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 seeks 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

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

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

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?

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

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

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

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

A. Yes.

Q. How does that work in general practice?

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

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

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

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

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

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

A. Yes, there should be.

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

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

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

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

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

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

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

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

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

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

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

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

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

So some of those services might have been very difficult to deliver in those immediate phases of the pandemic, and that has significant implications in terms of practice income. I believe, on the whole, services were suspended, but with an assurance of income, to enable the practice to keep functioning with its complement of staff.

Q. Thank you.

You've referred to the slight differences

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

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

A. Correct, yes.

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

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

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

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

Q. Thank you.

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

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

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

Q. Thank you.

Looking at the way GP operates across the

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

A. Yes.

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

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

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

A. Yes.

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

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

a university, alongside clinical practice.

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

A. Which --

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

A. Yes, that's right.

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

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

A. Yes, yes.

Q. -- in England?

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

actually very concerning.

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

A. Mm.

Q. -- and how that applies to general practice.

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

A. Okay.

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

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

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

healthcare system.

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

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

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

Q. Thank you.

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

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

available on the Scottish Government website.

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

A. Yes, that's right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Sorry to interrupt again, Ms Nield.

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

A. They develop their own contracts, my Lady.

LADY HALLETT: Right.

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

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

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

LADY HALLETT: Right.

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

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

LADY HALLETT: Sorry to interrupt, Ms Nield.

MS NIELD: Thank you, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

And could we -- thank you.

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

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

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

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

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

A. That's correct.

Q. Thank you.

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

Q. Than you.

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

A. Yes.

Q. This is on page 34 of your report.

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

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

A. That's right.

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

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

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

Q. Thank you.

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

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

Q. What sort of groups of patients would they be?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

The planning did not specifically address

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

Is that a fair summary of your findings?

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

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

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

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

by the seat of our pants.

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

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

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

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

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

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

MS NIELD: Thank you.

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

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

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

And relating to that, thinking: okay, what

does this look like for particular patient groups? The elderly, ethnic minority groups, et cetera.

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

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

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

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

Q. You mentioned there the ongoing long-term

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

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

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

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

getting called and recalled for the ongoing management.

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

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

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

A. That is exactly right, that's the scale.

And just to note that those 400 would not necessarily be 400 different patients, some patients might have had more than one of those conditions. But, yes, 400 missing long-term diagnoses in 10,000 patients.

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

This is on page 54, thank you, Lawrence.

So this is a photo of a typical pulse oximeter.

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

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

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

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

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

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

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

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

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

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

So what was your experience of how that

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

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

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

Q. So how did you use them?

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

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

Q. So that your patients could monitor themselves --

A. Yes --

Q. -- (overspeaking) -- at home, rather than --

A. If they couldn't access one themselves quickly.

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

A. Yes.

Q. Yes.

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

likely to be sicker. Or patients discharged from hospital?

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

A. I don't recall that, no.

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

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

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

A. Yes, three or four months later.

Q. Thank you.

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

pulse oximetry programme in England.

And you say in your report you haven't located any evidence about the extent of awareness of that advice amongst primary care staff.

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

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

Q. Thank you.

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

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

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

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

A. Okay, yes, thanks very much.

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

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

So what that means in reality two-thirds of

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

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

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

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

And if that partner workforce is eroding, as it has been -- over the last 20 years we've lost a quarter of the partner workforce -- that actually has a serious impact on the ability to deliver and develop services going forwards as needs continue to rise.

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

Q. Thank you.

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

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

A. Yes, I think largely stemming from this

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

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

A. I think that's correct, yes.

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

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

Q. So although there's a lack of

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

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

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

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

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

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

comments -- they were the ones which were from GPs amongst a whole range of contributions to that BMA survey.

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

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

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

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

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

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

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

And --

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

You've identified at paragraph 266 that interventions to improve wellbeing are crucial not just for those GPs who are affected but also to improve the resilience of the sector for future pandemics, but you identify that factors that

contribute to poor psychological wellbeing and negative outcomes, such as burnout, are poorly understood.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

A. Thank you.

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

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

11% of the NHS budget into primary care. That's therefore a 30% increase on where we are now.

Just to stand still, I think. Just to deal with the levels of provision that are made in relation to need, which is rising, and the workforce trends, which are actually very significant: reducing full-time equivalent numbers at the time of increasing patient numbers and increasing patient complexity.

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

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

And whilst also thinking about resource,

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

MS NIELD: Thank you very much.

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

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

LADY HALLETT: I have no other questions. I don't think there are any questions from the core participants.

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

THE WITNESS: Thank you, my Lady.

(The witness withdrew)

LADY HALLETT: I shall return at 12.05.

(11.50 am)

(A short break)

(12.06 pm)

MS HANDS: My Lady, may I call

Tracy Nicholls.

MS TRACY NICHOLLS (sworn)

Questions from COUNSEL TO THE INQUIRY

MS HANDS: Thank you.

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

A. Yes, Tracy Lee Nicholls.

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

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

A. That right.

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

A. Yes.

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

A. That's right, yes.

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

and students across the UK?

A. That's correct.

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

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

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

A. Absolutely.

LADY HALLETT: When did the college start?

A. 2001.

MS HANDS: Thank you.

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

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

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

A. No.

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

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

Q. Did the college seek to offer that help?

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

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

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

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

Q. Okay.

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

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

A. That's correct.

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

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

Q. Did that lead to any changes?

A. No.

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

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

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

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

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

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

Q. Thank you.

Moving on to a slightly different topic now,

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

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

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

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

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

have prevented recruitment of 999 or 111 call handlers?

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

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

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

A. Yes, absolutely.

MS HANDS: And that perhaps brings me to one

of my questions around training.

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

A. Certainly not for the call handlers. We -- you know, as I say, it's a very technical role that the ambulance service is very good at doing the training for.

Where we did have an involvement with was the student paramedics and we have a good relationship with all the higher education institutes -- so all the universities that offer the paramedic programme -- and what we did see is that some of the clinic placement, those areas where people try and put into practice what they've learnt in a theoretical way, that some of the students or quite a large number of the students actually were coming to us saying the clinic placements are no longer there, the very way that we try and sort of support our practice under supervision is no longer available, and they understood in the main that that was because placements were very difficult. Nobody

knew how safe it was for students to go on to the ambulances; so quite often they were diverted into the control centres or to do stocking of medications, et cetera.

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

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

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

A. I think where the students were nearing the end of their course, there -- we believe there's

been much less impact because they were ostensibly ready to go out with some additional supervision.

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

Q. Thank you.

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

Was that a complaint or an issue that the college was aware of during the pandemic? And, if so, did it take any action to escalate those concerns?

