inequalities.
- 4.5 The communication strategy should include information regarding self-care and utilising current strategies to access care, such as virtual consultations used in general practice, to ensure increased strain is not put on an already overwhelmed NHS services. However, public safety must also be addressed by encouraging the public to access necessary services when needed, such as emergency care. Patients need to be reassured that it is safe and appropriate for them seek emergency care from the NHS if they need it, as many appear to be staying away due to concerns about contracting or spreading COVID-19.

5. Meeting extra demand for mental health services as a result of the societal and economic impacts of lockdown

- 5.1 Lockdown measures imposed by the Government continue to have significant consequences for healthcare workers, patients and the wider community. A recent review from King's College London found negative impacts of past quarantines on the mental health of both healthcare workers and the wider population. This is likely to be linked to the economic and social impact of lockdown. The economic consequences of the lockdown measures will also be felt more strongly by the most vulnerable groups in society. It is well reported that economic recessions can impact rates of child abuse, domestic violence, substance misuse, mental illness and suicide, which will create extra demand for mental health care and support.
- 5.2 It is, highly likely that an increasing number of people will need mental health support due to a combination of factors including prolonged social isolation, increased rates of domestic violence, the impact of economic hardship and those coping with losing loved ones during the pandemic
- 5.3 Many therapy services have been put on hold during the pandemic and even before this had long waiting times for care.
- 5.4 This will undoubtedly results in extra demand for mental health services, which were already under pressure prior to the crisis to meet the population needs. In the short term, some secondary mental health services have reported a decrease in referrals as the health service has reoriented towards responding to immediate impact of the pandemic. However, services will need to prepare for an increase in referrals once the NHS restarts routine care to normal levels.
- 5.5 The pandemic has exposed weaknesses in the resources available to mental health services even before COVID-19. A BMA report in January examined this in more detail.¹ It will be vitally important to fund mental health services to meet the increased demand. With the focus on acute services during COVID-19, mental health services risk taking yet another back seat in funding allocation. We are a long way from seeing parity of esteem for mental health services, and disparity risks becoming further entrenched.
- 5.6 In the BMA mental health workforce report from January, we found mental health services were already struggling with workforce shortages and high levels of demand. For example, it found that the mental health workforce has had little growth over the past 10 years, many of the key staff groups either remaining at a similar level since 2009 or declining.² We believe issues highlighted in the report are likely to be exacerbated if there is indeed a rise in mental health issues.
- 5.7 To avoid drawing the attention disproportionately away from prevention to acute services as a result of COVID-19 (whilst remaining sensitive to the immediate necessity of acute services),

¹ <https://www.bma.org.uk/what-we-do/population-health/mental-health/beyond-parity-of-esteem-report>

² <https://www.bma.org.uk/media/2405/bma-measuring-progress-of-commitments-for-mental-health-workforce-jan-2020.pdf>

adopting a 'mental health in all policies' approach will be crucial. This is of particular importance given concerns about the wider impact of lockdown on population health.³

- 5.8 NHS staff who are presenting with complex mental health conditions, such as PTSD-like symptoms, need to be able to access appropriate treatment. There is a real concern that with NHS mental health services already over-stretched and facing increased demand, they will not have access to the necessary support that they desperately need. We would be concerned over any such staff member's fitness to be in work and go back to 'business as usual'.
- 5.9 This pandemic has demonstrated the vital role occupational health services play in ensuring that NHS staff are appropriately risk assessed and protected with regards to carrying out their duties. However, availability of and access to occupational health services for NHS staff is inadequate and inconsistent, particularly for those working in primary care. The BMA has long called for all NHS staff to have access to occupational health services which are free, and comprehensive. See our [BMA report](#) for full recommendations.
- 5.10 It is critical that healthcare workers are able to draw upon the support of mentors and peers to process any trauma they have witnessed. Peer-level interventions play a crucial part in building and promoting a positive and supportive NHS culture. We welcome all doctors being able to access appropriately resourced mentoring and peer support.
- 5.11 Wellbeing support initiatives introduced to support staff during the pandemic should be available in the medium and long-term (as take up may not be immediate) and be accessible across different NHS settings (e.g. primary and secondary care).

