UK Covid-19 Inquiry

Health roundtable

18 March 2022
Online

(Participants were offered an in-person meeting in Manchester but either chose to attend online or we moved the meeting online due to a lack of in-person attendees)

Participants

Samantha Edwards, UK Covid-19 Inquiry

Martin Hogg, Citizen Coaching and Counselling

Jenny Collard, Nursing and Midwifery Council

Dr Jack Parry-Jones, Academy of Medical Royal Colleges Wales

Saffron Cordery, NHS Providers

Tim Gardner, The Health Foundation

Dr David Shackles, Academy of Medical Royal Colleges Scotland

Dr Layla McCay, NHS Confederation

Mark Lyonette, National Pharmacy Association

Vibha Sharma, General Medical Council

Professor Laura Stroud, Medical Schools Council

Sally Warren, The King's Fund

Sophie Corlett, Mind

Alastair Henderson, Academy of Royal Medical Colleges (UK)

Catherine Chan, UK Covid-19 Inquiry

Samantha Edwards: [00:03:20] Thank you so much everyone for joining us for this roundtable. My name is Samantha Edwards, I am in the Covid Inquiry set-up team. I am one of the senior people on the team and work directly to the Secretary.

This meeting, amongst others that we've put in the diary, has been set up to start to gather views on the Terms of Reference that have been published about the UK's public inquiry. So thank you very much for making the time today, and I'm sure that your insights are going to be hugely valuable. We've had a few of these so far from various sectors, and they have been incredibly helpful in helping to shape our thinking.

So, I'm sure you are well aware that this is an independent inquiry. We are independent from Government, from Parliament and from any other body. We've been talking a lot about that

with people like yourselves and also bereaved families around the country about what it means to be an independent inquiry and making sure that we've got that independence – and ability to look at information with a very clear eye. I've got a couple of people in the room with me today. So I'd just like to introduce you to Catherine Chan, who is in the Covid Inquiry as well. She's going to be here taking notes for today's meeting. We've got Gary, who is probably hiding somewhere in the back, who is basically going to make sure that Zoom works perfectly well for us. He's also able just to kind of run a few of the things in the background, etc. The one thing he will not be able to do is take any of us off mute. So when you do want to speak, you'll have to take yourself off mute, and I'd also just like to introduce Martin Hogg, who is also in the room, and Martin has been accompanying us on these visits, both with – with representative organisations and also bereaved families. Martin, would you like just to do a very quick introduction from yourself?

Martin Hogg: [00:05:35] Yeah, thank you very much, Samantha. Good morning, everybody. My name is Martin Hogg from Citizen Coaching and Counselling, and basically, we're here throughout this Terms of Reference consultation to provide emotional support. Because as people are telling their stories and answering the questions, sometimes it can be overwhelming, and you need to step back and take a time-out. Myself and my team are here, whether it's during the session today, after the session, or even tomorrow, if you feel affected by any of the things that you hear today, then we're here to support you and can arrange a one-to-one session with you on the telephone or by Zoom, and details of how to get in contact with us are there in the initial communications you've had, or you can contact any member of the Inquiry, and we can sort that out for you. We've got people standing by.

Samantha Edwards: [00:06:36] Thank you, Martin. Right. So just a few housekeeping things for us, and just a bit more information about the Terms of Reference. So the purpose of today is – we're going to ask you a series of questions about the Terms of Reference, and they are quite deliberately broad, because I want to use this as an opportunity to capture as many insights and thoughts from you as possible. If there is time, we might stretch out a little bit more and ask broader questions around how we might engage people in the Inquiry itself.

I'm not sure how much people are really familiar with how an inquiry works. So, we are in the set-up phase, and we're not an official inquiry until the Terms of Reference are published by the Government. So what happens at the moment is, we've got four weeks of a consultation, and people can provide views through email, they can write to us, we also have an online consultation form that we're asking people to populate. If any of you have seen it, and passed it onto people in your organisations or friends and family, then I'm hugely grateful to you. Because we do want to have a really representative set of responses to this consultation.

We're meeting people around the country. So we've been in Cardiff, we've been in Exeter and Winchester this week. Next week, we're off to Belfast and Edinburgh and various other locations. I think the week after, I'm doing some starring appearances in places like Leeds and other areas. So we are trying to make sure that we are really accessible across the UK because this is the UK's public inquiry.

So making sure that we get a really good cross-section of views into the Terms of Reference, but also at a later point throughout the Inquiry is going to be hugely important to us. So today, we will

probably run for about 90 minutes or so; I won't curtail the conversation if it's flowing, and there are things to add in, and of course, if people do need to disappear for any reason, then absolutely fine.

I can't see the chat, but the chat is there if you want to use it. Basically, if you want to use the chat, just take a note that I haven't got it running, but we are keeping it as a record of what people are saying. We will make sure that everybody has had a chance to speak, and if you can use the hand function on Zoom, which is the button at the bottom of your screen and if you can raise your hand and let us know that that you want to contribute something and then obviously take yourself off mute.

I can almost guarantee that at some point during the course of the morning I will forget to take myself off mute. Because despite the fact that we've been doing these things for two years, it seems to be something that one person will always forget and it's usually me, so bear with me if I do something silly like that. Hopefully, that's all clear in terms of how we're going to run things. Brilliant to see everybody, and thanks very much everyone for being on camera. It's always so much nicer to run these when you've got people on camera rather than names. But I also do appreciate that sometimes our bandwidth doesn't live up to constant camera use. So if you do disappear, that's absolutely fine.

First of all, I'd just like to kind of kick off with some introductions so everybody knows who is who in the room. If it's okay, I'm just going to start with the person who's top right in my tiled version of the screen, which is Jenny Collard.

Jenny Collard: [00:10:24] Morning, everybody. I'm Jenny Collard. I'm Head of Regulatory Policy at the Nursing and Midwifery Council.

Samantha Edwards: [00:10:32] Thank you, Jenny, and then I've got Jack Parry-Jones.

Dr Jack Parry-Jones: [00:10:37] Good morning. I'm Jack Parry-Jones. I'm an intensive care consultant in Cardiff. I'm representing the Academy of Medical Royal Colleges of Wales, and I also sit on the faculty board for intensive care. Thank you.

Samantha Edwards: [00:10:52] Thank you, Jack, and then I have Saffron.

Saffron Cordery: [00:10:58] Hi, I'm Saffron Cordery, and I'm Deputy Chief Executive at NHS Providers.

Samantha Edwards: [00:11:03] Thank you Saffron, followed by Tim.

Tim Gardner: [00:11:06] Hi, my name is Tim Gardner, and I'm a Senior Fellow at the Health Foundation.

Samantha Edwards: [00:11:12] Thanks, Tim. David Shackles.

David Shackles: [00:11:16] Good morning, everybody. I'm Dr David Shackles. I'm representing the Academy of Medical Royal Colleges in Scotland. But I'm also one of the joint Chairs of the Royal College of General Practitioners in Scotland, and a GP by trade working up in Perthshire.

Samantha Edwards: [00:11:32] Thank you very much, David. I've got Layla next.

Dr Layla McCay: [00:11:36] Hi, I'm Layla McCay, Director of Policy at the NHS Confederation.

Samantha Edwards: [00:11:43] Great, Layla. Mark.

Mark Lyonette: [00:11:46] Hi, I'm Mark Lyonette. I'm the Chief Executive here at the National Pharmacy Association.

Samantha Edwards: [00:11:52] Thanks, Mark. I've got Vibha - have I pronounced your name right?

Vibha Sharma: [00:12:02] Nearly. Vibha. Not a bad attempt! So Vibha Sharma, Head of Regulation Policy at the General Medical Council, and I am responsible for overseeing all of our engagement with public inquiries and reviews.

Samantha Edwards: [00:12:15] Thanks, Vibha. Laura.

Laura Stroud: [00:12:23] Laura Stroud. I'm here representing the Medical Schools Council on the Covid-19 working group. But I'm also the Deputy Faculty Dean in Medicine and Health at the University of Leeds, but I'm here for the Medical Schools Council.

