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HCSA
The hospital doctors' union

COVID-19: Learning from the first wave

Lessons for the NHS in the next phase and beyond

The ***professional*** *association and trade union for hospital doctors, wherever you are in your career*

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Within just a few months of the emergence of a new respiratory illness in China, everyday life in countries across the world has been transformed beyond measure. The scale and pace of this new threat has posed the greatest challenge to our National Health Service in its history.

The response of clinicians, support staff and volunteers has been exemplary. Without the unparalleled commitment and flexibility that staff have shown, our health service would have been overwhelmed and pushed to the point of collapse.

The NHS has been able to maximise its capacity through a range of initiatives including postponing planned care, cancelling annual leave and training, introducing high-intensity rotas, incorporating private sector capacity, and encouraging the return of thousands of retired clinicians. It should be acknowledged that this response has so far focused solely on the short-term and cannot continue indefinitely.

While political leaders have joined the public in applauding key workers, including those on the NHS front-line, we must be clear that these extraordinary efforts have not come without a cost. A number of our colleagues have already tragically lost their lives and scores more have made the journey from carer to patient.

Staff have been working long hours at high intensity in a profoundly distressing environment, while facing worries about their own safety. There are significant questions to answer about whether governments and NHS bodies did enough to keep NHS staff safe, particularly around the initial approach to testing and ongoing concerns about Personal Protective Equipment.

In April, the Health Secretary said that workers "must treat protective equipment like the precious resource that it is." He was wrong. The precious resource is our people and we should never again face pressure to work in an environment that is unsafe without the protection that they need.

In coming months, the NHS will have to catch up on thousands of postponed procedures and appointments at the same time as continuing to cope with the challenge of Covid-19. It will need to grapple with the challenge of providing care to a highly vulnerable group with complex healthcare needs, who will continue to require shielding from the virus. As we move towards winter, we will have to manage new outbreaks alongside winter pressures including seasonal influenza.

These challenges must be met by a health service which did not start from a position of strength. But perhaps the greatest challenge of all will be supporting the number of staff affected by this crisis over a longer period. We cannot simply move to a "new normal" and continue as we are in perpetuity. We cannot allow the legacy of Covid-19 to be a wellbeing crisis among NHS staff.

The purpose of this paper is to learn the lessons from the first stage of our response to the virus and to set out some of the key challenges that we will face. It does not seek to attribute blame in hindsight, but rather provides an honest assessment from the front line of the challenges that we have faced and those that we are likely to face in coming months and years.

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How the NHS adapted

How prepared were we?

1. Learning lessons for the future

1.1 HCSA would expect a future public inquiry to examine our preparedness for a pandemic as well as the response to it.

1.2 It is clear that we have paid the price of insufficient preparedness and decisions based on risk assessments which appeared adequate on paper - in particular when cost was a driving factor - but which, when tested by the kind of real-life pandemic which experts had warned of for many years, were naive and wholly inadequate. The cost of these decisions in human and economic terms is already clear – we must never again fall into this trap.

1.3 However, this paper does not intend to allocate blame with the benefit of hindsight, but rather to ensure that the correct lessons are learned and the NHS continues to meet the needs of patients.

1.4 Doing so will help us to better prepare for any future Covid-19 wave, but also acknowledge the interplay with pre-existing and new challenges which face now the NHS.

2. How the NHS has adapted

2.1 There can be little doubt that a vast amount of work was undertaken by the NHS in an extremely short space of time.

2.2 This was achieved through the commitment and hard work of all those working within the NHS who, when presented with an unavoidable challenge at extremely short notice, were able to

overcome all the usual limitations that prevent rapid transformational change in normal conditions. Clinicians proved themselves at local level with a huge effort to plan reconfigure services which could not have taken place without their expertise and dedication.

2.3 However, the kind of measures adopted are only sustainable for a short period in the face of an initial peak. It is often said that climbing down a mountain is much more dangerous than reaching the summit and, in a similar vein, unwinding these measures and putting in place longer-term solutions could present an even greater challenge than the initial response.

2.4 Broadly, the NHS responded to Covid-19 by taking a number of steps at unprecedented pace:

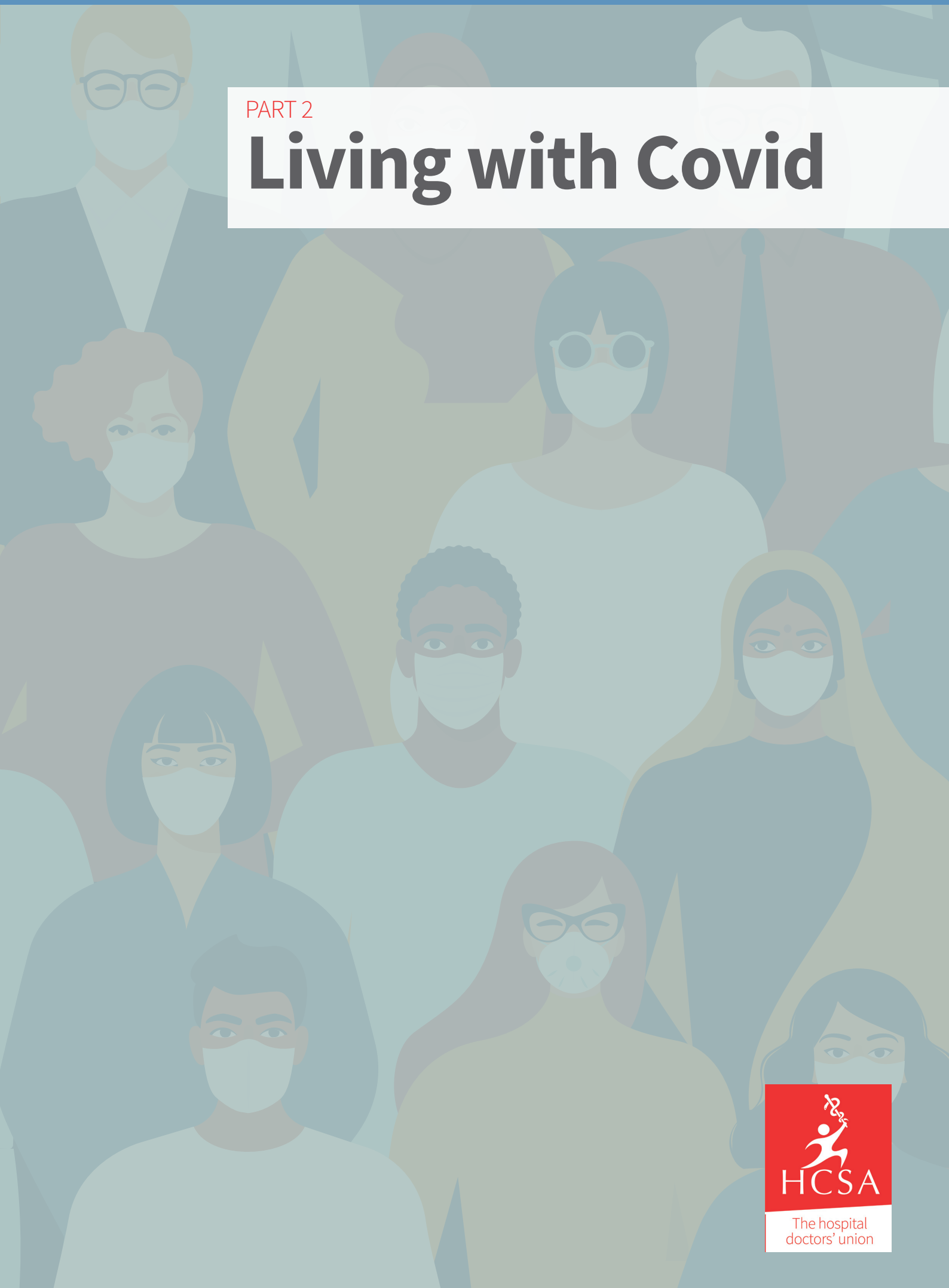
a) Changes to work patterns and intensity
b) Discharging medically fit patients
c) Diverting/postponing planned care
d) Creating extra critical care capacity
e) Bringing in retired staff, medical students and volunteers
f) Incorporating private sector capacity into the NHS

