Never Again
COVID from the frontlines

EveryDoctor

HCSA
The hospital doctors' union

A joint report of the experiences of UK doctors from HCSA and EveryDoctor

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EveryDoctor is a not-for-profit doctor-led campaign organisation representing 1,700 UK doctors with a wider network of 250,000 NHS staff and supporters. We advocate for the safety and well-being of every doctor, NHS worker and patient.

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HCSA is the UK's only professional association and trade union dedicated solely to hospital doctors wherever they are in their career, from student to Consultant. Our focus is advising and supporting our members, negotiating in their interests and campaigning for the profession and the future of the NHS.

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Foreword

Dr Julia Patterson
Chief Executive, EveryDoctor

Despite the outstanding service and sacrifice NHS staff have given in the last two years, decades of underfunding, understaffing and creeping privatisation has pushed our National Health Service to the brink.

Anyone who chooses the medical profession knows what they're getting into. The life-and-death decisions. The emotional toll. But Covid-19 led to situations like no other, which no doctor should ever have had to face. Situations which put the safety of their patients at risk, put loved ones in danger, made them fear for their lives and face losing their own colleagues to this virus. And yet time and again throughout this pandemic, when doctors tried to speak up, we were shouted down. Ignored. Silenced. This report is our latest attempt to have our voices heard.

The public's displays of support and affection for our NHS colleagues during the pandemic were overwhelming. But we need more than kind words and claps. EveryDoctor was founded because we believe in a future where every patient and every doctor is safe. If our NHS is to survive future national health emergencies and continue to serve our country for generations to come, we must address the huge challenges it faces.

As doctors, we not only need to be advocates for our patients but advocates for ourselves. It is our duty to bring the truth about what is happening in our profession to light and by raising our voices and sharing our experiences together, we can fight for a better NHS for everyone.

Dr Claudia Paoloni
President, HCSA

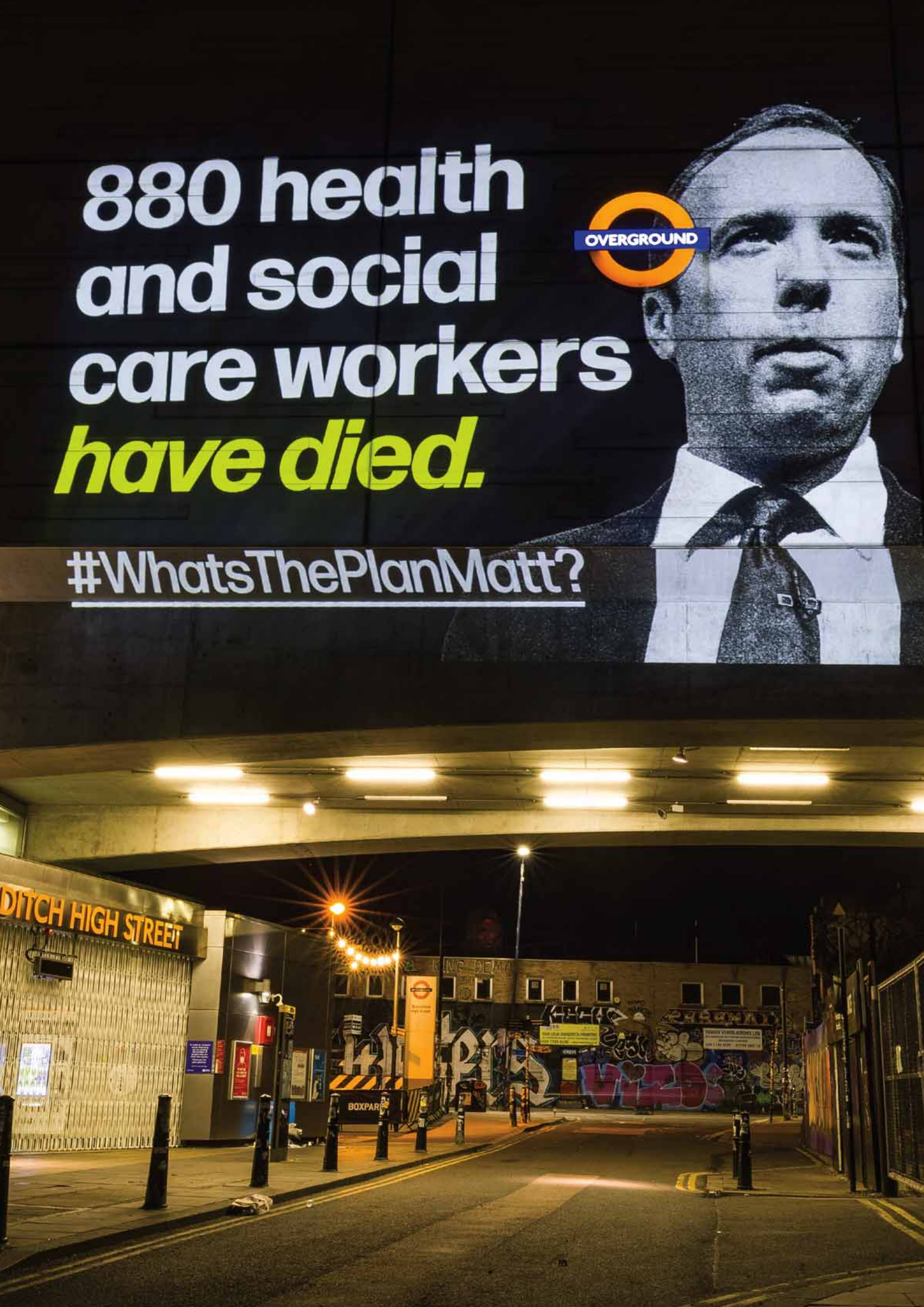
Staff are the most valuable resource within the NHS. Covid-19 has damaged their wellbeing and invaded their personal lives, ricocheting off their families and loved ones without limitation. Many have themselves battled their own or family illness with Covid-19 and too many have lost their lives after selflessly heading out to work. As President of HCSA, I have witnessed the toll on hospital doctors of all grades during this acutely distressing time.

The complete collapse of the NHS and an even worse fatality rate has only been avoided through the devotion and commitment of health professionals. Professionals who put themselves at risk even as more evidence came forward that exposed the dangers of the virus. Doctors who worked together, willing to do whatever needed to be done.

Yet the system was working against frontline staff. Decades of under-resourcing in infrastructure and staffing, coupled with an unforgivable lack of planning. No lessons were learnt from the SARS, MERS and Ebola outbreaks nor, inexcusably, from a simulation of a UK pandemic, Exercise Cygnus.

The work is not done. The pandemic is not yet over and, meanwhile, Covid-19 recovery work, clearing backlogs, addressing the consequences of delayed treatments and diagnoses will continue to pile pressure on the NHS and its staff for many years to come.

There will also be another pandemic, of that there is no doubt. Lessons must be learned. HCSA will continue to strive for all hospital doctors – we will continue to care for the carers.


880 health and social care workers have died.
#WhatsThePlanMatt?
OVERGROUND
DITCH HIGH STREET

Introduction

The Covid-19 pandemic tested our NHS like never before. Both of our organisations witnessed the huge impact the pandemic had on the lives of doctors throughout the NHS and this report seeks to bring to the fore the stories of our members, and the wider experiences of the medical profession, who fought this battle on the frontline.

Chapter one, Pandemic Readiness, begins by taking stock of the state of our National Health Service prior to Covid-19. It illustrates a number of systemic issues which left the NHS woefully unprepared as well as highlighting how previous public health simulations had been ignored.

Chapter two on the pandemic response details the reaction of doctors, the government and other national health bodies once the virus had hit. It details problems across several areas of public policy, from inadequate PPE procurement to the ineffective Test and Trace programme.

Chapter three, Caring for our Colleagues, delves into the personal toll the pandemic had on doctors – on their mental and physical health, families, careers and future – while chapter four outlines our recommendations.

This pandemic is not yet over. We are still fighting it. While we may have moved into a period of recovery, Covid-19 remains a public health threat. The additional enormous pressures of physical and mental fatigue are ever-present. We hope this report will not only provide space for reflection on the pandemic to date, but serve as a blueprint for action. Lessons must be learnt.

We intend that this report will also contribute to the evidence base of the national public inquiry into Covid-19 to ensure the recent past is neither forgotten nor discarded, and that political self-adulation over the UK response to this pandemic does not mask the true nature of Covid-19's impact on the most valuable NHS resource – its staff.

Timeline

2019

DECEMBER

31st December

The World Health Organisation is alerted to a new virus by Chinese officials

2nd December

National lockdown ends

8th December

First UK Covid-19 vaccine administered

2020

JANUARY

23rd January

First officially identified Covid-19 case arrives in UK on flight from China

24th January

Prime Minister Boris Johnson fails to attend first Cobra meeting about the virus. Health Secretary Matt Hancock, who did attend, says risk to the UK is 'low'

MARCH

11th March

World Health Organisation declares a global pandemic

18th March

NHS Trusts instructed to halt all non-urgent work from April 15th

20th March

Senior government advisor declares PPE shortages have been "completely resolved". Medical staff continue to report acute PPE shortages

20th March

Schools, colleges and nurseries closed

26th March

The UK enters first national lockdown

28th March

First NHS frontline worker dies after testing positive for Covid-19

NOVEMBER

5th November

Parliament votes for national lockdown

22nd November

UK daily Covid-19 death toll reaches 512 – the worst since 9th May

24th November

Plans announced to allow up to three households to mix for five days at Christmas

OCTOBER

12th October

Prime Minister Boris Johnson announces tiered system of local lockdowns, telling Parliament a national lockdown "would not be the right course"

"Almost like an iron man triathlon"

APRIL

3rd April
The first Nightingale Hospital opens in the ExCel centre, London

6th April
Prime Minister Boris Johnson admitted to hospital with Covid-19 symptoms

MAY

12th May
First loosening of strict lockdown rules in England

15th May
ONS reports 12,526 deaths in care homes involving Covid-19

20th May
Prime Minister Boris Johnson announces 181 NHS staff and 131 social care worker deaths involving Covid-19[1]

22nd May
UK Covid-19 death toll passes 50,000[2]

JUNE

15th June
Facemasks mandatory in all areas of hospitals and on public transport

JULY

4th July
Lockdown eased further in England, allowing household mixing and reopening of hospitality

8th July
Chancellor Rishi Sunak unveils Eat Out to Help Out, a scheme linked to 8-17% of new infections[3]

24th July
Facemasks mandatory in retail outlets

AUGUST

3rd August
'Major incident' declared in Greater Manchester due to rising infection rates, resulting in new local lockdown measures

SEPTEMBER

14th September
Government introduces legal limit on social gatherings to groups of six

21st September
Schools, colleges and nurseries fully reopen

21st September
Chief Medical Adviser Sir Patrick Vallance warns country faces new wave leading to 200 deaths a day by mid-November

22nd September
Government announces new social distancing measures and 10pm closure of hospitality venues

2021

JANUARY

6th January

Third national lockdown begins in England

19th January

UK daily Covid-19 death toll reaches 1,485 – the deadliest day of the pandemic

25th January

Office for National Statistics reports more than more than 880 health and social care workers have died after contracting Covid-19[4]

26th January

UK Covid-19 death toll passes 100,000

MARCH

8th March

UK Covid-19 death toll passes 150,000

MAY

20th May

Delta variant, first identified in India, becomes dominant strain in UK

19th July

"Freedom Day": most restrictions, including facemasks, removed in England.

JULY

27th September

Hospital infection controls including cleaning and patient testing reduced

SEPTEMBER

24th November

First case of Omicron variant identified in South Africa

27th November

First UK Omicron cases detected

NOVEMBER

8th December

Health Secretary Sajid Javid warns Omicron cases could pass 1 million a day in December

10th December

Facemasks made compulsory in most public indoor venues in England

13th December

Prime Minister Boris Johnson announces 1 million daily vaccine booster target in face of "Omicron tidal wave"

14th December

Parliament backs vaccine passports in England for larger venues

DECEMBER

6th January

24 NHS Trusts in England declare a "critical incident", signalling extreme staffing pressures and service demands

27th January

Face coverings and Covid-19 passes no longer legally required in England

2022

JANUARY

NEVER-ENDING...

Covid-19 recovery

“There is no slack in the system

1 Pandemic Readiness

The NHS entered the pandemic in a desperate state. This chapter seeks to highlight the underlying problems our NHS faced before anyone had ever heard of Covid-19, alongside multiple instances of recommendations resulting from pandemic simulations which went ignored, weakening the service's ability to respond to a public health crisis even further.

The systemic problems in our NHS, from understaffing to bed shortages, have become common knowledge. Annual reports of winter crises in the national press have sadly become a tradition, as have the emergency top-up funds provided by the government each November to try to cope with them. This situation led British Red Cross chief executive Mike Adamson to declare a "humanitarian crisis" in 2017.[5] Prior to the pandemic the situation had been getting steadily worse, with hospital and A&E waiting times heading into winter 2019 the worst ever on record.[6] The Covid-19 pandemic pushed an already strained NHS to breaking point.

> We've always had difficulty with staffing, staffing has been an issue even before the pandemic.
>
> **Hospital Consultant, South West**

Staff are the beating heart of the NHS. But despite being the UK's largest employer, with a 1.6 million-strong workforce, as it headed into the pandemic the NHS was critically understaffed.[7] In 2019 health-service UNISON cited figures showing there were 106,000 vacancies across the NHS in England.[8] NHS employers themselves have reported an official shortfall of 84,000 full-time equivalent posts in England alone.[9] Workforce planning has been much talked about, but no-one appears willing to grasp the nettle despite an increasing crisis.

Broadly, workforce planning is an analysis of current and future staffing needs, which allocates funds and devises strategy to rectify shortages. This requires an understanding of current staffing levels, taking into account vacancies and less-than-full-time (LTFT) workers. A longer-term view is also required, and in the NHS this must include consideration of shortages of training places, both geographically and in certain specialties, as these in turn impact the pipeline of health professionals coming through in future. Expected leavers must also be considered, whether retirees or those leaving to work elsewhere, and how best to retain more staff in the NHS.

The NHS England Long Term Plan promised a "*comprehensive new workforce implementation plan*" would be published later in 2019.[10] Three months later the Interim People Plan was published, which contained no detail on workforce planning. In July 2020, after the first wave of the pandemic, the NHS People Plan was released. Tellingly, the central crises of staff shortages, recruitment and retention received scant attention. Once again, this crucial area was deferred, with the plan stating: "*When the government further clarifies the available budget to expand the workforce and make sure that education and training is fit for the future … more details will follow*." Today, we are still waiting.

Clarity over the true level of staffing gaps is difficult in an NHS which has become reliant on deploying existing staff to cover gaps or, in our hospitals, to take extra shifts to deliver elective care through schemes such as the Waiting List Initiative. The vulnerability inherent in this approach was exposed sharply in the months leading up to the pandemic as many senior hospital doctors reduced non-contractual shifts due to concerns over pensions taxation, a situation which 68% of employers said had resulted in a medium to high impact on additional work being taken on by hospital consultants.[11] The unfolding crisis finally led the government to amend tax rules in the very same Budget that first acknowledged the coming impact of the Covid-19 pandemic on UK society in March 2020.[12]

What's more, the quality of data available on NHS vacancies is poor, evidenced by the NHS Digital preface to regular vacancy statistics in England recommending that they are read with "a degree of caution".[13] Much of the information is drawn from advertised vacancies, but research by HCSA supports the view that the true picture is obscured as vacant posts go unadvertised by employers.[14]

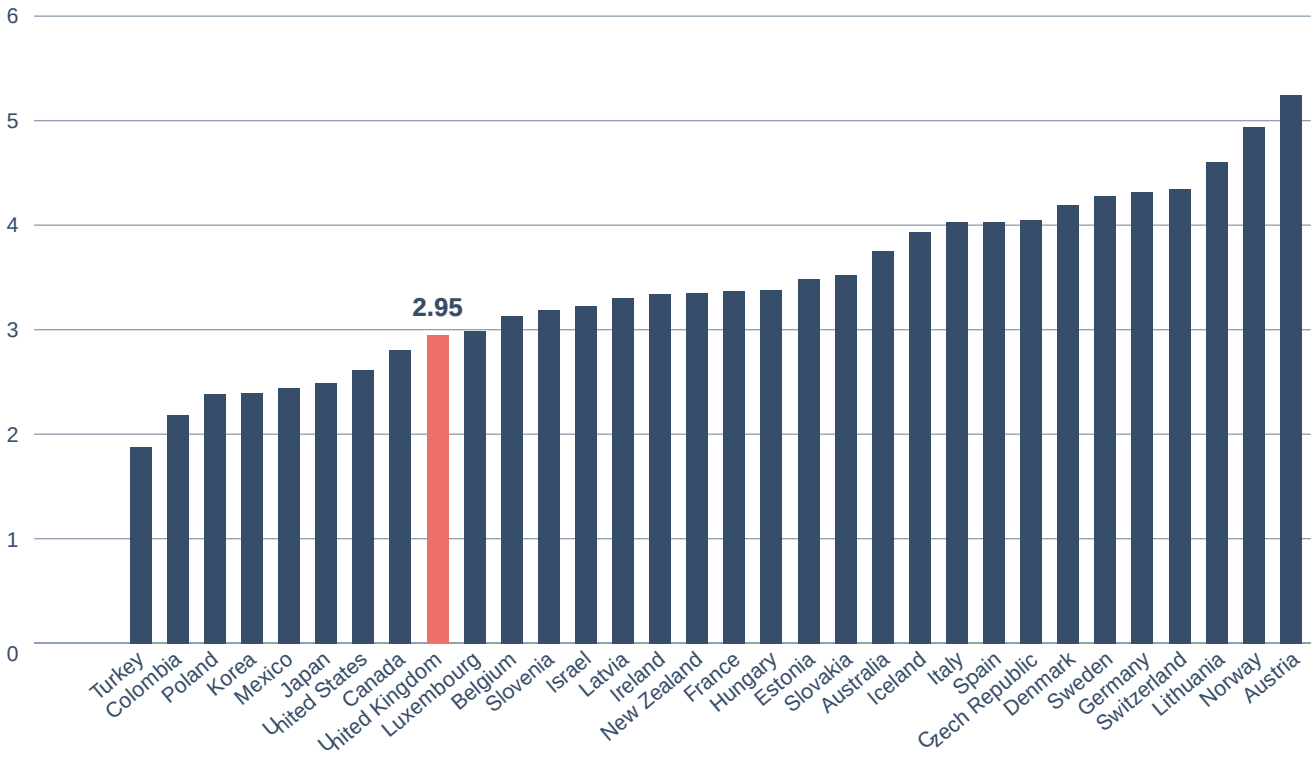
A survey by the Royal College of Physicians in 2019 found 40% of consultants and 63% of senior trainee doctors reported daily or weekly gaps in hospital medical cover.[15] There is also a very real concern from doctors over how staffing is accounted for. In HCSA's Doctors at Work Survey 2020 71% of doctors reported vacancies in their department, and 24% said there were vacancies in their department which were not officially recognised.[16] Masking staffing problems can only serve to reinforce them and lead to work piling on to existing staff.

