Thursday, 31 October 2024

(10.00 am)

LADY HALLETT: Ms Hands.

MS HANDS: Good morning, my Lady. May I please call Professor Bhangu, who will take the oath.

PROFESSOR ANEEL BHANGU (sworn)

Questions from COUNSEL TO THE INQUIRY

MS HANDS: Professor, good morning. You've provided the Inquiry with a report with a colleague, Dr Nepogodiev, titled "Unveiling the hidden impact: Colorectal cancer". That is INQ000474244.

Before we start, is it right that you have a small correction to page 22, table 4 of that report in relation to the time frame for diagnosis to treatment in Scotland?

A. That's correct. And it says 62 days. It should be 31 days.

Q. I'm grateful. Thank you.

LADY HALLETT: Just pause, I'm so sorry.

I can't see a transcript running. Is it just my screen? Is there a transcript?

MS HANDS: No, it isn't.

LADY HALLETT: Have you -- sorry, have you got -- ah, it's just me. Don't worry, it's just me.

MS HANDS: I don't have one either.

LADY HALLETT: Don't worry, it can be fixed at the break for me. But -- okay, as long as everybody else has one and we have one running. Sorry to interrupt.

MS HANDS: Not at all. Thank you, my Lady.

Professor, it's correct, isn't it, that you qualified in 2004, trained in general surgery and completed a PhD for research into colorectal cancer?

A. That's correct.

Q. And you are currently a consultant colorectal surgeon at University Hospitals Birmingham trust and professor of global surgery at University of Birmingham?

A. That's correct.

Q. We're going to be looking today at the impact of the pandemic on colorectal cancer. That is the fourth most common cancer and second leading cause of cancer-related deaths in the UK; is that right?

A. That's correct.

Q. And your report provides data where available for each nation of the UK, which is very helpful. We won't have time to go through each today so I want to ask you whether you've observed any significant difference in the data between each nation that you wish to set out at the outset?

A. No, from the data available, the pattern of events across the whole patient pathway appear to be very

similar across all the nations.

Q. Thank you. And in regard to terminology, it's correct, isn't it, that colorectal cancer is also referred to as bowel cancer?

A. Yes.

Q. So, starting with the diagnosis and screening of colorectal cancer, it's right that it can be symptomatic, in which case patients will present to their GP or A&E?

A. That's correct, yeah.

Q. And it can also be asymptomatic, and such cases are usually detected through screening?

A. Yes, for those in that age bracket of which they can be screened.

Q. And what is that age bracket?

A. So in England it's 54 to 74.

Q. Thank you. And briefly, what are the most common symptoms?

A. In brief, they're things like changes in bowel habits that are persistent and worsening, bleeding out of someone's bottom, what we call rectal bleeding, and some people present with pain and masses in their tummy.

Q. Thank you. And can you briefly explain the tests that are used for diagnosing colorectal cancer and whether any are more effective or suitable than others for

certain types of patients?

A. The first choice test for diagnosis is an endoscopy, which we call a colonoscopy, so that's also known as a bowel scope. So it's a camera that goes into the bottom. It can make a diagnosis based on what the endoscopist can see. And the advantage is it also allows a biopsy to be taken there and then.

We perform CT scans in some people who aren't suitable for an endoscopy, so people who are older and more frail, for example.

And those are the two common first line tests.

Q. And what was the most common method of diagnosis before the pandemic?

A. Around 50% of patients symptomatically via their GP, and then they come in on an urgent cancer referral pathway into the hospital.

Q. Did that change at all during the pandemic?

A. During that first wave the reduction in diagnoses was predominantly due to the difficulty in accessing the health system, which would have been affected mostly in those patients.

Q. We'll come on to look at that data in more detail in a moment. It's correct that there was a pause in the bowel screening programmes across the UK from around March and April 2020, which resumed in June to October

that year; is that right?
A. That's right. And that was timed with the cessation of all elective activity in that period.
Q. And is it your view that that was the right decision, to pause the screening programme at that time?
A. One of our recommendations coming out of this Inquiry will be to continue ante-diagnostics, which includes the screening programme, in future pandemics.

So, with hindsight, the answer is no, I would like to have seen that continue -- to have continued during that time period.
Q. Can we, please, have on screen INQ000474244, figure 21A.

We're going to look at figure 21A and B during your evidence this morning, but starting with A, which looks at the number of diagnosis rates in England for 2019 to 2020.

Please can you explain what the data in this graph shows about the diagnosis rate during that period.
A. So this shows the number of diagnoses per -- each month over the three years shown there, 2019, 2020 and 2021. And the key focus is on the orange bar, which is 2020, and you can see in March 2020, when the pandemic and lockdowns hit, there was a steep drop in diagnoses, and that lasted until the lockdown lifted, and then the diagnoses rapidly increased again, to what we'd expect.