2.5 Although there is talk in some quarters of an "exit strategy," in reality we may be facing a medium-term future where we will need to balance a continued response to Covid-19 with the resumption of a range of other services. We need to create the flexibility to rapidly increase and decrease surge capacity, while meeting the challenges of social distancing and infection control, and the needs of "non-Covid" patients. The changes forced by Covid-19 will be here in some shape or form for the foreseeable future, but not all the time and not everywhere.

2.6 Crucially, we need to avoid the shift to a "new normal" where long-term staff wellbeing, with all its attendant risks and issues for the NHS, is the loser in the face of these huge competing demands.

PART 2

Living with Covid



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Living with Covid: Lessons from the first wave

3. Routine hospital procedures in a Covid world

3.1 NHS Trusts were instructed[1] to halt all non-urgent work for at least three months from 15th April to free up capacity in the system, although many hospitals began to take steps before this date. Importantly, critical work continued to take place, including emergency procedures and urgent cancer operations.

3.2 This was a necessary step that HCSA lobbied for, but while some of this work has been undertaken through the use of rapidly established virtual clinics and telephone services, procedures like hip replacements and cataract operations clearly cannot be carried out remotely.

3.3 Just 916,581 people in England attended any kind of A&E unit in April 2020, which was the fewest since records began in 2010 and down 57 percent on April 2019[2]. It is clear that an element of this reduction in demand came from people in potentially life-threatening conditions who may not have accessed the care that they need. It is also likely that many other people have been putting off seeking treatment for as long as possible and could potentially be in worse condition as a result.

3.4 The summer months have traditionally been an opportunity to drive down backlogs in the system following the winter. This will be far harder to achieve this year even without a second wave of Covid-19.

3.5 With waiting lists for non-urgent operations already standing at record levels[3] prior to the pandemic, the cancellation of this work has created an unprecedented level of latent demand. The waiting list in England stood at 4.24 million in March and it is possible that this figure could reach 10 million by the autumn.

3.6 All of this demand will need to be addressed in the coming months and years. The government in its recovery strategy states it will "continue to increase NHS and social care capacity to ensure care for all Covid-19 patients while restoring 'normal' healthcare provision."[4]

3.7 But this will be no easy task.

3.8 Hospitals have already been urged by NHS England to seek to increase "non-Covid" procedures. Pressure for this will intensify as the months progress and waiting lists increase.

3.9 However, it is essential that we resist the temptation to try to increase capacity without considering necessary adjustments and accepting the reality that capacity must remain reduced for the foreseeable future. Attempting to tackle the backlog without learning the lessons of the first wave has the potential to far outweigh in terms of damage and danger any expected benefits of increasing capacity.

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[1] Department of Health and Social Care (2020) *Coronavirus (COVID-19): hospital discharge service requirements*. https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements

[2] NHS England and Improvement (2020) *A&E Attendances and Emergency Admissions*. https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

[3] BBC News (2019) *Hospital waiting times at worst-ever level*. https://www.bbc.co.uk/news/health-50397856

[4] https://www.gov.uk/government/publications/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy

4. There is no such thing as a 'non-Covid' facility

4.1 We must be clear – while we can mitigate some of the risks through proper precautions, SARS-CoV-2 remains a highly infectious virus. Studies into its impact on patients undergoing even routine procedures highlight a significantly higher risk of mortality associated with contracting the disease[5].

4.2 While some practical steps, such as screening tests, cleaning and the physical separation of care between those known to have Covid-19 and those thought not to, will lessen the chance of hospital-acquired (nosocomial) infection in our hospitals, there remains a high chance that we will see continued infection even in areas designated "non-Covid".

4.3 In mandating guidance around the use of personal protective equipment (PPE) for staff, patients and visitors, and infection control, it is therefore essential that, for the foreseeable future, all hospital facilities are treated as potential Covid-19 positive sites.

4.4 We must not allow a misplaced sense of security which may come with the label "non-Covid" to turn into complacency or be seen as an opportunity to lessen safety protocols which place strain on budgets and supplies. The risks to patients and staff in the case of an outbreak are far too great.

4.5 HCSA is clear that there is currently no such thing as a "non-Covid" facility – there are only Covid-confirmed facilities and Covid-unknown facilities.

5. Protecting our most precious resource – NHS staff

5.1 There can be no move towards a "new normal" where NHS staff are expected to continue to work at an unsustainable intensity in perpetuity.

5.2 Staff have had to continuously work at high intensity to support exceptionally ill patients, needing intensive therapy with a high level of deaths. They have faced the "moral distress" of having to provide a standard of care lower than they would want or trained for because of unparalleled demand and inadequate staffing levels. They have had to do so while facing exhaustion, fatigue and burnout caused by long-hours and the intensity of shifts.

5.3 There needs to be an urgent evaluation of the effects of Covid-19 on staff mental health and well-being, to inform a plan to ensure that the most severely impacted staff are able to access intensive support at an early stage.

5.4 Steps should be taken to ensure that appropriate levels of rest leave and annual leave can be taken by all staff and particularly by those who require it most. This should include staff who have worked long-hours at high intensity throughout the crisis, or who are suffering the effects of stress or burnout.

5.5 It is essential that NHS trusts and hospitals do all they can to mitigate the impact of high intensity work on the physical health of staff. This should include a recognition that the most intensive rotas must only be used when there is no other option and only for as long as they are required.

5.6 All staff who present with symptoms of mental health conditions, including post-traumatic stress disorder, should have an Occupational Health assessment.