This picture becomes even bleaker when mounted on the international stage. When comparing our number of doctors per head of the population, the UK ranks 23rd amongst OECD countries.

NHS staff shortages are also by no means contained to doctors. There is also a stark shortfall in the number of nurses; with 37,760 registered nurse vacancies at end of June 2020.[17] The shortage of nurses also contributed to the difficulties in delivering patient care experienced by doctors during the

Number of doctors per 1,000 population for OECD countries

Data from Nuffield Trust, 2021



pandemic. Between 2010/11 and 2017/18 the number of registered nurses in England's NHS barely changed despite a 26% rise in activity in the hospital and community.[18]

> Often the stresses of Covid were interlinked with the stresses of staff, staffing levels at all levels. Not just consultants or juniors but nurses as well and there's often nursing shortages, which makes you feel a little bit helpless and useless. You can come up with the most brilliant management plan for a patient but actually it's the nurses who put it into action.
>
> Junior Doctor, Covid-19 admission ward

To deal with this shortfall, many NHS Trusts turn to temporary staff. At a higher cost per head than full-time staff, this high level of dependence on temporary or locum staff, including substantive staff working additional shifts, equates to a massive expense for our already financially strained health service. Alongside the purely financial cost, there are a raft of other issues associated with this level of staff shortages. The higher turnover associated with temporary staff degrades the long-term sustainability of NHS workplaces. Institutional memory becomes limited, community relationships are disrupted, and the ability for doctors to build trust and provide continuity of care to their patients is constrained.

Staffing shortages became acutely visible as the pandemic hit in March 2020, when the Royal College of Physicians reported one in four doctors were absent due either to sickness or self-isolation.[19]

Prior to the pandemic the situation in primary care was also of grave concern. It is this section of the NHS which would go on to absorb many of the repercussions of cancelled and delayed secondary care provision and become the main delivery channel for the vaccination programme. Back in November 2019, then Health Secretary Matt Hancock had pledged to appoint 6,000 new GP doctors by 2024/25, a target which seemed particularly Herculean given that the number of GPs had actually fallen in recent years by more than 1,800 since 2015.[20]

> The whole system is so stretched and understaffed. So there isn't the staffing there to have the adequate levels of service, of patient care, which is really sad.
>
> **So we're doing the best we can in a stretched system, essentially.**
>
> Junior Doctor

Stretched would also be an accurate description of the state of NHS finances in England. The £7 billion in extra funds provided by the government in early March 2020 for the NHS to respond to Covid-19 was greatly welcomed. However, this figure was ultimately a drop in the ocean compared to what will be required. In September 2021 the NHS Confederation and NHS Providers called for an additional £10 billion to deal with the pandemic-related costs and backlog caused by Covid-19 in 2022 alone.[21]

A hospital's bed number is the ultimate measure used to judge a healthcare facility's capacity for patients. The term 'hospital bed' not only refers to actual permanent beds, but is defined by the NHS as "any device that may be used to permit a patient to lie down when the need to do so is a consequence of the patient's condition", hence the ability for patients, akin to Schrödinger's cat, to be physically in a bed and yet not – resulting in the sight of patients in beds lining hospital corridors.[22] Across 2019/20, the UK had 2.4 hospital beds per 1,000 people, compared to 5.8 in France, 7.9 in Germany and 12.8 in Japan.[23]

The King's Fund has documented the more than halving of hospital beds in 30 years, from around 299,000 in 1987/88 to 141,000 in 2019/20. While the largest decline was seen in mental health and learning disability capacity due to the drive to cut residential hospitals, general and acute beds have also fallen by 44% over the period.[24]

Clearly, there is an economic argument for minimising the number of inpatients and the NHS cannot afford to keep patients in hospitals for longer than the patient requires. Furthermore, new technologies have made procedures faster and lessened recovery times. But in the context of a significant long-term drop in bed capacity, even efficiencies and technological improvements have been

unable to adequately balance out increased demand from a larger and ageing population, new medical procedures and public expectations. The end result is a lack of inpatient capacity in hospitals. The NHS bed shortage becomes most apparent during the winter crises, which have sadly become a traditional fixture in British calendars, with overnight bed occupancy in general and acute settings averaging 90.2% in 2019/20, and regularly exceeding 95% in the winter leading up to the pandemic, routinely beyond the 85% mark which is deemed to be a safe operating level.[25]

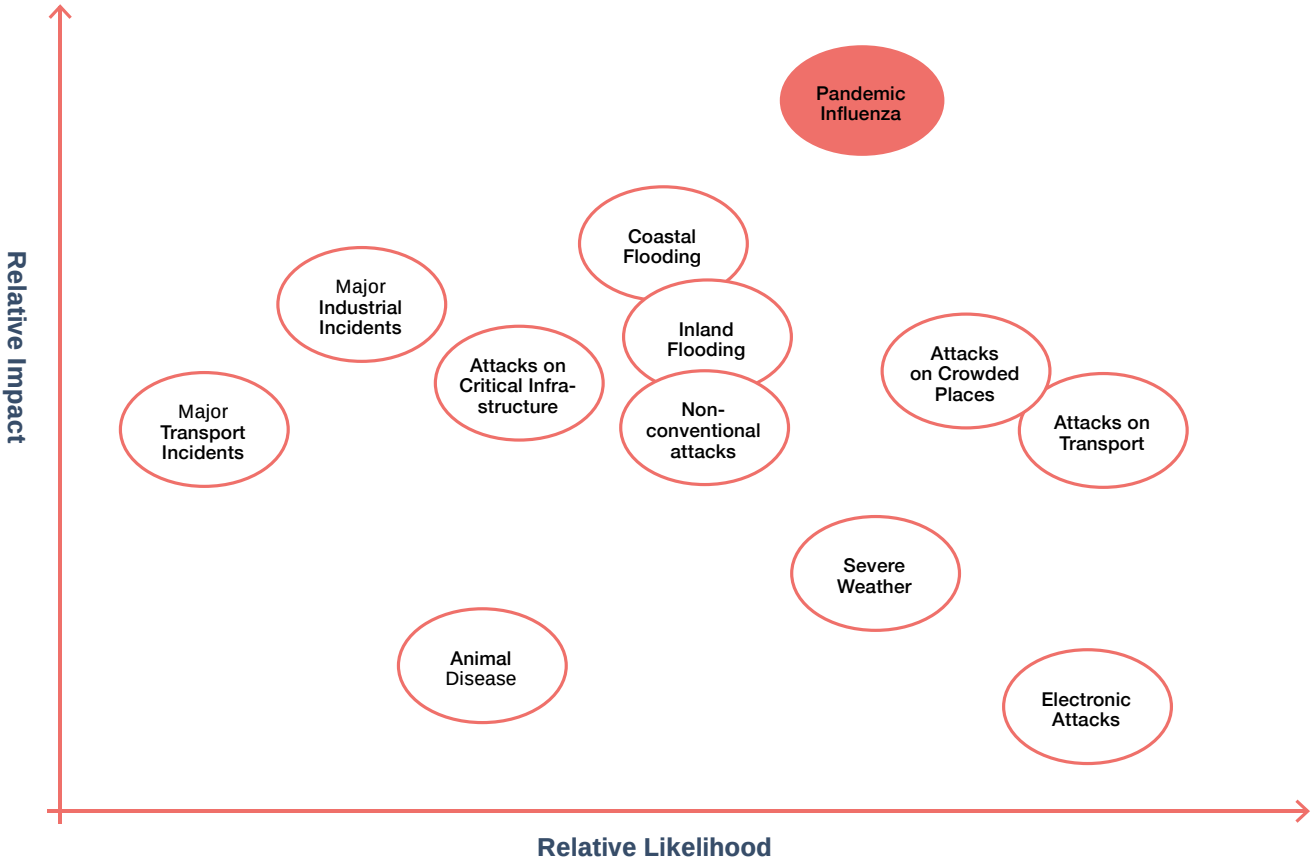
This disparity is not just a temporary issue, but part of a long-term decline which is placing additional strain on the NHS. The number of patients has soared in recent years, with a 28% increase in the number of hospital admissions and a 23.5% increase in the number of A&E department attendees between 2006/7 and 2016/17.[26]

In early 2020, running alongside this raft of foundational resource issues facing the NHS, was a still concealed vein of concern around the specific impact a pandemic-style event would have.

Where were you on the morning of Wednesday 19th October 2016? If you were then Health Secretary Jeremy Hunt, you would have been in the middle of chairing a meeting of civil contingencies committee COBR to prepare for the onslaught of an unknown international virus heading for our shores. This was sadly not the result of some Cassandra level of psychic foresight on the part of Mr Hunt but rather one of a number of simulation COBR meetings, taking place as part of the three-day national Exercise Cygnus.

While the virus we now know as SARS-CoV-2 was impossible to predict, the potential threat of a global influenza-type pandemic had been a concern of those at the top of the government for many years. It most recently topped the charts in the UK's 2020 National Risk Register.[27]

An illustration of the high consequence risks facing the United Kingdom



And that's why in 2016, Public Health England and the Department of Health carried out Exercise Cygnus to test how the UK would cope if such a pandemic struck. A Tier 1 (national level) pandemic influenza exercise, Exercise Cygnus involved the conscription of 950 individuals across central and local government bodies, the NHS and even some prison workers, to simulate a three-day outbreak of 'Swan-Flu' estimated to affect up to 50% of the population and result in 400,000 excess deaths.

The resulting report wasn't released publicly at the time, but after mounting pressure it was finally published in October 2020.[28] It not only revealed gaping holes in the government's pandemic preparedness strategy at the time but made many recommendations which were subsequently not implemented by government over the three years before Covid-19 hit. If they had been, this would have undoubtedly improved our public health bodies' response, increased the safety of NHS workers and in all likelihood saved many lives. The exercise was set during the seventh week of a pandemic, at which point a vaccine had been ordered but was not yet available, and encouraged participants to consider what their response, capacity and capability to act

would be. In a warning which would later come back to haunt the country during the Covid-19 pandemic, the 'Key Learning' section of the report concluded: "*The UK's preparedness and response, in terms of its plans, policies and capability, is currently not sufficient to cope with the extreme demands of a severe pandemic.*"

The report produced a total of 22 detailed lessons, which were grouped into four key learning outcomes. The full recommendations are publicly accessible, and this report seeks to highlight a number of recommendations which were not implemented.

First, was that a new single health body be set up, called a Pandemic Concept of Operations, to help provide an overview of the situation and clearer lines of communication between different bodies and agencies in order to avoid chaos in a real pandemic. This was not created.

Provision of personal protective equipment (PPE) was also discussed. Stockpiling was recommended alongside the need to plan for "surge capacity" as demand for equipment increased rapidly.

There was also a warning on communications. The report found: "*Information released from Health at the national level tended to be clinical and generic and failed to react to the exercise pseudo media stories … there was no communication strategy to accompany the key policy decision of the exercise which was to introduce population-based triage*".[29] The issues associated with centralised and vague communication sadly came to pass with Covid-19.

The Exercise Cygnus report was not the only Whitehall document on pandemics that was ignored. Another plan was put together by the Department of Health in 2005. This document began by outlining the UK's 2003 response to SARS, a coronavirus outbreak which was spread by the "*finer aerosols of infectious respiratory secretions, which stay in the air longer than droplets*" – the same way in which Covid-19 would one day go on to transmit.

Amongst the 2005 recommendations were the building up of infrastructure for virus testing, and the implementation of travel restrictions as cases started to appear in an "uncontrolled" manner in multiple countries. If followed this would have resulted in the UK beginning preparations in late January. One former government adviser was quoted as saying that, if this framework had been used as a guide to respond to Covid-19, "*tens of thousands of lives*" could have been saved.[30]

There was also Exercise Alice, a health planning exercise commissioned by then chief medical officer Dame Sally Davies which was carried out in February

2016. Exercise Alice participants suffered from imaginary cases of MERS-CoV, a respiratory syndrome originating in the Middle East which was similar to Covid-19 as there was no known vaccine and its fictional characteristics led to a potentially fatal respiratory illness and spread asymptomatically.[31]

As with Exercise Cygnus, the findings of Exercise Alice were not initially released into the public domain. In October 2021, it was exposed following a freedom of information request from NHS consultant and EveryDoctor member Dr Moosa Qureshi. Its key recommendations also focused on the need to ensure better stockpiling of PPE, limits on, or at least screening of, international travellers from highly infected areas, and the need for a functioning computerised contact tracing system.[32]

The inability of multiple governments to heed these warnings or implement recommendations from any of these reports is not only a failure of policy but speaks to a deeper and disturbing disregard for the safety of UK citizens, and for the lives of the frontline healthcare professionals who ended up bearing the brunt of Covid-19.

This chapter has made clear that the NHS was not prepared for this crisis. The institution was struggling under the weight of decades of under-resourcing, and dozens of recommendations from multiple large-scale pandemic preparedness exercises had been ignored. If the recommendations had been enacted, millions more items of PPE would have been stockpiled, travellers entering the UK from Covid-19 hotspots such as China and Italy would have been stopped and, ultimately, countless lives could have been saved.

“Heading into the abyss

2 Pandemic Response

In this chapter we provide an overview of the immediate impact of Covid-19 on doctors and how they responded. We explore the raft of implications this pandemic had, from immediate shifts in working patterns to impacts on standards of patient care and their own personal safety, before delving into the provision or, more accurately, the inadequate provision of personal protective equipment (PPE).

> “It happened all at once. It didn’t trickle in. It was the last week of March. Suddenly I did a shift where normally you might get one or two new patients coming to the intensive care department during a 12-hour shift. We had new patients coming in every hour, which was faster than we could see them. So instead of having five, six patients and lots of extra nurses in case someone should come in, the beds were full, and so they had nowhere to put them. I was having to initiate treatment myself because the nurses didn’t have experience in this disease, and that was unusual and quite scary. And it continued like that, I did three shifts in a row like that, three night shifts, where we were just rushed off our feet. Patients were just dying in front of us so quickly and they were young as well, they were all, again, under 60, but a lot of them were in their 20s. They came into A&E and they said: “I feel short of breath”. And then, even though they were sat up and looked fine, they would be saturation of 60%. They were desperately sick and the oxygen they were getting wasn’t anywhere near enough.
>
> **Junior Doctor, worked in intensive care unit for four months when Covid started**

As Covid-19 took hold of the country, the NHS moved at a remarkable pace to respond to the crisis. In HCSA’s Learning from the First Wave Report, a number of steps taken by the NHS in the initial Covid-19 response are outlined:

“These included changes to work patterns and intensity, discharging medically fit patients, diverting/postponing planned care, creating extra critical care capacity, bringing in retired staff, medical students and volunteers, and incorporating private sector capacity into the NHS”.[33]

Most impressive was the aptitude and willingness with which NHS staff adapted. For doctors, this meant significant changes to day-to-day duties as normal procedures were diverted and effort was refocused on the rush of Covid-19 patients. Doctors were redeployed, had enforced changes to working patterns and a constant stream of new practices and procedures to contend with.

Cancellation of routine procedures

As the first wave hit, non-urgent procedures began to be cancelled in local practices and Trusts. This was finally made national policy on 15th April, a month after the country went into lockdown, once most Trusts had already made the decision and lobbying had intensified from organisations including HCSA. Important resource was freed up to redirect efforts to the Covid-19 response, but some resource was maintained for critical work, including emergency procedures and urgent cancer operations. Although virtual and telephone services were set up at speed to allow some routine procedures to continue, the demands of this period mean the NHS has been left facing an unprecedented backlog.

A clear indication of the impact of Covid-19 can be seen in the number of patients presenting to A&E. April 2020 saw the fewest number of attendees to A&E in England since records began, down 57% on April 2019.[34] Worryingly, some reduction in demand likely came from people not accessing the care they required or delaying seeking advice and treatment, in turn worsening the outcomes of their conditions and increasing the recovery pressure due to likely disease progression.

As of October 2021, the current waiting list in England sits at 5.7 million. However, data analysis by NHS Confederation shows 7.42 million fewer cases presenting for care than would have been expected in 'normal' times.[35] This suggests an invisible backlog of people who have not sought the care they would otherwise have, and therefore whose conditions may be deteriorating. There is a similarly dire situation in the other constituent nations of the UK, with a waiting list of over 600,000 in Scotland[36], 669,000 in Wales[37] and 113,000 in NI.[38] In response, ambitious targets have been set with financial incentives to reward NHS providers which make progress in clearing backlogs. Yet, as we will explore further in chapter 4, the workforce is burnt out and in short supply, and the pandemic is far from over. Frontline NHS employees have a seemingly insurmountable task ahead of them to restore the usual activity levels that so many patients urgently require.

Emergency rotas

The initial pandemic response saw health workers placed onto physically and mentally demanding emergency rotas for weeks on end, with little choice in the hours they worked. Individual employers defined processes and pay, effectively creating a postcode lottery for overtime wages. Hospital doctors working gruelling additional hours were encouraged to fastidiously note down their start and finish times, yet a solution was not forthcoming. In some areas, the rotas continued for several months, which took a toll on staff wellbeing.

