

Thursday, 31 October 2024

1
2 (10.00 am)
3 **LADY HALLETT:** Ms Hands.
4 **MS HANDS:** Good morning, my Lady. May I please call
5 Professor Bhangu, who will take the oath.
6 **PROFESSOR ANEEL BHANGU (sworn)**
7 **Questions from COUNSEL TO THE INQUIRY**
8 **MS HANDS:** Professor, good morning. You've provided
9 the Inquiry with a report with a colleague,
10 Dr Nepogodiev, titled "Unveiling the hidden impact:
11 Colorectal cancer". That is INQ000474244.
12 Before we start, is it right that you have a small
13 correction to page 22, table 4 of that report in
14 relation to the time frame for diagnosis to treatment in
15 Scotland?
16 **A.** That's correct. And it says 62 days. It should be
17 31 days.
18 **Q.** I'm grateful. Thank you.
19 **LADY HALLETT:** Just pause, I'm so sorry.
20 I can't see a transcript running. Is it just my
21 screen? Is there a transcript?
22 **MS HANDS:** No, it isn't.
23 **LADY HALLETT:** Have you -- sorry, have you got -- ah, it's
24 just me. Don't worry, it's just me.
25 **MS HANDS:** I don't have one either.

1

1 similar across all the nations.
2 **Q.** Thank you. And in regard to terminology, it's correct,
3 isn't it, that colorectal cancer is also referred to as
4 bowel cancer?
5 **A.** Yes.
6 **Q.** So, starting with the diagnosis and screening of
7 colorectal cancer, it's right that it can be
8 symptomatic, in which case patients will present to
9 their GP or A&E?
10 **A.** That's correct, yeah.
11 **Q.** And it can also be asymptomatic, and such cases are
12 usually detected through screening?
13 **A.** Yes, for those in that age bracket of which they can be
14 screened.
15 **Q.** And what is that age bracket?
16 **A.** So in England it's 54 to 74.
17 **Q.** Thank you. And briefly, what are the most common
18 symptoms?
19 **A.** In brief, they're things like changes in bowel habits
20 that are persistent and worsening, bleeding out of
21 someone's bottom, what we call rectal bleeding, and some
22 people present with pain and masses in their tummy.
23 **Q.** Thank you. And can you briefly explain the tests that
24 are used for diagnosing colorectal cancer and whether
25 any are more effective or suitable than others for

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1 **LADY HALLETT:** Don't worry, it can be fixed at the break for
2 me. But -- okay, as long as everybody else has one and
3 we have one running. Sorry to interrupt.
4 **MS HANDS:** Not at all. Thank you, my Lady.
5 Professor, it's correct, isn't it, that you
6 qualified in 2004, trained in general surgery and
7 completed a PhD for research into colorectal cancer?
8 **A.** That's correct.
9 **Q.** And you are currently a consultant colorectal surgeon at
10 University Hospitals Birmingham trust and professor of
11 global surgery at University of Birmingham?
12 **A.** That's correct.
13 **Q.** We're going to be looking today at the impact of the
14 pandemic on colorectal cancer. That is the fourth most
15 common cancer and second leading cause of cancer-related
16 deaths in the UK; is that right?
17 **A.** That's correct.
18 **Q.** And your report provides data where available for each
19 nation of the UK, which is very helpful. We won't have
20 time to go through each today so I want to ask you
21 whether you've observed any significant difference in
22 the data between each nation that you wish to set out at
23 the outset?
24 **A.** No, from the data available, the pattern of events
25 across the whole patient pathway appear to be very

2

1 certain types of patients?
2 **A.** The first choice test for diagnosis is an endoscopy,
3 which we call a colonoscopy, so that's also known as
4 a bowel scope. So it's a camera that goes into the
5 bottom. It can make a diagnosis based on what the
6 endoscopist can see. And the advantage is it also
7 allows a biopsy to be taken there and then.
8 We perform CT scans in some people who aren't
9 suitable for an endoscopy, so people who are older and
10 more frail, for example.
11 And those are the two common first line tests.
12 **Q.** And what was the most common method of diagnosis before
13 the pandemic?
14 **A.** Around 50% of patients symptomatically via their GP, and
15 then they come in on an urgent cancer referral pathway
16 into the hospital.
17 **Q.** Did that change at all during the pandemic?
18 **A.** During that first wave the reduction in diagnoses was
19 predominantly due to the difficulty in accessing the
20 health system, which would have been affected mostly in
21 those patients.
22 **Q.** We'll come on to look at that data in more detail in
23 a moment. It's correct that there was a pause in the
24 bowel screening programmes across the UK from around
25 March and April 2020, which resumed in June to October

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1 that year; is that right?

2 **A.** That's right. And that was timed with the cessation of
3 all elective activity in that period.

4 **Q.** And is it your view that that was the right decision, to
5 pause the screening programme at that time?

6 **A.** One of our recommendations coming out of this Inquiry
7 will be to continue ante-diagnostics, which includes the
8 screening programme, in future pandemics.

9 So, with hindsight, the answer is no, I would like
10 to have seen that continue -- to have continued during
11 that time period.

12 **Q.** Can we, please, have on screen INQ000474244, figure 21A.
13 We're going to look at figure 21A and B during
14 your evidence this morning, but starting with A, which
15 looks at the number of diagnosis rates in England for
16 2019 to 2020.

17 Please can you explain what the data in this graph
18 shows about the diagnosis rate during that period.

19 **A.** So this shows the number of diagnoses per -- each month
20 over the three years shown there, 2019, 2020 and 2021.
21 And the key focus is on the orange bar, which is 2020,
22 and you can see in March 2020, when the pandemic and
23 lockdowns hit, there was a steep drop in diagnoses, and
24 that lasted until the lockdown lifted, and then the
25 diagnoses rapidly increased again, to what we'd expect.

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1 **LADY HALLETT:** Just before you do, I'm sorry to interrupt.

2 **MS HANDS:** Yes.

3 **LADY HALLETT:** You say that you made the recovery because of
4 the frontline staff picking up red flags. As far as the
5 cancer screening and the elective procedures were
6 concerned, had that changed or is it just that the
7 frontline staff took their own efforts?

8 **A.** So during the pandemic we still continued to do some
9 surgery, even during the lockdown, because there were
10 patients already in the system, and some were still
11 managing to flow through. One of the main rate limiters
12 were these endoscopies and the camera tests and -- for
13 various reasons.

14 And so that was the direct activity of the
15 hospital staff, that enabled that to reopen to the
16 highest number per day as possible.

17 **MS HANDS:** And we're going to come on to look at some of
18 those barriers to restarting endoscopies in a moment.

19 Looking at the data we have on screen at the
20 moment in terms of the diagnoses of colorectal cancer
21 per year, can you explain the crude reduction and crude
22 excess numbers and what that shows in relation to the
23 impact of the pandemic.

24 **A.** And so the crude reduction, that shows between 2019 and
25 2020, and if you add that all up that comes to the 4,725

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1 And that's the key period there, and we think in
2 that period there were 4,725 fewer diagnoses than would
3 be expected. And that's one of the key groups of
4 patients who were lost in this pandemic.

5 **Q.** And how did it recover so quickly?

6 **A.** So this graph shows us that there was a very quick
7 recovery in activity, and that's largely due to the
8 activities of the frontline staff, in the GP practices
9 and the hospitals, who got back to business and found
10 ways around the problems we had at the time.

11 So we did as much endoscopy as possible and the
12 endoscopy rates picked up, the scanning rates picked up,
13 and the GPs were able to provide enough access for the
14 patients with these we call them red flag symptoms to
15 get back into the system. And so that frontline
16 clinical activity enabled these rates to continue.

17 And then you can see in 2021 there may have been
18 a slight increase in the number of diagnoses expected,
19 and so there was an element of catch-up in the system
20 that enabled some of those patients hopefully to have
21 flowed through.

22 **Q.** And in your report you have provided a comparison of
23 diagnoses of colorectal cancer per year across the UK.
24 So if we could please have on screen table 5,
25 thank you.

6

1 patients we think were lost during that first lockdown
2 period. And so that's based on what we would expect to
3 happen year on year. And it has been relatively stable
4 year on year. So I do think those were lost patients in
5 the system.

6 And then compared -- if we compare 2019, that's
7 the pre-pandemic baseline, to 2021, there's an excess,
8 and that largely accounts for those 4,725. So
9 numerically things balanced out. Now, were they the
10 same patients is a really important question? Not
11 necessarily. It's possible that some of those 4,725
12 patients were lost in the system and never came back and
13 some of the excess presentations were other patients
14 entering the system during 2021 when they felt the
15 health system was more open.

16 We can't -- there's no data linking all that
17 together at the moment so that's the best estimation we
18 have.

19 So, to summarise, we think that the numbers
20 overall balanced out but we can't guarantee that there
21 weren't some patients lost in that system.

22 **Q.** And in your report you set out a number of reasons or
23 potential reasons why, in your view, there may have been
24 fewer cancer diagnoses, particularly in table 12.
25 That's page 58, 59.

8

1 Could you just summarise some of those potential
2 reasons for us, please.

3 **A.** One has to look at the patient pathway. So the first
4 perception from patients was that either the GPs were
5 closed or patients shouldn't go to their GPs to
6 overwhelm the system. So some of these patients with
7 symptoms stayed at home and they didn't call anyone,
8 they didn't try to call anyone, they didn't try to
9 contact anyone.

10 There were some patients who at that time did try
11 and contact someone but because mobility was poor,
12 lockdowns were happening they couldn't access the system
13 at all. So, again, some of those patients gave up and
14 waited until the lockdowns were lifted. So that was the
15 first phase.

16 The second point where people did manage to get
17 through the system are capacity for endoscopy, which are
18 the camera tests, fell dramatically, so it fell to
19 about 5% of what we'd normally be doing. And so our
20 capacity to provide diagnosis during that period also
21 fell.

22 And so those are the two main reasons why there
23 was a fall in diagnoses in that first phase.

24 **Q.** And one of the reasons you've mentioned is that GPs
25 thought that they should reduce or stop urgent suspected

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1 and the health service to the GP and the GPs
2 understanding who they should and should not be sending
3 in to hospitals at that time.

4 And that reflects an underprepared health system
5 for cancer diagnostics at that time.

6 **Q.** You've set out at your paragraph 62 that it is critical
7 to consider the counterfactual position. Can you just
8 explain what you meant by that and why you see that as
9 so important?

10 **A.** It is, and without that lockdown, hospitals may have
11 been even more overwhelmed than they were and that could
12 have had a lot longer effect on diagnostics, combined
13 with the fact that if we'd kept elective diagnostics and
14 surgery going at maximum capacity in, at the time, what
15 we called a mixed Covid environment, so hospitals
16 provided elective and emergency surgery at that time
17 point, Covid infections for those patients could have
18 been very harmful. These were often old, frail patients
19 coming for diagnostics and not all of whom will end up
20 with a cancer, so they would have been very heavily
21 exposed to Covid at that moment in time entering the
22 hospital. So the total harm of that could have been
23 even greater.

24 **Q.** And in your recommendations you've suggested that in
25 future there should be an evidence-based stratifier for

11

1 cancer referrals.

2 If we could have on screen, please, INQ000087325.
3 Thank you.

4 This is part of a 17-page letter that was sent
5 from the Medical Director for Primary Care to GPs in
6 England on 19 March 2020. It's at tab 24 if you do wish
7 to look at it.

8 The letter is dated 19 March 2020 and set out the
9 next steps for general practice.

10 Page 6, which is on the screen, is part of
11 an annex to the letter, headed "Actions we are taking
12 nationally to free up capacity".

13 And halfway down it states that:

14 "People who are concerned about any symptoms
15 related to suspected cancer should still contact their
16 GP and GPs should make sure that they continue to
17 refer those for suspected cancer for diagnostic tests
18 as normal."

19 In your view, was that instruction sufficiently
20 clear and accessible for GPs, particularly given the
21 volume of information coming out at that time in
22 mid-March 2020?

23 **A.** No, is the answer. I don't think that information was
24 accessible nor was it clear at that time, for both ends
25 of the spectrum, the information coming from hospitals

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1 diagnostic testing and potentially access to alternative
2 screening and diagnosis options in future.

3 In layman's terms can you just explain what you
4 mean by that?

5 **A.** So one of the things that was coming into place during
6 the pandemic and did help us with the recovery is what's
7 called a FIT test. So it's a screening test, it's
8 a home stool test, so patients get posted out a piece of
9 card, and forgive me for being graphic, you get a little
10 stick, you get a little bit of poo and you smear it on
11 the card and you put it back in the post, and that goes
12 off to a lab and they test it for hidden blood that you
13 cannot see with the naked eye. And then if it's
14 positive that triggers a referral into the hospital on
15 the faster diagnosis pathway and those are the patients
16 who progress very quickly to a diagnostic test which is
17 mostly a colonoscopy.

18 So that is very much come into frontline practice
19 now. It is a good stratifier because if it's a negative
20 test you're highly unlikely to have a cancer, so it
21 allows us to focus on the positive tests. So in the
22 next pandemic we should be focusing solely on that group
23 of people with a positive test to match our capacity at
24 that time.

25 **Q.** And to what extent were those tests available across the

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1 UK during the pandemic?
 2 **A.** They weren't as available as they are today. It was
 3 being rolled out by the bowel cancer screening programme
 4 at that time and, if anything, the pandemic increased
 5 the speed at which they were being rolled out, so by the
 6 end of 2021 they were far more commonly used than at the
 7 beginning of 2020.

8 **Q.** I want to look specifically at endoscopy now, as the
 9 gold standard test you've described it as in your report
 10 for colorectal cancer diagnosis and one that, as you've
 11 referred to already, was directly impacted by the
 12 pandemic. It's correct that there were no specific
 13 tools or guidance for prioritising endoscopy before the
 14 pandemic, was there?

15 **A.** Not for -- no, not related to the pandemic but the
 16 main -- one of the main focuses for that test is what
 17 used to be called the two-week wait pathway. So those
 18 are patients who, within two weeks of being referred by
 19 a GP, they should end up with a diagnosis of a cancer
 20 within that time period. So that was a focus for
 21 endoscopy and it's throughout the country.

22 **Q.** And that remained in place throughout the pandemic?

23 **A.** Yes, it did, and it still is. It's now called the
 24 Faster Diagnosis Standard.

25 **Q.** In your report you've explained that there was

13

1 and PPE. Were you aware of a delay in services
 2 restarting?

3 **A.** I think it did take a long time to get the full breadth
 4 of services restarted and one might argue we're still
 5 not quite there. In terms of the number of cancer
 6 diagnoses, we did -- it looks like we did get back there
 7 and we're back to how we were performing before the
 8 pandemic and that's a combination of what the GPs are
 9 doing to refer and stratify patients, that stratifying
 10 test, now all of the Faster Diagnosis Standard tests,
 11 what used to be called the two-week wait pathway, the --
 12 NICE recommends -- who make the recommendations over how
 13 we practise, that they have this accompanying FIT test,
 14 so we're better able to identify those with a very
 15 positive test and get them into the endoscopy slots.

16 But endoscopy was the hardest-hit unit in the
 17 whole of this pathway and even today the capacity is
 18 a struggle.

19 **Q.** And you referred earlier to colonoscopies and is it
 20 right they were also impacted to a significant extent
 21 for the same or very similar reasons?

22 **A.** Yes, so by -- endoscopy encompasses a colonoscopy, which
 23 goes all the way around the bowel, and what's called
 24 a flexible sigmoidoscopy, which goes halfway around the
 25 large bowel.

15

1 a divergence in guidance that emerged at the start
 2 of April 2020 when Public Health England and NHS England
 3 were advising that endoscopy could be safely carried out
 4 and indeed should be prioritised and the British Society
 5 of Gastroenterology, or BSG, advised suspending all
 6 non-emergency activity for six weeks including endoscopy
 7 due to concerns for staff safety in conducting
 8 aerosol-generating procedures and the need for
 9 redeployment.

10 To your knowledge which guidance was followed and
 11 was there any inconsistency in approach taken?

12 **A.** The guidance that was mostly followed was from the
 13 British Society of Gastroenterology which advised
 14 caution on behalf really of the staff working and it was
 15 a combination of the fears of the effects of aerosol
 16 generation and also some of the change in
 17 recommendations that came round at the time around
 18 changing air in the rooms between patients and the time
 19 that takes, and in combinations those slowed down both
 20 the total number of endoscopies that could be provided
 21 and also within an individual time slot, half a day, the
 22 number that could be provided there.

23 **Q.** And the guidance from the BSG was updated at the end
 24 of April 2020 to -- for the phased safe restart of
 25 endoscopies including measures such as Covid-19 testing

14

1 **Q.** The Association for Cancer Surgery provided a statement
 2 to this Inquiry and they said that the lack of
 3 a centralised system to gather, review and disseminate
 4 expertise, for example on AGP risks of endoscopy, caused
 5 inconsistency and confusion.

6 Firstly, would you agree with that?

7 **A.** Yeah, absolutely, and it reflects some of what we've
 8 said around the provision of endoscopy, the provision of
 9 information to GPs, and then the provision of surgery as
 10 well.

11 **Q.** And would you recommend that a centralised system be
 12 established prior to any future pandemic to ensure that
 13 we're in a better place if -- going into another one?

14 **A.** Yes, and I think two key recommendations there. Firstly
 15 is centralised communication which is harmonised and
 16 doesn't have too complex a flow so it can get out to
 17 those who need it quickly.

18 And secondly, since the pandemic, this concept of
 19 diagnostic hubs has increased so these are standalone
 20 units which can provide scans and endoscopies, outside
 21 of the major hospitals. And one of our recommendations
 22 is that these units need to be prepared for the next
 23 pandemic. So things like communication pathways,
 24 testing, they can be ramped up very quickly if this were
 25 to happen tomorrow.

16

- 1 **Q.** You've already covered some of my questions in regard to
2 the cancer screening programme and FIT testing. Is it
3 right that there's a variation in uptake of screening
4 across the UK, and is that impacted by geography or
5 demographic?
- 6 **A.** There is definite variation in uptake and it's both of
7 those things you said. There's geographical variation,
8 there's variation based on deprivation, so we know that
9 more deprived communities have lower uptake and then
10 there's variation based on ethnicity, with ethnic
11 minorities having a lower uptake as well. And then
12 there's the intersection of ethnic minorities in
13 deprived areas who have the lowest uptake.
- 14 **Q.** Were they pre-existing before the pandemic or did they
15 arise and worsen during that period?
- 16 **A.** They were pre-existing before the pandemic, I think they
17 were present during the pandemic and they are present
18 today.
- 19 **Q.** And I think in your report you've given some suggestions
20 as to how they could be reduced in a future pandemic.
21 Could you just explain some of those, please.
- 22 **A.** And a lot of it is around communication and it ties into
23 communicating around the bowel cancer screening
24 programme now, how do we most effectively communicate it
25 to the patients who are mostly to benefit from it.

17

- 1 **Q.** I was going to say, the proportion diagnosed with
2 stage 3 or 4 recovered by the end of 2020, you've said,
3 when diagnosis returned to normal?
- 4 **A.** Yes.
- 5 **Q.** Do we know yet if that's had any long-term impact?
- 6 **A.** No, we haven't got the five-year survival data from that
7 time period, and that data even then doesn't come out
8 for five years after the pandemic, it tends to -- first,
9 five years has to pass, which is the average of
10 five years for the patient, then the data has to be
11 prepared and published, and that itself could take
12 a few years. So we might not know for a few more years
13 the impact of that time period on overall survival.
- 14 **Q.** You've also said in your report that 20% of data was
15 missing. Are you able to opine as to why that was and
16 what impact that might have on our analysis of the data?
- 17 **A.** Yes, it's -- the data is probably missing because the
18 normal people who would collect that data and input it
19 into the various systems to exist were locked down
20 during that time period, with a large shift to not being
21 in a hospital and not having the system around it to
22 support that data collection.

23 So that's probably why it happened. And the
24 effects are that we don't know -- there are some
25 knowledge gaps. For example, there's some data on

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- 1 But also, if there is another pandemic, how do we
2 communicate to patients that the GPs remain open, that
3 people should take part in bowel cancer screening, that
4 if they have these symptoms they should seek medical
5 help. And that will require a whole system to address
6 that. It will be the hospitals, it will be the general
7 practitioners, it will be the public health physicians.
- 8 **Q.** I want to move on to staging. You've referenced staging
9 in your report, and is it right that that refers to how
10 advanced a cancer is?
- 11 **A.** That's correct, the stage at presentation.
- 12 **Q.** And there are four stages, with 3 and 4 being for the
13 most advanced cancers?
- 14 **A.** That's correct.
- 15 **Q.** And put simply, is it right that the rates of survival
16 are better in earlier stages of cancer, when they're
17 seen at presentation?
- 18 **A.** Yes, very much, and there's good evidence to support
19 that.
- 20 **Q.** In terms of the data during the pandemic, is it right
21 that it shows that during April to June 2020 there was
22 a small increase in the proportion of patients with
23 advanced disease when there were fewer diagnoses?
- 24 **A.** That's correct, there was a blip up, which came down
25 relatively quickly.

18

- 1 an excess of deaths at home during to colorectal cancer
2 and we can't link that all together. We don't know
3 whether that's because of the missing data or we don't
4 know if that's because these patients were present
5 before the pandemic and died at home and ...

6 So that's a really complex area, actually, that we
7 might -- I'm aware we might not ever be able to unpick
8 it.

- 9 **Q.** You've touched already on some of the performance and
10 the referral to diagnosis. So I want to continue on
11 that theme.

12 You've set out in your report very helpfully the
13 referral performance standards across the UK and the
14 different metrics and targets. Were those targets met
15 prior to the pandemic?

- 16 **A.** They were beginning to dip in 2019 across all countries
17 and across all health systems. So they were being met
18 five, eight years ago, before the pandemic. Then in
19 2019 they were dipping and the pandemic has exacerbated
20 all of that.
- 21 **Q.** You've said in your report that it's critical that
22 adherence to cancer performance standard is maintained.
23 Does that include throughout the pandemic?
- 24 **A.** Yes, we were very -- we and I and as a community we'd
25 like it see that happen. I think these targets in the

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1 NHS, they can be quite political words but equally they
2 hold the system accountable. Targets like this come
3 with a whole infrastructure of people behind them,
4 administrators, multidisciplinary team coordinators and
5 people who can chase test and ensure they're done. So
6 without that -- targets, that infrastructure is all
7 lost, and the accountability.

8 So keeping that target in place and ensuring
9 adherence is one way to ensure that both now and during
10 future pandemics we're all moving in the same direction
11 and aiming for the same thing.

12 **Q.** As a summary of your evidence, I'm looking at your
13 paragraph 71 in relation to referrals for treatment, is
14 it right that there was an initial fall, which recovered
15 around 2020 but didn't exceed 2019 levels?

16 **A.** Yeah, that -- if I've understood that correctly, that
17 makes sense. There was a fall in the number -- can
18 I just clarify --

19 **Q.** Yes. It should be page 45.

20 **A.** Yes. So there was a fall in the number of operations
21 that took place, which fits with the reduction in
22 diagnoses.

23 **Q.** And what about referrals?

24 **A.** Yeah, there was quite -- during that first phase of the
25 pandemic, sorry?

21

1 have these symptoms, and those are the reasons that led
2 to the drop in diagnoses.

3 **Q.** Thank you. I'd like to move on to treatment pathways
4 now.

5 You've helpfully provided a long list of the
6 specialised healthcare professionals that are involved
7 in the management of colorectal cancer in your report,
8 and you've placed particular emphasis on the importance
9 of shared decision-making between professionals and the
10 patient and the multi-disciplinary team approach. Was
11 that approach impacted by the pandemic?

12 **A.** I think yes. Communicating with patients definitely
13 changed and became harder in some ways. Getting
14 patients into the hospital physically for these
15 discussions was a major challenge to some of these
16 patients as well, combined with the stress and strain of
17 the rest of the pandemic.

18 The multidisciplinary team meetings continued, and
19 they did continue on a weekly basis. Not everyone was
20 there because a lot of people were redeployed. I was
21 redeployed during that first phase. But the meetings
22 did still take place by a range of other staff.

23 And that was critical to providing both the
24 surgery that did take place and the oncology treatments
25 that also took place during that time period. And these

23

1 **Q.** Yes.

2 **A.** Yes, there was a definite fall in the number of
3 referrals that took place during that phase.

4 **Q.** And it recovered around October; is that right?

5 **A.** Yeah, that's correct. So the number of diagnoses then
6 upticked very quickly, recovered by around October, but
7 it didn't exceed the number of 2019 referrals -- the
8 referrals in the same time in 2019.

9 **Q.** You've also addressed this at your paragraph 53 so it
10 may be helpful to look there. That's page 25. And
11 you've set out there some of the reasons for the decline
12 in those referrals?

13 **A.** Yeah, and it's -- as we discussed, it's -- patients were
14 anxious about leaving homes, and these are some of the
15 vulnerable patients with red flag symptoms. So lots of
16 people just stayed in their home for that time period.

17 There was the perception that GP practices were
18 closed, which they weren't but there was reduced
19 physical access into most GP practices at the time.

