Witness Name: Dr Jack Parry-Jones

Statement No.:1

Exhibits: 7

Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR JACK PARRY-JONES FRCP FFICM

I, Dr Jack Parry-Jones, will say as follows: -

PROFESSIONAL ROLE

1. I am a consultant in adult intensive care medicine. At the outbreak of the Covid-19 pandemic in the UK I had been employed in this role in Wales for 16 years. I am only employed as an Intensivist and worked throughout the pandemic in this capacity. Over the course of the pandemic I have been involved in the care of over 300 patients admitted to critical care (Intensive Care) with Covid-19 infection and its complications.

2. I was the Lead Clinician for the South East Wales Critical Care Network and, as such was involved in the intensive care response in Wales to the Swine Flu ("**Influenza A H1N1**") pandemic of 2009/10. A report was published by Welsh Government in 2011 on the impact of the Influenza A H1N1 pandemic by Professor Chris Jones, Deputy Chief Medical Officer for Wales **[JPJ/1 – INQ000480950]**. This report highlighted structural inadequacies in staffing and provision of critical care services in Wales. Despite this report, Wales went into the Covid-19 pandemic significantly under-prepared. Having been involved with this report I was well aware of the impact a viral pandemic could have on critical care services in Wales.

Although the order of magnitude of the Covid-19 pandemic was unprecedented, there were lessons that could have been learnt and practical structures implemented arising from the Swine Flu pandemic. These structures could have mitigated some of the worse effects of the Covid-19 pandemic and meant critical care services in Wales and more widely in the UK were more resilient and came out of the pandemic faster than it has been able. The main lessons of note that weren't learnt from the Swine flu pandemic were: the impact of too few staffed critical care beds, too few isolation beds, confusion around personal protective equipment, lack of extra corporeal membrane oxygenation service ("**ECMO**") in Wales, and the overall knock-on effect on other healthcare services of under provision of critical care. In particular, the excess pressure on elective surgery and anaesthetic services which have compounded waiting list lengths are in part due to a lack of staffed critical care bed capacity.

3. I am currently (appointed in October 2022 for a 3 year term of office) the Vice Dean for the Faculty of Intensive Care Medicine ("**FICM**"). The Faculty of Intensive Care Medicine is the professional and statutory body for the specialty of intensive care medicine, the doctors who lead critical acre services and Advanced Critical Care Practitioners, and also includes critical care pharmacists as members. During the Covid-19 pandemic I was Chair of the FICM Careers, Recruitment and Workforce Committee. In this Committee Chair role we surveyed our membership in the autumn of 2020 and published 'Voices from the Frontline' in November 2020 **[JPJ/2 – INQ000352926]**.

4. In my FICM role I had a public facing role for the specialty of Intensive Care Medicine ("**ICM**") including being interviewed by the media **[JPJ/3 – INQ000480955] [JPJ/4 – INQ000480953] [JPJ/5 – INQ000480954]**. These interviews document at the time my concerns going into the Covid-19 pandemic and during it. I was also the representative for intensive care on the Academy of Medical Royal Colleges Wales and during the pandemic represented intensive care on the Black Asian and Minority Ethnic ("**BAME**") working group in Wales (BAME Covid-19 Scientific Subgroup, chaired by Professor Keshav Singhal MBE). This group published a risk assessment tool - 'First Ministers Black, Asian and Minority Ethnic COVID-19 Advisory Group, Scientific Subgroup: risk assessment' **[JPJ/6 – INQ000082919]**. The group also published a summary report.

IMPACT OF COVI9-19 ON WORKING CONDITIONS

5. From 1 March 2020 to 28 June 2022 our working conditions in critical care were very different from pre-pandemic. To deliver care for the number of critically ill patients, critical care services had to expand massively, well beyond our usual critical care ward and into new areas (wards) of the hospital. In some places, expansion of critical care capacity was up to a four-fold increase in beds. This heavily impacted on other services e.g. elective surgery as well as the impact on the physical and mental health of critical care staff.

6. The inability to isolate patients with an infective respiratory disease meant patients needed to be cohorted with other Covid-19 patients but kept away, as far as possible, from critically ill patients without Covid-19 infection. This proved to be very difficult and meant additional ward areas needed to be requisitioned from other services to effectively separate Covid-19 infected critically ill patients from patients with other causes of critical illness.