Despite lobbying from staff bodies for a national framework and funding package to make the payments, this was rejected by the government. Our call remains for the government to reengage with employers and staff representatives to implement a national framework for emergency rotas, for the current and future pandemics. Although most emergency rotas have now wound down, a national policy should be agreed so that they can be implemented swiftly and consistently in future. The policy would ensure NHS staff are rewarded for their hard work, while creating transparency around the circumstances in which emergency rotas are used. Emergency rotas must be reserved only for emergencies.

Additional capacity in Nightingale Hospitals & private sector

Nightingale Hospitals were built to provide emergency critical care facilities in the early phase of the pandemic at a cost of £220 million. The bill rose to £532 million once running costs and decommissioning are taken into account.[39] The rapid and effective conversion of these facilities from conference halls and arenas to critical care hospitals was impressive yet the new hospitals were barely used. The King's Fund highlight the need for an investigation to determine the reasons for Nightingale underuse, citing many possible factors including the nature of Covid-19 making it near impossible to transport severely ill patients, the locations of the Nightingales and how this relates to local NHS facilities, and the limited range of services falling short of what would be required to treat a patient suffering from Covid-19 with its complexities.[40] Additionally, the role of chronic understaffing in the NHS must be considered as a contributory factor.

Another strategy employed by the government to address the influx of Covid-19 patients was to turn to the private sector. In March 2020, the private hospital sector and NHS England signed a contract that would require private hospital companies to make their facilities freely available for the NHS Covid-19 effort, in exchange for the NHS funding their operating costs. The bill is thought to have amounted to £2 billion in the first year.[41]

In reality, private hospitals were underutilised during the first and second waves. While it was hoped that private hospitals could provide a facility for urgent elective NHS procedures, instead the amount of NHS funded elective care work in private hospitals fell by 45% compared to the year before the pandemic.[42] This is in part reflective of understaffing across the health sector. Many doctors within the private sector also work in the NHS. During Covid-19, some doctors were working long hours in the NHS and not available for work in private hospitals. In summer 2020, the requirements on private hospitals in the contract were revised downwards so that providers could restart private work alongside Covid-19 NHS work, and to remove many private hospitals from the contract.

There are many factors that could be explored to identify the failure of these measures to provide better support to the core NHS, not least poor coordination and communication between stakeholders and the mismatch between existing NHS systems and the additional capacity that was found. The public inquiry must examine why billions of pounds of investment in Nightingales and block bookings in the private sector did not translate to a meaningful alleviation of NHS pressures.

Practical improvements in facilities

A more positive feature of the first wave was goodwill from the public and industry – leading to practical improvements for NHS workers. As panic buying from anxious consumers left supermarket shelves empty, a sense of goodwill for frontline workers emerged. HCSA joined calls for protected supermarket opening hours for NHS staff by writing to CEOs of all major supermarket chains, a policy which was enacted and became the norm. Meanwhile the third sector and local businesses made generous donations of food packages to NHS workplaces in support of staff.[43] The public stood on their doorsteps on Thursdays, clapping in appreciation of frontline workers, in what became known as ‘Clap for Our Carers’. Meanwhile, health employers also made simple improvements in facilities in recognition of the difficulties staff were facing. Hot food and overnight lunch boxes were provided in some Trusts.[44] Car parking charges were suspended in Scotland and England for NHS employees at their workplaces, a measure already in place in Wales prior to the pandemic. Free parking for NHS workers has long been a call of trade unions including HCSA – our 2019 research showed staff were paying £86 million a year simply to park at their workplaces.[45] It took the pandemic for this unacceptable ‘tax’ on staff to be acknowledged.[46]

These measures must be retained to avoid financial detriment for NHS workers, who continue to work long hours above and beyond the call of duty. Despite outcries, the government has already reneged on parking passes for health

and social care workers and volunteers, which ended free parking in local authorities in July 2021 – and we are hearing of individual Trusts following suit.[47] The government and NHS Employers must be mindful of the already fractured relationship between staff and their employers, and the harm to this relationship removal of such benefits could bring, particularly when staff are so crucial to the Covid-19 recovery.

Personal protective equipment

> No protective equipment at all, no information, no training, no support and no swabs. When we tried to order our own [we were] told public health have a supply they should be distributing, nil so far. We were always understaffed and underfunded, now we are underprepared, **this will break us.**
>
> GP, Leeds, 1st March 2020

In a battle against a highly contagious and airborne virus, personal protective equipment (PPE) is essential. Without it, those exposed not only risk catching it themselves, but spreading it to others. Sadly, both of these came to pass with Covid-19. NHS workplaces were later confirmed to be a prime source for infection as data from NHS England revealed. One in seven patients treated for Covid-19 between 1st August 2020 and 21st March 2021 caught it while in hospital, a total of 40,600 people.[48] Even before we had a full understanding of SARS-CoV-2, the international medical community knew PPE would be vital in our fight against it.

The term PPE covers a wide range of garments and equipment designed to protect the wearer from catching or transmitting infection. In this context, PPE refers to masks, gloves, gowns, googles, face shields (otherwise known as visors) and aprons.

On 29th January 2020, the World Health Organisation published this advice on the use of masks in healthcare settings: "*Health care workers should wear a medical mask when entering a room where patients suspected or confirmed of being infected with 2019-nCoV are admitted and in any situation of care provided to a suspected or confirmed case, use a particulate respirator at least as protective as a US National Institute for Occupational Safety and Health (NIOSH)-certified N95, European Union (EU) standard FFP2, or equivalent, when performing aerosol-generating procedures*".[49]

As lockdown was announced on 23rd March 2020, an HCSA snap poll demonstrated that 80% of hospital doctors did not feel safe, 69% were not confident that the Public Health England guidance was adequate and a further 34% reported that their own employer was not following the guidance.

Five months later, we were still hearing stories from staff on shortages of PPE and rationing:

> My GP surgery that I work with is currently struggling with stock of surgical facemasks for PPE, **recently we had a day where there were none for patients or staff to wear**, and at the moment we've had to stop giving them to patients because of low stock for staff … We've had barely any from the CCG – I was told we were given one box only and requests for more had been ignored or delayed ... Our practice has been buying their own but running out of suppliers with stock now ☹
>
> GP, Coventry, 4th June 2020

As discussed in our previous chapter on pandemic readiness, the UK government should have been prepared with a national stockpile of suitable PPE. However, even in the circumstances at the start of 2020, the government could have acted faster to procure more supplies. For instance, they missed several chances to join EU schemes to bulk-buy PPE, which were launched on the 28th February and 17th March.

> We cover one of the cohort wards with confirmed positive patients. I was on it all weekend. We only have plastic aprons, gloves and surgical masks. **There is 1 shared visor per bay (of 6 patients) for all healthcare workers. No gowns or FFP3 masks. I've been coughed on repeatedly.** Both SHOs [Senior House Officers] covering the ward last week are off sick. I'm not sure how many other healthcare workers are off. I'm just waiting … It's terrifying … It doesn't feel safe examining a coughing Covid patent on humidified O2 with an apron and a surgical mask. We still don't have visors.
>
> Hospital doctor, South West England, 30th March 2020

> Yesterday my hospital ran out of gowns. We had to use a pinny for intubation on a baby as we didn't have any gowns available. In my opinion that wasn't that big of a risk (babies produce very little aerosol and mum wasn't suspected as positive). However, the lack of gowns meant that for most of my shift (a shipment came later in the afternoon) we didn't have sterile gowns to do procedures. **If a baby had been born prematurely we wouldn't have had sterile gowns to put umbilical lines in! There is definitely a shortage.**
>
> Hospital doctor, Ipswich, 16th April 2020

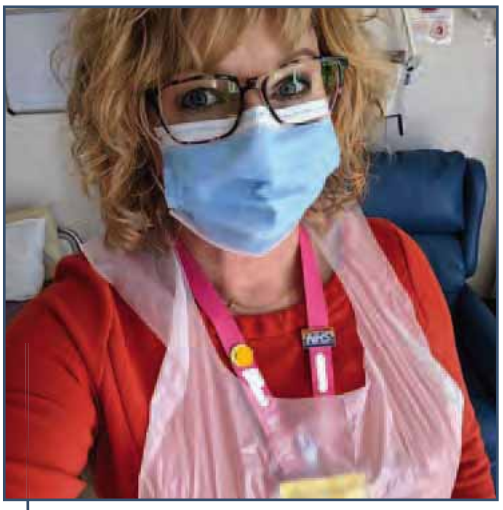
> We were worried about if we were going to catch it, on our clothes. If our PPE was good enough. This was early as well, so we didn't have a lot of PPE … And then suddenly, we ran out of masks, and we had to hunt down more, because we didn't have any.
>
> Junior Doctor, Intensive Care Unit

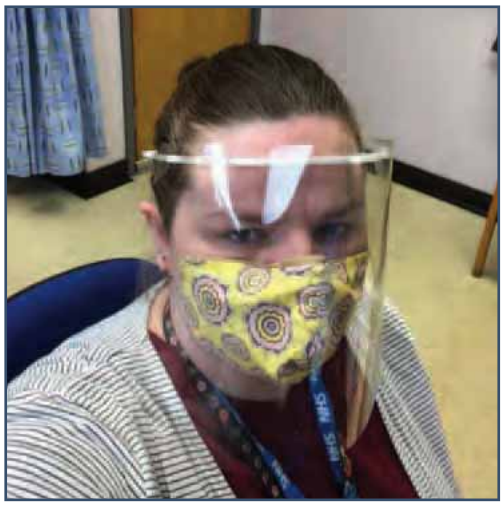
EveryDoctor went on to deliver an open letter to Simon Stevens, then CEO of NHS England, on the 19th March 2020 to highlight the shortage of protection for frontline workers. On the same day, HCSA wrote to then Health Secretary Matt Hancock expressing concern that "*hospitals across the country have been unable to access sufficient capacity of PPE*". As a result, it warned, hospitals were ordering healthcare staff to work in Covid-19-positive environments without the protection afforded even by Public Health England guidance in force at that time. It added that some Trusts were breaching PHE guidance by instructing staff in close contact with known Covid-19 cases to come to work rather than self-isolate. In the absence of testing or sufficient PPE, there is a high likelihood that such local policies were subsequently responsible for unnecessary nosocomial infection of staff and patients.

Despite responsibility for a significant proportion of total NHS provision, GPs also faced desperate shortages of PPE early in the pandemic response.[50] The first port of call for many seeking advice and treatment for the new outbreak, surgery staff were abandoned and left to source or craft their own PPE from whatever materials they could lay their hands on. Meanwhile, universities were producing PPE through 3D printing and businesses were making donations to local NHS facilities. As we will cover later in this report, many frontline workers were left footing the bill after having to source their own PPE for use in the workplace.

> We're a GP multisite surgery with over 20,000 patients. We received our PPE yesterday on the same day we had a confirmed Covid ITU case admitted in the hospital 1/4 mile from the surgery. Two rolls of plastic pinnies, a few boxes of standard gloves and four boxes of paper surgical masks, useful for our minor surgery clinics, laughable really. We've decided to go our own way and advise patients we're actively trying to reduce footfall in the surgery and working/consulting phone or online by default, posting out scripts/letters/sicknotes and not offering desk collection. We've also cancelled all non-urgent planned reviews cryo/minor surgery annual reviews for next two weeks pending further developments. **We don't trust waiting for the government. We've decided we'd rather be laughed at for going too early than wait to be told we've missed the boat which we probably already have.**
>
> GP, North East England, 10th March 2020

> The PPE was suboptimal and out of date.
>
> **Birmingham GP**





An associate specialist in stroke rehab medicine, working in a community hospital stroke recovery unit in the South West; At the point this photo was taken Covid swabs were by no means routine and 'everyone' was a potential risk.

Thankfully, there were some exceptions. Not every doctor who shared their experiences with us felt endangered in their workplaces, though unfortunately even in these less negative stories the same nationwide institutional failings appear.

> I thought I should praise the ones who get it right as well. The trust I work in has universally done what PHE has asked/altered. This in itself is insufficient but that is a different discussion … **The trust has even managed to source some waterproof reusable boiler suits for AGPs when gowns started drying up. I will support my trust of NOT being discriminatory, just being at the end of a UK universal shortage of PPE and a painfully inadequate PHE directive.**
>
> **Hospital doctor, South West England, 29th April 2020**

> In terms of my own trust, my experience has been completely the opposite … **we were very good at getting the appropriate PPE**, even now [speaking August 2021], we have adequate PPE and stocks of various different things. Yes some things run out, but then there is communication sent out immediately to say we have new PPE, come and get yourself fit-tested.
>
> Focus group – Hospital Consultant, South West England

> I was a Junior Doctor working in ICU and **it was two different worlds. In ICU we had all the gear,** full PPE, FFP3, we had everything we could possibly want, but if you had to go to a ward you had no chance of getting anything … **people who were working on the ward had barely anything** … so you had to move with PPE that you had found on your own unit to assess patients, which became quite difficult.
>
> Focus group – hospital doctor, Kent

For a lot of doctors their PPE situation depended on which department or ward within a hospital they worked in.

The weeks wore on and PPE shortages continued. A survey by the Royal College of Physicians released on the 5th April 2020 found only 78% of respondents could access the PPE they needed.[51] A HCSA snap poll of members on the 7th April 2020 reported 37% of their Trusts did not have an adequate amount of long-sleeved gowns and 47% the same in respect of full-face visors, while 44.5% of respondents said they had purchased their own PPE.

By late March, Hancock had admitted to "challenges" in the provision of PPE.[52] But not before he had publicly berated NHS workers for overusing and misusing PPE, saying they "*must treat protective equipment like the precious resource that it is*".[53] In reality, the most precious resource the NHS has is its workforce. Rather than admit the failings of his own department in distributing an adequate supply, his decision to lambast staff who were fighting this still novel virus from the frontlines was an insult. And ultimately his comments were not followed by suitable actions. The following Saturday, the government claimed the arrival of a large order from Turkey which turned out to be incorrect.[54] The order had only been placed that Sunday, and when it arrived the following Thursday, the gowns' quality was found to be inadequate and they were subsequently useless.

On the 21st April, it was revealed in the press that thousands of experienced PPE production companies had been trying to contact the government, only to hear "*nothing back*".[55] By now 80 frontline healthcare workers had died from Covid-19, and for the majority of doctors we and other health groups heard from in the first half of 2020, shortages continued to be commonplace.

Problems with PPE still did not end when stocks managed to arrive. Hundreds of thousands of items did not pass basic safety standards.[56] Yet another layer of misery and mistrust was added when NHS staff who felt fortunate enough

to receive boxes of PPE which had supposedly passed safety protocols discovered not only that they were out of date, but that steps had been taken to literally cover up that fact using adhesive stickers.

> Just wanted to flag up the mask issue about them being out of date – assume you've had loads of examples? This what we've got… **Absolutely scandalous!**
>
> Hospital doctor, South East England, 19th March 2020

> Last week the only masks available for all staff on the Covid wards went out of date in 2005 … The masks were surgical masks with elastic bands to go around your ears. You couldn't wear them for more than about 30 seconds without having them slip down past your nose. We were getting around it by tying knots in the elastic for a tighter fit … **The fact these masks were 15 years past their use by date aside, I think I speak for the majority in saying that no-one felt particularly safe wearing them** … Overall the hospital has been quite proactive in terms of procuring PPE and protecting its staff – suffice to say I was a bit disappointed to find that these masks were the only option provided to us at the time. They've since been replaced by in-date masks, but a week is a long time to be caring for Covid positive patients without adequate protection.
>
> Hospital doctor, Greater Manchester, 1st May 2020

> My hospital was not very prepared in terms of PPE, there was lack of PPE, lack of fit testing which only materialised after a bit of pressure on the CEO, there were messages sent out by the hospital management not to raise concerns on social media, threatening us with disciplinary action. I reported this [lack of PPE] to management, and HCSA and the BMA, raised it with other grassroots orgs, went to my medical defence union, and GMC, and recently the CQC as well. I went to the Health and Safety Executive, and they said to raise it internally, so it was **basically a circle.**
>
> **Focus group – Hospital Consultant, Birmingham**

On top of the initial lack of adequate PPE supplies and attempts to mislead doctors and staff into thinking some of the stock of PPE they received was in date, were the barriers and associated issues which arose when staff tried to highlight their concerns over these problems. This was either due to the lack of a clear chain of command for reporting problems, and fear from some over the repercussions they might suffer if they tried to whistleblow on the situation. On 9th April the Guardian reported a clampdown at local level with staff members being threatened with disciplinary action if they did not comply.[57]

But despite these ongoing disappointments from central government and public health bodies, NHS staff did not stand idly by and wait for solutions to be delivered. Instead, necessity proved to be the mother of invention, as many doctors crafted their own PPE from any suitable materials they could get their hands on, including bin bags, sanitary towels and rubber bands.

Doctors forced to use makeshift PPE

Doctors also found they could rely more on the kindness of strangers than they could on support from their national health bodies. The response and generosity from businesses, individuals and local community groups was absolutely overwhelming. Thousands of companies up and down the country stepped up to donate supplies, or retool factories to produce face masks, gowns or to 3D print face visors. This generosity should rightly be applauded, but it should not have been required, and it should never have to be repeated.

Donated visor for GP made by a local school and its 3D printer

This doctor's visor was donated by a 3D printing company, scrubs were handmade by seamstresses in North London and surgical masks were donated by beauticians and tattoo artists.

> So while they are expecting the current workforce to increase their hours to cope with the demand, and potentially reduce their own immune system from being unrested and tired, they will be putting those exact people in harm's way by not providing adequate PPE.
>
> **Hospital doctor, East Lancashire, 9th March 2020**

The impact of repeatedly misleading claims on doctors was understood by some in NHS management. As Niall Dickson, the chair of East Kent Hospitals Trust, told BBC Radio 4's Today show in May 2020 making promises that are not kept "*undermines confidence*" in the government among frontline staff.[58] And this was an understatement. Both HCSA and EveryDoctor were active contributors to the public domain at this time, taking every media opportunity to defend frontline staff and call for immediate action.