20 There was the perception from some GPs that these
21 urgent referral pathways were closed, as we've also
22 discussed.

23 So when we take that, it reflects a lack of
24 preparation in the system and a lack of consistent
25 messaging into the community around patients at risk who

22

1 multidisciplinary meetings and those pathways should
2 definitely continue in future pandemics.

3 **Q.** Was there use of remote technology in order to enable
4 those meetings and the patient involvement to continue
5 where appropriate?

6 **A.** Yes, especially around the staff of that team being able
7 to attend a once-a-week meeting. And that still happens
8 now, so it's been a positive impact.

9 **Q.** Can you briefly summarise the treatment options and
10 pathways for colorectal cancer. It's set out in full in
11 your report, and I would encourage anybody to have
12 a look who is interested, but if you could just
13 summarise those for us, please.

14 **A.** In brief, most patients will achieve a cure via surgery,
15 and that's surgery to remove the affected section of
16 bowel.

17 There's a small group of patients with a very
18 early cancer where it can be removed at the time of
19 a colonoscopy, avoiding the need for surgery.

20 And then there are some patients who can undergo
21 radiotherapy and chemotherapy to either bring them
22 benefit before or after an operation. And in some
23 patients that can make the cancer disappear altogether
24 and they can avoid surgery.

25 But surgery remains the mainstay of treatment.

24

1 **Q.** You have posed five research questions in relation to
2 surgery for colorectal cancer, at paragraph 51, page 23.
3 Could you briefly just summarise those questions and
4 your findings in relation to them, please.

5 **A.** Yes. So at the time we launched a big research response
6 to surgery in Covid-affected environments, and this
7 project, led from England, gave data to surgeons around
8 the world in what to do.

9 So the first question is: was it safe to have
10 surgery in an unselected mixed hospital?

11 And that's a huge question that was of interest to
12 the taxpayer and the general public around the world.
13 And the answer was no, it was not safe to have planned
14 surgery in what we called a mixed Covid environment at
15 that time. We call them "hot hospitals".

16 So that was the first question that was answered.
17 And that was one of the key critical questions that is
18 affecting and influencing the delivery of elective care
19 today: is it safe to have this all in one big hospital
20 where all the emergency infected patients can be mixed
21 in?

22 The other questions around delays for positive
23 patients, we answered that: it's better to wait for
24 several weeks.

25 What about testing regimes? Should they be
25

1 March and April 2020 period switched to open surgery for
2 the perceived safety risk to the staff.

3 **Q.** And is it right that that -- the lower proportion of
4 procedures led to an increase in stoma-forming
5 procedures?

6 **A.** They're slightly different questions. So the shift to
7 keyhole versus open, you can do the same operation
8 keyhole or open. So there was a shift to open surgery
9 to protect the staff and prevent this concept of aerosol
10 generation.

11 The shift to stomas was in some higher risk
12 patients because bowel surgery -- I describe it to
13 patients: it can be like plumbing, it can leak. And if
14 it leaks you end up in hospital for a long time, you
15 might have to go back to theatre. So to avoid the risks
16 of all of that we created more stomas than we would
17 perhaps today, to remove the risk at all of these leaks.

18 **Q.** Are there any disadvantages to the patients in that
19 move?

20 **A.** There are. Most patients at that time would not choose
21 to -- most patients now or before would not choose to
22 have a stoma. Most of those patients could have got
23 through surgery without a stoma at all. And then the
24 patients have to undergo a second operation to reverse
25 that stoma. So there were disadvantages to that

27

1 complicated or simple? We unpicked that: a simple swab
2 would be straightforward for most patients.

3 What is a safe -- how long can you wait with
4 cancer surgery before performing the operation safely?
5 We said a maximum of 4 to 8 weeks. That's the absolute
6 maximum we'd be aiming for.

7 And then what are the features of the safest place
8 to have surgery? We have identified those. Those are
9 Covid-free elective hubs. And those elective hubs are
10 being expanded today.

11 **Q.** Thank you. We will return to some of those points but
12 it's helpful to have that context set out. I want to
13 deal first with laparoscopic procedures in relation to
14 surgery. It's right that there is, again, initially
15 a divergence in the advice from the specialist
16 associations of the perceived risk of an increased
17 aerosol spread of Covid-19 during those procedures; is
18 that right?

19 **A.** Yes, with most people during that first phase of the
20 lockdown, most organisations eventually saying that they
21 perceived a risk from that procedure.

22 **Q.** And so you said some -- or "most" centres, so there was
23 some divergence between the centres as to whether they
24 continued to offer those procedures or not?

25 **A.** Yes, in pockets. Most people, most surgeons for that
26

1 practice.

2 **Q.** And I think you said the rate of the stoma reversal also
3 fell during the pandemic in your report; is that right?

4 **A.** It did, and there were some patients left for long
5 periods of time with stomas where we would not normally
6 have left them with stomas for that long.

7 **Q.** The guidance in relation to the safety of laparoscopic
8 surgery changed between May and June 2020. Again, is it
9 right that there was some variation in when there was
10 actually a return to the pre-pandemic rates of those
11 procedures being conducted?

12 **A.** Yeah, there was. As with restarting all technologies,
13 there's a curve to get it back to the existing levels
14 and to the levels that we'd want, and that did take
15 a little bit of time, but it was relatively quick to get
16 back to what the pre-pandemic keyhole surgery rates
17 were.

18 **Q.** In your opinion overall, was there an impact on patient
19 choice of treatment during the pandemic?

20 **A.** There definitely was. I actually -- the difference
21 between keyhole and open surgery is relatively minor.
22 The difference between surgery with and without a stoma
23 is relatively big, especially from the patient point of
24 view. So there was an impact there.

25 **Q.** And it's also correct that there was a move to
28

1 administer more short course radiotherapy regimes for
2 rectal cancer; is that right?

3 **A.** There was. And that is what -- radiotherapy can be
4 given over a five-day period, which is intense
5 radiotherapy, or it can be spread out over a five-week
6 period. So, again, to keep patients away from the
7 hospital, and also because there weren't as many staff
8 around either, there was a shift towards this shorter
9 course of radiotherapy.

10 **Q.** Do we know the impact of that yet on the patient
11 recovery rates?

12 **A.** No, there's no -- that gets so complicated in terms of
13 looking at exactly the type of tumor and the stage and
14 then the survival of that that we don't know the direct
15 effects of that yet, no.

16 **Q.** Were there any immediate effects on the patient of that
17 change in treatment?

18 **A.** I suspect some patients found it a lot easier to have
19 five days of radiotherapy rather than coming back to
20 these Covid-infected sites over a five-week period.

21 In terms of the biology, we've got no evidence
22 that it had a positive or negative effect, and we'll
23 have to look at that in the future.

24 **Q.** If we could have a look at your figure 21 in relation to
25 the number of resections.

29

1 desperation but as described there were still some
2 elective patients coming through.

3 **Q.** And I think you said in your report there was no major
4 shift observed to presentation via an emergency route
5 during the pandemic, is that right?

6 **A.** That's right, there wasn't a sudden increase in the
7 number of patients coming in, it was really
8 proportionate to what we'd normally expect.

9 **Q.** And were healthcare professionals supported or advised
10 on how to manage these changes -- any changes to the MDT
11 decision-making and treatment pathways?

12 **A.** There was guidance -- well, there was some guidance from
13 associations around timing of surgery and priority of
14 surgery, but things like stoma rates were largely made
15 by individual surgeons at the time with -- on discussion
16 with the patients and what the patients would tolerate
17 and what they wanted and how fit they were. So
18 incomplete guidance is how I'd phrase it.

19 **Q.** That brings me on to the next topic of prioritisation
20 guidance. Thank you.

21 So there were no specific tools for prioritising
22 surgery before the pandemic, was there?

23 **A.** No.

24 **Q.** And it's right that there were two types of
25 prioritisation that emerged initially from NHS England

31

1 So it's -- thank you.

2 So this is the second half of the graph that we
3 were looking at earlier. Can you just explain to us
4 what this shows in terms of the number of resections in
5 England between 2019 and 2022, please.

6 **A.** Sure. And it's consistent with the diagnostic data.

7 There was a fall in the number of resections performed
8 in that first phase of 2020, which is the orange graph.

9 Now, it wasn't as steep as the fall in diagnosis because
10 there were already patients in the system, and it didn't
11 fall down as low as the number of diagnoses, because
12 there were still some people coming through emergency
13 routes and other routes who we managed to get into
14 surgery.

15 So surgery did continue throughout the pandemic
16 in -- it was often in different locations, so we used
17 private hospitals a lot for this service, because we
18 didn't want to do these operations in the big Covid
19 hospitals. But, again, combined -- the frontline teams
20 and that flow of patients kept some surgery going.

21 **Q.** Does this include elective and emergency surgery, this
22 data?

23 **A.** Yeah, that includes all of the resections done, the
24 electives and the emergencies. So the emergency
25 patients still presented to A&E departments in

30

1 and NICE as to patient prioritisation for systemic
2 anticancer treatment and then surgical prioritisation;
3 is that right?

4 **A.** Yes.

5 **Q.** And I think you've said in your report that the
6 dissemination of that information from NHS England was
7 delayed, which you have attributed to a lack of
8 system-wide preparation which you've already touched on
9 this morning; so is that a fair summary?

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

11 **Q.** Quite quickly after that guidance was issued, on 9 April
12 the Federation of Surgical Specialty Associations was
13 asked to provide guidance and issued it on 9 April,
14 setting out four priority levels for surgical
15 prioritisation.

16 **A.** Correct.

17 **Q.** That was then updated and the NHS England advice was
18 also updated in line with that. In relation to colon
19 cancer and rectal cancer it advised that surgery could
20 be delayed by up to three months, so that's outside your
21 four- to eight-week period that you had advised. Did
22 that raise any concerns?

23 **A.** No, I think from our point of view if we were to say
24 a delay of two to three months is the maximum that we
25 would be looking for, that would -- I would consider

32

1 that to be consistent advice. I don't think those extra
2 few weeks for this type of cancer make that much
3 difference. We never try to get people to the maximum
4 we try to get people through the system as quickly as
5 possible. So the number of people with a diagnosis and
6 an MDT decision who get to two to three months down the
7 line is very small.

8 **Q.** Did that guidance help professionals make those ethical
9 prioritisation decisions, in your view?

10 **A.** I think so, and that advice by the Federation of
11 Surgical ... Associations was important and it was
12 quite -- one of the things that they did well was that
13 it was quite holistic so it covered a whole range of
14 procedures. All surgeons want to sort of fight their
15 patient's corner and advocate for their patients and get
16 them into operating theatres but under severe resource
17 constraints someone has to make a decision about who is
18 going to use that and that framework allowed us to do it
19 more objectively than if each hospital had tried to do
20 it themselves.

21 So I think that was very welcome and I think that
22 should be part of the future pandemic response as well.

23 **Q.** Was there any confusion caused by the multiple guidance
24 documents that were issued around a similar time?

25 **A.** Yeah, I think so, definitely. And we've already touched

33

1 **Q.** And in your report you've described the performance and
2 those points of 170 UK hospitals compared with
3 119 countries. We don't need to explore each country
4 and each score but perhaps you could identify the areas
5 where the UK scored the highest and lowest.

6 If it helps it's table 11, page 55 of your report.

7 **A.** So we -- at that time of the pandemic we scored lowest
8 around ring-fenced care. So that is -- ring-fenced
9 elective care means physical locations and staff who
10 were dedicated to the task. So the ability to have
11 ring-fenced elective surgery beds that aren't going to
12 be cancelled because of the pressures from an emergency
13 department. The same for the critical care units and
14 the pressures that will, again, come from the emergency
15 department. But also staff who aren't redeployed to
16 other areas. And that actually tends not to be so much
17 the surgeon, it's the theatre nurses, it is the
18 anaesthetist who might have to go and support other
19 areas of the hospital.

20 So ring-fenced staff and ring-fenced beds were
21 where we definitely scored weakest and that's where some
22 of the response has been to strengthen those areas.

23 **Q.** And perhaps where we scored highest?

24 **A.** Globally we scored highest around the reliability of
25 things like electricity and oxygen and drugs, which we

35

1 on some of the associations issuing guidance and then
2 there were updates to the guidance and then
3 hospital-specific guidance. So it definitely was
4 a confusing period for the frontline teams and I think
5 that, again, that reflects the lack of preparation for
6 elective cancer care.

7 **Q.** To your knowledge, are those prioritisation frameworks
8 still being used in the UK?

9 **A.** Yeah, we still use them to help guide and prioritise
10 patients into operations and around the concept of
11 waiting lists. They're not used as perhaps as directly
12 as they were, so by that I mean the capacity to provide
13 all types of surgery is obviously higher than it was.

14 But they were useful and they do remain useful as
15 well to keep patients on track and keep cancer patients
16 as high priorities.

17 **Q.** Moving on to the topic of preparedness. In your report
18 you've described a surgical preparedness index. Perhaps
19 you could just very briefly, in layman's terms, explain
20 what that it is.

21 **A.** It's a 23-point assessment tool that clinicians can use
22 themselves to assess their hospital across a range of
23 features, and come out with a score and then see where
24 their weak areas are, where their strong areas and where
25 they would potentially rank amongst everyone else.

34

1 are lucky enough to take for granted but in our -- we
2 know from places like Nigeria the operating theatre has
3 seven power cuts a day so we are lucky to take them for
4 granted and I'm glad about that.

5 **Q.** And you've set out in your report a helpful diagram that
6 there was also regional variation across the UK in your
7 findings, is that right?

8 **A.** There is, and at the time of that study there was
9 regional variation and we can see areas of the north of
10 England performed very well because they already had
11 some concept of elective hubs there, which were not
12 present in the rest of the country. And that regional
13 variation probably remains today but it's definitely
14 being strengthened by this concept of diagnostic hubs
15 which are meant to be small community-based environments
16 to provide diagnosis, but also the 20 or 22 such
17 elective hubs that are being set up around the country,
18 elective surgery hubs.

19 These are hubs that are meant to be physically
20 separate from hospitals, the A&E departments, and they
21 can provide elective surgery at volume without the risks
22 of cancellations and that strengthens the area of
23 ring-fenced care.

24 **Q.** Could this index be used to prepare for future
25 pandemics?

36

1 **A.** It definitely could, it definitely should. It was
 2 designed to be relatively easy to collect and not
 3 onerous which is really important for frontline staff
 4 who are doing these things but it also empowers
 5 frontline staff to try and make some of these changes.

6 **Q.** You've referred to the hubs and the Covid-free pathways
 7 a number of times already. Could you just set out the
 8 extent to which they were available and used during the
 9 pandemic and perhaps briefly where we are now in the
 10 development of those hubs?

11 **A.** So on sort of day 1 of the pandemic they didn't exist.
 12 Very quickly capacity was ramped up to provide this type
 13 of surgery predominantly in private hospitals. Where
 14 these hubs did exist, like The Marsden and The Christie
 15 and some of the centres in the north, they continued and
 16 they became regional hubs to provide this type of
 17 surgery. And they were able to provide all the testing
 18 and the things needed to get someone ready for a major
 19 operation.

20 Today there are more hubs in existence and the
 21 model to provide that type of surgery works. They're
 22 not -- you still need the major hospitals. If a patient
 23 needs a big operation and they've got heart and lung
 24 problems and they're very old and frail they still need
 25 to be in one of the big hospitals that has a huge ITU,

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1 **A.** I think it definitely fulfilled a role then and it was
 2 used to the potential that we needed it to be used.
 3 I think that since sort of drafting [...] this pandemic
 4 and how the hubs have developed, the hubs will provide
 5 a more reliable cost-effective solution to this problem
 6 and I think that the private sector should still be
 7 engaged -- it's this private sector capacity, it's the
 8 physical facilities to provide additional capacity if
 9 needed but actually as the community hubs open and the
 10 elective surgery hubs open they should provide the bulk
 11 of it now.

12 **Q.** Moving on to a slightly different topic. Was there any
 13 evidence of cancer patients receiving chemotherapy or
 14 other treatments being at an increased risk of mortality
 15 from Covid compared with those not on active treatment?

16 **A.** I don't think there's any evidence to suggest that they
 17 were at any excess risk compared to what they were
 18 anyway. A lot of those patients took quite extreme
 19 precautions around their lives at that time period. So
 20 they isolated very aggressively, they didn't see
 21 families, they travelled to and from very carefully, so
 22 that probably protected them at the psychological cost.

23 **Q.** And in your report you've set out the ONS data on excess
 24 deaths for England and Wales for March 2020
 25 to December 2022, at your paragraph 77, if it helps.

39

1 has a big radiology department, and by definition those
 2 hospitals have A&E departments. So these are
 3 ring-fenced but they can't stand alone from a major
 4 hospital.

5 Also, if the patient needs to go back to theatre
 6 at night for an emergency reason, again you need that
 7 big hospital to support that process.

8 So those are being expanded today and those are
 9 definitely part of the future of the NHS.

10 **Q.** Do you have any recommendation about how they could be
 11 used better in a future pandemic or perhaps ring-fenced,
 12 as you've suggested?

13 **A.** It's about getting them prepared as well for the next
 14 pandemic. At the moment, quite rightly, those hubs are
 15 focused on waiting lists and flow and diagnosis but if
 16 a pandemic was to hit tomorrow they will still have the
 17 problems over communication, pathways, PPE, testing,
 18 communication with the general public. So having plans
 19 in place now will mean that if that happens they can
 20 rapidly adjust without the pains that happened the first
 21 time.

22 **Q.** You've recommended an increase in public-private
 23 partnerships in the future in your report. In your view
 24 was the independent sector utilised to its full
 25 potential during the pandemic?

38

1 But is it right that you have surmised that there was
 2 1,630 excess deaths from colorectal cancer and anal
 3 cancer compared to what would have been expected on
 4 a five-year average?

5 **A.** Yes, and that's what the data says.

6 **Q.** And that there were 4,445 more deaths from the same
 7 cause at home than would have been expected?

8 **A.** Yes, but I'm quite cautious about that data. It doesn't
 9 tally up with the -- when we were looking at the graphs
 10 around the lost diagnosis and then the recovery in 2021
 11 so those graphs suggest that the numbers matched up and
 12 the number of diagnoses was eventually caught up and
 13 this data suggests that that's not necessarily the case.

14 That's because this data probably represents some
 15 patients who had cancer before the pandemic, never
 16 presented to the hospital, were never going to present
 17 to the hospital. We don't quite know during that time
 18 period how some of the death certificates were being
 19 completed, with a complete drop in post mortems being
 20 performed, again because of the same concerns.

21 Some of the death certificate completion, I'm
 22 uncertain about it. The data is not age standardised.
 23 So I'm cautious around that figure. I would like to see
 24 more research into that in the future if that was
 25 possible.

40

1 **Q.** And for completeness was there any data available for
 2 Scotland or Northern Ireland to include in your report?
 3 **A.** Not beyond what we found from the ONS. So no.
 4 **Q.** Thank you.
 5 Moving on, then, to your recommendations. Now you
 6 set out quite a few as you've gone through your evidence
 7 this morning. We also have a number of very helpful
 8 recommendations and solutions in your report. There are
 9 two topics that I'm conscious we haven't covered --
 10 that's IPC and research. Are there any key points in
 11 relation to those two that you wish to comment on?
 12 **A.** I think for your first one, infection prevention and
 13 control, I think we've got a much better understanding
 14 now around the risks around colonoscopy and laparoscopic
 15 surgery so I don't think we'll have those debates again
 16 hopefully, in the face of a new pandemic. However,
 17 understanding the pathway by which these associations
 18 can give that communication out, make these decisions
 19 and communicate it, is worth setting up now. So that
 20 there's not the mixed messaging.
 21 So that's number one.
 22 Research, I think that this, the preparedness for
 23 the hubs, the preparedness for communities will be best
 24 done by the research. For example, I talk about
 25 communicating with communities over cancer symptoms. We
 41

1 example, we can send out all these FIT tests but if we
 2 can't do anything about it it's pointless. So we really
 3 need well-prepared, well-staffed hubs to take that
 4 burden.
 5 **MS HANDS:** I'm grateful.
 6 My Lady, those are all my questions.
 7 **LADY HALLETT:** I think there is just one question from
 8 Mr Thomas who is behind you. Could you make sure your
 9 answers still go into the microphone. Thank you.
 10 **Questions from PROFESSOR THOMAS KC**
 11 **PROFESSOR THOMAS:** I only have the one question. My name is
 12 Leslie Thomas and I'm representing FEMHO, the Federation
 13 of Ethnic Minority Healthcare Organisations.
 14 This was touched upon in your evidence just
 15 earlier but I just want to go over it if I may.
 16 Professor, in paragraph 34 of your statement you note
 17 that cancer symptom awareness tends to be lower in
 18 ethnic minority communities and suggest that targeted
 19 interventions could help to reduce this problem. Here
 20 is my question.
 21 During the pandemic how can healthcare systems
 22 ensure that public health messaging and services are
 23 culturally tailored to meet the needs of ethnic minority
 24 communities particularly in relation to cancer care?
 25 **A.** I think that's a really critical and good question. My
 43

1 don't know how best that is done. When I first thought
 2 about it I thought, you know, the GPs can do that. But
 3 that is not necessarily the right thing to do. The GPs
 4 probably have a completely different role in this and
 5 the communication to the public around how pathways and
 6 practices and hospitals will remain open, we need to
 7 better understand how that's done, how is it cost
 8 effective and how is it best received by the
 9 communities, especially from our earlier comments around
 10 disparities with certain sections.
 11 **Q.** And then, finally, are there one or two headline
 12 recommendations from everything you've said this morning
 13 or solutions that you wish to draw our attention to?
 14 **A.** Number one, we should adhere to these cancer performance
 15 standards and I think we will see more emphasis on these
 16 targets over coming years rather than less emphasis.
 17 So number one, in the next phase of the pandemic
 18 we should do everything we can to adhere to those.
 19 Number two, we should, in that pandemic, focus on
 20 FIT testing and really prioritising patients with
 21 a positive FIT test, so making sure those pathways
 22 remain in place to get FIT tests out to patients.
 23 Then number three is the continued delivery and
 24 preparation of the elective hubs and diagnostic hubs
 25 which will be critical to maintaining capacity. For
 42

1 answer to that is tied into -- I would like to see
 2 relatively urgent research done that actually involves
 3 those communities in telling me and others how it should
 4 be done. I think if I try to create that type of
 5 messaging to communities I probably would not do a very
 6 good job because it will not be culturally and
 7 contextually specific enough.
 8 So my answer is I would like to identify --
 9 I think we need a research programme to identify
 10 community leaders who can create those contexts.
 11 The other point is we've learned that one method
 12 will not match all different types of communities and
 13 the messaging will need to be different for each
 14 community and so it's really important we don't just
 15 paint this with one brush.
 16 My opinion is that the only way to deal with that
 17 is through research response and we're lucky enough to
 18 have the NIHR in this country, the National Institute
 19 for Health Research, who have some of the world's best
 20 applied research pathways and I'd go as far as to say
 21 that's the only way that we're going to communicate more
 22 effectively with those populations.
 23 **PROFESSOR THOMAS:** Thank you very much.
 24 Thank you, my Lady.
 25 **LADY HALLETT:** Thank you, Mr Thomas.
 44

1 **Questions from THE CHAIR**

2 **LADY HALLETT:** Can I ask you a slightly different subject.
3 You mentioned at the very beginning that you were
4 redeployed at the beginning of the pandemic. You are
5 a bowel cancer specialist, if you'll forgive my using
6 "bowel" rather than "colorectal", and surgeon and you
7 saved lives via intervention. Were you consulted about
8 being redeployed?
9 **A.** As a department we made decisions and I was part of that
10 decision-making process, and those decisions were that
11 the older surgeons would go and do the elective
12 operating -- it was considered to be a safer
13 environment -- and the younger surgeons would take on
14 the emergency work. So we made -- those decisions we
15 made within our department. The redeployment decisions,
16 no, those came from the top of the NHS.

17 And I don't feel upset about that. I'm glad to
18 have been part of that response. I think due to the
19 lockdowns and the other things that happened we probably
20 don't need such a severe response again and we can
21 actually focus our specialist doctors more on their
22 specialist activities next time.

23 **LADY HALLETT:** And where were you redeployed to?

24 **A.** It was to the emergency surgery service which was -- it
25 remained busy, it's all the things like appendicitis

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1 **MS CHLOE SCOTT (affirmed)**

2 **PROFESSOR ANDREW JOHN METCALFE (sworn)**

3 **Questions from COUNSEL TO THE INQUIRY**

4 **LADY HALLETT:** I hope we haven't kept you waiting or, if we
5 have, not for too long.

6 **PROFESSOR METCALFE:** Not at all.

7 **MS SCOTT:** Not at all.

8 **MR FIREMAN:** Could you please give your full names.

9 **PROFESSOR METCALFE:** My name is Professor Andrew John
10 Metcalfe.

11 **MS SCOTT:** Chloe Elizabeth Henderson Scott.

12 **MR FIREMAN:** Thank you.

13 Professor Metcalfe and Ms Scott, between the two
14 of you, along with support and Mr Khatri and Ms Dhaif,
15 you have produced a report on the impact of the pandemic
16 on hip replacements. We find that at INQ000474262.