A. Yes. In terms of access to being able to get an ambulance to go out and do your shift on, we were aware that there were vehicles that were tied up at the emergency departments, meaning that crews that were coming on shift couldn't access an ambulance to start their shift, for example. And it wasn't unusual for a crew that were coming on either in the morning or the evening to have to go and relieve the crew in the car park of the hospital so that the off-going crew could get home.

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

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

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

they worsened certainly after the first lockdown.

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

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

Q. Thank you.

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

What does the college understand contributed

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

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

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

a failure to protect the paramedics and the ambulance clinicians.

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

A. Certainly during the first lockdown, none

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

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

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

A. No.

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

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

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

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

Q. Thank you.

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

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

Was there a response to that request?

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

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

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

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

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

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

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

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

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

college actually raised those concerns.

Were the correct type of aprons or suitable aprons provided?

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

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

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

Q. That's no problem.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

If we look down on the left, from risk of

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

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

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

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

she was so frightened that this protection was inadequate.

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

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

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

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

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

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

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

Q. Thank you.

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

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

That just goes on to page 5.

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

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

So each of the areas would come to an

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

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

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

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

Q. Thank you.

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

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

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

Q. Thank you.

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

Q. Okay. That was my next question. Thank you.

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

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

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

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

And then in the penultimate paragraph, the email says:

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

It reiterates that:

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

contact with Covid positive individuals would be helpful."

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

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

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

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

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

Q. Thank you.

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

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

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

A. Nothing could be further from the truth

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

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

So it just felt completely incongruous.

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

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

Q. Thank you.

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

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

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

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

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

splutter and have, you know, had high temperatures and, you know, were -- you don't sit in the back of an ambulance for 10 hours and not speak to your patient.

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

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

LADY HALLETT: Sorry to interrupt.

MS HANDS: Not at all.

LADY HALLETT: Just before we go -- do I take it from the words in blue at the bottom, "this should be based upon the individual's dynamic risk

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

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

LADY HALLETT: Sorry to interrupt.

MS HANDS: Not at all, thank you.

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

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

In some cases, supplies were very short. We know certainly from our colleagues in the Northern Ireland Ambulance Service that stock was very short

there. And we couldn't ascertain whether the management response to that was because they were worried that the supplies were short and they needed to hang on to some, or whether they were reinforcing the guidance and our members couldn't tell us either, other than the fact that, you know, if you had used RPE on a night shift, for example, there was no manager there to unlock the cupboard. So that's why people ended up buying their own protection.

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

A. Clinicians would either, you know -- when you're faced with a patient, you're not going to deal with yourself, you're going to deal with the patient and sometimes that put -- our members describe being put completely at risk and feeling very vulnerable, but they were trying to do the right thing for the patient. So sometimes they

would expose themselves to a risk knowing it was exposing themselves to that risk and sometimes they would just don the level of RPE that they had. A face mask isn't PPE but they would don that as some small form of protection and then worry about it for the rest of the shift.

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

A. No.

Q. No. Thank you.

Moving forward to January 2022 --

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

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

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

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

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

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

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

From an ambulance perspective, what led to

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

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

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

MS HANDS: Thank you.

My Lady --

LADY HALLETT: Can I just follow up? Having said you were coming to the end.

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

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

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

A. Yes, absolutely.

LADY HALLETT: Yes.

Right, I return at 2.05.

(1.05 pm)

(The short adjournment)

(2.05 pm)

LADY HALLETT: Ms Hands.

MS HANDS: Thank you.

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

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

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

And some of those you referenced this morning.

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

A. That's right.

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

A. That's right.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

What led to paramedics forming that view?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

said:

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

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

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

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

During the pandemic people's oxygen levels,

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

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

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

Q. Moving on to the topic of mental health

support and wellbeing.

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

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

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

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

NHS Practitioner Health also included, latterly, paramedics as well as doctors and nurses,

which was very welcomed. We'd managed to source a grant that hopefully would send people through NHS Practitioner Health, and then NHS England announced that NHS Practitioner Health would encompass paramedics and ambulance clinicians as well.

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

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

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

A. Yes, that's right. We recognised that

was novel for everybody, so the managers would be dealing with staff anxiety, stress and depression that they -- on a scale that they had probably never dealt with, and we felt it was incumbent upon us to support the managers in how to support their staff as well and offer a guide.

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

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

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

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

And what we did see is that the kind of

sickness payments changed and after a certain amount of time people were no longer being paid sick if they were diagnosed as having Long Covid.

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

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

A. Definitely.

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

A. I think that the sort of pragmatic evidence-based clearly communicated policies would just be so helpful. You know, to change things five times a day in a workforce that doesn't have access

to its emails, et cetera, is just not -- it doesn't work.

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

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

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

MS HANDS: Thank you. I'm very grateful, Ms Nicholls.

My Lady, that's all the questions.

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

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

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

A. I have.

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

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

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

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

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

(The witness withdrew)

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

DR MICHAEL MULHOLLAND (affirmed)

Questions from COUNSEL TO THE INQUIRY

A. Thank you.

MR MILLS: Your full name, please?

A. Michael Nial Mulholland.

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

A. Yes, that's correct.

Q. You've provided a witness statement for the transcript. That is reference INQ000339027.

Introduce us, please, Dr Mulholland, to the work the RCGP performs for its members.

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

Q. And a little bit about you, please.

How long have you been a GP for?

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

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

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

Q. Can I begin, Dr Mulholland, with the condition of general practice prior to the pandemic.

At paragraph 8 of your statement you say this:

"It was widely accepted that there were not enough GPs to meet the level of demand prior to the pandemic."

Are you able, in respect of each of the four nations, to set out (1) the workforce issues that were faced, and (2) what action was being taken by the respective governments in response?

A. Thank you.

Excuse me.

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

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

LADY HALLETT: Could you go a bit slower?

A. Sorry.

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

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

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

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

In Wales, there was a similar story. Our report of 2018, again presented to the First Minister in Wales, highlighted there would be

a shortfall in GPs, and that the budget invested in Wales was only 7.3% of the budget, of the healthcare budget, and this compared to a UK average of about 8%, 8-9%. The First Minister at the time took the report and said they would work more with us to try to improve that.

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

MR MILLS: That's workforce.

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

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

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

A. I think in the digital infrastructure we're not just talking about AI or ways to improve consultation, I think it was simple things, like the

number of laptops, the number of desktops, the telephony services that were not adequate for the number -- the demand that was coming into the practices, and often GPs were frustrated by the time it took for systems to turn on, the time for systems just to get going before we could even start our day to talk to patients. It was highlighted in our national conference and Dame Helen Stokes-Lampard pointed that out about four years ago.

