

Monday, 23 September 2024

(10.30 am)

LADY HALLETT: Good morning.

Ms Carey, I think you have an announcement to make.

MS CAREY: I do, my Lady.

Professor Helen Shooks was due to give evidence today but unfortunately over the weekend she fell and has sustained a concussion and requires surgery for a wrist fracture, which is likely to take place either today or imminently. Understandably, therefore, she's not currently fit to give evidence.

The Inquiry intends to seek an update on her progress and indeed her recovery, we hope, and we'll update your Ladyship and the core participants in due course.

Thanks to the efforts of the legal operations team, and indeed to the witnesses themselves, a number of this afternoon's witnesses have been brought forward, so we are very grateful we will be able to deal with Professor Edwards and then carry on with the timetable as envisaged.

LADY HALLETT: Thank you very much, Ms Carey, and could you ensure that you will send to the

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at Cardiff University, and you have held that role since 2005, is that right?

A. Correct.

Q. As part of that role you have been director of the PRIME Centre Wales; that's a research centre for primary and emergency care, is that correct?

A. That's correct. And we collaborate with Professor Snooks.

Q. And --

LADY HALLETT: Sorry, I missed that, and I think the stenographer may have missed it.

We have a new stenographer, Professor, so whereas we've all got used to certain acronyms, the NHS seems to be flooded with acronyms and also medical expressions. If we could make sure that we speak very slowly and clearly so the stenographers can find their way.

A. Okay.

MS NIELD: Thank you, my Lady, I'll make a mental note to do the same.

I think you said you collaborate with Professor Snooks at the PRIME research centre?

A. Correct.

Q. You have been director of the Wales

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Professor our best wishes.

MS CAREY: We will.

LADY HALLETT: Yes.

MS NIELD: My Lady, may I call Professor Adrian Edwards.

PROFESSOR ADRIAN EDWARDS (sworn)

Questions from COUNSEL TO THE INQUIRY

MS NIELD: Professor Edwards, could you give your full name, please.

A. Adrian Gwyn Konrad Edwards.

Q. Thank you.

Professor Edwards, you've been good enough to provide an expert report to the Inquiry dealing with general medical practice during the pandemic, is that right?

A. Correct.

Q. That report runs to 123 pages and it has been given the INQ number INQ000474283.

You're familiar with that report and I think you have a copy of it in front of you; is that right?

A. Correct.

Q. If we could deal first of all, Professor Edwards, with your professional background, you're a professor of general practice

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Covid-19 Evidence Centre between 2021 and 2023, is that right?

A. Correct.

Q. And as director of the Wales Covid-19 Evidence Centre, you were also a member of the Technical Advisory Group for the Welsh Government, is that right?

A. Correct.

Q. You're director of the Health and Care Research Wales Evidence Centre since 2023?

A. Correct.

Q. And you were a partner in general practice in Gwent between 1999 and 30 June 2020, is that right?

A. Correct.

Q. And you are now working one day a week as a salaried GP at a health centre, also in Gwent?

A. Correct.

Q. Thank you.

If we could move on, please, to your report, you outlined at the beginning of that report the organisation of primary care and general practice services in the UK, and you explain that general practice is just one of four components of primary care; is that right?

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1 **A.** Correct, as one of the contractor
2 professions, the others being pharmacy, dentistry
3 and optometry.

4 **Q.** So you've described them as a contractor
5 profession. I think it's right that general
6 practitioners are not directly employed by the NHS.
7 Could you explain that please?

8 **A.** So in the usual -- traditional model of
9 general practice, the practice, ie the partners in
10 that practice, contract with the NHS to provide the
11 general medical services to that population of
12 patients. So the partners own the business and they
13 employ various other staff, nursing staff, other
14 allied health and administrative staff. And as
15 I say, they have a contract to provide the general
16 medical services for the population; the contract is
17 with the NHS.

18 **Q.** We'll come on, if we may, in a little
19 while, to talk a little more about the nature of
20 that contract, but you said there that partners
21 employ other staff within the general practice
22 surgery, and you explain in your report that over
23 the last 10 to 15 years there has increasingly been
24 a multidisciplinary team model.

25 **A.** Yes.

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1 So there's a -- this group of the workforce,
2 healthcare assistants and related terms, providing
3 services face-to-face with patients, and then also
4 the administrative staff, increasingly management,
5 and then of course the reception and care navigation
6 staff.

7 **Q.** You mentioned there care navigation.
8 Is that in order to direct the patient to
9 the right person for their particular issue?

10 **A.** At the right time as well, hopefully,
11 yes. So they -- so these people, they might, again
12 traditionally, have been receptionists who gained
13 additional skills in care navigation. So the role
14 is to assist the doctors and clinical staff in
15 prioritising the patient's need and to the right
16 member of staff at the right time.

17 **Q.** So does that require also the degree of
18 training for the care navigator?

19 **A.** Yes, there should be.

20 **Q.** If we can come back then to the
21 contractual nature of the relationship between the
22 NHS and the partners of a general practice surgery.
23 Again, you set out in your report that across the UK
24 all GPs have to provide essential services and may
25 also provide enhanced or additional services.

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1 **Q.** How does that work in general practice?

2 **A.** So, first of all, I'll make a comment
3 about the partners themselves. So traditionally
4 they would have only been general practitioners, but
5 lately there have been other professional members as
6 partners of practices. So in fact in my own
7 practice, of two of the five partners, one is
8 an advanced nurse practitioner, one is a mental
9 health practitioner, so they are the partners with
10 three GPs.

11 But either way, the partnership will employ
12 a range of staff to provide its services. So they
13 would, again traditionally, have been practice
14 nurses, but then increasingly diversifying that to
15 advanced nurse practitioners, advanced care
16 practitioners, also pharmacists, a range of others
17 potentially, like physiotherapists or others. And
18 then lately, again, particularly staff to assist
19 with the provision of services, healthcare
20 assistants, sometimes maybe called nursing
21 associates -- they're not exactly the same but often
22 providing many of the same roles -- assisting the
23 nursing and medical staff, so, for example, taking
24 blood tests, doing ECGs, swabs and infections,
25 et cetera.

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1 Could you outline very briefly what are
2 those essential services and what are the enhanced
3 services?

4 **A.** So the essential services would be
5 what -- the core business of general
6 practice: seeing patients attending with same-day
7 needs or ongoing needs relating to long-term and
8 continuing conditions, as well as the related
9 nursing, pharmacy, other functions. Managing their
10 day-to-day and ongoing care. And that would also
11 include areas around health promotion, for example,
12 and prevention and screening.

13 Then there are the additional or enhanced
14 services, which are additional contracts that
15 a practice signs up for to provide a service, and
16 they can be various, in various districts. They can
17 be either locally determined or nationally
18 determined. But they might, for example, include
19 services like providing minor surgery in a practice
20 if a GP has those skills and is able to provide that
21 service, removing lumps and bumps and doing joint
22 injections and that type of thing. So that might be
23 a service.

24 Another one might, for example -- could
25 be -- it could be very specialist things, like

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1 substance misuse services. Again, if there's
2 a clinician in the practice who has those skills and
3 training, then they might provide a specific service
4 to patients/service users with problems of substance
5 misuse, who might otherwise have gone to secondary
6 care or other community services. But actually it
7 is helpful, and by and large efficient, to be
8 providing that service in the local practice.

9 **Q.** Would those enhanced services also
10 include things like a quality outcomes framework,
11 where it's necessary to conduct -- well, perhaps you
12 could explain what -- the quality outcomes
13 framework?

14 **A.** So the quality outcomes framework has
15 iterated in the different countries across the UK
16 but in principle it's to ensure quality, and it's
17 about pay for performance, demonstrating that the
18 practice is reaching quality targets.

19 As I say, it has been termed different
20 things in different countries, so in Wales it became
21 the Quality Assurance and Improvement Framework, and
22 I believe in Scotland it was actually disinvested.

23 The point about whether it's an additional
24 service, actually not. It was part of the core
25 contract. And as I say, when it started probably,

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1 that exist in that contracting model, or the details
2 of those contractual arrangements between the four
3 nations of the UK, but I think you set out in your
4 report that broadly that general practice model is
5 the same across the four countries of the UK.

6 And it might be appropriate to mention now
7 that in preparing your report, when you assess the
8 data that was coming from a variety of sources and
9 academic studies, sometimes directly comparable data
10 isn't available in each of those four nations,
11 slightly different data is collected or sometimes
12 not collected?

13 **A.** Correct, yes.

14 **Q.** I think you've noted at number of places
15 in your report a limitation or lack of data from
16 Northern Ireland in particular?

17 **A.** Yes, I think it's variable according to
18 which issue and metric we might be examining, but,
19 yes, on the whole data were stronger, more
20 comprehensive, from NHS England, and then sometimes
21 NHS Wales or NHS Scotland might be particularly
22 strong in a given area, and often I think it was
23 missing in -- from Northern Ireland.

24 Or sometimes data may be available but not
25 published completely, so different participants in

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1 best part of 20 years ago, it was a section of the
2 income to practices that was identified as very much
3 connected with achieving those performance targets.

4 **Q.** During the pandemic did that change that
5 position between the enhanced services that could be
6 offered by a general practice surgery, and
7 additional payment would come in if those services
8 were offered?

9 **A.** Well, I think it would be probably
10 an interesting problem, a difficult problem
11 sometimes, that clearly practices are built around
12 income and expenditure, and those incomes relating
13 to the enhanced services would have been built into
14 the way a practice delivers its services, with staff
15 and so on.

16 So some of those services might have been
17 very difficult to deliver in those immediate phases
18 of the pandemic, and that has significant
19 implications in terms of practice income.

20 I believe, on the whole, services were suspended,
21 but with an assurance of income, to enable the
22 practice to keep functioning with its complement of
23 staff.

24 **Q.** Thank you.

25 You've referred to the slight differences

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1 this Inquiry may have reported different elements of
2 data which may not always be publicly available.

3 **Q.** Thank you.

4 I think nevertheless you observe that the
5 similarities in the general practice model across
6 the four nations mean that conclusions that you've
7 reached based, for example, on data from NHS England
8 are going to be applicable to GP services in the
9 other nations of the UK; is that right, broadly?

10 **A.** I think in general we would be looking
11 for what can be transferable from one setting to
12 another, so studies or analyses would be undertaken.
13 We would -- from a research point of view, we would
14 examine whether they are generalisable: is the exact
15 setting and the participants in that survey, for
16 example, relevant in one setting, some part of
17 England, say -- is it relevant to generalise to
18 other areas of England? Or Wales, Scotland,
19 Northern Ireland?

20 Sometimes it's not completely generalisable
21 but nevertheless we're looking for transferable
22 lessons, and I think that's quite a key theme in
23 some of the evidence that we might be examining.

24 **Q.** Thank you.

25 Looking at the way GP operates across the

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1 UK, you undertake a brief comparison between the UK
2 and other developed countries in the world in terms
3 of the provision of full-time equivalent general
4 practitioners per 100,000 of the population, and
5 you've observed in your report that the UK doesn't
6 compare very well.

7 **A.** Yes.

8 **Q.** I think you've taken the example of
9 Australia, which has 120 full-time equivalent GPs
10 per 100,000 of the population.

11 **A.** Yes, actually just to check the detail on
12 that, I think that graph is actually headcount of
13 GPs, and a later graph in my report, which has some
14 slightly different figures, is about full-time
15 equivalent.

16 **Q.** So I think you've also identified that in
17 fact increasingly in the UK GPs are choosing to work
18 part-time?

19 **A.** Yes.

20 **Q.** So the full-time equivalent numbers are
21 quite different from the total headcount. Is that
22 correct?

23 **A.** Yes, very much so. We might call it
24 a portfolio career, usually combining other
25 activities, like myself, for example, in

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1 actually very concerning.

2 **Q.** Your report also makes mention -- this is
3 at paragraph 137 in your report -- of the inverse
4 care law --

5 **A.** Mm.

6 **Q.** -- and how that applies to general
7 practice.

8 Could you explain what the inverse care law
9 is and how that does apply in general practice in
10 the UK.

11 **A.** Okay.

12 So the inverse care law was a term,
13 a concept, conceptualised in 1971 by an author
14 called Dr Julian Tudor Hart, who was one of the
15 leading players in Welsh general practice at the
16 time.

17 It is actually a pun on a concept in
18 physics, which is the inverse square law, however
19 the inverse care law here states that the provision
20 of good medical or social care services is inversely
21 proportional to the medical need for it in the
22 population.

23 And actually there's a rider on that, which
24 is that the influence of that phenomenon is greatest
25 where market forces are most evident in that

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1 a university, alongside clinical practice.

2 **Q.** And I think data shows that England has
3 just 45 full-time equivalent GPs per 100,000 of the
4 population, is that right?

5 **A.** Which --

6 **Q.** I think this is in paragraph 22 of your
7 report, if that assists.

8 **A.** Yes, that's right.

9 **Q.** I think you note there: 120 full-time
10 equivalent GPs in Australia per 100,000; New Zealand
11 had 74 full-time equivalent GPs; Canada, 103 family
12 physicians.

13 Whereas England, as we've said, had 45
14 full-time equivalent GPs, and that was a decline, in
15 2022, from the figures in 2015, which showed that
16 there were then 52 full-time equivalent GPs --

17 **A.** Yes, yes.

18 **Q.** -- in England?

19 **A.** Yes. So there are disparities between
20 these different countries but many of which have
21 health systems and provision which are in some ways
22 similar to what we would recognise, and so as well
23 as the fact that our provision of GPs and other
24 staff actually have similar figures as well, our
25 provision is lower and then the trends are also

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1 healthcare system.

2 So the reality is that populations with the
3 highest medical and social care need have the lowest
4 level of provision. That is actually across all of
5 healthcare. It's a strong phenomenon, whether you
6 look at, you know, cardiology services or general
7 practice, but our interest here is in general
8 practice.

9 So what that means in reality is that a GP
10 in the poorest areas will on average have 2,400
11 patients, a GP in a more affluent area will have on
12 average 2,100 patients. And by the way, that GP in
13 the poorer area earns 7% less.

14 So it's a double whammy: there's greater
15 health need, more illness and disability, and less
16 provision.

17 **Q.** Thank you.

18 You identify in your report, in terms of
19 access to general practice appointments during the
20 pandemic, that there was a deteriorating patient
21 experience or deteriorating patient satisfaction
22 prior to the pandemic.

23 Can we get up, please -- this is on page 14
24 of your report, at paragraph 32. This is data from
25 the Health and Care Experience Survey which is

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1 available on the Scottish Government website.
 2 We can see that that graph begins in
 3 2009/2010, and there's a general decline in the
 4 number of patients rating their experience as
 5 excellent or good that continues all the way through
 6 to 2021, when it goes down to 67%. And then there's
 7 a slight -- a slight increase, by 2%, from 2021/22
 8 to the year 2023/24.

9 And you've said in your report that these
 10 ratings are a function of both experience and
 11 expectations, and that it may be that patients
 12 around the time of the pandemic, their expectations
 13 were -- were lowered; is that right?

14 **A.** Yes, that's right. So there are a number
 15 of significant contributions to what is -- is
 16 overall called access. It is about patient
 17 experience in relation to expectations. The other
 18 moving parts here are about provision, the amount of
 19 appointments, in relation to need.

20 But on that particular point, of experience
 21 in relation to expectations, as I say, there are
 22 other graphs which show a slight uptick in
 23 satisfaction in that particular stress point of the
 24 early pandemic, and I think what is actually -- what
 25 that reflects is that patients are making allowances

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1 We can also see that some additional
 2 questions I think were added to the survey in 2018,
 3 around experience of making an appointment and
 4 satisfaction with appointment times, and we see
 5 broadly the same trend there.

6 **A.** Yes, that's right.

7 And clearly what it reflects is that that
 8 process of access is actually quite multifactorial.
 9 Overall what everyone wants, everyone here has a GP,
 10 you want to be able to get an appointment reasonably
 11 efficiently and with a member of staff that you want
 12 or need.

13 So there are other variables here: as well
 14 as ease of speaking on the phone and that experience
 15 of making an appointment, yes, the satisfaction with
 16 appointment time, how long did you have to wait for
 17 the appointment that you were given, and also
 18 whether you were able to see the preferred
 19 clinician, the doctor or the nurse who would be able
 20 to follow through from a previous problem perhaps.
 21 So there are a number of variables at play in that
 22 overall experience of access.

23 **Q.** Your report also highlights that ethnic
 24 minority patients in particular consistently report
 25 lower satisfaction with GP services in recent years.

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1 for the change in services under the pressures of
 2 the pandemic and the effect on the health system at
 3 the time.

4 So they were probably, if you like, as they
 5 rate it in surveys, willing to make that allowance
 6 at that time, then as services return to normal the
 7 full influence of these moving parts, as I say,
 8 experience, expectations, provision and need, come
 9 together again and experience of access continues to
 10 deteriorate.

11 **Q.** Thank you.

12 Can we have a look, please, at I think
 13 probably a similar picture from England, but this is
 14 figure 2, it's at page 15 of your report. This is
 15 data from the NHS England annual GP Patient Survey.

16 We can see the blue line at the top is the
 17 overall experience at a GP practice. As you've
 18 referred to, there's a gradual decline, up to around
 19 2020, when there's a very slight upturn, and then
 20 quite a marked decline from 2021.

21 And that graph also shows in yellow ease of
 22 speaking to someone on the phone, which is a more
 23 marked decline than the overall experience, and
 24 again a slight lift at around 2020 and then a marked
 25 decline from 2021.

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1 Was that based on data from England or
 2 across the UK, do you know?

3 **A.** So that was data from England, from -- it
 4 was a quantitative analysis of those large-scale
 5 data from the GP Patient Survey.

6 **LADY HALLETT:** So the general position as far
 7 as -- we've seen Scotland and England graphs; is
 8 that replicated in Northern Ireland and Wales?

9 **A.** I think so, yes. I think there are some
 10 data I've seen from Wales which also reflect
 11 a deterioration in experience of access. I haven't
 12 seen data from Northern Ireland but, again, I would
 13 imagine this is one of those examples where there is
 14 very much transferable experience across the four
 15 nations.

16 **MS NIELD:** I think you explain in your report
 17 at paragraph 35 that there's very limited data from
 18 Northern Ireland on patient satisfaction and access
 19 to general practice; there was a single survey in
 20 2018?

21 **A.** That's right, that was in that last -- in
 22 the other graph that follows there's just a single
 23 point in it.

24 But that point about ethnic minority
 25 experience of access I think is important,

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1 concerning, as well. So it was a quantitative
2 analysis of those data from the patient survey
3 nationally. What they're able to do is analyse
4 things that are associated with poorer experience of
5 the general practice and access, and one of the
6 features they found was that the proportion of
7 patients in a practice who identify as ethnic
8 minority groups, that is associated with poorer
9 patient experience.

10 It is a quantitative analysis. There's
11 slightly limited -- or, shall we say, headline
12 information available about what underlies that, but
13 there were some issues that can be identified and
14 which could be taken forward to improve things, such
15 as patient's experience of using the website, but
16 also their experience of being treated with care and
17 concern, trust in professionals in that service, and
18 involvement in decision-making.

19 Which happens to be a particular area of
20 research interest for mine.

21 So there were, if you like, some headline
22 pointers from that quantitative analysis. What
23 would be really useful to get into the detail of --
24 of that finding, about the reasons for ethnic
25 minority populations having a poorer experience,

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1 peer group in England, say. So there are
2 differences.

3 **LADY HALLETT:** Sorry to interrupt, Ms Nield.

4 **MS NIELD:** Thank you, my Lady.

5 So in terms of access to general practice,
6 you've identified that before the pandemic there was
7 already an issue with that and that the pandemic
8 added further changes and pressures, and we'll come
9 on to talk in a little while about some of those
10 changes, such as the move to remote consultations.

11 But you observe that whilst general practice
12 did remain open during the pandemic, those changes
13 made general practice more difficult to access for
14 many patients and created a misperception that
15 general practice was closed to the public and not
16 operating. Is that right?

17 **A.** So I think there are definitely features
18 of what you describe there. I think that -- I think
19 essentially it's -- it's a spectrum from feeling
20 completely closed to feeling completely open, it's
21 not either or, and people may have reached
22 conclusions that it was more closed and less open
23 rather than either/or.

24 But nevertheless -- so I think what I would
25 be saying is, you know, some patients would

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1 would be some more detailed quantitative in-depth
2 work, such as interviews, to really get to the
3 meaning and the experience of these things.

4 **LADY HALLETT:** Sorry to interrupt again, Ms
5 Nield.

6 Can I just ask, when it comes to the NHS --
7 so the NHS will negotiate with GP leaders
8 a contract. Health is devolved around the four
9 nations. When a contract is negotiated, does that
10 apply in Scotland, Wales, England and Northern
11 Ireland, or do the different devolved nations --

12 **A.** They develop their own contracts,
13 my Lady.

14 **LADY HALLETT:** Right.

15 **A.** So there is a different group of GPs,
16 largely with the British Medical Association, who
17 negotiate that contract with each government.

18 **LADY HALLETT:** Are there glaring differences
19 or do they usually follow much the same?

20 **A.** Well, as we said at the beginning,
21 my Lady, there are slight differences in the way
22 particularly additional and enhanced services are --

23 **LADY HALLETT:** Right.

24 **A.** -- agreed, and we might say, in Wales,
25 that we have relative underfunding compared to our

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1 definitely be making that perception and
2 interpretation of health messages, the -- the stay
3 at home, save the NHS message, for example. Other
4 people will have been trying to access services as
5 they needed it, and generally probably experiencing
6 it in fairly normal ways, ie accessing via the
7 telephone. But what was obviously changing at the
8 time were these shifts towards more complete
9 triaging by telephone and other online systems,
10 effectively sending emails and so forth, giving
11 details about your illness, condition, rather than
12 turning up in person and wanting to book
13 an appointment as in previous years.

14 So I think it's about -- it's about shifts,
15 and trends.

16 **Q.** And do you think that the public
17 messaging around general practice remaining open
18 could've been improved?

19 **A.** So what I think is that there were
20 definitely coherent attempts to try to maintain the
21 message that general practice was here for business.
22 As we said, I think there were perceptions at times
23 that GP -- general practice was closed, but, for
24 example, the Royal College of GPs certainly had
25 a campaign that we're "open for business", and

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1 applying that in the different devolved nations as
2 well. And individual practices will have made their
3 attempts to convey that services are here to
4 provide, so, for example, with information on our
5 websites, or telephone messages.

6 But in reality, as I say, that may not
7 always have got through. I think, if you like, what
8 could've been improved was a more coherent or
9 stronger campaign to convey what was available in
10 general practice.

11 **Q.** In terms of individual surgeries, were
12 you aware that some surgeries did in fact have to
13 temporarily close because of sickness due to Covid
14 or the need to self-isolate if there had been
15 an outbreak at the surgery? And are there any steps
16 you think that could be taken to minimise surgery
17 closures in the event of a future pandemic?

18 **A.** So yes, I am aware that practices will
19 have experienced significant stresses on their
20 ability to provide, and this could be either one or
21 two key members of staff, particularly in small
22 practices. You know, we're talking 10 or 20 staff
23 and employee members in a practice. And if, you
24 know, two, three, four of those go off sick or have
25 to self-isolate at one time, that is a significant

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1 you've identified in your report that in addition
2 to, at least initially, a drop in the overall number
3 of general practice consultations at the start of
4 the pandemic across the UK, the most prominent
5 change probably to the way that general practice
6 actually operated was the shift towards remote
7 consultations.

8 Could we have a look, please, at figure 7.
9 That's on page 32 of your report.

10 This is a graph from the Health Foundation
11 based on English data, I think.

12 And could we -- thank you.

13 I think we can see there the red line is
14 face-to-face appointments, and the blue line is
15 telephone appointments, so we can see that, while
16 it's quite a jagged line, the red line along the
17 top, there was a very rapid drop-off in
18 around January/February of 2020, down to April of
19 2020, when there was the biggest drop.

20 And mirroring that, an increase, and
21 a sustained increase, in the number of telephone
22 appointments.

23 And then we see that the number of telephone
24 appointments continues from around May 2020
25 and June 2020, when it's at its highest point, and

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1 stress on the ability to provide. And that could be
2 either self-isolating or genuinely infected and ill.