And that's the key period there, and we think in that period there were 4,725 fewer diagnoses than would be expected. And that's one of the key groups of patients who were lost in this pandemic.
Q. And how did it recover so quickly?
A. So this graph shows us that there was a very quick recovery in activity, and that's largely due to the activities of the frontline staff, in the GP practices and the hospitals, who got back to business and found ways around the problems we had at the time.

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

And then you can see in 2021 there may have been a slight increase in the number of diagnoses expected, and so there was an element of catch-up in the system that enabled some of those patients hopefully to have flowed through.
Q. And in your report you have provided a comparison of diagnoses of colorectal cancer per year across the UK.

So if we could please have on screen table 5, thank you.

LADY HALLETT: Just before you do, I'm sorry to interrupt.
MS HANDS: Yes.
LADY HALLETT: You say that you made the recovery because of the frontline staff picking up red flags. As far as the cancer screening and the elective procedures were concerned, had that changed or is it just that the frontline staff took their own efforts?
A. So during the pandemic we still continued to do some surgery, even during the lockdown, because there were patients already in the system, and some were still managing to flow through. One of the main rate limiters were these endoscopies and the camera tests and -- for various reasons.

And so that was the direct activity of the hospital staff, that enabled that to reopen to the highest number per day as possible.
MS HANDS: And we're going to come on to look at some of those barriers to restarting endoscopies in a moment.

Looking at the data we have on screen at the moment in terms of the diagnoses of colorectal cancer per year, can you explain the crude reduction and crude excess numbers and what that shows in relation to the impact of the pandemic.
A. And so the crude reduction, that shows between 2019 and 2020, and if you add that all up that comes to the 4,725

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

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

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

So, to summarise, we think that the numbers overall balanced out but we can't guarantee that there weren't some patients lost in that system.
Q. And in your report you set out a number of reasons or potential reasons why, in your view, there may have been fewer cancer diagnoses, particularly in table 12. That's page 58, 59.

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

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

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

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

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

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

cancer referrals.

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

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

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

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

And halfway down it states that:

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

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

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

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

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

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

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

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

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

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

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

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

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

UK during the pandemic?
A. They weren't as available as they are today. It was being rolled out by the bowel cancer screening programme at that time and, if anything, the pandemic increased the speed at which they were being rolled out, so by the end of 2021 they were far more commonly used than at the beginning of 2020.
Q. I want to look specifically at endoscopy now, as the gold standard test you've described it as in your report for colorectal cancer diagnosis and one that, as you've referred to already, was directly impacted by the pandemic. It's correct that there were no specific tools or guidance for prioritising endoscopy before the pandemic, was there?
A. Not for -- no, not related to the pandemic but the main -- one of the main focuses for that test is what used to be called the two-week wait pathway. So those are patients who, within two weeks of being referred by a GP, they should end up with a diagnosis of a cancer within that time period. So that was a focus for endoscopy and it's throughout the country.
Q. And that remained in place throughout the pandemic?
A. Yes, it did, and it still is. It's now called the Faster Diagnosis Standard.
Q. In your report you've explained that there was

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

To your knowledge which guidance was followed and was there any inconsistency in approach taken?
A. The guidance that was mostly followed was from the British Society of Gastroenterology which advised caution on behalf really of the staff working and it was a combination of the fears of the effects of aerosol generation and also some of the change in recommendations that came round at the time around changing air in the rooms between patients and the time that takes, and in combinations those slowed down both the total number of endoscopies that could be provided and also within an individual time slot, half a day, the number that could be provided there.
Q. And the guidance from the BSG was updated at the end of April 2020 to -- for the phased safe restart of endoscopies including measures such as Covid-19 testing

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

But endoscopy was the hardest-hit unit in the whole of this pathway and even today the capacity is a struggle.
Q. And you referred earlier to colonoscopies and is it right they were also impacted to a significant extent for the same or very similar reasons?
A. Yes, so by -- endoscopy encompasses a colonoscopy, which goes all the way around the bowel, and what's called a flexible sigmoidoscopy, which goes halfway around the large bowel.

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

Firstly, would you agree with that?
A. Yeah, absolutely, and it reflects some of what we've said around the provision of endoscopy, the provision of information to GPs, and then the provision of surgery as well.
Q. And would you recommend that a centralised system be established prior to any future pandemic to ensure that we're in a better place if -- going into another one?
A. Yes, and I think two key recommendations there. Firstly is centralised communication which is harmonised and doesn't have too complex a flow so it can get out to those who need it quickly.

