Scottish Parliament - Health and Sport Committee
Call for Views
COVID Resilience and Emergency Planning

The Royal College of Physicians of Edinburgh is a professional membership organisation that sets clinical standards and aims to improve the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland and around the world with over 13,000 Fellows and Members in over 90 countries, covering 54 medical specialties and interests. The College enables a worldwide community of physicians and their teams to advance the health of our global population for the long-term benefit of society acting as the voice of our membership, engaging in health policy and promoting equality and human rights.

Did previous planning adequately prepare us for the current pandemic?

Fellows of the College who are specialists in epidemiology and public health have commented that previous planning did not adequately prepare us for COVID-19. That is not to say there was no planning; there was extensive planning from Scottish Government level down. It is important to recognise that it is nearly impossible to plan for every unique scenario that may arise. However, previous planning had a strong focus on flu; indeed it was often called pandemic flu planning. It was also based on a completely different assumption: that the first three months would be severe (usually worst at week 6) with a high death rate, but the population would gain some immunity and then normal life would move on. As a result the planning included a lot of emphasis on mortuary capacity and numbers of secondary care beds etc. College Fellows were not aware of policies such as extensive social distancing and lockdown being discussed prior to COVID-19.

It is clear that despite planning and risk management procedures being in place, it is not possible to plan for every scenario – the important emphasis has to be on resilience and business continuity at every level.

Secondary care planning worked well in COVID-19, with recognition of when to "switch off" the routine system and redraw the hospital to tackle the pandemic. It has also been helpful that organisational memory exists from the response to H1N1 in 2009.

With hindsight, what prevented better advanced planning to deal with the pandemic? Were the right people and organisations involved?

The focus on flu within closely defined parameters was not helpful, with hindsight. To a large extent the right people were involved – but there was lack of adequate learning and acting on findings from simulation exercises run. As an example, operation Cygnus was a major planning exercise which identified the issue of the fragility of the supply chain for stocks such as PPE and O2 but this was not acted on. There was undue emphasis on stocks of Tamiflu, which we know might not be effective even for a flu pandemic.

From a holistic viewpoint, it would have been helpful to have more focus on wider public health and the health and social care system as a whole, rather than concentrating on secondary care and the NHS.

Fellows feel that it would have been useful to have an understanding of the views of the public on issues such as the level of deaths due to the pandemic; lockdown and social distancing.

Following the MERS and SARS outbreaks overseas, an attitude developed in some quarters in the UK that 'it could not happen here', which was not helpful. These outbreaks were seen as being largely confined to countries in Asia with different health systems and highly unlikely to ever cause an outbreak in the UK. However, nations such as South Korea/Taiwan/Hong Kong learnt from their response to MERS and mounted an effective response to COVID-19.

A pressing issue is bed capacity across the whole health and social care system. It is widely acknowledged that in a typical winter, the NHS and care system in Scotland "just about copes". This is without the added pressures of COVID-19 and our Fellows have made clear that this needs to be addressed as a matter of urgency.

In terms of testing, the importance of Polymerase chain reaction (PCR) testing was not emphasised early enough and capacity for testing was not created quickly enough. This could have been done by pre-planning for the use of non NHS laboratories at universities etc. There was no advance planning for large scale community testing and population swabbing, and no advance planning for the scale up of contact tracing or prioritisation of contacts.

Fellows have also commented that coordination of the response to the pandemic was not always clear and effective. There was a cluttered landscape at all levels, particularly in the initial stages of response.

What lessons have been learned which could inform the response to future outbreaks of COVID-19 infection or another pandemic?

The focus must be on the supply chain – the whole world is looking for the same items during a pandemic. It is vital to have "sleeping" contracts in place for items which would be required to respond to a pandemic, including PPE, pharmaceuticals and resources such as laboratory space and staff. There needs to be the ability to move to rapid treatment and vaccine trials and scale up key resources quickly for activities such as testing. The training of key staff in eg ICUs, COVID wards needs to be prioritised. Isolation advice and facilities need to be made available. Action should be taken early on to protect vulnerable groups such as those in care homes and those in deprived populations.

There should be a clear strategy for outbreak response which is multidisciplinary and includes public health communicable disease control experts. Over reliance on modelling should be avoided but we

need to anticipate better- we should be always thinking forward to the next stage, not the previous or current stage.

The protection of health and care staff (and others on the frontline) must be a key consideration and scenarios must be planned in advance as to how staff can work safely.

It is vital that if the UK is not one of the areas to be first affected in a global epidemic, that we learn from other countries and their response - good or bad. There needs to be a whole system rapid workstream on understanding and learning the immediate lessons from the experiences of others. A four nation response is important in the UK, but we need to be aware of local variation in areas such as in Inverclyde or London.

Innovation should be promoted, such as the use of remote technology for consultations with patients or meetings, and staff working in cross disciplines, but not then immediately abandoned after the pandemic abates. These services should be repurposed or adapted to keep things moving in the system.

Disease surveillance is very important: "horizon scanning for next big one". Case and contact data management and IT systems need to be prepared. Population symptom tracking is very helpful using surveillance tools such as the ZOE app. NHS and university partnerships such as DataLoch will be increasingly important: research collaborations to find solutions should be the new normal. Initiatives which have been set up with outside partners need to link in to NHS services, for example UK Lighthouse testing results are not reaching GPs or Public Health teams.

Preventative measures will still need to be emphasised to try and slow the speed of transmission of a new virus around the world. Basic prevention advice such as handwashing must always be in place. In terms of local communities, the mobilisation of communities to support vulnerable people is essential. Initiatives which have started from the ground up to fill gaps in provision, eg making scrubs and face shields have also been very helpful. The creativity shown to keep spirits up such as rainbow posters and clap for carers has boosted all those who are key workers and beyond.

The population health costs of stopping routine health and social care, including dental care, for the pandemic need to be analysed as a priority. The Academy of Medical Royal Colleges and Faculties in Scotland have published a document which sets out the system challenges, principles, and priorities for services within the NHS as we move past the first surge of the disease, when a second surge remains possible, and health and social care must be delivered with COVID-19 as a new endemic disease.

The impact of COVID-19 will be felt for years in health and care services and in wider society. It is essential that we learn from this pandemic to ensure our resilience, planning and business continuity at every level is prepared as best we can be for whatever comes next.