3 Remember, there is a context here that
4 general practice was extremely fragile anyway
5 running up to the pandemic so the experience of
6 practice closures is not unknown, indeed as I -- as
7 we established at the beginning, my own practice
8 closed in June of 2020. We resigned the contract.
9 So these things go on. And therefore, the primary
10 care organisations, the health boards, and now the
11 integrated care system or boards, they have
12 a responsibility to ensure some continuity of
13 service. And -- and I think what would have
14 happened is that would have been on a case-by-case
15 basis working out how that could be provided in
16 a given locality. It depends how many other
17 practices in the locality would've had the same
18 stress and closure at the time.

19 So whether we would be referring patients
20 onward to NHS 111, for example, for telephone
21 advice, or perhaps to a neighbouring practice, it'd
22 be a case-by-case solution finding I think.

23 **Q.** Thank you.

24 Can we move on now, please, to look at
25 changes in general practice during the pandemic, and

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1 continues in a similar vein through to the end of
2 that graph, which is March 2021. But we can also
3 see that although there was an initial drop in the
4 number of face-to-face appointments, that then began
5 to pick up again as we move through into 2021.

6 And you've noted that this graph may in fact
7 overestimate the number of face-to-face
8 appointments, and underestimate the other types of
9 encounter, because the default setting for
10 appointment diaries, if I can put it that way, is
11 face-to-face; is that right?

12 **A.** That's correct.

13 **Q.** Thank you.

14 **A.** So as we see the percentage of telephone
15 consultations is roundabout 13 -- 1-3 -- per cent in
16 those years before the pandemic, and it rose to
17 something of the order of 47% in that immediate
18 pandemic phase.

19 **Q.** Than you.

20 I wonder if we can move on, please, to look
21 at figure 9. This is some data from Scotland.

22 **A.** Yes.

23 **Q.** This is on page 34 of your report.

24 If we could zoom in -- thank you,
25 Lawrence -- we see a similar picture there. I think

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1 the dotted line is lockdown in March of 2020. And
 2 we see, again, face-to-face appointments, the dark
 3 blue line, and the purple line showing virtual
 4 appointments, and it's showing the same sort of
 5 trend that we observed in the data from England, is
 6 that right? A sharp drop in face-to-face
 7 appointments around the time of lockdown, and
 8 a similar increase in the number of virtual
 9 appointments?

10 **A.** That's right.

11 My apologies, I'm not very good with colours,
 12 I'm colour blind, but the top line is the physical
 13 or the more face-to-face appointments, and the
 14 bottom line is telephone and/or virtual.

15 And so I think -- the other point that
 16 should be made about this graph, and the one before,
 17 is that the key point is to -- is to add the totals
 18 together as well to see how much activity was going
 19 on.

20 So in that early phase there is actually
 21 a net drop in total activity, but then quickly not
 22 only do we establish a new normal of the proportion
 23 which are telephone-based or other remote methods
 24 but actually the totals now exceed those prior to
 25 the pandemic.

29

1 **Q.** Would that also include patients with
 2 disabilities such as sensory impairments or learning
 3 difficulties? Would that be more difficult for
 4 them --

5 **A.** Yes, yes, very much so. And it could --
 6 depending on the nature of the disability, the
 7 particular route of access, whether it's, as I say,
 8 telephone or website, may be more difficult or less.

9 **Q.** Were you aware of any initiatives or
 10 measures taken either at a national or a more local
 11 level during the pandemic to ensure that those
 12 people who were digitally less able were not
 13 disadvantaged by that shift towards online bookings?

14 **A.** So in terms of the -- what I think you've
 15 described there as a national exercise, that would
 16 be implemented in different ways probably in the
 17 different four countries, but nevertheless I'm
 18 actually probably not aware of specific programmes
 19 that were undertaken to achieve that, except that
 20 I think -- and there was an awareness of it,
 21 a genuine knowledge and awareness, and
 22 an imperative, to try to assist people so that as we
 23 switched very much wholesale to remote access,
 24 triage and consulting in those early months of the
 25 pandemic, there was a specific attention to people

31

1 **Q.** Thank you.

2 Now, Professor Edwards, you go on in your
 3 report to explore a number of issues with remote
 4 consultations in general practice, and I don't think
 5 we're going to be able to address all of them this
 6 morning, but one point that you make is that some
 7 patients could be described as "digitally excluded".
 8 Could you explain what you mean by that, please.

9 **A.** So I think the issue that we're wanting
 10 to describe, and ultimately help with, are patients
 11 who are not -- not finding it so easy to use these
 12 remote methods, sometimes digital, sometimes
 13 telephone.

14 **Q.** What sort of groups of patients would
 15 they be?

16 **A.** So people who have more difficulty with
 17 either telephones or computers. It might be,
 18 typically, older patients, sometimes less educated,
 19 sometimes socioeconomically more deprived. Also,
 20 actually, probably sometimes the ethnic minority
 21 groups that we talk -- we mentioned earlier, they
 22 specifically identified in their GP Patient Survey
 23 difficulties with accessing the practice website.

24 So there's a range of groups who are
 25 typically more deprived and have more difficulty.

30

1 with particular needs. At the practice level
 2 I think, ultimately.

3 **Q.** You set out various issues with how
 4 general practice can make that shift towards remote
 5 consultations, and you point out that it's
 6 a different skill set and some further training is
 7 needed, really, to enable the practitioners to both
 8 assess what's the most suitable mode of consultation
 9 and then carry out that consultation.

10 And I think you identify in your report that
 11 there were a number of pre-pandemic studies and
 12 evaluations of moving to remote consultations in
 13 general practice which identified a lot of those
 14 issues.

15 So my question is this: do you consider or
 16 to what extent do you consider that those challenges
 17 or potential drawbacks of moving to a remote
 18 consultation model during the pandemic were
 19 foreseeable issues at the start of the pandemic?
 20 And did they appear to have been properly taken into
 21 account when general practice was asked to make that
 22 move to increasing the number of remote
 23 consultations?

24 **A.** I think there were really useful findings
 25 from those evaluations before the pandemic about

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1 telephone consulting and related issues of remote
2 access as well as provision of services.

3 So I think that -- for example, that is what
4 contributes to the knowledge and awareness for
5 digital exclusion and other aspects of social and
6 economic disadvantage as concerns to tackle. So
7 that's why the knowledge and awareness was there
8 when we made that change.

9 Sorry, I can't completely remember the
10 second part of that question. Was -- was -- was
11 more --

12 **Q.** Did that knowledge and understanding
13 appear to have been factored into the direction to
14 general practice to move to remote consultations,
15 which happened quite quickly at the beginning of the
16 pandemic?

17 **A.** So, yes, I think "factored in" is a very
18 reasonable summary of it.

19 So, for example, there were documents from
20 NHS England about moving to total triage and also
21 remote consulting, supported by Royal College of GPs
22 and so on. So yes, factored in.

23 How we actually -- how we operationalise
24 those solutions, I think we probably needed more.
25 As I say, we had knowledge and awareness, so at

33

1 primary care needs and continuity for non-pandemic
2 conditions, nor the contribution of primary care to
3 the management of patients in the community as part
4 of an overall healthcare delivery strategy in the
5 pandemic.

6 Is that a fair summary of your findings?

7 **A.** Well, the reason I was examining the
8 preparedness work across the healthcare system was
9 because I started looking at what had been done for
10 preparedness in primary care, and found very, very
11 little. Therefore, it was reasonable to look at
12 what had been done across the healthcare system.

13 But I think that the key point is there was
14 very, very little specific work for primary care
15 preparedness that was available to look at.

16 So, in my view, much more should have been
17 done.

18 There were elements that some would argue
19 from the preparedness work that had been done
20 looking at the strategy about how to deal with
21 things and the principles, but I would say
22 operational preparedness was much more important to
23 actually enable things to carry on. When the
24 challenge came in March/April of 2020 it really
25 wasn't there and I think, to be fair, we were flying

35

1 a practice level we could try to make adjustments to
2 allow for the needs of particular patients. And
3 remember, practice staff, they get -- they get a lot
4 of knocks but one thing they're very good at is
5 knowing their patients and they'll know particular
6 patients who have those particular needs and how to
7 try to help them.

8 So I think it was a reasonable direction of
9 the way things were going, but I think actually
10 probably more detail about how to support that
11 could've been valuable.

12 **Q.** Thank you.

13 I think that brings us, probably, to the
14 question of the degree of pandemic planning and
15 preparedness that appeared to have been undertaken
16 in terms of proactive planning for general practice.

17 I think you undertook a review of the
18 pandemic planning for healthcare that existed in the
19 four nations, and the extent to which that planning
20 included primary care, and I think your conclusions
21 in that were that preparedness largely appeared to
22 have been in terms of a repeat of the influenza
23 pandemic scenario. This is, I think, at
24 paragraph 58 of your report.

25 The planning did not specifically address

34

1 by the seat of our pants.

2 **LADY HALLETT:** Can you find specific examples
3 of what, if somebody had addressed the issues you're
4 talking about, they might have done things
5 differently in their planning?

6 **A.** So I think there are many areas that we
7 would want to examine for preparedness. It would be
8 issues around managing the -- well, a range of
9 presenting illnesses but particularly the presenting
10 illness of note in the pandemic, ie Covid. Also,
11 continuing healthcare problems, health promotion,
12 issues of help-seeking behaviour, communications,
13 vaccination, issues of managing risk and so on.

14 But -- so, for example, that one of looking
15 at managing the acute presenting illness, many
16 adaptations were required in terms of how practices
17 made that provision when patients were ringing up
18 and consulting and sometimes needing to be examined.
19 How would we do this in terms of high-risk areas of
20 the general practice building, for example? Or
21 using a branch surgery as our "hot" area for
22 consulting.

23 This was all largely, as I say, generated as
24 we went along in those early weeks, whereas
25 consideration of that in advance would have made

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1 things that much more efficient. And relating to
2 sites, we've got issues of getting the protective
3 equipment in the right place, getting oxygen
4 cylinders and oxygen saturation monitors in the
5 right place.

6 So all that preparedness and planning could
7 have been that much more specific for primary care,
8 and would've been really helpful.

9 **MS NIELD:** Thank you.

10 You've also identified in your report that
11 you consider -- this is paragraph 61 of your
12 report -- that specific planning is required to
13 minimise the unequal impacts of future pandemics,
14 including on those from black, Asian and minority
15 ethnic groups.

16 Could you identify what that specific
17 planning for primary care might entail for future
18 pandemic planning?

19 **A.** Well, I think it's -- it's similar to
20 that -- that last discussion. It's thinking: okay,
21 what would this look like about how we're going to
22 provide for patients with the acute -- acute
23 presenting illness or ongoing needs? And other
24 areas of screening and health promotion, et cetera.

25 And relating to that, thinking: okay, what
37

1 conditions, and, again in your report -- this is at
2 page 49 of your report -- you identify patients who
3 were missed during the pandemic. And you've
4 highlighted there a study, in fact using the SAIL
5 Databank from Wales, which looked at a number of
6 specified long-term conditions.

7 It identified a very large potential backlog
8 of undiagnosed patients; is that right?

9 **A.** Yes, that's correct. So we're using the
10 routinely collected data from general practices and
11 hospitals in Wales, and looking at this -- a number
12 of these long-term conditions, these were the
13 standard long-term conditions that we would have
14 been addressing in the quality outcomes framework
15 that we mentioned earlier. So these are the regular
16 conditions that get -- that quite rightly get
17 considerable attention to diagnosing and then
18 following up with evidence-based clinical
19 management.

20 So we identified that during that period in
21 2020 and thereabouts fewer patients had been
22 identified, been recorded into the database, making
23 that diagnosis for the first time. And if you
24 haven't got the diagnosis then you're unlikely to be
25 getting onto a register, and then unlikely to be
39

1 does this look like for particular patient groups?

2 The elderly, ethnic minority groups, et cetera.

3 So if we're thinking about long-term
4 conditions, for example, higher prevalence of
5 diabetes amongst ethnic minority populations, how
6 are we going to keep these services continuing to
7 function effectively when those challenges happen?

8 So those are the sorts of specific things
9 that we would have, could have, identified and made
10 plans for.

11 **Q.** Would that also include planning for
12 patients with disabilities who may struggle to
13 get -- may also have other long-term health
14 conditions or may struggle to use remote
15 consultation methods?

16 **A.** Yes, absolutely. So there's a number of
17 particular risk groups as I mentioned. I mentioned
18 elderly and ethnic minority. Disabled persons,
19 absolutely. We've actually mentioned the digitally
20 excluded and people with lower educational
21 attainment to be able to use the information
22 resources that we have. So there's a range of
23 particular groups with more needs, more challenges,
24 and greater risk.

25 **Q.** You mentioned there the ongoing long-term
38

1 getting called and recalled for the ongoing
2 management.

3 So we found these dips in -- in diagnosis
4 and recording of the incidence of these conditions,
5 across the board. The graphs are very consistent,
6 whether it's asthma or blood pressure or coronary
7 heart disease. And what we found was that, okay,
8 through 2021 or so the numbers returned pretty much
9 to the baseline levels, and at first sight you might
10 think, well, okay, so there's been a dent in the
11 figures and an impact, but a recovery. But actually
12 when we think about it, those numbers should rebound
13 above the baseline in order to make sure that those
14 patients lost in the previous year are also in the
15 total for the next year.

16 So there is actually still -- there's
17 evidence of a backlog there. Okay, those data were
18 from '21. I think we actually need to repeat that
19 exercise really, with further research, to identify
20 what is the extent of the backlog now, in '24.

21 **Q.** I think the extent of the backlog that
22 was identified in the study you mention from 2021
23 was that a GP practice of 10,000 patients might have
24 over 400 undiagnosed long-term conditions that would
25 in normal times have been picked up and diagnosed?
40

1 **A.** That is exactly right, that's the scale.
 2 And just to note that those 400 would not
 3 necessarily be 400 different patients, some patients
 4 might have had more than one of those conditions.
 5 But, yes, 400 missing long-term diagnoses in 10,000
 6 patients.

7 **Q.** Thank you.

8 Your report also highlights that there has
 9 been a reduction generally in help-seeking
 10 behaviours from patients during the pandemic, so
 11 patients not coming forward with the symptoms that
 12 might normally trigger those sort of investigations.

13 And it also notes the findings of some
 14 online surveys that identified a significant
 15 proportion of respondents had been unaware of the
 16 infection prevention and control measures that were
 17 in place in general practice surgeries, such as
 18 separating Covid patients from non-Covid patients,
 19 and so on.

20 And it concluded that almost a third who had
 21 delayed or avoided contact would've felt more
 22 comfortable contacting general practice had they
 23 known what measures were in place to keep them safe.

24 Whose responsibility was it to communicate
 25 to their patients that there were these measures in

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1 that in those studies about remote access, in fact
 2 probably -- you know, some groups -- some groups --
 3 actually found it more accessible, certainly in
 4 relation to their context, and I think that would be
 5 particularly for patients with -- who were
 6 clinically extremely vulnerable, who actually
 7 would've found -- who did find, they reported that
 8 in the evaluations -- they found it a reasonable way
 9 to access services more than they would have
 10 otherwise been able to do. So there's quite
 11 a complex interplay of factors.

12 **Q.** Thank you.

13 Can we move on, please, to look briefly at
 14 that section of your report that deals with how
 15 pulse oximetry was used in primary care to monitor
 16 patients with Covid-19.

17 This is pages 53 to 60 in your report, if
 18 that assists.

19 Could we begin, please, by having a look at
 20 a pulse oximeter.

21 This is on page 54, thank you, Lawrence.

22 So this is a photo of a typical pulse
 23 oximeter.

24 Could you describe very briefly how this is
 25 used and what it's used for.

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1 place? Is that something that should've been
 2 happening at a national level or a health board
 3 level or was that down to the general practice
 4 surgery to make sure their patients were aware?

5 **A.** So I think it's a shared responsibility,
 6 and I think it is pretty much the similar point that
 7 we made earlier about the messaging about being open
 8 for business in relation to the stay at home, save
 9 the NHS message.

10 We were open for business. Probably
 11 a clearer, more co-ordinated campaign across all
 12 those stakeholders that you mentioned, national,
 13 regional and local practice level, also with
 14 significant stakeholders such as the Royal College
 15 of GPs and others, that clearer, stronger message
 16 would have addressed exactly those issues about
 17 patients' fears that there weren't sufficient
 18 precautions of separating higher-risk from
 19 lower-risk patients and so on.

20 **Q.** And obviously that would've been
 21 particularly a concern to those patients who had
 22 been identified as clinically vulnerable or
 23 clinically extremely vulnerable because of other
 24 long-term conditions that they had?

25 **A.** Yes, yes, it would, although we also note

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1 **A.** So it is this small monitor which is
 2 intended that usually someone's finger or maybe
 3 thumb, sometimes a toe, in the case of children,
 4 might be inserted into the gap between the two
 5 halves of it to press onto a monitor, and that
 6 monitor is picking up both the oxygen level --
 7 that's there as SpO2, 98% there, which is good,
 8 level, and the pulse rate at 62, which is a fairly
 9 normal pulse rate.

10 **Q.** I think these were proposed to be used or
 11 were used during the pandemic to identify those
 12 patients whose blood oxygen saturation levels were
 13 deteriorating but didn't have other symptoms of
 14 deterioration, is that right? Is that so-called
 15 "silent hypoxia"?

16 **A.** Well, that is silent hypoxia. I think --
 17 I think there's a genuine discussion to be had about
 18 what was intended in the monitoring programmes and
 19 how they were interpreted as to whether it was
 20 exclusively a measurement of oxygen for silent
 21 hypoxia or whether actually it should have been part
 22 of a package of care assessing the clinical state of
 23 the patient, other key -- key measurements, their
 24 temperature, their blood pressure, et cetera, but
 25 also how they are feeling and getting on, what's

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1 their appetite like? Are they feeling sick?
 2 Breathlessness and so on. It's -- it's a -- it's
 3 part of a picture of the patient's clinical state as
 4 well as their support at home by family or others as
 5 to how they are actually managing with this
 6 condition.

7 So I think one of the key problems with
 8 oximetry is if it becomes a measurement in
 9 isolation.

10 **Q.** And in terms of those other symptoms that
 11 you mentioned, if a patient had silent hypoxia would
 12 those other symptoms be absent?

13 **A.** I think it -- it varies. I mean,
 14 theoretically, yes, you could have just a silent
 15 hypoxia and be reasonably well, apparently, on the
 16 basis of those other measurements or -- or lack of
 17 any symptoms.

18 I think more usually it was an additional
 19 feature to a patient feeling generally very unwell.

20 **Q.** You explain that how pulse oximetry was
 21 used across the UK or even within countries of the
 22 UK varied a great deal, and you mention in your
 23 report that in your practice you received a box of
 24 pulse oximeters in early 2021.

25 So what was your experience of how that
 45

1 as to whether it was for staff or for patients, but
 2 there were more oximeters than there were staff so
 3 we assume that it was actually intended to be given
 4 out to patients, and that is indeed what we did.

5 **Q.** So that your patients could monitor
 6 themselves --

7 **A.** Yes --

8 **Q.** -- (overspeaking) -- at home,
 9 rather than --

10 **A.** If they couldn't access one themselves
 11 quickly.

12 **Q.** Rather than the GPs taking the readings
 13 when the patient came into the surgery?

14 **A.** Yes.

15 **Q.** Yes.

16 **A.** And part of that, I think, is lack of
 17 clarity about what the programmes overall -- this
 18 includes, I think, Wales, Scotland and England --
 19 was it for self-monitoring by a patient at home?
 20 Was it actually home monitoring, with support by the
 21 clinical staff? And if it was home monitoring by
 22 the clinical staff, which patients were involved?
 23 Was it those presenting to general practice? Was it
 24 those who had presented to emergency departments and
 25 been discharged? Who, by the way, would be largely
 47

1 pulse oximetry was intended to be used? Did you get
 2 any instructions with that box of pulse oximeters?
 3 How were you supposed to use them?

4 **A.** Well, first of all, I was particularly
 5 interested in this issue because just a few weeks
 6 before I'd been involved in putting a proposal to
 7 the primary care programme of Welsh Government for
 8 evaluating a programme of implementing pulse
 9 oximetry, and we'd been invited to put that proposal
 10 in but ultimately, through those few weeks around
 11 Christmas of 2020, I think, it didn't come to
 12 fruition to lead to a more structured programme and
 13 an evaluation.

14 So I was interested. But then a few weeks
 15 later this box of pulse oximeters arrived in the
 16 practice and so -- from memory, it was about 20 or
 17 30 of them. And I don't believe there was very much
 18 instruction about how they were intended to be used,
 19 and still less any instruction about recording data
 20 to evaluate how they might have gone.

21 **Q.** So how did you use them?

22 **A.** So we used them by making them available
 23 to clinicians to give to patients. So first point
 24 is there were more -- I think it was unclear what
 25 they were intended for, as we saw it on the ground,
 46

1 likely to be sicker. Or patients discharged from
 2 hospital?

3 **Q.** So none of that information was
 4 forthcoming with this delivery --

5 **A.** I don't recall that, no.

6 **Q.** You mentioned that you had put together
 7 a proposal for evaluation around Christmas 2020 or
 8 before Christmas 2020.

9 I think that the Chief Medical Officer of
 10 Wales issued a Welsh health circular to GPs
 11 encouraging the use of pulse oximetry, monitored by
 12 GPs, so the recordings taken by GPs, and that was
 13 in -- on 4 August 2020.

14 So was it -- would it appear to have been
 15 after that Welsh health circular had been sent out
 16 that you submitted your proposal for evaluation to
 17 the primary care body --

18 **A.** Yes, three or four months later.

19 **Q.** Thank you.

20 You've also mentioned in your report that
 21 you're aware that there were some concerns regarding
 22 potential inaccuracies in pulse oximeter readings in
 23 darker skins or more pigmented skins and that that
 24 was raised in December of 2020, and NHS England
 25 issued advice in that same month in relation to the
 48

1 pulse oximetry programme in England.
2 And you say in your report you haven't
3 located any evidence about the extent of awareness
4 of that advice amongst primary care staff.

5 As you were working in general practice in
6 Wales at that time, did you receive any advice in
7 your surgery about those potential inaccuracies in
8 pulse oximeter readings? Either in December 2020 or
9 subsequently in 2021?

10 **A.** So I actually don't recall receiving it.
11 I don't -- I couldn't guarantee that we weren't sent
12 that information.

13 **Q.** Thank you.

14 If we can move on, please, and look at the
15 impact of the pandemic on the general practice
16 workforce. And can I summarise, please, you've
17 given quite a detailed analysis in your report over
18 pages 63 to 75, but you identify a general trend
19 which I'm going to summarise in this way, and tell
20 me if I'm wrong, please: that across all four
21 nations of the UK there was noted to be an increase
22 in the general practice workload over several years,
23 both pre and through the pandemic; a decrease in the
24 number of full-time equivalent GPs; and an increase
25 in the number of patients per general practitioner.

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1 people over 65 have two or more long-term
2 conditions. And by the way, that probably means
3 they are taking four or more medicines.

4 So it's workload and complexity as well as
5 actual numbers.

6 And I think that's actually where it's very
7 relevant with the GP partner workforce, because they
8 are typically the most experienced members of the
9 teams. So they are able to bring that experience to
10 bear on the delivery of high quality general
11 practice, characterised by a co-ordinated
12 comprehensive service, hopefully with continuity of
13 care as well, for complex medical and social care
14 needs. And then assisting their -- the team, the
15 primary care healthcare team, in that provision.

16 So it's education and it's mentoring and
17 it's training, either for those genuinely in
18 training or those who are actually in post and still
19 require that that education and mentoring, such as
20 the advanced nurse practitioners and the pharmacist
21 and other members of the team. They are independent
22 professionals, but nevertheless there is still that
23 role -- I mean, ultimately it's about the legal
24 responsibility in the practice which is held by the
25 partners. So they need to have that role.

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1 And you've concluded that it's not clear
2 that the pandemic has had a direct effect on what
3 were clear trends from before the pandemic.

4 You also identify in your report that in
5 addition to those trends there's also a noted
6 decrease in the GP partner workforce and that that
7 also has some quite important implications for the
8 resilience of the sector, which will affect how well
9 it's able to respond to a future pandemic.

10 Can you explain how the reduction in the GP
11 partner workforce is likely to affect the resilience
12 of the sector.

13 **A.** Okay, yes, thanks very much.

14 So that's a great summary of some of those
15 key statistics about reducing numbers of doctors and
16 increasing numbers of patients per doctor.