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

Q. You've already covered some of my questions in regard to the cancer screening programme and FIT testing. Is it right that there's a variation in uptake of screening across the UK, and is that impacted by geography or demographic?

A. There is definite variation in uptake and it's both of those things you said. There's geographical variation, there's variation based on deprivation, so we know that more deprived communities have lower uptake and then there's variation based on ethnicity, with ethnic minorities having a lower uptake as well. And then there's the intersection of ethnic minorities in deprived areas who have the lowest uptake.

Q. Were they pre-existing before the pandemic or did they arise and worsen during that period?

A. They were pre-existing before the pandemic, I think they were present during the pandemic and they are present today.

Q. And I think in your report you've given some suggestions as to how they could be reduced in a future pandemic. Could you just explain some of those, please.

A. And a lot of it is around communication and it ties into communicating around the bowel cancer screening programme now, how do we most effectively communicate it to the patients who are mostly to benefit from it.

But also, if there is another pandemic, how do we communicate to patients that the GPs remain open, that people should take part in bowel cancer screening, that if they have these symptoms they should seek medical help. And that will require a whole system to address that. It will be the hospitals, it will be the general practitioners, it will be the public health physicians.

Q. I want to move on to staging. You've referenced staging in your report, and is it right that that refers to how advanced a cancer is?

A. That's correct, the stage at presentation.

Q. And there are four stages, with 3 and 4 being for the most advanced cancers?

A. That's correct.

Q. And put simply, is it right that the rates of survival are better in earlier stages of cancer, when they're seen at presentation?

A. Yes, very much, and there's good evidence to support that.

Q. In terms of the data during the pandemic, is it right that it shows that during April to June 2020 there was a small increase in the proportion of patients with advanced disease when there were fewer diagnoses?

A. That's correct, there was a blip up, which came down relatively quickly.

Q. I was going to say, the proportion diagnosed with stage 3 or 4 recovered by the end of 2020, you've said, when diagnosis returned to normal?

A. Yes.

Q. Do we know yet if that's had any long-term impact?

A. No, we haven't got the five-year survival data from that time period, and that data even then doesn't come out for five years after the pandemic, it tends to -- first, five years has to pass, which is the average of five years for the patient, then the data has to be prepared and published, and that itself could take a few years. So we might not know for a few more years the impact of that time period on overall survival.

Q. You've also said in your report that 20% of data was missing. Are you able to opine as to why that was and what impact that might have on our analysis of the data?

A. Yes, it's -- the data is probably missing because the normal people who would collect that data and input it into the various systems to exist were locked down during that time period, with a large shift to not being in a hospital and not having the system around it to support that data collection.

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

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

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

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

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

A. They were beginning to dip in 2019 across all countries and across all health systems. So they were being met five, eight years ago, before the pandemic. Then in 2019 they were dipping and the pandemic has exacerbated all of that.

Q. You've said in your report that it's critical that adherence to cancer performance standard is maintained. Does that include throughout the pandemic?

A. Yes, we were very -- we and I and as a community we'd like it see that happen. I think these targets in the

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

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

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

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

Q. Yes. It should be page 45.

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

Q. And what about referrals?

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

Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But surgery remains the mainstay of treatment.

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

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

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

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

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

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

What about testing regimes? Should they be

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

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

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

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

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

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

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

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

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

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

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

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

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

practice.

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

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

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

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

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

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

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

administer more short course radiotherapy regimes for rectal cancer; is that right?
A. There was. And that is what -- radiotherapy can be given over a five-day period, which is intense radiotherapy, or it can be spread out over a five-week period. So, again, to keep patients away from the hospital, and also because there weren't as many staff around either, there was a shift towards this shorter course of radiotherapy.
Q. Do we know the impact of that yet on the patient recovery rates?
A. No, there's no -- that gets so complicated in terms of looking at exactly the type of tumor and the stage and then the survival of that that we don't know the direct effects of that yet, no.
Q. Were there any immediate effects on the patient of that change in treatment?
A. I suspect some patients found it a lot easier to have five days of radiotherapy rather than coming back to these Covid-infected sites over a five-week period.
In terms of the biology, we've got no evidence that it had a positive or negative effect, and we'll have to look at that in the future.
Q. If we could have a look at your figure 21 in relation to the number of resections.