Samantha Edwards: [00:12:37] Thank you, Laura. Sally.

Sally Warren: [00:12:41] Morning, everybody. Sally Warren, Director of Policy at the King's Fund.

Samantha Edwards: [00:12:46] Hello, Sally. I've got Sophie.

Sophie Corlett: [00:12:51] Morning. I'm Sophie Corlett, I'm Director for External Relations at Mind. We work in England and Wales, but not Scotland.

Samantha Edwards: [00:13:01] Thank you very much, Sophie. Alastair.

Alastair Henderson: [00:13:04] I'm Alastair Henderson. I'm Chief Executive of the UK Academy of Medical Royal Colleges.

Samantha Edwards: [00:13:12] Lovely, I really hope I've not missed anyone, I can't see anyone else on my screen. Brilliant. Okay. Well, I think we can get going. Just a very quick reminder, I know we announced at the very beginning, that this is being recorded, and it's being recorded for two reasons.

One is to make sure that we do get an accurate record of what is said, in terms of the themes coming out. But also, we do want to have an inquiry that has transparency and openness right the way through it. So transcripts will be available on our website, which is part of our promise to make sure that we are showing progress and providing access to what's happening throughout the Inquiry. So I just wanted to remind people of that, before we get started.

Right, hopefully, everybody has had a chance to read the draft Terms of Reference that we shared, and there are four questions that I'd like to guide the conversation around today, if that's okay for everybody. The first area is around whether or not you feel that the draft Terms of Reference cover all of the areas that you think should be addressed by the Inquiry itself, and I will very happily just take hands as they pop up and we can get your thoughts on that. Sally.

Sally Warren: [00:14:44] Great, thanks. Two different comments on the Terms of Reference and one is on what's in. So it feels to me like particularly when you get into the response of the health

and care sector bit of the Terms of Reference, it feels quite heavily leaning towards big institutions, so hospitals and care homes. But we know there was huge positive and negative transformation and disruption to a whole range of services. So primary care, dentistry, mental health services, home care provision. Whilst what was going on in hospitals and care homes was significant, I think, at the moment, it feels like it shifts a bit too much into kind of big institutions, rather than the full range of healthcare services.

You start to touch on impact of provision for non-Covid related conditions, but I think probably needs more of an emphasis on that, and then that emphasis point just leads me to a second point about, you've got a roomful of people here today. But none of the people in this room work in the social care sector. So you've got a lot of medical representation, a lot of NHS provider provision, representation, but I'm not quite sure where you're getting your social care engagement in your Terms of Reference.

So if this is intended to be a health and social care engagement, you've probably got just health in the room. So you need to think about your social care engagement as well, and for us, that tends to be when we're in this sector, we're talking about adult social care, there may well be children's social care issues as well; you kind of want to pick up with the kind of DFE community.

Samantha Edwards: [00:16:28] Thank you very much, Sally. I'm not sure who was next. So apologies. It is now going to feel like probably very unfair with Sam's roulette of picking people. Can I go to Jenny?

Jenny Collard: [00:16:45] Yeah. Hi. I was just going to say that I know you're talking about impact on health and care workers. But I just wonder whether that could be slightly expanded, to make it clear that that covers mental health, burnout and stress. I think it's maybe quite – I know, it's the Terms of Reference, but it is drafted narrowly, but I just think having some inclusion of that, which is still being felt by those professions, would be a helpful addition.

Samantha Edwards: [00:17:16] Thanks very much, Jenny. I'm going to go with Mark next.

Mark Lyonette: [00:17:23] Thanks, Sam. Just to back up and maybe sort of illuminate a little bit more from our point of view what Sally's saying. I think our only comment on all the bullets is really on that second one about the response of the health and care sector. It talks specifically about management of the pandemic in hospitals, and in terms of care homes and care settings.

Primary care was a very, very big part of this story, certainly in the community, and when I say primary care, I'd be including, you know, general practice, community pharmacy, dentistry, optometry, all of those things are in the round. There's a certain irony in it, because part of what we would want to contribute from community pharmacy during the evidence sessions, is that we were kind of overlooked time and time again, even though our pharmacies were open every single day, as normal, sometimes under immense stress. So, you know, there's a certain irony that the Terms of Reference might actually be repeating the experience of the last couple of years, certainly for our membership. You know, it's often forgotten anyway, it often comes secondary, doesn't it? So I'd support all that Sally said there about that needs a bullet point on its own. We could suggest one, if that would be helpful.

Samantha Edwards: [00:18:52] Yes, that would be really helpful. I think Saffron.

Saffron Cordery: [00:19:05] Thanks very much. Just a few points for me. I suppose there's something about how we think about how the Terms of Reference might help us focus on how people were involved in decision-making during the pandemic. So making sure we don't lump in, say, for example, the Department of Health and Social Care with NHS England or Improvement and Public Health England as was, so that we're absolutely clear about some of the chains of decision-making that took place because everybody had their kind of discrete roles and functions, and I think that's really important.

And another point linked to that is levels of coordination or otherwise and communication between different levels. So nationally and locally and how those decisions were made, and then linking into that point that people have made about sectors and who's included, I think we mustn't forget things like the ambulance sector, community services, as well as mental health and hospitals played a really, really important role.

And one slightly more niche one, which is about, how do we look at the impact of the state of the NHS estate? So things like practical bricks and mortar facilities and the impact that had; things like the supplies of oxygen, whether the estate was fit for purpose to manage that, and the impact that that had.

And then a final one, which is just around – when we talk about the parameters of the pandemic, so when are we talking about this starting and/or finishing? You know, what are we talking about? How are we defining this? Because, you know, are we saying when the pandemic ended? Because it hasn't ended. Or when did it officially start? So, just a bit more clarity around that. But that's it from me.

Samantha Edwards: [00:21:19] Thanks, Saffron. I'm going to go to Jack next.

Dr Jack Parry-Jones: [00:21:34] Actually what Saffron just said, did mention it, but I wanted just to sort of highlight the importance of infrastructure, in – particularly in NHS Services, where I work. An ageing infrastructure totally unsuitable for 21st century medicine, and especially a pandemic, infectious disease. So if the idea is to look to what needs to change, that is a key area, which I think needs to be highlighted. Thanks.

Samantha Edwards: [00:22:04] Thanks very much Jack. Vibha, I think you were next.

Vibha Sharma: [00:22:14] Thanks. So a few points from me. I think firstly, it'd be quite good if the Terms of Reference signalled a broader and more of a positive regulatory contribution, I think, just to better reflect the fact that actually a range of different regulatory levers came into play to maximise support for the sector.

So I think potentially something around flexing regulatory controls to get in the point about responsiveness, but also potentially the words “regulatory contribution”, because it isn't just about controls, it's about doing things differently. There are a number of examples around giving doctors temporary emergency registration and pausing revalidation, etc., as well as changing some of the approaches to fitness to practise that we would want to be giving about that.

I think secondly, I felt that the section on lessons learned was framed quite narrowly, in terms of what we can learn, focusing on future pandemics and crises, but actually, the pandemic has

driven changes, certainly for regulation, but I think more broadly, that make things quicker, easier and more flexible that we would want to bring through to our new normal, if you like. So, again, just to give an example from our perspective, there were reforms to some of our education and training processes through some of the derogations, and the changes to exams etc, to get doctors into patient-facing roles, more quickly and simply into practice is something that we're really keen to retain and build on.

I think my third point, and it relates to what Saffron said, was just a reflection on the Inquiry's timeframe. I think, you know, looking back from the start of the pandemic, up to and including the date of set-up, the pandemic is still very much going on and not over. And I think there were some real questions for the sector, about, for example, how to approach pandemic to endemic recovery planning and management; there are different challenges in this period but challenges still exist.

And for us, some of the things that are on our mind are – for example, what are some of the criteria for deciding that we no longer need emergency measures? What does it mean for prioritisation within healthcare in a sort of endemic Covid context? So I'm really keen that we don't lose sight of that.