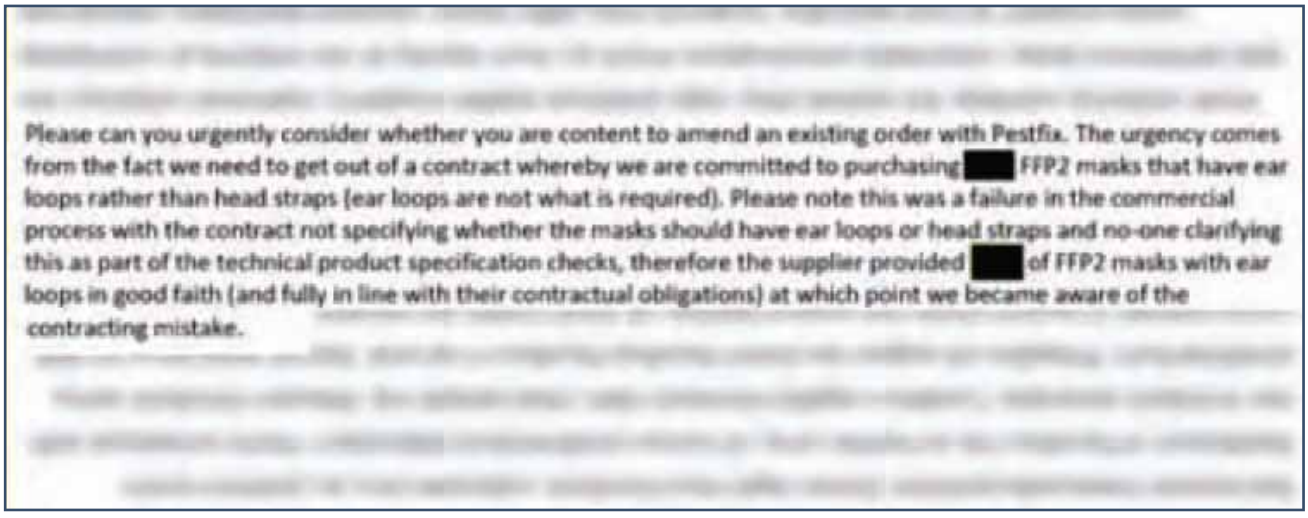
The lack of adequate PPE was not simply an institutional failing, it was an intensely personal assault on doctors' lives and the sacrifices they had been making. The strength of this feeling was the driving force behind the court cases which EveryDoctor decided to pursue alongside Good Law Project against the government, which made it to the High Court in May 2021.

These lawsuits helped reveal the true extent of miscommunication, corruption and wasted millions which surrounded the government's actions to procure PPE, much of which was either unusable or never delivered. During the worst crisis in NHS history, the government entrusted large sums of public money to companies with no experience in procuring safe PPE for healthcare workers.

> The corruption involved was staggering especially when you hear all these investigations afterwards and especially with the PPE contracts, and **PPE that wasn't even up to standards, that couldn't even be used, and was essentially wasted**.
>
> Focus group – hospital doctor, North West England

So, while NHS staff were unprotected, PPE contracts were being handed out by government ministers to "VIPs" and associates including a pest control company, a confectioner and a family hedge fund. Not only was this a waste of taxpayers' money, but it endangered the lives of those we needed the most during a public health emergency – our frontline staff.

These court cases resulted in many shocking findings, such as 1 million gowns which were ordered and paid for and yet vanished into thin air, which reinforced criticisms from many areas of the healthcare profession that there was layer upon layer of incompetence within the government's acquisition of PPE. One example is the instance evidenced below, where an order for masks was placed from a pseudonymised source (the government continues to argue that revealing their identity would compromise national security) that officials stated were "*not acceptable*" with a supplier who was a friend of a high-ranking government official.



Please can you urgently consider whether you are content to amend an existing order with Pestfix. The urgency comes from the fact we need to get out of a contract whereby we are committed to purchasing [redacted] FFP2 masks that have ear loops rather than head straps (ear loops are not what is required). Please note this was a failure in the commercial process with the contract not specifying whether the masks should have ear loops or head straps and no-one clarifying this as part of the technical product specification checks, therefore the supplier provided [redacted] of FFP2 masks with ear loops in good faith (and fully in line with their contractual obligations) at which point we became aware of the contracting mistake.

Because of the lack of national transparency or a centrally coordinated approach, hospital departments struggled to allocate PPE in a planned or equitable manner. The confusion and conflict this caused was also referenced in the Health and Social Care and Science and Technology Committee's joint report on Covid-19, which noted "*that there were similar tensions over PPE where PHE [Public Health England] was responsible for issuing guidance over the use of PPE but not for procuring or supplying the material*."[59]

To mark our High Court trial, EveryDoctor took to the streets of central London to highlight how reckless the government's approach to PPE procurement had been. Instead of providing adequate supplies, the government's constant empty assurances undoubtedly endangered the lives of healthcare workers, their patients and the wider public.

HCSA encountered the same issues. Throughout the Covid-19 crisis, members consistently raised concerns about a lack of clarity surrounding the correct guidance for the use of PPE. Responses to HCSA snap surveys demonstrated an improved understanding as time elapsed, however hospital doctors remained concerned about a complex and contradictory framework of ever-changing advice. This was compounded by inconsistent implementation at local or even departmental level. The government confirmed in response to a parliamentary question that there had been 21 separate updates to Covid-19 infection prevention and control guidance between 1st January and 7th May alone.[60] The resulting confusion led to multiple policies being adopted locally, sometimes even within the same hospital. There was also a perception that the guidance has often reflected supply rather than safety. One particular example was the failure to mandate mask-wearing in all areas of hospitals despite extremely high levels of Covid-19 across the community and the unavailability of rapid testing. These factors effectively made it impossible to tell who had Covid-19, whether patients, staff or visitors.

> "A significant number of patients with Covid may be asymptomatic and yet are able to transmit the disease to others. Doing aerosol-generating procedures without PPE, as things are at present, means that it is not a question of if but when the healthcare staff will get the infection themselves. I have written to our Trust infection control lead to highlight these concerns but they are following the PHE's guidance to the letter. This guidance is deeply flawed in my opinion and only written to conserve the insufficient supply of PPE equipment.
>
> **Hospital doctor, HCSA snap survey, March 2020**

At the time PHE also mandated only wearing higher level FFP3 masks during high-risk aerosol-generating procedures for "suspected or confirmed cases". In March 2020, front-line staff underlined the impracticality of this policy in the absence of any testing regime, reporting how they had performed AGPs on apparent non-Covid-19 patients without PPE, only to learn subsequently that the patient had been self-isolating due to Covid-19 symptoms.

EveryDoctor lit up London with a series of projections to mark their High Court trial with Good Law Project against the government in May 2021

> I have seen or heard of patients being intubated or extubated for one reason, only for it to be discovered the next day they were self-isolating due to cough and fever, no PPE has been used because they were asymptomatic or not known to be symptomatic. This problem is not isolated to theatre or ICU. The silent infective phase can affect all areas of the hospital.
>
> Hospital doctor, HCSA snap survey, March 2020

Both EveryDoctor and HCSA pushed for a broadened definition of PPE and for greater provision, writing open letters to public health bodies, working in partnership through bodies such as the Aerosol Generating Procedures Alliance, running public petitions which garnered tens of thousands of signatures and delivering briefings to MPs.

On 1st April 2020, HCSA called publicly for a change of guidance to redefine entire hospitals as a Covid-19-positive environment and mandate surgical masks for all areas. In a letter to Public Health England, President Dr Claudia Paoloni warned: "*Staff and patients may not even be aware they are spreading the virus because the symptoms can be so slight … by shifting to a policy where staff and patients are considered potential Covid-19 carriers, we will be cutting the prospect of infection and reducing the chances of crucial NHS staff being taken ill at the worst possible time*."[61]

Despite the clear and present risks right at the start of the pandemic, it was not until 15th June 2020, another two and a half months later, that this warning was heeded and facemasks were introduced in all areas of our hospitals.

There was also conflicting advice from international and UK bodies on the level of PPE required. The first round of UK guidance fell short of standards set by the World Health Organisation, which specified all healthcare workers should wear a mask, goggles, gown and gloves, and surgical masks in both clinical and non-clinical areas.[62] UK guidance had only set these standards for staff working in designated 'high-risk areas' where they would be performing aerosol-generating procedures (AGPs). This term itself went on to generate criticism, with many highlighting the fact that many more medical procedures than those listed include the risk of a patient generating aerosols, even by the act of breathing. While medical organisations representing staff advocated a safety first approach to guidance which would mean greater PPE use, there was staunch resistance by policy-makers to acknowledge the potential risk of aerosol transmission in enclosed spaces. It was only months later, as more evidence emerged on the ability of viral particles to linger in the air, that advice to the public caught up with what the workforce had argued all along. Today, official materials emphasise the need for good ventilation due

> When you think of the blatant systematic corruption that has been evident with the present regime, where **they've scandalously wasted tens of billions of public money.** Where you have this culture of cronyism, mates, chum's contracts for PPE … **It's just cringe-worthy.**
>
> Focus group – Hospital Consultant, Birmingham

to the existence of lingering infectious matter. Eventually, on 27th January 2022, the UK Health Security Agency updated guidance on healthcare settings to reflect that Covid-19 can be spread through airborne transmission, and therefore FFP3 masks should be available to all staff working with patients with suspected or confirmed Covid-19.[63] However, this information was not adequately communicated to employers, leading to concerning variations in practises between Trusts.

We recognise that blame for inadequate PPE supplies cannot solely rest on the shoulders of national health organisations, sub-contractors and the UK government. The WHO itself noted in a report from 19th March 2020 that "*the current global stockpile of PPE is insufficient*".[64] However, responsibility for the lack of preparation and central coordination, wasted public funds, poor choices in suppliers, lack of information, transparency and accountability all can be.

As healthcare professionals, we care about people, and we often go above and beyond to help our patients, but this should not be at the risk of our own lives and the lives of our loved ones. No member of the NHS workforce should have been exposed to this virus at the level many were.

According to HSE guidance on application of the law, "*It is an employer's duty to protect the health, safety and welfare of their employees and other people who might be affected by their business. Employers must do whatever is reasonably practicable to achieve this*".[65] Safe working conditions are the very basic anyone should expect from their employer and the fact that so many were not offered this was and should remain in the public mind as a national disgrace. HCSA and EveryDoctor will continue to campaign for high grade FFP3 masks to be widely available throughout the NHS and, as a minimum, for every patient-facing staff member to have access to them.

Safety measures for staff at work

PPE is an important part of a larger picture in infection control. Other known risk factors for infection transmission within healthcare settings include short staffing, poor building design, lack of ventilation, overcrowding and inadequate testing.[66] Staff shortages become a risk factor when staff are asked to move between different areas in the hospital to provide cover, therefore potentially transmitting infection across the workplace. A reliance on agency or bank staff also impacts on infection control, as the nature of their work involves moving across different workplaces from day to day. Buildings were transformed quickly to accommodate social distancing and 'red' and 'green' areas established to try to distinguish where higher PPE was required due to perceived differences in virus risk. However, many older buildings do not lend themselves to new infection control standards, with inflexible layouts

and poor ventilation, and high levels of community transmission undermined the idea that any area could truly be Covid-19-free.

It is also important to recognise that each employee has an individual risk propensity, and therefore the required protections from Covid-19 can differ. NHS England and NHS Improvement issued guidelines in April 2020 that included a recommendation that employers risk assess staff who were deemed to be at higher risk from the virus.[67] This included staff from Black, Asian and minority ethnic groups in recognition of the disproportionate impact of Covid-19 upon them. On 12th May 2020, the Health & Safety Executive followed this up with a toolkit for employers on conducting individual risk assessments to handle Covid-19, in line with employer duties under health and safety legislation.[68] However, an HCSA survey in June 2020 found that two-thirds of respondents had not yet had individual risk assessments, which led it to call for the consistent implementation of risk assessments for every NHS staff member as a matter of urgency.[69]

Clinically extremely vulnerable colleagues were sent home as part of the government's 'shielding' guidance, with strict limits on social contact in order to protect those deemed most vulnerable from the virus. This group experienced isolation more severely and for a greater period of time than the rest of the population. One study shows clinically significant anxiety rates rose from 27% pre-Covid-19 to 54% during Covid-19 in those deemed clinically vulnerable.[70] Government changes in guidelines were particularly difficult for shielding colleagues who were expected to return to the workplace at various points during the pandemic, when the virus was deemed to be less of a risk, then sent home again as guidelines changed.[71]

> There was a lack of testing, mainly for people who were symptomatic but weren't fitting into the Public Health England testing criteria, who didn't have a cough or loss of smell etc. but they had regular headaches or were tired all the time, or sore throats, which would not allow you to have a test but these are some of the symptoms which were well known. So **guidelines should've been expanded to allow a greater amount of testing** [in] around April or May 2020, when the CDC in America expanded their list of symptoms.
>
> Focus group – Hospital Consultant, Birmingham

Test and Trace

The government Test and Trace scheme, launched on 28th May 2020, soon gained notoriety for its failure to deliver on targets despite a gigantic £22bn budget. Factors impacting on performance included an overreliance on for-profit private-sector firms, and central control limiting the efficiency of local authority teams. Reports of employees not being provided with any work, and operations run from primitive Excel spreadsheets, exposed the poor governance of the contact tracing side of the scheme.[72] In June 2021, a National Audit Office report found that while performance of the scheme had improved over time,

inefficiencies continued, such as costly yet unused capacity, the procurement of providers without competitive tendering and an over-reliance on private consultancies to carry out contact tracing. Local authorities reported that engagement has improved, but data-sharing remained inadequate.[73]

The 'testing' element of the scheme has also been plagued with issues and in August 2020 demand far outstripped supply for tests for those displaying Covid-19 symptoms. Doctors and other healthcare workers were reporting three-day waits for a booking at a test centre. This translated to increased staffing pressures as health workers were forced to isolate at home for prolonged periods while awaiting test results. The government stated on 3rd September 2020 that the situation was improving, and that by Friday 4th September "*no-one should be asked to travel more than 75 miles to get a test*" – but the situation carried on throughout the autumn.[74] Finally, on 21st September 2020 the Health Secretary announced a priority testing service for the health service. Yet despite the urgency of the situation, in a poll by EveryDoctor of 26,000 doctors more than a week later on 29th September 2020, 32% of respondents reported that there was no priority service for their healthcare facility, nor had they been informed that one was being set up.

> GP surgery in Oxford – 6 members of staff off today – 1 GP, 2 nurses, 1 physiotherapist and 2 receptionists. None of them can get a test despite trying all weekend.
>
> **GP, Oxford, 15th September 2020**

> I spent much of Tues evening and night and Weds morning attempting to get a test on the gov.uk website. It suggested Leicester to me, and then also Telford and Edinburgh airport (I live in Ely). I made a decision not to travel so far, as I would likely have to make a stop with my toddler, and I couldn't justify making a long trip while symptomatic. I know of colleagues who travelled to Telford, but I didn't feel this was at all the right thing to do. I managed to get home kits booked after refreshing the page innumerable times. The tests arrived Thursday 10th mid-morning and I sent them off the same day. Fast forward to today [Monday] and I have not had a result yet. I was due to do four night shifts starting tonight and HR have been helpful and put these out as locums. I have missed two working days last week (I am LTFT). My son and I are both well and I feel fit to work. I was on hold with 119 for over an hour last night with no answer, and over half an hour this morning just after 07:00 with no answer, and a new recorded message stating that it would not be possible for them to chase a test result. I know that others are in far worse positions than me, but I am so angry with the testing system. I felt guilty feeling equivocal about the cough and whether that merited a test given the scarcity of them, and now I feel guilty that I am well and unable to work because I haven't received a result. In May/June I was able to access drive-through sites very close to me (between 1-15 or so miles) and received results quickly on both occasions.
>
> **Psychiatry trainee, East of England, 14th September 2020**

In November 2020, asymptomatic staff testing was also rolled out for NHS workers.[75] This was a welcome measure in infection control, although there are conflicting assessments of efficacy of the lateral flow tests. PHE and Oxford University reported a false positive rate of just 0.32% and a detection rate of 76.8% for all PCR positive individuals.[76] Contrarily, the U.S. Food and Drug Administration (FDA) published a warning over significant concerns on performance of the tests and subsequent false positives or negatives leading to worse health outcomes.[77] It is clear that testing alone does not guarantee the safety of doctors and other health professionals – testing can only supplement adequate infection control which is best achieved through high-grade PPE, distancing measures and strict cleaning regimes, and safe staffing levels.

As restrictions eased in summer of 2021, community infection led to a further staffing crisis within the NHS, and the phrase 'pingdemic' was coined, which in the NHS saw colleagues being 'pinged' by the Track and Trace app after coming into contact with someone with Covid-19, and resultantly required to stay home and isolate. One Trust reported 500 staff in isolation at once.[78] The impact of community transmission would not have been so acute on the NHS had it entered the pandemic with adequate staffing levels. The serious staffing situation prompted the government to ease the Covid-19 guidelines further, no longer requiring isolation for asymptomatic key workers and those who have been double-vaccinated.[79]

> I am a Consultant in Cheshire. My wife is a GP… After a flurry of coryzal symptoms in our children last week, my wife developed a cough and temperature on Sunday night. She contacted her practice and tried to arrange a priority test via her CCG. This proved impossible. We also applied via my employer for staff and family testing. Neither of the above yielded any fast help so my wife got a walk-in test after a one-hour quest on Monday lunchtime I subsequently got a call from staff testing at 14:50 on Monday afternoon by which point she'd already had a test. The lady at staff testing told me **they'd had 40 test requests from staff in my Trust alone on Monday morning (this is with a background of regular routine staff testing as well) – my Trust employs 4,500 people so 1% of staff on one day alone.** We are still awaiting results but have been warned that viral swabs currently face a 5-7 day backlog. Currently we are both working from home while trying to care for our children … I heard the health secretary respond to an urgent question yesterday stating that the majority of tests are back within 24 hours. This does not currently seem to be the case.
>
> **Consultant, Cheshire, 16th September 2020**

In October 2021, NHS Test and Trace suspended test processing operations at a megalab after it was estimated to have produced up to 43,000 false negative PCR results between 2nd September and 12th October, primarily affecting residents of the South West of England. Clearly, false negative results represent a major failure to control the virus, as people infected with Covid-19 are wrongly told they do not have the virus and do not isolate.[80] By 18th October, cases in the South West had risen sharply to 7,541, the highest case numbers the region had seen during the pandemic.[81] It is highly likely that some of this spike can be attributed to the errors of the Test and Trace processing lab.