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[5] Guardian (2020) *Up to 20% of hospital patients with Covid-19 caught it at hospital.* https://www.theguardian.com/world/2020/may/17/hospital-patients-england-coronavirus-covid-19

5.7 And as we move towards the next stages of our response to the virus, including a potential future Covid-19 wave, we must ensure that staff can get regular, planned, rest and respite at work, annual leave and a full work-life balance.

5.8 We highlight elsewhere in this paper the underlying staffing shortages which have been exposed by this crisis and bridged through the implementation of punishing emergency rotas.

5.9 Given the continuing threat from Covid-19, pressure from rising waiting lists must not be used as justification to keep NHS "running hot" on emergency working patterns. Doing so will risk breaking the staff who are vital to the long-term success of the NHS response.

6. Funding for Covid-19 care

6.1 HCSA is extremely concerned that the government appears to have rowed back on funding pledges made early on in the Covid-19 pandemic to provide "whatever it takes" to the NHS.

6.2 The crisis has seen health workers placed onto punishing emergency rotas for weeks on end, at times without a clear rationale and with no clear accompanying policy from the centre on pay rates.

6.3 While healthcare workers remain focused on patient need, and indeed have made great sacrifices to deliver care in exceptionally difficult circumstances, they have faced uncertainty and a postcode lottery when it comes to wages for the many additional hours worked.

6.4 The government has rejected approaches by national employer and staff bodies to underwrite a consistent payment structure at a national level, preferring to devolve this decision to individual employers. However, it has not provided a funding package to meet the payments, rowing back on its "whatever it takes" pledge.

6.5 This has seen hospital doctors merely asked to note down their hours in the hope a solution will emerge. We are now told there will not be. As NHS employers assess the winding down of emergency rotas – something which may only prove a temporary respite if we experience a second spike – we have a window of opportunity to resolve this issue.

6.6 The government should reengage with employers and staff representatives to ensure a standard pay policy is put in place which would be applied fairly in any future Covid-19 peak, whether local or national, whenever these punishing emergency rotas are implemented.

6.7 This would reward NHS staff fairly for their hard work, but also act as a disincentive to employers which would help to ensure that front-line are not forced onto emergency rotas without clear justification and without a clear end date.

6.8 While we appreciate the demands on the health service as a result of the Covid-19 crisis, it is only possible to drive our health workers so hard before they break and the care that they deliver becomes unsafe. Emergency rotas must be reserved only for emergencies, while those working them should also be paid fairly for the long shifts and extremely difficult working conditions into which they are placed.

7. Winding down the initial response

7.1 It is clear that whether their access to services was reduced, or whether they voluntarily decided to stay away, a substantial number of patients will have suffered adversely as a result of decisions

taken to contain the virus. It is therefore vitally important that as many services as possible are re-established as soon as this can be achieved in a safe and sustainable way.

7.2 Yet decisions around when to attempt a return to "business as usual" for NHS services will prove extremely difficult.

7.3 At all stages, the risk of delaying the reopening of services must be balanced against the possibility of a spike in nosocomial infections with catastrophic outcomes for patients. Issues such as testing and PPE availability must be resolved before any substantial progress can be made on the reestablishment of services.

7.4 Work will need to be carried out by NHS leaders at pace in order to resolve the challenge of how to manage the balance between tackling ongoing demand related to Covid-19, and "ordinary" healthcare demand in a way that maximises overall patient benefit and minimises the risk of patient harm identified above.

a) The continuing status of private-sector capacity should be clarified as soon as possible, including detailed planning on how this will be wound down.
b) The role of Nightingale hospitals should be set out, including how the facilities will be properly supplied, equipped, and staffed.
c) Guidance should be provided on the continuing role of returning retirees, including GMC licensing if their presence continues beyond the "emergency" stage.
d) Updated PPE and infection control guidance should be published, including information on the segmentation of designated "non-Covid" settings.

7.5 Detailed planning for the gradual reinstatement of routine work should be published as soon as possible, including provisions for subsequent peaks in demand. Such plans should set out when and how sufficient PPE and testing capacity will be secured to ensure that services can be delivered safely.

8. Reducing transmission in our hospitals

8.1 As we continue to meet the challenge of this virus while attempting to tackle the backlog of "non-Covid" cases, it is essential that guidance for healthcare settings is not diluted.

8.2 PPE will be required at current levels for the foreseeable future. The recent serious Covid-19 outbreak at Weston General Hospital and a smaller outbreak among staff at the Royal Lancaster Infirmary underline the dangers which persist within healthcare settings.

8.3 In order to reduce transmission, there must be a clear restatement of the current national guidance and the need for hospitals to supply PPE at current levels.

8.4 HCSA urges the following steps to reduce the impact of Covid-19 for the foreseeable future, in particular as lockdown measures are loosened in the wider population:

a) The use of physically separate locations to treat Covid and "non-Covid" patients, reconfiguring services to use separate hospital sites wherever possible
b) The retention of current guidance on PPE for the foreseeable future, including the continued deployment of facemasks and face coverings by all individuals in all areas of hospitals to reduce transmission
c) PCR screening of all patients. This should take place at least twice a week for longer-term patients in order to mitigate the known shortcomings of the test in detecting positive cases.

d) PCR screening of staff. It would be optimal to test all hospital staff twice a week, but, where this is not possible due to capacity, regular testing across all hospital staff should take place as frequently as capacity allows to aid the early identification of possible nosocomial infection.
e) Compulsory 14-day isolation for all assumed "non-Covid" patients prior undergoing a hospital procedure, and an accompanying education campaign to underline the need for compliance with this measure – particularly evidence of significantly increased risks of fatality among Covid-19 positive patients undergoing or recovering from routine operations.
f) PCR testing prior to admission and, as technology for rapid and more mobile PCR testing and results develops, as near to their point of admission as possible.

9. Better and clearer guidance

9.1 Throughout the Covid-19 crisis, our members have raised concerns consistently about a lack of clarity round the correct guidance for the use of PPE. While responses to HCSA snap surveys demonstrated an improved understanding as time elapsed, hospital doctors remained concerned about a complex and contradictory network of ever-changing advice. This is compounded by inconsistent implementation at local or even departmental level.

9.2 Alongside guidelines at a local level and from professional bodies, the Government confirmed in response to a parliamentary question[6] that there were 21 separate updates to the Covid-19 infection prevention and control guidance between 1st January and 7th May alone. Multiple policies have often been adopted within the same hospital and there is a perception that the guidance used has often reflected supply rather than safety.

9.3 It is now essential that we reflect on this experience and learn the lessons for the future. As we move forward and begin to re-establish services alongside management of Covid-19, it is crucial that distancing measures are strictly adhered to. This would be greatly aided by unambiguous national guidance about the continued need to adopt social distancing measures.

9.4 Unfortunately, recent choreography surrounding the relaxation of lockdown measures has continued to be erratic and with insufficient regard for the requirements to ensure a consistent message across the healthcare system.