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

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

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

Please can we have on screen INQ000492277. Thank you.

For context, these are the results from the

RCGP's survey of workload in general practice in Wales conducted in December 2020, and I'd like us to consider the average capacity figures, along the bottom row.

So we have:

"Pre-COVID ... 108.

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

And then finally:

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

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

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

A. Thank you. I think at the start of the pandemic patients were understandably extremely scared of doing things, of coming in to see health services. We had seen on TV images from Italy, and China before that, of what -- health services being overwhelmed, and so patients wanted to keep themselves safe, they didn't want to attend face-to-face appointments. GP surgeries were in buildings often in an older state where it's very

difficult to isolate and keep yourself separate. And the way of general practice working over the years had been that people sat in crowded waiting rooms waiting for a doctor to call them in for an appointment. So people did not want to be in that situation at the start of the pandemic.

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

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

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

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

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

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

A. Okay.

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

A. Yes.

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

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

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

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

Q. We'll come to that.

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

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

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

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

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

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

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

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

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

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

Q. Thinking about patient access, were some

patients left behind by the move to digital consultations?

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

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

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

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

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

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

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

LADY HALLETT: Could you slow down.

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

LADY HALLETT: It's very difficult to change

your speech patterns.

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

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

LADY HALLETT: Sorry, what kind of consultation?

A. Asynchronous.

LADY HALLETT: Asynchronous.

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

MR MILLS: Please can we have on screen INQ000492268.

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

But I'd like to consider the response to 4(e).

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

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

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

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

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

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

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

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

The question is this:

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

I'd like us to consider the fourth row down. We have 90% saying it was important to have a method to quickly identify patients that should not be given a remote consultation.

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

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

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

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

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

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

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

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

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

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

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

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

A. Mm-hm.

Q. What was the aim of this campaign?

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

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

Q. Please can we have on screen INQ000474283. Thank you.

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

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

Now this:

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

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

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

And right through to November 2021, when it was suggested that there might be a table that GPs

doing -- how many were doing face-to-face and how many not, which led people to feel that there would be a name and shame campaign for practices. GPs reported to us that they were feeling attacked, got at, despite working at more than 100 per cent of capacity throughout certainly 2021.

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

Q. New topic, please.

Workload prioritisation guidance.

If we return to INQ000492268, please.

This time the response to question 2(a).

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

A. Mm.

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

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

A. Yes, we were very concerned that -- we knew we did not have capacity to see everybody. But

we were also very concerned that we do an enormous amount of chronic care for long-term conditions in general practice, and that was not happening in the same way as it had pre-pandemic. Our members were concerned about those patients being left without the care they normally had, but what we needed to do in the pandemic situation was actually have a prioritisation that we really would call those patients that we knew were most at risk and that is why we tried to produce it.

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

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

If I may, that's INQ000280653.

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

A. Mm-hm.

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

So help us, please, what factors brought a service into the high priority category?

A. I wasn't part of the group specifically writing it at the time but it was those people that needed care, as normal today, that their illness would deteriorate, their health would deteriorate as a result of not having the care put them into that category.

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

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

That's INQ000280654.

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

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

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

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

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

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

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

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

A. They didn't.

Q. Did they give reasons why not?

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

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

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

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

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

You alluded to this earlier this afternoon.

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

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

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

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

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

A. Yes.

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

A. That's correct.

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

A. It was enormous scale that it was

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

Q. Can we please have on screen INQ000492272.

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

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

A. Mm-hm.

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

second half of 2020 but throughout the pandemic -- did you see an increase in the numbers of people leaving general practice?

A. Sorry, I didn't -- I don't have that figure to hand.

Q. Anecdotally, can you help us Dr Mulholland?

A. I think anecdotally we're aware that people found it very difficult. Those who had vulnerabilities did not want to work. We had great difficulty early in the pandemic with a lack of central guidance as to help stratify the risk that clinicians would face. So many organisations created their own risk stratification and practices were often left to design or choose what is used to say whether it was safe for staff to work or not.

My own practice, doctors of a minority ethnic background we supported them to stop seeing patients face-to-face which naturally created an extra stress for others, but they felt a real vulnerability during that time and for some of those doctors -- fortunately not in my practice, but others did find that they did not want to return to face that afterwards.

Q. Just on that point, at your paragraph 106

you say this:

"There was a lack of guidance from the NHS on which staff should be considered as most vulnerable to Covid-19."

Help us: in the absence of such guidance, what did individual practices do to assess the risk?

A. There was some guidance came out from different groups. One I remember from the British Association of Physicians of Indian Origin, one from the General Practice Committee, I think it was, of the BMA, they gave us some guidance based on what we thought the risks of Covid were at that time, whether it was the ethnicity, age, obesity, other things were in those lists of vulnerable categories.

And practices often wrote to their staff and said, "Where do you fit on these?" and then rated them on hand and practices then had to make a decision for themselves whether they could run the service and who worked and who didn't so it was very much an individual practice decision as to who was able to be off and who couldn't and smaller practices really struggled because they may have only had a few members of staff there. To have someone off meant the service wasn't able to be worked.

Q. In your view, is that a good situation for individual practices to be in?

A. No, it wasn't. And I think, again, part of that was certainly in the early parts we didn't have the access for people to work from home where they could have worked more safely remotely. They all felt in many places had to be in work, seeing patients face-to-face where the risks were much higher.

Q. At your paragraph 52 onwards, Dr Mulholland, you set out a number of actions that the RCGP took to support the wellbeing of GPs.

A. Mm-hm.

Q. Can you take us through some of those, please?

A. The RCGP pivoted all our work in March 2020 to focus entirely as we saw the pandemic approaching us and going to affect healthcare in England, or in the UK, that we thought we needed to actually purpose all our work into helping GPs get through this. So we started to focus our advocacy -- was to help advocate for policy and make sure that NHS England and the other bodies were all focusing on what GPs needed in that space.

We also developed resources for our members,

developed what was called the "Covid hub" where we had resources explaining initially what the virus was, what we thought the symptoms were, what the response should be, right through to ethical concerns that we may come to later.

We had over the first year of the pandemic a million hits from healthcare practitioners across the world because we opened this up not just to our own members but to all healthcare practitioners worldwide, and in that space we had a million hits, people looking for the information that as RCGP we pride ourselves that what we put out as continuing professional resource is reliable, it's accurate, it's evidence based and that then became a standard others could use wherever they were.