The shortcomings of Test and Trace highlight a wider flaw in the government's predisposition towards privatised solutions. For example, Deloitte overseeing Lighthouse Labs which were ultimately unable to get tests done quickly enough.[82] Similarly, Serco was one of two companies involved in the contact-tracing system that regularly missed the government's own targets.[83] While emblazoned with NHS branding, such ventures had almost nothing to do with the NHS and led to millions of public money being wasted.

The second wave

> From a basic geographical standpoint if you're an island you have a distinct geographical advantage over other nations, and the fact that they [the government] had people coming in and out at the beginning with no testing, no minimal quarantine and no checks, and track and trace being essentially useless, massively contributed to people spreading it to whomever.
>
> **Focus group – ST1 Junior Doctor, North West England**

As the first wave subsided, summer 2020 was an opportunity for the government to take stock and plan for the winter. The more contagious Delta variant had begun to arrive in the UK, yet international borders remained open despite expert warnings. Inaction and delay characterised this period. Despite calls from HCSA in April, face coverings were only made mandatory for NHS staff and hospital visitors on 15th June 2020.[84] This was finally extended to retail on 24th July 2020.[85] In August that year, the government launched Eat Out To Help Out, a discount scheme designed to boost the economy by encouraging the public to dine out in restaurants. University of Warwick research attributed between 8-17% of Covid-19 cases in August and early September to the scheme.[86]

As winter 2020 approached, calls grew for a national 'firebreak' lockdown and school closures, yet these were ignored in favour of local lockdowns. The three-tier system, where regions were assigned restrictions according to Covid-19 status, did not account for people moving between boundaries, and

rules such as curfews on bars led to large numbers of people assembling together outside at once. Cases accelerated and the NHS warned of overload with the winter flu season on the horizon. EveryDoctor launched its Protect NHS Workers pledge, and gained the support of 104 MPs for its five calls:

1. Priority access to testing for health and social care workers and their household members, within 24 hours of onset of symptoms.
2. PPE for all health and social care workers in line with World Health Organisation standards.
3. A fair death-in-service package for all bereaved families of health and social care workers who have tragically died of Covid-19 in the line of their work.
4. Fair sick and isolation pay arrangements for all health and social care workers, including temporary and locum staff.
5. Provision of accommodation for health and social care workers living with vulnerable people.

Finally, England moved into national lockdown on 31st October 2020, over a month after a 21st September meeting of SAGE had advised the government to do so with the Prime Minister justifying the lockdown to resistant Conservative MPs as a means to avoid a "medical and moral disaster" for the NHS.[87] It was promoted by Downing Street as a short measure needed in order to 'save Christmas', a pledge which was to come back to haunt the nation and our NHS.

The five-week delay in implementing a national lockdown was publicly criticised by government adviser Professor Andrew Hayward who said had a lockdown been implemented immediately "*we would definitely have saved thousands of lives*".[88] The one-month lockdown served to suppress daily case numbers from a seven-day average of 22,330 on 31st October to 14,400 when it ended on 2nd December.[89] Yet within 48 hours cases again began to rise exponentially as the more transmissible Delta variant swept across the country. It would take over three months and a new national lockdown before the seven-day average fell below 15,000 again, on 7th February 2021.[90]

Two weeks on from the November lockdown, the writing was already on the wall as case numbers spiralled upwards relentlessly. HCSA's internal analysis of rising hospital numbers showed clearly that on the current trajectory NHS hospitals faced being swamped. Despite this, the government appeared bound to its pledge to 'save Christmas', a position HCSA's President branded "kamikaze".[91] It was only on 19th December, with daily cases passing 27,000 and a record 16,000 Covid-19 patients being cared for in hospital beds, that the UK and devolved governments finally responded with a trimming down of numbers for household mixing and the loosening of restrictions only on

Christmas Day itself. However, the last-minute nature of these limited steps was bound to impact on their effectiveness, with many of the public reluctant to alter plans at short notice or in a position where they had already travelled elsewhere for Christmas.

As hospitals were inundated with a record number of Covid-19 patients in the run-up to the new year, the government appeared paralysed in the face of growing calls for a new national lockdown. HCSA warned publicly on 29th December that, without a new lockdown, hospitals would collapse within days.[92] Yet it was not until 4th January 2021, with cases passing 76,000 in a single day and more than 30,000 Covid-19 patients occupying hospital beds, that the Prime Minister finally moved to call a fresh national lockdown.[93]

For the rest of January 2021 the NHS and its staff were left confronting the grim consequences of this delay. The UK reached the tragic milestone of 100,000 Covid-19 deaths. This was soon followed by the UK's 'deadliest day' of the pandemic on 19th January, with a total of 1,485 deaths.[94]

EveryDoctor and HCSA were receiving reports that ambulances were unable to unload Covid-19 patients because A&E departments were full. Staffing levels continued to drop and beds were in short supply.[95] With hospitals in Greater Manchester and Liverpool full with Covid-19 patients, they were forced to care for them and others in corridors. Meanwhile, arrangements were put in place to share resource throughout the NHS, with patients moved around the country in what was an incredible team effort, and a deeply stressful time for staff. It is inevitable that government indecision and delay caused unnecessary deaths in this period, overloaded the NHS and in turn added to future waiting lists.

> We have four juniors off from one ward with stress. Still no redeployment and despite elective operations being stood down, surgical juniors are not being released to Covid wards. It needs a push from above. In the words of one junior – the Trust values saving money above our well-being and safety and that of our patients.
>
> **Hospital doctor, 12th November 2020**

> By the time of the second wave we knew more about which people were at higher risk and staff had had risk assessments done.
>
> **Focus group – Hospital Consultant, Birmingham**

National vaccination programme

As the winter wave progressed and the UK population was subject to a stay-at-home order, the government and public pinned their hopes on the newly launched vaccination programme. In contrast to Test and Trace, the UK's vaccination programme had a successful start, administering more vaccine doses per head than any other country in the world.[96] A significant factor was the decision to run the programme through the NHS, and in turn the expertise with which the NHS workforce delivered the programme. Sir Simon Stevens, head of NHS England and in charge of rolling out vaccination, avoided the pitfalls of outsourcing or developing new models that had plagued Test and Trace. Instead, the strategy in England depended on tapping into pre-existing Primary Care Networks – effectively groups of GPs, which themselves cluster into Clinical Commissioning Groups. GPs were advised that within every PCN, one surgery would be designated a vaccination hub. It wasn't without logistical issues, as GPs were given a short deadline to decide whether to agree to the proposals yet with very little information as to what was being asked of them. In particular, there appeared to be no planning for how primary care was to be delivered to the populations normally covered by vaccine hub practices. Nonetheless, GP surgeries sprung into action to assist with the delivery. Hospital and mass vaccination sites also played a pivotal role in the programme.[97]

On 30th December 2020, the government changed rules suddenly on spacing of vaccine doses, causing delays for many vulnerable health workers in receiving their second injection.[98] The decision was made to prioritise greater access to first doses, and therefore a higher number of vaccinated individuals, than timely second doses. Yet this change was poorly communicated with little planning, leading to the short-notice cancellation of thousands of appointments for health workers in high-risk environments who were then left in limbo awaiting the top-up vaccination. HCSA and EveryDoctor launched calls for every healthcare worker to be vaccinated by the end of January.

> As a GP working at the front line during the Covid pandemic remaining unvaccinated fills me with dread. Not just for myself, running the risk of contracting Covid from a patient and dying. Not just for my family who would lose their mum and main breadwinner, and who risk getting it because I bring it home. But also for my patients, many of whom are vulnerable, whom I may infect or, in the event of my illness or death, leave without health care. The toll that would also place on my colleagues having to take up my share of the work is unthinkable. There is no slack in the system to allow for me to be absent.
>
> **GP, North West England, 6th January 2021**

> My day-to-day shift pattern massively changed, especially in the first wave. We were doing 12 or 12 and a half hour days, and we were doing three on, three off, switching between days and nights ... for your three days off you were asleep to be brutally honest, because after three nights you were knackered, and then after three long days you were knackered. **It was just quite relentless** and the continuous switching between them was very difficult, and that was just so we had more people on the unit out-of-hours basically, because we had a higher volume of patients meant that we needed so many doctors on each shift. That's how our Trust came to staff it. But it was very, very knackering and especially doing it for six months.
>
> Focus group – ICU Junior Doctor, Kent

Despite the initial success, over 2021 vaccine take-up slowed. On 20th October 2021 around 67% of the UK population was fully vaccinated, making the UK 32nd in the world and behind countries such as Portugal and Spain.[99] As winter approached, health and care staff and vulnerable members of the public began to receive further vaccinations. Meanwhile recent moves to vaccinate school children have happened later than other European countries, rolling out to 12 to 15-year-old children in England from 21st September.[100] This was four months after the European Medicines Agency had recommended vaccination in over-12s from 28th May 2021, which saw many EU countries beginning their rollout over the summer months.[101] While commissioned by the NHS, the School Age Immunisation Service frequently contracts private providers to operate in schools, and it is yet to be seen whether this will run as efficiently as the initial NHS-led vaccination programme.

> It [staffing] was quite stretched in ICU when they changed the rules about how many patients an ICU nurse could look after during the pandemic. Normally it's one-to-one for level 3, and two-to-one for a level 2 patient. But during the pandemic it was essentially three or four level 3 patients to 1 ICU nurse, and as good as an ICU nurse can be, looking after three level 3 patients who are very sick is incredibly difficult. **I fully appreciate they did their best but** things happen and things are missed and care is delayed, **they [patients] wouldn't have gotten the same care they would've done with a one-to-one ICU nurse.**
>
> Focus group – Hospital Junior Doctor, Kent

> It genuinely feels like as NHS workers we are only good enough to be cannon fodder and allowed to risk our lives and put our families at risk by doing so every day at work, yet when it comes to our personal lives which often are our coping mechanisms then we are not allowed to do basic things which are a lot safer than going to work… I have a genuine fear of getting the virus and ending up another frontline NHS statistic, and the most horrible thing about that, I fear that I would be lying on my deathbed thinking back to the last however many months of my life during lockdown where all I was allowed to do was work and could not do any of the things that usually have brought meaning to my life outside work. Including seeing my loved ones, or being hugged by my boyfriend. Or seeing my brother. I have the same fear for my family members if they were to catch it from me, Or from visiting the supermarket.
>
> I hope that it doesn't come to that. But I hope the government realises that these are the types of thoughts that their frontline NHS staff are having, I do not think I am alone in that. **More than once I have wondered if I should make sure all my finances etc are in order 'just in case', or if I should write a 'just in case' note to my family and friends, 'just in case' my work causes me to contract Covid due to inadequate PPE. I do not like the stats amongst healthcare staff. No amount of clapping on a Thursday night can take these genuine fears away** … I will continue to do my job (like every other NHS and care worker) to the best of my ability and always with a smile and compassion and kindness even though some days inside I may be crying or trembling with fear or both. Is that what it is to be an NHS doctor in 2020?
>
> **GP, Scotland, 22nd May 2020**

GPs

Primary Care doctors and their surgery staff have been neglected and scapegoated by the media, statutory bodies and the government throughout the pandemic. This is despite the twin facts that primary care has had to absorb higher levels of demand from patients unable to access secondary and tertiary hospital services, alongside a pre-existing and longstanding GP shortfall of around 7,000 doctors, meaning that primary care provision was already strained under normal circumstances.[102]

Multiple health secretaries have promised to fix this. In 2015, Jeremy Hunt pledged to increase the GP workforce by 5,000 by 2020.[103] In 2019, Matt Hancock pledged to increase the GP workforce by 6,000 by 2024/5.[104] However, neither health secretary took the steps necessary to fulfil these aims. The reality is that there are 1,904 fewer full-time GPs in 2021 than there were in 2015.[105] According to a BMA staff survey in July 2021, due to these workforce shortages on average each full-time GP in the NHS currently does 1.3 full-time roles. That is an additional 11-12 hours extra per week per full-time doctor.[106]

August 2021	61,032,314
August 2020	60,423,015
August 2019	59,957,750
August 2018	59,234,413

Number of registered GP patients in England
Source: Table built with data from NHS Digital

In the UK in 2019, there were just 76 GPs per 100,000 people.[107] In comparison, in 2018 Cyprus had 105 per 100,000, Belgium 115 and Portugal 244. At the same time, the total number of patients registered at GP surgeries has been increasing year on year meaning that, like every area of the NHS, GPs were extremely stretched even before the pandemic began.

GPs were instructed to move immediately to a different way of working on 19th March 2020, utilising telephone consultations as one method to keep communities safe during the pandemic.[108] Many pushed back on this instruction due to concerns for their patients' safety – although just a few months later it was GPs who were again criticised by politicians and the press for having made the switch to remote surgeries. Far from closing their doors and hiding behind their phones, most GP practices have been extremely busy for the past 18 months. A quarter of a million more appointments were carried out by GPs in the third week of August 2021 compared to the same pre-pandemic week in 2019.[109] An Ipsos Mori survey found patients are actually more satisfied with the type of appointment they were offered recently compared to that which they were receiving before the pandemic, a rise from 74% in July 2019 to 82% in July 2021.[110] Despite general levels of satisfaction, the rise of anti-GP rhetoric across the media and by some frontbench politicians – including the new Health Secretary Sajid Javid – have led to a sharp rise in levels of verbal and physical abuse. In one instance this culminated in a terrifying attack in a surgery in Manchester injuring four members of staff and resulting in a GP and another member of staff being taken to hospital.[111]

We all rely on primary care as patients and colleagues. It is the foundation upon which much of the infrastructure of the NHS rests, and it comprises an enormously compassionate workforce who are dedicated to the care of their communities. However, the numbers of GPs taking sick leave, early retirement or quitting the profession altogether is on the rise. Once again we face a cliff-edge. If we do not improve the working lives of our GPs soon, patients and the wider health of our communities will face an even greater struggle.

"Freedom Day"

The 19th July 2021 was heralded 'Freedom Day', as the government removed almost all remaining restrictions in England, including mandatory mask-wearing and social distancing measures. This approach diverged from the devolved nations, and guidelines on mandatory mask-wearing continued in Wales, Scotland and Northern Ireland, as well as much of Europe. In September 2021, a further relaxation was recommended by the UK Health Security Agency, including a lessening of social distancing within health

settings and a downgrading of cleaning requirements to standard rather than enhanced.[112] We are deeply concerned about the impact of lessening protections on the safety of the NHS workforce particularly, as we will go on to discuss, with the high prevalence of long Covid in this group.

One factor is transmission within schools, and SAGE experts warned in August 2021 that we were likely to see a spike as schools returned.[113] This was confirmed by the Office for National Statistics data for the week ending 9th October, which demonstrated that cases had risen to the extent that 8.1% of children in secondary school years 7 to 11 in England were estimated to have Covid-19 in that single week.[114]

The Omicron variant

When the first case of the Omicron variant was identified in the UK on 27th November 2021, its increased transmissibility was a cause of great concern. Cases were doubling at 2.5 days and little was known about the severity of the strain.[115] The Government responded by funnelling resources into the acceleration of the vaccine booster programme. The NHS rose to the challenge once again, redeploying staff at speed and creating pop-up sites to vaccinate the public as quickly as possible. 'Plan B' measures were also introduced, including compulsory face coverings, mandatory Covid-19 passes for visiting larger venues and a reintroduction of the work from home guidance. Ultimately, these measures did not halt the inevitable jump in cases as families gathered over Christmas and the highly transmissible variant spread through the generations. It was estimated that one in 10 people in London had Covid-19 in the final week of December, and one in 15 in England.[116]

With so many of the public in Covid-19 isolation, a staffing crisis broke out across the NHS. Nearly 50,000 healthcare staff were absent for Covid-19-related reasons on 5th January 2022.[117] This represents an increase of greater than 400% from 5th December 2021. This extraordinary leap created huge pressures on the workforce, leading to 24 NHS Trusts in England declaring a "critical incident" in January 2022. Furthermore, with no requirement for Trusts to declare 'critical incident' status, it is likely this measure understates the problem, with many Trusts facing the same issues undeclared.[118] Some Trusts were left with no option but to suspend or delay non-urgent procedures.

The saving grace of the Omicron variant is the lesser severity of its symptoms in comparison to the Delta variant. Whilst January 2021 saw a surge in Covid-19 hospitalisations up to 4,583 per week, in January 2022, the rise in hospitalisations had a lower peak at 2,612 admissions. This has given cause for Government to unwind the 'Plan B' restrictions in place and row

back on the mandatory vaccine policy for healthcare workers. The devolved governments in Scotland, Northern Ireland and Wales also moved to ease measures, albeit at a more gradual and cautious pace.

Whilst there appears to be light at the end of the tunnel for this year's winter pressures, it is important to remain mindful of the incredibly stressful period healthcare workers have gone through. Omicron required NHS staff to fill impossible rota gaps, and led to another Christmas without time to rest, recharge and connect with family. And the pandemic is far from over, with 220 Covid-19 deaths across the UK in the last week of January.[119] The NHS workforce that desperately needs to rest must also be prepared to respond to the possibility of a future, more virulent strain.