9.5 A recent example of shielding patients highlights this issue, where refreshed guidance issued to front-line doctors was contradicted without notice 48 hours later by advice issued from the centre, apparently with no consultation.

9.6 Elsewhere, debate continues over the pace and scale of the wind-down measures. Ultimately the wisdom will be measurable only after the event.

9.7 HCSA was clear from the beginning that simple, unambiguous advice was necessary. After expressing concerns publicly on a number of occasions, on 26th March HCSA President Dr Claudia Paoloni wrote to Public Health England[7] to call for urgent updates to guidance. This included ensuring that staff and patients are mandated to wear surgical masks both in clinical and non-clinical areas and tightening PHE guidance to fully comply with advice from the World Health Organisation.

[6] *Coronavirus: Protective Clothing: Written question – 38606.* https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-04-21/38606/
[7] HCSA (2020) *HCSA requests urgent strengthening of PPE guidelines*. https://www.hcsa.com/covid-19/latest-updates/2020/03/hcsa-requests-urgent-review-of-guidelines-by-public-health-england.aspx

9.8 New guidance was subsequently published on 2nd April 2020[8], which was significantly clearer and more comprehensive than previous iterations. Importantly, it also belatedly acknowledged the existence of sustained community transmission, meaning that all patients were finally recognised as being possible Covid-19 cases.

9.9 However, it is to HCSA astonishing that it was not until a further revision in early June that the government acted to shift guidance for face coverings hospitals fully behind the HCSA position, which was based on evidence in other countries. It is not yet clear what impact this delay may have had on nosocomial infections, nor is it clear why there was such a significant delay in enacting this change. However, it does again give the impression that supply rather than safety was an important factor in formulating policy.

9.10 The interaction between supply and safety guidance was formally recognised on 17th April when Public Health England issued guidance on "considerations for acute PPE shortages[9]." We remain concerned that considerations about supply have played an important role in the formulation of guidance on other occasions.

9.11 However, this guidance remains deficient in a number of key respects. One key concern is that while the Resuscitation Council UK has issued clear guidance[10] that Cardio-Pulmonary Resuscitation (CPR) is an Aerosol Generating Procedure, which would require higher standards of PPE, Public Health England continue to state that respirator masks are not required.

9.12 This conflicting guidance has led to a mixed picture across the country, with some NHS Trusts following the lower standards set by PHE. HCSA have consistently lobbied PHE to err on the side of caution and update its guidance to ensure that staff are not left at risk.

9.13 We are clear that moving forward, PPE guidance should only ever focus on best practice for safety, rather than the availability of items. Front-line clinicians should also be actively engaged centrally and locally in the formulation of guidance to ensure that it is more closely related to the realities that they face.

9.14 The priority for guidance must be to prevent a future resurgence of Covid-19 while the NHS begins to deal with an increasing number of "non-Covid" cases.

9.15 One key area of wider debate has focused on the wearing of facemasks by the wider public.

9.16 Wider use of facemasks has the potential to reduce transmission by the wearer, and by extension reduce the chance of another surge in cases overwhelming hospital services. Recent WHO guidance has also highlighted some protective benefits for the wearer. The government has already on its own web pages published a sewing pattern advising the public how to make their own mask[11]

9.17 HCSA has not promoted a public position on the wider use of facemasks, but we are clear that the final judgement on advice must be stated clearly and firmly and it must be based on the best

[8] Public Health England (2020) *COVID-19: infection prevention and control (IPC).* https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control
[9] Public Health England (2020) *Considerations for acute personal protective equipment (PPE) shortages.* https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe
[10] Resuscitation Council UK (2020) *RCUK Statement on PHE PPE Guidance.* https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/statement-on-phe-ppe-guidance/
[11] Public Health England (2020) *Instructions on how to wear and make a cloth face covering.* https://www.gov.uk/government/publications/how-to-wear-and-make-a-cloth-face-covering

scientific evidence rather than cost or economic concerns. Available evidence points to the fact that facemasks have an important role to play in reducing transmission of Covid-19.

10. Supply of adequate PPE for all NHS staff

10.1 Clearly because of the global nature of the pandemic, supply of PPE became extremely challenging at an early stage. Consideration of the international supply chain is beyond the scope of this paper, as is determining the adequacy of stockpiling ahead of the pandemic, particularly in response to the lessons of Exercise Cygnus. Both of these issues will no doubt be key considerations for the future public inquiry.

10.2 It is however clear that there was not sufficient transparency to determine the adequacy of national stocks at any given point and there were serious supply issues at a local level. This led to a situation where 44.5 percent of our members told us that they had purchased their own PPE, 37 percent told us that their Trust did not have adequate of long-sleeved gowns and 47 percent said the same in respect of full-face visors[12].

10.3 While the ingenuity of clinicians and local businesses in dealing with supply shortages is to be applauded, it is also an indictment of a serious systemic breakdown which exacerbated international supply issues. Because of the lack of national transparency or a coordinated approach, hospital departments have been unable to allocate PPE in a planned way. As the time and quantity of future deliveries were unknown, the response within hospitals was often to ration the use of vital items of PPE, often, as it transpired, unnecessarily.

10.4 The communication of issues relating to PPE at a national level was at times lamentable. When the primary requirement was for a comprehensive reflection of the current position to be communicated at all levels, what was instead provided was empty assurances of adequate supplies and ambitious announcements about future shipments, which subsequently failed to meet safety standards[13].

10.5 If similar issues around supply occur during our continued response to Covid-19, or at any other point in the future, the role of national leaders should be to ensure that gaps in supply are publicly acknowledged and the reasons for that clearly set out along with the steps that are being taken to resolve the situation.

10.6 Amidst a deeply concerning situation, in which 87 percent of hospital doctors responding to a survey[14] told us that they did not feel safe attending work, the Health Secretary warned staff not to "overuse" equipment and to "treat PPE like the precious resource it is."

10.7 We are clear that staff are the precious resource.

11. Additional protection for vulnerable NHS staff

11.1 A Public Health England analysis[15] of the factors impacting on outcomes for Covid-19 has confirmed higher risk for older men in general, and Black, Asian and Minority Ethnic (BAME) members of the population of all ages in particular.

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[12] *HCSA snap survey – 7 April 2020*

[13] BBC News (2020) *Coronavirus PPE: Gowns ordered from Turkey fail to meet safety standards.* https://www.bbc.co.uk/news/uk-52569364

[14] HCSA snap survey – 23 March 2020

[15] Public Health England (2020) *Disparities in the risk and outcomes of COVID-19*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891116/disparities_review.pdf

11.2 The latter has been reflected in the alarming trend in healthcare settings where more than 90 per cent of doctors who have died have are from a BAME background, many of them also older and male.

11.3 A separate report from the Office for National Statistics (ONS)[16] clearly demonstrates the disproportionate impact of Covid-19 more widely on people from BAME backgrounds. This was still the case even after adjusting for a range of factors including age, other socio-demographic characteristics and measures of self-reported health and disability. The methodology of the ONS research also states that "occupations involving close contact with the public are deemed to be a risk factor for Covid-19 infection."