Q. Can I ask you about testing. It's right, isn't it, that early on the RCGP pressed for GPs and their families to be prioritised for testing? The phrase used was to test "the right people at the right time".

Why was it so important to prioritise GPs for testing in your view?

A. I think we recognised that GPs are the front door of the NHS for most people -- we do 1.2 million consultations a day normally -- and if

that clinical frontline workforce was not available, there was a huge gap for the NHS which would then struggle to provide the care that many patients needed at that time.

We extended it to families because we knew that if a family member became ill in the immediate family that often meant that the clinician was also off work. Clinician -- also our receptionists, the admin teams that back up general practice day to day, we felt it was important to keep that service functioning as key frontline NHS work.

Q. At your paragraph 121 you tell us this:

"In December 2021, the chair of the RCGP was still expressing concern that GP staff were struggling to access Covid-19 tests."

Is that a real concern to you that even at the end of 2021 GPs found themselves in this position?

A. Absolutely. It felt at times that general practice was a second thought or an afterthought in planner's minds, that hospitals were often prioritised, as we saw it, in the thinking that was going on and general practice and the services and the testing and everything else came as an afterthought to that.

Q. You're not in their minds. But help us, as someone who has been with the RCGP in an active role for some time, why do you think it is that general practice becomes, in your words, an afterthought?

A. I think general practice is often felt that there's a lack of what we call parity of esteem between primary care and our secondary care colleagues and that has been something that has gone on for many years. In the context of the pandemic, the -- primary care sees patients one at a time, usually fairly quietly. People don't come into our rooms to see it. We have someone with a bad infection, we refer to a hospital. We don't have the same services and -- excitement, if it were, of an A&E department where things are happening very rapidly and quickly and ambulances go to them. We have usually quite quiet conversations. Our consultations are very different.

So general practice is a different environment and the funding of the NHS is over 90 per cent to secondary care services, so that's where many perceive the NHS works. The 10 per cent or the less than 10 per cent in general practice can be perceived as less important potentially to some

if they're thinking in big picture terms.

Q. Finally, my Lady, before perhaps we take an afternoon break, can we return, Dr Mulholland, to my favourite survey, INQ000492268.

This is the end of March 2020, question 4(b), please, on PPE. 94 per cent of respondents thought it was very important or quite important to have more guidance on how to use PPE. Can you help us: in which particular areas were GPs most searching for further guidance? Thinking about fitting, when to wear it, what to wear in certain situations?

A. All of those. And what to use and what we had, what we should be doing with them -- excuse me -- there was a concern that rose as we saw PPE being used in other countries, on television and the news, and what we were being told about in the NHS was different. What was being supplied to us was different. We had reports from GPs of out-of-date PPE arriving at their practices to be used that had gone before the best before dates.

We had concerns that the WHO had issued guidance that was different to the UK guidance, which naturally made GPs anxious that we wouldn't be seeing patients in well air-conditioned, ventilated places; we would be seeing them in a consultation

room, potentially in a building that shouldn't -- that wasn't entirely fit for seeing patients, an old converted house or whatever. And so we were very concerned --

LADY HALLETT: Slow down, please?

A. Sorry.

LADY HALLETT: The stenographer is doing a brilliant job but it's really difficult.

A. Apologies, my Lady.

That we were concerned at the amount or the adequacy of the PPE that people were receiving and, if it was adequate, that we didn't have sufficient information to reassure our members that it was adequate and the appropriate thing for us to be using.

MR MILLS: Did the RCGP take action to try and resolve the issues its members were raising about PPE?

A. Yes, we publicly express concern in 26 March 2020 about the availability and guidance for PPE and wrote to the Secretary of State for Health and Social Care, asking for clarity as to what was happening and asking about whether GPs should begin wearing PPE for all face-to-face consultations because, even at that stage, after the

national lockdown, or around the time of the national lockdown, we still did not know whether there was a national recommendation for us to use face-to-face or use masks in face-to-face consultations.

We continued to advocate as we went along. We recognised there was an improvement in PPE a week or so later when some guidance came out, but there was still concerns amongst members whether we had the right face masks, whether the guidance we were being given was correct, and whether eye protection was needed -- things like that that weren't entirely clear.

MR MILLS: My Lady, I'm about to move on, would that be a convenient moment?

LADY HALLETT: Certainly. I hope you're warned that we take breaks, Dr Mulholland. I shall return at 3.30.

(3.15 pm)

(A short break)

(3.30 pm)

LADY HALLETT: Mr Mills.

MR MILLS: My Lady.

Dr Mulholland, shielding.

At your paragraph 155 you say:

"The decision to designate some of those at high risk to be part of a 'shielding' group caused an immense amount of work in general practice."

What steps did someone working in general practice have to take in order to, first, identify, and then, second, communicate a person's shielding status?

A. The shielding policy came in at the end of March 2020 when GPs were informed and asked to identify the most clinically vulnerable, which meant us (a) knowing a list of those people thought to be most clinically vulnerable, then doing searches on our practice computer systems to try to identify those people, following which they needed to be contracted by the practice teams in some way to inform them of this, and then put in the steps in the form of what else needed done after that.

Q. Were there issues caused by the function of data, for example issues with how illnesses or medications were coded, or examples of prescriptions not making it into a person's medical records?

A. Indeed, yes. The patients that were clinically vulnerable with the disease that we had coded in general practice were relatively straighforward to search for, but there were

medications that sometimes were prescribed by hospital specialists that identified someone as being clinically vulnerable, and they were then -- needed to be searched for in hospital systems that don't connect with our own general practice ones, and somehow that information shared between us.

There was then other challenges between -- that required the secondary care and primary care systems to be connected by NHS Digital to make sure that we could really identify those.

Patients were also asked to self-identify at one stage, during the early stage of shielding, and those records all needed checked back to make sure they were the people that had been prioritised and set out as being clinically vulnerable.

Sorry, my Lady.

Q. In your view had there been conflicting communications about who needed to shield?

A. Some of the variation was based on our understanding of Covid-19 at the time, that initially we thought that people with diabetes should be shielded, and then shouldn't be shielded, and at a later stage went back onto the shielding list.

The groups that needed to do the searches

hadn't been set up before the announcement was made, and so the data was not flowing between our organisations to patients to -- it seemed to be going backwards, so that patients were aware they -- there was going to be shielding, after which we were doing the searches, after which our secondary care colleagues were trying to connect with us to make sure the searches were correct, leaving the patients vulnerable and confused at the end of it all.

Q. Were there instances of patients calling their GP practice to stay, "I think I ought to be shielding, I haven't received a letter, can you help me"?