17 The other feature that I think actually is
18 quite relevant is the increasing complexity of
19 patients' health and healthcare needs per patient.
20 So there is a steady increase in the number of
21 people with long-term conditions, been rising 4% per
22 year. There's a steady increase in the number of
23 patients with multimorbidity, more than one
24 long-term condition, raising 8% per year.

25 So what that means in reality two-thirds of
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1 And if that partner workforce is eroding, as
2 it has been -- over the last 20 years we've lost
3 a quarter of the partner workforce -- that actually
4 has a serious impact on the ability to deliver and
5 develop services going forwards as needs continue to
6 rise.

7 And as you've said, the point is: okay,
8 that's the situation now, but if we're actually also
9 talking about the resilience of the primary care
10 sector to be there and be ready to deal with the
11 next pandemic, then we've got a real problem to
12 tackle.

13 **Q.** Thank you.

14 So having looked at the impact of the
15 pandemic on the workforce and the sector more
16 generally, could we move on to look at a more
17 individual level and the impact of the pandemic on
18 general practitioners' mental health and their
19 emotional wellbeing, and indeed their physical
20 health.

21 I think it's not been possible to identify
22 any data on sickness absence rates in general
23 practice specifically in general practice rather
24 than across the NHS. Is that right?

25 **A.** Yes, I think largely stemming from this
52

1 contractor status of practices as independent
2 businesses, I don't think they have to provide those
3 data to health boards and others who would put them
4 together, so those data are actually largely
5 unavailable.

6 **Q.** And although you have been able to
7 identify data on sickness absence rates across the
8 NHS, which has shown an ongoing and sustained rise
9 over the pandemic period, I think it's right that
10 those figures do actually include GP staff, they
11 are not counted in those overall figures?

12 **A.** I think that's correct, yes.

13 **Q.** So we can try to extrapolate something
14 from that but, as you've pointed out, the situation
15 in general practice is quite different from the
16 situation in hospitals in terms of the infection
17 prevention and control measures that are in place?

18 **A.** Yes. So this is an example where we were
19 talking about earlier. We can't generalise from
20 those data which are largely from the
21 hospital-employed services in the NHS but we can try
22 to identify transferable lessons, what is happening
23 about sickness absence in the primary care
24 workforce.

25 **Q.** So although there's a lack of
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1 comments -- they were the ones which were from GPs
2 amongst a whole range of contributions to that BMA
3 survey.

4 But maybe just to -- in terms of what that
5 looks like in general practice, maybe to try to put
6 a little bit of story into it, to help us
7 understand.

8 So in my own practice, for example, during
9 those early lockdown months, we had two patients who
10 died. One was a woman who was a victim of domestic
11 violence, which led to a prosecution, and one was
12 a young boy with type 1 diabetes, 11 years old, who
13 had not presented at all to us.

14 So we talked about those figures of
15 long-term conditions being missed, that's what that
16 looks like in the extreme example, an 11-year old
17 boy died because he didn't come to any healthcare.

18 And by the way, he was not in school either
19 at the same time, where someone might have said "He
20 looks pretty unwell, you'd better take him to the
21 doctor."

22 So, you know, there's a huge shock -- again,
23 our staff know the patients. You know, most of our
24 staff live on the same two housing estates where
25 our -- our two surgeries are, friend of a friend,
55

1 quantitative data on this, you have identified
2 qualitative data, and particularly a survey by the
3 British Medical Association of its members, about
4 their experiences of the pandemic and the way that
5 it had impacted upon them.

6 I think you set that out around paragraph 256
7 in your report.

8 And the BMA survey also identified general
9 practitioners specifically who responded to the
10 survey, and you've included some quotations from
11 those GPs in your report, and they've identified
12 a range of concerns. Perhaps I can summarise them
13 in this way.

14 They noted hazardous workload levels in
15 general practice, a lack of representation for some
16 ethnic minority GPs, emotional impacts of increased
17 patient deaths in primary care, moral injury and
18 moral distress, burnout, demoralisation, experiences
19 of abuse of GPs, and a serious deterioration in
20 their physical and mental health.

21 You go on to say that that BMA survey raises
22 some important issues for further consideration.
23 Could you expand on that and the nature of that
24 further consideration that you consider is needed.

25 **A.** Yes, so as you say, I've drawn those
54

1 tight-knit communities, everybody knows everybody.
2 And then these -- these deaths and -- what appear to
3 be avoidable deaths, occur.

4 Again, we'd had alerts from the local
5 paediatric service in April/May/June saying: we
6 normally see four children per month with new
7 diagnoses of type 1 diabetes, we're not seeing any,
8 they must be out there, please be alert. So
9 everyone was on it. And yet, you know, variety of
10 constellation of factors, this child was not brought
11 to services. And it makes a huge impact for
12 everyone concerned. Clearly, obviously, a tragedy
13 in the family, but in terms of the impact in the
14 family -- sorry, in the practice, you know, in
15 the practice family, it really makes a significant
16 impact on us all. And then it's about how do we
17 respond to that and support each other.

18 And --

19 **Q.** Can I ask you, please, about the support
20 that was made available to GPs during the pandemic.

21 You've identified at paragraph 266 that
22 interventions to improve wellbeing are crucial not
23 just for those GPs who are affected but also to
24 improve the resilience of the sector for future
25 pandemics, but you identify that factors that
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1 contribute to poor psychological wellbeing and
2 negative outcomes, such as burnout, are poorly
3 understood.

4 In terms of the support that was made
5 available to GPs during the pandemic, were those
6 interventions at a local or national level in terms
7 of support by national bodies?

8 **A.** So I think we need to consider that there
9 would be different provisions across the four
10 countries of the UK.

11 In my experience in Wales, there were
12 services which were available to professionals, so
13 therefore not all of the primary care team, for
14 example the administrative members, but
15 professionals would be able to access help for their
16 health problems through confidential enquiry lines,
17 et cetera.

18 I don't believe those services were changed
19 during the pandemic. I think there were specific
20 services that were available in NHS England for
21 primary care but which have now been made more
22 generic across the health service. So I think
23 there's variable provision.

24 What we're left with is a lack of
25 primary care-specific support, both what you might

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1 And in that context, where it is very
2 fragile, I think actually practices need support
3 from their organisations, the health boards and
4 integrated care systems or boards, clinical
5 commissioning groups as they were back then.

6 So I think actually, to enable it to happen
7 reasonably and effectively, the practices do
8 actually need that support.

9 So I didn't personally experience a risk
10 assessment. And by the way I felt that I probably
11 had a couple of risk factors at the time in the
12 early pandemic, by virtue of age and gender --

13 **Q.** And were you aware of any other GPs who
14 hadn't been given risk assessments?

15 **A.** I'm not aware of GPs who had, I'm aware
16 of some other GPs in the locality who made
17 specifically efforts with their practices. For
18 example, a very well known member in a practice
19 nearby, with a position of seniority in the
20 profession and she said -- in her practice -- "Look,
21 you know, I'm 60, I'm from an ethnic minority,
22 I think I've got some risk factors here, we need to
23 make some adjustments in the way I'm seeing
24 patients, should I be doing the on-call?" For
25 example.

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1 call treatment, including issues of burnout, and
2 also health promotion and prevention in terms of
3 promoting wellbeing and how to support that across
4 the workforce to make sure that the sector is
5 resilient. So that is lacking at the moment.

6 **Q.** Can I ask you about one other very
7 specific matter in terms of supporting general
8 practice staff during the pandemic. One of the
9 issues raised in that BMA survey or by one of the
10 participants in that BMA survey was the need for
11 mandatory risk assessments, particularly for black
12 and minority ethnic staff, in general practice.

13 Where did the responsibility lie for
14 carrying out risk assessments for GPs? Would that
15 be at surgery level or was that from the local
16 health board or beyond that?

17 **A.** So I think -- I think -- it is connected
18 with the contractor status of practices. Which is
19 that the business -- the practices are their own
20 businesses and they are responsible.

21 What I think actually nevertheless is
22 relevant is that -- is the context in primary care,
23 both before and during the pandemic, which is
24 an extremely fragile service, variable from
25 reasonable to very weak.

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1 So I think it was probably left to
2 individuals to make the running, often.

3 **Q.** Thank you.

4 If we can move on, please, to your
5 recommendations for general practice, and how best
6 to equip general practice to be able to cope with
7 a future pandemic. And you set out a number of
8 recommendations or potential recommendations in your
9 report, and I'm not going to go through all of them,
10 but you identify, I think as a headline, that
11 resilience of the general practice sector is key.

12 Could you give us a summary or the headlines
13 of what areas you think are key to address in order
14 to improve resilience so that the general practice
15 sector is equipped for a future pandemic?

16 **A.** Thank you.

17 So I think the key to it, ultimately, is
18 about the workforce and the workload, and what that
19 actually means is about resource and provision into
20 the general medical practice sector.

21 So resource as a proportion of the NHS
22 budget has reduced over the last 20 years from
23 roundabout 11% of the NHS, now down to the 8-point
24 somethings, possibly even less, for example 7.6% in
25 Wales. So at the very least we need to get back to

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1 11% of the NHS budget into primary care. That's
2 therefore a 30% increase on where we are now.
3 Just to stand still, I think. Just to deal
4 with the levels of provision that are made in
5 relation to need, which is rising, and the workforce
6 trends, which are actually very significant:
7 reducing full-time equivalent numbers at the time of
8 increasing patient numbers and increasing patient
9 complexity.

10 Ultimately, we've got to get that resource
11 into primary care. It's not about, you know, fit
12 for individuals, it's about resource into the
13 sector, and that means a sustained plan of the right
14 numbers that are needed, both GPs and other staff
15 members, nurses, pharmacists and various, but
16 basically political priority to deliver on those
17 numbers. We've had targets and they haven't been
18 achieved.

19 It's absolutely essential that we get back
20 to where we were, and then to try to improve it in
21 terms of looking at different ways of working, more
22 integrated systems between practices, different ways
23 of providing care, as care is shifted to community
24 and for prevention.

25 And whilst also thinking about resource,
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1 Tracy Nicholls.

2 **MS TRACY NICHOLLS (sworn)**

3 **Questions from COUNSEL TO THE INQUIRY**

4 **MS HANDS:** Thank you.

5 Good afternoon, Ms Nicholls. Can you state
6 your full name, please.

7 **A.** Yes, Tracy Lee Nicholls.

8 **Q.** Thank you. You have your signed witness
9 statement in front of you. That is INQ000281189.

10 Ms Nicholls, you are here today to give
11 evidence on behalf of the College of Paramedics and
12 its members as the chief executive, a role that you
13 held from 2019 to date, is that right?

14 **A.** That right.

15 **Q.** Thank you. You're a qualified paramedic
16 yourself, since 1998?

17 **A.** Yes.

18 **Q.** Before holding the chief executive role,
19 it's right that you were the director of infection
20 prevention and control, or DIPIC, and director of
21 clinical equality and improvement at the East of
22 England Ambulance Service?

23 **A.** That's right, yes.

24 **Q.** And the College of Paramedics has
25 approximately 22,000 members representing paramedics

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1 which really is the key factor, we also need to be
2 looking at issues for the workforce but supporting
3 individual resilience, wellbeing, and dealing with
4 those with particular issues of burnout.

5 **MS NIELD:** Thank you very much.

6 I've no more questions for you. Thank you,
7 Professor Edwards.

8 I wonder, my Lady, we're a little bit --

9 **LADY HALLETT:** I have no other questions.

10 I don't think there are any questions from the core
11 participants.

12 Professor Edwards, thank you so much for your
13 help, both at producing your written report and your
14 oral evidence. Please rest assured that if there's
15 anything you haven't covered, I will be very much
16 taking into account your written report as well as
17 your evidence this morning, so I'm really grateful
18 for your help.

19 **THE WITNESS:** Thank you, my Lady.

20 **(The witness withdrew)**

21 **LADY HALLETT:** I shall return at 12.05.

22 **(11.50 am)**

23 **(A short break)**

24 **(12.06 pm)**

25 **MS HANDS:** My Lady, may I call
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1 and students across the UK?

2 **A.** That's correct.

3 **Q.** Was the college involved in any pandemic
4 planning prior to Covid-19?

5 **A.** No, not -- not in so many words. We were
6 aware that -- obviously in my previous role there
7 was annual pandemic flu planning, and something that
8 the college was at a stage in its growth where we
9 felt it needed to start thinking about things of
10 that nature. However, I wasn't expecting within
11 three months for that to become a reality, even
12 though we knew that the flu was circling. We
13 certainly didn't have the capacity to start anything
14 of that nature. But it is something we should do as
15 a professional body.

16 **Q.** That brings me to my question: is it
17 something that you think it would be beneficial to
18 be involved in in future?

19 **A.** Absolutely.

20 **LADY HALLETT:** When did the college start?

21 **A.** 2001.

22 **MS HANDS:** Thank you.

23 Moving on then to the college's
24 relationships and representation during the
25 pandemic.

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1 From 23 to 25 March there was
2 a centralisation of ambulance services in England
3 into the National Ambulance Coordination Centre.

4 Was the college involved or consulted by the
5 centre during the pandemic?

6 **A.** No.

7 **Q.** And from your experience, was the
8 decision to centrally coordinate ambulance services
9 in England one that was effective in allowing
10 a response for the ambulance services in England?

11 **A.** I think certainly operationally that was
12 the correct process to happen. I think what that
13 missed is the professional body support and capacity
14 to help.

15 **Q.** Did the college seek to offer that help?

16 **A.** So we -- we certainly -- they -- we knew
17 of each other's existence, we had regular contact,
18 so it wasn't like we didn't know each other existed,
19 but we didn't formally say: do you want some help?
20 Because they're normally very good at cracking on
21 with things on their own.

22 **Q.** And another cell that the college was
23 represented on was the frontline clinical cell,
24 which is the NHS England emergency preparedness,
25 resilience and response team.

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1 **A.** Pretty much through scouring the websites
2 ourselves, through speaking to stakeholders, other
3 professional bodies, other allied health
4 professions, of which, you know, pandemics are one.

5 And really the same way that everybody else
6 was finding out. Really we didn't really have any
7 formal route as such.

8 **Q.** And looking to to the future, do you
9 think a formal route for channels of communication
10 would be beneficial?

11 **A.** I do. Because it certainly helps support
12 information roll-out. You know, we have a huge
13 amount of membership, so it certainly would help
14 fall date when changes are being made that we could
15 link in with the Association of Ambulance Chief
16 Executives and provide combined support and
17 communication, but also that -- sometimes that
18 critical challenge from a professional body lens
19 that isn't necessarily inwith the ambulance sector.

20 Our members work within the ambulance sector
21 and outside, for example the military and
22 independent sector as well, so we're not just
23 ambulance sector focused.

24 **Q.** Thank you.

25 Moving on to a slightly different topic now,

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1 Can you provide some examples of the issues
2 that were considered by the cell and how effective
3 that was in the ambulance context?

4 **A.** We had no involvement with that at all,
5 I'm afraid, so I couldn't answer that.

6 **Q.** Okay.

7 The Inquiry's heard some evidence about the
8 UK IPC cell. The Association of Ambulance Chief
9 Executives -- or AACE is the acronym used --
10 represented the sector on that cell.

11 In your statement you have said that there
12 was no formal route to having information from the
13 cell, either from the AACE or from NHS England; is
14 that right?

15 **A.** That's correct.

16 **Q.** Did you raise any concerns about that
17 during the pandemic?

18 **A.** Yes, we did, and -- and we facilitated
19 some meetings with the ambulance representative on
20 the IPC cell through semi-regular meetings.

21 **Q.** Did that lead to any changes?

22 **A.** No.

23 **Q.** And so without those formal communication
24 channels, how did the college receive information
25 that was agreed at that cell?

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1 around the ambulance workforce. The Inquiry
2 understands that there was a big effort to increase
3 the workforce, particularly call handlers, at the
4 very start of the pandemic both in 999 and 111
5 services. So were you aware or involved in any of
6 those recruitment drives at the start of the
7 pandemic?

8 **A.** No, we were aware that the 999 call
9 handlers were impacted by the Covid virus as well.
10 They're historically a very low paid workforce and
11 it's always difficult to retain the call handler
12 personnel because the private market often offers
13 more money. But also, you know, it's a very, very
14 draining and demanding role, answering the calls to
15 the public.

16 So we knew that psychologically people were
17 suffering and unless that they were catching the
18 virus as well, but we had no involvement in the
19 recruitment. That would be the ambulance sector
20 itself.

21 **Q.** And you've spoken there to one of the
22 barriers perhaps being pay in the working
23 conditions.

24 In the context of the pandemic, were you
25 aware of there being any other barriers that might

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1 have prevented recruitment of 999 or 111 call
2 handlers?

3 **A.** I think people wanted to help. You know,
4 the ambulance service is a great way for people to
5 feel like they can help the public. The realities
6 of that job are very arduous. You know, the calls
7 just keep coming in, and it's a very difficult job.
8 It takes I think it's 12 weeks of training normally
9 and I know some ambulance services try to reduce
10 that length of time for call handlers. But it's
11 a very technical job. There's -- you know, the call
12 handlers are trying to type information and speak to
13 the caller at the same time, and it's -- you know,
14 you can -- it's very difficult when you're dealing
15 with someone and you can't see what you're dealing
16 with. That's quite psychologically difficult for
17 people.

18 So it's not for everybody, but people want --
19 people did, you know, come through the recruitment
20 during Covid because they wanted to help.

21 **LADY HALLETT:** And people at the other end of
22 the call, the person making the call, is likely to
23 be very distressed and --

24 **A.** Yes, absolutely.

25 **MS HANDS:** And that perhaps brings me to one
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1 knew how safe it was for students to go on to the
2 ambulances; so quite often they were diverted into
3 the control centres or to do stocking of
4 medications, et cetera.

5 But we were involved in liaising with the
6 higher education institutes and the Association of
7 Ambulance Chief Executives to say there are trusts
8 where students are falling through the gaps, there
9 is no real liaison with the higher education
10 institutes in some areas, so students are not really
11 sure how they can help and actually if they want to
12 help because they didn't have to. That wasn't part
13 of their contractual obligations as a student, but
14 many of them obviously wanted to.

15 **Q.** Thank you. I have two questions arising
16 out of that.

17 The first is around whether there's been any
18 long-term impact of that impact of students on
19 students' development and education during the
20 pandemic, and whether any support was offered or put
21 in place during the pandemic or since then to allow
22 them to catch up to ensure that it doesn't impact
23 the workforce longer term?

24 **A.** I think where the students were nearing
25 the end of their course, there -- we believe there's
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1 of my questions around training.

2 Were you involved in any of the training
3 that was delivered during the pandemic, and did you
4 receive any complaints of issues or concerns around
5 the training that was provided to not only the new
6 recruits but also those that were dealing with the
7 unprecedented situation they found themselves in?

8 **A.** Certainly not for the call handlers.

9 We -- you know, as I say, it's a very technical role
10 that the ambulance service is very good at doing the
11 training for.

12 Where we did have an involvement with was
13 the student paramedics and we have a good
14 relationship with all the higher education
15 institutes -- so all the universities that offer the
16 paramedic programme -- and what we did see is that
17 some of the clinic placement, those areas where
18 people try and put into practice what they've learnt
19 in a theoretical way, that some of the students or
20 quite a large number of the students actually were
21 coming to us saying the clinic placements are no
22 longer there, the very way that we try and sort of
23 support our practice under supervision is no longer
24 available, and they understood in the main that that
25 was because placements were very difficult. Nobody
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1 been much less impact because they were ostensibly
2 ready to go out with some additional supervision.

3 Where students were in year 1 or 2, that's
4 very, very different and, because they haven't had
5 the exposure, as with many other healthcare workers
6 in other professions, their confidence levels have
7 suffered. And certainly, as a college, we've spoken
8 about during a retrospective study about how people
9 feel post-pandemic in their profession, and we also
10 are starting to see early signs that people who did
11 join as students during the pandemic are not staying
12 in the profession.

13 **Q.** Thank you.

14 Moving again to a slightly different topic
15 around capacity, this time the capacity of ambulance
16 vehicles, you've had sight of the response the
17 Inquiry received to the research it commissioned
18 into escalation of care in which 45 per cent of
19 paramedics and 55 per cent of general practitioners
20 said that one of the barriers to escalating care was
21 access to an ambulance.

22 Was that a complaint or an issue that the
23 college was aware of during the pandemic? And, if
24 so, did it take any action to escalate those
25 concerns?
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1 **A.** Yes. In terms of access to being able to
2 get an ambulance to go out and do your shift on, we
3 were aware that there were vehicles that were tied
4 up at the emergency departments, meaning that crews
5 that were coming on shift couldn't access an
6 ambulance to start their shift, for example. And it
7 wasn't unusual for a crew that were coming on either
8 in the morning or the evening to have to go and
9 relieve the crew in the car park of the hospital so
10 that the off-going crew could get home.

11 And also there were a number of vehicles
12 that were off the road due to mechanical -- that's,
13 you know, when a service runs as hot as the
14 ambulance service does in terms of constant demand,
15 constant calls, the vehicles don't tend to fair very
16 well and don't last very long in some aspects, so
17 brakes fail, et cetera.

18 **Q.** Yes, and looking at the wider picture,
19 obviously you've spoken a bit about the impact on
20 the workforce of a lack of available vehicles. What
21 was the impact on the patient care, the treatment,
22 and the time that perhaps it would take therefore
23 for an ambulance to respond?

24 **A.** It's horrific. It's absolutely horrific.
25 There were ambulance delays before the pandemic but

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1 to such high rates both on the front line but also
2 in the call handling centres, the emergency
3 operation centres, and those non-clinical areas as
4 well?

5 **A.** Mostly it was -- in my view, and the view
6 of the college, it was the failure to provide
7 adequate respiratory protective equipment. The back
8 of an ambulance is very small. The new
9 specification from NHS England is a Fiat Ducato.
10 That's 3.67 metres long by 1.84 wide, with the
11 equipment also added in there and that makes you
12 around 900 millimetres from anywhere you're sitting
13 from a patient, and even in the -- that's in the
14 saloon. That's the back of the ambulance. The cab
15 is where the crew and the attendants sit. That too
16 is around 900 metres, you're -- 900 millimetres from
17 one another there.

18 The control room staff are all sitting in
19 a large room, not dissimilar to this, and infections
20 can spread very easily. You know, you have
21 outbreaks in normal times of sort of diarrhoea and
22 vomiting and you can guarantee pretty much that will
23 spread around a large space like that without good
24 adherence to infection control procedures. But for
25 the pandemic I have no doubt in my mind it was

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1 they worsened certainly after the first lockdown.

2 So, you know, if you put yourself in
3 a patient's position of calling for an ambulance,
4 being told that they can't guarantee when one is
5 coming, and then calling back maybe an hour, two
6 hours later, and still nothing's coming, the
7 ambulance service can't give you an ETA because
8 calls are coming in all the time and there may be
9 a higher priority call comes in that pushes other
10 patients further down the line in the queue which is
11 a terrible state of affairs when the demand is so
12 high.

13 So the crews were very aware of not only
14 a terrible patient experience of someone sitting in
15 an ambulance with them outside the ED for hours,
16 they were also acutely aware of all those patients
17 who had not been seen by any healthcare professional
18 waiting in the community and quite often
19 deteriorating.

20 **Q.** Thank you.

21 On the topic of sickness rates in the
22 ambulance sector, you've said in your statement that
23 ambulance trusts recorded the highest rates of
24 sickness absence across the NHS.

25 What does the college understand contributed

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1 a failure to protect the paramedics and the
2 ambulance clinicians.

3 **Q.** Staying on that topic then of infection
4 prevention control in the ambulance sector, you've
5 gone into some detail about this in your statement
6 starting at paragraphs 10. You've said that the
7 guidance that was disseminated at the start by the
8 government bodies (for example, Public Health
9 England) was often confusing and contradictory to
10 the evidence from other professional organisations
11 and the lack of clear guidance had a profound impact
12 on the members of the college and their ability to
13 do their jobs. You describe how a one-size-fits-all
14 approach was taken to the guidance and that the
15 college sought to fill that gap.

16 Presumably that's the IPC guidance there
17 that you're referring to.

18 **A.** Yes.

19 **Q.** Filling that gap, is that a role that the
20 college played prior to the pandemic?