11.4 Given the increased risk to which healthcare workers are exposed by virtue of their close contact with patients, including Covid-19 positive cases, it is vital that personalised risk assessments are undertaken for all staff and must be amended when areas or patterns of work are changed. The assessments must consider all factors which could give rise to additional risk and this must include ethnicity. Risk assessments should also consider the cumulative impact of several risk factors and where necessary should recommend redeployment away from patient-facing duties.

11.5 Guidance should be issued by NHS Employers to prevent job plans being agreed which are directly or indirectly discriminatory. Doctors must not be treated adversely either financially, or in terms of development opportunities, because of steps taken as a result of their susceptibility to Covid-19.

11.6 HCSA also firmly believes that one crucial issue which warrants further examination is whether an element of this apparent increased risk factor is related to BAME workers being treated disadvantageously by their employers, or the perception that they may be treated disadvantageously if they seek to exercise their rights at work. This could include considering whether requests for risk assessments or additional PPE by BAME workers are more likely to be refused, or whether those requests are less likely to be made because of fear of adverse treatment.

12. Monitoring and testing for SARS-CoV-2, the causative agent for Covid-19

12.1 Testing has at times dominated the narrative over recent months, with the volume of tests often the focus. HCSA has focused consistently on the quality and appropriate use of tests, and continues to urge a cautious approach, in particular around false negative polymerase chain reaction (PCR) test results.

12.2 The arrival of antibody tests is an extremely welcome step, but we are clear that no steps should be taken based around a presumption of either short or long-term immunity until a significant body of reliable scientific evidence is in place.[17]

[16] Office for National Statistics (2020) *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020.*
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

[17] British Medical Journal, *Rapid Roll out of SARS-CoV-2 antibody testing – a concern: 24 June 2020.*
https://www.bmj.com/content/369/bmj.m2420

13. PCR tests

13.1 PCR tests were introduced at an early stage of our response to Covid-19 and were initially used for all suspected cases. However, on 12th March the government restricted testing to those who were admitted to hospital[18], before gradually increasing the number of groups eligible for testing.

13.2 PCR tests, often described as antigen tests, detect the genetic information of the virus, which is only possible when someone is actively infected. They can provide a good indication of who is infected so that they can be managed appropriately, including through the use of isolation and contact tracing. However, errors can occur at several stages of the PCR testing process, which gives rise to a false negative rate of up to 30 percent. This means that they are more useful for confirming the presence of an infection than in giving someone the all-clear in a suspected case.

13.3 On 17th March, NHS England and Improvement set out a plan[19] to establish targeted staff testing for "symptomatic staff who would otherwise need to self-isolate for seven days." HCSA expressed concern at the time at the use of PCR tests for negative screening for staff, as the significant false negative rate could lead to test-negative cases returning to work and spreading the virus to colleagues and patients. Therefore, clearly without repeat PCR testing to confirm a negative result, staff should not at any point have been told to return to a clinical setting. HCSA is aware of hospital staff having received a negative PCR test result, returning to work, and subsequently testing positive for antibodies.

13.4 HCSA considers openness around the efficacy of tests an essential component in order to ensure they are used as part of an effective regime. This becomes particularly important when they form part of the regime used pass individuals fit to mingle in public, educational or workplace settings including hospitals.

13.5 A report by the Mayo Clinic[20] is clear about the risks presented by false-negative results: *"as tests become more available, observing principles of evidence-based clinical reasoning concerning the meaning of diagnostic tests is essential. For negative tests in particular, failure to do so has direct implications for the safety of the public and health care workers and for the success of efforts to curb the pandemic."*

13.6 To date crucial data around test sensitivity, in particular, has been glaringly absent. Responding to written parliamentary questions from MPs[21], the government has refused to provide details of the manufacturers of the tests in use, their false negative rates, or the names of any tests no longer in use. The only reason that has been offered for this refusal was "commercial confidentiality."

13.7 Public Health England belatedly, after much prompting, released details of its own "rapid assessment" of the tests[22], but these are based on very small sample sizes in a laboratory setting, and seem to make no assessment of the potential for false negative results (meaning someone who has the disease is not picked up by the test).

13.8 This remains an issue of real concern. As we enter what may be a very short-term lull or seasonable pause in Covid-19, it is essential that we put in place necessary safeguards to mitigate any shortcomings in the PCR tests being used.

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[18] Prime Minister's Office (2020) *PM statement on coronavirus: 12 March 2020*. https://www.gov.uk/government/speeches/pm-statement-on-coronavirus-12-march-2020

[19] NHS England and Improvement (2020). *Letter to Chief Executives of NHS Trusts and Foundation Trusts.* 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

[20] Mayo Clinic (2020) *COVID-19 Testing: the threat of false-negative results.* https://www.mayoclinicproceedings.org/article/S0025-6196(20)30365-7/pdf

[21] *Coronavirus: Screening: Written question – 41079*. https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-04-28/41079/

[22] Public Health England (2020) *COVID-19: PHE laboratory assessments of molecular tests.* https://www.gov.uk/government/publications/covid-19-phe-laboratory-assessments-of-molecular-tests

13.9 PHE's own guidance underlines that a single negative test is not proof that someone does not have Covid-19. This raises the prospect that, for instance, individuals should be expected to have a repeat test within 72 hours. While this would slow return to work for those who are indeed negative, if a more stringent regime were to prevent even one outbreak or a wider resurgence of the disease then it must be worth applying.

13.10 We can only speculate as to whether the official reluctance to reveal the precise effectiveness and even identity of the tests being used was linked to pressure to meet ambitious political targets. However, our concern relates directly to front-line medical staff, their colleagues and patients.

13.11 Our call to government is therefore for urgent transparency on this vitally important issue.

13.12 If the tests are inadequate then there should be a clear and transparent acknowledgement of this, and guidance should be reviewed to ensure employers are able to fulfil their legal obligations on health and safety.

13.13 This will also be essential to the success of the "test and trace" system.

14. Antibody tests

14.1 Unlike PCR tests, which can indicate whether an individual is currently infected with the virus, antibody tests indicate whether someone has previously been infected. They cannot provide an immediate picture because the antibodies are generated after a week or two, after which time the virus should have been cleared.

14.2 When confirmed, the arrival of an effective antibody test is to be welcomed and will no doubt hugely aid our ability to detect those who have previously been infected by Covid-19. As we learn more about the role of antibodies, this could open the door to different ways of working and reduce the level of risk to NHS staff by allocating those who have had the virus to care for Covid-19 patients.

14.3 However, huge uncertainties remain while we do not know the level and length of any immunity which antibodies will offer. While so much is unknown, the new test's arrival should not simply be seen as a green light to reduce PPE and other protections for NHS staff who test positive.

14.4 Only when there is a significant body of reliable scientific evidence should a conversation begin on the potential benefit of antibodies in designing care for Covid-19 patients.