6. Meeting the needs of rapidly discharged hospital patients with a higher level of complexity

- 6.1 As part of the emergency measures set out by the Government to tackle COVID-19, access to social care has been temporarily expanded. In order to respond to the increased demand for critical care the Government announced plans to redirect staff and services, which led to imposing the urgent discharge of all hospital in-patients who were medically fit to leave. The rapid discharge of these patients with complex needs is now putting increased pressure on the social care system.
- 6.2 It is crucial that the Government continues to support Local Authorities (LAs) and CCGs financially to enable them to cover COVID-19 related costs. There is a need to ensure that the £3.2bn provided to LAs actually and the additional £1.3bn provided to the sector to support hospital discharge make their way through to adult social care services and is not getting blocked at a local level. If care services are unable to operate as a result of the financial consequences of COVID-19, this will have significant impacts on patients, residents, staff and the wider community.
- 6.3 At all times local care providers should maintain the rights to make admissions based on their understanding of the type of care they have the capacity to provide and to protect existing staff and residents. It is therefore important for local commissioners to avoid making the provision of emergency funding conditional to the admission of COVID-19 positive individuals by local care providers.
- 6.4 Older residents in care homes are extremely vulnerable and some of the most at risk to COVID-19. It is absolutely crucial therefore there is widescale, accurate and systematic testing in care homes and community care settings and that those working in these environments have adequate PPE as a matter of urgency.

7. Providing healthcare to vulnerable groups who are shielding

³ New research commissioned by charity Alcohol Change UK has found that more than one in five (21%) adults who drink alcohol are drinking more often since lockdown began on 23 March <https://alcoholchange.org.uk/blog/2020/covid19-drinking-during-lockdown-headline-findings>

- 7.1 The government will need to ensure continued provision of shielding for high-risk groups with improved protection and support. Stricter social distancing rules for those at higher risk will be important. This should include advice on working from home (where relevant), advice and, where necessary, provision for having food delivered to their household and finally continued emphasis on strict social distancing when leaving their home.
- 7.2 Resources should be available to care homes and shielding patients to enable them to have full internet access and, if necessary, iPads or similar devices. This would enable reliable video consultations and facilitate care delivery over the coming months; help to address digital health inequalities; and help to keep vulnerable patients safe.

8. Supporting mass testing and vaccination once they become available.

- 8.1 As the restoration of non-COVID-19 services moves forward, the Government must put in place a credible and transparent strategy on testing. This should include, but not be limited to, continuing to increase national testing capacity. The tests used (both serum antibody and nasopharyngeal RNA-PCR swab testing) will need ongoing assessment of their sensitivity and specificity as population prevalence of the disease changes, particularly as several of the tests used have questionable validity. This assessment needs to be made transparently available to NHS providers who are relying on the accuracy of the tests to manage the safety of staff and other patients.
- 8.2 Patient testing must be expanded, particularly for vulnerable patients such as those in residential and nursing care homes, and for symptomatic and asymptomatic patients who are accessing routine care.
- 8.3 Alongside this a further significant increase in capacity is needed to enable much more widespread testing of whole communities – including the ability to test potential asymptomatic carriers where evidence suggests there are pockets of infection. Capacity is also needed to effectively track and prevent further spread of the disease through quarantining those with the virus wherever possible. To achieve this we need to increase funding for local public health services so that they can lead this next phase of the response to the outbreak. The BMA is concerned that outsourcing parts or all of these functions to the private sector will mean that the expertise and knowledge of local populations within public health services will be underutilised, and money will potentially be wasted.
- 8.4 For both staff and patients, it is crucial that a clear process is established for storing results consistently across primary and secondary care records as well as the Summary Care Record. As the scale of testing increases it is likely and increasingly apparent that tests will be administered by a range of different health and non-health care providers. Clear guidance on how their systems interact with NHS systems will be necessary and both quality and consistency in performance of standards such as test reliability, sensitivity and specificity of tests used; quality of interpretation and reporting, turnaround times and not least adequate swab samples. Where private sector testing operations fall short of the information governance (IG) and quality assurance standards of the NHS, contracts should be reviewed to ensure compliance with IG laws and regulations.