And I think my last point was that there wasn't any explicit kind of coverage around national planning frameworks and guidelines. I think that's quite important because obviously there are a set of frameworks in place around pandemic management, from the Department and elsewhere in relation to how to handle ethical challenges, prioritisation decisions about care. One of the really strong messages from the frontline in the early months of the pandemic was, actually, there's a huge number of guidelines and statements, they're all a little bit contradictory. We're not quite sure what it is that we're supposed to be doing. And I think in terms of any future approach, nailing the kind of clarity on that, and the coordination is really important.

Samantha Edwards: [00:25:26] Thank you very much Vibha. I can see Alastair's got his thumb up there with – echoing that point. Right, I'll go to Laura, and then we'll do Layla.

Laura Stroud: [00:25:37] Thank you. I think that's quite a nice segue into what I was going to raise from the Medical Schools Council perspective, which is really, I don't see much emphasis on that kind of workforce and pipeline impact. So it's talking about restrictions on attendance at places of education. But actually, there's a flow through in that we will see a number of years to come with the disruptions to exams, how we've had to take in additional medical students, but also, as Vibha has described, the work that medical schools did collectively to think about – in consultation and in conjunction with health education, England and the GMC – around the interim FY1s, and that response to that. But actually how that learning will go forward. But secondly, how the impact, whether it's emotional, the need for that additional support, that preparedness for practice in a different environment.

So I think the education and training element, the disruption to our clinical academics and so on, I think that that is something that we do need to think about. In some cases, there is some positive learning, and I don't think we should lose that. But I think there are also some elements that we need to really consider very carefully as we go into the future around the whole workforce. It's certainly not just medicine, it encompasses dentistry, but also the nursing and midwifery, and I

know there are colleagues on the call, who will be able to speak more – with more insight than I can. But I think the education and training, it's not just restrictions on attendance at place of education, and also the huge learning that came from that in terms of the virtual resources that we were able to pool. So I'd just like that to be noted.

Samantha Edwards: [00:27:24] Thank you very much. Layla.

Dr Layla McCay: [00:27:27] Thank you. I think you have a real challenge here, of course, in trying to figure out the parameters of this Inquiry. Because while I agree with a lot of what has already been said, and I don't want to duplicate that, I think it was really important to think about, what are we trying to achieve with this Inquiry? What should the scope and scale of it be? The wider we make it, the longer and more unwieldy it becomes, and the more challenging it may be to just seize those lessons in a timely and practical way. I think those are lessons that we've certainly seen from past inquiries.

So certainly from my perspective, I think that there's real merit here to thinking, what do we most want to get out of this and using that to guide the ToRs and – and perhaps I would advise against going too wide, depending, of course, on what your ultimate ambition is. Certainly, from my perspective, I think that the two areas where it feels that there's the most scope for this Inquiry to achieve real change and real value are around preparedness – the extent to which the country was prepared, the extent to which the various actors were prepared, for example, thinking of the NHS context, people raised some really important points, about the estate, about workforce, about the various decisions that had been made, in terms of how we had planned for this pandemic, if we had be planned better, etc.

And then the other one, as many people have said, is decision-making at that national level, in the different layers that that was delivered, feels like a really important place to be focusing if we want that impact. Clearly, this is a complex piece and thinking about scoping it tightly and thinking about proportionality are going to be really important principles.

Samantha Edwards: [00:29:40] Thank you, Layla. I see a lot of people nodding and likewise, Catherine and myself are nodding vigorously. It is a very difficult challenge of how do we do what our Chair has set out, which is to be fast yet thorough, which is a very difficult one to balance - and you're right. How do you make sure – we're all very aware of how long some public inquiries can run for, and how do you make sure that you can actually get tangible things out of it? And we will talk a little bit in the second question about that in more detail.

Alastair, I think you've been incredibly patient. I suspect you had your hand up second. So Alastair, why don't you go next?

Alastair Henderson: [00:30:23] Don't worry. Listening to other people has given me some other ideas. So bad luck. I've got a couple of points and the first one, which to me is the most important, really goes back and gets into Sally's point, and also what was said by Mark.

I do think it is a major issue that does need to be changed, or there will be more noise about primary care. Just focusing on the management of pandemic in hospitals does miss the point particularly, and I think, a similar type thing, or just adding sort of in hospitals and primary care, because a number of those issues apply in just the same way. From my perspective, it's obviously

particularly around general practice, but I fully recognise the other parts of primary care too. So I do think that is a really, really crucial sort of addition.

Just wanted really to support a couple of the other things I have said, I mean, slightly sort of second tier for that. I think the point that was made about guidelines, and that might come into – you've got intergovernmental decision making, I think it's intergovernmental and cross governmental as well – it wasn't wildly contradictory things, but you were sometimes getting different nuances from guidance and guidelines coming out. So about the coordination within Government, and then across Government as well, I think is crucial, and using guidance and guidelines as the example of that seems sort of important.

And I'd just finally endorse the thing about changes, there are a series of lessons learned, I think, we could pick up a number of those things about new ways of working, new ways – we would not be doing this pre-Covid. All of us are working in very different ways. I'm sure we're not going into our offices five days a week, etc. But those sorts of things.

And then just very finely it was picked up. There is something – again, a bit niche in health service terms about how you recover training as well as service. But the first key issue really is around ensuring that there's that focus on primary care and GPs from my perspective. Thanks.

Samantha Edwards: [00:33:17] Thank you very much, Alastair. I'm very conscious that we've still got three people very patiently have their hands up. So I'm going to go Sophie, David, Tim, in that order, if that's okay.

Sophie Corlett [00:33:30] Thank you very much. Yeah. That question that was raised, I think by Layla about the purpose, I think is quite interesting. The next thing that we're preparing for may not be a health emergency, it might be a rather different emergency, which might not involve hospitals to quite the same extent at all. So it does seem to me to be important to be having a purpose that's quite broad in terms of our civic emergency preparedness for major things that entirely disrupt how we operate as a country, and that have a massive impact on the community.

And the remit here looks very narrow, not just because it's in terms of hospital and just on social care actually, Mind does provide social care through its local groups, although obviously, we are nothing compared to the wider social care sector, and we focus on mental health and this very much more.

But this seems really focused on the sort of the management of an infectious disease, and there is so much more than this. So when you're thinking about mental health, which obviously is where I'm coming from, at the moment, it seems to fall into the consequences of non-Covid related conditions section. But actually, the nation's mental health and mental wellbeing has been an enormous element of what's been going on here, and that feels very silent in this. One in six young people have mental health problems, when it used to be one in nine; we're likely to see a long lasting - longer lasting than Covid - impact of mental health, and that isn't just as a result of Covid, it’s the result of all the changes that we've seen, that have been attached to the pandemic.

That's not to argue that we shouldn't have had lockdowns or we shouldn't have had this, we shouldn't have had that. That's to argue that it is a fundamental element of what our resilience and our preparedness and our recovery ought to be.

Because even where we have been having things that have been responding outside of the purely Covid-specific things, we've not actually then thought about the mental health elements of that. So we were constantly trying to persuade Government in their 5pm announcements to reference mental health, reference people's wellbeing, to talk positively. You know, they were very reluctant to do that; Public Health England didn't come out with anything about looking after your wellbeing until very late, all the money that we've seen go into Covid recovery - the money's not been for mental health, they're just going to talk about the long-term plan for mental health and not putting anything extra in.

And it's an attitude towards the nation's mental health and mental wellbeing that is almost in denial. It's either in denial of it being there, or it's in denial of the country being able to do anything about it, which is very short sighted, because of course, there's so much that we can do to prepare the nation and so much that we can do to help the nation recover on that point. And the absence of a broader understanding of what we mean by resilience, of the factors that have actually mitigated against us being resilient, such as inequalities, racial inequalities, it's much more bright young people than it is for older people, all of those social inequalities, issues around poverty, those not being visible either in this makes it feel as if, actually, we're just going to be looking at how do we set up hospitals to respond better to an infection that comes again, and that seems very narrow, and almost to fragment people out of this sort of wider societal issue.