17 If I may begin with your professional roles.

18 Professor Metcalfe, you are a professor of orthopaedics
19 at the University of Warwick and a consultant
20 orthopaedic surgeon at the University Hospitals Coventry
21 and Warwickshire NHS Trust; is that correct?

22 **PROFESSOR METCALFE:** That's correct.

23 **Q.** Ms Scott, you are a consultant hip, knee and trauma
24 surgeon at the Royal Infirmary of Edinburgh, NHS
25 Lothian; is that right?

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1 through to blocked bowel through to people bleeding.

2 There were a number of traumas coming through the doors
3 as well because some people carried on with their
4 activities and people were still driving cars, so the
5 wider effects in the hospital, the wider emergency
6 service was still in place and still needed a tremendous
7 amount of support.

8 **LADY HALLETT:** Thank you very much. I'm sorry to ask you,
9 you probably weren't expecting that given you've come
10 here to give evidence as an expert but I thought it
11 would be interesting to know.

12 Thank you very much for your assistance you've
13 given the Inquiry both in preparing your report and in
14 your evidence today.

15 **A.** Thank you.

16 **(The witness withdrew)**

17 **LADY HALLETT:** Thank you, I shall break now and return
18 at 11.20.

19 **(11.04 am)**

20 **(A short break)**

21 **(11.20 am)**

22 **LADY HALLETT:** Mr Fireman.

23 **MR FIREMAN:** May I please call Professor Metcalfe and
24 Ms Scott who will swear and affirm respectively.

25

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1 **MS SCOTT:** That's correct.

2 **Q.** And you are also an NHS Scotland research clinician and
3 an honorary senior clinical lecturer at the University
4 of Edinburgh?

5 **MS SCOTT:** Yes, that's correct.

6 **Q.** For the purpose of producing your report in addition to
7 reviewing relevant literature and evidence, is it right
8 that you also spoke to a number of NHS staff across the
9 country to get a sense of the clinical realities of hip
10 replacements during the relevant period?

11 **PROFESSOR METCALFE:** Yes, that's correct.

12 **Q.** I'm going to ask you about a number of the topics which
13 you've covered in your report. Broadly, these will be:
14 an overview of hip replacements, hip replacements during
15 the relevant period, the impact of the pandemic both on
16 patients requiring hip replacements and staff involved
17 with the provision of orthopaedic care and elective
18 care, the health service's resilience and lessons
19 learned and future recommendations.

20 You have agreed amongst yourselves which topic
21 you're going to deal with and I will try to direct the
22 questions to whichever of you is best placed to deal
23 with those particular topics.

24 So if we can start with you, Ms Scott and some --
25 or would you prefer to be called Dr Scott?

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1 **MS SCOTT:** Ms Scott is fine.
 2 **MR FIREMAN:** Whichever you prefer.
 3 **MS SCOTT:** Ms Scott is fine.
 4 **LADY HALLETT:** Surgeons are Mr, aren't they?
 5 **MR FIREMAN:** Yes, I thought --
 6 **MS SCOTT:** Yes, Ms.
 7 **MR FIREMAN:** That was my understanding, yes. Just in case,
 8 worth clarifying.
 9 If we could start with you. You explain in your
 10 report the way in which the hip socket works. It's
 11 a ball and socket joint, you describe, and there are
 12 a number of different conditions to it being worn out
 13 and a need for a total hip replacement.
 14 If we could look at your report.
 15 This is INQ000474262.
 16 This is a picture that you have put in your
 17 report. Could you relatively briefly just explain what
 18 a total hip replacement involves.
 19 **MS SCOTT:** Sure.
 20 So the hip joint is one of the biggest joints in
 21 your body. It can wear out due to various different
 22 causes. Osteoarthritis of the hip is very common in
 23 an ageing population, so very common in the over 60s,
 24 but there are other reasons that your hip joint can wear
 25 out sooner than normal.

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1 hip replacement, is it right that that is hip
 2 osteoarthritis?
 3 **MS SCOTT:** Yes, that's correct.
 4 **Q.** Can you assist with roughly what proportion of the
 5 population experiences hip osteoarthritis.
 6 **MS SCOTT:** So radiographically, so if you take x-rays of
 7 everybody over 60, probably half of them have
 8 radiographic changes of hip arthritis. That's not that
 9 50% of the over 60s are suffering from hip pain but
 10 I think in our report approximately 8% of the UK
 11 population over 45 have sought treatment for
 12 osteoarthritis of the hip. So it is a very common
 13 condition that fortunately we have an excellent
 14 clinically proven treatment for.
 15 **Q.** Does it follow then that hip osteoarthritis is a problem
 16 that predominantly affects an older population?
 17 **MS SCOTT:** It does, but slightly different to knees and
 18 shoulders and other large joint arthritis. Because of
 19 the kind of childhood diseases of the hip that you can
 20 get, it can affect younger patients. And that is
 21 important because it affects working age patients, many
 22 of whom kind of put off having a hip replacement for as
 23 long as possible, because hip replacements don't last
 24 forever.
 25 **Q.** That can come down.

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1 So obviously rheumatoid arthritis and other
 2 inflammatory-type conditions can cause it as well, but
 3 there are a number of conditions of childhood and
 4 adolescence that can cause your hip joint to form in
 5 an altered shape which make it more likely to wear out
 6 sooner.

7 So this tends to generate a lot of pain in the hip
 8 joint, that people feel in their groin, down their thigh
 9 and into their knee, which ultimately limits their
 10 mobility and their ability to work, care for their
 11 family, sleep, you know, lots of activities of daily
 12 living.

13 So fortunately we have hip replacements, which are
 14 probably one of the best treatments in all of medicine
 15 in terms of restoring patient' health-related quality of
 16 life. That involves removing the worn-out bit of the
 17 socket. So the ball comes away. That gets replaced by
 18 a metal or a ceramic ball on a metal stem that gets
 19 fixed into the femur, and then the socket gets replaced
 20 either with the plastic that's cemented in but most
 21 commonly a metal socket with some kind of liner inside.

22 So instead of bone rubbing on bone, which is stiff
 23 and painful, they have an artificial joint which should
 24 be pain free.

25 **Q.** In terms of the most common reason to require a total

50

1 Your report describes several measures that are
 2 used to assess patient outcomes and patient experiences,
 3 and you have set these out, including -- I don't know if
 4 it's "PROMs", patient-reported outcome measures, the
 5 Oxford Hip Score, the EuroQol 5D score. Briefly, what
 6 is the value of these scoring mechanisms?

7 **MS SCOTT:** So hip replacements are very common, we do
 8 100,000 of them a year normally in the UK. If you're
 9 doing that volume of something, you need to know if it
 10 works or not, so there are a number of validated,
 11 heavily validated in fact, patient-reported outcome
 12 measures within orthopaedics and particularly within hip
 13 and knee osteo -- well, hip and knee replacement and hip
 14 and knee osteoarthritis.

15 So the Oxford Hip Score is the score that's most
 16 commonly used in the UK as a measure of hip-specific
 17 pain and function.

18 The EQ5D, the EuroQol 5D, by contrast is
 19 a validated measure of health-related quality of life.
 20 So that is important because all of the conditions in
 21 medicine can be measured using health-related quality of
 22 life. So anybody can do an EQ5D score, and in fact it's
 23 how cost effectiveness of a treatment is calculated. So
 24 the amount of health-related quality of life you gain
 25 from being on a certain treatment lets you compare

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1 a blood pressure medication with a hip replacement with
 2 a cancer drug.

3 **Q.** Without going into the background in terms of how we get
 4 these scores, is it right that generally the way in
 5 which it's calculated is that the figures that are given
 6 to a EuroQol 5D score are from 0 to 1, and if you're
 7 closer to 1 you have a better health-related quality of
 8 life and if you are closer to 0 you have a worse related
 9 quality of life?

10 **MS SCOTT:** Almost. So it goes from minus 0.594, so 0.6, up
 11 to 1. So 1 is perfect health, 0 is supposed to be
 12 death, and the negative scores are termed as
 13 health-related quality of life state worse than death.
 14 And that's not worse than death according to us as
 15 researchers or clinicians, and it's not that the
 16 patients say "Living with this pain is worse than
 17 death", it's that those scores have been given to the UK
 18 general population and they have been asked: if you had
 19 this score and these symptoms, how long would you be
 20 willing to carry on in that health state? And if the
 21 general population are not willing to carry on in that
 22 health state then it's one of these negative worse than
 23 death scores.

24 **Q.** If we could look at your report where you've set out
 25 some of the comparisons of conditions. This is on
 53

1 hip replacement. And you can see there the mean dropped
 2 from 0.39 down to 0.24.

3 And one of the important things about that is
 4 really the number of patients who had these negative
 5 worse than death scores.

6 So prior to the pandemic, when the waiting lists
 7 were about three months for a hip replacement, a fifth
 8 of patients waiting for a hip replacement had a negative
 9 EQ5D, worse than death, score, but during the pandemic
 10 that increased up to a third.

11 **Q.** Where someone has hip osteoarthritis, taking that as the
 12 most common reason for a hip replacement, prior to
 13 having the offer of a hip replacement, what are the ways
 14 in which a patient in those circumstances will be
 15 treated by the healthcare system?

16 **MS SCOTT:** So people can access care for hip arthritis from
 17 different sources. Some go straight to a physio, have
 18 a period of physiotherapy, some might see an osteopath
 19 or a chiropractor. Others will go straight to their GP.

20 In terms of the management for hip arthritis, when
 21 it's early on or when the symptom burden is not too
 22 significant, obviously simple painkillers, activity
 23 modification, physiotherapy, weight loss, things like
 24 that are what are initiated in the first instance.
 25 The problem comes when those more conservative
 55

1 page 13, figure 2. You have here a series of different
 2 conditions and the mean EuroQol 5D scores.

3 If you wouldn't mind, can you just explain what we
 4 can see in terms of the comparison here?

5 **MS SCOTT:** Sure. So the -- we did a study based in
 6 Edinburgh on 4,000 patients, 2,000 of which were
 7 awaiting hips and 2,000 of which were awaiting knees, to
 8 look at what their health-related quality of life was
 9 prior to hip replacement. And that is that first bold
 10 result there.

11 So awaiting total hip replacement, pre-Covid the
 12 mean EQ5D score was 0.39. So it's not a negative score
 13 but it's a lot worse than other EQ5D scores that are
 14 reported for other chronic health conditions, like
 15 type 2 diabetes, chronic obstructive airway disease,
 16 asthma, heart failure, inflammatory arthropathy, which
 17 is things like rheumatoid.

18 Because the EQ5D score is used across the health
 19 system you can get these scores for lots of other
 20 conditions which could have been included in this graph
 21 but weren't.

22 We then repeated our study, or a similar study but
 23 this time across ten centres, during the pandemic to see
 24 how people's health-related quality of life had changed
 25 during the pandemic when they were waiting for a total
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1 treatments and walking aids and things like that aren't
 2 helping people live their life as they want to anymore,
 3 at which point a hip replacement is what would be
 4 considered.

5 **Q.** So in the circumstances in which those first options are
 6 not successful, at that point a hip replacement will be
 7 offered?

8 **MS SCOTT:** Yes.

9 **Q.** Are there circumstances in which a hip replacement will
 10 be offered as the first course of treatment?

11 **MS SCOTT:** So if somebody -- if the first time somebody
 12 comes to see their GP they have debilitating groin pain
 13 that limits their ability to function in day-to-day
 14 life, they can't work, they can't get in and out of
 15 a car, they can't get in and out of the bath, they're
 16 needing sticks or crutches, they're needing strong
 17 painkillers, not just simple ones, opiate medication
 18 lots of people end up on, even though it doesn't work
 19 for arthritis -- so, often, people wait until they're at
 20 that point before they see their GP or before their GP
 21 refers them to us, in which case we would offer them
 22 a hip replacement the first time we see them.

23 **Q.** Following from that, is it right that there is a direct
 24 link between delay and the progression of the hip
 25 osteoarthritis and the symptoms that are experienced
 56

1 directly?

2 **MS SCOTT:** So it doesn't always follow the same course. So
3 some people can have mild arthritis and they can have
4 mild arthritis for years. Some people can have mild
5 symptoms and then six months later they're in dire
6 straits with a hip joint that is collapsing. So it is
7 not that all patients follow the same course, but in
8 general, over a period of time which is variable, the
9 symptomatic burden increases as the wear and tear or
10 whatever changes get progressively worse.

11 It is true that once patients are at a point where
12 they would be offered a hip replacement, they do then
13 deteriorate markedly while they wait for one. They've
14 already got severe disease and a severe symptom burden,
15 and why they've been offered a hip replacement, and they
16 then tend to continue that deterioration. So the longer
17 they wait, the worse they get, and then the worse the
18 outcome of their hip replacement is.

19 **Q.** When you first described what a total hip replacement
20 was, you described it as a very effective form of
21 treatment. Is that because for most patients for whom
22 a hip replacement is recommended, provided that that
23 treatment is done within a reasonable time, it is a very
24 successful way of removing their pain and getting their
25 life back to a much higher quality?

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1 cost-effective treatment that really shouldn't be left
2 to that level.

3 **Q.** And just concluding this area, Ms Scott, is it right
4 that there is research that you have looked at that also
5 links the impact of waiting on the mental health of
6 patients who are waiting for total hip replacement, and
7 indeed then the outcomes of patients who have
8 experienced anxiety and depression, perhaps due to or
9 for other reasons while awaiting a total hip
10 replacement?

11 **MS SCOTT:** So there are very close links obviously between
12 having a chronic pain condition and having
13 a depressive -- or anxiety and depression symptoms. But
14 specifically for hip arthritis patients, we've looked at
15 a group in Northern Ireland who have unfortunately been
16 waiting three years for a hip replacement and their
17 levels of depression shoot up as they wait. As does
18 their amount of opiate use, so -- which further
19 exacerbates any depressive symptoms.

20 And we've done studies prior to the pandemic and
21 since the pandemic demonstrating that the worse your
22 scores are pre-operatively, the worse your
23 post-operative scores are.

24 So, leaving people to get into these terrible
25 health states, with frailty and poor mobility, comes

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1 **MS SCOTT:** It absolutely is. I mean, patient satisfaction
2 a year after having a hip replacement is 93-95%. In
3 terms of the gain in health-related quality of life and
4 the quality of life years gained, it is one of the best
5 treatments we have in all of medicine.

6 **Q.** Given what you've said about the impact on people's
7 lives when they are awaiting total hip replacement, and
8 the potential effectiveness of the treatment, is there
9 an issue perhaps in the way in which this treatment is
10 described, in that is called "elective care" rather
11 than, perhaps, "planned care"?

12 **MS SCOTT:** Absolutely. I think there's a real disconnect
13 between most patients' experience of having bad hip
14 osteoarthritis and what the public perception of it is.
15 I think -- and that goes across healthcare,
16 non-orthopaedic healthcare, as well.

17 I think many people think: oh, if you've got
18 arthritis in your hip you maybe can only manage 9 holes
19 of golf instead of 18 holes of golf. That may be the
20 case for some patients but that is not all patients with
21 hip arthritis. And if the hip starts to collapse, it
22 can become rapidly debilitating, with patients ending up
23 housebound, wheelchair-bound, and then never able to get
24 their mobility back. So it's a condition that has
25 an incredibly well validated clinically and

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1 with a cost, and that is that they never get the outcome
2 from their hip replacement that they would have got had
3 they had timely access to treatment.

4 **Q.** Turning now to the changes to and suspension of elective
5 care during the relevant period, and if I can turn to
6 you, Professor.

7 First of all, the Inquiry has heard about the
8 decision that was communicated in mid-March 2020 across
9 all four nations in various different guises to suspend
10 elective surgery. Do you think that initial decision
11 was a justified one?

12 **PROFESSOR METCALFE:** Yes, I think that was justified for two
13 reasons. Clearly there was a huge resource burden on
14 the NHS which needed to be managed and that was entirely
15 necessary. But we should also recommend that patients
16 were in real danger at that point as well with elective
17 surgery so to put this in context, the normal rate of
18 dying from a hip replacement is between 1 and 3 in
19 1,000, very unlikely, and that's across everyone
20 including, you know, the more unwell patients who have
21 hip replacements.

22 The early data coming out of the pandemic was that
23 if someone had Covid which we, of course, may not be
24 aware of and had an elective joint replacement, their
25 risk of mortality was about 1 in 5, about 20%. So, in

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1 fact, patients were at huge risk at the start of the
2 pandemic both from Covid and indeed just from the
3 capacity of the NHS.

4 So the decision to suspend surgery at the start
5 was, I think, entirely appropriate.

6 **Q.** That's a similar thing to the evidence we heard
7 previously from Professor Bhangu. Presumably the
8 messages are the same across elective surgery in the
9 orthopaedic sphere as they are within the cancer sphere.

10 **PROFESSOR METCALFE:** Indeed, in fact the key piece of
11 evidence that Professor Bhangu, well, led the authorship
12 of, in fact, and presented was the same piece of
13 evidence that drove the COVIDSurg -- the COVIDSurg
14 document was the key piece of evidence that drove
15 changes in elective surgery across the world.

16 **Q.** Turning, though, then, to the restoration of elective
17 surgery. Can we please go through the individual
18 approaches of each nation and I'll start, Professor,
19 with you, with England.

20 Are you aware of the steps that were taken --
21 first of all, we have the decision in March 2020 to
22 suspend elective care. I understand there was then
23 a letter from NHS England on 29 April 2020 encouraging
24 trusts to consider whether they could resume elective
25 care; is that right?

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1 year's levels MRI/CT and endoscopy procedures ..."

2 Some of these things will not necessarily directly
3 apply to elective care, some of them might. And then:

4 "100% of ... last year's activity for first
5 outpatient attendance and follow-ups ... from September
6 through the balance of the year ..."

7 Taking that down, in your view was setting out
8 this pathway in such clear fashion a useful exercise?

9 **PROFESSOR METCALFE:** I think it was a useful exercise, yes.

10 I think it's clear both from just the letters but also
11 the submission of NHS England to the Inquiry, that
12 actually there was planning for this from quite an early
13 phase from at least March '20, if not earlier, and there
14 was at least a directive to restore capacity. Now,
15 whether or not trusts could achieve that or not was
16 hugely variable and we'll talk about that, I'm sure, but
17 it was at least a directive for trusts to do what they
18 can to do it, which I think was helpful.

19 I think there was a separate issue of course which
20 is the practicality of doing so, so this is developing
21 safe pathways for care so that patients can be managed
22 safely and the ability of different units to do that and
23 then their resource availability to deliver that care
24 which was, you know, the availability of theatre staff
25 and anaesthetists and theatre facilities and spaces that

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1 **PROFESSOR METCALFE:** That's right.

2 **Q.** And there was then a further letter, which we're going
3 to look at, on 31 July 2020 from Sir Simon Stevens and
4 the then COO Amanda Pritchard.

5 So if we get that up, that's INQ000051407.

6 So this is the letter which went to all NHS
7 trusts. If we could go to page 3, please, we see under
8 the heading "Accelerating the return of non-Covid health
9 services, making full use of the capacity available in
10 the window of opportunity between now and winter".

11 And then if we come out of there and we go to A2,
12 "Recover the maximum elective activity possible between
13 now and winter, making full use of the NHS capacity
14 currently available, as well as re-contracted
15 independent hospitals".

16 Then over the page, if we could enlarge the bullet
17 points, please.

18 On the screen you should see the targets that were
19 set out:

20 "In September for at least 80% of ... last year's
21 activity for both overnight electives and for
22 outpatient/day-case procedures, rising to 90%
23 in October ..."

24 And then:

25 "... swiftly return to at least 90% of ... last

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1 you could deliver green pathways in, which were green
2 pathways, the sort of safe pathways that patients could
3 have where their Covid risk would be very low, and the
4 ability to deliver that was a challenge.

5 But, yes the central guidance definitely motivated
6 that and motivated trusts to invest and focus on that
7 which I think is a really important step, because it's
8 the ability of trusts to focus on the need to do it
9 which is a real key step, I think.

10 **Q.** If we can go back to that letter, please, just under the
11 bullet points there is a series of paragraphs, the third
12 paragraph which says this, underneath the bullet points:

13 "Trusts, working with GP practices, should ensure
14 that, between every patient whose planned care has been
15 disrupted by Covid receives clear communication ..."

16 So do you understand that to be a mandate that
17 trusts essentially get in touch with patients whose care
18 has been disrupted?

19 **PROFESSOR METCALFE:** I think that -- yeah, I think that
20 was -- I think that was probably applied variably and
21 that could be interpreted by different trusts in
22 different ways but I would imagine many trusts would be
23 writing to their patients at that point.

24 **Q.** That can come down now, please. Thank you.

25 Is it right that in addition to that, though, and

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1 this is something you mention in your report,
 2 NHS England also took steps to incentivise trusts with
 3 specific funding were they to recover 70% of their '19,
 4 '20 baseline by April 2021. Could you just explain
 5 a little bit about how that worked?

6 **PROFESSOR METCALFE:** So 25 March '21 they released a letter
 7 which was -- as part of an operational planning guidance
 8 that included details of £1 billion worth of elective
 9 recovery funding, but it was predicated on a trust's
 10 ability to restore certain levels of activity. That
 11 started at 70% and then the expected percentage rose
 12 over time but there was definitely a clear financial
 13 incentive to restore activity in NHS English trusts.

14 **Q.** And what are the benefits of doing something like this,
 15 of incentivising trusts? It's perhaps obvious, that it
 16 gives them a direct financial incentive, I suppose?

17 **PROFESSOR METCALFE:** Well, yeah, so I think as Chloe said
 18 it's easy to have this belief in a health service that
 19 hip replacements aren't important and that elective
 20 orthopaedic care isn't important, and actually patients
 21 are suffering terribly, they are just suffering terribly
 22 quietly at home where you don't see them. Now, having
 23 a financial incentive means that there is a direct focus
 24 on the ability to treat those patients.

25 So yes, it gives trusts a real focus and so,
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1 front door is acute services, so the emergency
 2 department, and acute medical admissions, which
 3 of course at the time were very much overwhelmed.

4 So without any financial incentive, without any
 5 specific targets to encourage the health boards to
 6 restart their elective surgery there wasn't much
 7 pressure on them to do so, so many of them did not
 8 really push to restart elective. And then later that
 9 same year, in fact in December 2020, the Chief Medical
 10 Officer in Scotland again issued a statement that all
 11 elective operating should be ceased.

12 And it wasn't until, I think, July 2021 that the
 13 formal kind of recovery plan was published by the
 14 Scottish Government and interestingly the recovery plan
 15 again didn't really include specific targets of
 16 restoring capacity but rather focused on the delivery of
 17 national treatment centres which had already been
 18 planned prior to the pandemic as being necessary for
 19 delivering for the ageing population. So it wasn't
 20 additional capacity to respond to the backlog from the
 21 pandemic.

22 **Q.** We'll touch on geographical variation in a moment or
 23 later on, but does it follow from what you're saying
 24 that the lack of bespoke targets for Scotland across the
 25 board may have risked further local variation in
 67

1 you know, we've been in a situation of hundreds of
 2 thousands of people suffering quietly at home, unseen,
 3 and those patients are focused on when you deliver
 4 financial incentives and if you don't, it's very easy
 5 for trusts not to focus on those because they have
 6 operational pressures. They have many other pressures
 7 they have to deliver on. And, you know, we've got to be
 8 very sympathetic to the fact these are not trusts in
 9 an easy unchallenged situation; they're under a huge
 10 amount of pressure.

11 So yes, I think it allowed a focus on a group of
 12 patients that could easily be forgotten.

13 **Q.** Turning now to Scotland, Ms Scott was a remobilisation
 14 plan for elective care made in Scotland?

15 **MS SCOTT:** So in July 2020 there was a remobilisation plan
 16 that was made in collaboration with individual health
 17 boards. The issue or rather the difference between the
 18 Scottish plan compared to the English plan was there
 19 were no specific targets that went along with it so
 20 there was no "you need to restore 80% capacity". So
 21 there were no numerical targets. But also they left the
 22 decision to restore elective surgery capacity to two
 23 individual health boards who could decide whether to
 24 prioritise that in their recovery plan or whether they
 25 wanted to continue to prioritise the front door. So the
 66

1 response?

2 **MS SCOTT:** Well, I think the decision was specifically left
 3 to health boards so by definition it was creating
 4 geographic variation and in fact two health boards
 5 performed very well in restoring elective capacity and
 6 everybody else performed very poorly.

7 **Q.** Are you aware of whether there was a similar incentive
 8 provided to health boards to the one that NHS England
 9 provided NHS trusts?

10 **MS SCOTT:** I am not aware of a similar statement of specific
 11 financial incentives going into Scotland. There is
 12 a different set up in terms of how joint replacements
 13 are normally funded in Scotland compared to England and
 14 I think that culture whereby in England trusts can make
 15 money from doing lots of joint replacements well because
 16 they then get paid the tariff for doing those joint
 17 replacements, that same culture and kind of internal
 18 market doesn't exist in Scotland. In Scotland it's
 19 rather: this is your budget and if you're spending it on
 20 hip replacements you're not spending it on cancer or the
 21 emergency department.