A. Absolutely, yes, we made many, many calls from patients asking just those questions, because they had understood from what they had read or seen on the news that they were in the shielding groups. Although sometimes the detail of what the shielding group was hadn't been communicated in those reports, so they weren't actually in the right groups but required our teams to spend time going through that data very carefully to work out. Often leading to some difficult conversations by admin staff or the doctors, clinicians themselves, trying to explain why someone who felt vulnerable wasn't in the -- on

one of these extremely vulnerable lists.

Q. Was there flexibility within the system for a GP who had a patient not on the shielding list to advise them to shield nonetheless?

A. We could advise any patient to shield if we thought they were vulnerable, but it didn't always connect then with the national picture of who should be. And at the start of the pandemic there were some things that happened if you were on the extremely vulnerable list, like there were food -- food delivery prioritisation, because people were staying at home and not going out. And that didn't happen for those patients that we identified necessarily.

Q. Moving on, please, Dr Mulholland, to DNACPR.

At paragraph 208 you say this:

"There was a lack of central guidance for GPs on DNACPR and how best to implement the policy."

Help us, what was the basis for your view there?

A. The RCGP doesn't and still doesn't have a role in formulating policies, and we recommend that for clinicians and GPs on the ground that every DNACPR decision or advanced care planning decision

is one taken by the clinician and the patient in a shared decision-making process, where they decide what the best options are for our patients, and they decide the best option for themselves, and we come to an agreement about that, about how they want to proceed with their care and future wishes should they die.

Q. At 211 you say:

"[You] heard nationally that GPs were pressured to make these decisions [DNACPR decisions] at speed, and without time for adequate discussion with patients and families ..."

What were the causes of that pressure?

A. We'd heard of reports of GPs being asked to do frailty scores, and at the time NICE, the National Institute of Clinic Excellence, had set out some guidance for those working in the intensive care setting or the hospital setting as to who maybe should be -- how you would prioritise using a frailty score for those going forward for intensive care treatment. And it seemed that -- although we don't have the exact information where this happened -- that some GPs were being asked to do frailty scores on either patients in care homes or their elderly, vulnerable -- or more ill

patients, and complete escalation plans and documents, DNACPR decisions, or CPR decisions.

Q. Please can we have on screen INQ000400508.

We will come to the substance of this in a moment.

But we can see here, can't we, that on 1 April 2020 a joint statement on advance care planning was published which the RCGP co-authored with the BMA, the Care Provider Alliance and the Care Quality Commission.

Can I start with this. What prompted the development of this joint statement so early in the pandemic?

A. I think it's what I just referred to, that we were hearing reports of information being completed by GPs, either being encouraged to by systems or because they felt that was the guidance they were getting. And some of them were feeling pressured, they were feeling uncomfortable, that they didn't feel it was the right thing to do, and were informing the college that this was happening.

And we felt it was very important for our patients and our members that we gave -- set out as clear guidance as we could that we still believed

everything that we normally did, that a shared decision-making process was the way to make these decisions, not blanket decisions for populations.

Q. How is a statement like this shared with those working on the ground in general practice? Do they receive an email?

A. I can't remember the detail of how we did it, but in the RCGP, we would've put it in our weekly blogs, we would've put it in email correspondence that we have with members, and I suspect the other organisations were doing similar. So we hoped that we would convey the information out as fast as we could to as many doctors as possible.

Q. Can you take us through, Dr Mulholland, the instruction that is contained in this statement and help us with what it was designed to achieve?

A. This statement talks initially about a person -- the importance of having personalised care plans, which we believe is what every patient should have as their care is becoming more complex. We discuss what we prioritise, what we don't. Specifically older patients, those with frail, serious conditions. And during the pandemic these conditions were worsening and Covid was making some

of these patients very ill.

It moves on to talk about capacity. And what we believe is that every patient has capacity, has the right to make their own decision, and it should be discussed with them. An advanced care plan is what you put together with the patient, not something that you provide for them.

And if someone doesn't have capacity we work with family carers, those responsible, with them, to make what's called a best interests decision for the patient, involving as many people as we can who know the patient well.

Sometimes an advanced care plan in some of my palliative care patients includes a statement where they have decided that should they die they do not want cardiopulmonary resuscitation attempted. And we would put that into a care plan for some of those patients that are often on a palliative care journey because of cancer or some other illness. But these are individual decisions, they were individual before the pandemic, we recommended and said they should be individual decisions during it, and we continue to work on that basis.

And then the last statement was because of the thoughts that we'd -- or the things that we'd

been hearing, it is unacceptable for advance care plans, with or without a DNR form, to be applied to groups of people of any description, because that immediately removes the individual choice, and that was just something we thought was such a clear line, we needed to make it -- reiterate it to all practitioners as fast as we could.

Q. Thank you.

Can I return momentarily to the concerns that were being raised.

You've said GPs were being asked to make these decisions.

Can you help us, who was asking GPs to make these decisions?

A. We understood that some of these were coming from system -- the healthcare system, so CCGs or otherwise. And whether it was formally or an informal feeling that GPs had to protect the NHS, they should be limiting the number of referrals in to hospital or setting out advance care plans that would say "I do or don't go in for further care" or "I do or do not receive resuscitation".

So it was informal feedback that was coming in to us, but we understood it to be from clinical commissioning groups who were the system providers

at that -- the commissioners at that time.

Q. After the publication of the joint statement did those concerns continue to be raised with the RCGP, or was a real change perceived?

A. We heard from GPs who felt pleased that we'd made such a clear statement and so quickly in the early pandemic. We also went on to produce very clear guidance. We involved the Royal College of GPs ethics committee, who spent time working with the teams to produce, on our Covid hub, an ethical resource hub, which included how GPs could approach end of life decision, advance care planning decisions, working through it with scenarios that they could learn from.

So it was a learning place as well as a reference point that GPs, who were dealing with difficult ethical issues at the time, would be able to work through and see what best practice should look like.

Q. Can I move to our penultimate topic, Dr Mulholland, Long Covid.

Please can we have on screen INQ000492271.

These are the results of an RCGP survey conducted between August and September 2020 about Long Covid.

Let's consider the answer to the second question:

"Do you have a long-Covid clinic you can refer to?"

23 per cent, yes.

What did the 77 per cent of GPs who did not have access to a Long Covid clinic in practice do with patients who presented to them with Long Covid symptoms?

A. In practice they would've had to manage them themselves, as best they could, with the information available.

The RCGP had started to hear concerns about patients having prolonged symptoms following an infection with Covid quite early on during the pandemic. And we started to talk with our research colleagues around the country to look at it, we monitored feedback and talked to members. And RCGP then joined, for the first time, with NICE, the National Institute of Clinical Excellence, and SIGN, the Scottish guidelines network, to write the first definition of Long Covid, or post-Covid syndrome, as it was known then, as joint stakeholders or joint writers with the two guideline organisations.