So that to me feels very missing, and just to take a leaf out of the Lords Select Committee book, which has looked very thoroughly at this point about resilience in quite a wide way, and thinking about wellbeing. So I think there are some very specific things that are missing, inequalities, and much more about frontline workers, but also the general wellbeing of the population, which we know, people's anxiety levels, both about Covid and about restrictions and calls to our helpline, which rocketed in later periods of pandemic, went up massively when restrictions were imposed, and when restrictions were eased. Everything about this pandemic has been phenomenally anxiety-inducing. So yeah, thanks.

Samantha Edwards: [00:39:20] Thanks very much, Sophie. We'll come to David now.

David Shackles: [00:39:30] I don't want to repeat too much of what's already been said. I very much take Layla's point about the risk of broadening things out too far. I would absolutely agree with the points just made that we are a little bit late on the impact on health equalities for that; I think that is something that has been significant. We've certainly seen it in general practice. I think it's something that's been exacerbated by this pandemic and I don't think it should be ignored.

The same would go I think for ethnicity as well. Both for those affected by the pandemic as patients, but also those who have been caregivers, both either medical or social care. I think this has been significant as well. I'd also put that as part of the difficulties we see where both those with health inequalities and also ethnicity have been some of the harder to reach both for getting medical services, social care services, but also vaccination and the messaging out as well, and I think we need to learn lessons about how that can be improved going forward.

Honestly, I definitely agree with Laura about the impact on training, both at medical school level, but also the impact that we've seen on specialty training within both primary care and hospital

services, and how that is going to pan out going forward: with a two year disruption and training. How are our doctors, nurses, and other professionals going to be prepared, going forward? Are they going to be as well trained as they might have been? I think we have to see. Are they feeling as confident and as prepared to go out into the workforce? Are they going to feel secure in that? Or are they going to feel they've been let down in their training, and not able to provide the services that maybe they could have done had the training not been disrupted?

I absolutely echo the calls for a more in-depth look at the wider impact on primary care, not just my own field of general practice, but in all of the primary care services. I very much commend the point that it was the community pharmacists that provided an excellent service going forward, and we need to look at the ability they had to manage that; what we could learn from some of the structures they had in place that allowed them to continue to function. The [inaudible] way they can do that. Thanks very much.

Samantha Edwards: [00:41:49] Thank you very much, David. Finally, Tim, your patience will be rewarded.

Tim Gardner: [00:41:56] Thank you. So I really wanted to echo what Layla was saying earlier. The Health Foundation has got a bit of a background in looking at public inquiries and investigations, and specifically in the context of the NHS. We've also done some looking around at public inquiries more widely. Declaration of interest, when I used to work with DHSC, where I was involved in the second Mid Staffs public inquiry. So I've got a bit of an interest in that as well.

I do really think it's – I completely understand given what an all-encompassing event we've been experiencing over the last few years – there are a lot of hopes riding on what this Inquiry can deliver. So the desire for a broad-ranging comprehensive inquiry is entirely natural. But I think we do also need to be clear about the risks of setting an even broader Terms of Reference.

Stepping back and looking at the Terms of Reference as a whole, while there are clearly from what others have already said – there are clearly things that can be added to it. But it is already a very, very broad ranging inquiry. Having looked back at inquiries generally, I would struggle to find one that is of comparable size and complexity. We already know inquiries take an awful long time, I think the evidence is fairly clear that the broader, more wide-ranging the inquiry, the longer it will take, the higher it will raise expectations, and quite possibly, to a level that cannot possibly be met.

And I think the really key thing is that it's not simply about time, because there is – from a policy perspective - there is always going to be a limited opportunity to bring about real change that is necessary, and taking too long risks missing that window for change, because people will move on, organisations will change. We've already seen, for example, Public Health England has been abolished and replaced, and that was less than a year into the pandemic.

We will kind of kid ourselves that change has happened and we're all fine and it won't have done. I think a lot of the issues that have been discussed – I think one of the questions I would ask is – I'm not suggesting I know the answer – can this wait for an inquiry to address those questions? So I think that the nearest inquiry I could think of is something that is remotely close to the complexity of this pandemic, is the Chilcot Inquiry into the invasion of Iraq. That took seven years to

conclude. Some of its recommendations have still not been acted upon. So I wanted to underline that.

I'd also echo the two points that Layla raised as priorities in terms of preparedness and decision-making, especially early on during the pandemic, and I also want to say I agree with Sophie, that something that was focusing on a broader response to, and preparation for, emergency situations would be very welcome. I think the last thing anyone wants is a voluminous set of reports that gather dust on a shelf because they're not seen as being clearly applicable to future situations. Thank you.

Samantha Edwards: [00:45:42] Thank you very much, Tim. Vibha.

Vibha Sharma: [00:45:48] Sorry, I just had a point actually off the back of what Tim said, which I think really resonates around inquiries and expectations. It was really just a question, and I appreciate if you want to take this at the end because I don't sort of mess with the agenda. But is the intention, just looking at the Terms of Reference, in terms of what it's actually going to achieve, it's about coming up with a set of broader lessons rather than, for example, specific recommendations for different sectors or different organisations? Because I'm thinking about it from a patient perspective and a transparency perspective, and you know, when there's inquiries, people always want to know who specifically is going to be making a change and taking things forward, and I just wondered what the intention was around what you expect the end output to look like in terms of how specific some of the lessons might be?

Samantha Edwards: [00:46:48] Thank you. It's an excellent question, and we will probably talk a little bit about it in question three, in terms of some of the discussions we've started having around, how do you maybe chunk things up and do interim reports, that then recommendations can be acted on? And in question four, there is something that I would like to explore a little bit around actually being able to test the validity of those recommendations with forums like yourselves, so that actually, you've got much more of a circle of kind of feedback testing, and then implementation when it's in a faster process.

But Tim is absolutely right. Lots of you are right, this is the biggest public inquiry that the UK has ever taken on, and you're absolutely right; the broader the Terms of Reference - this could be significant. Also, there is a danger if you try and literally list everything, there is a real danger that you then leave something off inadvertently, and then you cannot look at it at a later point. So it's how do you find that balance of getting the right, top level of what's important without making people feel that actually we're just ignoring great big swathes of sectors or society, etc. and it's incredibly challenging.

I'm going to turn us to question two, which sort of leads us into what topics and issues do you think the Inquiry should look at first? This may be a question that you throw straight back at me and say, well, frankly, it's your job, you sort it out, and quite understandably. But does anybody have any thoughts about things that should absolutely take priority in terms of the very long list of what could be a public inquiry? Sophie's straight in there.

Sophie Corlett: [00:48:40] Yeah, I think some of the things that – just taking a sort of mental health specific hat off for a minute, I think some of the things that the public really wants to see is

some sort of particular look at some of the decisions that were made, because people feel that bad decisions were made, and I think if you don't get some of those dealt with, it's going to be very difficult to look more generally at how prepared we were and how resilient we can be next time, and so I just think you need to do some of that. Really, and almost separate that off from these more general points that I was making earlier about general resilience, preparedness, and attitudes towards decision-making, longer term decision-making, broader understanding of society, inequalities, some of those things so just specific looking at some of those decisions around when to lock down, what to lock down, etc.

Samantha Edwards: [00:49:48] Thanks, Sophie. I'm going to go to Jack next.

Dr Jack Parry-Jones: [00:49:54] I think a good place to start, I'm afraid – probably one of the hardest is the traumatic nature of families not being able to visit people. I think it's a huge area across multiple sectors. And it had impacts on both the patients, the relatives and staff, particularly mental health issues, but also families. So it's a very difficult area I acknowledge. But I think that's a key area early on. Thanks.

Samantha Edwards: [00:50:26] Thank you very much, Tim.