22 So there is a different -- there is a different
 23 approach.

24 **Q.** Does it mean that it's harder to incentivise health
 25 boards to take on additional orthopaedic cases?
 68

1 **MS SCOTT:** I think very much so unless you are a specific
2 treatment centre.
3 **Q.** Turning back to you, Professor, and looking at Wales.
4 If we can go to a witness statement of
5 Judith Paget. This is INQ000486014 and paragraph 630.
6 This sets out the way in which elective hip
7 replacement was dealt with. It was -- it says here it
8 was:

9 "... by definition not considered to be urgent and
10 as such it was for Local Health Boards to decide when to
11 continue to provide such elective surgery based on
12 an assessment of whether it could be done safely and
13 without compromising their ability to respond to
14 Covid-19 patients and deliver essential services."

15 Reading that, does it follow that in Wales
16 a similar approach was taken to that of Scotland in that
17 it was left to local health boards?

18 **PROFESSOR METCALFE:** Yes, that's consistent with the health
19 structure in NHS Wales. It was considered appropriate
20 that trusts should individually make decisions about the
21 provision of orthopaedic care. Yeah, so in many ways a
22 very similar structure, very similar structure to
23 Scotland, and I think that varied a lot between trusts.

24 **Q.** Are you aware of how the process of or if the process of
25 target setting took place for return of elective care in

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1 objective and not linked to financial incentives. And
2 consequently treatment delays in Wales are absolutely
3 huge. You know, it's quite -- it's absolutely
4 commonplace for a patient in Wales to wait two years or
5 more for a hip replacement. And it remains so.

6 **Q.** Turning then to Northern Ireland. If we go further down
7 the page on page 25 of your report, you deal with
8 Northern Ireland and the approach that was taken there
9 with respect to the reformulation of targets in terms of
10 remobilising elective surgery. These bullet points here
11 set out the blueprint.

12 It looks as if it was published in July 2020. Is
13 that right?

14 **PROFESSOR METCALFE:** Yes, that's right. So there's
15 a blueprint in July -- well, the blueprint in July 2020
16 which recommended elective care but again the
17 recommendations were fairly non-specific and I don't
18 think were well adhered to. There certainly wasn't
19 a financial incentive and in many ways the structure was
20 a similar experience as what was experienced in Wales.

21 They had a review in February 2022 by the GIRFT
22 programme, which was initially an NHS England initiative
23 that went to visit Northern Ireland and made a series of
24 recommendations which were much more about having much
25 more focused central organisation of care for

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1 Wales?

2 **PROFESSOR METCALFE:** So the guidance and central management
3 of elective care in Wales was significantly delayed
4 compared to what we saw in NHS England so in the same
5 report in two paragraphs later, it documents that the
6 first meetings were first held about elective
7 orthopaedic care in 2021 and the first guidance document
8 was released in 2022. And, in fact, that guidance
9 document is much more vague than NHS England.

10 **Q.** In fact if we look at your report, this is at page 24
11 and 25 of your report, paragraph 62.

12 I'll just wait for it to come up. It might take
13 a moment whilst we change over.

14 You've set out here the targets that were set in
15 2022 by the Welsh Government. These are the bullet
16 points that we can see there at the bottom. So:

17 "No patient waiting more than a year for their
18 first outpatient appointment by the end of 2022.

19 "No patients waiting longer than two years in most
20 specialities by March 2023 ...

21 "No patients waiting longer than one year in most
22 specialities ... by Spring 2025."

23 So is this what you are referring to when you say
24 they were less clear in terms of the targets?

25 **PROFESSOR METCALFE:** Yes, they're much less clear an
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1 orthopaedic waiting patients.

2 **Q.** It says at the first bullet point here:

3 "By March 2026, no-one should wait more than 52
4 weeks for a first outpatient appointment and
5 inpatient/day case treatment; or, 26 weeks for
6 a diagnostics appointment."

7 March 2026 is quite a long way away from when this
8 was first published. Are you surprised by quite how
9 long that target appears to be?

10 **PROFESSOR METCALFE:** Well, it is certainly later than even
11 the recommendations in Wales and much later than you
12 would see from the recommendations from Scotland or,
13 indeed, NHS England. So, yeah, very delayed.

14 And our -- certainly the communication we've had
15 with doctors around the country, those in Northern
16 Ireland are reporting really very substantial delays for
17 surgery, again commonplace for two or more years and, in
18 some cases, three- to four-year waits for treatment.

19 **Q.** So does this target reflect the extent of the waiting
20 lists issue in Northern Ireland?

21 **PROFESSOR METCALFE:** I would say, I mean, the waiting list
22 issues in Northern Ireland are really substantial and
23 really long, you know, it's very clear. Well, Wales is
24 clearly struggling, Northern Ireland is clearly
25 struggling and perhaps even longer. I think the long

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1 delay to setting a target which we've still not reached
 2 is part of the pattern that we see that is just
 3 reflective of, you know, really quite marked
 4 difficulties in the health service there.

5 **Q.** That can come down.
 6 Reflecting, then, on all of the four nations of
 7 the UK and their approaches you've sort of touched on it
 8 as you've gone along but are there any other comments
 9 you'd like to make about the way in which the countries
 10 compare in terms of their approaches to restoring
 11 elective surgery?

12 **PROFESSOR METCALFE:** Those are probably the key points.
 13 I would say there was a lot of individual variation even
 14 within regions which I think we're going to take on in
 15 further discussion. You know, even within hospitals
 16 within regions there are quite marked differences that
 17 tell us a lot of about how elective care can and should
 18 be delivered or might be better not delivered. But
 19 I think this central management and incentivisation was
 20 quite a powerful thing that we discovered as we were
 21 doing the report. It wasn't something I had necessarily
 22 processed as much before we did the report but it became
 23 quite stark as we were doing it.

24 **Q.** Turning to once the decision to restore had been set
 25 out, there was a need, wasn't there, to identify how

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1 it's like -- it's similar to a kind of rapidly
 2 progressive arthritis picture. They could be defined as
 3 P3. So a small number of hip replacement patients could
 4 be defined as P2 or P3. Everyone else was very much in
 5 the P4 bracket.

6 **LADY HALLETT:** Sorry to interrupt, I'm not sure we're
 7 looking at the same document. I haven't got a P2 in the
 8 document I'm looking at.

9 **MR FIREMAN:** I think there's a few errors on the document
 10 that's on the screen.

11 **PROFESSOR METCALFE:** Yes.

12 **MR FIREMAN:** We're looking at page 26.

13 **PROFESSOR METCALFE:** Yes, it's the same -- it says table 2.
 14 It's the same layout but I think some of the P1as have
 15 been --

16 **MS SCOTT:** So it should be P1a, P1b, P2, P3, and P4. So
 17 I don't know where that has come from. Apologies.

18 **MR FIREMAN:** In any event, can I run through what they are,
 19 then, with you?

20 **MS SCOTT:** Sure.

21 **MR FIREMAN:** P4, which is where, in fact, you were saying
 22 you expect hip replacement to be, that's procedures to
 23 be performed in over three months' time --

24 **MS SCOTT:** Yes.

25 **Q.** That's right, isn't it, rather than what it says there?

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1 patients would be triaged and prioritisation guidance
 2 was set out. If we could go to page 26 of your report
 3 in table 2. You have set out here a number of priority
 4 guidance -- a table which sets out the order in which
 5 priority is to be given to procedures.

6 I think at the bottom it should say -- it says
 7 P1a, P1b, P1a, P3, but I think it should say P4, is that
 8 right? Which of these categories would hip replacement
 9 have fallen into?

10 **MS SCOTT:** This was guidance from the combined royal
 11 colleges and then other organisations produced very
 12 similar guidance whereby you could apply the same kind
 13 of triage across surgical specialties. So it goes from
 14 P1, which is emergency or urgent, through to P4, and P4
 15 was procedures to be performed in greater than
 16 three months. So, kind of, routine hip replacement was
 17 very much defined as a P4-type condition.

18 P2, which was procedures to be performed in less
 19 than a month. Some cases where the hip had completely
 20 collapsed may have been able to be defined as P2 because
 21 the document does include arthroplasty where delay will
 22 prejudice outcome. So some patients were classified as
 23 P2s and some patients with something called avascular
 24 necrosis, so the ball part of your hip joint, if the
 25 blood supply to that gets damaged it can collapse and

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1 **MS SCOTT:** Yes.

2 **Q.** And P2 is what is in fact now --

3 **MS SCOTT:** Less than a month.

4 **Q.** -- less than a month, exactly. It's been removed from
 5 our screen.

6 **LADY HALLETT:** Our document wizard is thinking about whether
 7 he puts in the 2 or the 4, I think, he has already --
 8 no.

9 **MR FIREMAN:** It might be a bit much to do it on the hoof,
 10 but the key point is hip replacements fell within the P4
 11 category --

12 **MS SCOTT:** Yes.

13 **Q.** -- which means that they were, in this ranking, the
 14 lowest ranked.

15 **MS SCOTT:** Yes, so the point of this was theatre time and
 16 capacity was very limited and so, rightly, hospitals
 17 wanted to use it for the most -- the patients in the
 18 most need, whether that was -- whether they needed
 19 a general surgeon or a colorectal surgeon or an ENT
 20 surgeon or an orthopaedic surgeon, to maximise the use
 21 of limited theatre capacity. So this is not a system
 22 that we would normally apply well to orthopaedics and to
 23 joint replacement specifically and I think when it came
 24 out there was an overwhelming feeling within
 25 orthopaedics that it didn't apply very well to us and

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1 because most of our patients would be P3 and P4, they
2 would never get to the top of the list. There would
3 always be a P1 or a P2 that would trump them.

4 **Q.** And something that came up before, and her Ladyship was
5 dealing with with Professor Bhangu, was what about the
6 circumstances where someone has been waiting for
7 a longer period of time, how does that impact
8 prioritisation?

9 **MS SCOTT:** So this was the guidance for prioritisation from
10 the Colleges. The British Hip Society gave some more,
11 kind of, more granular and more hip-specific guidance
12 that did indicate some other conditions that -- of the
13 hip that may be a P1 or a P2 and similarly the European
14 Hip Society also produced that.

15 In terms of long waiters, they were not included
16 in this original guidance and that was very much left to
17 clinicians to decide whether you thought someone was
18 a P2 or a P3 because that was the only way they were
19 going to get an operation, and in fact latterly what has
20 happened is certainly in my health board is if you've
21 been waiting longer than two years you get redefined as
22 urgent. Because the problem is with this system and
23 limited capacity, if you're not urgent you'll never get
24 to the top of the list and you'll never get your hip
25 replacement.

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1 the bottom of what happened there, but that can come
2 down.

3 In terms then -- turning to you, Professor, in
4 terms of actually resuming elective surgery, there were
5 some challenges, weren't there, in terms of the way in
6 which the healthcare system had been restructured as
7 a result of responding to the initial waves of the
8 pandemic?

9 **PROFESSOR METCALFE:** Absolutely. And I think
10 Professor Bhangu explained that actually the problem was
11 largely not the surgeons availability, it was largely
12 the staff availability, particularly theatre nurses and
13 anaesthetic staff. Who are, of course, probably the
14 best qualified people to support critical care, behind
15 critical care themselves obviously, in the sense they
16 have those sort of anaesthetic skills that are valuable.

17 So there was a mass redeployment of staff into
18 critical care particularly and to support Covid wards.

19 There was, of course, an earlier physical
20 deployment as well. You know, the space had to be
21 reused. There's a number of examples of patients being
22 ventilated in theatre spaces. But those were restored
23 sooner than the staff resource was restored.

24 The second challenge was how do we operate on
25 patients safely and learning these concepts of a green

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1 **Q.** That process, though, and the way in which it's done is
2 entirely dependent on the judgment of the clinician?

3 **MS SCOTT:** It is completely and there's no agreement on
4 whether somebody who is working age and is off work and
5 unable to support their family because they've got
6 terrible pain from hip arthritis whether you give the
7 hip replacement you've got to that patient or whether
8 you give it to the 85-year-old who is housebound at home
9 and is rapidly becoming more frail and isolated and
10 lonely because of that. There's no guidance on how to
11 prioritise between these.

12 **Q.** You touched on it earlier when you spoke about how you
13 felt that really this prioritisation guidance didn't
14 that well apply to orthopaedic settings. You also say
15 that you felt that the effect may have been that for
16 orthopaedic patients they may have been deprioritised as
17 a result of using this sort of criteria; is that right?

18 **MS SCOTT:** Absolutely. And there's evidence that through
19 the time period in question for the Inquiry, orthopaedic
20 surgery was the lowest volume surgery other than dental
21 surgery. So we really -- you know, there's firm
22 evidence that we were -- orthopaedics in general was
23 deprioritised, and hip replacement patients as part of
24 that.

25 **Q.** Thank you, that can come down now. We'll try to get to

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1 pathway. Should I explain what a green pathway means?

2 **Q.** I think we can probably guess but it would be helpful
3 just for clarity.

4 **PROFESSOR METCALFE:** Yes, so a green pathway is essentially
5 a pathway in which you are confident that -- as
6 confident as you can be that someone doesn't have Covid.
7 And it required quite a few things. Now, the most
8 important step was probably patient isolation before
9 surgery, followed by a test usually about three days
10 before their operation, a Covid test. And the chances
11 of them having Covid having had a period of isolation
12 and then a Covid test was very small.

13 But critically it also meant that you had to have
14 a separate group of staff delivering care for those
15 patients, a separate ward, separate entrances, separate
16 corridor spaces, separate theatre, separate recovery.
17 So there was a physical change to the facility that had
18 to be in place. And some facilities were well set up
19 for that and some facilities weren't well set up for
20 that.

21 Typically, because a lot of orthopaedic care is
22 delivered in acute hospitals alongside acute care, you
23 know, it might be ward 11 or ward 23 or something, you
24 know, up the stairs and -- quite hard to separate.

25 Whereas others are much easier to separate because

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1 they're already in dedicated units.

2 **Q.** It seems that you need, in fact, an alignment between
3 the repurposing of spaces and also the availability of
4 staff?

5 **PROFESSOR METCALFE:** Indeed.

6 **Q.** Did, in fact, the restoration of elective care
7 necessarily align with the ending of things like
8 redeployment or the provision of care being given in
9 different spaces to -- they were previously?

10 **PROFESSOR METCALFE:** It was hugely variable around the
11 country, is the simple answer to that. So, you know, we
12 have a growing number of elective-focused sites, and in
13 specialist orthopaedic hospitals, which are effectively
14 elective-focused sites, they are able to redeploy
15 relatively quickly, and clearly some of their staff had
16 redeployed to other hospitals. But those were mostly
17 restored. And of course they had the physical space and
18 the ability to deliver those pathways.

19 Other units found it very, very difficult, both
20 from a physical space -- physical structure organisation
21 sense but also from a staffing sense.

22 And I think that explains the really quite marked
23 variability even within individual regions.

24 **Q.** We're going to look now at the geographical variation,
25 and if we could look at your report and look at

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1 careful. So in my region there were really marked
2 differences, to the point that now there is probably
3 a difference in waiting times of a year whether you
4 drive half an hour down the road or not, between
5 different hospitals. So you can really have quite
6 marked disparities even in small regions, often because
7 one hospital is set up one way and one is set up
8 another.

9 **Q.** In terms of national differences --

10 **PROFESSOR METCALFE:** Yes.

11 **Q.** -- can we derive any messages from looking at the map
12 here?

13 **PROFESSOR METCALFE:** Yes, indeed. From this map, and indeed
14 from multiple of the figures presented in the report, we
15 see that, in general, England was better able to
16 restore, but variable -- very variable across the
17 country but better able to restore its activity.
18 Scotland less well so but had some pockets of
19 excellence, pockets of real success. Wales less so
20 again. And in fact there's -- multiple figures show
21 that the delivery of restoration of elective care in
22 Wales was really, you know, quite a long way behind, and
23 Northern Ireland even more so.

24 **Q.** If we go over the page we can look at 2021. It's
25 figure -- it should be slightly further on.

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1 figure 12, please, on screen.

2 We have here what's described as a "Heat map of
3 proportion of pre-pandemic total hip replacements
4 performed in 2020". It might help if you just describe
5 what we can see in terms of the key with the colours
6 there.

7 **PROFESSOR METCALFE:** Yes. So we've used data on hip
8 replacement volumes -- actually we received it per month
9 but we've obviously used 2020 data -- looked at
10 2019 data and then divided it by region. So each
11 individual region we've looked at: did they -- what did
12 they achieve as a percentage of their pre-pandemic
13 volume? If they're blue, they're achieving above 100%
14 and if they're sort of yellow they're achieving a bit
15 below, if they're pink they're achieving quite a bit
16 below, and if they're red they're way below.

17 **Q.** So if we come back and look at it in the round, what is
18 the message that we can see from this diagram?

19 **PROFESSOR METCALFE:** Well, the first message it's really
20 patchy and variable. This, and then I'm sure we'll come
21 to a 2021 version, we'll see actually there are more --
22 the reduction in services was more marked in Wales,
23 Northern Ireland and Scotland, and then across England
24 very variable.

25 Even when looking at this we have to be quite

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1 **PROFESSOR METCALFE:** Indeed, yes. And I think this is
2 telling both because of how red Wales is and -- but
3 also, interestingly, Scotland is quite interesting
4 because there's a patch that did really very well, in
5 the centre of Scotland, and that was representative of
6 one specific trust, I believe, who were much more able
7 to restore their activity using a sort of elective care
8 hub model.

9 **MS SCOTT:** So one health board, in Forth Valley, did
10 prioritise the delivery of elective care and actually
11 exceeded their previous volume of work in terms of
12 elective surgery. They've subsequently also become
13 a national treatment centre. So that was happening in
14 the background that they were expanding.

15 The Golden Jubilee Hospital, as well as a kind of
16 national treatment centre for Scotland, obviously was
17 protected as well.

18 So those two units have kind of driven this but
19 the rest of Scotland remained pretty dire. Certainly
20 locally we had until not very long ago four and a half
21 thousand people waiting for hip and knee replacements in
22 my hospital alone. So it is very patchy.

23 And interestingly as well, the centre that did
24 prioritise elective over the front door had significant
25 front door issues as a consequence and problems with the

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1 emergency department and the acute medical unit.

2 **Q.** Is it right that that hospital, I think it's the Golden
3 Jubilee Hospital, it does take patients -- sorry --

4 **MS SCOTT:** So, no, that dark blue there, that is
5 Forth Valley.

6 **Q.** That's Forth Valley.

7 **MS SCOTT:** Yes.

8 **Q.** And the Golden Jubilee Hospital --

9 **MS SCOTT:** The Golden Jubilee is its own health board and
10 it's based in Glasgow, and it does take -- it takes
11 patients from the whole of Scotland but different health
12 boards have different arrangements with it. So it
13 doesn't take patients from across Scotland based on some
14 national waiting list, it takes patients based on
15 X health board sends 100 a month to the Jubilee, that
16 kind of arrangement, rather than a national waiting
17 list.

18 **Q.** That can come down.
19 But is it right that during your research you
20 identified that actually there was a correlation between
21 the areas of greatest deprivation and the highest
22 deficit in terms of restoration of hip surgery?

23 **PROFESSOR METCALFE:** Yes. That was not -- the figure shows
24 a small but definite change -- effective deprivation on
25 the waiting times for surgery -- or, sorry, our ability

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1 It wasn't really used for orthopaedic care. There
2 was only so much capacity, of course, and it was pretty
3 quickly returned to its original functioning in the
4 independent sector care, in which case they resumed
5 activity as they would normally do so. But in terms of
6 NHS delivery of care in the independent sector it wasn't
7 really used for orthopaedics at all. With very small
8 numbers it was but at a very small rate.

9 **Q.** Next, the impact of the delays which were caused by the
10 pandemic and the decision to suspend elective care. If
11 I start with another passage of your report on screen,
12 please, section 2.3, page 19, where you set out here the
13 targets.

14 Yes, here we go.

15 In England the key target we see here is for
16 elective care such as hip replacement to have a referral
17 to treatment time of 18 weeks and all care to be
18 completed by 52 weeks.

19 Then we go to Wales and we can see there that 95%
20 of patients should have a referral to treatment of
21 26 weeks. No patients waiting longer than 36 weeks.

22 Go down to Scotland. And we can go through it,
23 again, 90% of people should not wait longer than
24 four weeks from referral by a GP to be seen by an allied
25 health professional. And then Northern Ireland, there

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1 to restore elective surgery.

2 And I would also comment that the sort of central
3 guidance allowed some of that -- allows it -- it
4 prevents inequalities because it allows the trusts that
5 are most suffering with pressures, because of their sort
6 of demographic, to best deal with -- to address elective
7 care priorities as well. So otherwise those centres
8 that are most under pressure from their acute side then
9 also deliver more delay to care in the elective side,
10 which worsens the problem of inequality.

11 **Q.** Is there also a link between the types of patients who
12 may seek care for hip osteoarthritis?

13 **PROFESSOR METCALFE:** I'm sure that's true. It's a thing we
14 don't -- I couldn't say we have strong data on, but I'm
15 sure there is lots of evidence across healthcare that
16 those who are more socioeconomically deprived have
17 a lower rate of healthcare seeking and lower rates of
18 healthcare engagement, and I'm sure that would be true.

19 **Q.** Finally on restoration of care. Professor, do you
20 consider that the independent sector was sufficient
21 utilised to restore this type of care?

22 **PROFESSOR METCALFE:** Well, I would say Professor Bhangu
23 quite rightly said that it was used largely for cancer
24 care, and he felt that it was well mobilised for that
25 and I'm inclined to agree with him from what I've heard.

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1 weren't specific targets but the current ministerial
2 waiting time targets state that 50% of patients shall
3 wait no longer than 9 weeks for a first outpatient
4 appointment, with no patient waiting longer than
5 52 weeks.

6 The first thing arises from looking at this is it
7 appears that there are various different ways in which
8 the nations are measuring their ability to perform total
9 hip replacements; is that right?

10 **PROFESSOR METCALFE:** Yes, that's absolutely right. Yes.

11 **Q.** If we can take that down.
12 Is it right that actually this lack of consistency
13 in terms of the data and the way in which nations are
14 measuring their success in terms of performing
15 orthopaedic care makes it very difficult to actually
16 assess and compare the impact of the pandemic?

17 **PROFESSOR METCALFE:** Yes, it does. I mean, actually it's
18 very hard to get referral for treatment times for hip
19 replacements at all. We haven't been able to provide
20 that data. There are -- so the way it is measured, it
21 also tends to be collected in aggregate by specialty.
22 But if you think of the specialty of trauma
23 orthopaedics, it's hugely diverse. So, you know, carpal
24 tunnel operations, you could do a lot of those in the
25 pandemic because you didn't need an anaesthetic and you

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1 needed a lot less physical space and you could -- so
2 there was a long period where a lot of day case
3 operations were being performed but not hip replacements
4 and knee replacements, and -- because, of course, they
5 require general anaesthetic and they're a big operation
6 and recovery space in a ward.

7 So the waiting times that are stated are often
8 poorly representative of what actually happened to
9 people who had joint replacements, and I think that's
10 quite important to recognise. We can be overly
11 reassured by waiting times, by specialty, because they
12 contained a multitude of different issues.

13 **Q.** You can use the data then perhaps to spin whichever
14 message you wish to send; is that right?

15 **PROFESSOR METCALFE:** Well, yes, to some degree. I mean, in
16 many ways the -- you know, if you've got a large number
17 of people who are waiting a long time, you can be pretty
18 confident you've got a lot of people waiting a long
19 time. But if you can't be reassured by, say, a median
20 figure of, you know, X number of people at --
21 X percentage of people achieving this in trauma
22 orthopaedics, because you might have just done lots of
23 local anaesthetic procedures and not many hip
24 replacements.

25 And we see that, I think, in -- so to compare in
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1 there was a 46% reduction, consistent with about
2 50,000 people -- less people having hip replacements
3 in 2020 compared to 2019. You can ascertain how long
4 you would expect that recovery to be to bring them back
5 to previous standards, to bring them back to the sort of
6 waiting times people were achieving. We know that's
7 going to be a number of years.

8 So we can ascertain that waiting lists are
9 definitely longer, definitely variable, and longer in
10 the devolved nations. It's actually quite hard to put
11 an exact figure on exactly how much but we can be pretty
12 confident of the sort of scale.

13 **Q.** Taking a step back, does it follow then that -- you said
14 earlier you didn't criticise the decision to initially
15 suspend elective surgery. The issue here is about the
16 variability in restarting it?

17 **PROFESSOR METCALFE:** Absolutely, yes.

18 **Q.** In terms of internationally and comparing
19 internationally, at paragraph 146 you deal with how the
20 UK has fared internationally. How did it fare?

21 **PROFESSOR METCALFE:** Very poorly, is the simple answer. So
22 I think we have a figure which shows -- from the OECD.
23 So this is data that compares -- yes, here we go,
24 figure 25 on page 62.

25 **Q.** Can we get that on screen, please.

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1 England and Wales right now, there are very few people
2 in England waiting two years for treatment. There are
3 23,000 at least waiting to that time in Wales, so -- for
4 orthopaedic care. So that's -- at least that was
5 a press release recently.