7. The number of critical care staff was not able to increase sufficiently to care for the expanded number of patients. We worked longer hours, more nights, more frequently and with no leave during the first wave (annual or study leave) to try and best meet the huge surge in demand. The changes in UK FICM members working practices are documented in the FICM report 'Voices from the Frontline' published in November 2020 **[JPJ/2 – INQ000352926]**. More than 80% of members increased their working hours and more than 70% had to cover colleagues on sick-leave.

8. Despite these changes to working practice, the professional standards of care, as delineated in the Guidelines for the Provision of Intensive Care Services ("**GPICS**"), were frequently unable to be met. GPICS is a joint publication of the FICM and the Intensive Care Society ("**ICS**"). The publication includes standards and recommendations on staff to patient ratios. The Covid-19 pandemic waves had a greater impact on nurse to patient ratios. The standard ratio is one nurse for every ventilated patient. During peak pressures in the pandemic this dropped to one nurse for two patients and in some places 1 to3 and even 1 to4. Staff sickness due to Covid-19 and mental health also at times heavily impacted on the ability to meet rota requirements and staff to patient ratios.

9. Critical care medical staffing was not sufficient to meet demand in the first and second waves. We were very fortunate to have invaluable support from, in particular anaesthesia and respiratory medicine. I, as the FICM chair of Careers, Recruitment and Workforce publicly recorded our appreciation and gratitude in various publications for this support at our time of need **[JPJ/7 – INQ000480956]**. During the second wave many anaesthetists returned to their job of anaesthetising for elective surgery. This put pressure back on critical care medicine.

10. Doctors-in-training (**"DiT"**) made a massive contribution to critical care service delivery and patient care as well as to morale on units. Without their major contribution, critical care services would not have been able to come anywhere near meeting the increase in demand or for so long.

11. In my experience, camaraderie in critical care was very high in the first wave. By the second wave, critical care staff were exhausted. Morale dropped significantly. Furthermore, many of the anaesthetists who had been redeployed to help in Intensive Care Unit (**"ICU"**) during the first wave had been deployed back to support elective surgery, meaning far fewer were available to help. Our consultant rota arrangements also changed in recognition of the need to provide better continuity of care for the number of patients with Covid-19 who took much longer to recover than many with other causes of critical illness. The duration of critical illness had a major impact on critical care bed availability. At times during the pandemic 25% of patients with Covid-19 ventilated in ICU who survived their critical care admission had lengths of their intensive care stay greater than 27 days.

12. In my experience, whilst not universal, older, more experienced Intensive Care Medicine (**"ICM"**) consultants tended to be impacted less than younger colleagues who often had young children at home being schooled and who were trying to juggle family and work commitments. For many of them this was extremely stressful.

13. As Covid-19 was a new disease, the impact and stress of trying to keep up with medical developments was significant. Individual clinician's concerns that if only they had known more, or done more, then their patient would have survived, had a significant impact on many people's mental health and also more widely across the health care sector. This made 'switching' off more difficult for many people.

COVID-19 INFECTION PREVENTION AND CONTROL MEASURES

14. I had confirmed Covid-19 infection twice during the pandemic; in March 2020 and April 2021. The first time was very early on in the pandemic and certainly caught from a patient, with subsequently confirmed Covid-19 infection, from outside the critical care unit. This was identified as a 'super spreader' event. At that time the R number (Reproduction number, or the average number of people catching the infection from one other infected person) was said to be around 3. This patient is thought to have infected 36 other people - staff and other patients.

15. The risk of actually catching Covid-19 when working inside critical care units was relatively low. This was not universal, but where I worked, we had very good supplies of personal protective equipment ("**PPE**"). The PPE outside of critical care were significantly lower and the risks of infection correspondingly higher. In the units I worked in we never had to re-use PPE. Guidance lagged behind the evidence that this was an airborne virus. The amount of PPE we used was highly significant and the duration we used it for, was of major concern as to its environmental impact.

COVID-19 TESTING KITS

16. Once Covid-19 testing kits were available we could easily obtain personal testing kits through work. Prior to this, it was not difficult from the outset to get a test done provided you worked as frontline clinical staff. In my experience, people were not reluctant to get tested and at work were encouraged to do so. The duration of time away from work changed over the course of the pandemic as evidence on infectivity changed.

17. Covid-19 vaccination uptake amongst staff was also very good, was well organised and easily accessible.

VISITING RESTRICTIONS

18. Decisions about family visiting loved ones were made outwith of critical care services. The inability for family and significant others to visit had a major impact on staff. It made some staff seriously question what we, as healthcare professionals were actually doing this for if partners, parents, children and siblings could not visit when a loved one was dying or critically ill. Other staff saw it as a necessary restriction - a view consistent with the equivalent of wartime measures which some people viewed it as.