Tim Gardner: [00:50:30] Yes, I briefly mentioned this shortly. I think there is a very clear case we're looking at preparedness. So this is not something that is particularly well understood. We know that these activities happen within Government, and in different parts of the public service. But very rarely do you see a particularly good spotlight shone on this.

It's not the case that this was some sort of 'black swan', unpredictable, unforeseeable event that happened. It was in our national risk register from at least 2008 onwards, it's something we had a chance to prepare for – you don't very regularly see results of exercises or assessments for preparedness put into the public domain. We have seen some during the pandemic, but those have been in extraordinary circumstances, and actually all indications prior to 2020, based on publicly available data was that the UK was in a very strong position.

And so understanding why, when we had every chance, we looked really good, why did we fail so badly. I think it's a really important thing to understand. Secondly, I completely agree with Sophie that I think it's those initial – as well as preparation and response. It's how, especially in those early days, how quickly did the central Government register that this was a threat? And what were the considerations that guided those early, really critical decisions, and thereafter?

I think that's particularly early in the pandemic. But we've also seen that mistakes that were made early in the pandemic were also sometimes repeated later on. So, the Christmas 2020 mess - should we have another lockdown, despite there being clear advice, despite repeating a mistake that happened earlier? I think really understanding what's going on, and I think that's where an inquiry, you know, being able to compel disclosure of documents, being able to put people on the stand under oath. I think that's where the Inquiry can add an awful lot of value.

Samantha Edwards:. [00:52:49] Thank you, Tim. Layla.

Dr Layla McCay: [00:52:52] I feel like a lot of the things that I was about to say have been already said by Tim. So I'm just going to restrict this to me not knowing specifically what should be

covered first. But from my perspective, it'd be really helpful to have early focus on practical recommendations that can be implemented. We don't know when something like this could happen again, but it could be tomorrow. So it would be really nice if we could try to focus on things that can be actionable as soon as possible.

And, as I'm sure you're familiar with, for example, the fast-track inquiry used during the Hillsborough disaster, which meant we're able to quickly adopt recommendations in stadiums to prevent that terrible situation happening again. I think that there are opportunities here to identify what are the key things that we could take rapid action on and try to get these near the beginning.

Samantha Edwards: [00:53:53] Thanks, Layla. Jenny is next.

Jenny Collard: [00:53:57] It follows quite nicely from what Layla said, actually. I would say that working in health and care anyway, that I think that sort of the focus on health and care, because – a lot of the issues there remain in different guises, and actually, if you're doing that iterative approach where you are sort of dividing up into chunks, and you're producing lessons learned as you go, they will have an impact and will continue to have an impact now. Whereas some of the things that we encountered have maybe fallen away or aren't such – we hope we're not going to have another lockdown. We still need to learn lessons from that, but doing that learning as you go, and what Layla was saying about being able to implement those recommendations would be really key.

Samantha Edwards: [00:54:40] Thank you. I'll go to Laura and then David.

Laura Stroud: [00:54:45] So I think, at root, all public inquiries are about rebuilding trust. Because if you want to be prepared for the next major event, you've got to have that compact with society where they believe in the leadership, they believe in the evidence and so on. So, whether it goes back to Mid Staffs, Ockenden, whatever, it's listening, reflecting and enacting so that we don't go around this loop again.

So if the Inquiry is to achieve anything, it goes back to that purpose – what can this meaningfully do to that kind of trust, and for me, it probably comes down to that leadership, and I think we saw some really good examples of a collective leadership at points. But now, I think the impacts that we are perhaps experiencing, certainly within the health sector, is actually there have been changes, reverses, and there's different focus and spotlight shone on different parts of the system. That's possibly not the best articulation of that point. But I think the fundamental thing is, what will this Inquiry do to rebuild that trust?

Samantha Edwards:. [00:55:59] Thank you, Laura. David.

David Shackles: [00:56:04] Thank you. Yes, I would agree, I think one of the difficulties - if we go right back to the beginning, and look at all the decisions and the problems that happened, then you might get an output for that. But you're not necessarily going to get anything that's going to really guide us right now. I do think the public, and all of the health workers in every sphere in social care will be looking for something that can be done, some answers that can be put in quickly for whatever is coming next.

I think one of the things that struck me over the pandemic was the agility of health services and social care services to be able to change very quickly in the ways they worked - to be able to put things into place that you'd never have thought: remote working, building the Covid assessment centres very rapidly, changing hospital configurations so quickly. The joint work that came up for that. We're going to try and marry that with the Inquiry, but it's got to be able to be agile and get answers out reasonably quickly, as well, and not just be this great, you know, behemoth of an inquiry that goes on for seven years, and then produces recommendations at the end of it, that by that time might be out of date.

So I think we need things that are coming out reasonably rapidly from that, and I would agree that one of the things that is very important to be able to look at to help is some of the evidence around a lot of the non-pharmacological intervention we've had, around lockdown, around mask wearing, around all the restrictions that the public had, because those might be the ones that we're asking people to have that again, more difficult to quantify, more difficult to communicate out and lead people into again.

It's much easier if you can produce medical evidence about a therapy that you produced, they often accept that. But actually, the non-pharmacological interventions have been the ones that might create the greatest angst. Those are the ones that possibly – not guessing before we get to it - have caused a significant amount of mental health damage and other damages and disruption to society than the pure medicine from it. So investigating that so if things do happen along that way again, you can carry it forward with best evidence from that, quicker.

Samantha Edwards: [00:58:07] Thanks very much, David. Vibha and then Sally.

Vibha Sharma: [00:58:14] Thanks. Yeah, just a couple of points. I mean, it may be that this is what was intended by the question anyway, in terms of looking within the health sector, rather than more broadly. But I'm presuming that because of the impact of the pandemic on this sector specifically, this would be more of a focus, and then I guess, some of the other areas, somewhat of a question, but it might be rather obvious.

The second thing, and it touches on what Jenny said, and reinforces what others have said as well is, I think there is something about looking across all areas at where there is an opportunity to apply lessons pretty much immediately, where things are still in play. So if we're thinking about burnout across the workforce, we're thinking about the wellbeing of people across the community, actually I would bring those things forward in terms of there is still an opportunity to affect really positive change now, while things are still live, and kind of think about it in that way, as well as the order of things more broadly, I suppose.

Samantha Edwards: [00:59:17] Yeah. Thank you very much, Sally.

Sally Warren: [00:59:21] Thanks. So I suppose I'm trying to reflect on almost an impossible task, which is what to go first, and I'm just hearing what some people are saying about almost what's the most live area for applying lessons learned. Now I suppose, to me, this is about kind of breadth and point of the Terms of Reference, because if you're thinking, particularly on decision-making and kind of decisions around lockdown, if we're thinking back to about how do

we make decisions about NPIs in a future pandemic, you might think, well, hopefully, we've got a couple of years and we can leave that later.

But actually, I think there's a wider set of lessons learned about these decisions, which is how does Government interact with scientific advice and knowledge, when scientific advice and knowledge is learning as it goes into the emergency. There's a whole host of Government agendas at the moment, which have a similar set of dilemmas where we don't quite know how to kind of move with an evidence base that moves or make a decision without a firm evidence base. So I think there is actually quite a lot of potential for wider work across Government on the back of some of the lessons learnt.

So I suppose my thing would be almost not to put that towards the end of the list, because actually, I think there's a really important set of things about how does Government use expertise and grapple with uncertainty in a way it's not been comfortable doing often?

And my second point, it's just a kind of quite niche one. But particularly doing things like preparing us, just as a inquiry, be aware about how far that could take you into history and into other issues. So I used to work in Government, and, well, up until 2019, I did a huge amount of Brexit, civil contingencies and preparedness work. The reason why there wasn't a lot of flu and pandemic planning from 2016 onwards, was because all of the crisis planning, and civil contingency planning was about No Deal, and kind of how far are you going to go into all of that. You've got to have lines somewhere, but that will be something that comes up.