6 So that's the sort of figures we should be,
7 you know, cautious of.

8 **Q.** Do you think then there would be value in having
9 a uniformity of measures in terms of how to assess
10 someone's waiting time across all four nations and
11 across the individual countries as well?

12 **PROFESSOR METCALFE:** Indeed. I think uniformity of data,
13 and sufficiently granular data that it is meaningful,
14 would be really valuable.

15 **Q.** Were you, though, able to in general terms ascertain how
16 much of an impact, in terms of delays, the initial
17 decision to suspend, and indeed the pandemic generally,
18 caused?

19 **PROFESSOR METCALFE:** Say that again, sorry --

20 **Q.** Are you able to ascertain at all what level of delay can
21 be attributed to the decision to suspend elective care?

22 **PROFESSOR METCALFE:** Well, I think we can say that --
23 I mean, we can say what percentage of hip replacements
24 weren't done compared to what we'd expect. So in
25 England, for example, only about -- I think it was --
90

1 Thank you.

2 **PROFESSOR METCALFE:** This compares the United Kingdom's
3 performance against multi-other EU countries. To put
4 this in context, the -- for hip replacement --

5 **MS SCOTT:** 24.

6 **Q.** So page 62.

7 **MS SCOTT:** Figure 24.

8 **Q.** Figure 24, sorry. If we could just go back a page.

9 **PROFESSOR METCALFE:** So the UK chart is pretty obvious
10 because that's the lowest one by far, towards the right
11 of the screen. So the EU block percentage in terms of
12 the reduction in delivery of hip replacement over 2019
13 to -- the change between 2019 to 2020 --

14 **Q.** Just the top one.

15 **PROFESSOR METCALFE:** -- the EU average was minus 14, the UK
16 average was minus 46%. And we were by far the worst
17 performing country.

18 **Q.** What are the main factors for the UK performing so
19 poorly?

20 **PROFESSOR METCALFE:** So I think we have to reflect that
21 the UK was already struggling to meet demand. So the
22 supply of elective orthopaedics was already falling
23 behind and waiting lists were already rising before the
24 pandemic. I think we have a lot of mixed acute and
25 elective care delivery that meant that responding to the

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1 pandemic meant -- was incredibly difficult, because we
2 couldn't deliver the green pathways and the separated
3 care that could have happened if we'd had more of an
4 elect -- separate elective and acute setups, in the
5 model of sort of elective care hubs.

6 And I think that's probably the biggest change
7 that would allow us to be more resilient in future
8 pandemics, would be the ability to have elective care
9 hubs that are physically distinct and can deliver green
10 pathways and deliver care efficiently and effectively,
11 is probably the biggest difference. I think the overall
12 capacity in the NHS is definitely a factor as well.

13 **Q.** You touched on elective hubs and you describe in your
14 report an example, or two in fact, of innovative
15 practices. One of them is at the South West London
16 Elective Orthopaedic Centre. What did they do that was
17 different to the general approach?

18 **PROFESSOR METCALFE:** They are a ring-fenced elective
19 orthopaedic unit, where -- and physically ring-fenced,
20 in the sense that their whole facility is physically
21 separate from acute care. So that allowed them to
22 deliver green pathways very efficiently, allowed them to
23 re -- utilise their staff resource effectively and
24 allowed them to restart, you know, much more efficiently
25 than others.

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1 capacity. And they've gone from waiting lists of
2 two years to well below one year, you know, nine months
3 to a year already, in very short space of time actually.
4 So it's demonstrating that these things can be done, can
5 improve your capacity and can make you much more
6 resilient.

7 **Q.** Turning to the overall messages, if I could start with
8 you, Ms Scott. What is your overall message from
9 reviewing what went on during the pandemic and how it's
10 impacted orthopaedic care and hip replacements?

11 **MS SCOTT:** So I think it's clear from all the data that
12 orthopaedic surgery was deprioritised more than other
13 specialties and there are a lot of lessons that we can
14 learn from that deprioritisation and from the lack of
15 ability that certain regions have had in restoring
16 elective surgery capacity and I hope that we can then
17 apply those to what happens not just in the next
18 pandemic, which is obviously the point of this Inquiry,
19 but what literally happens every winter, to hip
20 replacement patients they always get cancelled and
21 deprioritised first.

22 So the lessons I think that are key are: in the
23 pandemic response a centralised decision-making, I think
24 is key, and where that happened with specific quantified
25 targets in England it gave trusts the ability to respond

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1 In fact, if you look at their performance, you
2 know, they've outperformed the rest of the NHS
3 consistently since the pandemic. And that I think is
4 reflective of, you know, a separate elective hub
5 structure that's physically distinct and allows the
6 organisation to plan very much and to deliver this care
7 efficiently.

8 What's also very good about it is it takes staff
9 from other trusts in the region, so it's not attached to
10 a trust, which means that you can -- you know, you can
11 develop a network of trusts that aren't undermining the
12 ability of other trusts to deliver, they're actually
13 supporting the ability of trusts to deliver in a region.

14 And if I may follow on to the Exeter centre as
15 well. So Exeter used a Nightingale model to deliver
16 elective care, and this was for the South West. So the
17 South West was one of the poorest performing regions in
18 terms of its ability to -- in England anyway, one of the
19 poorest performing regions in England in terms of its
20 ability to restore elective care. And it's been
21 absolutely transformed by using a Nightingale unit and
22 opening two extra elective theatres.

23 And that, again, is trust neutral. It's not --
24 it's bringing in staff and surgeons and other staff from
25 all sorts of trusts in the region to deliver extra

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1 and restore elective care much better than it did in the
2 devolved nations where it wasn't mandated. Recovery was
3 not mandated, it was left to individual health boards to
4 decide whether they had the capacity to do that or not,
5 and that has led to massive regional variation.

6 So I think better top down messaging in terms of
7 mandating recovery is fundamental.

8 I think inter-trust sharing of waiting lists and
9 patients is also fundamental. It's not fair that if you
10 live in one location you have to wait three years for
11 your hip replacement, and if you live half an hour down
12 the road you get it in six weeks which is the level of
13 disparity that is being experienced currently.

14 So that would be my two key messages and I'll hand
15 on to Andy for --

16 **PROFESSOR METCALFE:** Yes, I wanted to follow on with the
17 experience of elective care hubs which were clearly
18 essential in both the ability to restore care and then
19 transforming care when we realised that there were
20 backlogs. And the ability to deliver elective surgical
21 hubs, to deliver focused care for those patients,
22 I think is transformative to our resilience for the
23 future.

24 **MR FIREMAN:** Thank you very much.

25 Those are my questions, my Lady.

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1 **LADY HALLETT:** Before I ask -- Mr Thomas, I think, has some
2 questions for you.

3 **Questions from THE CHAIR**

4 **LADY HALLETT:** Can I spring on you the question I sprang on
5 the Professor this morning --

6 **PROFESSOR METCALFE:** Of course.

7 **LADY HALLETT:** -- Professor Bhangu. Were either of you
8 redeployed?

9 **PROFESSOR METCALFE:** Do you want to go first?

10 **MS SCOTT:** So my practice was -- prior to the pandemic was
11 50% joint replacements and 50% trauma, so my joint
12 replacements disappeared immediately but trauma kept
13 going so I was full on trauma and we were -- we helped
14 with proning in ITU and things like that but I wasn't,
15 fortunately, redeployed to a completely different
16 department because trauma kept on coming.

17 **PROFESSOR METCALFE:** So I was -- in the first wave I was
18 redeployed to help deliver minor injury care so we
19 actually set up a separate minor injury unit in our
20 elective footprint to take the pressure and physical
21 space off A&E. In the second wave I did a few shifts on
22 Intensive Care Unit, although much less than my junior
23 doctor colleagues, I have to say.

24 **LADY HALLETT:** And were you consulted about where you went?

25 **PROFESSOR METCALFE:** Yes. So, similar to Professor Bhangu's
97

1 inequalities related to total hip replacement access,
2 and there you note disparities in both utilisation and
3 outcomes amongst ethnic groups.

4 Could you share your view on whether targeted
5 public health initiatives are necessary to encourage
6 greater uptake of elective procedures such as total hip
7 replacement in these kinds of communities and, if so,
8 can you assist the Inquiry with what might such
9 initiatives include?

10 **PROFESSOR METCALFE:** So I would support Professor Bhangu's
11 answer to a very similar question which I thought was
12 excellent. I think we need significant research on how
13 best to engage in the wide variation of ethnic minority
14 communities and how to ensure that people have -- feel
15 they can access care appropriately.

16 Now, that is very much not a one thing fits all,
17 it means engagement with community groups, engagement
18 with cultural groups, engagement with religious groups.
19 In terms of understanding how people should be
20 communicated with and should be engaged with and
21 improving trust as well in the community and I think
22 there's a combination of confidence and trust in
23 communities and their ability to engage with healthcare
24 that is definitely a thing that needs to be addressed.

25 **Q.** Can I just piggyback on what you've just said. Are
99

1 answer, the -- with the department certainly when we
2 made the first decision we sat down together as
3 a department and said: how are we going to help and how
4 can we support the hospital? And we split ourselves
5 into, like Chloe, a group delivering trauma and a group
6 delivering minor injury care.

7 In the second there was a request -- it was very
8 much a voluntary request but a request for support for
9 intensive care and we as a department sat down and
10 agreed that would be appropriate, except in cases where
11 people didn't feel they were able to. So, yes, we did
12 agree on that but it was quite an experience.

13 **LADY HALLETT:** I can imagine. And not one you'd wish to
14 relive, no doubt.

15 **PROFESSOR METCALFE:** No, no, very challenging. Very
16 challenging.

17 **LADY HALLETT:** Mr Thomas.

18 **Questions from PROFESSOR THOMAS KC**

19 **PROFESSOR THOMAS:** Good morning, Professor -- good
20 afternoon --

21 **PROFESSOR METCALFE:** Good afternoon.

22 **Q.** -- Professor Metcalfe and Dr Scott. I only have a small
23 handful of questions for you. I represent FEMHO, the
24 Federation of Ethnic Minority Healthcare Organisations.

25 In paragraph 136 of your report you discuss health
98

1 there any examples from other health organisations or --
2 that could serve as a model?

3 **PROFESSOR METCALFE:** That's a very interesting question.

4 **MS SCOTT:** My understanding, specific to joint replacement,
5 is there's a lot more research coming out of the
6 United States for example in terms of racial disparities
7 in access to joint replacements. There's also gender
8 disparities in access to joint replacements. It can be
9 difficult -- and deprivation issues and what have you.
10 So I think it's certainly something that needs
11 addressing not just in joint replacement surgery but
12 probably across the board in all healthcare.

13 **Q.** Let me move on to my second question. Moving on to the
14 impact of the pandemic on elective surgeries. Has the
15 pandemic exacerbated delays in procedures like total hip
16 replacements for ethnic minority patients as compared to
17 other groups?

18 **PROFESSOR METCALFE:** So we know there was a relationship
19 with social deprivation and we know that both ethnic
20 minority -- proportions of ethnic minorities and social
21 deprivation are two interlinked -- are often
22 interlinked, so it is likely that there was. We don't
23 have data on that and perhaps similar to the point that
24 was being discussed earlier about granularity of data,
25 then actually granularity of data in terms of ethnicity,
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1 gender, social deprivation, would be valuable if there
 2 was a way of making that available and that would
 3 improve our ability to -- because ultimately the
 4 availability of data allows you to act in a --
 5 **Q.** In a more targeted way?
 6 **PROFESSOR METCALFE:** In a more targeted way and motivate
 7 change, so I think that sort of granularity of data
 8 would be really valuable.
 9 **Q.** Let me come on to my last question. From your
 10 perspective how can healthcare providers improve
 11 cultural competence throughout hip replacement care
 12 pathway from diagnosis through to post-operative
 13 recovery to ensure that ethnic minority patients receive
 14 equitable and culturally sensitive care?
 15 **PROFESSOR METCALFE:** Do you want to start?
 16 **MS SCOTT:** So I think part of the barrier often is a lack of
 17 diversity within orthopaedics itself and actually if
 18 orthopaedics itself could have a more diverse workforce
 19 then it may help more diverse individuals whether --
 20 regardless of the reason for their diversity, it might
 21 make them more confident in accessing healthcare for
 22 their joint problems. So that's certainly something
 23 that is in the spotlight at the moment and definitely
 24 needs work, but lots of people are working to try and
 25 improve that.

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1 **LADY HALLETT:** Ms Nield.
 2 **MS NIELD:** My Lady, may I call, please, Julie Pashley.
 3 **MS JULIE PASHLEY (affirmed)**
 4 **Questions from COUNSEL TO THE INQUIRY**
 5 **LADY HALLETT:** I hope you haven't been hanging around for
 6 too long.
 7 **THE WITNESS:** No, thank you.
 8 **MS NIELD:** Ms Pashley, could you give your full name,
 9 please.
 10 **A.** Julie Pashley.
 11 **Q.** You've provided a witness statement to this module of
 12 the inquiry dated 20 June 2024, that's INQ000486003,
 13 which sets out the experiences of your daughter who was
 14 a young person detained in hospital, in a children and
 15 young persons mental health services inpatient unit,
 16 between March 2020 and June of 2021; is that right?
 17 **A.** Yeah.
 18 **Q.** I think when your daughter was first admitted she was
 19 16 years of age; is that correct?
 20 **A.** That's correct.
 21 **Q.** I think you are a mother of two children in fact?
 22 **A.** Yeah.
 23 **Q.** We're not going to name your daughter today. We are
 24 going to refer to her by the initials CB --
 25 **A.** Yeah.

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1 **PROFESSOR METCALFE:** Yes, I would agree and again I would
 2 follow on from Professor Bhangu's suggestion that there
 3 really should be much more research in this area.
 4 I think we recognise it as something we could do better
 5 at, and I think as clinicians and in fact our clinical
 6 bodies recognise that this is an important issue we need
 7 to improve on. I don't think we're there yet in terms
 8 of our ability to do that well and I think we could be a
 9 lot better and we probably do need to invest in research
 10 that focuses on that.
 11 **PROFESSOR THOMAS:** Thank you very much.
 12 Those are my questions.
 13 **LADY HALLETT:** Thank you, Mr Thomas.
 14 I think that completes the questions for you.
 15 Thank you both very much indeed, Professor Metcalfe,
 16 Ms Scott, for all your help in preparing the report, for
 17 making it understandable and for all your help today.
 18 I'm really grateful to you.
 19 **PROFESSOR METCALFE:** Thank you very much.
 20 **MS SCOTT:** Thank you.
 21 **(The witnesses withdrew)**
 22 **LADY HALLETT:** 1.40.
 23 **(12.37 pm)**
 24 **(The short adjournment)**
 25 **(1.40 pm)**

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1 **Q.** -- if that's all right?
 2 **LADY HALLETT:** Sorry to interrupt. Given that you've given
 3 your name, which is now public, is your daughter all
 4 right for you to talk about her?
 5 **A.** Absolutely.
 6 **LADY HALLETT:** I just wanted to check, because obviously
 7 people will be able to identify her even if we don't
 8 name her.
 9 **A.** Yes.
 10 **MS NIELD:** Thank you, my Lady.
 11 I think your daughter was first admitted to
 12 a tier 4, that's inpatient, mental health unit at the
 13 end of January 2020; is that right?
 14 **A.** Yes.
 15 **Q.** And she was admitted as a voluntary patient, so she
 16 wasn't admitted under the Mental Health Act; is that
 17 correct?
 18 **A.** That's correct.
 19 **Q.** And what was her diagnosis at that time?
 20 **A.** So she was depressed, anxious, at risk of suicide, risky
 21 behaviour and diagnosed autistic at that point.
 22 **Q.** Thank you. When your daughter was first admitted to
 23 that tier 4 inpatient ward, you say in your witness
 24 statement that most things seemed to function properly
 25 within the unit. How would you describe the culture or

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1 the atmosphere on the unit at that point?

2 **A.** It was really warm, friendly, open. It was designed to
3 feel like home from home. It was -- families were
4 involved, families were welcomed on to the ward, we were
5 part of the care and that continuity of care.

6 **Q.** Thank you. And then I think towards the end of February
7 or beginning of March you say that things changed on the
8 ward as everyone was becoming more aware of Covid-19 and
9 its risks. Can you tell us what changed on the unit at
10 that point?

11 **A.** So we were no longer allowed on the unit. We could go
12 to the family room. We had to wear a mask, we obviously
13 had to use hand sanitiser. All the staff had to wear
14 scrubs, they were also wearing masks. So we kind of
15 lost that connection, I suppose, with the ward, so it
16 became a gap between us and them.

17 **Q.** And how were those new rules communicated to families?

18 **A.** Randomly, as and when they were brought in I suppose.
19 As soon as something changed we were told relatively
20 quickly, but it wasn't consistent. It was constantly
21 changing I suppose.

22 **Q.** I think there was an incident on 18 March 2020 where
23 staff believed that your daughter had swallowed a blade?

24 **A.** Yeah.

25 **Q.** And you were contacted I think by the unit to explain

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1 result.

2 **Q.** And did you get a negative result?

3 **A.** We did.

4 **Q.** And so at that point you took CB, your daughter, back to
5 the ward. Was she taken back in, was she readmitted?

6 **A.** No.

7 **Q.** Did they explain why?

8 **A.** Just -- I don't think we'd had the negative result
9 actually at that point so they weren't prepared to take
10 her back, because they were taking a number of -- well,
11 probably over 24 hours to get the results at that point.
12 So, yeah.

13 **Q.** And how did you feel about taking your daughter home
14 with you at that stage?

15 **A.** Absolutely petrified. She was obviously in
16 a risk-taking mood, she had potentially swallowed
17 a blade so therefore she was clearly quite unstable, and
18 we had to take her home and have her at home with us in
19 our care for potentially two weeks or at least hopefully
20 until the negative result had come through.

21 **Q.** Had she had any home leave during her inpatient stay at
22 that point?

23 **A.** I think she'd had one or two one-night stays at home.

24 **Q.** Did you explain your concerns about her risky behaviour
25 and the risk she posed to herself?

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1 this. What were you asked to do then at that point?

2 **A.** So we were asked to take her to A&E to be assessed.

3 **Q.** I think that was in a different hospital?

4 **A.** Yeah, in a physical health hospital, not a mental health
5 hospital.

6 **Q.** And were you told whether you could bring your daughter
7 back to the inpatient unit after you had been to A&E?

8 **A.** We were told we couldn't take her back to the unit
9 because she was a risk, Covid risk, to the patients and
10 staff on the ward of the mental health unit.

11 **Q.** So the concern at that point was while she was in the
12 A&E department she could have contracted Covid?

13 **A.** Yeah.

14 **Q.** All right. And how long were you told she would have to
15 stay away from the unit for?

16 **A.** Two weeks.

17 **Q.** I think, given that, you made attempts to persuade the
18 staff at the Accident & Emergency Department to
19 undertake a Covid test?

20 **A.** Yeah, it wasn't -- testing wasn't routine at that point
21 and hospitals weren't testing on arrival, so we managed
22 to persuade them -- I'm not entirely sure, my husband
23 managed to do that persuading -- we managed to persuade
24 the doctor to test our daughter for Covid, so that we
25 would at least get the result if we needed a negative

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1 **A.** Yes.

2 **Q.** Did you explain that to the inpatient staff?

3 **A.** Yeah.

4 **Q.** And what was their response?

5 **A.** "We cannot take her back."

6 **Q.** Were you given any documentation to explain why she was
7 being sent home at that point?

8 **A.** No.

9 **Q.** Did there seem to have been a formal risk assessment
10 undertaken?

11 **A.** Not that we were aware of.

12 **Q.** Did they give you any what's sometimes called safety
13 netting advice, did they give you any advice about where
14 you could go or what you could do or who to contact if
15 any of your fears were realised?

16 **A.** We could always contact I think it was a crisis team
17 number, but I'm not even sure they were 24 hours a day.

18 **Q.** How did your daughter respond to being told that she
19 wasn't able to go back on to the unit? What were her
20 views?

21 **A.** She was anxious, she knew she wasn't safe. She didn't
22 want to come home. We tried really hard to make it as
23 pos -- possible -- and easy for her as possible to
24 try -- we were quite sort of: it'll be fine, we'll all
25 be fine, we'll get through it, it'll be okay. We spent

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1 that evening playing games and trying to entertain and
 2 distract her from her own thoughts and feelings
 3 I suppose.
 4 **Q.** If I can just take you back then to that point where the
 5 unit were saying they were not going to take CB back
 6 because of the Covid risk, the potential Covid risks,
 7 and CB was not feeling ready to go home at that point.
 8 Do you know whether CB communicated her views about her
 9 own state of mind and her own risks to the unit staff at
 10 that point?
 11 **A.** She wasn't given the opportunity at that point.
 12 **Q.** So, I'm sorry, I had moved you back from that evening
 13 when she was discharged, so I think that was 18 March.
 14 **A.** Yes.
 15 **Q.** And you tried to distract her that evening. I think the
 16 following day or the following evening your daughter did
 17 actually leave the home at night after you'd all gone to
 18 bed; is that right?
 19 **A.** Yeah, yeah.
 20 **Q.** And I think you were able to, once you realised that she
 21 was missing -- I think you heard the front door
 22 closing --
 23 **A.** Yeah, my husband heard the front door go. I didn't,
 24 I was asleep, but he woke me up. And of course we
 25 panicked.

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1 back there. That's where they wanted to take her back
 2 and they were prepared to hold her under a section 136.
 3 **Q.** What was the initial response of the hospital?
 4 **A.** "No, we can't take her back."
 5 **Q.** So I think you explain that it was when the police
 6 mentioned section 136 of the Mental Health Act which
 7 enables them to hold a patient until they're assessed by
 8 a medical professional; is that correct?
 9 **A.** Yeah.
 10 **Q.** And at that point --
 11 **A.** They gave in and said, "Okay, we'll take her back."
 12 **Q.** The unit took her back.
 13 **A.** Yeah.
 14 **Q.** Thank you.
 15 Did the unit explain why they were reluctant to
 16 take her back?
 17 **A.** It was still around the risk of spreading Covid.
 18 **Q.** And was there any discussion about isolation rooms, that
 19 she could be put in isolation when she came back onto
 20 the unit?
 21 **A.** We asked if she could go into an isolation room and they
 22 said, "No, they're for children who can't go home, who
 23 don't have homes to go to."
 24 **Q.** Once the hospital eventually agreed to admit her and to
 25 conduct a mental health assessment I think the following

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1 **Q.** And were you able to track your daughter?
 2 **A.** Yeah. Thankfully, we've always had an app on our phones
 3 that we could -- we can track both of our children
 4 wherever they are.
 5 **Q.** And so you were able to locate her?
 6 **A.** Yeah, we could see where she had gone.
 7 **Q.** And where had she gone?
 8 **A.** She'd gone half a mile up the road to a bridge.
 9 **Q.** And what were your concerns then?
 10 **A.** That she was going to jump off the bridge.
 11 **Q.** I think fortunately you were able to find her?
 12 **A.** Yeah.
 13 **Q.** And I think the police were also called and arrived
 14 shortly after you'd found her; is that correct?
 15 **A.** Yes. So my husband arrived first and pulled her back
 16 off the bridge because she'd climbed over the barriers
 17 at that point and then the police arrived around about
 18 the same time. They'd gone under the bridge first. She
 19 had called them to say, "You're going need to pick me up
 20 off the road so that no motorists will be hurt by my
 21 body."
 22 So the police arrived and -- at that time and they
 23 were obviously quite concerned about her mental health,
 24 and we explained the situation that we'd had with the
 25 unit and they called the unit to try to get her taken

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1 day, in fact 20 March, your daughter again expressed
 2 suicidal thoughts --
 3 **A.** Yes.
 4 **Q.** -- whilst she was on the unit and asked to leave the
 5 unit.
 6 **A.** Yeah, she wanted to leave the unit in order to end her
 7 life.
 8 **Q.** But I think it wasn't until the following Monday, until
 9 after the weekend that your daughter was formally
 10 admitted --
 11 **A.** Yeah.
 12 **Q.** -- under the assessment provisions of the Mental Health
 13 Act, section 2 of the Mental Health Act?
 14 **A.** Yeah.
 15 **Q.** Which allowed her to be detained --
 16 **A.** For up to 28 days, yes.
 17 **Q.** -- pending an assessment?
 18 **A.** Yeah.
 19 **Q.** Did you have a conversation with a consultant at the
 20 unit about that assessment process and the likelihood of
 21 when she was going to be discharged from that?
 22 **A.** Yeah, so we -- her usual consultant said she was too
 23 unwell to be sent home so she would be detained for as
 24 long as it was necessary to ensure her safety, and to
 25 start the right treatment, which was a relief, a huge

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1 relief that actually she might get what she needed, and
 2 we wouldn't have to have her at home for a while. And
 3 then we moved on to, I think it was, 26 December (sic),
 4 was it, lockdown, the day, or the day after?
 5 **Q.** I think she was formally discharged on 26 March, day 2
 6 of lockdown; is that right?
 7 **A.** Yeah. So on the Monday, which I think was the 25th,
 8 24th or 25th of March, I can't remember, the Monday she
 9 was -- we were told that she wouldn't be discharged.
 10 And then it was something like 24 hours later when
 11 a different consultant, one that didn't know her, said,
 12 "No, she needs to be discharged, we need the beds for
 13 crisis."
 14 **Q.** And did you challenge that discharge decision?
 15 **A.** Yeah. Yep.
 16 **Q.** Presumably that challenge --
 17 **A.** Got nowhere.
 18 **Q.** -- made no difference?
 19 **A.** No.
 20 **Q.** I think you've explained that the discharge note dated
 21 26 March stated that your daughter was extremely
 22 vulnerable, showed risky and impulsive behaviour?
 23 **A.** Yeah.
 24 **Q.** And went on to explain that the hospital had justified
 25 the decision to discharge her on the basis that your

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1 autism diagnosis?
 2 **A.** Absolutely useless.
 3 **Q.** And how did this second discharge from inpatient
 4 services seem to impact on your daughter and her
 5 attitude and trust in the mental health services system?
 6 **A.** I think she'd lost all trust by that point. I guess she
 7 felt that nobody cared, that nobody was willing to look
 8 after her. She couldn't get the treatment she needed,
 9 the support that she needed. She just felt really let
 10 down. I think we all felt really let down.
 11 **Q.** And do you think that had an impact on her mental health
 12 at the time?
 13 **A.** Absolutely.
 14 **Q.** In the first few months after she was discharged
 15 in March how was CB coping?
 16 **A.** She wasn't too bad at home. We managed to not have any
 17 significant incidents for a couple of weeks, which was
 18 really positive. She wasn't great and she was
 19 definitely deteriorating from that point.
 20 **Q.** Was she able to engage with any community mental health
 21 services?
 22 **A.** Not at that point.
 23 **Q.** I think CB was admitted again to inpatient mental health
 24 services, again as an informal or voluntary patient on
 25 15 May, 2020?