21 **A.** Yes and no. I mean, you know, I'm
22 struggling with the lack of common sense to
23 understand that not all environments are the same.
24 The ambulance sector is very unique, and I'm sure
25 a lot of professions would say the same, but the

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1 environment that the profession works in is very
2 unique in the ambulance sector.

3 **Q.** Can you give us some examples of how it's
4 unique?

5 **A.** So you are going to a 999 call or a 111
6 referral. It may say, for example, on the screen
7 that you're going to a patient whose fallen. Now,
8 that fall could be a simple trip or slip; that could
9 be that someone has tripped and hit their head and
10 fallen; it could mean that someone is suffering
11 a cardiac arrest but the person that's calling has
12 just seen them fall. So you're going to what we
13 call an undifferentiated patient. So it means you
14 don't know what has actually happened until you get
15 through the front door or inside the office or
16 wherever that patient is and that's the only time
17 you truly know what is happening.

18 So the idea of making a risk assessment
19 about Covid-19, for example, was impossible because
20 you didn't know what you were going to. You rarely
21 do. And I think there is something around --
22 paramedics and ambulance clinicians are very good at
23 a sort of a different risk assessment. So that is:
24 is there anything in this area that I need to be
25 careful of immediately? Is there a dog that's going

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1 at all. There was, you know, no testing no
2 vaccination. And, you know, patients did present in
3 an asymptomatic way. It may be that people had just
4 lost their sense of smell or taste. So, you know,
5 you had to weigh up that risk: has someone got Covid
6 but they're not symptomatic? And it very much
7 focused on the symptomatic cases, and in that first
8 lockdown, people were gravely ill. You know, our
9 profession saw patients in a volume of, you know,
10 being profoundly unwell, that -- that we had not
11 experienced before.

12 **Q.** We're going to come back to the topic of
13 risk assessments in a moment, but just staying on
14 the topic of the guidance.

15 So you've described how there was
16 a one-size-fits-all approach taken to the guidance.
17 Was the college consulted at all in the process of
18 the guidance being developed, either in the early
19 stages of the pandemic or later on?

20 **A.** No.

21 **Q.** And do you think it would have been
22 useful if it had been?

23 **A.** I think so, and I don't -- you know,
24 I don't wish to diminish the ambulance
25 representatives' role in, you know, being on the

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1 to be very protective of the owner? Is there drug
2 paraphernalia on the floor that I need to be
3 cautious of? Is there, you know, something that's
4 going to harm either yourself or the patient?

5 So we describe it as sort of "bandwidth".
6 You have a certain amount of bandwidth to check all
7 of that as you're going in towards the patient.

8 Then you've got the Covid aspect on top of
9 that which, behind a front door, you're going into
10 invariably a closed space, no windows open. And, if
11 I can be honest, not everybody obeyed the lockdown
12 rules. So you might have thought you were going to
13 one patient with a relative and actually there would
14 be three or four relatives there because they're
15 genuinely concerned for their relative and have been
16 waiting a very long time.

17 So the exposure to risk there in terms of
18 a Covid perspective was very different.

19 **Q.** Thank you.

20 And are you aware as to whether there was
21 any systems that were introduced or in place to
22 alert teams or crews that were attending incidents
23 as to whether there were cases of suspected or
24 confirmed Covid-19?

25 **A.** Certainly during the first lockdown, none

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1 cell, but it felt like a big echo chamber and what
2 our members were telling us in huge volume is that
3 it didn't feel right on the ground, it didn't feel
4 right to be front of a patient who was seriously
5 unwell and be less than a metre from them at all
6 times having to provide care and treatment to that
7 patient without discrimination.

8 And that felt completely incongruous to what
9 was being sort of fed down the chain from the IPC
10 cell in that there was no -- there was no evidence
11 to say there was any risk but, in clinical practice,
12 it feels much more in line with common sense to say
13 let's support you to make your own decision about
14 what the risk is until there's further evidence.
15 And that's all we've ever asked for, is, you know,
16 can we take a precautionary approach until such time
17 as evidence is around that says -- either confirms
18 that or says otherwise.

19 **Q.** Thank you.

20 And the first time that that -- you asked
21 for that, I think, if I'm right in saying, was
22 around 20 March 2020 when the college raised their
23 concerns with the Health Secretary, Matt Hancock, at
24 the time highlighting the PPE shortage on the
25 ground, asking for a review of the unique

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1 environment in which ambulance workers were working
2 in and, as you say, that precautionary approach to
3 be taken.

4 Was there a response to that request?

5 **A.** No. And, you know, I would caveat that.
6 I recognise that the government are in a stage where
7 they're having to do a lot of preparation but, you
8 know, it's a very unique environment and those
9 patients that were being conveyed and treated by the
10 ambulance crews and the paramedics were then going
11 through ED into ICU or ITU and they'd been sitting
12 in the back of an ambulance for some time already.

13 So we were trying to convey that it's the
14 start of the chain and you want ambulance workers
15 and paramedics to be in work, not to be off work
16 sick, so that they can keep this whole kind of
17 patient flow piece going and give the very best care
18 to the patients that they can.

19 So disappointing we didn't get a response
20 but I guess at the very beginning of a novel virus,
21 did I expect anything else? Probably not.

22 **Q.** And it's right, isn't it, that shortly
23 after that the recommendations for the level of PPE
24 that ambulance workers should wear was published by
25 Public Health England and that was for them to wear

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1 college actually raised those concerns.

2 Were the correct type of aprons or suitable
3 aprons provided?

4 **A.** No. The move was to go to gowns which we
5 felt was much more appropriate. We know that there
6 were issues with the supply of the respiratory
7 protective equipment. And we know that not all the
8 suits and the gowns were able to fit the ambulance
9 staff themselves. If you were very, very small or
10 very, very large, the gowns didn't fit so you had to
11 revert to an apron. And, I mean, many members told
12 us they were buying their own protective equipment
13 from a very large online retailer.

14 **Q.** Thank you. And can you recall when there
15 was a move towards gowns being issued?

16 **A.** I think it was quite soon after people
17 realised the aprons were a terrible idea and people
18 needed to cover their uniform, but I can't remember
19 the exact date.

20 **Q.** That's no problem.

21 Continuing on the topic of supply, in your
22 statement you've described how the IPC PPE guidance
23 found this work is different to other high risk
24 environments and gives the example of ICU or A&E or
25 ED and that you'd heard reports of ambulance staff

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1 a surgical mask, or FRSM mask, an apron and gloves
2 unless they were undertaking an aerosol-generating
3 procedure, or an AGP, in which case it was an FFP3
4 respirator mask that they were advised to wear.

5 Can you just describe to us what the
6 response was to that guidance from your members on
7 the ground?

8 **A.** It was horror actually. So the aprons
9 were completely inappropriate for the environment
10 that paramedics and ambulance clinicians work in.
11 You may appreciate they're going in and out of
12 a patient's house, potentially to get kit or to take
13 a patient, and the minute you went outside the gown
14 blew up in your face and, you know, our members felt
15 that that was inappropriate. One member actually
16 said to me they seemed to have better protective
17 equipment on the repair shop than they do in our own
18 workforce, and it felt just so incongruous to them.

19 They were looking at the guidance as well.
20 They're healthcare professionals, they're able to
21 research themselves and they felt -- the words they
22 used for "cannon fodder" and "canaries in a coal
23 mine".

24 **Q.** And I think you've used the example of
25 aprons in your statement as an area where the

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1 having to don and doff, or take on/take off, PPE in
2 order to put on the RPE in order to hand over the
3 patient in the hospital.

4 As far as you're aware, what impact did that
5 have on not only patient care and treatment but did
6 it impact on supplies at all?

7 **A.** Yes, well, the supply issue was very
8 inconsistent. So you may have -- I think you've
9 heard already in the Inquiry about this sort of push
10 stock, this stock that comes through the supply
11 chain, and my current chief operating officer was
12 a very senior manager in the ambulance service
13 during Covid and he describes sort of four or five
14 times a day there would be guidance changes and
15 telephone calls about you've got two pallets of
16 respiratory protective equipment coming in for one
17 organisation, where is the most need? So trying to
18 coordinate that. Sometimes the stock was then
19 quarantined because it was the incorrect stock or
20 out of date.

21 So it was -- you know, for those people that
22 were trying to negotiate the logistics of all of
23 that it was, you know, a real nightmare for them,
24 I think, in terms of trying to protect the staff
25 with sometimes very little respiratory protective

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1 equipment or not knowing when the next batch would
2 come in.

3 **Q.** And where there factors that are unique
4 to the ambulance environment, again, that make the
5 distribution of PPE stock, when it's kind of
6 unpredictable, more difficult than, let's say,
7 a hospital where you've got one big building?
8 Obviously, with an ambulance you have many different
9 stations. So did that make it any more difficult?

10 **A.** It did and it's a very remote workforce.
11 So, you know, there wasn't an opportunity for the
12 staff to always come back to their base station to
13 replenish their respiratory protective equipment.
14 There was very little acknowledgment of that, that
15 maybe people needed to take enough stock with them
16 and then flag to the control centre when they
17 perhaps needed to go back to station to pick up more
18 equipment.

19 And, parallel to that, there were people who
20 were with patients for hours on end in an ambulance
21 outside ED where they were wearing the same
22 protective equipment. And the Association of
23 Ambulance Chief Executives had a proposal that the
24 crew rotate around so that they minimised the risk,
25 but, in many EDs, the staff first not allowed in

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1 effect from the hierarchy of controls is really
2 around lateral flow testing for administration
3 controls or, you know, donning and doffing training,
4 and then you're left with PPE which is the last
5 resort and even that wasn't adequate.

6 So it felt a complete misnomer in terms of
7 how the hierarchy of controls were also being sort
8 of reinforced to the college, certainly, and AACE
9 were doing that as well. We spoke with the IPC
10 representative and said it makes no sense that we're
11 at the bottom end of this hierarchy, and all the
12 crews are just being told to wash more surfaces and,
13 you know, make sure that they're compliant with
14 their IPC practice, which they were. And it felt a
15 bit disingenuous to say that that was the only thing
16 they could do to mitigate their risk of infection.

17 **Q.** Thank you.

18 I want to take you to a document now which
19 is an example from an ambulance service of the local
20 guidance on risk assessments. This is INQ000300332.
21 Thank you. And this is page, yes, 4 and that is
22 behind tab 14, if that helps you to have it in front
23 of you as well. This was the risk assessment that
24 was in place in February 2020.

25 If we look down on the left, from risk of

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1 because the staff didn't know whether the patient
2 was Covid positive and therefore paramedics and
3 ambulance clinicians coming into the ED were
4 stopped, so they couldn't -- there is no soap and
5 water in an ambulance. You can't wash your hands,
6 you can't take off your PPE and dispose of it
7 easily, you can't eat or drink or go to the toilet.
8 It's just a very unique environment and the
9 distribution of respiratory protective equipment
10 linking in all those factors is quite a logistical
11 nightmare.

12 **Q.** Staying on the topic of IPC guidance, you
13 have said in your statement, and indeed raised this
14 as an issue throughout the pandemic I understand,
15 that the hierarchy of controls which the sector were
16 encouraged to follow was not in fact suitable for
17 the ambulance environment you've described.

18 Can you explain why that was the college's
19 view and what response it received when it raised
20 those kind of concerns?

21 **A.** You're at the very base of the triangle,
22 really. You're on the last two sections, the
23 administration controls and the PPE. You can't
24 eliminate the hazard, you know. So the ability for
25 those working in the ambulance sector to have any

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1 infection to ambulance staff, it states there that
2 it can still occur within 1 to 2 metres of a patient
3 with possible or confirmed Covid-19. However, the
4 evidence and guidance from the World Health
5 Organisation and Public Health England is that
6 a different level of PPE is required. Then on the
7 right it says that staff are encouraged to continue
8 to carry out dynamic risk assessment in relation to
9 PPE that was used.

10 I have a couple of questions about this
11 document for you. First of all, in regard to the
12 apparent contradiction highlighted first of all,
13 that obviously echoes a lot of what you've been
14 saying around the difficulties with maintaining
15 social distance from a patient in the ambulance
16 setting.

17 What kind of concerns or problems was that
18 causing for paramedics on the ground with that
19 apparent contradiction?

20 **A.** It created such anxiety and fear. So one
21 of my team who was also supporting South East Coast
22 Ambulance Service had said that she was -- because
23 she didn't feel protected, when she went home, in
24 full sight of her neighbours, she would strip off in
25 the garden before she stepped in her house because

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1 she was so frightened that this protection was
2 inadequate.

3 So, you know, you make light of it a little
4 bit to say, well, your neighbours must have had
5 a terrible shock but literally who strips off in
6 their garden to save their family? That's the sort
7 of level of anxiety we were talking about. People
8 were hiring shepherd's huts to live in so they
9 didn't have to go back to their family because they
10 didn't feel protected.

11 **Q.** And moving then to the guidance on
12 dynamic risk assessment in relation to the PPE used,
13 that's a phrase that we see that comes up quite
14 a few times, and was there any guidance for
15 paramedics that you were aware of as to how to
16 conduct a dynamic risk assessment in the context of
17 Covid-19?

18 **A.** No. I think, as I explained before, the
19 phrase "dynamic risk assessment" probably means
20 something a little different to people who work for
21 the ambulance sector in that they're looking at
22 something very different: you know, dangers and
23 hazards and things of that nature. I'm not aware
24 that anyone had specific training on risk
25 assessments for Covid-19 specifically. There didn't

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1 **Q.** Thank you.

2 At the bottom of the document that's on the
3 screen, page 4, it comes on to the topic of fit
4 testing and it says that:

5 "FFP3 masks must only be used by staff who
6 have been fit tested for the masks they are using
7 and staff must complete a fit check every time they
8 are required to wear one."

9 That just goes on to page 5.

10 Can you describe for us how practical it was
11 for a paramedic that is attending an incident to
12 carry out a fit test when they identify that an FFP3
13 mask is required in order for them to respond?

14 **A.** So the fit testing would normally be done
15 in a controlled environment, as I think
16 Professor Shin may have said last week. It wasn't
17 the perfume being held. It was in a sort of tented
18 environment where you would measure the particles to
19 make sure that the mask fit correctly. And the
20 Ambulance Service, because it has dealt with MERs
21 cases, SARS-1 cases, et cetera, fit testing was not
22 new to the ambulance sector. And it had been
23 certainly something in my previous role that we used
24 as a sort of compliance figure for our staff.

25 So each of the areas would come to an

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1 feel like there was the time or the resource to be
2 able to do that.

3 But we did know that the Royal College of
4 Nursing produced some risk assessments which was
5 just a template for how to conduct a risk
6 assessment, much of it being about your own
7 competence and about the controls you can exert. So
8 we were just grateful that that had happened so that
9 people could access it. But, despite mentioning it
10 to the Association of Ambulance Chief Executives,
11 I'm not sure it was signposted other than by us.

12 And what I would say, Ms Hands, is while
13 this was going on we had -- our paramedic members
14 are not just those on the frontline. They're senior
15 managers. They're executive directors. And we
16 heard the phrase of "We know this is what the
17 guidance says but we're going under the radar",
18 which felt very, very difficult for them because
19 they clearly were told to adhere to the guidance,
20 and that was the national agreement. But some of
21 them were doing something different because they
22 just felt it wasn't right.

23 And that phrase "under the radar" just
24 seems -- seems that they were in a very difficult
25 place.

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1 accountability meeting we'd ask how they're getting
2 on with their fit testing for staff, because it was
3 inevitable that the pandemic flu planning might
4 elicit, you know, the fact that we were over
5 100 years since the last flu pandemic, so we wanted
6 to be prepared in that sense.

7 So the fit testing was difficult, was --
8 took specialised people to do the fit test.

9 The fit checking was making sure that the
10 mask had the integrity and then that it was seated
11 well on the crew member.

12 And if you were working with another crew
13 member you could check the seal for each other in
14 that sense, but with that rolling stock issue that
15 I was talking about, sometimes you would get
16 a completely different FFP3 mask that no one had
17 been fit tested for. So we know that some ambulance
18 services, West Midlands, South-east Coast and
19 latterly London Ambulance Service, went for the
20 powered respiratory hoods because it negated the
21 need for fit testing, still needed the good control
22 and good fit of the powered hood, but that negated
23 the fact that they needed to be fit testing their
24 staff.

25 **Q.** Thank you.

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1 And were you aware of any -- you've
2 mentioned obviously there were shortages in the type
3 of mask or the brand of the masks that would be
4 provided wouldn't necessarily be consistent.

5 Were you aware of there being any issues
6 with alternative options made available and whether
7 that had any impact on members from a black ethnic
8 minority background?

9 **A.** Certainly. So not everyone passes a fit
10 test. Women tend to have smaller facial anatomy and
11 we know staff from ethnic minority backgrounds
12 didn't always pass through a fit test. Sometimes,
13 and I think certainly those three ambulance services
14 I've mentioned, provided mitigation by powered
15 respiratory hoods. In some cases, our members from
16 ethnic backgrounds said that they had failed a fit
17 test but were given no alternative.

18 **Q.** Thank you.

19 Dealing briefly with guidance for
20 non-emergency patient transport services which you
21 mentioned the college also represents, it's right,
22 isn't it, that there wasn't any national guidance
23 forthcoming for those services until September 2020.
24 So did the college play any role in advocating for
25 the needs of that part of the sector, and are you

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1 assessment done for our PTS staff until very, very
2 late and we did lose PTS staff to Covid.

3 **Q.** And just to confirm they were at points
4 during the pandemic conveying Covid-19 confirmed or
5 suspected patients as well?

6 **A.** Yes.

7 **Q.** In other non-clinical settings, you've
8 discussed briefly the guidance around ambulance
9 cabs.

10 I also just want to ask you about other
11 non-clinical areas, for example ambulance staff rest
12 areas or the ambulance emergency control rooms, and
13 whether you were aware of IPC measures being
14 implemented in those spaces and any barriers or
15 difficulties that they had with following or
16 implementing such measures?

17 **A.** I think they tried. You know, certainly
18 in the control centres they were putting up plastic
19 screens. But, again, if, you know, we suspect the
20 transmission is other than droplet it would make
21 very little difference. We know a lot of our
22 control room staff were off sick with the virus.

23 The crew rooms: depends on the estate of the
24 station itself. So some are very small. Larger
25 ones it was a little easier. But certainly from

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1 able to provide any examples of the unique
2 challenges that they faced that were perhaps
3 slightly different?

4 **A.** This is the patient transport as in
5 taking the patients for their dialysis treatment
6 and --

7 **Q.** Indeed, and Covid patients as well during
8 the pandemic.

9 **A.** Yes. So we didn't have a key part to
10 play in that, although we had raised it in our
11 discussions about patient transport staff as well.

12 What we heard was that in the emergency
13 ambulance there was some ventilation, the --
14 I haven't seen the evidence but we know that the
15 national specification says that the ventilation
16 will work a certain amount of times per hour,
17 despite the fact that the plume will pour past the
18 patient and the attendant as it's going into the
19 vent and there's no HEPA filter. We know for
20 transport vehicles there is no extractor, there is
21 no national specification for those services and we
22 knew that where the patient transport staff were
23 conveying more than one patient at a time, that they
24 were less than 1 metre apart often, and that whole
25 risk assessment -- I'm not aware there was any risk

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1 December 2020 crews were lucky to get in a rest room
2 at all. They were out all the time in the back of
3 the ambulance, at ED or going to 999 calls.

4 **Q.** And it's right, isn't it, that there
5 wasn't any national guidance from the public health
6 bodies or NHS England or government for those areas,
7 and so the AACE actually produced guidance known as
8 the Working Safety Guidance that went through many
9 iterations during the pandemic. Is that right?

10 **A.** As far as I'm aware, they didn't involve
11 us in that. That was their development.

12 **Q.** Okay. That was my next question. Thank
13 you.

14 I want to -- you brought me neatly on to
15 winter 2020 into 2021, December, and I want to take
16 you through some of the correspondence that the
17 college had with the government and ministers at
18 that time raising some of the concerns that we've
19 been discussing. This is set out at paragraphs 47
20 to 51, if that helps you, through your statement.

21 If we could start at document INQ000257964
22 and it's page 3. It's tab 17 of your bundle. This
23 is internal email correspondence between colleagues
24 at Public Health England, but referring to a meeting
25 that they'd had with the college and with AACE as

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1 well and, as you can see, this is dated 11 January
2 2021.

3 They talk about the concerns that yourselves
4 and AACE had raised in light of the increased
5 handover delays, that the ambulance sector was
6 experiencing 10 to 15 per cent staff sickness, and
7 that the college was requesting flexibility for
8 staff to be able to undertake a dynamic risk
9 assessment that we've been discussing to determine
10 the level of PPE they think is needed, and asking
11 for guidance on handovers, and also asking for
12 enhanced PPE.

13 And then in the penultimate paragraph, the
14 email says:

15 "This is placing pressure on the frontline
16 workforce and the call centre staff, part of the
17 critical infrastructure of the ambulance services.
18 These two issues alone have and will develop
19 critical points in the patient care continuum."

20 It reiterates that:

21 "Ambulance staff are maintaining
22 professional IPC behaviours and responsibilities but
23 guidance for long delays and pro-activity during
24 these long waits plus advice for enhanced PPE to
25 safeguard against increased time spent in close

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1 you can't -- it's not good enough to do your best,
2 you have to do what's necessary to succeed and
3 that's very much what we were trying to put across
4 to PHE in that call.

5 **Q.** Thank you.

6 If we go up to page 2, we can see the
7 response to that email. In summary, the Public
8 Health England response set out there is that there
9 would be no changes to the PPE guidance or any
10 additional guidance issued, and they reiterated the
11 need to double down on the existing IPC guidelines
12 and local systems and to carry out dynamic risk
13 assessments adopting the hierarchy of controls.

14 We don't need it on the screen but we can
15 see from email correspondence from the AACE
16 representative who attended the UK IPC cell, on
17 behalf of the sector, showing that that was
18 discussed. That essentially that is a summary of
19 what was discussed at the UK IPC cell in January
20 2021.

21 Was the college satisfied with that response
22 and the suggested approach and would it provide the
23 protection and reassurance that the college's
24 members were seeking at the time?

25 **A.** Nothing could be further from the truth

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1 contact with Covid positive individuals would be
2 helpful."

3 Is that an accurate summary of what was
4 discussed during the call with Public Health England
5 as far as you can recall?

6 **A.** It was -- partly. So much of it was
7 around the fact that, you know, surely no healthcare
8 system wants to render its emergency services
9 useless by not having the amount of staff required
10 to do what they need to do.

11 So we presume this was on the back of the
12 letter we had sent and it was interesting, we felt,
13 that AACE had also had concerns even though they
14 were telling us they were happy with the guidance,
15 they were compliant with the guidance, but this sort
16 of speaks to something else.

17 But we certainly felt that if this issue
18 remained unaddressed, that the ambulance delays
19 would worsen in that there were no additional staff
20 to go to patients in the community or even deal with
21 them through the telephone system, through triage
22 with clinicians in the call centre. You know, if
23 you reduce your workforce through sickness, you
24 don't have enough to do what you need to do. Some
25 Churchill quote that one of our members said about

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1 on that, no. We were completely unsatisfied and,
2 for us, it just felt again that there was this sort
3 of reticence to understand the very unique nature of
4 the work.

5 You know, someone just needed to apply some
6 common sense. Go in at back of an ambulance and
7 have a look yourself and see the space in there, see
8 what the crews are dealing with, just when they're
9 in the ambulance, let alone going into patients'
10 homes and environments where the risk is unknown
11 a lot of the time.

12 So it just felt completely incongruous.

13 **Q.** And that point of going into the back of
14 an ambulance, obviously this at the time of the peak
15 of the second wave of Covid-19, but also the middle
16 of the winter. Did those factors impact the ability
17 of those in the back of an ambulance to carry out
18 these kind of or implement these kind of measures?

19 **A.** Absolutely. Most ambulances don't have
20 a window to open. So that, again, was something
21 that had been failed to be recognised by anybody.
22 And to open the back door of an ambulance when the
23 temperatures were down to around minus 2, with
24 someone who may be frail and elderly who is
25 profoundly unwell, was simply not acceptable.

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1 Q. Thank you.

2 If we move on to the next document which is
3 INQ000257965 and that's at tab 13 of your bundle,
4 this is a statement -- well, a document,
5 a statement, put out by the AACE following the
6 advice that they'd received or you'd received from
7 Public Health England.