You know, I know, exercises were delayed, because we had to do other exercises. So it's all of that kind of stuff that you can't just keep peeling the onion, you've got to be clear, how far back you're going to go in history? And then how wide do you allow the explanation or the reasons to go and where do you just accept that reason versus where do you then need to investigate things? Were there reasonable decisions in those trade-offs? So just there is every risk that people wanting you to look at – basically, how was Government run for the last ten years? And that would definitely keep you up at night. It would keep you busy for about the next 25 years.

Samantha Edwards: [01:02:01] It would indeed. Thanks very much, Sally. Sophie, you've got a hand up?

Sophie Corlett: [01:02:17] Yeah. Sorry to come back for another bite of the cherry. I think it's an interesting point about things that are still in play, and the mental health element is definitely still in play. But I think this comes back round again, I think it was Sally's point about the scientific advice that was being taken. There was no scientific advice being taken about the nation's mental health. I'm not quite sure what was in the civil contingency preparation for any sort of emergency around mental health. We've been involved in conversations post-terrorism incidents, about preparedness for those. Mental health is being considered for those more in the nature of trauma for those involved.

And again, we have looked at the mental health of – we've begun to consider the mental health of those who are bereaved, who have been intubated, the mental health of those who've been frontline health workers, but the wider implications on the mental health and wellbeing of society, I think it's continually just sort of put to one side as, well, we'll just get through it, and people just

have to screw their courage up, and then it'll be over, and then it will be back to normal. That is not what is happening or has happened.

And we've either not prepared for that, or we prepared for that but this Government didn't see fit to involve that element in their thinking and decision-making. So there is still quite a lot that we could do at this late stage. You know, it isn't lost, and for me, that is the biggest thing that we could do now, and that is still in play. I still actually don't think anyone is prepared to listen to that until we've dealt with some of the things about why we didn't have enough PPE. So, you know, maybe we need to be running some things in parallel. But I do think those other questions, potentially, you know, 'Why couldn't I see my dad when he was dying?' You know, those are the things that are important to people, I think.

Samantha Edwards: [01:04:28] Thank you very much, Sophie. Right. I don't believe I can see any new hands up. So if everyone's happy, I'd like to move on to the $64,000 question of, do you believe that the Inquiry should set proposed end dates for public hearings?

And I know we've touched on a little bit of this throughout. You might have seen – so as soon as the final Terms of Reference are published, we become official in terms of an inquiry. That's when we start seeking disclosure of evidence and documents, and we start planning for the first wave of hearings. At the moment, we are saying 2023, and I know for some of you that might feel an extraordinarily long time away, but actually, the disclosure is going to take an awful lot of time. I'll talk a little bit in question four about what we want to do for the duration in the run up to hearings, so that it doesn't feel like it's just gone deathly silent.

But actually, there are a number of different ways, and you have absolutely alighted on key issues around how inquiries can take a really long time, and how do you make sure that recommendations are relevant when they come out? So we have considered are there ways of doing things like interim reports, etc.

I don't know whether or not anybody has any strong views on whether or not there should be an end date on public hearings or whether there shouldn't be an end date. Does anybody have any thoughts on that area? Alastair?

Alastair Henderson: [01:06:08] I feel supremely unqualified to actually give you a set sort of answer on that. I suppose – and it was much really a question – and isn't it about a form and timetable – of what your approach as an inquiry is to receiving information and if you like, particularly from the public and/or staff about their experience.

I've had a bit to do with some of the sexual abuse inquiries, which were set up – well, not primarily, but absolutely at the core was the opportunity for people to publicly talk about their experience, and that seemed to me to be absolutely right, that you do that. If you are doing that, clearly it is quite difficult to put a sort of set at a time limit on that. I'm sure there will be a lot of people, both, you know, staff, and bereaved people, etc., who may want to give and quote their experience, and that has to be part of it.

It presumably can't be unlimited – we cannot have the relatives of 160,000 people wanting to come in and talk to you, and also, to be blunt, I'm not sure that is the primary purpose of this Inquiry. That might sort of dissatisfy some people. But I think some of the things we've talked

about or other things that need to – I don't see there is just an opportunity for individuals to – or any individual that wants to, to be able to give their personal sort of experience, and that does mean possibly setting a time limit on the amount of time that you do give for that part of the experience. You will get criticised for that, undoubtedly, but you're going to get criticised whatever you do, and so…

Samantha Edwards: [01:08:25] Very true. Yeah, I'll talk a little bit more about the thinking that we're doing in question four. Vibha.

Vibha Sharma: [01:08:37] Yeah, similar point in a sense. I think it's just in terms of setting expectations, and transparency, and delivering against the aim that that you're – where you're trying to get to, which I think goes back to the question about, what is it that you're planning on coming up with? You know, is it specific recommendations? Or is it broader – broader lessons for the sector?

I think, you know, my personal view is that, you know, it's a really good aspiration to try and come up with a proposed end date. However, you know, there's obviously a huge amount of work that needs to go into determining when that can feasibly be and I'm certainly not qualified to understand what that looks like. So yeah, I guess we might come on to it in terms of next steps. But yeah, just a personal view really.

Samantha Edwards: [01:09:27] Thank you. Does anyone else have any thoughts they would like to share on end dates?

Sally Warren: [01:09:34] Samantha, just a quick thought, and this might not work, but is there a way to have an end date in mind about a first overall view? So we've got the kind of broad umbrella of your big findings and then you could say, and then the next phase is more of a kind of two or three parallel deeper dives into specific issues that you're getting, quicker and sooner, lessons learned and a kind of sense of pace so bereaved families feel like things are happening. But then you haven't had to rush what are some very, very complicated issues.

Because part of the dilemma we have today about consciously trying to increase your Terms of Reference, just how interdependent some of the decisions were. If you were just to look at hospitals, you would have a different judgement of the decisions taken there. But then when you think about the implications of the decisions you made in hospitals for care homes, for primary care, it gets very, very complex.

And it would be complex enough, if you were just trying to think about lessons learned. But if you're at all getting into a space where individuals might feel that they are being held to account, declaimed, whatever, that there will need to be a kind of a level of robustness in your analysis to be able to say, was x decision right or wrong, and what can we learn from that decision being right or wrong? So whether there's that phasing option to me, that's not that we're saying we might have nothing for five years, but it's more that you might have most of it, or the big picture by this time, and then identify the key areas where you think there's more potential for more in-depth debate.

Samantha Edwards: [01:11:15] Thank you. Yeah, that does mirror thinking that we've been doing around how do you kind of satisfy the appetite of people to know what is going on and to feel that

progress is being made. And that is something that Lady Hallett is absolutely focused on. She wants to make sure that we show transparency, we show progress, we show recommendations and lessons learned as quickly as possible so that they are relevant, as you've all said. David.

David Shackles:. [01:11:48] Thanks. So I was just going to come in on that, which I suppose is really much more of a personal view about that. But I think if we don't start to set some sort of limits, going back to this point, then this change will happen anyway, and we will have moved on, and we'll be putting a great deal of money into an inquiry, and the public will then just see it as yet another of these inquiries, it goes on and on and on with no reasonable timescales and no reasonable conclusions made. So at least making effort to show that there's willingness to get results out. I think that builds public confidence, that there are endpoints there. If it's just left too open ended, I think there's a risk of losing confidence from the public in this, and that seems to be one of the big points for having an inquiry like this is to show that there is transparency, there is openness, there is willingness to look at it, and that has to be [inaudible].

Samantha Edwards: [01:12:45] Yeah. Thank you very much. I know there's quite a few things in the chat. Does anybody who is using the chat want to raise anything so that everyone can hear the point? Just want to make sure people have got the chance. Alastair.

Alastair Henderson: [01:13:03] It was just a really, really quick question. Where can I begin? I maybe should know this. Is it just Baroness Hallett, supported by you and the team? Or is there a panel on this sort of inquiry? Or is it just her as an individual?

Samantha Edwards: [01:13:30] So at this point, Lady Hallett is the Chair, we are taking views on whether or not a panel is appropriate, and it will be part of what goes back to the Prime Minister in terms of the Terms of Reference, and he will be the decider on whether or not we have a panel as well. I think there are pros and cons on each side of that. It will not be for us to determine, we can only make recommendations.