> One thing I will say, I did feel a bit lucky in the first wave, when everyone had to isolate at home, at least we got to go to work, chat to other people, chat to our colleagues and I did find that **team bonding did improve in that time** because essentially we were the only people you could talk to face to face, as opposed to everyone else who was stuck at home and that enhanced our team ethic.
>
> Focus group – ICU Junior Doctor, Kent

“

We are doctors, but we are also human beings

3 Caring for our colleagues

As restrictions required the public to stay home for their own safety, frontline workers were expected to do the opposite. This chapter will explore the physical, psychological and economic impact felt by doctors who stepped up to respond to the pandemic. Firstly examining the implications for doctors who contracted Covid-19, including NHS deaths, the disproportionate impact of the pandemic on BAME colleagues and the experience of long Covid. The chapter will also consider how the pandemic impacted on the wellbeing of the medical profession, in particular the mental toll of working in extremely stressful circumstances, and the wider economic impact of the pandemic. Finally, it will discuss the interruption to training and implications thereafter for the careers of doctors in the future.

> “I was on night shifts for the first weekend after the UK went into lockdown and it felt like just driving towards the Apocalypse. There were literally no other cars on the road. It was like being in a horror film.
>
> **Junior Doctor, working in anaesthetics and ITU through Covid**

NHS deaths

First and foremost, we seek to pay tribute to NHS workers who lost their lives. In the first wave of the pandemic, studies were conclusive that health and social care workers were at higher risk of contracting Covid-19.[120,121] Data also points to an increased likelihood of health workers experiencing severe Covid-19, determined by hospitalisation or death – in one study, the increased risk was sevenfold.[122] There were 1,561 recorded deaths as a result of exposure to Covid-19 amongst health and care workers between 9th March 2020 and 7th May 2021 in England and Wales.[123] In Scotland, 54 deaths related to Covid-19 of health and social care workers have been recorded to date.[124] Unfortunately such data is not available for Northern Ireland.

These perturbing statistics represent heroes of the pandemic, who lost their lives in service to the public. We have already demonstrated the lack of protection in place for key workers at the beginning of the pandemic. These systemic problems contributed to the deaths of NHS workers.

> [Describing putting a patient on a ventilator] Being that person at the top, instrumenting the airways, putting yourself in the direct path of all those Covid particles that the patient is producing because they're so sick: that's what puts you at risk of getting sick yourself.
>
> **Junior Doctor, working in anaesthetics and ITU through Covid**

> I personally suffered lots of tragedy, I lost four friends in the first wave and two in the second wave, which was terrible. It just seemed an awful thing to happen, but that's life I suppose.
>
> **Focus group – Hospital Consultant, South West England**

Death in service benefits

The UK government has gone part-way to recognising the risk that workers were asked to take, by making a £60,000 recognition payment to families of eligible workers in England who die from coronavirus in the course of their frontline essential work.[125] Similar schemes are also in place in Scotland and Wales.

Yet the Department of Health and Social Care confirmed that as of 21st July 2021, there had been only 521 successful claims to the NHS and Social Care Coronavirus Life Assurance Scheme.[126] This represents only a third of eligible families receiving the payment they are entitled to. Furthermore, those usually in receipt of Universal Credit have found themselves ineligible for benefits after receiving the payment.[127] Meanwhile, the scheme available in Scotland excludes social care, leaving bereaved families without recompense.[128]

It is clear the scheme is not functioning as it should, and does not go far enough. The respective UK and Scottish governments must do more to make these schemes effective. A starting point would be to invest in raising awareness of the scheme as well as practical support with applications. It is vital that bereaved families receive the support to which they are entitled.

Disproportionate impact on BAME doctors

> Another thing the pandemic has highlighted is health inequality.
>
> **Focus group – hospital Consultant, South West England**

A Public Health England (PHE) analysis 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.[129] Alarmingly, in the first few months of the pandemic, analysis showed 18 out of the first 19 UK doctors to die of Covid-19 were BAME. This represents 94% of deaths in a staffing group where 44% are BAME. The vast majority of the doctors to die were also male and the median age was 62, echoing the higher risk factor identified by PHE. The same analysis also found more widely across all NHS staff groups that 63% of deaths were from an ethnic minority background, despite a much lower 23% of the workforce coming staff from an ethnic minority background.

The latest dataset from ONS shows that in the first wave in England, the rate of death amongst the public was highest for the black African group, at 3.7 times higher for a black African male than a white British male.[130] In the second wave, the difference between white British and Bangladeshi and Pakistani mortality increased, and for Bangladeshi groups this represented a five times greater likelihood of death in Bangladeshi males than white males. Even adjustments for location, disadvantage, occupation, living arrangements and pre-existing health conditions left black and south Asian groups at higher risk than white British groups in the second wave.

It is clear that the coronavirus pandemic has exacerbated existing inequalities and their impact. The reasons for the high death rates of BAME individuals are undoubtedly complex and multifactorial, encompassing structural health inequalities, underlying health issues and socio-economic reasons. This extract from an EveryDoctor briefing delivered on the 30th April 2020 analyses these five factors as contributory to the disproportionate number of BAME healthcare worker deaths:

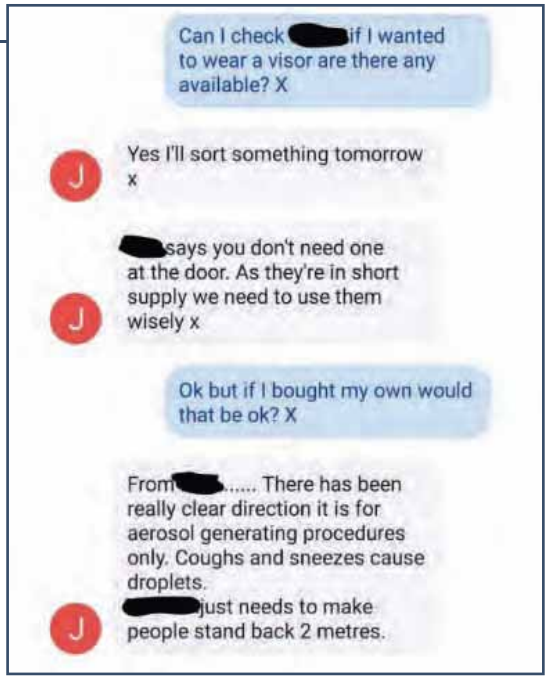
- In the NHS, BAME staff are more likely to be working in junior, temporary roles and they are inherently less supported in a healthcare system with a known racial pay gap and poor BAME representation in senior roles. BAME staff make up 17% of the NHS workforce but only 11% of senior managers are BAME. This drops to 6.4% at a very senior level.[131] Junior and temporary staff find it more difficult to speak up about workplace difficulties such as lack of PPE.

- The BMA ran a survey which found BAME healthcare workers are more likely to be put in 'hot wards' with Covid-19 patients. Sixty-four percent of BAME doctors have felt pressured to work in settings with inadequate PPE where AGPs are carried out, exposing them to risk of infection, compared with 33% of doctors who identified as white.[132]
- BAME healthcare workers are more likely to belong to poorer socioeconomic groups with higher rates of child poverty, overcrowded or multigenerational households, and ill health; all these factors increase risk of contracting the virus from others.[133]
- There are underlying health issues amongst some groups within the BAME community such as increased risk of heart disease, diabetes and Vitamin D deficiency. However the evidence base showing direct correlation between these risk factors and susceptibility to Covid-19 is not yet robust.
- Finally, we know that BAME doctors are more likely to be referred to the GMC than their white colleagues. A study released in June 2019 states "*disproportionate referrals of BAME doctors to fitness to practice processes could be driven by poor induction and support, working patterns which leave them isolated, and poor feedback by managers*".[134] This fear of referral to the GMC contributes to a doctor's inability to advocate for themselves in pressurised situations; impacting BAME doctor's ability to access safe PPE.

BAME doctors are placed in an impossible situation where advocating for their health and safety often results in irrevocable career detriment. This in turn creates and exacerbates the ethnicity pay gap. HCSA highlighted the impact of institutional racism on pay and called for action in the Review Body on Doctors' and Dentists' Remuneration Forty-Ninth Report for 2021.[135] Without tackling systemic racism within the health sector and wider society, BAME colleagues will continue to experience disproportionate impact from Covid-19, ultimately leading to preventable deaths.

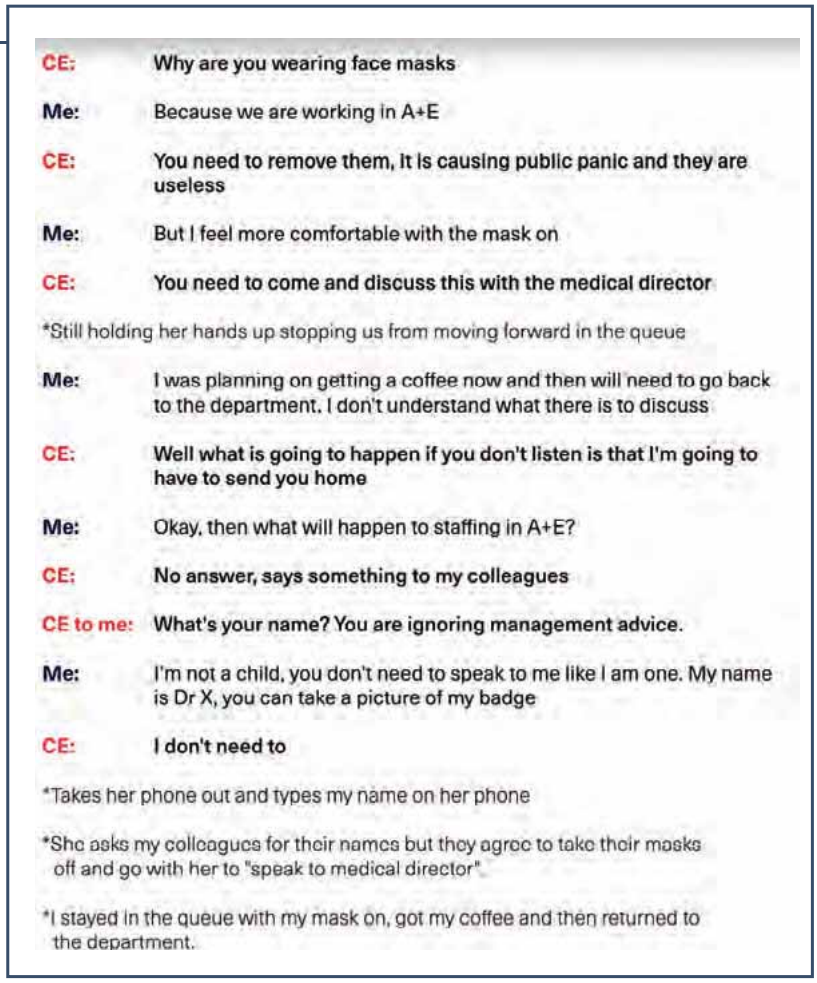
Two case studies of BAME EveryDoctor members facing barriers in their workplaces to obtaining safe PPE:

1.



2. A BAME ED member:

"I was very upset about the conversation I had with the chief executive. The last thing we need is an atmosphere of intimidation and bullying but that is how I feel. She approached us in front of numerous colleagues, also in the queue, and likely some members of the public as well. I couldn't believe that she threatened to send me home for wearing a surgical face mask and 'causing panic', when colleagues are calling in sick almost on a daily basis and the majority of the public are wearing their own face masks anyway. I have not been made aware of any formal trust policy about not wearing surgical face masks within the trust, outside of ED."



CE:	**Why are you wearing face masks**
Me:	Because we are working in A+E
CE:	**You need to remove them, it is causing public panic and they are useless**
Me:	But I feel more comfortable with the mask on
CE:	**You need to come and discuss this with the medical director**

*Still holding her hands up stopping us from moving forward in the queue

Me:	I was planning on getting a coffee now and then will need to go back to the department. I don't understand what there is to discuss
CE:	**Well what is going to happen if you don't listen is that I'm going to have to send you home**
Me:	Okay, then what will happen to staffing in A+E?
CE:	**No answer, says something to my colleagues**
CE to me:	**What's your name? You are ignoring management advice.**
Me:	I'm not a child, you don't need to speak to me like I am one. My name is Dr X, you can take a picture of my badge
CE:	**I don't need to**

*Takes her phone out and types my name on her phone

*She asks my colleagues for their names but they agree to take their masks off and go with her to "speak to medical director".

*I stayed in the queue with my mask on, got my coffee and then returned to the department.

Long Covid

In April 2021, the ONS reported that health service workers were the occupational group with the highest prevalence of self-reported long Covid at 3.6% of the entire workforce.[136] This is deeply concerning for a health service that is already struggling with staffing shortages and recovery. It is highly likely that many health workers experiencing long Covid contracted the virus at work, and therefore the NHS must mitigate the risk by upgrading primary protection measures including making FFP3 masks available.

Symptoms of long Covid include brain fog, fatigue, pain and breathlessness. For some these are so severe that it is impossible to work, while others find symptoms come on suddenly. NICE guidelines are now available to assist medical practitioners in diagnosing and treating the condition, yet it will be familiar to many through personal experience and that of their colleagues.[137] Funding of £20m has been committed by the National Institute of Health Research into 15 studies to expand knowledge of the condition.[138] In the meantime, the health service must invest in raising awareness and combating stigma.

Some countries recognise long Covid as an occupational disease and compensate workers who have contracted it – but there appears to be no appetite from the UK government to follow suit.[139] There has also not yet been a legal test case that determines long Covid to be a disability. The Trades Union Congress and collective NHS trade unions are playing an important role in lobbying NHS bodies for rights for employees with long Covid, including enhanced sick pay and, where necessary, redundancy pay.[140] The NHS must do everything it can to support colleagues experiencing long Covid to remain in the workforce, including making reasonable adjustments regardless of whether the employee is considered protected under the Equality Act 2010.

> Trying to talk to people openly without being judged, it's quite difficult when there's that lack of understanding.
>
> **Focus group – Hospital Consultant, Birmingham, with long Covid**

Mental health and wellbeing impacts

> It has impacted family life, purely because I work longer hours so you can't do the things that you would normally do, and I've carried a lot of work home … **I feel guilty about it but I have a duty for my work.**
>
> Focus group – Hospital Consultant, South West England

The Covid-19 recovery must mean recovery for the workforce. The physical and psychological impact of the pandemic on the medical profession cannot be understated.

We are extremely concerned by responses to HCSA's latest Doctors at Work survey, where 70.3% of respondents described morale in their workplace as very low or low and one in 10 hospital doctors reported they had had suicidal thoughts in the last 12 months.[141] In the face of the unknown, and given little direction or protection from central bodies, many doctors made sacrifices which took heavy personal and emotional, as well as physical, tolls, such as living apart from their families. While actions like this improved the immediate safety of their patients and their loved ones, it denied doctors access to their usual crutches of emotional support. With fewer tools available to restore their wellbeing after difficult shifts, burnout became more likely.

> My registrar that I was with, he lived in a hotel for three months. We didn't know if he was taking it home on his clothes, making his family sick … he both had the stress of being separated from his toddler [and] he had to kind of manage as well, like, engaging with him every day and all that, his wife had to look after his son. That's a big stress.
>
> Junior Doctor, Intensive Care Unit

The psychological impact of Covid-19 has been felt across society. The day-to-day anxiety of a life-threatening infection has been particularly stark for vulnerable groups and their relatives. Many have experienced bereavement or are themselves battling with the impact of long Covid. Meanwhile, separation from loved ones with social distancing measures and travel restrictions meant total isolation at points for those living alone and, contrarily, the stress of being confined with close relatives for others. Closures of leisure facilities, hospitality venues, entertainment and retail left day-to-day life dramatically pared back. This meant the usual respites after a stressful day at work no longer existed for much of society.

Many NHS staff, conscious of the heightened risk of working in a health setting, moved out of their family homes to prevent transmission between the work-place and their loved ones.[142] Temporary accommodation included camper-vans and hotels, where staff lived for months on end without any contact with

their families. This selfless act enabled frontline workers to protect their loved ones while continuing to support the families of others every day at work. Frontline workers could not retreat from Covid-19 and faced an increase of workplace stress. Disturbingly, in a study of ICU staff, "*almost half reported symptoms consistent with a probable diagnosis of post-traumatic stress disorder, severe depression or anxiety or problem drinking*".[143] Factors identified by the study as relevant were long working hours, caring responsibilities compounded by lockdown school closures, and troubles with PPE supplies leading to increased anxiety around Covid-19 infection.

'Moral injury' was also identified as a stressor, referring to a condition created by encountering moral dilemmas. Making potentially life-threatening decisions over access to care on a daily basis has been shown to trigger symptoms akin to PTSD in some doctors. This comes with an increased risk of staff experiencing litigation as a result of medical decisions made during the pandemic. HCSA data shows one in five hospital doctors experienced moral injury in 2021.[144] HCSA worked in coalition with the Medical Protection Society to campaign for emergency legislation that would protect medical professionals from inappropriate legal challenge when treating Covid-19 patients.[145] Yet the government decided against introducing emergency legislation. HCSA remains concerned that actions taken by health professionals at the height of the pandemic, and under extremely stressful working conditions, could still in future lead to retrospective legal claims. This could result in medical professionals facing criminal convictions and GMC referrals.[146]

> "In the first wave, everyone was swamped. I was going home absolutely exhausted and having a cry. At one point we ran out of ventilators. It was a terrifying time.
>
> **Junior Doctor in Emergency Medicine**

Meanwhile, two-thirds of respondents to HCSA's survey described feeling 'unreasonably stressed at work' about half the time or more, a 5% increase on 2019/20.[147] Stress is an obvious side effect of a tense working environment in which difficult decisions have to be made.