19. In my experience the public were incredibly respectful of imposed visiting restrictions. We provided regular phone updates and virtual meetings at the end of life (**"EoL"**) where possible and wanted but these are no real substitute for seeing loved ones at the end of their lives. These virtual meetings were also particularly difficult for nursing staff who experienced the secondary trauma of their patient dying with their loved one on a screen.

20. The most severe visiting restrictions - no visiting under any circumstances, applied during the first wave. During the second wave, visiting was restricted to EoL only and had to be booked. During the third wave, visiting was restricted in time and number of visitors and had to be booked. Post pandemic we have returned to normal visiting arrangements.

21. There were visiting restrictions that were particularly difficult. Social deprivation, poor housing and the link to ethnic minorities contributed to an increased risk of severe infection resulting, in some instances to multiple members of the same family becoming critically ill and being admitted to intensive care.

22. Caring for other healthcare workers infected either in their work or outside hospitals was traumatic. The deaths of any healthcare workers admitted to critical care had a particularly heavy mental impact on those caring for them. We were perhaps fortunate that no critical care staff from the units I worked in, were admitted to critical care and died. We did care for non-critical care health care staff some of whom died in our unit.

23. Obesity was a risk factor for severe infection and many of these patients required prone ventilation to improve oxygenation. This required a 'proning' team to turn patients over usually twice a day. A rota was required to do this and medical students, physiotherapists and other healthcare workers often volunteered to form these teams.

24. Certain underlying conditions increased the risk of severe Covid-19 infection and complications. These included patients on renal replacement (dialysis), and patients with poor immunity either from a disease or from its treatment. This included patients with haematological malignancy and those with solid organ transplants. Some patients also had very poor, or no immune response to Covid-19 vaccination. These people were particularly vulnerable, as were those who did not take up the

vaccination on offer. In the later stages of the pandemic these patients made up an increasing proportion of patients in critical care.

LONG TERM IMPACT

25. There are two major effects the pandemic has had on me as a healthcare professional. The first is in my work environment where we have lost a huge number of highly skilled and experienced critical care nurses. We have been able to replace the nurses, almost exclusively from South Asia, but you can only replace those skills and experience over a prolonged period of training and time. This impacts on the care we deliver. Staff retention was very difficult and remains challenging.

26. The second major effect is on my confidence that we will learn and implement any real changes as a consequence of this pandemic. Early on in the pandemic, during shut-down and clapping healthcare workers the political call was for the country to 'protect critical care services'. If we had put in place some of the recommendations from a decade earlier to have sufficient staffed critical care bed capacity, in line with most other European countries, we would have been in a much better position to meet demand. Pre-pandemic, Wales for instance needed to double its critical care bed capacity to reach the European average of 11 beds per 100,000 of the population. To put this into perspective Germany has 27 critical care beds per 100,000 population. The message that we need more critical care beds across the UK, better critical care staffing, and more medical training places for ICM doctors had been made consistently pre-pandemic. We will continue to make it, but the confidence that it will be acted upon is called into question. I hope the Inquiry helps address historical inadequacies so we don't go into another pandemic in the same situation again.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

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INDEX OF EXHIBITS OF DR JACK PARRY-JONES FRCP FFICM

JPJ/1 – INQ000480950	Report on the Impact of Influenza of Welsh Critical Care Units during the Winter of 2010-2011, undated
JPJ/2 – INQ000352926	FICM 'Voices from the Frontline of Critical Care Medicine' survey, dated 18 November 2020
JPJ/3 - INQ000480955	ITV News article: 'Intensive care consultant 'extremely concerned' about second wave of Covid-19', dated 12 May 2020
JPJ/4 – INQ000480953	BBC News article: 'Coronavirus: Wales 'uniquely at risk' with lack of ICU beds', dated 11 March 2020
JPJ/5 – INQ000480954	BBC News article: 'Coronavirus: 'Huge deficit' in critical care doctor training', dated 12 May 2020

JPJ/6 - INQ000082919	Welsh Government 'First Minister's BAME Covid-19 advisory group report of the scientific risk assessment subgroup.', dated October 2021
JPJ/7 – INQ000480956	RCP news article: 'NHS staff are exhausted and need a break, but there aren't enough of us', dated 27 April 2021