15. The role of private hospitals

15.1 On 21st March, the NHS announced a deal[23] with the private sector, which increased capacity by an additional 8,000 hospital beds, 1,200 ventilators and 18,700 clinical staff. The NHS block booking of private sites is expected now to continue in order to cope with rising waiting lists and lower hospital capacity, and to facilitate greater physical separation between Covid and "non-Covid" patients.

15.2 Our members on the front line have reported that additional requirements such as cleaning, distancing and PPE mean that capacity has been reduced by approximately half in some NHS hospitals and departments.

[23] NHS England and Improvement (2020) *NHS strikes major deal to expand hospital capacity to battle coronavirus.* https://www.england.nhs.uk/2020/03/nhs-strikes-major-deal-to-expand-hospital-capacity-to-battle-coronavirus/

15.3 Yet private hospitals remain underutilised by the NHS, and what is more they are also currently unable to service patients who have opted to pay for private healthcare. The latter phenomenon is potentially placing a greater burden on public health services by shifting private patients onto NHS waiting lists[24].

15.4 Clearly a common-sense approach is required that strikes a balance between the needs of private and NHS patients. This, alongside the prospect of future waves which may demand further rebalancing of care provision, will require a hitherto unseen level of strategic co-ordination between the NHS and private providers to ensure that all facilities are used to the maximum possible level while retaining a safe approach.

15.5 However, the scale of the transformation which may be required within private hospitals should not be underestimated, in particular regarding their capacity to deal with more complex and serious cases.

15.6 In some circumstances, non-medical staff may have limited or no experience of some of the complex procedures they may now need to support, and this needs to be acknowledged when devising rota patterns and by formulating training to ensure the best outcomes for patients.

15.7 We must also restate that a designated "non-Covid" facility will not remain a Covid-free facility: due to pre-symptomatic, asymptomatic or low symptom cases and the ease with which coronavirus spreads, nosocomial infection cannot be ruled out, although a regime of repeat PCR testing for hospital staff and patients will help to lessen the risk.

15.8 "Non-Covid" patients may suddenly require the application of intensive care methods we have come to associate with Covid-19. If private hospitals will not be expected to treat Covid-19 cases, there must be a clear process for the treatment of these patients, including safe protocols for transfer, something which becomes increasingly difficult for the patient as the disease progresses.

15.9 If a more serious outbreak does occur in a private setting, clear contingency plans must be in place to ensure that the correct treatment is available to sufferers.

15.10 For the foreseeable future all hospitals, including private hospitals, must still be treated as possible Covid-positive environments. Therefore, adequate PPE supplies will continue to be needed and worn in private settings to protect vulnerable "non-Covid" patients and reduce nosocomial infection.

16. Training for all grades of doctor

16.1 All grades of hospital doctor have seen some impact on their training and development due to the emergency response to Covid-19.

16.2 Contractual rights which have been temporarily suspended should be reinstated as soon as possible. This should include professional development, study leave, education and training.

16.3 Senior grades have seen Supporting Professional Activity time, used for training, teaching and development, removed and used for direct clinical care. Allowances will need to be made in future job planning to assess learning which has had to be deferred and ensure that time is granted to maintain required standards.

[24] Independent Practitioner Today (2020) *Scale of pandemic disruption exposed.* https://www.independent-practitioner-today.co.uk/2020/06/scale-of-pandemic-disruption-exposed/

16.4 Junior doctors have had rotations postponed, training cancelled and their career plans put into question. This cohort of doctors will require both immediate support in terms of wellbeing and measures to ensure they continue to meet their career goals. Medical students have been fast-tracked into the profession, examinations and assessments have been postponed, and teaching has been lost in the rush to put emergency rotas in place.

16.5 The expectation of a second wave, and potentially future waves, means that Covid-19 will continue to have an impact in this area, and in particular on junior doctors. This means that those responsible for the education of doctors need to act decisively to deliver greater certainty and clarity for Junior Doctors.

16.6 A considerable amount of training has been missed and junior doctors now need a clear plan detailing how they can catch up.

16.7 A review of postgraduate training should be urgently established to ensure that the next generation of hospital leaders is fully supported.

16.8 Across all junior doctor grades, individual assessment processes must ensure that no detriment is suffered as a result of Covid-19 and steps should be taken to ensure that the new skills and experiences acquired in the most challenging of environments are recognised, and devise a way of counting this towards training. This is particularly the case where they may have been deployed to another specialty area on a temporary basis.

16.9 If this requires additional training, we will need to make sure that juniors can attend the training, which is likely to require additional funds for locum cover. Senior grades will need to be allocated sufficient time to deliver teaching, and also will need adequate cover.

16.10 Juniors should also be able to carry over some study leave between Trusts to create space for catch-up learning.

16.11 An urgent assurance should be provided that the summer rotation will continue as planned and guidance issued about how this will work practically.

17. Safeguarding the future for Junior Doctors

17.1 Aside from the interruption to training, there are a number of unique issues affecting Junior Doctors:

17.2 The status of trainees who are shielding in line with government advice.
The NHS must clearly state that these doctors will not be adversely affected as a result, and that their pay and career progression is protected.

17.3 Rotas
Hospitals have been far too rigid in maintaining emergency rotas, a policy which if it continues will have a significant impact on training and well-being. While of course patient care is the top priority, in order to balance learning and staffing requirements in the coming period, rotas will need to be made more "responsive" – stepping up when they need to, but also quickly winding back when there is a drop-off in demand.

17.4 Inability to take annual leave
Because Junior Doctors rotate between employers, they have traditionally had to use up a tranche of annual leave prior to the next rotation or been paid a sum in exceptional circumstances where this is not possible. The Covid emergency has often seen annual leave suspended. Where pay is agreed for

annual leave not taken, there is no consistency in the formula used. But perhaps more importantly, the current situation means that junior doctors who may desperately want and need time to rest and recuperate will have no opportunity to do so. We urgently need an agreed mechanism to allow Junior Doctors to take annual leave with them as they rotate.

18. The future of Nightingale hospitals

18.1 It became clear as Covid-19 loomed that without action existing NHS critical care capacity would be overwhelmed.

18.2 In addition to the creation of Nightingale hospitals, NHS Trusts acted urgently to expand their own critical-care capacity thanks to the efforts of their staff. Entire units were relocated within hospitals and previously underutilised space was upgraded to create additional ICU capacity.

18.3 Thankfully, while extremely challenging, the demand on ICU capacity fell below the levels initially feared. This was fortunate, because although the creation of physical infrastructure was impressive, the new wards have not been matched with equivalent ICU trained staff. Instead, the wards were staffed with volunteers and redeployed staff without the full skill complement, which means that, at full capacity, the standard of care delivered could not meet the required levels.

18.4 Aside from this fact, in medical terms Covid-19 patients in need of ventilation are very difficult to move from location to location, so the Nightingale model as originally envisaged may also be restrictive in terms of the volume of these cases they could accept to reduce demand on ICUs.