8 If we go to the bottom of that document,
9 again, we can see here this reference to the
10 importance of carrying out an individual dynamic
11 risk assessment with consideration of the
12 transmission route and PPE guidance and reiterating
13 that there's no evidence that increasing the level
14 of PPE in non-AGP scenarios would provide any
15 additional protection.

16 At this point, was there any guidance or
17 support available to those carrying out an
18 individual dynamic risk assessment on the frontline
19 as to how to consider the transmission route of the
20 virus and the PPE guidance and how that should feed
21 into their risk assessment during Covid-19?

22 A. Other than if they'd done one themselves,
23 no.

24 So, you know, we talk about the AGPs and the
25 non-AGPs. You know, people with Covid cough and
101

1 assessment with consideration of the transmission
2 route", that the individual paramedic was meant to
3 assess the transmission route?

4 A. Yes, exactly, and most paramedics felt it
5 was airborne, my Lady.

6 **LADY HALLETT:** Sorry to interrupt.

7 **MS HANDS:** Not at all, thank you.

8 Is the college aware of any occasions where
9 an individual risk assessment would lead to the
10 paramedic deciding that a higher level of PPE would
11 be appropriate in the circumstances and whether that
12 was always available to them at that point in time?

13 A. Sometimes they did. You know, when
14 situations availed themselves and people felt very
15 vulnerable, they would use a higher level of
16 respiratory protective equipment, and a couple of
17 things happened. So in some areas, the respiratory
18 protective equipment was locked away and needed
19 a manager to access replacement RPE, at which point
20 the crew or paramedic would have to explain why
21 they've used a higher level of RPE for a non-AGP
22 procedure.

23 In some cases, supplies were very short. We
24 know certainly from our colleagues in the Northern
25 Ireland Ambulance Service that stock was very short
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1 splutter and have, you know, had high temperatures
2 and, you know, were -- you don't sit in the back of
3 an ambulance for 10 hours and not speak to your
4 patient.

5 So all of these were non-AGPs but, you know,
6 the paramedics and ambulance clinicians were equally
7 concerned about that as well. So if people have
8 difficulty in breathing, you might do something
9 called nebulisation which is where you put some
10 medication in a port it's driven by oxygen and that
11 comes out. And, you know, it's really -- it's
12 really difficult. They can reinforce this as much
13 as they like and did reinforce it over and over
14 again. It didn't satisfy the workforce and we will
15 have a generation of workforce who feel undervalued
16 and not listened to.

17 But also, it didn't stop the ambulance crews
18 getting Covid and, you know, those poor patients in
19 terms of being in that environment as well, you
20 know, it just -- none -- there was no common sense.

21 **LADY HALLETT:** Sorry to interrupt.

22 **MS HANDS:** Not at all.

23 **LADY HALLETT:** Just before we go -- do I take
24 it from the words in blue at the bottom, "this
25 should be based upon the individual's dynamic risk
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1 there. And we couldn't ascertain whether the
2 management response to that was because they were
3 worried that the supplies were short and they needed
4 to hang on to some, or whether they were reinforcing
5 the guidance and our members couldn't tell us
6 either, other than the fact that, you know, if you
7 had used RPE on a night shift, for example, there
8 was no manager there to unlock the cupboard. So
9 that's why people ended up buying their own
10 protection.

11 Q. And if you were -- if you take a
12 practical example of being on the scene attending to
13 an incident, carrying out this risk assessment and
14 identifying that a high level was appropriate, was
15 it always available in those circumstances if, for
16 example, as you're saying, it was locked away or
17 they needed permission, what would happen in that
18 moment in the scene?

19 A. Clinicians would either, you know -- when
20 you're faced with a patient, you're not going to
21 deal with yourself, you're going to deal with the
22 patient and sometimes that put -- our members
23 describe being put completely at risk and feeling
24 very vulnerable, but they were trying to do the
25 right thing for the patient. So sometimes they
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1 would expose themselves to a risk knowing it was
2 exposing themselves to that risk and sometimes they
3 would just don the level of RPE that they had.
4 A face mask isn't PPE but they would don that as
5 some small form of protection and then worry about
6 it for the rest of the shift.

7 **Q.** Just finishing on that time period in
8 2020, winter 2021. There were no changes to the IPC
9 guidance for the ambulance sector during that
10 period, was there?

11 **A.** No.

12 **Q.** No. Thank you.

13 Moving forward to January 2022 --

14 **LADY HALLETT:** Before you do that -- sorry,
15 Ms Hands -- would that be a convenient moment to
16 stop there or would you rather deal with January?
17 It's entirely up to you.

18 **MS HANDS:** I have two questions and then
19 I think it will be a convenient time, my Lady.
20 Thank you. I will keep them brief.

21 In January 2022 we see IPC guidance
22 specifically relevant to the sector published by
23 Public Health England essentially saying that RPE
24 should be available if a risk assessment indicates
25 it would be appropriate and that the assessments

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1 that letter being sent and the issues that were
2 addressed therein? Were they responded to at that
3 point?

4 **A.** The -- because we were -- had formed
5 a part of the Covid Airborne Protection Alliance, as
6 it was in 2021, that was a kind of consensus view
7 amongst us that there were areas that were still not
8 addressed by Public Health England and we certainly
9 co-signed that letter on that belief, that actually
10 the weight of professional bodies and unions behind
11 that letter should make someone sit up and think
12 maybe we need to look a little more closely at some
13 of the unique environments, like ambulance
14 paramedics and speech and language therapists for
15 example.

16 So, yeah, the responses -- you know,
17 Professor Whitty has always responded to us. He
18 responded to us in the middle of a shift on New
19 Year's Eve one night when we'd asked him to. So
20 I believe people were doing the best they could but
21 still nothing was addressed and today, if a new
22 variant comes in within the next month or so, we're
23 still in the same position.

24 **MS HANDS:** Thank you.

25 My Lady --

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1 should include an evaluation of ventilation, and
2 also requiring trusts to identify all staff that
3 might be at risk of exposure to airborne particles,
4 not just AGPs if rigorous mitigations are not in
5 place and to provide access to FFP3 masks and
6 training.

7 So did that guidance go any way in
8 addressing the concerns that frontline ambulance
9 staff had felt during the pandemic and the period
10 we've just been discussing?

11 **A.** To a degree. It's better late than never
12 but I think by that stage some of the staff just
13 felt that there was -- you know, there's little to
14 celebrate with that at all because the high risk had
15 passed. Even though Covid is -- you know, Covid is
16 still here. We've got a new variant circling around
17 now. So, you know, there is little confidence in
18 the IPC guidance.

19 **Q.** And perhaps that leads me to my last
20 question well and that is that in February 2022 the
21 college was a signatory to a letter to the Chief
22 Medical Officer, Professor Whitty, setting out the
23 inconsistencies in the public messaging on airborne
24 transmission in Covid-19 guidance across the UK.

25 From an ambulance perspective, what led to
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1 **LADY HALLETT:** Can I just follow up? Having
2 said you were coming to the end.

3 As far as you -- the letter went to
4 Professor Sir Chris Whitty, Chief Medical Officer
5 for England. Did the letter go to the devolved
6 nations? You've made reference, for example,
7 earlier to Northern Ireland and the like. What
8 about the other nations of the UK?

9 **A.** Certainly there had been previous
10 correspondence, my Lady, that had gone to all four
11 nations, and the college had also sent around the
12 chief allied health professional officers across the
13 four nations as well. I'm not aware that that
14 letter did. I can certainly check that, my Lady.

15 **LADY HALLETT:** But the point is that even if
16 the letter only went to the Chief Medical Officer
17 for England, these are problems that were going
18 around the UK?

19 **A.** Yes, absolutely.

20 **LADY HALLETT:** Yes.

21 Right, I return at 2.05.

22 (1.05 pm)

23 (The short adjournment)

24 (2.05 pm)

25 **LADY HALLETT:** Ms Hands.

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1 **MS HANDS:** Thank you.

2 Good afternoon, Ms Nicholls, I have just
3 a few additional topics and questions to cover with
4 you this afternoon.

5 The first topic is around AGPs,
6 aerosol-generating procedures, so following on from
7 what we were discussing this morning.

8 In your statement you have referred to some
9 of the issues that your members faced with the AGP
10 list during the pandemic, and specifically
11 procedures that were not included on the list.

12 And some of those you referenced this
13 morning.

14 Now it's correct, isn't it, that the College
15 of Paramedics issued a statement supporting the view
16 taken by the Resuscitation Council UK that CPR and
17 intubation should be added to the list of AGPs at
18 the end of March 2020?

19 **A.** That's right.

20 **Q.** And a different view was reached by the
21 AACE, which supported the view taken by Public
22 Health England, and that was endorsing NERVTAG's
23 findings, and that statement was announced
24 in May 2020; is that right?

25 **A.** That's right.

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1 can happen. So the muscle tone goes, people can
2 regurgitate their stomach contents, people become
3 incontinent with faeces and urine. There's lots of
4 different things that can happen, which is
5 incredibly distressing if anyone else is around, any
6 family member, watching that.

7 However, CPR and intubation are two bits of
8 a longer chain of cardiac arrest management. So you
9 may be pushing air into someone's lungs through
10 manual ventilation, a bag valve mask you've probably
11 seen in any number of ambulance dramas, and that can
12 sometimes generate particles and sometimes,
13 particularly if someone has been sick or has vomited
14 into their airway, we need to suction that out so
15 that we can maintain a proper airway.

16 So there's lots of factors within that that
17 make that whole process very, very difficult to
18 isolate to specific things.

19 And I think that plays again into my comment
20 about not understanding, not reading the room and
21 understanding how people actually have to do their
22 work.

23 So to isolate two of those aspects is again
24 incongruous in terms of the whole cardiac arrest
25 management. There may be cardiac arrests where

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1 **Q.** So essentially, we had statements from
2 the college and we had statements from the AACE, and
3 they'd reached differing views?

4 **A.** Yes.

5 **Q.** And you have provided in your statement
6 a practical example of the impact that the decision
7 had on paramedics when responding to an emergency.
8 It's paragraph 34 of your statement.

9 But could you, please, just describe the
10 impact of that, the guidance, on the ground at the
11 time?

12 **A.** Certainly. And if I say anything that
13 emotionally triggers anybody who is in here or is
14 watching I apologise.

15 The -- every minute counts when someone is
16 in cardiac arrest. That's why it's a category 1
17 call. That's why the speed of response is so
18 important and the time to getting your hands on the
19 chest is so important.

20 And that's fine in and of itself without
21 Covid-19, so we're well trained, well drilled, well
22 skilled in dealing with cardiac arrests in those
23 situations.

24 Unfortunately, sometimes when people
25 collapse into a cardiac arrest, a number of things

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1 indeed there -- you know, very simple, the airway
2 isn't soiled, there isn't anything in the airway and
3 you can do CPR and, you know, there is nothing
4 particularly generated, but you'd never know. You
5 just never know. And each person is so very
6 different and you can't dynamically risk assess that
7 when you're on the scene to do that. You should
8 just be fully protected.

9 So if you imagine inherently in every
10 healthcare professional's DNA is to preserve and
11 save life, so when someone has collapsed you want to
12 just get to their side and help them where you can.

13 And the PPE thing was difficult because the
14 guidance was that the first person would go out in
15 a fluid-resistant surgical mask and do basic
16 procedures until the other attendant could don level
17 3 PPE and then go and do some more intricate airway
18 management, for example.

19 **Q.** If I just pause you there for a moment,
20 how long, roughly, would it take to don that PPE
21 before the second person could come in and assist?

22 **A.** Anything realistically from 3 to
23 5 minutes. At the beginning of the pandemic it was
24 towards the end of that timescale, certainly as the
25 pandemic progressed people were much quicker at

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1 being able to don their PPE and get to the side of
2 the patient.

3 So what everybody was keen to do is that
4 someone was starting to compress the chest, for
5 example, but our members said: it's really -- it's
6 a frightening thing because we don't know if we're
7 exposing ourselves to risk. So sometimes when --
8 you know, certainly some of our members said they
9 went in without any PPE at all because they were so
10 focused on supporting patient care.

11 It's not ideal but, you know, in reality,
12 things happen that you can't control.

13 **Q.** In terms of the different approaches that
14 we just discussed, how did the college support its
15 members around those two different sets of
16 statements, those two statements?

17 **A.** We found ourselves in a really difficult
18 position because we knew that our evidence -- that
19 our statement was contrary to the national guidance.
20 But we have really intelligent members who are
21 healthcare professionals who understand that
22 sometimes evidence will be different. We, as the
23 professional body, have an absolute right to say we
24 think that this is the evidence, this -- this feels
25 like the evidence. Other people who were eminent in

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1 study in a closed environment with anaesthetised and
2 paralysed patients. Well, that's not the patient
3 that we find in the community who has collapsed in
4 cardiac arrest.

5 So there was no evidence and -- and when we
6 were challenging that, it was -- it was, like: well,
7 that's the only evidence we have, so we're going
8 with that. But we're saying: but common sense would
9 tell you that the reality isn't like that, you're
10 not in a confined room, with HEPA filters, where
11 there are a number of people around; it's normally
12 you and your crew mate in a toilet, with respect,
13 trying to carry out a cardiac arrest in a very small
14 space.

15 **Q.** And the issues that you've referred to
16 around this guidance, were they pervasive across the
17 UK?

18 **A.** Yes.

19 **Q.** You said earlier on this morning in your
20 evidence that the general view of paramedics, or
21 certainly one of the views, was that the
22 transmission of Covid-19 was airborne.

23 What led to paramedics forming that view?

24 **A.** So most of the time it was sitting in
25 that environment with the patient. So if you speak

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1 this field, like the Resuscitation Council, feel the
2 same way we do. And what we urge you is to take
3 precautions where you can and just to think about
4 your safety and the safety of others around you when
5 you're doing that.

6 Now, we know by issuing that, that puts
7 a dichotomy into play of: what do I do? Do I do
8 that, do I not do it?

9 Even if we hadn't said anything, the resus
10 council were saying that they are the eminent people
11 in resuscitation, as far as we are all concerned in
12 the pre-hospital field, so we knew we'd be causing
13 additional anxiety but sometimes you just have to
14 tell the truth and lean in and say what you think is
15 right.

16 **Q.** And in terms of that evidence that you
17 were just referring to, did you feel or the college
18 feel that there was sufficient evidence and
19 information from the -- the national decision-makers
20 and those producing the guidance at a national level
21 as to the reasons and the evidence base that
22 informed their decisions and guidance?

23 **A.** Well, yet again, there was no
24 pre-hospital evidence, so the paper that kept being
25 quoted was the Tran et al that was a hospital-based

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1 to a number of our members, they will tell you they
2 can probably identify which patient they caught
3 Covid from, because of the length of time they were
4 in a confined space. And we've heard previously in
5 the Inquiry about the environment that people are in
6 for prolonged periods. Well, 6, 10, 12 hours in the
7 back of an ambulance is a prolonged period. And it
8 was not -- when they were doing an AGP, it was
9 because it was because a patient was coughing, or
10 they were having a conversation with the patient if
11 they were well enough.

12 So it's through experience that they decided
13 that -- excuse me -- that it wasn't AGP-related
14 necessarily, it came from a breadth of ways.

15 They were really conscious also that there
16 was a lot of discussion about spreading healthcare
17 worker to healthcare worker, but also they were
18 worried about them passing and transmitting the
19 virus on to patients as well who were already
20 unwell. So there was a -- just, you know, through
21 their own experience, really.

22 **Q.** Moving on to a different topic, and this
23 is around the risk assessment tools that were
24 available to employers and managers that were
25 managing people that were obviously on the front

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1 line but also in non-clinical settings, emergency
2 operation centres as well.

3 Were you aware of any risk assessment tool
4 specifically for ambulance services during the
5 pandemic?

6 **A.** No, other than the Royal College of
7 Nursing, who published one latterly and we'd had
8 sight of a draft copy, and that -- we felt that
9 there was a lot greater experience and skill in the
10 people doing that, so we just contributed in terms
11 of remember those that are in the ambulance service.

12 **Q.** And in May 2020 a letter was sent to
13 ambulance trusts from the National Ambulance Black
14 and Minority Ethnic Forum referring to a national
15 risk assessment tool, is that right, so that wasn't
16 specific to the ambulance sector?

17 **A.** Not as far as I'm aware, no.

18 **Q.** And in your view-- was that appropriate
19 for use in the ambulance sector?

20 **A.** I -- I can't recall it specifically, but
21 there are very few things that translate well into
22 a pre-hospital setting because it's a different
23 environment. You know, the -- the concept of the
24 Royal College of Nursing risk assessment was almost
25 starting from the beginning, so: make sure you're

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1 said:

2 "As a paramedic working for the ambulance
3 service, I was advised to use
4 different physiological parameters to contribute to
5 discharging care at home -- patients were being left
6 at home with lower oxygen levels than would be
7 acceptable pre-pandemic."

8 Did the college receive any feedback or
9 comments from frontline paramedics about the absence
10 of any kind of national tool or any support that was
11 available to them for decision-making in the
12 circumstances of the pandemic?

13 **A.** No, only through conversations with some
14 of the medical directors who were working on some of
15 the guidance changes.

16 So -- so pre-pandemic if a patient had
17 a parameter of a low oxygen level, that would
18 normally indicate that they needed to go into
19 hospital or were being supported by a community team
20 of -- you know, a community rehab alliance, for
21 example, where a multi-disciplinary team might come
22 in and support a patient normally, even though their
23 oxygen levels were lower because of a condition that
24 they had.

25 During the pandemic people's oxygen levels,

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1 competent to undertake a risk assessment and
2 understand what you're trying to do, then look at
3 the training and look at what your mitigations can
4 be. So that felt more appropriate. But the
5 ambulance sector is quite often a bolt-on or
6 an afterthought, I would have to say.

7 **Q.** Moving now to a different topic, and this
8 one is in relation to conveyance to hospital and
9 decision and support tools available for that
10 decision-making.

11 I would like to put on the screen, please,
12 INQ000499523. And it's page 21.

13 This is the response received again from the
14 research survey the Inquiry commissioned into
15 escalation of care and decision-making around
16 conveyance or non-conveyance to hospital during the
17 pandemic.

18 And you can see the headline at the top here
19 that:

20 "A majority (71% [of those that responded])
21 agreed that during the pandemic, the patients they
22 were unable to escalate were more severely ill
23 compared to the 12 months before."

24 There is also on this page a quote from
25 a paramedic at the bottom, which -- the paramedic

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1 if they were unwell or clinically vulnerable, were
2 greatly reduced, and sometimes normally fit and well
3 people had low oxygen saturations as well. So we
4 knew that some of the guidance was being done by the
5 medical directors, so we were just -- we asked them
6 to keep us in the loop in terms of understanding how
7 they were setting the thresholds, why they were
8 setting them, what the evidence was, et cetera. But
9 it's something that the college wouldn't
10 necessarily -- we're quite often involved in the
11 clinical guidance but, you know, during the pandemic
12 these were decisions that were having to be made
13 very quickly and with the best intentions for the
14 most people.

15 **Q.** So from what you've just said can we
16 understand that there were different approaches
17 taken across the ambulance trust, across the whole
18 of the UK, to conveyance and non-conveyancing
19 decisions to hospital during the pandemic?

20 **A.** Yes, the Association of Ambulance Chief
21 Executives doesn't cover Scotland and Northern
22 Ireland as part of their partnership, but certainly
23 their conversations -- they were still included in
24 those conversations.

25 **Q.** Moving on to the topic of mental health

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1 support and wellbeing.

2 You exhibited to your statement a study of
3 sickness absence levels, including for mental health
4 conditions, during the pandemic which found that 50%
5 of ambulance staff were experiencing burnout, and
6 87% had moderate to high levels of depersonalisation
7 towards their work caused by lack of management
8 support, involuntary overtime and poor work-life
9 balance during the pandemic.

10 And you also exhibited a report from
11 Nuffield Trust suggesting that one in 10 paramedics
12 had left their job in 12 months -- in the 12 months
13 to June 2020.

14 Can you provide some examples of the type of
15 mental health support that was made available during
16 the pandemic? And any that you received from
17 feedback were effective or perhaps not effective?

18 **A.** So we have The Ambulance Staff Charity,
19 which is a specific charity for anybody that works
20 or has worked within the ambulance sector, and they
21 provide counselling, so -- that's free at the point
22 of the person accessing it, and we referred people
23 there.

24 NHS Practitioner Health also included,
25 latterly, paramedics as well as doctors and nurses,
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1 was novel for everybody, so the managers would be
2 dealing with staff anxiety, stress and depression
3 that they -- on a scale that they had probably never
4 dealt with, and we felt it was incumbent upon us to
5 support the managers in how to support their staff
6 as well and offer a guide.

7 **Q.** Then at paragraphs 62 to 64 of your
8 statement you've discussed the impact of Long Covid
9 on the ambulance workforce.

10 Can you explain what the impact has been and
11 whether support, if any has been made available, has
12 been sufficient and effective?

13 **A.** I wouldn't be able to comment about
14 whether it's effective or sufficient necessarily,
15 but what we recognised is that a number of our
16 members and people who aren't members of the college
17 are experiencing Long Covid. They can now no longer
18 work.

19 The Ambulance Staff Charity, who we link in
20 with, also spoke about -- they'd spent some of their
21 funds on fitting stairlifts for paramedics that
22 can't even walk up the stairs without becoming
23 breathless, so can no longer fulfil their role and
24 have had to leave.

25 And what we did see is that the kind of
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1 which was very welcomed. We'd managed to source
2 a grant that hopefully would send people through NHS
3 Practitioner Health, and then NHS England announced
4 that NHS Practitioner Health would encompass
5 paramedics and ambulance clinicians as well.

6 We also linked in with some organisations
7 like Mind Over Mountains and Blackdog Outdoors and
8 Surfwell, because what we found throughout the
9 pandemic is that the talking therapies were good and
10 useful and helped a number of people but their
11 trauma was so great that actually it was physical
12 therapy with trained counsellors that really seemed
13 to resonate with our members. So, for example, we
14 taught them hill guiding, learning to surf with --
15 with trained counsellors who were also ex-police
16 officers and could surf.

17 So it was unlocking that kind of physical
18 activity that really seemed to do something for our
19 members that we hadn't seen before in the talking
20 therapies.

21 **Q.** And it's right, isn't it, that the
22 college produced guidance for managers to support
23 the mental health and wellbeing for ambulance
24 personnel in a pandemic crisis in April 2020?

25 **A.** Yes, that's right. We recognised that
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1 sickness payments changed and after a certain amount
2 of time people were no longer being paid sick if
3 they were diagnosed as having Long Covid.

4 And, you know, we offered some Long Covid
5 support through an e-learning package, but we're not
6 a trade union, it's a difficult space for us to be
7 in, but we certainly -- we just had listening events
8 for our members to contact us about anything they
9 felt we could signpost or refer them on to.

10 **Q.** You have provided in your statement
11 a number of recommendations, and I'd like to ask you
12 in a moment whether there's any that you would like
13 to draw particular attention to, but before I do
14 we've been asked by some of the CPs to ask about
15 specific recommendations, and the first is to
16 whether the college thinks that it would be
17 beneficial to have a single source for all guidance
18 available?

19 **A.** Definitely.

20 **Q.** So are there any other recommendations
21 that you would like to draw attention to?

22 **A.** I think that the sort of pragmatic
23 evidence-based clearly communicated policies would
24 just be so helpful. You know, to change things five
25 times a day in a workforce that doesn't have access
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1 to its emails, et cetera, is just not -- it doesn't
2 work.

3 The compassionate leadership, I know
4 Professor Gould spoke about this last week, about
5 hearts and minds, and just showing some compassion
6 and active listening and involving some of those
7 people in the decision-making or on the periphery of
8 the decision-making would be really helpful.

9 And more awareness and support for mental
10 health and wellbeing. This has devastated our
11 profession, and I can't speak strongly enough about
12 that. I know it's devastated everybody but, you
13 know, we're seeing for the first time less people
14 applying to become paramedics, we're seeing people
15 leave early. This cannot happen. We need to
16 support our people.

17 And if I may, Ms Hands, I don't know if it
18 would be helpful to yourself or my Lady, but I have
19 drawn a template of the back of an ambulance that
20 you can stand on, not for now but for later, just so
21 you can visualise the space that people work in. So
22 I'll give it to the witness team.