> It's very difficult to convey over a phone to a next of kin how unwell somebody is. It was extremely difficult to convince people, especially people who didn't think Covid was a thing, that their relative was extremely unwell and dying in some cases … when they'd seen their relative come in with shortness of breath or a cough and then now, two or three days later, I'm telling them they're going to die. Obviously pre-pandemic you would bring them in, have a chat, have them see their relative, and I think that massively helps bring it home. But over the phone that doesn't happen and it's extremely hard … **I'm not complaining but it was quite an arduous task to bring them round to how unwell their relatives were, and that was a daily occurrence** … It did help when they brought in the video chats and the i-pads but in the beginning we didn't have that or the resource wasn't available, so it was much, much more difficult.
>
> Focus group – ICU Junior Doctor, Kent

> I left that shift having attended two relatively traumatic arrests … and got on the bus to go home and just felt physically exhausted, but also just emotionally, drained and numb. The concept of coming back to work after I'd had a sleep just felt completely trivial and I couldn't quite muster up the energy to even think about that let alone achieve it … **I couldn't bring myself to go up the stairs to get into my flat when I got home, I was so exhausted** in every way and sat on the steps outside my flat and called one of my best friends from medical school and just spoke to her about what happened and how it had made me feel and had a bit of a cry about it on the phone, which made me feel better.
>
> Junior Doctor, Intensive Care, Ware

Psychological issues have undoubtedly been compounded by physical exhaustion from working long hours. Yet there has been little time to recuperate and, in January 2021, less than half of HCSA survey respondents indicated they would be able to take full annual leave allowance in the current leave year.[148] The mean average number of days taken was 16 since the start of the pandemic, with a median of 15. Meanwhile, some NHS Trusts sought to resolve the issue through encouraging staff to trade annual leave for money in a 'buy back leave' scheme, which ignores the vital need for staff rest and recovery. We have also received anecdotal reports from doctors of NHS employers disallowing unused leave to be carried over, leading to staff losing out as a result of their contribution to the pandemic response.

> It was very hard to get locum cover so I had to do lots of extra shifts and work on call to cover colleagues' absence, and that takes its toll as **you're exhausted and tired all the time**.
>
> Focus group Hospital Consultant, South West England

> I was in my second year rotation [and] I couldn't leave on time so I was staying three or four hours extra … and **I was so cabbaged when I came home I had to call in sick the next day because I just was so tired, so exhausted because I didn't take a break**. That's happened a couple of times."
>
> Junior Doctor

> The successes we had were very marathon-esque. **After three or four months you may have got one positive result out of 20 or something like that. But it felt very hollow when you had all these others who didn't make it**, to be honest. And **as it progressed you got more and more ground down**, whether that's from lack of sleep or just continuous working, so I'm not sure there were many successes.
>
> Focus group – ICU Junior Doctor, Kent

The inevitable outcome of burnout in staff is mental health-related absence. It is clear that the goodwill of NHS staff in the early stages of the pandemic masked a looming crisis in mental health. Data from FirstCare in August 2021 suggested a massive leap of 37% in NHS staff off work with mental health-related absence from 9,500 in February 2021 to 13,000 in June 2021.[149] This also represents a leap of over 40% on the same months in 2020.

> You don't get the sort of empathy that you'd give to patients from your colleagues I don't think. **I think amongst the medical profession, the expectation is that we're all super humans** and everyone's perfect and the amounts of compassion that you get from your colleagues is way less than you'd expected of them to be giving towards patients and others.
>
> Junior Doctor, Intensive Care Unit

This is particularly concerning as mental health absence tends to be prolonged, with the average duration at 19 days – longer than every other type of absence with the exception of cancer. In total, absence from mental health has amounted to 2.6 million days lost for the NHS in 2020 and 1.1 million days from January-June 2021. This comes at a huge cost for the NHS, expected to be £149m for the first half of 2021, excluding admin costs and agency fees.

Another toll on NHS staff wellbeing has also appeared this year in the form of a rise of verbal and physical abuse from members of the public. A survey of 1,000 GPs conducted by the primary care publication Pulse in September saw 74% state that levels of patient abuse had increased 'significantly' or 'slightly' since before the pandemic.[150] Sadly, this chimed with the experiences of other NHS staff groups. For example, South Western Ambulance Service reported an 85% increase in overall incidents and twice as many assaults over the festive period in 2020/21 as in the previous year.[151]

> The majority of patients were fine but there was a subset of people who just weren't cognisant of the fact that we were under an incredible amount of pressure and I think the reception staff got that experience more than we did.
>
> **Junior Doctor on GP rotation**

The BMA reported that calls from GPs to its helpline were at an all-time high for July at 290, double the number at the same time last year, and triple that of July 2019.[152] One frightening example is an attack on surgery staff by a man in Manchester, where four members of staff were injured, resulting in two being taken to hospital with head injuries, and his subsequent arrest, which sent shockwaves through the medical community.[153]

Public anger has been attributed to the backlog, but has been exacerbated primarily by the misconceived notion that face-to-face appointments have stopped and must therefore 'return'. This false claim has been repeated by numerous press outlets in a series of misjudged media attacks.

These misleading assertions have also been amplified by front bench politicians. Health Secretary Sajid Javid said in a House of Commons session: "*It is high time that GPs started operating in the way they did before the pandemic and offering face-to-face appointments to everyone who would like one … Everyone can understand why at the height of a pandemic GPs couldn't provide access in the normal way. But we are way past that now and life is starting to return almost back to completely normal.*"[154] This was in a week where more than 10 times the number of people were being admitted to hospital with Covid-19 compared to the same time in 2020, and there were almost 14 times more deaths. Meanwhile, Prime Minister Boris Johnson publicly backed a Daily Mail campaign demanding that face-to-face GP appointments should be the default for all patients.

The comments of the Health Secretary and Prime Minister were in conflict with the message of the NHS Long Term Plan, which was launched in January 2019 with backing from then Health Secretary Matt Hancock to cover the next 10 years. It had an emphasis on digital transformation and remote consultations.[155] In this case, political rhetoric is at odds with public policy that has been championed by the same politicians. GPs have continued to offer face-to-face appointments through the pandemic and in fact the total number of GP appointments increased by 1 million per week in January 2021 compared to the previous year.[156] We must consider the very real damage which discourse like this will have if unchecked. The unacceptable risk of violence at work will lead to enhanced service pressures, as staff are forced to use work time to deal with such incidents. We are concerned that in the long-term this will contribute to the sense among staff that working in the profession has become simply too difficult, driving people to choose to leave the NHS and making it harder to recruit in future.

This morning just before I got to the surgery at 6am (because as a partner that has been the norm – working from 6am until 8pm at the surgery, getting home and logging on from home to do all the admin etc … until 11pm most nights) I stopped to get a coffee from the petrol station. I glanced at the newspaper stand and the front of the Daily Mail completely floored me. **I didn't get angry, I just broke down. I stood there crying my eyes out** … The last 18 months have been tough on so many people, and as a GP it has nearly broken me but every day I get up and do this job because I care about patients. From someone to write that as GPs we are responsible for killing people broke my heart. How are we ever going to recruit more people into this specialism when all they will get is hate and abuse?"

GP

Financial impacts

Four in 10 doctors (42.3%) responding to HCSA's Hospital Doctors at Work survey reported additional costs or lost income during the Covid-19 pandemic.[157] Travel and childcare costs were the single biggest additional costs. This may be the inevitable result of members working additional or changed hours and therefore requiring increased travel or childcare costs.

Many of the additional costs NHS frontline staff faced involved them having to compensate for basic equipment that should have been provided by their employer. Costs ranged from £50 for PPE through to £6,500. This included measures to support home working such as broadband or heating, and infection control items such as clothing which could be sterilised at high temperatures or personal items of PPE or hospital garments. The average cost was £1,390.

Training disruption

Junior Doctors, otherwise known as 'trainees' or 'doctors in training', made an immeasurable contribution to the Covid-19 response. Inevitably, the Covid-19 effort took precedent over training. As we move forwards, it is incumbent on Health Education England (HEE) and its counterparts in NHS Employers and the government to ensure Junior Doctors are supported to catch up – for individuals to fulfil their career potential, and to avoid a future staffing crisis.

> "Initially, all rotations were postponed to allow for better cover through Covid. Then, for me, my six-month placement also became five months, but with the same amount to get done which was stressful. Then all regional teaching was cancelled six months after my first move. And this year, I had no local training for six months. All of these measures are to get trainees out on wards in a system that is under pressure. Consultants are completely burnt out, and **whilst teaching is in their job plans, it's the first thing that goes in a system under pressure**. In some ways, that's a good thing – patient care must be the priority – but on the other hand it's not sustainable. Then there were across the board changes to the Annual Review of Competency Progression (ARCP) sign-off process and the requirements changed. So there's the worry of how you are going to catch that up. I suspect the impact on training has been massively underreported. There is a whole culture of it in medicine. If you say you don't know, you end up penalised. And pay is linked to progression. So everyone is incentivised to cover up.
>
> Junior Doctor in Emergency Medicine

In their foundation years, doctors in training would typically rotate between three or four jobs per year, in an array of specialties and workplaces. This is to give a range of experiences to satisfy academic requirements, and allow individuals to move onwards into their chosen area of specialism.

When, on 16th March 2020, HEE postponed all rotations for Junior Doctors, it caused serious disruption to career paths.[158] Training was cancelled, and some was replaced with virtual lessons. Many trainees were redeployed to meet the demands of Covid-19. There were not the same opportunities for training available day to day, as clinics and operations were cancelled, and little chance for supervision as Consultants were required elsewhere. There have also been changes made to the requirements for the Annual Review of Competency Progression – the formal assessment process that determines whether a Junior Doctor progresses.

Almost a third of trainees told the GMC in 2020 that they had not been able to compensate through transferable skills from other aspects of training. Half of trainees felt they had "not been provided with effective alternatives through simulation facilities and/or exercises". A fifth of trainees reported they did not "expect to acquire enough training opportunities to prepare them for their next professional exam".[159] This is balanced with an overall 76% of trainees rating the quality of teaching as good or very good. A further 74% of trainees felt virtual learning environments were being used effectively, indicating that there are benefits to adopting some digital learning methods on a permanent basis. Hybrid learning models should not be implemented simply because we have grown accustomed to them through the pandemic – careful thought must be given to how best to train doctors of the future. For Junior Doctors training through Covid-19, there is an urgent need to compensate for the face-to-face opportunities missed, allowing trainees to broaden their skillsets as well as to develop specialism. HCSA has been lobbying for this through meetings with HEE and participation in HEE workforce strategic framework meetings. HEE have issued guidance that warns against continuous redeployment of trainees, advising this should only be used as a last resort, and account for individual training needs.[160] However, with extreme staffing pressures prevalent at the time of writing, it's unlikely NHS managers will be able to avoid redeployment.

Also of note are the experiences of medical students at the very start of their careers. Tens of thousands of medical and nursing students were recruited to meet the demands of Covid-19, undertaking new roles across hospitals, GP surgeries, care homes and the 111 service. They have readily adjusted to online learning and the cancellation of clinical placements, but this is attached to a negative impact on mental health and wellbeing.[161] Students are more likely to have taken on new roles beyond their existing skillset. This group must be supported, both academically and in terms of wellbeing, so that they go on to lead fulfilling careers in medicine. It is vital that the adverse impact of Covid-19 on studies is mitigated to avoid higher than usual dropout rates among students.

It is also important to acknowledge the dedication to their field shown by many medical students, some on the wards as student volunteers, others final-year students who willingly graduated early, often at home alone via video link, before heading out to work in our swamped hospitals and practices[162, 163]. This remarkable start to medical careers must be applauded but also recognised. Training, both for students and Junior Doctors, must not be an afterthought to service recovery. The service cannot recover without restoring the pipeline of trained doctors entering the NHS year on year. Any shortage or delay in doctors progressing will have a cataclysmic impact on an already stretched workforce.

> The workforce is very short and the system is under extreme pressure. Teaching requires a certain amount of headspace so that's the problem. Everyone is phenomenally burnt out – not just trainees, but Consultants too. Where teaching used to be very supportive, now it feels as if exhausted Consultants just snap at you for doing something wrong. All of this, to fix the backlog and to train doctors, it needs a joined up workforce. You can't ask Consultants to address the backlog and train people at the same time when they are so burnt out. Everybody is just done.
>
> **Junior Doctor, Emergency Medicine**

> Moving online had its pros and cons – on the one hand, it was great to have more control over our schedule, with the uni providing a suggested timetable, but pretty much the freedom to watch the lectures whenever we wanted. Although, as much as possible, I tried to log in to attend the lectures live, because that way I could ask questions to the lecturer. Somehow, the chat made it easier for people to ask the lecturer questions – for a lot of people, it felt less scary than speaking up in a lecture theatre. On the other hand, online learning was taxing – it's exhausting to watch a screen all day, and we felt misled by the university about what the blended learning offering was going to be. The university urged us all to head to our university city, but in the entire academic year I ended up having about six hours of face-to-face teaching. Now that we're on the wards for our first year of clinical medicine, it's great to be in the hospital meeting real patients, but it's evident we've got a lot of catch-up to do in terms of our clinical skills. Of course, clinicians are exhausted by the pandemic, but they are trying their best to give us learning opportunities and that is greatly appreciated. It's difficult for me to compare the learning experience to pre-pandemic, as I wasn't in clinical teaching at that time, but it seems that there are potentially fewer learning opportunities as staff are so stretched and we have to avoid certain parts of the hospital due to Covid-infected patients. Additionally, we are slightly anxious about what kind of health service we'll be working in when we qualify – there's a lot of uncertainty about the direction of the NHS, which is concerning for us.
>
> **Third year medical student**

“

It was like being in a horror film

4 Recommendations

This chapter makes a number of short and long-term recommendations which would both address the immediate challenges Covid-19 has brought to the fore for doctors, and also aim to alleviate the foundational and ongoing problems facing the NHS, first highlighted in our chapter on Pandemic Readiness.

1 Publish terms of reference for public inquiry and give a voice to doctors

We begin with the subject of the Covid-19 public inquiry. On the 24th August 2021 the Scottish government announced it would hold an independent, judge-led public Inquiry into its handling of the Covid-19 pandemic by the end of the year. In comparison, the lack of clear information and delays surrounding a UK-wide inquiry have been hugely disappointing . At the time of writing this is expected to start by the unreliably vague 'Spring 2022'.

> "I stopped going on Facebook because I started to have fall outs with family members who put up posts going "We all met up and had lunch today". And I lost my rag with some of them. But it was early, we didn't go into lockdown, I said "we should be locked down, but you're right, legally, they can do what they want.
>
> Junior Doctor, Intensive Care Unit

We ask for the terms of reference to be published imminently to give all those stakeholders who wish to be involved an opportunity to prepare and ensure the inquiry gets off the ground without further delay. The inquiry should be split into multiple strands to prevent delays while allowing robust investigation. We cannot afford for the inquiry outcomes to come years and years down the line, when we could face another dangerous variant and wave at any time. Furthermore, doctors should be given a platform within this inquiry. The voice of healthcare workers cannot be ignored. As they fought this public health battle from the frontlines, their experience should be centre-stage.

2 The role of experts in pandemic planning

Alongside a role in the inquiry, healthcare workers and scientific experts should be given a greater role in future pandemic planning. If the government, other public bodies and the press had paid greater attention and placed more weight on their experiences and recommendations, we would have likely entered our first national lockdown much earlier. The very fact that an Independent Scientific Advisory Group for Emergencies had to be founded is a clear sign of the lack of regard and respect given to expert opinion. We cannot risk ignoring these voices again.

3 Maintain investment in public health

Years of underinvestment in public health had to be compensated for at speed in the pandemic response. Analysis by the Health Foundation points to a 24% real-terms cut in public health spending since 2015/16, and it is a cause for concern that the largest cuts locally have fallen on the most deprived areas – such as Blackpool, where the cut has been equivalent to £43 per person per year.[164] Public Health England has recently been restructured into two new offices; the UK Health Security Agency and Office for Health Improvement & Disparities. With the Covid-19 effort set to continue for some years, and the threat of future diseases creating similar crises, it is clear long-term, planned investment in public health is required.

4 Workforce analysis and planning

> In my hospital at the moment [speaking in August 2021], **it's a question of capacity**. Covid's still there, the Covid ICU is still reasonably full. But with all the services trying to come back at the same time, the wards are full so we're having to divert patients from other places, and other units nearby have actually shut, so there is a higher capacity required in all the units combined, and they're struggling to cope. It's resulting in reduced care … and it all makes things more difficult and **creates emergencies that probably wouldn't have been emergencies, had the care occurred at the proper time**.
>
> Focus group, hospital doctor, North West England

We have already demonstrated the scale of the task that awaits NHS staff in tackling waiting lists. The workload now facing the NHS is greater than it has ever been, and with fewer staff to tackle it, resource provision needs to skyrocket to cope. Furthermore, the longer this backlog is left, it not only continues to grow but does so at an exponential rate. The longer even minor ailments are left untreated, the more serious they become and result in tragic, preventable deaths. This is exacerbated by huge growth in service users, with an ageing population following the baby boom that peaked in 1965.

First and foremost, the NHS requires a detailed workforce plan and associated funding, accompanied with a strategy for how the workforce will deliver the Covid-19 recovery. We have highlighted elsewhere the poor data that exists at present on workforce numbers, which makes it difficult to gain a clear picture of the situation. In September 2021, the government announced the raising of National Insurance contributions by 1.25% in order to raise an additional £12bn per year for the NHS and social care, and in October 2021 the Chancellor's Comprehensive Spending Review earmarked £5.9bn to NHS recovery.

Whilst investment is welcome, the figures do not compensate for a decade of unprecedented underfunding. Data from the Institute of Fiscal Analysis demonstrates that the average growth in public spending on health has been 3.6% since 1949 in the UK. However, since 2009, the average growth rate has dropped to a low of 1.3% per annuum.[165] Furthermore, any investment must be accompanied with detailed plans on how to translate funding into workforce planning. There is a risk that political gestures, such as financial sums, detract from the detailed strategic work that needs to be undertaken. It is crucial that an independent body is involved in workforce planning to ensure it remains apolitical.