In that we started to set out what was known

about Long Covid or post-Covid syndrome, set out symptoms that GPs could start to look for and recognise and to -- the -- best practice that we knew of at the time in terms of management of Long Covid symptoms.

Q. Finally this, lessons and recommendations.

We began your evidence this afternoon, Dr Mulholland, by exploring the resilience of general practice at the start of 2020.

Can I ask you this. If another pandemic was to strike next year, in your view is general practice in a better or worse condition to cope now than it was in March 2020?

A. I think general practice is probably in a worse condition than it was at the start of March 2020, demand and responding to patients' needs and access and the requirements has risen. Our waiting lists across the country and -- in all hospital specialties have risen dramatically, and that workload, while patients wait for care in a hospital, ends up coming back to GPs and our practices and our practice teams.

We feel that to be able to meet current demand, let alone a pandemic or a stress on the

system, from another illness that came through the country, we need to be significantly better resourced, significantly better both in terms of finance coming in, but workload and workforce in -- workload reduced and workforce increased to make it possible to be able to treat the number of patients and provide the care for them that is needed.

So that we could both continue to treat the new illness as well as manage all the illness that's in the community already and our patients and our populations need looked after.

MR MILLS: Dr Mulholland, thank you.

My Lady, that's all I ask.

LADY HALLETT: Thank you, Mr Mills.

Ms Iengar.

Although it is natural to look at the questioner, Dr Mulholland, but it's really important we get your evidence transcribed, so keep speaking into the microphone, please.

Questions from MS IENGAR

MS IENGAR: Dr Mulholland, I appear on behalf of the Long Covid groups. I have a number of questions and a very short period of time.

My first question is from the perspective of the physical impact of Long Covid on your members.

You've said in your witness statement -- it's paragraph 110 for your reference -- that:

"Many GPs have been impacted by 'Long Covid' and ... [that several of them] are no longer able to work because of ongoing symptoms."

Are you aware of any support that is specifically available for GPs with Long Covid who are no longer able to work?

A. I'm not aware of any particular support for GPs with Long Covid beyond what is available on the NHS for everybody. There are various services from practitioner health, the NHS and the NHS GP service, but not specifically for Long Covid.

But we're aware of that group of GPs that have -- had Covid during the pandemic and since that now have symptoms that are stopping them working.

And as mentioned in our evidence, there isn't a GP occupational health service that does -- it doesn't exist and that is something that would be a development that would allow us to be able to get proper help for those GPs that become ill.

Q. So that would be a development you say was necessary?

A. Absolutely.

Q. Thank you.

Then my next questions look from the other side of the coin: the impact of Long Covid on your members as clinicians caring for patients with Long Covid.

You said this afternoon that quite early in the pandemic GPs started observing and reporting to your college that a significant number of patients were presenting with what we now know is Long Covid.

Are you able to assist us with the timestamp of what is "early in the pandemic", roughly what month the college was receiving these reports?

A. One moment while I try to ...

Q. It's -- you refer to it quite early in the pandemic, it's 195 of your witness statement. There isn't a timestamp in the statement itself.

A. I think at that stage it was anecdotal.

We report that in July 2020 we were talking to our clinical adviser group, seeking their opinions on -- the clinical advisers are a group of GPs who work for the clinical policy team and provide advice and support when we deal with consultations, when we have clinical questions, and it was from that group that we understood that this was becoming an increasing phenomenon throughout the country that patients were having these prolonged

symptoms.

Q. So those conversations began in July 2020, so is that when the reports would have been received by --

A. The reports would've been received before July.

Q. Before July.

A. And then put to our advisers for confirmation in July 2020.

Q. Thank you.

You've said -- you've explained that the college engaged directly with decision-makers and politicians, and you've named the Secretary of State for Health, the four CMOs, Sir Simon Stevens of NHS England, Public Health England, and then the DHSC, who you say you lobbied to commission the NICE guidelines on Long Covid.

Would those reports of the significant numbers of patients with Long Covid have been shared with any of those stakeholders that you were in conversation with?

A. I'm sure that the information would've been shared with them at the time if they were being lobbied. I wasn't at the meeting so I'm afraid I don't know that detail.

Q. So you can't tell us which of those bodies the college might have shared the earlier reports of Long Covid with but you assume that they were shared?

A. They would've been shared. I'm just checking my notes ...

But we were talking to NICE and SIGN from around July or August 2020. At that stage I'm sure we'd have shared it in other meetings that we were at. As the evidence -- or as my report said, that we were having consultations weekly with NHS England, Sir Stephen Powis and Sir Chris Whitty during that time and we would've been bringing it up in discussion in those meetings. But I don't have documentation for those.

Q. But you say the CMOs would've known by then, by July 2020?

A. Yes.

Q. Thank you.

And surveys carried out by the Long Covid groups in September 2020 and then again in April 2021 record that many patients reported not being believed by their GPs for the symptoms they were suffering from and GPs not knowing how to help them.

That's something that's mirrored by your college's own surveys. You were taken to the survey of September 2020 where GPs say they were not very confident in treating patients with Long Covid symptoms.

Dr Mulholland, do you believe that the NSS and Public Health England could have done more to support primary care clinicians in anticipating and responding to Long Covid?

A. I think as this was -- it was the second new disease our members were facing that year. They were learning how to understand it. It was unexpected that came out on top of the pandemic and the Covid infection itself. The support from around the healthcare system would've been appropriate and good if we'd all had more of it. It was the RCGP that -- we wrote a top tips document for GPs or -- we approached NICE and SIGN and got this done, because we felt that was the fastest and most appropriate way we could get that information out to our GP colleagues.

Q. My final set of questions, Dr Mulholland, is on data collection and coding of Long Covid by GPs.

Firstly and very quickly, Professor Hopkins

of UKHSA said in oral evidence last week that there isn't standardised coding of Long Covid, which is not correct, is it, because you say at paragraph 201 of your statement that RCGP created new codes for Long Covid as soon as the NICE definition of Long Covid was published in 2020.

So codes were in place for Long Covid by December 2020. That's right, isn't it?

A. That's correct. I think it was called post-Covid syndrome, was what it was classified by NICE, and that's what we worked for the PRSB, the public records standards body, and NHS Digital to have put in place.

Q. In relation to that coding, both NHS England and your own college have noted that coding on Long Covid is essential for public health planning.