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1 daughter had asked to go home --
 2 **A.** Yeah.
 3 **Q.** -- and that they were taking steps to limit exposure to
 4 Covid-19 on the unit, is that right?
 5 **A.** Yeah.
 6 **Q.** How did you feel after you read those discharge notes?
 7 **A.** A bit sick really. Again really anxious, thinking:
 8 could we keep her safe at home again? Yeah, I think it
 9 was just dread, absolute dread.
 10 **Q.** Was there any care planning put in place for providing
 11 care to your daughter in the community when she'd been
 12 discharged?
 13 **A.** I can't remember if it was that time or the next one,
 14 the next discharge.
 15 **Q.** I think you describe it in your witness statement as
 16 "limited care planning --
 17 **A.** That's right, yeah.
 18 **Q.** -- in place", and the only support that she in fact
 19 received in the community was over the phone?
 20 **A.** Yes, that was, yeah, the things were still quite tricky
 21 at that point with regards to community services.
 22 She -- it was phone calls so we could get a phone call
 23 from the community team but that was it.
 24 **Q.** How beneficial would you say that support over the
 25 telephone was for your daughter in particular, given her

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1 **A.** Yeah.
 2 **Q.** And you noted in your witness statement that it was
 3 immediately clear that the rules around infection
 4 prevention and control were more rigid but also more
 5 consistent.
 6 **A.** Yes.
 7 **Q.** Is this to the same unit that she'd been at previously?
 8 **A.** Yeah, yeah.
 9 **Q.** And this was a short admission with 72 hours' crisis
 10 support on the ward, is that right?
 11 **A.** Yeah. Yeah.
 12 **Q.** And then I think your daughter made good progress during
 13 that admission?
 14 **A.** Yeah, I mean, I think she'd felt so let down, there was
 15 an element of she'd just hit crisis again quite quickly
 16 and was taken back, supported, and realised that
 17 actually she'd rather be at home and she could manage at
 18 home. But with the right support at home, which seemed
 19 to materialise at this point.
 20 **Q.** I think she was discharged then on 1 June 2020?
 21 **A.** Yeah.
 22 **Q.** So just a two-week admission period?
 23 **A.** Yeah.
 24 **Q.** How was the care planning prior to that discharge and
 25 the community support that she received?

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1 **A.** I think that's when it improved. I think that's when we
 2 had the key worker from Transforming Care came in, and
 3 we had the intensive care -- intensive support team
 4 coming out and visiting. So she was being visited at
 5 home much more regularly after that admission. And
 6 actually some of that started to -- she was only in
 7 hospital for three days although she was under their
 8 care for the two weeks, so they were putting in place
 9 those -- that support in that time.

10 **Q.** And how did that support seem to affect your daughter?
 11 **A.** Positively. It was a real positive step forward.

12 **Q.** I think then was your daughter planning to try to resume
 13 her education then in September?
 14 **A.** Yes, which was a huge progress for her. She was totally
 15 against education for a while and didn't see the point
 16 in any future planning at all so we were really positive
 17 that she wanted to go to college.

18 **Q.** I think she did have some concerns about the impact of
 19 her disrupted education.
 20 **A.** She did. She did. So although she was quite excited to
 21 go, as soon as she could think: oh, my GCSE results are
 22 coming, what if I can't get to college, what if I don't
 23 have the grades that I need to get into college?
 24 Because it was all teacher assessed and she'd missed
 25 most of year 11, so that sent her back down into

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1 in a room --

2 **A.** In a room on her own. There would be a member of staff
 3 not in the room. They would be outside the room for
 4 when she needed to -- if she needed to -- needed any
 5 support, I suppose, if they needed to do any
 6 interventions.

7 **Q.** And how did your daughter find those periods of
 8 isolation?
 9 **A.** Soul destroying probably, I think that's fair to say.
 10 I can't even begin to imagine what it must be like as
 11 a healthy teenager to be stuck in a room on your own for
 12 that length of time, never mind a mentally unwell
 13 teenager to be stuck in a room on your own with all your
 14 own thoughts and all those things that have led you to
 15 be in that place in the first place, so I -- yeah, it
 16 wasn't great.

17 **Q.** I think outside of the periods of isolation, at that
 18 time on that unit your daughter did have access to some
 19 outside spaces and some green spaces?
 20 **A.** Yeah.

21 **Q.** And she had access to her mobile phone and other
 22 communications devices at that point?
 23 **A.** Yeah.

24 **Q.** Was that true also in isolation she was able at least to
 25 contact --

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1 a spiral.

2 **Q.** And I think unfortunately her mental health deteriorated
 3 to the point that she was admitted again to inpatient
 4 care?
 5 **A.** Yeah.

6 **Q.** This time on 4 August 2020?
 7 **A.** Yeah.

8 **Q.** Still Covid infection rules in place on the unit. At
 9 that time there were some loosening of restrictions in
 10 the community but not on the inpatient unit, is that
 11 right?
 12 **A.** Yeah, that's right.

13 **Q.** And so whenever your daughter had a home visit from --
 14 **A.** Yeah, when she could come home, yeah.

15 **Q.** She was having to then isolate when she went back on to
 16 the unit, is that right? And how long was she having to
 17 isolate for at that time?
 18 **A.** In theory it should have been about 24 hours but it was
 19 about 72 by the time -- so they would test -- so if she
 20 went back on a Sunday night, for example, they wouldn't
 21 test until Monday morning, then that test would take at
 22 least 24 hours to come back, so it wasn't until they'd
 23 had a negative test that she could actually resume
 24 activities on the ward and leave her room.

25 **Q.** So what would it mean to be in isolation then literally

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1 **A.** Yes, she could always have her phone. She wasn't
 2 allowed a charging cable because of the risk of ligature
 3 so we didn't manage to find a really short charging
 4 cable that she could use and they would allow that in.
 5 But, yeah, she could connect with us.

6 **Q.** Another thing that you have noted at that time in terms
 7 of changes on the unit from pre-pandemic times was that
 8 staff were wearing PPE and in particular face masks and
 9 I wanted to ask how that affected your daughter
 10 particularly given her neurodivergence?
 11 **A.** So if she can't see someone's face -- she struggles with
 12 facial expressions anyway but if you're wearing a mask
 13 she has no idea what mood somebody is in, if they're
 14 asking something, what that tone is, you know, she
 15 struggles quite significantly with that sort of
 16 communication. And she struggles to make connection
 17 with people anyway so being able to see someone's face
 18 is really, really important to her and being able to
 19 hear their voice and yeah, it's just -- I think, again,
 20 it was quite isolating I suppose.

21 **Q.** So it was impacting on her ability to form a trusting --
 22 **A.** Form any relationship.

23 **Q.** -- relationship or rapport with the therapeutic staff?
 24 **A.** Yeah.

25 **Q.** And speaking of staff, you've indicated that the

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1 staffing levels were noticeably lower --
 2 **A.** Yeah.
 3 **Q.** -- on the ward at this period and there was also more
 4 use of agency staff because permanent staff were
 5 sometimes absent.
 6 **A.** Yeah, I mean, staff did get Covid, staff were ill so
 7 they were off and of course they were off for a long
 8 time. Some of them were very poorly. So staffing
 9 levels were affected, definitely. And then agency staff
 10 were brought in to fill the gaps if they can.
 11 **Q.** How did your daughter get on with new staff, making new
 12 relationships with those staff?
 13 **A.** Not great. It takes her a lot longer to build
 14 a relationship with anybody, never mind a continually
 15 changing staff. I mean, she would struggle from the --
 16 for the shift from day staff to night staff until she'd
 17 got used to that. So having different staff in each
 18 day, people that she didn't feel she could communicate
 19 with, and then they were -- faces were covered, then
 20 there's just -- yeah, they were -- I mean, they were
 21 literally containing, I suppose, at that point. There
 22 wasn't really -- she wasn't able to access the therapy,
 23 the therapeutic levels.
 24 **Q.** In terms of therapeutic support, was there a move to
 25 remote delivery, so online video calls, telephone calls

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1 **A.** Yes, so it would depend who was on the ward to what the
 2 restrictions were. So the restrictions were similar to
 3 the previous ward in that they -- you know, if she went
 4 home there were still issues but she -- some staff would
 5 let her out, if she was isolating they would let her
 6 out, if they were using the corridor they could get her
 7 outside so she could get some fresh air, but some staff
 8 said: no, you can't do that, you just literally have to
 9 stay in your room. And it just depended who was on.
 10 **Q.** I think at that time if your daughter was allowed home
 11 for home leave, when she was more stable, she had to
 12 isolate for 72 hours every time she came back on the
 13 unit; is that right?
 14 **A.** Yeah, if she stayed home, yeah.
 15 **Q.** But the rules were that if she went out of the unit just
 16 during the daytime, so she could go out for I think you
 17 say in your --
 18 **A.** It was up to 8 hours.
 19 **Q.** Yes, 8 hours daily, as long as that didn't involve
 20 an overnight stay she didn't have to isolate when she
 21 was back on the unit; is that right?
 22 **A.** Yeah.
 23 **Q.** So at that point you were presumably driving two hours
 24 from your home to the unit?
 25 **A.** Yeah, yeah. Then we would drive her home, then we would

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1 and so on. Was your daughter able to engage with remote
 2 therapy?
 3 **A.** No, she absolutely hates remote. Again, I think there
 4 is -- when you're with somebody face to face you pick up
 5 on feelings and other things that makes it easier to
 6 understand that person. When it's a 2D image, she just
 7 can't -- she cannot engage at all.
 8 **Q.** I think following an overdose in May 2021, so
 9 13 May 2021, I think CB was admitted again to inpatient
 10 mental health services, but this time to a unit
 11 two hours away from your home; is that right?
 12 **A.** That's right, yes.
 13 **Q.** And is that because there wasn't a bed closer to home
 14 that was available?
 15 **A.** Yeah.
 16 **Q.** And this time she was admitted under the Mental Health
 17 Act, section 3 of the Mental Health Act, so she was
 18 detained on a compulsory basis at that point.
 19 **A.** Yeah.
 20 **Q.** And you've noted that the culture, if I can put it that
 21 way, on the unit was quite different, the staff were
 22 stricter?
 23 **A.** Yeah.
 24 **Q.** But also that the rules around Covid prevention seemed
 25 to be applied less consistently?

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1 spend four hours at home, and then we would spend
 2 two hours driving her back, and then we would drive
 3 home. So we were 8 hours in the car.
 4 **Q.** 8 hours driving in the car every day?
 5 **A.** Not every day. We weren't that nice to her, we didn't
 6 visit that often! But we did -- you know, it was
 7 several times a week.
 8 **Q.** And on those occasions your daughter had spent --
 9 **A.** 4 hours in the car.
 10 **Q.** -- 4 hours in an enclosed car with you and didn't have
 11 to isolate?
 12 **A.** No. Which seems bonkers really.
 13 **Q.** But you explain that, in fact, you didn't want to do the
 14 overnight stays because of the impact on your daughter
 15 becoming so distressed from the experiences of
 16 isolation?
 17 **A.** Yeah.
 18 **Q.** I think CB was then discharged from that inpatient unit
 19 on 11 August 2021, and was not too far off becoming --
 20 turning 18 and becoming an adult?
 21 **A.** Yes.
 22 **Q.** At which point her responsibility for her care would
 23 move to adult mental health services; is that right?
 24 **A.** Yeah.
 25 **Q.** So she was due to be discharged before she turned 18,

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1 and I think at that point she wanted to live in
 2 supported accommodation; is that correct?
 3 **A.** Yeah, she wanted to live in -- on her own. She didn't
 4 want to come back home, it was too traumatic for her to
 5 be in the house.
 6 **Q.** And what was your view of her moving into supported
 7 accommodation? Were you happy for that to happen?
 8 **A.** I suppose it's a -- it's a tricky one. You never want
 9 them to leave, but knowing her vulnerability, allowing
 10 her to live on her own was for us quite risk taking, but
 11 we were assured that she would have supported living and
 12 that there would be support in place for her.
 13 **Q.** I think because she had been detained under the Mental
 14 Health Act, she then has a right to quite an extensive
 15 aftercare support package; is that right?
 16 **A.** Yeah, so section 117 aftercare, funded by Health and
 17 Social Care.
 18 **Q.** So did it appear -- were you assured that that package
 19 was in place?
 20 **A.** Yeah.
 21 **Q.** And was that the responsibility of social services?
 22 **A.** The accommodation was, yeah. The accommodation was
 23 responsible for -- I think it was children services,
 24 because she was still a child at that time.
 25 **Q.** And so your daughter's discharged, you're told there's
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1 she just wanted to live on her own. She didn't want to
 2 be with us so she -- I think in her mind it was: right,
 3 if I cut off communication with them, somebody will have
 4 to do something.
 5 **Q.** So at that point I think was there any support in place
 6 from social services?
 7 **A.** No. Well, she did have a social worker. She did have
 8 a social worker. But he didn't provide any support.
 9 **Q.** Did there appear to be any communication or cooperation
 10 between the children's mental health service or children
 11 social care and adult social services?
 12 **A.** No. So she was discharged from CAMHS services, in
 13 principle to adult services. Adult services were not
 14 available for her because they didn't feel -- she didn't
 15 sit with -- she couldn't access what they were going to
 16 offer, which was group therapy online. So she couldn't
 17 access that because of being autistic.
 18 So social services -- so she had nothing, mental
 19 health support wise, and the communication between
 20 children services and adult social services was adult
 21 services saying: we have to reassess, we have to do
 22 a full new assessment, nothing children services said --
 23 no longer counts.
 24 **Q.** I think your daughter did eventually have access to
 25 a supported flat with a low level of support in
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1 a care package available. I don't think she went
 2 immediately into any supported accommodation though?
 3 **A.** No. So we got home and I had a phone call from social
 4 services to say there was no placement, there was
 5 nowhere for her to go, she would have to stay at home.
 6 At that point, I mean, we didn't want her to be
 7 discharged because we didn't want her to not go into
 8 supported living -- we wanted her at home -- we'd
 9 have -- you know, if she'd wanted to come home we'd have
 10 had her home, there is no question. But she didn't want
 11 to come home and we knew pushing her into that situation
 12 of coming home would cause her distress and an
 13 escalation of distressed behaviour.
 14 **Q.** Was there ever an explanation of why that care package
 15 which had been agreed to in principle didn't
 16 materialise?
 17 **A.** Because she was about to be an adult so it would be
 18 adult social services' problem.
 19 **Q.** I think, in fact, your daughter effectively ended up
 20 homeless?
 21 **A.** Yeah.
 22 **Q.** And between September and December 2021 you did not know
 23 her location, you did not know where she was?
 24 **A.** No, she cut communication to us completely at that
 25 point, which was upsetting but understandable given that
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1 December 2021 but it wasn't providing the level of
 2 support that she required at that point?
 3 **A.** No. So she went into -- she had a crisis in December,
 4 when she finally got back in contact with us. And she
 5 was put into 24/7 support in a flat for -- which was
 6 one-to-one, for a couple of months, and then she went
 7 into a low-level flat after that.
 8 **Q.** And I think at that point when she was in a low-level
 9 support flat you explain that in fact her flat ended up
 10 being cuckooed by a drug dealer, who was using the flat
 11 to deal drugs, sexually assaulted your daughter and beat
 12 her over a 3-week period?
 13 **A.** Yeah.
 14 **Q.** She became addicted to heroin and cocaine in that time?
 15 **A.** Yeah.
 16 **Q.** There was no one from the community mental health team
 17 visiting to check on her and in fact it was when she
 18 went to the police herself to explain what was happening
 19 that that situation was brought to an end. After that
 20 point she continued to ask for help.
 21 **A.** Yeah.
 22 **Q.** And I think it wasn't until June of 2023 when your
 23 daughter jumped from a bridge and broke her spine in
 24 three places that she was provided with the support that
 25 she needed from adult mental health services and social
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1 care services, is that right?

2 **A.** Yeah. Yeah.

3 **Q.** Can I ask you, please, Ms Pashley, what's your overall
4 assessment of the impact of the Covid restrictions and
5 rules on the care and treatment that your daughter
6 received and her experiences as an inpatient during the
7 pandemic?

8 **A.** I think it potentially delayed any progress in her
9 mental health, any benefit, really, I suppose, of her
10 getting any better, being looked after both as well as
11 she perhaps could have been. I think if she'd come out
12 into the community with the services that were available
13 previously then maybe again we would have seen a better
14 progress, a better prognosis, I suppose.

15 I'd like to think we wouldn't have gone down the
16 road we'd gone down and she would never have jumped off
17 the bridge, she would never have been cuckooed, she
18 wouldn't have had to have all those horrific experiences
19 that she suffered and us as a family, I think. The
20 trauma that the whole two years, three years, put on our
21 family was horrific.

22 **MS NIELD:** Ms Pashley, I have no more questions for you,
23 thank you very much.

24 **A.** Thank you.

25 **LADY HALLETT:** Ms Pashley, I have to ask, how is she doing

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1 **MS NIELD:** Dr Northover, could you give your full name,
2 please.

3 **A.** Dr Guy Northover.

4 **Q.** Dr Northover, you have provided an expert report on
5 inpatient child and young persons mental health services
6 for module 3 of this Inquiry, co-authored with
7 Dr Sacha Evans, it's dated 23 July 2024, and it has
8 a reference number INQ000474300.

9 Do you have a copy of that report in front of you?

10 **A.** Yes, I do.

11 **Q.** And you're familiar with it?

12 **A.** Yes.

13 **Q.** Dr Northover, you are a consultant child and adolescent
14 psychiatrist and I think you took up your first
15 consultant post in 2010; is that correct?

16 **A.** Yes.

17 **Q.** And you're presently working at Berkshire Healthcare NHS
18 Trust in the children and young people psychosis and
19 mania pathway; is that right?

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

21 **Q.** I think you've been the trust's lead clinical director
22 since 2016 and you have extensive experience working
23 within and designing child and adolescent mental health
24 crisis services?

25 **A.** Yes.

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1 now?

2 **A.** Much better than she was. We still have a long way to
3 go. There's a lot of still stuff to unpick. There's
4 a lot of trauma still that needs to be -- that's sort of
5 happened in the process of where she was, so -- but she
6 is much better than she was. I feel, touching wood,
7 that we're not at risk of loss of life anymore.

8 **LADY HALLETT:** I'm sure we all hope that. I don't know if
9 you were dreading coming along or whether you wanted to
10 talk about it or whether you felt it was a terrible
11 thing to do but you've been really helpful.

12 **A.** It's been a privilege, actually.

13 **LADY HALLETT:** Well, it has been our privilege to listen to
14 you even though it's an extremely sad and distressing
15 story. Anyway, with your support we all hope that she
16 makes as good a chance at her life as she can, as best
17 a chance as she can. Thank you very much indeed.

18 **A.** Thank you.

19 **(The witness withdrew)**

20 **MS NIELD:** My Lady, I'd like to call, please, Dr Guy
21 Northover.

22 **DR GUY NORTHOVER (sworn)**

23 **Questions from COUNSEL TO THE INQUIRY**

24 **LADY HALLETT:** I hope you have not been waiting a long time.

25 **THE WITNESS:** No.

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1 **Q.** And I think between 2018 and April 2024 you were the
2 Getting It Right First Time national clinical lead for
3 child and adolescent mental health crisis and inpatient
4 services.

5 Could you please summarise for us the Getting It
6 Right First Time programme?

7 **A.** Yes, absolutely. So the Getting It Right First Time
8 programme is a national quality improvement programme
9 that uses -- it's a data-driven approach to identify
10 across the country areas of variation and that's
11 followed up by clinical visits to sites to understand
12 whether the variation is warranted or unwarranted and
13 then based on understanding whether it's warranted or
14 unwarranted it's providing support and recommendations
15 to specific units or trusts on how they might improve,
16 and that's been followed up by the creation of
17 a national report with national recommendations.

18 **Q.** Thank you.

19 I think during the period of the report which
20 covers the relevant period of module 3, that is the
21 1 March 2020 to 28 June 2022, you were actively
22 participating in the clinical reference group for
23 children and young people's mental health, learning
24 disability and autism services, where you chaired the
25 data subgroup; could you very briefly explain the

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1 clinical reference group to us, please?

2 **A.** Absolutely. So that's a clinical reference group which
3 was supporting the specialist commissioning team for
4 child and adolescent inpatient services. So it's
5 a group of clinicians whose professional opinion was
6 listened to to help shape the specialist commissioning
7 team's direction of travel.

8 **Q.** Thank you. And I mentioned earlier that you've
9 co-authored this report with Dr Sacha Evans who is
10 currently based at the Mildred Creak unit at Great
11 Ormond Street Hospital, and that's a specialist unit
12 treating children aged 8 to 13 years; is that correct?

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

14 **Q.** If we can move briefly to the methodology of your
15 report, and the sources of information that you've drawn
16 upon to produce that report. You've explained in
17 paragraphs 26 to 29 of your report that you've obtained
18 both quantitative, numerical, data and qualitative data
19 to prepare the report and I think it's right that whilst
20 you've included statistical data where possible from all
21 four nations of the UK, you observed that the amount of
22 data available from England was considerably greater
23 than that available from the devolved nations, is that
24 right?

25 **A.** Yes, that's absolutely right.

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1 future pandemics.

2 Can we begin also with some terminology because
3 we've heard "children and young people's mental health
4 services" and "child and adolescent mental health
5 services"; is there a difference between the two?

6 **A.** There isn't, and of course there's the third terminology
7 as well, "children and young people mental health", and
8 it is confusing but they all mean the same thing. It's
9 just where it's used in different policy teams and
10 within different trusts, and I probably have to
11 apologise in advance to say that I will be shifting
12 between the three terminologies myself without
13 realising it.

14 **Q.** Well, for ease of reference I'm probably going to be
15 saying CAMHS because it's less of a mouthful than the
16 other acronyms.

17 So can we begin, please, with a brief overview of
18 the inpatient sector and could we look please at page 16
19 of your report. This is table 1.

20 We can see there the number of inpatient units and
21 beds in each nation. So we see that in England there's
22 considerably greater provision -- it's a larger
23 country -- with 59 units, six of which are for children.
24 What does it mean to have a children's unit? What age
25 group is that?

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1 **Q.** And you've also observed that the number of Child and
2 Adolescent Mental Health Services inpatients in the
3 devolved nations is a small number and sometimes those
4 small numbers means it can be identified difficult to
5 identify whether a trend is statistically significant
6 from that data. But nevertheless is it correct that in
7 your view there's been no obvious divergence or
8 difference in the trends observed between the four
9 nations of the UK?

10 **A.** Yes, I think that was absolutely the interpretation we
11 took from the data we were able to see.

12 **Q.** Thank you.

13 Dr Northover, I'm going to ask you to help us
14 today with a number of topics that you've explored in
15 detail in your report. Firstly, I'm going to ask you to
16 give us a brief overview of the outline of provision of
17 mental health services, inpatient services for children
18 and young people across the UK, and then I'm going to
19 ask if we can go on to look at changes during the
20 pandemic to the number of young people admitted and
21 discharged from inpatient care, and changes to the care
22 provided in those inpatient units and how those changes
23 impacted upon patients' experience. And then I will be
24 asking you for your reflections on the impact of the
25 pandemic on CAMHS services and your recommendations for

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1 **A.** So children's unit is up to the age of 12. There's
2 theoretically no lower age limit to these units but it
3 would be very to admit somebody to a children's unit who
4 is under the age of, say, 6 -- or 6, 7 or 8 years old.