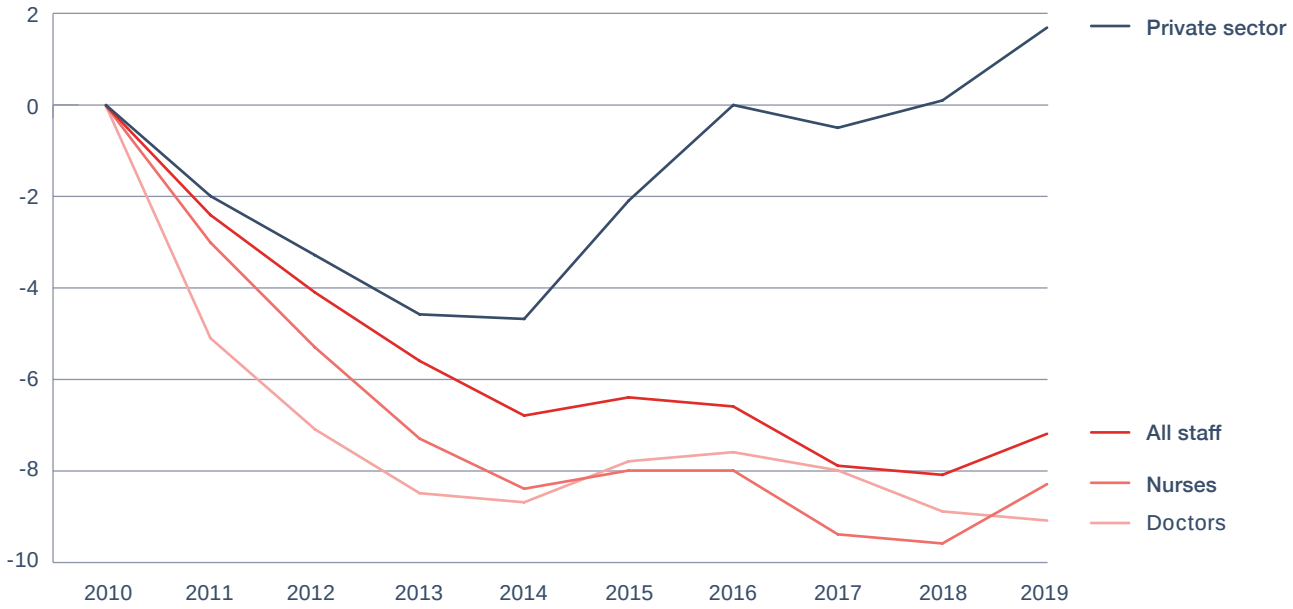
Retention of staff is also key to workforce planning. This report touches on many factors that impact on retention, including safety at work, terms and conditions, stress, work-life balance, hot food, rest facilities and childcare. Most of all, NHS staff must have a sense of being 'valued', particularly after the trauma of responding to Covid-19. One way to value staff is through pay, which forms our fifth recommendation. We therefore strongly recommend that a detailed analysis of the current workforce is undertaken and published as part of a wider NHS staff plan, with thought given to how funds can be targeted at retention and recruitment to ensure staff are available to tackle the backlog.

5 A meaningful pay award to shore up retention

A large spending increase is also required to cover meaningful growth in NHS salaries. Wages in the NHS have not kept pace with pay in comparable jobs, nor inflation, over the last decade. In July 2020, the Nuffield Trust found the average real-terms pay drop for doctors since 2010 was 9%, while for some senior doctors the drop has been even greater, reaching 28.6%.[166]

Pay compared to 2010 eearnings in real terms

Data from Nuffield Trust, 2021



In July 2021, the government announced a pay rise for NHS staff of 3%. Whilst an improvement on a proposal made by the Department for Health and Social Care in March of 1%, this figure is vastly inadequate, as evidenced by the reaction of many, if not all, health groups. Crucially, it also excluded Junior Doctors in England, citing the multi-year pay deal they are locked into by way of explanation. With the pay award so intrinsically linked to staff efforts during Covid-19, excluding a key group sent the message that the government does not value doctors in training. It also exacerbates the gap between the higher and lower earners within the medical profession.

HCSA's Doctors Deserve Better campaign focuses on the significance of a meaningful pay award to retain, recruit and show respect to the medical profession. Meanwhile, campaigning groups such as EveryDoctor and Nurses United demanded a 15% award to reflect the value and contributions of healthcare workers. A pay rise was also not the only financial option available to reward NHS staff. Both the Scottish and Welsh governments

announced a one-off £500 bonus. This could still be considered and enacted by NHS England. We have previously highlighted the additional costs related to the pandemic incurred by individuals, such as sourcing PPE, childcare, accommodation, and lost income. Without any expenses or bonus, these costs have been shouldered by NHS employees.

> At the minute with everything that's happening with Covid and the economy and everything like that, you don't want to bring things back to money. and I think a big thing around the Junior Doctor strikes was 'oh these money-grabbing doctors blah blah blah' but I think a particular area that does make you lose heart a little bit is when you see [the money spent on locums to cover staffing gaps].
>
> Junior Doctor on General Practice rotation

The NHS faces a long-term crisis in staffing and recruitment. A substantial pay increase would not only reward healthcare workers for their sacrifices and performance during the pandemic, but is a logical move to improve retention and to attract more staff to join the profession. It would also serve to correct pay deflation that has occurred as pay awards have fallen out of step with inflation. Investment in staff wages must be seen as an investment in the NHS, playing a crucial role in workforce planning.

6 Implement pandemic exercise recommendations in full

As highlighted in chapter 1, it is perturbing that the recommendations from multiple planning exercises have not been implemented. All recommendations must be implemented in full as a matter of urgency. This includes the establishment of a new single health body to provide an overview of the situation and engage with various stakeholders, the compiling of PPE supplies including plans for 'surge capacity' and an effective public communications strategy. Frontline staff are clear – we cannot risk a repeat of what we have undergone during the response to Covid-19.

7 Get the basics right for staff wellbeing

The Caring for our Colleagues chapter laid clear the spike in mental health absences and the incredible amount of pressure healthcare professionals have been under during the Covid-19 pandemic. The pandemic presented unique challenges, but the answer to improved staff wellbeing is simple – investment in the basics. Many of the stressors our members report are related to having to face challenging situations without adequate staffing levels. Resultantly, our members work long hours to fill in the gaps created by patient demand and vacancies. The testimony in this report points to gruelling 12-hour shifts with

inadequate rest breaks, and our data suggests little time to recuperate with less opportunity to utilise annual leave entitlement. For doctors and other NHS workers, this represents time away from families and friends: time at work that could be spent resting or pursuing the activities that allow us to unwind. We are calling for greater emphasis on the wellbeing of our staff, as we fear the current situation is becoming increasingly untenable. In practical terms, this means investment in staffing numbers to allow for work-life balance.

8 Maintain improvements to practical facilities and amenities

Free parking and the provision of hot meals are simple measures that make a notable difference to the working life of NHS colleagues. These measures must be retained to avoid financial detriment for NHS workers, who are working long hours above and beyond the call of duty. As covered in the Pandemic Response chapter, we are deeply disappointed by moves to reverse these improvements and urge that they are maintained.

9 Urgently reinstate higher cleaning and social distancing measures in health settings

We are deeply concerned about the impact of lessening protections on the safety of the NHS workforce, already more susceptible to Long Covid. This also has an impact on nosocomial infection, where transmission occurs in a hospital infection, which can only serve to increase Covid-19 cases. We are currently embarking on Winter 2021/22 facing heightened pressures, yet the lessening of such restrictions also gives the impression that the pandemic is over, which in turn sends a message to the public that there is no need to act with caution. To add to this, the Prime Minister was photographed on 9th November 2021 in a health setting without a mask on – against current guidelines. The government must urgently rethink lessening of restrictions within health settings, and as a minimum, reintroduce higher cleaning and social distancing measures.

10 Increase access to Covid-19 Life Assurance Scheme

The deaths of NHS staff in public service are unthinkable, and the absolute minimum their families should receive is access to the compensation they are entitled to. As outlined previously, we are disappointed by the low take-up rates of the scheme and are concerned that not enough has been done to widen participation. We call on the government and NHS Employers to increase access to the Covid-19 Life Assurance Scheme, including raising awareness of the scheme and mechanisms to support applications to the scheme.

11 Public inquiry must consider systemic racism in NHS as contributory factor in disproportionate BAME deaths

The toll on Black, Asian and minority ethnic communities throughout the pandemic cannot be understated. Our colleagues have lived with heightened fear and personal grief. Systemic racism has played a role in the disproportionate deaths of BAME colleagues. Our members tell us they have felt unsafe speaking out about safe working conditions and have had difficulties accessing the PPE they require. Meanwhile, figures shared previously show BAME staff are more likely to work in Covid-19 areas. For doctors from BAME backgrounds, the disproportionate likelihood of being referred to the GMC puts into focus the reality of the insecurity our colleagues face. Systemic racism must be ringfenced as an area of investigation by the public inquiry, for considering the deaths of Black, Asian and minority ethnic frontline workers.

12 Support colleagues experiencing Long Covid to remain in the workforce

The higher prevalence of long Covid in NHS workers laid out earlier demonstrates that it is an occupational risk for doctors and other medical professionals. A legal precedent has not yet been set that considers long Covid a disability, but in lieu of this NHS employers must do everything within their remit to support colleagues to remain in the workplace. This must include making reasonable adjustments for those experiencing long Covid, regardless of whether the employee is considered protected under the Equality Act 2010.

13 Upgrade PPE to FFP3 and reintroduce mandatory mask wearing in public places

With such prevalent risks including the long-term impact of Long Covid, improvements must be made to the health and safety of staff. As explored in the section on PPE, frontline workers were let down on personal protective equipment throughout the pandemic, leading to harrowing experiences of homemade equipment and binbags for gowns. As discussed, poor planning and tendering of contracts without due diligence by the government compounded global and national supply issues. It remains the case that high grade FFP3 masks are not the standard, thus we are calling for all staff in patient-facing roles to have access to FFP3. Furthermore, the move away from mask wearing in public places puts our members at risk. We are calling on the government to reintroduce mandatory mask wearing, and to show leadership on this issue. The message must get through to the public that the pandemic is not over, and we must protect the NHS.

14 Training to be prioritised in NHS recovery

Doctors in training and medical students have faced huge disruption to their studies, as outlined in chapter 3. It is therefore of utmost importance that meaningful measures are put in place to put careers back on track. This includes an assessment of hybrid learning models and additional lessons to compensate for the face-to-face opportunities missed. Doctors in training must be empowered to broaden their skillsets as well as to develop specialism. This is a crucial component in preparing the workforce for the Covid-19 recovery and beyond. Without adequate planning and progression of Junior Doctors, a staffing crisis is on the horizon.

15 Significant changes must be fully assessed in consultation with staff and a national policy on use and funding for emergency rotas

The pandemic has created a host of changes to working practices and our members showed willingness to adapt, and quickly. Now that we are no longer in the initial wave, and can expect the present situation to continue for some time, thought must be given to the significant changes to working practices, such as changes to rotas, lengthened working hours, redeployment and additional responsibilities. In normal times, such changes would have been fully assessed in consultation with staff. We therefore call for all changes that have occurred during the pandemic to be brought under review. This involves

an opportunity to pass through the appropriate processes, including arenas for trade union and staff involvement such as Local Negotiating Committees and Joint Negotiating Committees. This extends to a national review on the use of emergency rotas, to allocate ring-fenced funding and a policy on the circumstances and processes by which such rotas would be used.

> Every Trust in the country is having to cancel cases, there's a waiting list that's increasing, theatres are being shut, we are all in the same position.
>
> Focus group – Hospital Consultant, South West England

> I don't think any [country's] got everything right, but our problem in the UK has been the corruption … that's been a big issue, there should be a public inquiry into that and it shouldn't be forgiven.
>
> Focus group – Hospital Consultant, South West England

> Our day surgery unit is an exemplar across the country for the type of work that we do and the level of complexities that we address there. **That has been shut because of Covid.** That has been used as an extended casualty or what's known as a medical receiving unit, so that is not functioning to its full capacity and that has caused a number of difficulties with the staff. **No-one has gone away or resigned, but that may happen if people's morale stays down**, and they say: "Look, we worked really hard to set this thing up and it's what people are looking up to." I get invited to various day surgery conferences to go and talk about how we do our gynae pathways as a day case, and if you can't do that or you're not there for the last one and half years, you've not really used it properly. People say what's the point? And it **might push people into early retirement or resignation even**.
>
> Focus group – Hospital Consultant, South West England

> I think it [the pandemic] was used as an underhand way of imposing change and altering terms and conditions without consent in many Trusts.
>
> Focus group – Hospital Consultant, Birmingham

“

Only good enough to be cannon fodder

Conclusion

At the time of writing, Covid-19 has killed more than 150,000 people in the UK – including over 1,561 healthcare workers – and we don't yet know how high this number will ultimately climb. Our country suffered significantly more deaths from the virus, in both absolute and proportional terms, than many others and we must have an open and honest conversation about why. This will not be the last pandemic we face and, while every life lost is a tragedy, many of these tragedies were preventable.

In chapter one we explored how a number of underlying problems in the NHS, including inadequate staffing and funding levels, meant our health service was in a severely weakened state even before the pandemic struck. We also highlighted how subsequent governments disregard to implement recommendations which arose from previous pandemics, both real and simulated, left us woefully prepared to tackle Covid-19. The lack of a sufficient stockpile of PPE, a lack of infrastructure to manage virus testing and a lack of implementation of travel restrictions, to name just a few, all left the UK and our NHS workforce overly vulnerable.

In chapter two we set out in greater detail the government's failings surrounding the procurement and distribution of personal protective equipment. The personal testimonials in this report evidence the levels of distress and anxiety this created, not only endangering the personal and mental wellbeing of doctors, their patients and their loved ones, but also contributing to the spread of Covid-19 within medical settings around the country. We laid bare the resources wasted on Nightingale hospitals and Test and Trace, and highlighted the success story of the NHS-led and implemented national vaccination programme.

In chapter three, Caring for our Colleagues, we delved into the personal toll this pandemic has had on the mental health and wellbeing of our doctors. Their exposure to situations and decisions no worker should ever have to experience is ultimately a testament to their resilience and dedication. Doctors went above and beyond in this crisis. In the words of one respiratory consultant from London, "*this is my vocation — we are never not doctors. When we are called upon to step up, there is only one answer.*" Our NHS doctors were there for us when we needed it most. Doctors are certainly not

alone or unique in this respect: it is only due to every health and social care worker's efforts that the impact of Covid-19 was not worse, and we cannot let these endeavours go unrewarded.

By 'rewards' we do not mean hollow gestures. No more claps on doorsteps or posters in windows. While these displays of public affection are appreciated, they are not an acceptable replacement for concrete action by the government to improve the safety and working lives of NHS staff. Our recommendations in chapter four outline the steps we direly need to take, not only to improve the UK's capacity to deal with another pandemic but to strengthen and protect our National Health Service to make it truly fit for the 21st century.

If things don't improve soon, doctors and large numbers of other NHS workers are likely to vote with their feet. Given the staff shortfall the NHS already faces, we cannot afford to lose more colleagues.

> There's just a lot of mud-slinging that's going around and no-one wants to take responsibility. **Responsibility lies with the government** and their bad handling of the entire pandemic. So many mistakes [and] it all materialised on a health service that was frankly on its knees, on the point of breaking, before Covid even happened.
>
> **Hospital Consultant, Birmingham**

The belief that this government made egregious errors in their response to Covid-19 is now broadly held even by those within the government's own party, as evidenced by the joint Health and Social Care and Science and Technology Committee's report 'Coronavirus: lessons learned to date' released in October, and chaired by Conservative former Health Secretary Jeremy Hunt. Holding a government to account is a fundamental part of democracy. It is our duty to scrutinise their actions, not in a baseless attempt to point the finger of blame and spread malice without regard, but to protect people and ensure that the future is better than the past. This report is one contribution to the wider national reckoning which must take place. It may be a small contribution but it is a vital one, as it is representative of the experiences of our communities of frontline doctors.

Ultimately NHS doctors – as they have become far too used to doing – accepted the tsunami that Covid-19 hit them with. But every wave like this, be it an international pandemic or one of our all-too-regular winter crises, weakens the profession more and more. Unlike SARS, and Exercises Alice and Cygnus, this time around lessons must be learned and real change enacted. We regard the National Health Service as a fundamental part of life in the UK but if we don't act to safeguard it soon, how many more waves can we really expect the NHS and its staff to withstand?

Acknowledgements and Methodology

This report mainly draws on research from secondary sources, including a range of governmental and public bodies, media outlets, and civil society organisations. This is supplemented by primary data and personal testimony provided by doctor members of EveryDoctor and HCSA. Most of this testimony was supplied via email or Facebook messenger over the course of the last year and a half. The dates of quotes correspond to when these messages were sent. Explicit permission was sought from these doctors to re-share their stories in this format. Some additional testimony was also gathered from a focus group on 24th August 2021, where these quotes are used, they are undated.

A special thanks to Ruth Riley and Johanna Spiers, researchers based at the University of Birmingham, for insight into their forthcoming paper 'What challenges did junior doctors face whilst working during the Covid-19 pandemic? A qualitative study', currently under review for publication by BMJ Open, as well as to Louise Griffin, a fourth-year medical student at the University of Birmingham for insight into their forthcoming paper 'The psychological impact of working during Covid-19 on medical and nursing students: a qualitative study', currently also under review for publication by BMJ Open.

Many thanks also to Dr J D Williamson for the use of his photograph for our cover and the wonderful work of our designer Alice Haworth-Booth. And finally our greatest thanks are reserved for our members, all those who contributed to this report by sharing their testimony online or in our focus group, and everyone working in the NHS throughout the pandemic.

EveryDoctor relevant research & briefings

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- A priority Covid-19 testing service is essential for UK health and social care workers in order to safeguard the public this winter (EveryDoctor, 17.09.2020)
- #ProtectNHSworkers re-launch; The UK has one of the highest healthcare worker death tolls' we must protect NHS workers during the Covid-19 second wave (EveryDoctor, 08.10.2020)

- Expert Perspectives; The voices of trust experts can and should be amplified to support second wave planning (EveryDoctor, 22.10.2020)
- The reality of the Covid-19 frontline; The experiences of clinicians in the North of England as the second wave escalates (EveryDoctor, 05.11.2020)
- Vaccine planning and corridor medicine Logistical barriers and lack of healthcare resilience planning (EveryDoctor, 19.11.2020)
- #ProtectNHSworkers Every UK healthcare workers needs to be vaccinated within the next 14 days (EveryDoctor, 07.01.2021)
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