18.5 The future of Nightingale hospitals currently remains unclear. However, HCSA believes that, given the investment to date, consideration should be given to the possibility of repurposing these facilities to provide non-emergency care that could assist in reducing the waiting lists which the NHS now faces. We need to have a realistic conversation about the implementation of social distancing and safe care, and associated costs, and Nightingales have the potential to form part of the solution.

18.6 There is already a precedent for this, with Nightingale facilities being used to carry out CT scans to assist with the growing backlog.

18.7 Repurposing Nightingales could also reduce NHS reliance on the private sector to deliver care, which has the potential to both unlock public savings and increase overall UK hospital capacity.

PART 3

After the pandemic

HCSA
The hospital doctors' union

After the pandemic: Why we need a new NHS settlement

19. The need for a new settlement

19.1 The NHS did not start the battle against Covid-19 from a position of strength.

19.2 In 2018, the King's Fund identified workforce issues as a greater threat to the NHS than funding[25], while the full NHS People Plan was still in its germination as the crisis hit.

19.3 As well as exposing long-standing NHS workforce issues, the pandemic has created a raft of new concerns. Taken collectively and if left unaddressed, these issues could prove to be a greater challenge to the long-term stability of the NHS than the virus itself.

19.4 None of them can be resolved by the centre alone. The scale of these challenges is such that they can only be met through genuine and continuing partnership working, including a strengthening of the social partnership between the NHS leaders and trade unions.

20. Future of the NHS Long-Term Plan

20.1 There are many noble aims within the NHS Long-Term plan. However, even before the outbreak hit, HCSA had doubts about its achievability both due to funding and in the absence of an ambitious and robust strategy to address staffing issues. Because of the impact of the virus, even the most modest elements of the plan will now be at best delayed and at worst no longer deliverable.

20.2 There is a clear risk in the face of record waiting lists following this Covid-19 outbreak that the NHS will be forced into an emergency "coping position" which will threaten a chain reaction in terms of burnout and retention, compounding workforce problems.

20.3 Given the strategic lacuna that will be left in the absence of a deliverable plan, it is vital the NHS leaders work with trade unions and other stakeholders to develop a revised long-term plan.

21. Workforce planning

21.1 We have consistently warned of a growing vacancy crisis, which meant that the NHS in England had 100,000 vacancies[26] before the crisis hit. Our members told us in nearly two-thirds of cases medical workforce gaps were being covered by existing staff, rather than by locum or agency staff.

21.2 The long-term failure of the NHS to recruit sufficient numbers of hospital doctors has been exacerbated by a retention crisis, which is driven a range of factors including long-term pay restraint, the impact of pension taxation and stress.

21.3 This meant that the NHS faced a struggle to handle both the increased levels of demand brought by Covid-19 and the surge in staff absence caused both by infections and self-isolation requirements.

[25] Kings Fund (2018) *The health care workforce in England: make or break?* https://www.kingsfund.org.uk/publications/health-care-workforce-england

[26] NHS Providers (2020) *Confronting coronavirus in the NHS*. https://nhsproviders.org/confronting-coronavirus-in-the-nhs

21.4 To mitigate this shortage of staff, the NHS acted to fast track medical students into employment, and urged thousands of retired doctors and nurses (at higher risk from Covid-19) to return to the service.

21.5 The twin challenges of high levels of staff absence and long-standing vacancies presented an immediate challenge in our response to the virus. Short-term measures to meet the Covid-19 challenge enabled the NHS to respond initially, but as they are scaled back widespread staff shortages will once again be laid bare.

21.6 The government and NHS must now act urgently to develop a new workforce strategy to respond to the current and future challenges that we face. This should be developed in partnership with trade unions and must start by addressing the longstanding issues around recruitment and retention that predated the pandemic.

21.7 The impact on longer-term work-life decisions for NHS staff involved in the most intense Covid-19 response is not yet known. It is possible it will cause an acceleration in requests for less than full time working. This is a trend which has already being seen prior to Covid-19, in part fuelled by issues around pensions taxation and in part by changing expectations and priorities among the wider population. HCSA's own research has underlined a growing desire for reduced hours in order to lower stress levels and increase wellbeing[27].

21.8 This would naturally be preferable to the alternative of forcing doctors to retire early, leave the NHS or seek a career change. However, the NHS remains slow to acknowledge this cultural shift. Once the immediate Covid-19 crisis has passed, it will need to act urgently to assess the demand and employment intentions of hospital doctors and other staff.

21.9 Steps should be taken to increase recruitment to address both pre-existing and Covid-related staff shortages.

21.10 A key element of this workforce strategy should be to avoid taking what appears to be the easier route and continuing to work the existing workforce harder while reducing training opportunities, time for supporting professional activities and annual leave. We are facing a marathon, not a sprint and the first goal must be to retain as high a proportion of the existing workforce as possible.

22. Funding

22.1 One of the most pressing challenges is to ensure that the NHS is adequately funded to not only continue responding to Covid-19, but also to ensure that necessary future plans and infrastructure improvements continue as soon as possible. It is vitally important that the government give the same "whatever it takes" assurances to the NHS for the medium and long term.

22.2 A statement should be made confirming that sufficient funds will continue to be provided to the NHS beyond the short-term.

22.3 We would also warn the Government that any move to institute a new era of pay restraint or austerity in response to the financial challenges presented by Covid-19 must not be contemplated. To do so would risk accelerating the problem of staff shortages we already see.

[27] *HCSA member survey – November 2019*

23. Organisation

23.1 The pandemic has shone a light on organisational deficiencies in our health system, which HCSA has repeatedly called for action to resolve, most recently in our 2019 election manifesto[28].

23.2 There is now a growing consensus that structural changes brought about by the Health and Social Care Act 2012 may have hampered our ability to respond effectively to Covid-19. The reforms created a fragmented and sometimes dysfunctional network of Trusts and NHS bodies, which led to huge issues when seeking to coordinate the supply of PPE, or roll out a coherent testing strategy.

23.3 It now seems clear that some of the tensions around PPE supply and guidance, and the testing strategy were caused by muddled lines of accountability between range of bodies.

23.4 The 2012 Act also significantly changed the public health landscape, with the Health Protection Agency replaced by Public Health England and a range of services devolved to councils. This also notably disqualified PHE from any protection from Government funding cuts. In October 2011, nearly 400 public health experts signed an open letter[29] warning that these changes would "undermine the ability of the health system to respond effectively to communicable disease outbreaks and other public health emergencies."

23.5 The Government had to some degree been working around the confines of the 2012 Act and had announced its intention to legislate. The intention behind this work was to formalise the role of the emerging sustainability and transformation partnerships (STPs) and integrated care systems (ICSs).

23.6 Our advice to the government would therefore be to pause and take stock of the response of the NHS before proceeding, and to reflect upon the lessons learned before implementing widespread legislative changes.