23 **MS HANDS:** Thank you. I'm very grateful,
24 Ms Nicholls.
25 My Lady, that's all the questions.

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1 **DR MICHAEL MULHOLLAND (affirmed)**
2 **Questions from COUNSEL TO THE INQUIRY**

3 **A.** Thank you.

4 **MR MILLS:** Your full name, please?

5 **A.** Michael Nial Mulholland.

6 **Q.** You are the Honorary Secretary of the
7 Royal College of General Practitioners, that's the
8 RCGP.

9 **A.** Yes, that's correct.

10 **Q.** You've provided a witness statement for
11 the transcript. That is reference INQ000339027.
12 Introduce us, please, Dr Mulholland, to the
13 work the RCGP performs for its members.

14 **A.** Thank you. The RCGP is a professional
15 membership organisation of about 54,000 GPs across
16 UK. Our charitable object is to encourage, foster
17 and maintain the highest standards of general
18 practice in the UK, and we work to continually
19 improve patient care, support GPs to develop their
20 care and their skills, and promote general practice
21 as a discipline through all stages of medical
22 training, from medical students interested in
23 general practice right through to senior and retired
24 members.

25 **Q.** And a little bit about you, please.

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1 **LADY HALLETT:** I don't think there are any
2 core participant questions.

3 **MS HANDS:** No, there's no further questions.

4 **LADY HALLETT:** I gather you've been following
5 our proceedings in this module, Ms Nicholls?

6 **A.** I have.

7 **LADY HALLETT:** Absolutely, it shows. So
8 thank you very much for your focused and very
9 constructive answers.

10 Did you, in following the proceedings, see
11 the impact film at the beginning?

12 **A.** I did, with John. I did, my Lady.

13 **LADY HALLETT:** I mean, all the films are
14 moving, and for those of us who have to watch them
15 more than once I can tell you they -- they tug at
16 your heart strings, but if ever there's a moving one
17 I thought that his account was extremely moving. So
18 thank you for all that obviously you and your
19 colleagues do and thank you for all your help in
20 this module.

21 **THE WITNESS:** Thank you so much. Thank you
22 for including us in the Inquiry. Thank you.

23 **(The witness withdrew)**

24 **MR MILLS:** My Lady, may I please call
25 Dr Michael Mulholland.

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1 How long have you been a GP for?

2 **A.** I've been a GP for 26 years.

3 **Q.** Did you work as a GP throughout the
4 pandemic?

5 **A.** Yes, I was in practice in my practice,
6 Unity Health Buckinghamshire, where I'm a partner.

7 **Q.** Can I begin, Dr Mulholland, with the
8 condition of general practice prior to the pandemic.
9 At paragraph 8 of your statement you say
10 this:
11 "It was widely accepted that there were not
12 enough GPs to meet the level of demand prior to the
13 pandemic."
14 Are you able, in respect of each of the four
15 nations, to set out (1) the workforce issues that
16 were faced, and (2) what action was being taken by
17 the respective governments in response?

18 **A.** Thank you.

19 Excuse me.

20 As you say, general practice was already
21 close to breaking point when the pandemic hit. It
22 was widely accepted there weren't enough GPs to meet
23 the level of demand prior to the pandemic. In
24 England the government had recognised this and in
25 2015 committed to expand the number of GPs by 5,000

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1 by 2020 and in '29 (*sic*) recommitted to make it
2 6,000 by the end of the parliamentary --

3 **LADY HALLETT:** Could you go a bit slower?

4 **A.** Sorry.

5 **LADY HALLETT:** It's just that we do have to
6 make a note of what you say.

7 **A.** And by 20 -- by 2019 committed to have
8 6,000 by the end of the Parliament.

9 However, despite those commitments, figures
10 published by NHS England showed that we knew that
11 the number of full-time equivalent GPs has been
12 falling since 2015.

13 In Scotland we had a report from the college
14 in June 2019 making it clear again that general
15 practice faced significant workforce challenges,
16 highlighting the 4% decline in GPs between 2013 and
17 2017, and we called for the establishment of new
18 targets, encouraging the Scottish government to
19 commit it to 800 additional GP headcount by '27, but
20 this was not a reliable way to do it as headcount
21 and full-time equivalent GPs are different and they
22 would not meet that target was our opinion.

23 In Wales, there was a similar story. Our
24 report of 2018, again presented to the First
25 Minister in Wales, highlighted there would be
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1 number of laptops, the number of desktops, the
2 telephony services that were not adequate for the
3 number -- the demand that was coming into the
4 practices, and often GPs were frustrated by the time
5 it took for systems to turn on, the time for systems
6 just to get going before we could even start our day
7 to talk to patients. It was highlighted in our
8 national conference and Dame Helen Stokes-Lampard
9 pointed that out about four years ago.

10 **Q.** Taking all of what you have told us
11 together, how would you characterise the resilience
12 of general practice in early 2020 as it was on the
13 precipice of the pandemic?

14 **A.** I think general practice has kept going
15 for many years despite always being underfunded, and
16 GP resilience does keep the service running at that
17 stage, but general practice was in a precarious
18 place where the extra burden of a pandemic was not
19 something we thought we would be able to deal with.

20 **Q.** Next, please, I'd like to consider the
21 fluctuations in the workload of GPs across the
22 pandemic.

23 Please can we have on screen INQ000492277.
24 Thank you.

25 For context, these are the results from the
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1 a shortfall in GPs, and that the budget invested in
2 Wales was only 7.3% of the budget, of the healthcare
3 budget, and this compared to a UK average of about
4 8%, 8-9%. The First Minister at the time took the
5 report and said they would work more with us to try
6 to improve that.

7 Northern Ireland, again a similar picture,
8 with a number of GPs both in headcount and in
9 full-time equivalence was falling and the investment
10 into general practice was not sufficient to meet
11 that and improve it over the time.

12 **MR MILLS:** That's workforce.

13 Is it right that in 2019 the RCGP published
14 reports demonstrating the need to invest in the
15 digital infrastructure in general practice?

16 **A.** Yes, we recognise that there was a need
17 for digital improvement. There was also a need for
18 infrastructure improvements across the general
19 practices estate in all four nations.

20 **Q.** Can you help us have a sense of the
21 specific issues you were highlighting with the
22 problems within the digital infrastructure?

23 **A.** I think in the digital infrastructure
24 we're not just talking about AI or ways to improve
25 consultation, I think it was simple things, like the
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1 RCGP's survey of workload in general practice in
2 Wales conducted in December 2020, and I'd like us to
3 consider the average capacity figures, along the
4 bottom row.

5 So we have:

6 "Pre-COVID ... 108.

7 "First peak [defined here as the first 4 to
8 6 weeks of the pandemic] ... 90."

9 And then finally:

10 "Current, ie in that last week
11 within December '20] ...127."

12 Can I start with that decrease in capacity
13 that we see in the first peak.

14 Can you help us with what factors contributed
15 to that decrease? And if it assists, Dr Mulholland,
16 I'm at your paragraph 177.

17 **A.** Thank you. I think at the start of the
18 pandemic patients were understandably extremely
19 scared of doing things, of coming in to see health
20 services. We had seen on TV images from Italy, and
21 China before that, of what -- health services being
22 overwhelmed, and so patients wanted to keep
23 themselves safe, they didn't want to attend
24 face-to-face appointments. GP surgeries were in
25 buildings often in an older state where it's very
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1 difficult to isolate and keep yourself separate.
 2 And the way of general practice working over the
 3 years had been that people sat in crowded waiting
 4 rooms waiting for a doctor to call them in for
 5 an appointment. So people did not want to be in
 6 that situation at the start of the pandemic.

7 Government messaging at the same time had
 8 been stay at home, protect the NHS, and patients
 9 very reasonably decided to do so. They did not want
 10 to leave their houses if they did not need to. And
 11 so patients were listening to that messaging as well
 12 as having the fear as well -- together.

13 **Q.** So do I take it that as well as the fear
 14 there was perhaps a pervasive sense of guilt about
 15 going to overwhelm the NHS by turning up to their GP
 16 surgery?

17 **A.** I'm not sure if it was guilt but patients
 18 certainly felt that they were being encouraged not
 19 to attend the NHS and the service could be
 20 overwhelmed and they did not want to contribute to
 21 that.

22 The disruption of services as well meant
 23 services and practices and elsewhere were not the
 24 same as normal. We had been instructed by the NHS
 25 to move to a total triage system where instead of

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1 worse, so they started to come back and needed to be
 2 seen in practices.

3 Getting to the end of 2020, we started to
 4 have the vaccine programme and developments were
 5 being made to try to have vaccination --

6 **Q.** We'll come to that.

7 **A.** And we also had that doctors were
 8 becoming ill and practice staff were becoming ill
 9 and so there was a reduction in the service that
 10 could be provided. So those that were working were
 11 at times working, as it says here, at 127 per cent
 12 of capacity rather than below it.

13 **Q.** Next, please, the move to remote care.

14 At your paragraph 86 you describe how prior
 15 to the national lockdown in March 2020 70% of GP
 16 appointments were face-to-face.

17 Then during the first lockdown, we see the
 18 inverse: 70% of GP appointments conducted by
 19 telephone or video.

20 Help us, what was the impact of this on GPs
 21 and their patients?

22 **A.** This was a complete change to the way
 23 that most of us had worked before. It was a --
 24 overnight we had to learn new skills, how to consult
 25 over the telephone and take most of our information

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1 patients coming in to book appointments that they
 2 came in online or on a phone system, after which
 3 they got a phone call back. And that was an unusual
 4 way to consulting. Some practices had started that
 5 before the panic and were doing it but for most
 6 patients it was a new way to contact the GP, and so
 7 that new system again created probably some barriers
 8 when it was almost imposed overnight --

9 **Q.** I'll ask you about those barriers in due
 10 course, Dr Mulholland.

11 **A.** Okay.

12 **Q.** Returning to this page, of course we have
 13 here 127 capacity in December 2020.

14 **A.** Yes.

15 **Q.** Can you help us, at what point during
 16 2020 did the workload of GPs start to increase after
 17 that first peak?

18 **A.** I think after the first peak we had
 19 a period, as I recall, of lockdown being lifted and
 20 patients started to try to come out of their homes
 21 and see people. We had a period in the summer that
 22 year where I think Eat Out to Help Out occurred and
 23 patients had started to return but also had become
 24 sicker having not seen GPs. And so people had
 25 illness that needed to be treated that was getting

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1 from the telephone rather than seeing people
 2 face-to-face.

3 For patients, they had to get used to giving
 4 information that they normally wouldn't give on
 5 a telephone to healthcare staff, they usually keep
 6 private things for face-to-face, they had to get
 7 used to sharing these things.

8 Our consultations changed a bit as well. We
 9 started to look at -- we had to look at remote
 10 consultation as a new way of consulting because
 11 a lot of our assessments for GPs during their
 12 clinical examinations -- so the -- our RCGP exam --
 13 were based on face-to-face consultation. And
 14 mentioned later in our evidence that we had to stop
 15 the clinic skills assessment early in the pandemic
 16 because we could not bring trainees and GPs from
 17 around the country to a central base in London to
 18 assess them, and during the first 12 weeks we did
 19 start introducing a new examination, which we
 20 conducted for the first time in July, based on
 21 remote consultations.

22 So it was a complete different way of
 23 working for the GPs and for patients to access that
 24 care.

25 **Q.** Thinking about patient access, were some

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1 patients left behind by the move to digital
2 consultations?

3 **A.** I'm sure there were. Not everybody was
4 set up, as many GPs weren't set up, to be able to do
5 digital consultations on day one. So, as I said,
6 our telephone systems weren't always adequate, or IT
7 systems, and when people were starting to try to do
8 what everyone else was, which was work from home, we
9 found that GPs weren't in a position to do that
10 because we didn't have the hardware in terms of
11 laptops to take home and access our clinical systems
12 from.

13 So there was -- that was happening in the
14 healthcare system.

15 Our patients, who had a varying level of
16 digital literacy and access to the tools, again had
17 the same problems, which some really found it very
18 hard. If you'd imagine the patients, my practice
19 has a lot of elderly patients, many with hearing
20 problems, and they found it hard to hear someone on
21 a telephone. And when our phone lines weren't as
22 good as they are now with the new digital systems,
23 they found it hard to communicate their issues and
24 what was needed. They said "I want to see you,
25 Doctor", which is what they usually said on the

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1 your speech patterns.

2 **A.** So when that was happening, when we
3 changed to a telephone system, in some ways there
4 was good things, that a GP was the person that the
5 patient first talked to, and that a GP made some of
6 those decisions. But it also meant that patients
7 were not able to -- weren't used to it and they
8 often were then told "We need to see you again
9 because we can't get all the information from the
10 telephone" or "You're not able to share all the
11 information". So it required a whole different way
12 of us thinking about contact.

13 Some places used a digital system with what's
14 called asynchronous consultation, where someone puts
15 a message in and gets a reply later. Again, that
16 was completely new to many patients.

17 **LADY HALLETT:** Sorry, what kind of
18 consultation?

19 **A.** Asynchronous.

20 **LADY HALLETT:** Asynchronous.

21 **A.** So it didn't occur at the same time.

22 **MR MILLS:** Please can we have on screen
23 INQ000492268.

24 Dr Mulholland, these results are taken from
25 an RCGP survey of members at the end of March 2020.

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1 phone when we did it. So it was much harder for
2 them to communicate.

3 And as GPs we normally took a lot of our cues
4 from how a patient looks, what's in front of us. We
5 were having to learn as well, with these patients,
6 how they were, because it was very hard over a
7 telephone.

8 **Q.** You said your paragraph 89, you've
9 touched on it this afternoon, that the way that
10 patients were triaged went through a dramatic
11 transformation. Can you describe that to us?

12 **A.** What had been traditional in general
13 practice was that patients either walked into
14 a surgery or phoned up the surgery and talked to our
15 receptionists, who then added them usually to a GP
16 or a nurse or other healthcare provider list, and
17 they would then be seen by that GP usually.
18 Sometimes they had a telephone call but it was
19 usually allocated on that basis. And the triage or
20 the care navigation was made by our reception teams
21 in general as to who was the most appropriate to see
22 the person.

23 **LADY HALLETT:** Could you slow down.

24 **A.** Sorry, I'm going too fast again.

25 **LADY HALLETT:** It's very difficult to change
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1 But I'd like to consider the response to 4(e).

2 If we add those very and quite important
3 figures together we get that 95% of respondents
4 thought it was either very important or quite
5 important to receive more guidance on how to manage
6 appointments with a mix of remote working and
7 triage.

8 Was this level of concern something that the
9 RCGP raised with either the Department of Health or
10 NHS bodies?

11 **A.** I'm quite sure it was. It was something
12 that we were all familiar with from our practices,
13 that we needed more information to be able to change
14 our practices overnight to a new way of working.
15 And we didn't have national guidance on how to do
16 this, just that we should be doing it. So the very
17 important and quite important seems what we were
18 experiencing at the time and reflected what we were
19 trying to put forward in our advocacy for our
20 members to policymakers.

21 **Q.** Can you recall what if anything came of
22 those conversations?

23 **A.** New guidance -- further guidance did come
24 out, once further calls had been made and time had
25 been there. We also became involved in writing

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1 guidance on remote consultation and remote -- on how
2 to do safeguarding, which was a real concern to us
3 remotely, that we knew that safeguarding was
4 something that, even very early in the pandemic, we
5 were clear could be at risk, so we were part of
6 those writing teams too.

7 **Q.** Next, can we go to INQ000492276, please.

8 These results come from a survey conducted
9 in September 2020, so some time since the March
10 results we've just looked at.

11 The question is this:

12 "Which of the following do you need to
13 ensure general practice can get the most out of
14 remote consultations?"

15 I'd like us to consider the fourth row down.

16 We have 90% saying it was important to have a method
17 to quickly identify patients that should not be
18 given a remote consultation.

19 Firstly, are you able to give some examples
20 of patients who should not be given a remote
21 consultation?

22 **A.** I think some of them I've talked about
23 already: the elderly with special sense impairment,
24 who may not hear you well on a telephone. There are
25 other groups of vulnerable patients, those with

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1 decisions from face-to-face consultation to
2 something completely new, and there was learning
3 that was happening at pace as to what groups, but it
4 wasn't defined clearly, no one had told us how to do
5 it, it wasn't part of a training that we'd been able
6 to do beforehand, so GPs were learning this as it
7 went along. Guidance at the beginning maybe
8 could've helped further but I'm not sure if it
9 existed anywhere at that stage.

10 **Q.** Moving on slightly to paragraph 97 of
11 your statement, you say that the RCGP identified
12 a media narrative that purported to blame GPs for
13 the perceived lack of face-to-face appointments.

14 First this: can you help us with when this
15 narrative developed?

16 **A.** I'm not sure that I can pinpoint an exact
17 time but probably to -- after the first wave.
18 During the first wave there was times of everybody
19 being very supportive that doctors were at work.
20 But as people perceived the general practice was
21 closed, although we weren't, the media narrative
22 seemed to grow and many of our members reported --
23 and felt unfairly blamed for what was becoming out
24 in newspapers and reports that wasn't then being
25 countered by anybody else to say: no, GPs are at

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1 safeguarding issues, for example, we would probably
2 want to see face-to-face. Others, you know,
3 a learning disability -- with learning disabilities,
4 you probably want to see because of the
5 communication that you might lose if you were not
6 seeing them face-to-face. There are some more
7 physical things that we'd want to see face-to-face
8 as well. Those people with abdominal pain, we often
9 want to feel their abdomen in an examination.

10 So what we were finding at that time was that
11 we didn't know exactly who should, and often you
12 would have a telephone call and then realise through
13 your telephone call, which obviously occupied
14 an appointment, that you needed another appointment,
15 and GPs were recognising that it would be better to
16 get those patients in straightaway to a face-to-face
17 consultation rather than telephone.

18 **Q.** Given the issue was raised in March 2020,
19 was it concerning to you that in September 2020
20 general practitioners were saying a method to
21 quickly identify these kind of patients was still
22 needed.

23 **A.** I think it was a concern but not
24 a surprise as GPs had changed completely the way
25 they had been taught to consult and how to make

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1 work, GP doors are open, and they're working in this
2 new way that is different but it is not that they
3 are closed.

4 **Q.** In November 2020 the RCGP launched the
5 campaign "general practice is open"?

6 **A.** Mm-hm.

7 **Q.** What was the aim of this campaign?

8 **A.** The aim of this was primarily to build on
9 what we'd been saying since March/April 2020, that
10 patients who were unwell or had symptoms that they
11 would normally go to a doctor with should still be
12 contacting their GP. Just because we were not
13 seeing as many people face-to-face did not mean that
14 they should not be turning up, it meant that we
15 would just take their history over the telephone
16 rather than in a consultation in our room. Those
17 people that then needed seeing we would still see.

18 But it was -- we were very concerned that we
19 knew that there were people who would have -- as
20 Professor Edwards said this morning, many people who
21 would have diseases developing who did not seem to
22 be coming into our rooms and seeing us in the same
23 way.

24 **Q.** Please can we have on screen
25 INQ000474283. Thank you.

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1 This is an extract from the report produced
2 by Professor Edwards, and I just want to read from
3 the second sentence of paragraph 44:

4 "While General Practice remained open, these
5 changes made General Practice more difficult to
6 access at times and created a misperception that
7 General Practice was 'closed' to the public and that
8 services were not operating."

9 Now this:

10 "Public messaging that General Practice was
11 'open' could and should have been clearer."

12 This morning during his evidence
13 Professor Edwards said there could have been
14 a stronger, more coherent campaign. What are your
15 reflections on that?

16 **A.** We would agree with Professor Edwards
17 that our members felt that there was not enough
18 clarity saying that we were open, that we were doing
19 what had been directed that we should do, which was
20 to go to total triage and stop our face-to-face
21 appointments as many -- or as many face-to-face
22 appointments. And that was not backed up in
23 statements.

24 And right through to November 2021, when it
25 was suggested that there might be a table that GPs
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1 we were also very concerned that we do an enormous
2 amount of chronic care for long-term conditions in
3 general practice, and that was not happening in the
4 same way as it had pre-pandemic. Our members were
5 concerned about those patients being left without
6 the care they normally had, but what we needed to do
7 in the pandemic situation was actually have
8 a prioritisation that we really would call those
9 patients that we knew were most at risk and that is
10 why we tried to produce it.

11 We tried to produce the guidance more with
12 NHS England as well --

13 **Q.** Well, let's -- we'll come on to that,
14 Dr Mulholland. Let's look at the first iteration of
15 that guidance.

16 If I may, that's INQ000280653.

17 Published on 10 April 2020. If we move down
18 to page 2, we see that services are allocated as
19 being high, medium or low, priority.

20 **A.** Mm-hm.

21 **Q.** I'd just like to consider together how
22 the RCGP and the BMA approached the challenge of
23 categorising services in this way.

24 So help us, please, what factors brought
25 a service into the high priority category?
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1 doing -- how many were doing face-to-face and how
2 many not, which led people to feel that there would
3 be a name and shame campaign for practices. GPs
4 reported to us that they were feeling attacked, got
5 at, despite working at more than 100 per cent of
6 capacity throughout certainly 2021.

7 So I think we would agree entirely with
8 Professor Edwards that a concerted campaign to say
9 that general practice was open would've made
10 a difference.

11 **Q.** New topic, please.

12 Workload prioritisation guidance.

13 If we return to INQ000492268, please.

14 This time the response to question 2(a).

15 Again, this is the end of March 2020 survey,
16 Dr Mulholland.

17 **A.** Mm.

18 **Q.** We have 92 per cent of members either
19 very concerned or quite concerned about being able
20 to provide a business as usual service to patients.

21 Was it in response to this level of concern
22 that the RCGP and the BMA produced guidance for GPs
23 on workload prioritisation?

24 **A.** Yes, we were very concerned that -- we
25 knew we did not have capacity to see everybody. But
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1 **A.** I wasn't part of the group specifically
2 writing it at the time but it was those people that
3 needed care, as normal today, that their illness
4 would deteriorate, their health would deteriorate as
5 a result of not having the care put them into that
6 category.

7 In the lower priorities were those things
8 that might have been -- checks -- things that --
9 like coil checks and non-urgent screening, we
10 thought were -- did not need to be part of the
11 priority of a GP during the lockdown phases in the
12 early waves of the pandemic but instead we should be
13 prioritising the urgent care, the chronic care, for
14 those that were most unwell, to make sure their
15 health didn't deteriorate, or those that become
16 acutely unwell that they got the treatment at the
17 time.

18 **Q.** Next, let us look at the version of the
19 guidance published in January 2021.

20 That's INQ000280654.

21 On page 3 we have this table setting out
22 various Covid-19 response levels.

23 Can you help us with what these response
24 levels were designed to achieve, and how they
25 interacted with those three categories of
148

1 prioritisation that we've looked at in the first
2 iteration of this guidance?

3 **A.** I think the Covid response levels, from
4 memory, were related to the government's response
5 levels, they were levels we were at, and so we've
6 tried -- the guidance was trying to make it fit with
7 that.

8 They're very similar in some ways, that the
9 "Prevalence high or rising rapidly" side was more
10 akin to do the green work and it only prioritised
11 the green levels. As the response went down to
12 levels 0 and pandemic over, you're back to doing
13 everything that you were doing everything before.

14 So it was trying to work with these new
15 levels that we had, Covid response, and trying to
16 say to GPs: we don't have exact things you should be
17 doing, your patient you can make clinical decisions
18 yourself, but these are the sort of messages we'd
19 like you to think about when you're making those
20 decisions in your practice.

21 **Q.** You alluded earlier to the RCGP
22 approaching NHS England seeking to co-produce
23 updates to this guidance.

24 Did NHS England agree to co-produce or
25 endorse the guidance?

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1 guidance and not to do everything they normally did.
2 And the risk was, to them, then if something
3 happened afterwards and they were criticised, who
4 would be there to protect or indemnify them, saying
5 this was a national piece of work? It didn't
6 happen, we couldn't provide that as a college, nor
7 could the BMA as a union.

8 **Q.** Next, please, the vaccine roll-out.

9 You alluded to this earlier this afternoon.

10 Is it right that this was a critical
11 workstream that impacted the ability of GPs to
12 deliver their business-as-usual care during the
13 pandemic?