So we need to know how many people are suffering from long-term symptoms in order to model demand and plan for service delivery.

And the college, your college, in June 2021 reported to the Long Covid ministerial round table that one of the key areas it was working on was improving coding on Long Covid because there was a disparity between coded figures and ONS figures on

the prevalence of Long Covid.

My question, Dr Mulholland, is: has the use of coding for Long Covid in 2024, so now, has it improved so that it's an accurate data source for prevalence of Long Covid?

A. I'm afraid I don't have that information.

Q. And finally, Dr Mulholland, my question involves looking forward and your opinion on whether you can assist the Inquiry with any observations on how improvements could be made to ensure that accurate and consistent use of coding systems for long-term sequelae of novel viruses by primary care practitioners are correct from the outset?

A. I think the model that we had where NICE and SIGN and the RCGP worked together to define the condition and then our work to get coding systems in place was the start of it. The next step would've been to potentially spread this wider and make sure that it was in everybody's consciousness, I guess, that we use it the same way as we use other codes.

People probably were still learning about the disease in 2021, or the end of 2020, and time would be to develop that, but it could still be developed that people should be able to use the code more, as it becomes more familiar.

There was the challenge as well within this one that some people called it "Long Covid" and other people "post-Covid syndrome"; I'm not sure if that made a difference in the number of coding episodes we have on the computers.

Q. So Dr Mulholland, just following on from that, when you say that it's in everyone's consciousness, I glean from that that you mean that there is more training and more education on the coding of Long Covid to ensure that primary care practitioners are consistently applying it and understand that post-Covid and Long Covid denote the same illness?

A. Yes.

MS IENGAR: Thank you.

Thank you, Dr Mulholland.

LADY HALLETT: Thank you, Ms Iengar.

Mr Thomas, I think you have moved over there. Yes.

That way, Dr Mulholland.

Questions from MR THOMAS KC

MR THOMAS: I am representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations, which advocates for the health and wellbeing of black, Asian and minority ethnic

healthcare workers and patients who were disproportionately affected by the pandemic.

FEMHO is particularly concerned about how the pandemic impacted patient contact and access to care for ethnic minority patients.

In your witness statement you mention various factors that contributed to the fall in patient contacts during the pandemic.

Question: were there, in your understanding, reduced contacts from black, Asian, minority ethnic patients during this time?

A. Yes, I believe there was a lack -- a reduction in all groups of patients, but possibly particularly.

Q. Building on that then, you discuss the shift to remote care during the pandemic in your statement. FEMHO is concerned about how this move might have impacted black, Asian and minority ethnic patients, especially in terms of their access to primary care.

Question: so how did the move to remote care impact the ability of black, Asian and minority ethnic patients to access primary care during the pandemic?

A. I think in the evidence we described that

there is a risk of a digital inverse shared care law, as Professor Edwards described the shared care law earlier, about some populations not getting the care despite the need.

We recognise that there was -- some populations didn't have the same digital access as others. And I think some of our work within the health and equalities group has shown that some of the black, Asian and minority ethnic groups fall into some of those places where digital access was less available. And so that would've impacted them adversely.

Q. Just as a follow-up, what was done to address that?

A. Ourselves -- our health and equalities group work very hard to try to help members recognise groups that could be adversely affected. On our Covid hub that I described earlier we did have a particular section written by our health and equalities group at the college outlining ways that groups might be contacted, might be noted, might be supported in different ways. And that included not only black, ethnic -- minority ethnic community, but also those with learning disability and others that may not be accessing the service in the same way.

Q. Lastly, FEMHO is keen to understand the issue of racial bias in medical devices, particularly the pulse oximeter which you refer to in your statement.

You see, this is of particular concern given that black, Asian and minority ethnic patients were disproportionately impacted by Covid.

So, question: what, if anything, was done by the Royal College of General Practitioners once it became known that there was racial bias in the pulse oximeter?

A. We became aware that when it was published in December 21, I believe -- 2020/2021, I can't remember which one offhand -- and would've informed our members, I looked earlier, and I don't have a record of the communication, it may have been through our Chair's blog which went out weekly, but we wanted to inform members that in subsequent webinars or resources that were published it would've been highlighted in that as well. So that GPs became aware that there was a bias in the way that pulse oximeters picked up --

Q. Would you agree that more could and should've been done? Would you agree with that?

A. Not being able to exactly recall what was

done, I'm not sure. I think, once we found out about it, there was a need that we did inform people and that people were aware very quickly over that pre-Christmas period that pulse oximeters were not providing accurate readings.

MR THOMAS: Thank you, Dr Mulholland.

Thank you, my Lady.

LADY HALLETT: On Mr Thomas's question, pulse oximeters weren't new for the pandemic, were they?

A. No.

LADY HALLETT: So -- I suppose, why was it it took so long for anyone to recognise this potential for a racial bias, as Mr Thomas has called it?

I appreciate, Mr Thomas, you may have felt you were excluded from asking that question, so --

MR THOMAS: Thank you, my Lady.

A. That part I'm not aware of. The first research we heard of was New England Journal of Medicine, and very quickly after that people were made aware that this existed. But why nobody had thought of it and explored it before, I don't know.

LADY HALLETT: So roughly how long have we had these devices in common practice?

A. They'd become cheaper in common practice and general practice in the past decade, but they've

been around in hospital medicine for many years before that.

MR THOMAS: My Lady, can I -- just one small -- I mean to say, we're talking years, aren't we, that these devices have been around?

A. Yes.

LADY HALLETT: Thank you, Mr Thomas.

Questions from MR WAGNER

LADY HALLETT: Mr Wagner, where have you gone? There you are.

MR WAGNER: Thank you.

Good afternoon, I ask questions on behalf of the Clinically Vulnerable Families. I have two areas to ask you about. The first is infection prevention and control in GP surgeries.

At paragraph 77 of your statement you say that one of the factors which in your view led to a fall in patient contacts was, and I quote:

"Patients being understandably scared of attending face-to-face appointments. GP surgeries are often in buildings where it is not possible to have comprehensive infection controls and there is a large overlap between the groups who attend general practice most frequently and those who are most at risk from Covid-19."

Do you agree that further improvements to infection prevention and control, particularly to building design and ventilation, remain necessary in GP practices?

A. Absolutely. I think we're very aware that GP practices have often been set up in buildings that aren't suitable for modern healthcare, and have been adapted and improved to make them fit-for-purpose, but could have significant changes in the way they are designed from the original.

My own practice, which was a five-site practice across a rural community, a very small -- four/five small practices, we actually had to close one of our practices to patient contact during the pandemic because it was an old converted chapel that did not have sufficient ventilation, did not have sufficient space for patients to move around it, nor for our staff to feel safe within it if consulting with patients who were infected.