24. Capacity

24.1 Medical advances including an increase in day-case surgery have led to the majority of advanced health care systems reducing bed numbers. However, the UK has cut much deeper than comparator nations and as a result has fewer acute beds relative to its population. OECD data[30] shows that ahead of the crisis, the UK had 2.5 hospital beds per 1,000 people, compared to six in France, eight in Germany and 12.3 in South Korea.

24.2 Between 1987/88 and 2019/20, the total number of NHS hospital beds fell by 53 percent – from 299,4000 to 141,000[31]. This drastic reduction in beds led the NHS constantly running at the limits of its capacity, with general and acute occupancy averaging above 90 percent and frequently exceeding 95 percent in winter[32].

24.3 This lack of capacity left the NHS vulnerable to surges in demand and required difficult decisions to be taken to limit "non-Covid" related work.

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[28] HCSA (2019) *General Election 2019.* https://hcsa.com/media/143997/HCSA-manifesto.pdf
[29] Daily Telegraph (2011) *Nearly 400 public health experts warn Lords to reject NHS reforms*. https://www.telegraph.co.uk/news/health/news/8804619/Nearly-400-public-health-experts-warn-Lords-to-reject-NHS-reforms.html
[30] OECD (2019) *OECD Data: Hospital Beds.* https://data.oecd.org/healthcat/hospital-beds.htm
[31] The Kings Fund (2020) *NHS hospital bed numbers: past, present, future.* https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers
[32] Ibid

24.4 Beds occupied by a medically fit patient whose discharge has been delayed can represent between 20-30 percent of hospital patients.

24.5 To cope with Covid-19, the NHS had to rewrite its procedures[33] to discharge significant numbers of patients at a rapid pace. This increased the number of beds available for coronavirus patients, but it has since been suggested that this policy led to a spate of serious outbreaks within the social care sector.

24.6 The shock to the system provided by Covid-19 exposed the risk of constantly running the health service at the very limits of its capacity.

24.7 The time has arrived for a far-reaching debate about the kind of health service that we want to see in this country.

24.8 Linked to the challenge around funding is a fundamental question about the value that we place on our health service.

24.9 Although it is often correctly lauded as one of the most efficient and best run health services in the world, the fact is that we also spend a lower amount per head than many comparable nations for a system offering a lower level of capacity.

24.10 Overall bed capacity in our hospitals and our social care capacity both desperately demand renewed focus. The impetus for better integration between social and hospital care systems, driven by the experience of the Covid pandemic, must not be lost as we shape a vision for the future.

25. Staff wellbeing

25.1 The pandemic has created a perfect storm for current and long-term wellbeing issues and it is clear that the psychological impact of the crisis will be on an unprecedented scale.

25.2 As NHS Providers have set out[34], while the NHS has good experience of supporting smaller groups of frontline staff through major, short duration crises, "supporting the number of staff affected by this crisis, over a much longer period, feels to be of an exponentially greater magnitude."

25.3 In the past few months, hospital doctors and other NHS staff have faced stress associated with fear of contracting the disease or taking it home to loved ones, worsened by concerns over inadequate PPE.

25.4 Staff who have been exposed to such profound and continual levels of stress would in any other circumstances be provided with time off to recover. Because of the number of staff affected and the challenge of continuing to respond to Covid-19 while gradually reopening other NHS services, clearly this will not be possible in all cases.

26. Mental health services

26.1 For the wider population, the psychological impact of lockdown and social distancing, the impact of the economic repercussions, and the need to come to terms with loss of life on a devastating scale will put an immeasurable amount of pressure on mental health services that were already straining at the seams.

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[33] Department of Health and Social Care (2020) *Coronavirus (COVID-19): hospital discharge service requirements*. https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements

[34] NHS Providers (2020) *Confronting coronavirus in the NHS*. https://nhsproviders.org/confronting-coronavirus-in-the-nhs

26.2 Responding to this challenge will require a rapid expansion of capacity to ensure that services can be accessed at an early stage to prevent further harm.

After the Pandemic: Embedding positive change

27. Clinical leadership

27.1 Covid-19 has underlined the inestimable value of clinical leadership to our medical systems.

27.2 Many of the changes that enabled the system to transform itself so quickly to meet the challenges of the pandemic have been led by clinicians, who were given the autonomy to organise themselves effectively. This is a stark contrast to the experience of recent years, which have seen senior doctors micro-managed and the development of new systems often farmed out to private management consultants.

27.3 We need to continue to put the experts – front-line staff – in the driving seat when determining how the health service should adapt to meet challenges in future. We also need to reflect on just how much the NHS has been able to achieve at pace when restrictive and arcane regulations and procedures are bypassed.

28. Innovation

28.1 We have heard from a number of our members who have lobbied without success for years to secure innovative changes to service delivery such as virtual clinics, only to see those changes made almost overnight following the onset of this viral epidemic. Some of the move towards greater levels of homeworking and online service delivery could have significant benefits to staff and patients alike if they are embedded moving forward.

29. Rest and facilities

29.1 Although this is clearly been an extremely challenging time for staff, what has been valued has been the availability of hot food and rest areas especially during night-shifts, access to free parking and generally a much greater focus on the link between good facilities and improved physical and mental wellbeing.

29.2 These positive changes must not be seen as temporary, just as the challenges that the NHS faces will exist for the foreseeable future. Better rest facilities and real hot food have always been an objective of the HCSA.

After the Pandemic: The Future Public Inquiry

30. The need for a two-stage public inquiry

30.1 Although the government not yet confirmed its intention to establish a public inquiry into our response to Covid-19, it is inevitable that such an inquiry will eventually take place. As we have stated, we would expect the process to examine in detail our preparedness for a pandemic as well as the response to it.

30.2 Although there will no doubt be a political desire to put off the establishment of an inquiry until after the event, this will not be possible for two key reasons. Firstly, because it is extremely unlikely that there will be a defined end point to the outbreak of the virus and our response to it, indeed its impact could continue for a significant number of years. Secondly, the timescale for public inquiries is lengthy, for example the final publication of the Chilcot Inquiry came more than seven years after its establishment.

30.3 As the Covid-19 Bereaved Families for Justice UK group recently argued[35], there are a number of urgent lessons which need to be learned to prevent future deaths. These lessons cannot wait until an undefined future point when the virus has finally been eradicated, if indeed such a point will ever be reached.

30.4 We would therefore urge the government to launch a two-stage independent inquiry process.

30.5 Such a process should include an urgent limited inquiry focussing on action in the short to medium term to be launched no later than August 2020 with an aim to report by January 2021. This would be followed by a detailed longer-term process to commence by March 2021, a year after our response to the virus began in earnest.

[35] BBC News (2020) *Coronavirus: 'Start public inquiry now to prevent more deaths.'* https://www.bbc.co.uk/news/uk-53009946


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COVID-19: Learning from the first wave

Lessons for the NHS in the next phase and beyond

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