14 **A.** Yes. The vaccines came on December 2020.
15 The first vaccination was given, the first
16 vaccination in general practice, about ten days
17 after the first one in the country. And it was
18 something GPs had been involved with from the start.
19 The RCGP wrote guidance on mass vaccination
20 around April 2020 when we were thinking of what
21 would happen to our flu campaigns for the winter,
22 and safe guidance was written that in fact became
23 the basis for a lot of the national guidance.

24 But what it meant was that although the
25 initial plans had been for mass vaccination hubs to

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1 **A.** They didn't.

2 **Q.** Did they give reasons why not?

3 **A.** We recognised there was a need for speed.

4 Our GPs were asking us, particularly for that first
5 piece of guidance, for the guidance very quickly and
6 to help them make decisions on the ground and in
7 practices with patients. NHS England felt that
8 their sign-off process for guidance going out as
9 a joint piece of work would take some time, and as
10 BMA and RCGP, together, we felt that was too long
11 for our members to actually wait so we went ahead
12 and produced it together, having discussed it with
13 NHS England and CQC.

14 **Q.** In your view was there any discernible
15 impact of NHS not endorsing the guidance?

16 **A.** Yes, there was, and there was concern
17 from our members at the time that by not having the
18 endorsement of a national body rather than
19 a membership body meant that our members weren't
20 sure who was taking responsibilities for these
21 decisions, and inevitably it fell back to the
22 individual doctors who made the decision on the day
23 to do it and they sometimes didn't feel that was
24 an appropriate level of risk that they were taking
25 if they decided not to see if they decided to follow

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1 maybe take the bulk of the work, patients wanted it
2 done and trusted GPs and places where they knew
3 vaccination was given safely year after year to do
4 this for them, particularly with a new novel vaccine
5 that hadn't been used before and when they had
6 not -- many of my elderly patients, when they came
7 to the first vaccine clinic in December 2020, it was
8 the first time they'd left the house since the
9 beginning of the lockdown, so they wanted somewhere
10 safe, somewhere they knew, but it meant that a lot
11 of our workforce was diverted for a time into
12 delivering vaccines.

13 **Q.** Just to give some figures to this -- this
14 point, you explain at your paragraph 78 that between
15 December 2020 and June 2022, primary care delivered
16 over 63 million vaccinations in England?

17 **A.** Yes.

18 **Q.** At paragraph 65, you say that by the end
19 of October 2021, GP practices and community
20 pharmacies had delivered 71% of all doses of the
21 Covid-19 vaccine administered in England?

22 **A.** That's correct.

23 **Q.** Does that give a sense of the scale of
24 it?

25 **A.** It was enormous scale that it was

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1 happening on -- across the whole country, where GPs,
2 practice groups and communities had got together as
3 group -- GPs to -- and our teams, to do this. And
4 many teams and many volunteers joined in that. So
5 it often felt a community thing as well. Our
6 volunteers from various surgeries would man the
7 staffing of it, security, all those things, and
8 people came together to deliver millions and
9 millions of vaccines.

10 **Q.** Can we please have on screen
11 INQ000492272.

12 These are results from a survey that the
13 RCGP published at the end of January 2021, so in the
14 early stages of that vaccine roll-out.

15 In the first row, right-hand column, we have
16 81% of respondents concerned about being able to
17 deliver essential business-as-usual work on top of
18 the vaccination programme?

19 **A.** Mm-hm.

20 **Q.** In your view, was this fear borne out as
21 GPs played their part in the vaccination effort?

22 **A.** I think GPs are very good at turning
23 their hand to the immediate work that needs done to
24 help them protect our patients, and we know that the
25 work of many of the chronic clinics that we do, many

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1 Now, no matter how many times I try and add
2 those up, I make 99 but, setting that aside, would
3 it be fair to describe this as a mixed picture?

4 **A.** Yes.

5 **Q.** Next, let's go to the December survey,
6 INQ000492277. We have the same question at 9. This
7 time, the net negative figure is 80 per cent.

8 Taking these two results together, what do
9 they tell us about the experience of working in
10 general practice between July and December 2020,
11 Dr Mulholland?

12 **A.** I think they reflect some of what we had
13 in that earlier slide showing that the workload had
14 increased between the beginning of the pandemic and
15 the 127 per cent the Welsh GPs reported by December
16 2020, that the workload was going up, the demands
17 were higher, the stresses were higher. Many
18 practices had seen both doctors, staff, patients get
19 sicker during that time as well, with lots of
20 anxiety about were the right thing was to do both in
21 practice and personally at home where many of our
22 colleagues and staff had been affected personally by
23 Covid impacting them with illness.

24 **Q.** Can you help us with the attrition rate
25 during -- and please don't limit yourself to the

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1 of that follow-up side, the long-term conditions,
2 probably did take a back seat as we provided acute
3 care for those that needed it on the day and
4 immediate care and for the vaccine clinics.

5 Staff were diverted -- and with time we saw
6 that different groups of people were able to do the
7 vaccine clinics and it didn't require so much of
8 a clinical GP or nurse-led programme, but very early
9 on it was predominantly practice staff that were
10 doing the vaccinations.

11 **Q.** New topic, please: the impact of the
12 pandemic on the mental and physical health of those
13 working in general practice.

14 On mental health, can I approach this topic
15 by looking at two surveys conducted by the RCGP, one
16 in July 2020 and the second in December 2020.

17 First, please, INQ000492269. Let us
18 consider the responses to question 17, to what
19 extent, if at all, would you say your experience of
20 working in general practice during the Covid-19
21 pandemic has had an impact on your wellbeing.

22 If we net those responses, we have: net
23 positive 25 per cent; net negative 46 per cent;
24 neither positive nor negative 27 per cent; don't
25 know, 1 per cent.

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1 second half of 2020 but throughout the pandemic --
2 did you see an increase in the numbers of people
3 leaving general practice?

4 **A.** Sorry, I didn't -- I don't have that
5 figure to hand.

6 **Q.** Anecdotally, can you help us
7 Dr Mulholland?

8 **A.** I think anecdotally we're aware that
9 people found it very difficult. Those who had
10 vulnerabilities did not want to work. We had great
11 difficulty early in the pandemic with a lack of
12 central guidance as to help stratify the risk that
13 clinicians would face. So many organisations
14 created their own risk stratification and practices
15 were often left to design or choose what is used to
16 say whether it was safe for staff to work or not.

17 My own practice, doctors of a minority ethnic
18 background we supported them to stop seeing patients
19 face-to-face which naturally created an extra stress
20 for others, but they felt a real vulnerability
21 during that time and for some of those doctors --
22 fortunately not in my practice, but others did find
23 that they did not want to return to face that
24 afterwards.

25 **Q.** Just on that point, at your paragraph 106

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1 you say this:

2 "There was a lack of guidance from the NHS
3 on which staff should be considered as most
4 vulnerable to Covid-19."

5 Help us: in the absence of such guidance,
6 what did individual practices do to assess the risk?

7 **A.** There was some guidance came out from
8 different groups. One I remember from the British
9 Association of Physicians of Indian Origin, one from
10 the General Practice Committee, I think it was, of
11 the BMA, they gave us some guidance based on what we
12 thought the risks of Covid were at that time,
13 whether it was the ethnicity, age, obesity, other
14 things were in those lists of vulnerable categories.

15 And practices often wrote to their staff and
16 said, "Where do you fit on these?" and then rated
17 them on hand and practices then had to make
18 a decision for themselves whether they could run the
19 service and who worked and who didn't so it was very
20 much an individual practice decision as to who was
21 able to be off and who couldn't and smaller
22 practices really struggled because they may have
23 only had a few members of staff there. To have
24 someone off meant the service wasn't able to be
25 worked.

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1 developed what was called the "Covid hub" where we
2 had resources explaining initially what the virus
3 was, what we thought the symptoms were, what the
4 response should be, right through to ethical
5 concerns that we may come to later.

6 We had over the first year of the pandemic
7 a million hits from healthcare practitioners across
8 the world because we opened this up not just to our
9 own members but to all healthcare practitioners
10 worldwide, and in that space we had a million hits,
11 people looking for the information that as RCGP we
12 pride ourselves that what we put out as continuing
13 professional resource is reliable, it's accurate,
14 it's evidence based and that then became a standard
15 others could use wherever they were.

16 **Q.** Can I ask you about testing. It's right,
17 isn't it, that early on the RCGP pressed for GPs and
18 their families to be prioritised for testing? The
19 phrase used was to test "the right people at the
20 right time".

21 Why was it so important to prioritise GPs for
22 testing in your view?

23 **A.** I think we recognised that GPs are the
24 front door of the NHS for most people -- we do
25 1.2 million consultations a day normally -- and if

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1 **Q.** In your view, is that a good situation
2 for individual practices to be in?

3 **A.** No, it wasn't. And I think, again, part
4 of that was certainly in the early parts we didn't
5 have the access for people to work from home where
6 they could have worked more safely remotely. They
7 all felt in many places had to be in work, seeing
8 patients face-to-face where the risks were much
9 higher.

10 **Q.** At your paragraph 52 onwards,
11 Dr Mulholland, you set out a number of actions that
12 the RCGP took to support the wellbeing of GPs.

13 **A.** Mm-hm.

14 **Q.** Can you take us through some of those,
15 please?

16 **A.** The RCGP pivoted all our work in March
17 2020 to focus entirely as we saw the pandemic
18 approaching us and going to affect healthcare in
19 England, or in the UK, that we thought we needed to
20 actually purpose all our work into helping GPs get
21 through this. So we started to focus our
22 advocacy -- was to help advocate for policy and make
23 sure that NHS England and the other bodies were all
24 focusing on what GPs needed in that space.

25 We also developed resources for our members,
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1 that clinical frontline workforce was not available,
2 there was a huge gap for the NHS which would then
3 struggle to provide the care that many patients
4 needed at that time.

5 We extended it to families because we knew
6 that if a family member became ill in the immediate
7 family that often meant that the clinician was also
8 off work. Clinician -- also our receptionists, the
9 admin teams that back up general practice day to
10 day, we felt it was important to keep that service
11 functioning as key frontline NHS work.

12 **Q.** At your paragraph 121 you tell us this:

13 "In December 2021, the chair of the RCGP was
14 still expressing concern that GP staff were
15 struggling to access Covid-19 tests."

16 Is that a real concern to you that even at
17 the end of 2021 GPs found themselves in this
18 position?

19 **A.** Absolutely. It felt at times that
20 general practice was a second thought or an
21 afterthought in planner's minds, that hospitals were
22 often prioritised, as we saw it, in the thinking
23 that was going on and general practice and the
24 services and the testing and everything else came as
25 an afterthought to that.

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1 Q. You're not in their minds. But help us,
2 as someone who has been with the RCGP in an active
3 role for some time, why do you think it is that
4 general practice becomes, in your words, an
5 afterthought?

6 A. I think general practice is often felt
7 that there's a lack of what we call parity of esteem
8 between primary care and our secondary care
9 colleagues and that has been something that has gone
10 on for many years. In the context of the pandemic,
11 the -- primary care sees patients one at a time,
12 usually fairly quietly. People don't come into our
13 rooms to see it. We have someone with a bad
14 infection, we refer to a hospital. We don't have
15 the same services and -- excitement, if it were, of
16 an A&E department where things are happening very
17 rapidly and quickly and ambulances go to them. We
18 have usually quite quiet conversations. Our
19 consultations are very different.

20 So general practice is a different
21 environment and the funding of the NHS is over
22 90 per cent to secondary care services, so that's
23 where many perceive the NHS works. The 10 per cent
24 or the less than 10 per cent in general practice can
25 be perceived as less important potentially to some

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1 room, potentially in a building that shouldn't --
2 that wasn't entirely fit for seeing patients, an old
3 converted house or whatever. And so we were very
4 concerned --

5 **LADY HALLETT:** Slow down, please?

6 A. Sorry.

7 **LADY HALLETT:** The stenographer is doing
8 a brilliant job but it's really difficult.

9 A. Apologies, my Lady.

10 That we were concerned at the amount or the
11 adequacy of the PPE that people were receiving and,
12 if it was adequate, that we didn't have sufficient
13 information to reassure our members that it was
14 adequate and the appropriate thing for us to be
15 using.

16 **MR MILLS:** Did the RCGP take action to try
17 and resolve the issues its members were raising
18 about PPE?

19 A. Yes, we publicly express concern in
20 26 March 2020 about the availability and guidance
21 for PPE and wrote to the Secretary of State for
22 Health and Social Care, asking for clarity as to
23 what was happening and asking about whether GPs
24 should begin wearing PPE for all face-to-face
25 consultations because, even at that stage, after the

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1 if they're thinking in big picture terms.

2 Q. Finally, my Lady, before perhaps we take
3 an afternoon break, can we return, Dr Mulholland, to
4 my favourite survey, INQ000492268.

5 This is the end of March 2020, question 4(b),
6 please, on PPE. 94 per cent of respondents thought
7 it was very important or quite important to have
8 more guidance on how to use PPE. Can you help us:
9 in which particular areas were GPs most searching
10 for further guidance? Thinking about fitting, when
11 to wear it, what to wear in certain situations?

12 A. All of those. And what to use and what
13 we had, what we should be doing with them -- excuse
14 me -- there was a concern that rose as we saw PPE
15 being used in other countries, on television and the
16 news, and what we were being told about in the NHS
17 was different. What was being supplied to us was
18 different. We had reports from GPs of out-of-date
19 PPE arriving at their practices to be used that had
20 gone before the best before dates.

21 We had concerns that the WHO had issued
22 guidance that was different to the UK guidance,
23 which naturally made GPs anxious that we wouldn't be
24 seeing patients in well air-conditioned, ventilated
25 places; we would be seeing them in a consultation

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1 national lockdown, or around the time of the
2 national lockdown, we still did not know whether
3 there was a national recommendation for us to use
4 face-to-face or use masks in face-to-face
5 consultations.

6 We continued to advocate as we went along.
7 We recognised there was an improvement in PPE a week
8 or so later when some guidance came out, but there
9 was still concerns amongst members whether we had
10 the right face masks, whether the guidance we were
11 being given was correct, and whether eye protection
12 was needed -- things like that that weren't entirely
13 clear.

14 **MR MILLS:** My Lady, I'm about to move on,
15 would that be a convenient moment?

16 **LADY HALLETT:** Certainly. I hope you're
17 warned that we take breaks, Dr Mulholland. I shall
18 return at 3.30.

19 **(3.15 pm)**

(A short break)

20 **(3.30 pm)**

21 **LADY HALLETT:** Mr Mills.

22 **MR MILLS:** My Lady.
23 Dr Mulholland, shielding.

24 At your paragraph 155 you say:

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1 "The decision to designate some of those at
2 high risk to be part of a 'shielding' group caused
3 an immense amount of work in general practice."

4 What steps did someone working in general
5 practice have to take in order to, first, identify,
6 and then, second, communicate a person's shielding
7 status?

8 **A.** The shielding policy came in at the end
9 of March 2020 when GPs were informed and asked to
10 identify the most clinically vulnerable, which meant
11 us (a) knowing a list of those people thought to be
12 most clinically vulnerable, then doing searches on
13 our practice computer systems to try to identify
14 those people, following which they needed to be
15 contracted by the practice teams in some way to
16 inform them of this, and then put in the steps in
17 the form of what else needed done after that.

18 **Q.** Were there issues caused by the function
19 of data, for example issues with how illnesses or
20 medications were coded, or examples of prescriptions
21 not making it into a person's medical records?

22 **A.** Indeed, yes. The patients that were
23 clinically vulnerable with the disease that we had
24 coded in general practice were relatively
25 straightforward to search for, but there were

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1 hadn't been set up before the announcement was made,
2 and so the data was not flowing between our
3 organisations to patients to -- it seemed to be
4 going backwards, so that patients were aware they --
5 there was going to be shielding, after which we were
6 doing the searches, after which our secondary care
7 colleagues were trying to connect with us to make
8 sure the searches were correct, leaving the patients
9 vulnerable and confused at the end of it all.

10 **Q.** Were there instances of patients calling
11 their GP practice to say, "I think I ought to be
12 shielding, I haven't received a letter, can you help
13 me"?

14 **A.** Absolutely, yes, we made many, many calls
15 from patients asking just those questions, because
16 they had understood from what they had read or seen
17 on the news that they were in the shielding groups.
18 Although sometimes the detail of what the shielding
19 group was hadn't been communicated in those reports,
20 so they weren't actually in the right groups but
21 required our teams to spend time going through that
22 data very carefully to work out. Often leading to
23 some difficult conversations by admin staff or the
24 doctors, clinicians themselves, trying to explain
25 why someone who felt vulnerable wasn't in the -- on

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1 medications that sometimes were prescribed by
2 hospital specialists that identified someone as
3 being clinically vulnerable, and they were then --
4 needed to be searched for in hospital systems that
5 don't connect with our own general practice ones,
6 and somehow that information shared between us.

7 There was then other challenges between --
8 that required the secondary care and primary care
9 systems to be connected by NHS Digital to make sure
10 that we could really identify those.

11 Patients were also asked to self-identify at
12 one stage, during the early stage of shielding, and
13 those records all needed checked back to make sure
14 they were the people that had been prioritised and
15 set out as being clinically vulnerable.

16 Sorry, my Lady.

17 **Q.** In your view had there been conflicting
18 communications about who needed to shield?

19 **A.** Some of the variation was based on our
20 understanding of Covid-19 at the time, that
21 initially we thought that people with diabetes
22 should be shielded, and then shouldn't be shielded,
23 and at a later stage went back onto the shielding
24 list.

25 The groups that needed to do the searches

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1 one of these extremely vulnerable lists.

2 **Q.** Was there flexibility within the system
3 for a GP who had a patient not on the shielding list
4 to advise them to shield nonetheless?

5 **A.** We could advise any patient to shield if
6 we thought they were vulnerable, but it didn't
7 always connect then with the national picture of who
8 should be. And at the start of the pandemic there
9 were some things that happened if you were on the
10 extremely vulnerable list, like there were food --
11 food delivery prioritisation, because people were
12 staying at home and not going out. And that didn't
13 happen for those patients that we identified
14 necessarily.

15 **Q.** Moving on, please, Dr Mulholland, to
16 DNACPR.

17 At paragraph 208 you say this:

18 "There was a lack of central guidance for
19 GPs on DNACPR and how best to implement the policy."

20 Help us, what was the basis for your view
21 there?

22 **A.** The RCGP doesn't and still doesn't have a
23 role in formulating policies, and we recommend that
24 for clinicians and GPs on the ground that every
25 DNACPR decision or advanced care planning decision

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1 is one taken by the clinician and the patient in
2 a shared decision-making process, where they decide
3 what the best options are for our patients, and they
4 decide the best option for themselves, and we come
5 to an agreement about that, about how they want to
6 proceed with their care and future wishes should
7 they die.

8 **Q.** At 211 you say:

9 "[You] heard nationally that GPs were
10 pressured to make these decisions [DNACPR decisions]
11 at speed, and without time for adequate discussion
12 with patients and families ..."

13 What were the causes of that pressure?

14 **A.** We'd heard of reports of GPs being asked
15 to do frailty scores, and at the time NICE, the
16 National Institute of Clinic Excellence, had set out
17 some guidance for those working in the intensive
18 care setting or the hospital setting as to who maybe
19 should be -- how you would prioritise using
20 a frailty score for those going forward for
21 intensive care treatment. And it seemed that --
22 although we don't have the exact information where
23 this happened -- that some GPs were being asked to
24 do frailty scores on either patients in care homes
25 or their elderly, vulnerable -- or more ill

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1 everything that we normally did, that a shared
2 decision-making process was the way to make these
3 decisions, not blanket decisions for populations.

4 **Q.** How is a statement like this shared with
5 those working on the ground in general practice? Do
6 they receive an email?

7 **A.** I can't remember the detail of how we did
8 it, but in the RCGP, we would've put it in our
9 weekly blogs, we would've put it in email
10 correspondence that we have with members, and
11 I suspect the other organisations were doing
12 similar. So we hoped that we would convey the
13 information out as fast as we could to as many
14 doctors as possible.

15 **Q.** Can you take us through, Dr Mulholland,
16 the instruction that is contained in this statement
17 and help us with what it was designed to achieve?

18 **A.** This statement talks initially about
19 a person -- the importance of having personalised
20 care plans, which we believe is what every patient
21 should have as their care is becoming more complex.
22 We discuss what we prioritise, what we don't.
23 Specifically older patients, those with frail,
24 serious conditions. And during the pandemic these
25 conditions were worsening and Covid was making some

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1 patients, and complete escalation plans and
2 documents, DNACPR decisions, or CPR decisions.

3 **Q.** Please can we have on screen
4 INQ000400508.

5 We will come to the substance of this in
6 a moment.

7 But we can see here, can't we, that on
8 1 April 2020 a joint statement on advance care
9 planning was published which the RCGP co-authored
10 with the BMA, the Care Provider Alliance and the
11 Care Quality Commission.

12 Can I start with this. What prompted the
13 development of this joint statement so early in the
14 pandemic?

15 **A.** I think it's what I just referred to,
16 that we were hearing reports of information being
17 completed by GPs, either being encouraged to by
18 systems or because they felt that was the guidance
19 they were getting. And some of them were feeling
20 pressured, they were feeling uncomfortable, that
21 they didn't feel it was the right thing to do, and
22 were informing the college that this was happening.

23 And we felt it was very important for our
24 patients and our members that we gave -- set out as
25 clear guidance as we could that we still believed

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1 of these patients very ill.

2 It moves on to talk about capacity. And
3 what we believe is that every patient has capacity,
4 has the right to make their own decision, and it
5 should be discussed with them. An advanced care
6 plan is what you put together with the patient, not
7 something that you provide for them.

8 And if someone doesn't have capacity we work
9 with family carers, those responsible, with them, to
10 make what's called a best interests decision for the
11 patient, involving as many people as we can who know
12 the patient well.

13 Sometimes an advanced care plan in some of
14 my palliative care patients includes a statement
15 where they have decided that should they die they do
16 not want cardiopulmonary resuscitation attempted.
17 And we would put that into a care plan for some of
18 those patients that are often on a palliative care
19 journey because of cancer or some other illness.
20 But these are individual decisions, they were
21 individual before the pandemic, we recommended and
22 said they should be individual decisions during it,
23 and we continue to work on that basis.

24 And then the last statement was because of
25 the thoughts that we'd -- or the things that we'd

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1 been hearing, it is unacceptable for advance care
2 plans, with or without a DNR form, to be applied to
3 groups of people of any description, because that
4 immediately removes the individual choice, and that
5 was just something we thought was such a clear line,
6 we needed to make it -- reiterate it to all
7 practitioners as fast as we could.

8 **Q.** Thank you.

9 Can I return momentarily to the concerns
10 that were being raised.

11 You've said GPs were being asked to make
12 these decisions.

13 Can you help us, who was asking GPs to make
14 these decisions?

15 **A.** We understood that some of these were
16 coming from system -- the healthcare system, so CCGs
17 or otherwise. And whether it was formally or
18 an informal feeling that GPs had to protect the NHS,
19 they should be limiting the number of referrals in
20 to hospital or setting out advance care plans that
21 would say "I do or don't go in for further care" or
22 "I do or do not receive resuscitation".

23 So it was informal feedback that was coming
24 in to us, but we understood it to be from clinical
25 commissioning groups who were the system providers

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1 Let's consider the answer to the second
2 question:

3 "Do you have a long-Covid clinic you can
4 refer to?"

5 23 per cent, yes.

6 What did the 77 per cent of GPs who did not
7 have access to a Long Covid clinic in practice do
8 with patients who presented to them with Long Covid
9 symptoms?

10 **A.** In practice they would've had to manage
11 them themselves, as best they could, with the
12 information available.

13 The RCGP had started to hear concerns about
14 patients having prolonged symptoms following
15 an infection with Covid quite early on during the
16 pandemic. And we started to talk with our research
17 colleagues around the country to look at it, we
18 monitored feedback and talked to members. And RCGP
19 then joined, for the first time, with NICE, the
20 National Institute of Clinical Excellence, and SIGN,
21 the Scottish guidelines network, to write the first
22 definition of Long Covid, or post-Covid syndrome, as
23 it was known then, as joint stakeholders or joint
24 writers with the two guideline organisations.

25 In that we started to set out what was known

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1 at that -- the commissioners at that time.

2 **Q.** After the publication of the joint
3 statement did those concerns continue to be raised
4 with the RCGP, or was a real change perceived?