5 **Q.** Thank you.

6 We can see also there are low secure and medium
7 secure units there; is that for forensic units, as
8 they're called?

9 **A.** It is. It's slightly different within child and
10 adolescent services to how it is within adult services.
11 So a medium secure unit is what you'd think of as
12 similar to a secure unit in adult services where young
13 people within a medium secure unit will have a court
14 order to be within that unit, so due to their mental
15 illness they will have committed a crime that requires
16 them to be within a safe environment.

17 Within child and adolescent services a low secure
18 unit is more often used for young people who are
19 presenting with significant challenges in terms of their
20 behaviour and self-harm risk that mean that they are --
21 that it's difficult to manage them within a general
22 admission unit, so they require a higher level of
23 security and that would be security in terms of, sort
24 of, locked doors, security in terms of the more
25 restrictive policies and procedures and security around

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1 the staffing than they would do within a general
2 admission unit, but they're unlikely to be there because
3 of a court order.

4 **Q.** Thank you. We can see there that in England there are
5 in total about 1300 beds that are available. In
6 Scotland there's a -- is this a general adolescent unit
7 (GAU), there are three of these providing 54 beds, one
8 children's unit providing six beds, and in Wales two
9 general admission units providing 30 beds and in
10 Northern Ireland one unit with two wards providing 25
11 beds plus an additional -- what's a PICU bed?

12 **A.** So a PICU bed is a psychiatric intensive unit. So,
13 again, that's similar to a low secure unit but a young
14 person would only be expected to stay a short period of
15 time on a PICU unit before going back to a general
16 admission unit.

17 **Q.** Is that a psychiatric intensive care then?

18 **A.** Yes.

19 **Q.** And we can see there that the low secure units and
20 medium secure units are provided in England, I think
21 it's right that if there are forensic admissions those
22 are the units that are used for patients from Scotland,
23 Wales or Northern Ireland; is that right?

24 **A.** Yes, absolutely during the time of the report that was
25 the case.

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1 admission, and that would be for where -- where the
2 admission is part of a care pathway, where the community
3 element to that care pathway has come to the end of
4 its -- what it's able to provide.

5 So, for example, if you're starting specific
6 medication such as clozapine in somebody with psychosis,
7 that is something which should almost always happens
8 within an inpatient unit. You may have somebody who has
9 very, very severe OCD who is not able to leave the home
10 who needs more intensive therapeutic support within
11 a different environment.

12 **Q.** Thank you. And you have mentioned there referrals.
13 I think referrals to inpatient services are made by
14 community CAMHS team, the tier 3 CAMHS team, is that
15 right, or from a crisis presentation at the emergency
16 department, as you said. So when a referral is made, is
17 it right that staff on the receiving unit are the ones
18 to make the assessment of whether it's appropriate to
19 admit?

20 **A.** So the appropriateness to -- the initial assessment is
21 carried out within the community and it's not usually
22 carried out by the inpatient team itself. So they --
23 but that assessment would usually be carried out by a
24 crisis service or somebody who specialises within the
25 crisis assessment and then a recommendation for an

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1 **Q.** We can take that down now, thank you.

2 Can you help us, please, Dr Northover with the
3 nature of the mental health presentations that are seen
4 in inpatient CAMHS services, why children and young
5 people would be admitted to inpatient care?

6 **A.** As we've just seen across the four nations there's only
7 just over 1,400 beds so it is a very small proportion of
8 young people with mental health difficulties who end up
9 being admitted into a psychiatric inpatient unit, and
10 it's not necessarily just the type of mental illness,
11 it's also the extent of the presentation. So you will
12 see young people with very severe mental illness, they
13 might be presenting with a psychotic illness, they might
14 be presenting with a mute disorder with serious
15 self-harm. But it's also about how that is an illness
16 that can't be treated in the community and it may not be
17 able to be treated in the community because of the
18 degree of risk or, again, the degree of security that
19 the young person will need, or it may be that they can't
20 be treated in the community because of the intensity of
21 the support that is required.

22 When it comes to the intensity of the support,
23 it's -- the majority of young people admitted into these
24 units are admitted in a crisis, as an emergency, but
25 a smaller proportion are admitted for a planned

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1 admission would be made by that team and then that
2 recommendation would be reviewed by the inpatient unit
3 who would then decide whether it is appropriate or not
4 for that young person to come into their inpatient unit.

5 **Q.** And so would this decision usually be made by
6 a psychiatrist?

7 **A.** It's usually a multidisciplinary team. So it's usually
8 not a single clinician who would be making that
9 decision, it will be discussed within
10 a multidisciplinary team to decide whether the treatment
11 available within that unit is actually going to be able
12 to support and treat the young person who's been
13 referred.

14 **Q.** You set out in your report that the majority of
15 admissions into inpatient CAMHS units are voluntary so
16 they're not compulsory detentions under the Mental
17 Health Act; is that right?

18 **A.** Yes.

19 **Q.** But I think it's also possible that a patient could be
20 admitted voluntarily and then be subsequently detained
21 under the Mental Health Act?

22 **A.** Yes, and the recording of admission -- of use of the
23 Mental Health Act is not as good as the recording of
24 people who are admitted under the Mental Health Act. So
25 we don't have the high-quality data to know how many

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1 young people were assessed and then admitted but not
2 detained and how many were assessed, detained and then
3 admitted. And sorry, when we say "detained" that's
4 when, under the Mental Health Act, that the young person
5 is placed under the section of the Mental Health Act on
6 admission.

7 **Q.** Can you help us, please, aside from the Mental Health
8 Act but the admission criteria for admission to
9 an inpatient CAMHS unit?

10 **A.** So the admission criteria will be, first of all, that
11 the treatment can't be provided in a less restrictive
12 environment. So an inpatient unit is a very restrictive
13 environment, the doors are always locked, the young
14 person is not able to get out unless they are asked --
15 unless they ask and they are accompanied.

16 The second part is that the unit must have
17 an intervention that is going to support that young
18 person. So if -- the young person needs to have
19 a mental illness that is going to be able to improve
20 through the process of admission.

21 **Q.** And what would be a reason for declining to admit
22 a young person who's been referred to in-patient
23 services?

24 **A.** So the main reason to decline would be that there is
25 a community alternative that is less restrictive. So

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1 links to the local community teams, so there can be the
2 appropriate level of inreach and the discharge can be
3 managed as a single pathway rather than it being from
4 a different pathway. And, as I said, we know that
5 around about 20% of admissions are outside of that area
6 which would suggest that the health service in that area
7 has had to seek a bed further away.

8 **Q.** Can we move on now, please, to the pandemic period and
9 first of all to look at admissions during the pandemic.

10 You've identified in your report that the data shows
11 a decline in the number of admissions, the number of
12 young people admitted across all nations of the UK
13 during the pandemic. What were the reasons for that
14 decline in the number of admissions in your view?

15 **A.** It is multi-factorial. The report also indicates there
16 was a decline in the number of beds. So beds had to be
17 closed for a number of reasons, so in some circumstances
18 because of social distancing and the potential that
19 there was multi-occupancy rooms, that those rooms had to
20 become single occupancy. We know because of staffing
21 levels some units had to be closed and I think the
22 report indicates throughout the pandemic between five
23 and seven units at any one time were closed within
24 England.

25 So the decrease in beds would have caused

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1 again, if the inpatient admission is for therapeutic
2 support and that can be provided elsewhere then the
3 in-patient admission wouldn't need to be taken ahead.
4 The other reason would be that the inpatient unit may
5 not be able to provide the level of intervention or the
6 type of intervention required.

7 So for some young people going into an inpatient
8 unit with its restrictive environments can actually
9 cause a worsening of the presentation in the initial
10 admission, and there is that question about: is that
11 worsening of the presentation going to be in that young
12 person's best interests or not?

13 **Q.** And if there's a referral made to a unit and there isn't
14 actually a bed available in that unit, is there
15 a process by which it's possible to see if there is
16 a bed available outside of that local area?

17 **A.** Yes. So around about 20% of all admissions, that's been
18 quite consistent, actually, for a number of years,
19 around 20% of admissions are for young people outside of
20 their local area.

21 So what we describe it -- we describe it as
22 outside of the natural clinical flow.

23 So we try not to use distance as the factor about
24 whether a young person is admitted to the right place,
25 but whether they're admitted to a unit that has strong

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1 a decrease in admissions, but then the process of
2 admission itself became more difficult and the criteria
3 I mentioned before around whether the unit is able to
4 provide the appropriate intervention or whether it's
5 going to be a better place for a young person shifted
6 and changed.

7 So, for example, if somebody needed more intensive
8 therapeutic support but the therapists were, through
9 social distancing, doing the majority of their therapy
10 online then actually there may be little benefit for
11 that person coming into an inpatient unit.

12 On the other side, when you -- during the period
13 of self-isolation, when young people were being put into
14 the situation of self-isolating in their bedroom for
15 a long period of time, again the risk of a deterioration
16 of the young person's presentation increased so
17 potentially the criteria for admission changed.

18 **Q.** Thank you. Do you think that this change in the --
19 potential change in the criteria for admissions on the
20 part of professionals meant that the profile of the
21 patients who were admitted changed so that it was only
22 the most acutely unwell or the most at risk patients who
23 were then admitted to patient care?

24 **A.** I'm sure that the profile changed. While one of the
25 factors that looking at the risk and the intensity of

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1 the presentation, is if we look at the number of young
2 people who were admitted under the Mental Health Act and
3 that didn't statistically change during the period of
4 Covid. So if we were expecting only young people with
5 a much higher level of presentation to be admitted we
6 would have expected to see an increase in the number of
7 people detained under the Mental Health Act.

8 **Q.** Is that because the criteria for detention under the
9 Mental Health Act makes reference to whether that young
10 person is a risk to themselves or others?

11 **A.** Yes, yes, absolutely. However, there are other areas
12 that we can see there was a change in the profile. So
13 when -- speaking to the units in Wales, the units
14 indicated that they had to have a change in their
15 process of admission because it was no longer possible
16 for them as a unit to go out and assess every young
17 person before the admission. So --

18 **Q.** Was that the situation prior to the pandemic in Wales?

19 **A.** Yes. Yes. So that meant that the units were less able
20 to assess a young person based on the therapeutic milieu
21 and the young person's presentation, so the types of
22 admission that they were getting may have changed
23 a little bit.

24 **Q.** Once a decision was made then to admit a young person,
25 in pre-pandemic times how long would it usually take on
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1 often find there are young people being admitted who
2 have significant social deprivation and social
3 challenges, and in those circumstances sometimes
4 identifying a social care alternative is a better
5 therapeutic approach than a mental health inpatient
6 approach. And understanding that prior to an admission
7 can sometimes take a long time to resolve.

8 **Q.** Taking aside those outliers, do you think there were
9 reasons related to the pandemic and the pandemic
10 countermeasures that resulted in an increase in wait
11 times?

12 **A.** Yes. So, again, in terms of assuring the physical
13 health status of a young person prior to admission, that
14 added additional time. So, again, when Covid testing
15 was being done, to ensure that the results of the Covid
16 test were back. The fact that the -- it is difficult
17 for an inpatient unit to manage more than one or two
18 young people who are self-isolating at a particular
19 time. So whilst a bed might have been available on the
20 unit, the ability to admit multiple young people at the
21 same time may have changed as well.

22 **Q.** And you explain in your report that whilst -- some of
23 these children whilst they were waiting to be admitted
24 to a CAMHS inpatient unit would have been kept on an
25 adult ward, an adult psychiatric ward; is that right?
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1 average between that referral decision and the young
2 person arriving on the unit?

3 **A.** I would have to check the graph to see, but I do know
4 that that time went up during the Covid period.

5 **Q.** So there was a longer -- I think we can have a look at
6 figure 8 on page 28 of your report, please.

7 And this is the average wait times. I'm not going
8 to ask you to explain the difference between medium wait
9 and mean wait, unless you'd very much like to, but we
10 can see that by either metric the length of time waiting
11 increased?

12 **A.** My understanding of this is what we're seeing is we're
13 seeing a bigger increase in the very long waits for an
14 admission than we were seeing an overall increase in
15 waits. And that can also be held up -- so I think that
16 when we were looking at the very worst there was a --
17 I think the report identifies in one instance there was
18 a wait of 111 days for a bed.

19 And this, again, becomes quite complicated,
20 because this was happening at a time that community
21 services were transforming and providing more community
22 care for young people with -- who were presenting in
23 a crisis.

24 Within child and adolescent mental health
25 services, young people are being admitted -- you quite
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1 **A.** So, again, we did see an increase in the number of young
2 people who were being admitted to an adult psychiatric
3 inpatient unit prior to going to a child and adolescent
4 unit. And that was a double whammy of challenge,
5 because the young person would be in an inappropriate
6 environment, because they'd be in an adult environment,
7 where they would have to self-isolate. And then once
8 a bed became available they would then have to move to
9 a child and adolescent unit, where they would have to
10 self-isolate again.

11 **Q.** And what is the impact on a young person of being kept
12 on an adult psychiatric ward, in terms of their access
13 to therapy and their progress towards eventual
14 discharge?

15 **A.** So the -- a young person on an adult ward has to be
16 accompanied at all times by a member of staff, so that
17 one-to-one staffing has to be in place. The young
18 person on the ward is usually kept -- if not separate,
19 they would usually not be part of the group therapeutic
20 interventions on the adult ward.

21 The therapists on the ward themselves may not have
22 the training or the expertise to support a young person
23 in those circumstances.

24 So when Covid wasn't an issue you would usually
25 find that a CAMHS therapist would come from the
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1 community to support the young person whilst on an adult
2 ward, however during Covid that was something that was
3 far, far less likely to happen.

4 **Q.** Thank you.

5 I think data also showed an increase in the number
6 of young people in an acute hospital setting awaiting
7 a specialist CAMHS bed in England. Is that an acute
8 paediatric ward?

9 **A.** Yes.

10 **Q.** How would admission to an acute paediatric ward rather
11 than an inpatient CAMHS unit impact on the care and
12 treatment of that young person?

13 **A.** So the majority of the time it would be a negative
14 impact, because the majority of the time that young
15 person wouldn't be getting the psychological support
16 that they need. So we know there's been feedback from
17 paediatric wards the staff don't feel that they've had
18 the skills or the expertise to support young people with
19 mental health problems. So there's absolutely a delay
20 in the treatment.

21 However, there are some circumstances where being
22 on a paediatric ward is the right place to be. So, for
23 example, if the young person has a physical health
24 problem at the time, if they've taken an overdose, then
25 that's where they need to be whilst their physical

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1 illness and you end up within your family home, then
2 there's a risk, particularly with eating disorders, that
3 you end up in your bedroom, that you start isolating
4 yourself further, and you start getting drawn into some
5 of the behaviours that led to the eating disorder
6 starting in the first place.

7 **Q.** Can we have a look, please, at the witness statement of
8 Dr Elaine Lockhart. She's the chair of the Royal
9 College of Psychiatrists' child and adolescent faculty.

10 At paragraph 31 she makes this observation about
11 the changes in the presentations of young people to
12 mental health services during the pandemic. She says
13 this:

14 "Following an initial decrease in the demand for
15 CAMHS in the early months of the first lockdown, and
16 over the second lockdown (although less
17 significantly), we have heard from our members that
18 children and young people who then presented to
19 services were more unwell than had ever been seen
20 before, and in a greater volume. It is not simply
21 that presentations and contacts with services
22 increased, but rather, the nature and severity of
23 mental ill-health among those presenting had worsened
24 markedly."

25 Do the observations of Dr Lockhart, repeating the

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1 health is stabilised. And also with eating disorder
2 presentations, there are a number of areas within the UK
3 that operate a model where a young person with an eating
4 disorder will be supported and managed from the
5 paediatric ward if they require refeeding, if they
6 require NG tube feeding, prior to a discharge back to
7 community care.

8 **Q.** And I think it's right that there was a significant
9 increase in eating disorders during the pandemic. Were
10 other mental health conditions also observed to increase
11 or was the greatest increase seen in eating disorders?

12 **A.** The greatest increase was absolutely seen in eating
13 disorders, and that's partly because eating disorders
14 is -- it's the mental illness that's got the greatest
15 rate of fatality, and it's a mental disorder that
16 becomes quite obvious to everybody as the weight drops.

17 **Q.** And do you have a view of why during the pandemic there
18 were more children presenting, children and young people
19 presenting with eating disorders?

20 **A.** Yes, so one part of it is school. Schools were absolutely
21 fantastic in providing social support to children and
22 also being a safety net for children who may be starting
23 to show deterioration in the mental health and with
24 eating disorders.

25 The second part of it is if you have a mental
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1 concerns of members of the Royal College, correlate with
2 what you heard from CAMHS inpatient staff that you spoke
3 in compiling your report?

4 **A.** Yes, absolutely, yeah.

5 **Q.** You also observe in that report an increase in
6 admissions from more deprived areas, and you mentioned
7 earlier those social indicators of poor mental health.
8 Did you find any data on inequalities in relation to
9 black and ethnic minority children and young people?

10 **A.** So there's one report which has been done based on --
11 the Far Away from Home study, which did indicate that
12 during the first lockdown that there was actually
13 a decrease in the admission of young people from black
14 and ethnic minorities. However, during the second
15 lockdown there was an increase.

16 So the hypothesis from this paper is that during
17 the first lockdown, this was a cohort of young people
18 who actually ended up accessing services less, so
19 earlier intervention towards their mental health wasn't
20 able to be put into place, and that became more apparent
21 with the second lockdown, when the severity of their
22 mental illness became such that it was no longer
23 possible for them to -- it was no longer possible for
24 them to stay where they were and they required the
25 support at a higher level at that time.

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1 Q. At which point they were at a crisis point?
 2 A. Yes.
 3 MS NIELD: Thank you.
 4 My Lady, I'm about to move to a new topic.
 5 I don't know if that's a good point to take a break?
 6 LADY HALLETT: Certainly. I shall be back at 3 o'clock.
 7 I hope you were warned we take breaks.
 8 THE WITNESS: Yes.
 9 (2.50 pm)
 10 (A short break)
 11 (3.00 pm)
 12 MS NIELD: Dr Northover, can we move on, please, to look at
 13 changes to discharge from CAMHS inpatient care during
 14 the pandemic, and could we go to page 31, figure 10, in
 15 your report. We can see there plotted, for England,
 16 monthly discharge rates from CAMHS inpatient services.
 17 We can see there a rapid spike, a rapid rise in
 18 monthly discharges at the onset of the pandemic in
 19 around March 2020, and you attribute this in your report
 20 to the NHS directive to free up bed capacity at that
 21 time.
 22 Was that directive directed, so far as you are
 23 aware, to mental health units as well as to acute
 24 hospital?
 25 A. So whilst the directive may not have been directly as
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1 all of the young people who might have been referred on
 2 to their services.
 3 Q. If a young person's discharged effectively too soon
 4 before their therapeutic stay has really completed,
 5 what's the likely future consequences of that?
 6 A. The most likely future consequence is they need to be
 7 readmitted into an inpatient unit. And I think that's
 8 what we see when we look at this graph, because we see
 9 a drop off then we see a slight rise again, when we
 10 think, okay, potentially we're seeing some of those
 11 young people who were initially discharged being
 12 readmitted again at that point.
 13 Q. Can we look, please, at the figure that appears on that
 14 page but below figure 11.
 15 This is the average length of stay. We can see
 16 a gradual increase throughout the relevant period.
 17 Again, we have it in the mean and the median length of
 18 stay here.
 19 Is it right that this increased length of stay for
 20 patients was correlated to the decline in monthly
 21 discharges?
 22 A. It does appear to be, yes. Yes, I think certainly we
 23 can say that one of the reasons for the increase -- the
 24 decrease in discharge is an increased length of stay.
 25 The other reason is likely, as I said earlier, that
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1 useful to mental health inpatient units, I think at the
 2 time there was a consideration that the reduction in
 3 discharging patients wasn't just around freeing up bed
 4 capacity, it was around the potential risk of staffing
 5 issues and within mental health units would we be able
 6 to maintain all of the beds that we presently had at
 7 that time.

8 Q. Thank you.
 9 And then after that spike we see very rapid drop
 10 in the number of discharges, in April of 2020, and then
 11 a more gradual trend of decline throughout 2021 and
 12 2022.
 13 This graph is based on data from England. Is it
 14 right that that trend of declining discharges was in
 15 fact consistent across the four nations of the UK?
 16 A. Yes, as far as I'm aware, yes.
 17 Q. Have you identified any evidence that young people were
 18 being discharged during that spike too early and whilst
 19 still unwell in order to -- either to free up beds or
 20 for any other reasons?
 21 A. Yeah, and in contact with the units that I spoke to
 22 there was a concern that some young people were being
 23 discharged when perhaps their treatment hadn't been
 24 completed and at a time when potentially the community
 25 intensive support teams were not in a place to manage
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1 there were less beds available.
 2 Q. And you identify in paragraphs 95 and 96 of your report
 3 that the rules about self-isolation impacted discharge
 4 and length of stay, particularly in relation to trial
 5 periods of leave prior to discharge.
 6 Could you enlarge upon that, please, and explain
 7 how trial periods of leave were generally utilised prior
 8 to discharging a patient.
 9 A. So, as we all know, children and young people are rarely
 10 discharged into a flat on their own. They are almost
 11 always discharged back into family or into carers. And
 12 that shift from an inpatient unit back into the family
 13 or carers environment is something -- it's difficult to
 14 predict how that will go. So you often have periods of
 15 extended leave where a young person will go back home,
 16 will spend a night, maybe two nights with the family,
 17 and then come back into the unit to have an assessment
 18 of how that went, and that's -- that gives
 19 an opportunity to then adjust the discharge plan to make
 20 sure that it's most appropriate for the young person and
 21 the family.
 22 Q. So it's effectively a trial period back at home but
 23 before formal discharge has taken place?
 24 A. Yes, it's a little bit more than a trial period, it's
 25 part of the treatment plan but it can absolutely be seen
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1 as a trial period.
 2 **Q.** In terms of the impact of longer stays on the unit on
 3 the outcomes for patients, Dr Lockhart has stated in her
 4 witness statement that prolonged admissions are
 5 associated with poorer outcomes. Could you enlarge upon
 6 that for us, please.

7 **A.** So, again, this was some data which came out of the
 8 GIRFT report as well, which is the longer you spend in
 9 a CAMHS inpatient unit the worse your long-term outcome
 10 is, when you look at that young person's trajectory over
 11 months or years.

12 **Q.** That seems perhaps a little bit surprising because
 13 clearly it's supposed to be a therapeutic environment
 14 that they've gone into, so what's the reason for that?

15 **A.** There's a number of reasons. So, first of all, if it
 16 takes you longer to recover you have probably got a more
 17 severe presentation in the first place, so that could be
 18 one of the reasons why it takes longer to recover.

19 The second part behind it is because of the
 20 restrictive nature of inpatient units. So when you are
 21 in an inpatient unit as a young person you don't have
 22 the freedoms that you would usually have, as
 23 I previously mentioned. You don't have the opportunity
 24 to leave the unit when you want to, you don't meet your
 25 friends, you get separated a little bit from your

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1 quite intensively staffed --

2 **A.** Yes.

3 **Q.** -- inpatient units. On average 35.2 staff per 12 beds
 4 and in an eating disorder unit 33.7 staff per 12 beds.
 5 In terms of reduction of the number of staff who are
 6 available then, whether that's due to illness or
 7 self-isolation rules, what would the impact be of a unit
 8 being understaffed?

9 **A.** So an understaffed unit is unlikely to be able to have
 10 meaningful activities going throughout the day. So if
 11 we're looking at meaningful activities, if you're
 12 a young person and you're admitted into an inpatient
 13 unit, staying in your bedroom continuously isn't going
 14 to be the type of intervention that's going to help you,
 15 so you need to have these structural activities
 16 throughout the day which may be therapeutic in some
 17 circumstances, such as group therapies, may be trips and
 18 visits out of the unit and other circumstances but may
 19 also be things such as having sporting activities,
 20 having other sort of activities that the young people
 21 can get involved with as a group that are not
 22 necessarily overtly therapeutic. If you don't have the
 23 staffing levels for that, then you end up in a situation
 24 that you might be able to maintain some of those
 25 therapeutic activities, but in between those there might

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1 family, and the longer you're in an inpatient unit in
 2 that way the -- I'm trying to avoid using the word
 3 "institutionalised" because that's not what I mean, but
 4 the longer you are within an inpatient unit, the more
 5 challenging it appears to go back into the environment
 6 that potentially was part of the reason that you got
 7 admitted in the first place.

8 **Q.** So children were spending longer in inpatient units
 9 before discharge. Can we look now at some of the
 10 changes that they would have been experiencing whilst
 11 they were staying in the inpatient unit and how that
 12 might have impacted on inpatients and their progress.

13 First of all, there were some changes to staffing
 14 during the pandemic and overall a reduction in the
 15 number of staff that were available; is that right?

16 **A.** Yes. So staff sickness did lead to an increased use of
 17 agency staff and decreased staff levels on the units.