Great. Okay. Well, if nobody could give me the answer to the $64,000 question – which is, quite frankly, very reflective of other conversations I've had. It’s a really hard one to put a kind of final answer on – I'd like to move on to my fourth question.

And this is much more focused around, how do we make the Inquiry accessible? And how do we give people an opportunity to share their experiences? Absolutely appreciating that again, can you really provide something that is kind of, you know, available to 66 million people, for example, and what is the right balance? But we are doing some work within the set-up team around what could we provide and we have looked at the models that have been used in both the Infected Blood Inquiry and also the child sexual abuse inquiry. They are really, you know, at the time, they were definitely best practice, and I think there's some really, really good examples that we can build from.

So – and I think there'll be a question of how ambitious can we be? And how much can we kind of make available, but some of the things that we've been talking about is making digital options available to people to provide their experiences. But also, I think, if you're going to do it properly, I think there is going to need to be an element of expert face to face, working in partnerships with

bodies across the UK, so that actually you can talk to the right people, but also talk them in the right way, with the right support around that.

You know, exactly the reason that we've got Martin Hogg in the meetings today is you've got to make sure that we're providing the safeguarding and support for people because I think every single one of us in the UK will say that we've been impacted by the pandemic in a variety of ways. So all those different impacts are affecting people at different points. So does anybody have any thoughts on that broad question about how do we make it easier for people to tell the Inquiry about their experiences, outside of that legal framework, but actually being able to gather views? The ideal would be to actually gather experiences and that forms some foundation and part of evidence so that it's not only a listening exercise, it is actually something that helps us produce evidence that would go into the hearings. Sophie.

Sophie Corlett: [01:16:34] I have a couple of thoughts on this. First, to make sure that we don't draw this too narrowly. It's not just people who have been bereaved or directly affected by Covid. But to look much more widely, this isn't like the infected blood scandal in that it has been a nationwide experience - people have been affected by domestic violence because of lockdown or become addicted to alcohol or young people who are still struggling with their mental health, and that's deteriorated, or particular communities that because of deprivation and lower social capital, have really been hit harder.

So I think it needs to be wider. My other thought is that there's been quite a lot of work done amongst quite wide groups of people collecting information, both during the initial stages of the pandemic, and now looking at how people have experienced it, and how people have experienced it both in real time as it were, and looking back at the sort of journey through and that that ought to be used. Potentially some of the groups that have been good at bringing people together with different interests or experiences should be used in a devolved way to bring that in, rather than expecting people necessarily to engage directly.

I think the breadth of the impact – that has affected everybody makes it much too difficult to try and deliver that all through one method, and it needs to be much broader and multi streamed, and I do think we should be expecting as a nation, that actually, those wider things are taken into account. I do think we will all feel very disappointed – I know, people have said it needs to be manageable and whatever. But I think the nation is expecting that it is wide; might not be able to be wide and deep on everything. But I think it does need to take into account that wider experience that people had if they were a zero hours worker for Amazon or whatever it was, you know, that needs to be evidenced as having been taken into account.

Samantha Edwards: [01:19:17] Thank you very much, Sophie. Let's go with Sally.

Sally Warren: [01:19:34] I had two quick reflections on this: one is kind of slightly picking up on Sophie's point about definitions and you talk here about bereaved families and those who've suffered harm. I suppose, so would key workers be considered as part of this kind of approach to listening or are you thinking about how to engage with key workers be that in health and care or teachers etc. So what's your kind of definition of different groups of people you might want to engage with?

And I think a lot of what you said about the different ways to collect the insight, and particularly the need to support people as they're giving that insight is absolutely spot on. I suppose my other reflection was just to what extent is listening to bereaved families and those who suffered harm – to what extent do you do it once at the start versus where are you doing it frequently throughout the Inquiry? Because I suppose the former civil servant in me worries that we can be very people-oriented at the start, and then go quite system and structure and almost forget the people bit of it. So are there some ways to have – I don't know if it's a kind of citizens panel or something that would allow you to come back to, as you're getting more information about the ins and outs of decision-making implementation to keep bringing it back to how did the public experience that, I think might be quite useful and keep that people side of this alive throughout. Because otherwise, just the sheer volume of very complicated Government and public sector documentation and evidence about what they did when, I just worry, it could, it could end up being a bit distant from people.

Samantha Edwards: [01:21:19] Yeah, I agree. Really, really good points. Thank you, Sally, I see in the chat, other people agreeing as well. David, I'll come to you now.

David Shackles:. [01:21:28] Thanks very much. Yes, absolutely agree with that last point. I think it is quite difficult, isn't it? Do you go right back to first principles and start collecting a whole load of new evidence? Or do you start looking over again, a bit of a meta-analysis on all the great work that's been done already? I'm thinking of the Alliance work in Scotland, about patient experiences of healthcare, and other such stuff like that, and if you can look over that, at that meta-analysis, then are there other themes that you need to explore more widely, and get either public or other health input on as well. So that gives you a head start and allows you to make some recommendations, thoughts quicker, and might advance the Inquiry further, rather than starting right back at first principles.

I do appreciate, as has been said, there might be a public expectation that they can have input *de novo* from that. But that might be something that can be run along in parallel as well, if we have themes that have been brought out, that people can be asked to contribute to, rather than something that's very generally, because otherwise, there might be so much evidence that we never get through it, and that's not going to help anybody.

Samantha Edwards: [01:22:35] Yes. Good points. Thank you; Tim.

Tim Gardner: [01:22:38] Yeah, thanks. I agree with what others have already said. I think it's really, really welcome, and I just want to underline this, that you are thinking about this right from the outset. I think it's really important, and I think it's a really positive thing that you're doing this now.

I agree with the point that we need to think more broadly beyond people who've been bereaved directly due to Covid to capturing a wider range of experiences. One slight note of caution to anyone who's ever run a consultation exercise, is, I think be careful about sort of setting a clear boundary of whose experience you want, and what you are prepared to accept. Having dipped accidentally the other day into Covid conspiracy Twitter – it wouldn't be sadly beyond the bounds

of possibility for, you know, antivax groups or conspiracy groups to try and hijack this process, and I think that's absolutely the last thing that anyone wants to happen.

So I think trying to get that balance between being as open and having as few barriers to allowing people to tell their story and share their experience as possible, without having that process derailed by people who are out to sabotage it.

One of the big advantages you do have is because this has been such an all-encompassing thing that has affected everyone, the Inquiry won't be the first person – the first institution – to try and capture some of this. So I think building on and working with, do a bit of mapping about what is already there, what could be used to help with this might be worthwhile.

I think you kind of alluded to that earlier that this might be something that, whilst a lot of that, you know, really hard work on disclosure and getting lines of inquiry and everything else done in the background, this might be a really good way of demonstrating that things are happening. So, yeah, that would be great.

I'd also support Sally's point about how do you do that throughout the process. Some sort of citizens' panel might be one way of doing it. Another way might be to think about how you might give the people with the most direct stake, the people who have lost the most, however you define that, representation in the Inquiry almost as a core participant alongside some of the others who will be acting in that. So, in the Mid Staffs inquiry, the sort of patient and family group who were most directly affected had representation, publicly funded in the Inquiry itself. So they had a voice in those proceedings, and that seemed to work reasonably well. There's, obviously, only so far you can take that, but that that may well be an option worth considering as well.

Samantha Edwards: [01:25:50] Thank you very much, Tim. I'll bring in Jack next.

Dr Jack Parry-Jones: [01:25:54] Thank you. I mean, it's just it's termed a UK inquiry, and I don't know what consultation you've had with the devolved nations. I thought David might bring this up, actually. So I think that when you are seeking representation, or the voices, I think the voices of Wales, Scotland and Northern Ireland need to be heard. Otherwise, well, there is already a call in Wales for a separate inquiry. I don't know what's happening in Scotland and Northern Ireland. But I think if it's going to try and be labelled as UK, those voices really need to come through strongly.