So I think, yes, there's a real need for many of these older buildings that we have in the general practice estate across all four nations needs to improve to be adequate for some of the modern infection prevention and control.

Q. Thank you.

And would you agree that if that was done it would be helpful in addressing the ongoing problem that some vulnerable patients feel it's not safe for them to access those GP surgeries in -- in those older buildings?

A. I would hope it would, yes, that some of the patients who are where they are vulnerable because of drugs they are taking or illnesses they have may not want to sit in a waiting room with other people who are coughing or sneezing or whatever else in it. And so if we had better spaces and bigger spaces they may feel safer in that.

Q. And that's ventilated spaces; is that fair?

A. That's ventilated, yes.

Q. And would you also agree that that would help GPs -- GP practices better to prepare for a future pandemic?

A. Yes. A lot of time went into GPs trying to work out how to separate hot and cold, or red and green parts of their building at the start of the pandemic, with many practices really struggling because they had one way of -- into the building and one way out. Some were lucky to have a way in and

an exit that others could leave through. But it became very difficult for many practices that weren't ever designed as purpose-built health centres to find their way through that.

Q. So you referred to hot and cold. Can you just explain what you mean by that?

A. We often refer to the places where you would have Covid or infection, acute infections, as the hot area, and patients that were coming for follow-up of long-term conditions without an infection as the cold area, or the red area and the green area. It was just ways of describing different places that we would -- we needed different areas of prevention and control in them.

Q. Thank you.

And the second and final area I want to ask you about is shielding.

You said in your oral evidence, you said there was some difficult conversations by admin staff, or the doctors and clinicians themselves, trying to explain why someone who felt vulnerable wasn't in the extremely vulnerable list.

Can you expand on why those conversations were difficult, and was that confusion, in your experience, cause -- causing some distress amongst

the patients?

A. Yes, it was causing distress. It's hard to remember back to the beginning of the pandemic, looking from where we are now, all in a room together, but patients felt so anxious that they could be the person who got Covid at that stage and could become really ill because we saw it happening around us. That the greater protection you could provide for yourself and others could offer you seemed to be for many the best way forward.

So for someone to feel that they were vulnerable enough that they were prepared to isolate for 12 weeks and not talk to someone else or be in their space -- my parents had to do it and they reluctantly said goodbye to the grandchildren and all that sort of thing -- for them to feel that concerned, if someone had turned to them and said, "Actually, you're not that vulnerable after all, you're not as sick as you think you are", was very difficult. And it wasn't saying it that you're not as sick as you think you are, because we often knew that these people were very ill, they just did not hit the list of criteria that we've been given.

And so for elderly people -- some of my patients are very elderly but have very few

illnesses, and sometimes they didn't actually hit the criteria that got them into the clinically extremely vulnerable group. And it's a very difficult conversation to say to someone, "Well, I'm sorry, I know you're at risk, but on this list I have you don't fit that criteria."

MR WAGNER: Thank you.

LADY HALLETT: Thank you, Mr Wagner.

Ms Munroe, I think it's you.

Questions from MS MUNROE KC

MS MUNROE: Good afternoon, Dr Mulholland.

A. Good afternoon.

Q. My name is Allison Munroe and I ask questions on behalf of Covid Bereaved Families for Justice UK.

My Lady, in fact most of my questions have been addressed either by counsel, Mr Mills, or indeed answers that Dr Mulholland has given to other CPs this afternoon. So just a few matters, please.

In relation to shielding, you've just been asked about shielding, but just after our afternoon break, in answer to some questions from counsel Mr Mills, re shielding, you told us what GPs could advise compared to what support patients had access to, et cetera.

Now, my first question was on the flexibility of GPs. That's been covered.

But sort of bringing together your written and oral evidence, it seems that what you've described is a lack of clarity and changes within the groupings for those who were defined as clinically extremely vulnerable.

So bringing that all together, Dr Mulholland, in your opinion was it clear to GPs who should or shouldn't be included within the formal shielding categories and what discretion they had over this?

A. I don't think it was entirely clear because some of what we were working from was what we thought should be in the shielding category, like people with respiratory illness initially we thought to be at risk, and later less so.

So, much of what our experience had been as GPs was based around flu pandemics and the Swine flu and things in the past. This was an entirely new disease that we were dealing with, and nobody was quite sure what made someone extremely vulnerable. But we had seen very quickly and from other countries that some people were more vulnerable than others, very clearly, but we didn't quite know who

they were.

We had to go on the guidance that was given to us, on the basis that it was given by experts, and we had to trust that. But we didn't have enormous flexibility to change it. We could agree with someone if they wanted to stay at home and self-isolate, as some of my patients did, we could support them in that way and deal with them from telephone calls and home visits, if needed, but we couldn't actually add them to this clinically extremely vulnerable list.

Q. And just following on from that, Dr Mulholland, do you feel that that lack of a discretion for the GPs was a hindrance and potentially a great difficulty for patients?

A. I think -- I can see it from both sides that there are times when you thought your patient was vulnerable, but the evidence you were being told was no, that group wasn't. The risk would've been that if GPs had a lot of flexibility many more people could've been put into the group to shield and isolate unnecessarily.

I can see for other patients that we knew very closely, because they were patients who we know their illnesses and what's going on, that maybe they

did have other risks that weren't part of that. And the lack of flexibility putting them into the groups might have hindered the individual.

So with the population level we might have increased the groups massively if we'd gone from what we thought was right rather than the evidence we have. But on an individual level some flexibility would've been useful.

Q. Thank you.

Next question, and my last question, in fact.

In -- different topic -- in relation to reports that GPs were asked to do frailty scores, and you touched upon frailty scores this afternoon, Dr Mulholland, can you comment on whether this practice disproportionately affected older people and those with disabilities?

A. I think all frailty scores are higher, you have a higher index of frailty depending on the other illnesses you have, disability, age. So yes, it would've had more impact on that group because they would've had higher scores, or depending on the scale this would've been higher up the frailty index.

MS MUNROE: Thank you.

My Lady, the other questions were on PPE but

those have been sufficiently covered this afternoon. So thank you.

LADY HALLETT: Thank you for your help, Ms Munroe.

Dr Mulholland, thank you very much for your help, I am very grateful to you. I hope we haven't kept you too long today. But what you have to say is obviously extremely important in relation to primary care.

Thank you.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: Very well, 10.00 tomorrow, please.

(4.12 pm)

(The hearing adjourned until Tuesday, 24 September 2024 at 10.00 am)

I N D E X