18 And agency staff may not know the unit as well as
 19 regular staff and the young person may find it more
 20 difficult to establish those therapeutic relationships
 21 if you have a continually changing staff member who is
 22 trying to support that young person.

23 **Q.** In terms of the numbers of staff that were available
 24 during the pandemic, you set out the NHS benchmarking
 25 network data on average staffing numbers, so they're

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1 be very little for the young person to do which, in
 2 itself, can lead to a less beneficial inpatient
 3 admission.

4 **Q.** That's an impact on the quality of care really for the
 5 patients at the time. Are there potential impacts on
 6 patient safety from understaffing?

7 **A.** So for staffing levels to get to the point that it has
 8 an impact on safety, it does have to be quite extreme.
 9 So that would be at the point where a unit feels that
 10 it's no longer able to provide one-to-one staffing for
 11 young people who require to be under that constant level
 12 of observation.

13 What we did see within England is when staffing
 14 levels started to get to the point that there was
 15 a concern around safety, a trust might have made the
 16 decision to say, okay, we're going to close one of our
 17 units so we can ensure that we've got enough staffing
 18 level on another unit.

19 **Q.** Can we perhaps have a look at the graph that shows that.
 20 That's figure 7, page 26 of your report.

21 And we can see that between -- in 2020, between
 22 two and seven units were closed at any one time.
 23 However, you have observed that the units -- the CAMHS
 24 inpatient units in the devolved nations remained open
 25 throughout. Do you know why there was this discrepancy

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1 between England and the devolved nations in that regard?

2 **A.** I haven't -- it's not something I can definitely answer
3 but I do feel that part of the answer is the staffing
4 plans that were potentially put into place. So within
5 England most units -- sorry, most wards are part of
6 a unit that will have more than one ward. So staffing
7 cover between the wards is something that's possible so
8 your staffing emergency plans would be: let's use staff
9 from another ward to cover.

10 If you're a single ward on a unit, then your
11 staffing plans will involve: where can we find other
12 staff from within the system that can support? So that
13 might be thinking about the community teams or the
14 crisis teams. So it's possible within the devolved
15 nations to keep their less number of units open, that
16 they relied on the staff from the community services to
17 come in and make sure that safe staffing levels were
18 always in place.

19 **Q.** So you mentioned there staffing emergency plans or
20 contingency plans and in your report you refer to the
21 fact that some independent providers, and I think it's
22 right that a number of inpatient psychiatric units are
23 provided, not by NHS providers, they are paid for by the
24 NHS but they are provided by independent providers; is
25 that right?

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1 and in particular the rules around social distancing and
2 self-isolation for new patients.

3 Is it right that throughout the UK during the
4 relevant period there were isolation rules for all new
5 admissions on to inpatient CAMHS units?

6 **A.** Yes.

7 **Q.** So that meant that the young person had to isolate for
8 between seven and 14 days at various points throughout
9 the pandemic?

10 **A.** Yeah.

11 **Q.** What was the impact of a period of isolation on a young
12 person's mental state?

13 **A.** I was very fortunate to be able to hear the evidence
14 provided by the impact witness earlier and I think I --
15 it's just building on what she said, it is a terrible
16 time for a young person to be placed in isolation when
17 they're at their most distressed from a mental illness
18 that means they can no longer be at home. So to be
19 placed in isolation at that time with a mental health
20 nurse outside your room inevitably had an impact in
21 terms of the distress on that young person but also the
22 time that it would have actually taken to get them the
23 appropriate therapeutic input and also for them to be
24 able to be engaged within that therapeutic milieu within
25 the unit.

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1 **A.** It is, and actually the way that these independent
2 providers are commissioned and used is slightly
3 different to other areas of the NHS. So whilst they are
4 units that have effectively been built and staffed by
5 independent providers, all of the young people in those
6 units are NHS patients and it's a commissioning
7 arrangement that they will provide the NHS services
8 rather than it being an independent unit that you place
9 somebody at at a point of need.

10 However, those units themselves are often single
11 units and they are often in isolation of any community
12 service that could provide that type of emergency
13 staffing that I described that the devolved nations may
14 well have been able to use. So that does leave those
15 units at a greater risk of having unsafe staffing
16 levels.

17 **Q.** And you set out in the report one independent provider
18 unit which reported that its staffing contingency plan
19 was to provide basic training for the reception and
20 administrative staff to provide cover on the ward if
21 that was required. What were your views about the
22 appropriateness of that arrangement?

23 **A.** Thank goodness it never had to be implemented.

24 **Q.** If we can move on to deal with the impact of infection
25 prevention and control measures in inpatient CAMHS units

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1 **Q.** You have also set out that because of the self-isolation
2 rules there were restrictions on the number or frequency
3 of visits from friends and family. What are the
4 importance of -- what is the importance of family visits
5 for mental health inpatients?

6 **A.** It's crucial, family and carers. Some young people may
7 be admitted where actually they haven't got family or
8 don't have access to their family, but I think family
9 and carers is absolutely crucial. I think any mental
10 health presentation within a young person doesn't just
11 affect the young person, it affects the family and
12 carers as well. So it's about how the treatment needs
13 to involve those systems and not just an individual. So
14 delaying or not enabling that to happen has a negative
15 impact on the therapeutic delivery of care.

16 **Q.** So it's not just that it's nice for the inpatient to
17 have some visits and someone come along and keep them
18 company but it actually very much impacts on the
19 therapeutic progress. Is it right that in pre-pandemic
20 times family therapy would be part of the inpatient
21 treatment and take place on the unit often?

22 **A.** Yes, absolutely, and I would have to go and check the
23 staffing numbers but every child and adolescent
24 inpatient unit should have a family therapist.

25 **Q.** You've also identified that because of the social

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1 distancing rules that existed on the inpatient units as
 2 everywhere else, there was less contact between
 3 patients, between inpatients during the pandemic, less
 4 use of communal areas and a need to divide patients into
 5 bubbles. To what extent is contact with other
 6 inpatients helpful for those children and young people
 7 and did that reduction in contact impede their progress?

8 **A.** And again, that contact is very important. It's very
 9 difficult for a young person to fully recover or
 10 understand their mental illness if they're doing that in
 11 isolation, so being able to have those conversations and
 12 normal teenage time with other people whilst you're in
 13 an inpatient unit is part of the therapeutic.

14 And when I describe the therapeutic milieu, that's
 15 sort of what I'm trying to describe there, it's about
 16 how a young person can be on a unit which is friendly
 17 and supportive and is able to provide the advice in the
 18 way that we all hope that we're able to provide at home
 19 to our own children.

20 **Q.** Also I think there was a reduction in group therapies
 21 that were able to take place for the same reasons
 22 because of the social distancing rules; if there wasn't
 23 a room large enough to accommodate everybody with the
 24 appropriate 2-metre distance between them.

25 Was there an observable effect or impact on
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1 may find remote therapy easier or they may find it more
 2 difficult depending on the make-up of the young person.
 3 But absolutely it would have an impact.

4 **Q.** And was there any national guidance provided on that
 5 during the pandemic in terms of identifying what kind of
 6 patients and what kind of presentations and what kind of
 7 therapies would be most appropriate for remote delivery
 8 of therapeutic interventions?

9 **A.** It was very much more a blanket that, you know, if you
 10 can work remotely you should be working remotely rather
 11 than thinking more closely around what would work
 12 remotely and what wouldn't.

13 **Q.** Do you think that's an area in which national guidance
 14 would be useful in the event of a future pandemic or
 15 generally with a general move towards remote delivery of
 16 therapies?

17 **A.** Absolutely, yes. I think it's an area that probably
 18 needs the research first. I think it is actually a very
 19 complicated area and it's quite easy for us to make
 20 assumptions about what will or what won't work, but I
 21 think whilst we have got an opportunity we should be
 22 exploring the evidence behind it and then being able to
 23 put that into national policy.

24 **Q.** Staying then with the impact of IPC measures on
 25 inpatient wards. You've set out the possibility on
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1 children and young people from not being able to access
 2 group therapy?

3 **A.** For this I would just have to hypothesise yes. We do
 4 know that those units that weren't able to provide group
 5 therapy, because they didn't have a large enough room,
 6 felt that that was a big hindrance to their delivery of
 7 care. However, actually finding clear evidence for that
 8 I think would be much more difficult to do.

9 **Q.** And we've heard that there was a move to delivering
 10 therapies online or remotely. Did that happen as well
 11 on inpatient units?

12 **A.** Yes, it did. So you would find that the therapist or
 13 the psychologist on the unit may not be going into the
 14 unit to provide therapy but would be doing that remotely
 15 from their home beaming into the inpatient unit.

16 **Q.** And are there drawbacks and benefits to remote delivery
 17 of therapy for these cohort of patients?

18 **A.** Yes, absolutely. And, you know, the drawbacks and the
 19 benefits can vary from presentation to young person to
 20 type of therapy, so it's quite difficult to unpick. So
 21 certain therapies such as psychoanalysis, psychotherapy
 22 or an art therapy, which is going to be much more
 23 difficult to deliver remotely than a manualised,
 24 structured cognitive behavioural therapy and then
 25 a young person with social communication difficulties
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1 an inpatient ward and with these particular children and
 2 young people who may pose a risk to themselves that PPE
 3 could actually be used for self-harm?

4 **A.** Yes, and this was a specific example from one of the
 5 units that I talked to where they had a young person who
 6 was at risk of self-harming by removing small bits of
 7 wire from the mask.

8 **Q.** So that's the part that goes over the nose and enables
 9 a closer fit?

10 **A.** Yeah, and the other thing to remember is PPE has string
 11 attached to it so, again, that in itself can bring
 12 a risk of tying of ligatures.

13 **Q.** Is it also right that, particularly in terms of mask
 14 wearing, that that can impact on children and young
 15 people in terms of establishing a relationship of trust
 16 and understanding with the staff on the unit?

17 **A.** And that is certainly feedback that we received is that
 18 it can be much more difficult to establish that
 19 therapeutic relationship. However, we did on occasions
 20 get feedback which suggested that young people and the
 21 therapist felt much safer when they had the right levels
 22 of PPE which allowed them to engage better in the
 23 therapy, but overall it was deemed to be a barrier.

24 **Q.** So you've identified in your report that the Covid rules
 25 in particular impacted on children and young people in
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1 terms of reduced visits from families and carers, the
 2 self-isolation periods and reduction in staffing levels
 3 and less continuity of care. Were you able to identify
 4 any measures or guidance at a national level or indeed
 5 at a trust level that were aimed at mitigating those
 6 impacts?

7 **A.** I'm tempted to say no. But I think the fact that I'm
 8 sitting here not able to recall any is probably
 9 an indication itself that if there was that the way that
 10 it was communicated was probably -- the communication of
 11 that was probably outweighed by the communication of the
 12 safety, the social distancing rules and the PPE rules.

13 **Q.** If we can come on to look at some potentially positive
 14 changes or initiatives in response to the pandemic.
 15 I think your research did identify some efforts to
 16 establish alternatives to inpatient admissions in
 17 particular community crisis hubs. Can you explain how
 18 they worked for children and young people in the
 19 community?

20 **A.** And this is certainly one of the areas that Covid has
 21 allowed to develop within mental health services and
 22 that's about how do we make sure that we've got the
 23 right support in the right place for young people, and
 24 there's a recognition that actually going to
 25 an emergency department within a mental health crisis

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1 of hubs are quite resource-intensive so you need to
 2 resource them with quite a large number of staff who are
 3 going to be working there potentially 24/7, and the
 4 question is where are these staff going to come from and
 5 I think the trusts will always want to be able to make
 6 sure that there's an evidence base before they do
 7 something that's potentially resource-intensive and I'm
 8 not sure that the evidence base was there at the time
 9 and whilst there was positive feedback, I'm still not
 10 sure we have the clear evidence of the benefits of these
 11 hubs. I hope we do, I hope it's an area that we get the
 12 evidence for.

13 **Q.** If we can move on, please, to lessons learned and
 14 recommendations for future pandemics. You have set out
 15 that whilst the response to the pandemic and in
 16 particular lockdown and specifically closing schools,
 17 these were known risk factors for children and young
 18 people's mental health but that nevertheless the
 19 pandemic preparedness plans did not appear to have
 20 included any plans for mental health services prior
 21 to March 2020. In your opinion how should pandemic
 22 planning have addressed a predictable increase in demand
 23 for children's and young persons' mental health
 24 services?

25 **A.** The first part to this question, which is around some of

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1 may not be right place for you to go, and during Covid
 2 it was identified it absolutely wasn't the right place
 3 to go because you didn't want to be in an emergency
 4 department with people with physical health problems,
 5 probably Covid around the place when you could be
 6 supported and managed somewhere else.

7 So a number of trusts tried to establish crisis
 8 hubs where a young person or an adult could go to have
 9 their mental health crisis needs met without them having
 10 to go into the acute paediatric ward.

11 I think Great Ormond Street was one example of
 12 this.

13 They had great feedback but it's an area that
 14 doesn't seem to have really become as established as was
 15 expected at the time that -- during the Covid time when
 16 the benefits were being realised.

17 **Q.** Have you been able to identify why they don't seem to
 18 have been continued or taken up?

19 **A.** It's -- I think these are complex systems to set up. If
 20 you set up a hub for people in the mental health crisis,
 21 then there's the risk that somebody who has a mental
 22 health crisis and physical crisis isn't actually treated
 23 in the right place. So you need to have some very good
 24 working policies with the acute hospitals.

25 I don't think that these are -- that these types

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1 the social determinants of health, we understand social
 2 determinants of health and we should be addressing those
 3 anyhow, and I think if we don't address those then we
 4 have to expect a pandemic will make those social
 5 determinants worse and that will have an immediate
 6 impact. So for that not being in any pandemic planning
 7 is a bit of an oversight.

8 When we know that that's -- that it's going to
 9 happen, we then need to start thinking about what are
 10 those protective factors within the community that we
 11 need to be considering. School is a huge protective
 12 factor for children and young people. I know there's
 13 plenty of children who don't enjoy going to school but
 14 it's another social safety net to understand when
 15 children are struggling and another route for children
 16 to start getting help. So we need to be thinking in the
 17 future what do we do with schools so we don't remove
 18 that safety net, or if we do remove that safety net what
 19 can we put in place.

20 We then have conditions such as eating disorders
 21 within the report. We can predict that eating disorders
 22 will significantly increase during a pandemic because it
 23 hits all of the risk factors for an eating disorder. So
 24 what pre-pandemic planning can eating disorders services
 25 actually do to make sure that they can increase

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1 a predictable -- so they can meet a predictable increase
2 in demand?

3 And just having to think through that as
4 a service, should enable them to put some relatively
5 straightforward plans in place to start managing that
6 demand.

7 **Q.** Given that an increase in demand from mental health
8 services is predictable in a pandemic, as you have set
9 out, do you think there needs to be a surge capacity
10 plan for mental health services as there was for the
11 anticipated surge in demand for acute hospital services?

12 **A.** Yes. Yes.

13 **Q.** And in terms of the inpatient CAMHS provision across UK,
14 was there sufficient capacity to meet demand before the
15 pandemic?

16 **A.** No.

17 **Q.** And so to what extent do you think the current state of
18 the inpatient CAMHS service has ramifications for how
19 resilient the service is in the event of a future
20 pandemic?

21 **A.** So thinking about the inpatient aspect and the inpatient
22 side of any planning for the future, it's about how can
23 we reduce the need and demand for inpatient services.
24 If we had the crisis and intensive home treatment team
25 services that we now have at the time of Covid we

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1 it's a policy that we can't change, we should at least
2 at that point know what the impact on quality is going
3 to be, so once we are past the crisis point we know what
4 the issue is and what we may have to deal with at that
5 point in time.

6 The other thing which I think we need to mention
7 is the inpatient units themselves. The fact that
8 inpatient units had to -- some units didn't have enough
9 room to do group therapy is something that we have to
10 prepare for in the future.

11 Our units have to be designed in the way that they
12 can manage a social distancing situation in the future.
13 And we're already at a position where I think there are
14 very few, if any, rooms that have more than one person
15 in them on an inpatient unit, which is fantastic, but we
16 just need to make sure those communal areas and the
17 therapy rooms are large enough and that we have the
18 visiting facilities for families so they can come, when
19 there is social distancing, to still see their children
20 and support with the therapy.

21 **MS NIELD:** Thank you very much. I have no more questions
22 for you, Dr Northover.

23 **LADY HALLETT:** Thank you very much, Ms Nield.

24 Mr Pezzani, who is to the back to your right. But
25 if you could make sure your answers go into the

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1 probably would have seen even less young people needing
2 admission because we would have had a viable community
3 alternative.

4 But that doesn't mean that we should stop here.
5 We should continue to look at that community offer and
6 how can we continue to provide the care that's required
7 and needed in the community and potentially get
8 ourselves to a position where we need less and less
9 inpatient beds. We're never going to need no inpatient
10 beds but we can potentially have less and for it to be
11 much clearer and much better defined about who should be
12 admitted and why and what that treatment looks like.

13 **Q.** Dr Northover, you've included there a number of the
14 recommendations that you've identified in your report.
15 Are there any other areas where you would like the area
16 to consider a recommendation in relation to inpatient
17 CAMHS services in the event of a future pandemic?

18 **A.** The first one I'd just like to mention, I know
19 I've touched on it briefly when you asked me earlier,
20 but it really is -- as the policies are released during
21 a pandemic, which are understandably there to support
22 the demands on the acute hospitals, I think there has to
23 be a very, very clear process to make sure that there's
24 a quality impact assessment of those policies on mental
25 health inpatient units as well. Because we -- even if

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1 microphone, I'd be grateful.

2 Questions from MR PEZZANI

3 **MR PEZZANI:** Doctor, I ask questions for Mind, the mental
4 health charity.

5 I say I ask questions, almost all of my questions
6 have already been asked and answered, but I may be able
7 to formulate some opportunities for you to perhaps
8 expand on some of your shorter answers.

9 The first is in relation to capacity, capacity to
10 meet demand. You've already been asked, and answered
11 bluntly, in relation to whether capacity was there to
12 meet demand even before the pandemic.

13 Can I ask specifically in relation to eating
14 disorders, please, Doctor. I am looking at part of your
15 statement that deals with eating disorders at
16 paragraphs 164 and 165, where you say at 164 what we've,
17 I think, already established, that following an initial
18 decrease, eating disorder presentations rose
19 significantly during the Covid-19 pandemic.

20 And then at paragraph 165 you note that prior to
21 the pandemic, eating disorder services had already been
22 struggling to meet demand.

23 You also more generally report, at paragraphs 104
24 and 158, that the staff that you spoke to identified
25 a feeling that there was decreased capacity across the

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1 sector, and there were even ethics committees set up to
2 meet the potential for reduced capacity and increasing
3 demand causing crisis.

4 How then would you respond to an assertion that
5 during the pandemic, in specific relation to children
6 and young people's mental health services, demand never
7 exceeded capacity?

8 **A.** Certainly I would -- so, again, the first part of the
9 question is whether we're looking at inpatient care,
10 because if we're looking at inpatient care in particular
11 then you can manage your demand, because your demand is
12 how many beds you've got.

13 So by seeing young people spending longer within
14 inappropriate settings before they're admitting would
15 suggest that we weren't meeting the demand for inpatient
16 beds at that time.

17 I'm not sure whether that's entirely answered your
18 answer (sic). And I'm just going to finish saying that
19 and then turn around and look at you again.

20 **Q.** If you have anything that you wish to add then please
21 do.

22 I did specifically mention eating disorders, and
23 I wonder whether you would be able to comment
24 specifically on the demand and capacity to meet that
25 demand during the pandemic in relation to eating

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1 geographical isolation or isolation from NHS services,
2 either inpatient or community or both?

3 **A.** So it's certainly not a geographical isolation. It is
4 an isolation from the provision of other services. So
5 if I look at the trust that I work in, Berkshire
6 Healthcare, it employs nearly 6,000 people, so that's
7 a large group of people that you can pull on and
8 identify those who have got the expertise and the
9 knowledge to support an inpatient unit if it's getting
10 to the point that the sickness on that unit is not
11 allowing enough safe staffing levels.

12 The independent units may have -- they may have
13 more than one unit but they're likely to be spread over
14 the country and you're not able to have that large
15 resource of staff within close proximity or with the
16 right level of skills to come in and support a unit.
17 And that's why, as I mentioned in the report, some of
18 these units were having to resort to looking at the
19 staff they did have that they could pull in and how can
20 we upskill those staff to the best of their abilities to
21 provide the best care that they possibly could, which at
22 that time may not have been what we would consider to be
23 good during a time outside of a pandemic.

24 **LADY HALLETT:** I think we are going to have to leave it
25 there, Mr Pezzani.

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1 disorders?

2 **A.** So, again, with eating disorders, one of the challenges
3 with eating disorders, and the reason why we saw
4 an initial drop off, is for young people staying in
5 their family homes and the weight loss not being
6 recognised in the first instance. So it may well not be
7 that demand -- we could meet demand in terms of the
8 young people being referred but that doesn't mean that
9 we were being referred everybody who had an eating
10 disorder.

11 So then once we got past that initial phase of
12 young people deteriorating significantly within their --
13 basically within their bedrooms, that's when we suddenly
14 saw an increase in demand, at which point I think all
15 services were starting to recognise that they couldn't
16 meet the demand for the referrals for eating disorders.

17 **Q.** The second topic that I would wish to raise has also
18 been expressly asked of you already, and that's about
19 what you say at paragraph 122 of your report about
20 independent providers reporting greater challenges in
21 developing staffing contingency plans because they were
22 more isolated and not able to call on community mental
23 health staff, community teams, to provide emergency
24 cover. Are you able to explain what you mean by
25 "isolation" though in that context? Do you mean

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1 **MR PEZZANI:** Thank you, my Lady.

2 **LADY HALLETT:** Thank you very much.

3 That completes the questions we have for you,
4 Dr Northover. Thank you very much for your help in
5 producing your written report and for your help in
6 giving evidence today. I'm very grateful.

7 **THE WITNESS:** Many thanks.

8 **(The witness withdrew)**

9 **LADY HALLETT:** Ms Carey.

10 **MS CAREY:** Thank you, my Lady.

11 Before we conclude this week's proceedings, can
12 I invite you, please, to publish a number of additional
13 statements and documents at this stage. That includes
14 three statements on behalf of royal colleges:
15 Dr Edward Morris, who is the former president of the
16 Royal College of Obstetricians and Gynaecologists;
17 Dr Katherine Henderson, who is the president of the
18 Royal College of Emergency Medicine; and Sir Andrew
19 Goddard, the former president of the Royal College of
20 Physicians.

21 In addition, there are four impact witness
22 statements that we'd invite to you publish. They are
23 from Vivienne Wilkes, who is a member of the Disability
24 Charities Consortium. She is registered blind and was
25 sent a shielding letter in inaccessible format during

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1 the pandemic, and she speaks to that and other
 2 difficulties she had in accessing healthcare.
 3 Kafeelat Adekunle is a community matron and
 4 a member of the RCN, and she describes the difficulties
 5 that she had with PPE and the impact of the pandemic.
 6 Adrian Warnock, a member of the Clinically
 7 Vulnerable Families core participant group isolated from
 8 his parents during the pandemic and he attests to the
 9 impact of shielding on him.
 10 And your Ladyship will recall yesterday hearing
 11 from Natalie Rogers. In addition to the -- speaking on
 12 behalf of the Long Covid core participant group she made
 13 an impact statement which sets out her own personal
 14 experience. I invite you to publish three chronologies
 15 provided by the Long Covid groups which sets out
 16 a number of documents they provided to government, work
 17 being done with their membership, and indeed other work
 18 they have undertaken to provide impact evidence to the
 19 Inquiry.
 20 Can I also invite you to publish the expert report
 21 from Professor Christopher Gale and Dr Nadarajah, they
 22 are the experts in ischaemic heart disease.
 23 And finally this, can I invite you to publish
 24 an additional statement from Professor Jonathan Wyllie.
 25 Your Ladyship will recall on 10 October he gave evidence
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1 and was asked about whether the Resuscitation Council
 2 had received reports of inappropriate or blanket
 3 DNACPRs. He indicated he thought there had been reports
 4 of a trust behaving in this way and over the course of
 5 the two-week break the module 3 Inquiry legal team asked
 6 Professor Wyllie for further details about that
 7 evidence. He's provided an addendum in which he
 8 clarifies. The example he was talking about in fact
 9 related to a restrictive approach to the circumstances
 10 in which CPR should be administered and not in fact to
 11 an example about blanket or inappropriate DNACPRs.
 12 Can I ask your Ladyship, in order to have his
 13 evidence in its proper context, for you to publish his
 14 statement which is INQ000474448.
 15 **LADY HALLETT:** I authorise publication of all the
 16 statements.
 17 **MS CAREY:** Thank you very much, my Lady.
 18 **LADY HALLETT:** Thank you very much. That completes the
 19 hearings for this week. I'll see those who have to
 20 attend and those who are interested on Monday,
 21 4 November at 10.30.
 22 **MS CAREY:** Thank you.
 23 **(3.41 pm)**
 24 **(The hearing adjourned until 10.30 am**
 25 **on Monday, 4 November 2024)**
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