There's a big issue with social deprivation; I think trying to get the voices of people who are socially deprived, and that would include ethnic minorities in this particular instance – around social deprivation, and that includes other social health issues, which include weight, smoking, etc. Those sorts of things need to come through in some way. So how you get that voice through is going to be important, and then that includes also people with mental health issues, because they don't often engage well, and I'm sure Sophie would know that. So how you get that voice coming through in a useful way, it can be very difficult that people know from – when we're dealing with this in the healthcare situations.

Yeah, that's enough from me. So I think it's more about trying to get those voices through. There could be – I mean, everybody on this call is relatively – speaking for myself, but we're on the older side of this. So it needs youth; the message from youth needs to come through as well, and I think there would need to be representation from younger people. Thanks so much.

Samantha Edwards: [01:27:51] Thank you. Yeah. All excellent points, and something that, I think, is a really a real kind of challenge for an inquiry because they are seen as an extension of sort of, you know, traditional Government institutions about how do you get people who might be mistrustful of things like this. Generally, how do we make sure that people don't believe that it is going to be a set of whitewash recommendations, for example.

On your devolved point, so the Prime Minister has engaged with the devolved Governments on the Terms of Reference, and there is a Scottish inquiry but it has actually started just slightly ahead of the UK one, and the focus very much for us is to make sure that we work really, really closely and understand how we can kind of work in synergy so that we're not duplicating things in Scotland. I know that Wales are absolutely calling for their own public inquiry, because health and social care are devolved issues, and they're really saying, it doesn't feel like this is going to work for us. That's out of our hands. But our focus is making sure that we have a public inquiry that is absolutely UK and is representative of the whole of the UK. So yeah, it is a really, really important point. Jenny?

Jenny Collard: [01:29:07] It's not a new point, it's really just to sort of come in on what other people have said, that, I suppose when I was thinking of this question, it was thinking about that combination of having a free call where people are able to share their views, you know, through a digital platform or whatever works, but also utilising those existing networks, to find those lesser heard groups, and I think what's really struck me is – is it Sophie, sorry, just to get your name right. You know, some of the groups you've been talking about and how you reach out to those to make sure that you've got that representation geographically and for different groups affected, different ethnicities.

You can envisage there's a whole sort of matrix that sits behind this of ensuring in accordance with the representation of the population, what sort of numbers you might want to reach, so that you can be assured that you've spoken to all those groups that are facing different ways well as where they are geographically. I think that would be, you know – if that was done that it would just increase the confidence significantly.

Samantha Edwards: [01:30:09] Thank you. Yes, and I think reaching disaffected, seldom heard groups is going to be absolutely crucial. The thing that we are very alive to is that it would be absolutely foolish if there's a small group of Inquiry people sat in a dark room thinking 'we've got the answer'. So one of the things that we want to put as the heart of – of whatever it is that we roll out is that we want to co-design it with people who are far more expert than ourselves, in terms of how to reach the right people, what sort of kind of channels are going to work for them? Will some people need support or face to face help for other people?

Is digital going to be good enough? How do you make sure that you don't exclude people who need digital assistance, etc. So there's a huge variety of options for us, but actually, the important thing, are we picking the right options and making sure that we co-design it with the people who've got the expertise with those sectors. Just checking to see if there are other hands appearing? I don't have any at the moment, and I'm very conscious of time. Is there anything else that people would like to raise either attached to any of the questions or kind of more broadly on the Terms of Reference that you'd like to either question or just kind of raise a point on. Vibha?

Vibha Sharma: [01:31:35] This doesn’t strictly fall under either of those categories, but it was more just a question on process and next steps. You mentioned about seeking disclosure, and thinking about hearings in 2023, and I just wondered if you could say a little bit more about, in terms of disclosure – are you planning on oral evidence sessions, written submissions, more roundtables? What kind of form do you envisage it taking?

Samantha Edwards: [01:32:04] I don't have that answer at the moment. That has to be worked through in terms of working through – we've got to appoint a legal team and various other things in terms of how would that look. But, you know, just going back to what we were talking about, in terms of listening to people's experiences, I think the smartest thing to do is – that isn't just a cathartic exercise that is about gathering experiences from people who have been impacted, and I would say when we talk about the definitions, I think impact has to be as broad as you would have it, I don't think it's simply about people who've been bereaved, and actually, how do you then take those insights and put them into some form of evidence?

The answer isn't necessarily, then you say, please come along and sit at a hearing. I think it would be about bringing that together in some form of written report that would then provide evidence into the hearing. So that's an example where our thinking is, but the actual design hasn't been done yet. Does anybody have anything further? Jenny.

Jenny Collard: [01:33:18] I suppose it was just a question about, I'm quite conscious that I was sort of a late addition to this group. I found out through Vibha that it was taking place, and I suppose it was just a question about other sort of key organisations such as the Care Quality Commission in England and the equivalent and you know, people like the BMA, the Royal College of Nurses, Royal College of Midwives. I know they have an opportunity to submit a response online, but I just wondered if there was any scope for further roundtables? Or is it just for us to ensure that they're aware of the Terms of Reference and the ability to respond?

Samantha Edwards: [01:33:59] No, it's a great question. So the position is that, if we can, we will make time and accommodate sort of follow-up meetings with people who've either not had an invite, or perhaps didn't kind of make it to some of these. So I think within the bounds of our consultation time, and you know, if I can find time or others in the Inquiry unit, we will absolutely try to meet with people where actually they're going to bring some diverse thought, other perspectives, etc. I think that is absolutely right.

If people don't have that ability to sort of say, oh, we'd like a meeting, then, we will encourage people to use the consultation form because that is an incredibly helpful way to ask, because it really does help us kind of feel for what we're getting as well, which will be really helpful.

But, without overpromising and saying that we'll meet with everybody, if there are bodies that feel that a meeting would be incredibly helpful, then we are going to look to see what we can do within this four-week timetable, we're sort of coming to the end of week one.

Jenny Collard: [01:35:06] And, just on that, sorry, second bite of the cherry, in terms of our response; would it be helpful for us to submit a more formal response? Or is this sufficient for your purposes?

Samantha Edwards: [01:35:19] This is sufficient, because we are going to have a proper transcription of it, and we'll be able to pull out all of that, and Catherine has been diligently taking notes, which are, frankly, going to be far better than my spider scrawl that I've been writing next to us. If you wish to provide a more formal response, then by all means, but this is part of the consultation process. So don't feel that you have to if you don't wish to.

Right, anything final from people? I don't want to keep people over time. So, all that remains for me to say is thank you so much. It's been a fascinating conversation, it has definitely opened my eyes into the broader health and care sector, which has been incredibly helpful, and I know that Catherine and I in particular, will have found that so helpful, we've taken huge amounts of notes and thoughts from you. So it will all be fed into the consultation process.

But this won't be the only bite of the cherry, so to speak, in terms of people being able to give their views throughout the lifetime of the Inquiry, we're very conscious of that. If anybody does need to speak to Martin Hogg after this event, or in the coming days, then he's magically appeared on screen to remind you of his presence. Martin's a brilliant addition to our team in terms of making sure that we are thinking about everybody; some of this is - it's hard conversations when we think about just the scale of what has happened to the UK and the world during the pandemic. So do get in touch with Martin, if you find that it would be helpful.

Thank you very much for all of your insights and your honesty, you can get in touch with us, we've got a Covid-19 Inquiry mailbox. So you're very welcome to use that for anything that you'd like to follow up with, and we will start putting in plans on how we can work with yourselves going forward into the lifetime of the Inquiry. So I hope that this will not be the only time that we speak because I think the advice that you've given is going to be hugely helpful to us throughout the lifetime of designing what comes next.

So thank you so much for your time, it has been hugely valuable to me. I hope it's been useful to you, and I hope that we'll speak again another time. Thank you so much and enjoy the rest of your Friday. Thank you all.

[END OF TRANSCRIPT]