5 **A.** We heard from GPs who felt pleased that
6 we'd made such a clear statement and so quickly in
7 the early pandemic. We also went on to produce very
8 clear guidance. We involved the Royal College of
9 GPs ethics committee, who spent time working with
10 the teams to produce, on our Covid hub, an ethical
11 resource hub, which included how GPs could approach
12 end of life decision, advance care planning
13 decisions, working through it with scenarios that
14 they could learn from.

15 So it was a learning place as well as
16 a reference point that GPs, who were dealing with
17 difficult ethical issues at the time, would be able
18 to work through and see what best practice should
19 look like.

20 **Q.** Can I move to our penultimate topic,
21 Dr Mulholland, Long Covid.

22 Please can we have on screen INQ000492271.

23 These are the results of an RCGP survey
24 conducted between August and September 2020 about
25 Long Covid.

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1 about Long Covid or post-Covid syndrome, set out
2 symptoms that GPs could start to look for and
3 recognise and to -- the -- best practice that we
4 knew of at the time in terms of management of Long
5 Covid symptoms.

6 **Q.** Finally this, lessons and
7 recommendations.

8 We began your evidence this afternoon,
9 Dr Mulholland, by exploring the resilience of
10 general practice at the start of 2020.

11 Can I ask you this. If another pandemic was
12 to strike next year, in your view is general
13 practice in a better or worse condition to cope now
14 than it was in March 2020?

15 **A.** I think general practice is probably in
16 a worse condition than it was at the start
17 of March 2020, demand and responding to patients'
18 needs and access and the requirements has risen.
19 Our waiting lists across the country and -- in all
20 hospital specialties have risen dramatically, and
21 that workload, while patients wait for care in a
22 hospital, ends up coming back to GPs and our
23 practices and our practice teams.

24 We feel that to be able to meet current
25 demand, let alone a pandemic or a stress on the

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1 system, from another illness that came through the
2 country, we need to be significantly better
3 resourced, significantly better both in terms of
4 finance coming in, but workload and workforce in --
5 workload reduced and workforce increased to make it
6 possible to be able to treat the number of patients
7 and provide the care for them that is needed.

8 So that we could both continue to treat the
9 new illness as well as manage all the illness that's
10 in the community already and our patients and our
11 populations need looked after.

12 **MR MILLS:** Dr Mulholland, thank you.

13 My Lady, that's all I ask.

14 **LADY HALLETT:** Thank you, Mr Mills.

15 Ms Iengar.

16 Although it is natural to look at the
17 questioner, Dr Mulholland, but it's really important
18 we get your evidence transcribed, so keep speaking
19 into the microphone, please.

20 **Questions from MS IENGAR**

21 **MS IENGAR:** Dr Mulholland, I appear on behalf
22 of the Long Covid groups. I have a number of
23 questions and a very short period of time.

24 My first question is from the perspective of
25 the physical impact of Long Covid on your members.

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1 Then my next questions look from the other
2 side of the coin: the impact of Long Covid on your
3 members as clinicians caring for patients with Long
4 Covid.

5 You said this afternoon that quite early in
6 the pandemic GPs started observing and reporting to
7 your college that a significant number of patients
8 were presenting with what we now know is Long Covid.

9 Are you able to assist us with the timestamp
10 of what is "early in the pandemic", roughly what
11 month the college was receiving these reports?

12 **A.** One moment while I try to ...

13 **Q.** It's -- you refer to it quite early in
14 the pandemic, it's 195 of your witness statement.
15 There isn't a timestamp in the statement itself.

16 **A.** I think at that stage it was anecdotal.

17 We report that in July 2020 we were talking
18 to our clinical adviser group, seeking their
19 opinions on -- the clinical advisers are a group of
20 GPs who work for the clinical policy team and
21 provide advice and support when we deal with
22 consultations, when we have clinical questions, and
23 it was from that group that we understood that this
24 was becoming an increasing phenomenon throughout the
25 country that patients were having these prolonged

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1 You've said in your witness statement -- it's
2 paragraph 110 for your reference -- that:

3 "Many GPs have been impacted by 'Long Covid'
4 and ... [that several of them] are no longer able to
5 work because of ongoing symptoms."

6 Are you aware of any support that is
7 specifically available for GPs with Long Covid who
8 are no longer able to work?

9 **A.** I'm not aware of any particular support
10 for GPs with Long Covid beyond what is available on
11 the NHS for everybody. There are various services
12 from practitioner health, the NHS and the NHS GP
13 service, but not specifically for Long Covid.

14 But we're aware of that group of GPs that
15 have -- had Covid during the pandemic and since that
16 now have symptoms that are stopping them working.

17 And as mentioned in our evidence, there isn't
18 a GP occupational health service that does -- it
19 doesn't exist and that is something that would be
20 a development that would allow us to be able to get
21 proper help for those GPs that become ill.

22 **Q.** So that would be a development you say
23 was necessary?

24 **A.** Absolutely.

25 **Q.** Thank you.

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1 symptoms.

2 **Q.** So those conversations began
3 in July 2020, so is that when the reports would have
4 been received by --

5 **A.** The reports would've been received
6 before July.

7 **Q.** Before July.

8 **A.** And then put to our advisers for
9 confirmation in July 2020.

10 **Q.** Thank you.

11 You've said -- you've explained that the
12 college engaged directly with decision-makers and
13 politicians, and you've named the Secretary of State
14 for Health, the four CMOs, Sir Simon Stevens of NHS
15 England, Public Health England, and then the DHSC,
16 who you say you lobbied to commission the NICE
17 guidelines on Long Covid.

18 Would those reports of the significant
19 numbers of patients with Long Covid have been shared
20 with any of those stakeholders that you were in
21 conversation with?

22 **A.** I'm sure that the information would've
23 been shared with them at the time if they were being
24 lobbied. I wasn't at the meeting so I'm afraid
25 I don't know that detail.

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1 Q. So you can't tell us which of those
2 bodies the college might have shared the earlier
3 reports of Long Covid with but you assume that they
4 were shared?

5 A. They would've been shared. I'm just
6 checking my notes ...

7 But we were talking to NICE and SIGN from
8 around July or August 2020. At that stage I'm sure
9 we'd have shared it in other meetings that we were
10 at. As the evidence -- or as my report said, that
11 we were having consultations weekly with NHS
12 England, Sir Stephen Powis and Sir Chris Whitty
13 during that time and we would've been bringing it up
14 in discussion in those meetings. But I don't have
15 documentation for those.

16 Q. But you say the CMOs would've known by
17 then, by July 2020?

18 A. Yes.

19 Q. Thank you.

20 And surveys carried out by the Long Covid
21 groups in September 2020 and then again
22 in April 2021 record that many patients reported not
23 being believed by their GPs for the symptoms they
24 were suffering from and GPs not knowing how to help
25 them.

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1 of UKHSA said in oral evidence last week that there
2 isn't standardised coding of Long Covid, which is
3 not correct, is it, because you say at paragraph 201
4 of your statement that RCGP created new codes for
5 Long Covid as soon as the NICE definition of Long
6 Covid was published in 2020.

7 So codes were in place for Long Covid by
8 December 2020. That's right, isn't it?

9 A. That's correct. I think it was called
10 post-Covid syndrome, was what it was classified by
11 NICE, and that's what we worked for the PRSB, the
12 public records standards body, and NHS Digital to
13 have put in place.

14 Q. In relation to that coding, both NHS
15 England and your own college have noted that coding
16 on Long Covid is essential for public health
17 planning.

18 So we need to know how many people are
19 suffering from long-term symptoms in order to model
20 demand and plan for service delivery.

21 And the college, your college, in June 2021
22 reported to the Long Covid ministerial round table
23 that one of the key areas it was working on was
24 improving coding on Long Covid because there was
25 a disparity between coded figures and ONS figures on

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1 That's something that's mirrored by your
2 college's own surveys. You were taken to the survey
3 of September 2020 where GPs say they were not very
4 confident in treating patients with Long Covid
5 symptoms.

6 Dr Mulholland, do you believe that the NSS
7 and Public Health England could have done more to
8 support primary care clinicians in anticipating and
9 responding to Long Covid?

10 A. I think as this was -- it was the second
11 new disease our members were facing that year. They
12 were learning how to understand it. It was
13 unexpected that came out on top of the pandemic and
14 the Covid infection itself. The support from around
15 the healthcare system would've been appropriate and
16 good if we'd all had more of it. It was the RCGP
17 that -- we wrote a top tips document for GPs or --
18 we approached NICE and SIGN and got this done,
19 because we felt that was the fastest and most
20 appropriate way we could get that information out to
21 our GP colleagues.

22 Q. My final set of questions, Dr Mulholland,
23 is on data collection and coding of Long Covid by
24 GPs.

25 Firstly and very quickly, Professor Hopkins
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1 the prevalence of Long Covid.

2 My question, Dr Mulholland, is: has the use
3 of coding for Long Covid in 2024, so now, has it
4 improved so that it's an accurate data source for
5 prevalence of Long Covid?

6 A. I'm afraid I don't have that information.

7 Q. And finally, Dr Mulholland, my question
8 involves looking forward and your opinion on whether
9 you can assist the Inquiry with any observations on
10 how improvements could be made to ensure that
11 accurate and consistent use of coding systems for
12 long-term sequelae of novel viruses by primary care
13 practitioners are correct from the outset?

14 A. I think the model that we had where NICE
15 and SIGN and the RCGP worked together to define the
16 condition and then our work to get coding systems in
17 place was the start of it. The next step would've
18 been to potentially spread this wider and make sure
19 that it was in everybody's consciousness, I guess,
20 that we use it the same way as we use other codes.

21 People probably were still learning about the
22 disease in 2021, or the end of 2020, and time would
23 be to develop that, but it could still be developed
24 that people should be able to use the code more, as
25 it becomes more familiar.

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1 There was the challenge as well within this
2 one that some people called it "Long Covid" and
3 other people "post-Covid syndrome"; I'm not sure if
4 that made a difference in the number of coding
5 episodes we have on the computers.

6 **Q.** So Dr Mulholland, just following on from
7 that, when you say that it's in everyone's
8 consciousness, I glean from that that you mean that
9 there is more training and more education on the
10 coding of Long Covid to ensure that primary care
11 practitioners are consistently applying it and
12 understand that post-Covid and Long Covid denote the
13 same illness?

14 **A.** Yes.

15 **MS IENGAR:** Thank you.

16 Thank you, Dr Mulholland.

17 **LADY HALLETT:** Thank you, Ms Iengar.

18 Mr Thomas, I think you have moved over there.

19 Yes.

20 That way, Dr Mulholland.

21 **Questions from MR THOMAS KC**

22 **MR THOMAS:** I am representing FEMHO, the
23 Federation of Ethnic Minority Healthcare
24 Organisations, which advocates for the health and
25 wellbeing of black, Asian and minority ethnic

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1 there is a risk of a digital inverse shared care
2 law, as Professor Edwards described the shared care
3 law earlier, about some populations not getting the
4 care despite the need.

5 We recognise that there was -- some
6 populations didn't have the same digital access as
7 others. And I think some of our work within the
8 health and equalities group has shown that some of
9 the black, Asian and minority ethnic groups fall
10 into some of those places where digital access was
11 less available. And so that would've impacted them
12 adversely.

13 **Q.** Just as a follow-up, what was done to
14 address that?

15 **A.** Ourselves -- our health and equalities
16 group work very hard to try to help members
17 recognise groups that could be adversely affected.
18 On our Covid hub that I described earlier we did
19 have a particular section written by our health and
20 equalities group at the college outlining ways that
21 groups might be contacted, might be noted, might be
22 supported in different ways. And that included not
23 only black, ethnic -- minority ethnic community, but
24 also those with learning disability and others that
25 may not be accessing the service in the same way.

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1 healthcare workers and patients who were
2 disproportionately affected by the pandemic.

3 FEMHO is particularly concerned about how
4 the pandemic impacted patient contact and access to
5 care for ethnic minority patients.

6 In your witness statement you mention
7 various factors that contributed to the fall in
8 patient contacts during the pandemic.

9 **Question:** were there, in your understanding,
10 reduced contacts from black, Asian, minority ethnic
11 patients during this time?

12 **A.** Yes, I believe there was a lack --
13 a reduction in all groups of patients, but possibly
14 particularly.

15 **Q.** Building on that then, you discuss the
16 shift to remote care during the pandemic in your
17 statement. FEMHO is concerned about how this move
18 might have impacted black, Asian and minority ethnic
19 patients, especially in terms of their access to
20 primary care.

21 **Question:** so how did the move to remote care
22 impact the ability of black, Asian and minority
23 ethnic patients to access primary care during the
24 pandemic?

25 **A.** I think in the evidence we described that
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1 **Q.** Lastly, FEMHO is keen to understand the
2 issue of racial bias in medical devices,
3 particularly the pulse oximeter which you refer to
4 in your statement.

5 You see, this is of particular concern given
6 that black, Asian and minority ethnic patients were
7 disproportionately impacted by Covid.

8 **So, question:** what, if anything, was done by
9 the Royal College of General Practitioners once it
10 became known that there was racial bias in the pulse
11 oximeter?

12 **A.** We became aware that when it was
13 published in December 21, I believe -- 2020/2021,
14 I can't remember which one offhand -- and would've
15 informed our members, I looked earlier, and I don't
16 have a record of the communication, it may have been
17 through our Chair's blog which went out weekly, but
18 we wanted to inform members that in subsequent
19 webinars or resources that were published it
20 would've been highlighted in that as well. So that
21 GPs became aware that there was a bias in the way
22 that pulse oximeters picked up --

23 **Q.** Would you agree that more could and
24 should've been done? Would you agree with that?

25 **A.** Not being able to exactly recall what was
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1 done, I'm not sure. I think, once we found out
2 about it, there was a need that we did inform people
3 and that people were aware very quickly over that
4 pre-Christmas period that pulse oximeters were not
5 providing accurate readings.

6 **MR THOMAS:** Thank you, Dr Mulholland.

7 Thank you, my Lady.

8 **LADY HALLETT:** On Mr Thomas's question, pulse
9 oximeters weren't new for the pandemic, were they?

10 **A.** No.

11 **LADY HALLETT:** So -- I suppose, why was it it
12 took so long for anyone to recognise this potential
13 for a racial bias, as Mr Thomas has called it?

14 I appreciate, Mr Thomas, you may have felt
15 you were excluded from asking that question, so --

16 **MR THOMAS:** Thank you, my Lady.

17 **A.** That part I'm not aware of. The first
18 research we heard of was New England Journal of
19 Medicine, and very quickly after that people were
20 made aware that this existed. But why nobody had
21 thought of it and explored it before, I don't know.

22 **LADY HALLETT:** So roughly how long have we
23 had these devices in common practice?

24 **A.** They'd become cheaper in common practice
25 and general practice in the past decade, but they've

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1 Do you agree that further improvements to
2 infection prevention and control, particularly to
3 building design and ventilation, remain necessary in
4 GP practices?

5 **A.** Absolutely. I think we're very aware
6 that GP practices have often been set up in
7 buildings that aren't suitable for modern
8 healthcare, and have been adapted and improved to
9 make them fit-for-purpose, but could have
10 significant changes in the way they are designed
11 from the original.

12 My own practice, which was a five-site
13 practice across a rural community, a very small --
14 four/five small practices, we actually had to close
15 one of our practices to patient contact during the
16 pandemic because it was an old converted chapel that
17 did not have sufficient ventilation, did not have
18 sufficient space for patients to move around it, nor
19 for our staff to feel safe within it if consulting
20 with patients who were infected.

21 So I think, yes, there's a real need for many
22 of these older buildings that we have in the general
23 practice estate across all four nations needs to
24 improve to be adequate for some of the modern
25 infection prevention and control.

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1 been around in hospital medicine for many years
2 before that.

3 **MR THOMAS:** My Lady, can I -- just one
4 small -- I mean to say, we're talking years, aren't
5 we, that these devices have been around?

6 **A.** Yes.

7 **LADY HALLETT:** Thank you, Mr Thomas.

8 **Questions from MR WAGNER**

9 **LADY HALLETT:** Mr Wagner, where have you
10 gone? There you are.

11 **MR WAGNER:** Thank you.

12 Good afternoon, I ask questions on behalf of
13 the Clinically Vulnerable Families. I have two
14 areas to ask you about. The first is infection
15 prevention and control in GP surgeries.

16 At paragraph 77 of your statement you say
17 that one of the factors which in your view led to
18 a fall in patient contacts was, and I quote:

19 "Patients being understandably scared of
20 attending face-to-face appointments. GP surgeries
21 are often in buildings where it is not possible to
22 have comprehensive infection controls and there is
23 a large overlap between the groups who attend
24 general practice most frequently and those who are
25 most at risk from Covid-19."

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1 **Q.** Thank you.

2 And would you agree that if that was done it
3 would be helpful in addressing the ongoing problem
4 that some vulnerable patients feel it's not safe for
5 them to access those GP surgeries in -- in those
6 older buildings?

7 **A.** I would hope it would, yes, that some of
8 the patients who are where they are vulnerable
9 because of drugs they are taking or illnesses they
10 have may not want to sit in a waiting room with
11 other people who are coughing or sneezing or
12 whatever else in it. And so if we had better spaces
13 and bigger spaces they may feel safer in that.

14 **Q.** And that's ventilated spaces; is that
15 fair?

16 **A.** That's ventilated, yes.

17 **Q.** And would you also agree that that would
18 help GPs -- GP practices better to prepare for
19 a future pandemic?

20 **A.** Yes. A lot of time went into GPs trying
21 to work out how to separate hot and cold, or red and
22 green parts of their building at the start of the
23 pandemic, with many practices really struggling
24 because they had one way of -- into the building and
25 one way out. Some were lucky to have a way in and

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1 an exit that others could leave through. But it
2 became very difficult for many practices that
3 weren't ever designed as purpose-built health
4 centres to find their way through that.

5 **Q.** So you referred to hot and cold. Can you
6 just explain what you mean by that?

7 **A.** We often refer to the places where you
8 would have Covid or infection, acute infections, as
9 the hot area, and patients that were coming for
10 follow-up of long-term conditions without an
11 infection as the cold area, or the red area and the
12 green area. It was just ways of describing
13 different places that we would -- we needed
14 different areas of prevention and control in them.

15 **Q.** Thank you.

16 And the second and final area I want to ask
17 you about is shielding.

18 You said in your oral evidence, you said
19 there was some difficult conversations by admin
20 staff, or the doctors and clinicians themselves,
21 trying to explain why someone who felt vulnerable
22 wasn't in the extremely vulnerable list.

23 Can you expand on why those conversations
24 were difficult, and was that confusion, in your
25 experience, cause -- causing some distress amongst

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1 illnesses, and sometimes they didn't actually hit
2 the criteria that got them into the clinically
3 extremely vulnerable group. And it's a very
4 difficult conversation to say to someone, "Well, I'm
5 sorry, I know you're at risk, but on this list
6 I have you don't fit that criteria."

7 **MR WAGNER:** Thank you.

8 **LADY HALLETT:** Thank you, Mr Wagner.
9 Ms Munroe, I think it's you.

10 **Questions from MS MUNROE KC**

11 **MS MUNROE:** Good afternoon, Dr Mulholland.

12 **A.** Good afternoon.

13 **Q.** My name is Allison Munroe and I ask
14 questions on behalf of Covid Bereaved Families for
15 Justice UK.

16 My Lady, in fact most of my questions have
17 been addressed either by counsel, Mr Mills, or
18 indeed answers that Dr Mulholland has given to other
19 CPs this afternoon. So just a few matters, please.

20 In relation to shielding, you've just been
21 asked about shielding, but just after our afternoon
22 break, in answer to some questions from counsel
23 Mr Mills, re shielding, you told us what GPs could
24 advise compared to what support patients had access
25 to, et cetera.

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1 the patients?

2 **A.** Yes, it was causing distress. It's hard
3 to remember back to the beginning of the pandemic,
4 looking from where we are now, all in a room
5 together, but patients felt so anxious that they
6 could be the person who got Covid at that stage and
7 could become really ill because we saw it happening
8 around us. That the greater protection you could
9 provide for yourself and others could offer you
10 seemed to be for many the best way forward.

11 So for someone to feel that they were
12 vulnerable enough that they were prepared to isolate
13 for 12 weeks and not talk to someone else or be in
14 their space -- my parents had to do it and they
15 reluctantly said goodbye to the grandchildren and
16 all that sort of thing -- for them to feel that
17 concerned, if someone had turned to them and said,
18 "Actually, you're not that vulnerable after all,
19 you're not as sick as you think you are", was very
20 difficult. And it wasn't saying it that you're not
21 as sick as you think you are, because we often knew
22 that these people were very ill, they just did not
23 hit the list of criteria that we've been given.

24 And so for elderly people -- some of my
25 patients are very elderly but have very few

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1 Now, my first question was on the
2 flexibility of GPs. That's been covered.

3 But sort of bringing together your written
4 and oral evidence, it seems that what you've
5 described is a lack of clarity and changes within
6 the groupings for those who were defined as
7 clinically extremely vulnerable.

8 So bringing that all together,
9 Dr Mulholland, in your opinion was it clear to GPs
10 who should or shouldn't be included within the
11 formal shielding categories and what discretion they
12 had over this?

13 **A.** I don't think it was entirely clear
14 because some of what we were working from was what
15 we thought should be in the shielding category, like
16 people with respiratory illness initially we thought
17 to be at risk, and later less so.

18 So, much of what our experience had been as
19 GPs was based around flu pandemics and the Swine flu
20 and things in the past. This was an entirely new
21 disease that we were dealing with, and nobody was
22 quite sure what made someone extremely vulnerable.
23 But we had seen very quickly and from other
24 countries that some people were more vulnerable than
25 others, very clearly, but we didn't quite know who

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1 they were.
 2 We had to go on the guidance that was given
 3 to us, on the basis that it was given by experts,
 4 and we had to trust that. But we didn't have
 5 enormous flexibility to change it. We could agree
 6 with someone if they wanted to stay at home and
 7 self-isolate, as some of my patients did, we could
 8 support them in that way and deal with them from
 9 telephone calls and home visits, if needed, but we
 10 couldn't actually add them to this clinically
 11 extremely vulnerable list.

12 **Q.** And just following on from that,
 13 Dr Mulholland, do you feel that that lack of
 14 a discretion for the GPs was a hindrance and
 15 potentially a great difficulty for patients?

16 **A.** I think -- I can see it from both sides
 17 that there are times when you thought your patient
 18 was vulnerable, but the evidence you were being told
 19 was no, that group wasn't. The risk would've been
 20 that if GPs had a lot of flexibility many more
 21 people could've been put into the group to shield
 22 and isolate unnecessarily.

23 I can see for other patients that we knew
 24 very closely, because they were patients who we know
 25 their illnesses and what's going on, that maybe they
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1 those have been sufficiently covered this afternoon.
 2 So thank you.

3 **LADY HALLETT:** Thank you for your help, Ms
 4 Munroe.

5 Dr Mulholland, thank you very much for your
 6 help, I am very grateful to you. I hope we haven't
 7 kept you too long today. But what you have to say
 8 is obviously extremely important in relation to
 9 primary care.

10 Thank you.

11 **THE WITNESS:** Thank you.

12 **(The witness withdrew)**

13 **LADY HALLETT:** Very well, 10.00 tomorrow,
 14 please.

15 **(4.12 pm)**

16 **(The hearing adjourned until**

17 **Tuesday, 24 September 2024 at 10.00 am)**

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1 did have other risks that weren't part of that. And
 2 the lack of flexibility putting them into the groups
 3 might have hindered the individual.

4 So with the population level we might have
 5 increased the groups massively if we'd gone from
 6 what we thought was right rather than the evidence
 7 we have. But on an individual level some
 8 flexibility would've been useful.

9 **Q.** Thank you.

10 Next question, and my last question, in fact.

11 In -- different topic -- in relation to
 12 reports that GPs were asked to do frailty scores,
 13 and you touched upon frailty scores this afternoon,
 14 Dr Mulholland, can you comment on whether this
 15 practice disproportionately affected older people
 16 and those with disabilities?

17 **A.** I think all frailty scores are higher,
 18 you have a higher index of frailty depending on the
 19 other illnesses you have, disability, age. So yes,
 20 it would've had more impact on that group because
 21 they would've had higher scores, or depending on the
 22 scale this would've been higher up the frailty
 23 index.

24 **MS MUNROE:** Thank you.

25 My Lady, the other questions were on PPE but
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