So it's -- thank you.
So this is the second half of the graph that we were looking at earlier. Can you just explain to us what this shows in terms of the number of resections in England between 2019 and 2022, please.
A. Sure. And it's consistent with the diagnostic data. There was a fall in the number of resections performed in that first phase of 2020, which is the orange graph. Now, it wasn't as steep as the fall in diagnosis because there were already patients in the system, and it didn't fall down as low as the number of diagnoses, because there were still some people coming through emergency routes and other routes who we managed to get into surgery.
So surgery did continue throughout the pandemic in -- it was often in different locations, so we used private hospitals a lot for this service, because we didn't want to do these operations in the big Covid hospitals. But, again, combined -- the frontline teams and that flow of patients kept some surgery going.
Q. Does this include elective and emergency surgery, this data?
A. Yeah, that includes all of the resections done, the electives and the emergencies. So the emergency patients still presented to A&E departments in

desperation but as described there were still some elective patients coming through.
Q. And I think you said in your report there was no major shift observed to presentation via an emergency route during the pandemic, is that right?
A. That's right, there wasn't a sudden increase in the number of patients coming in, it was really proportionate to what we'd normally expect.
Q. And were healthcare professionals supported or advised on how to manage these changes -- any changes to the MDT decision-making and treatment pathways?
A. There was guidance -- well, there was some guidance from associations around timing of surgery and priority of surgery, but things like stoma rates were largely made by individual surgeons at the time with -- on discussion with the patients and what the patients would tolerate and what they wanted and how fit they were. So incomplete guidance is how I'd phrase it.
Q. That brings me on to the next topic of prioritisation guidance. Thank you.
So there were no specific tools for prioritising surgery before the pandemic, was there?
A. No.
Q. And it's right that there were two types of prioritisation that emerged initially from NHS England

and NICE as to patient prioritisation for systemic anticancer treatment and then surgical prioritisation; is that right?
A. Yes.
Q. And I think you've said in your report that the dissemination of that information from NHS England was delayed, which you have attributed to a lack of system-wide preparation which you've already touched on this morning; so is that a fair summary?
A. Yes, that's right.
Q. Quite quickly after that guidance was issued, on 9 April the Federation of Surgical Specialty Associations was asked to provide guidance and issued it on 9 April, setting out four priority levels for surgical prioritisation.
A. Correct.
Q. That was then updated and the NHS England advice was also updated in line with that. In relation to colon cancer and rectal cancer it advised that surgery could be delayed by up to three months, so that's outside your four- to eight-week period that you had advised. Did that raise any concerns?
A. No, I think from our point of view if we were to say a delay of two to three months is the maximum that we would be looking for, that would -- I would consider

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. And perhaps where we scored highest?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. And for completeness was there any data available for Scotland or Northern Ireland to include in your report?
A. Not beyond what we found from the ONS. So no.
Q. Thank you.

Moving on, then, to your recommendations. Now you set out quite a few as you've gone through your evidence this morning. We also have a number of very helpful recommendations and solutions in your report. There are two topics that I'm conscious we haven't covered -- that's IPC and research. Are there any key points in relation to those two that you wish to comment on?
A. I think for your first one, infection prevention and control, I think we've got a much better understanding now around the risks around colonoscopy and laparoscopic surgery so I don't think we'll have those debates again hopefully, in the face of a new pandemic. However, understanding the pathway by which these associations can give that communication out, make these decisions and communicate it, is worth setting up now. So that there's not the mixed messaging.

So that's number one.

Research, I think that this, the preparedness for the hubs, the preparedness for communities will be best done by the research. For example, I talk about communicating with communities over cancer symptoms. We

don't know how best that is done. When I first thought about it I thought, you know, the GPs can do that. But that is not necessarily the right thing to do. The GPs probably have a completely different role in this and the communication to the public around how pathways and practices and hospitals will remain open, we need to better understand how that's done, how is it cost effective and how is it best received by the communities, especially from our earlier comments around disparities with certain sections.
Q. And then, finally, are there one or two headline recommendations from everything you've said this morning or solutions that you wish to draw our attention to?
A. Number one, we should adhere to these cancer performance standards and I think we will see more emphasis on these targets over coming years rather than less emphasis.

So number one, in the next phase of the pandemic we should do everything we can to adhere to those.

Number two, we should, in that pandemic, focus on FIT testing and really prioritising patients with a positive FIT test, so making sure those pathways remain in place to get FIT tests out to patients.

Then number three is the continued delivery and preparation of the elective hubs and diagnostic hubs which will be critical to maintaining capacity. For

example, we can send out all these FIT tests but if we can't do anything about it it's pointless. So we really need well-prepared, well-staffed hubs to take that burden.
MS HANDS: I'm grateful.

My Lady, those are all my questions.
LADY HALLETT: I think there is just one question from Mr Thomas who is behind you. Could you make sure your answers still go into the microphone. Thank you.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: I only have the one question. My name is Leslie Thomas and I'm representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

This was touched upon in your evidence just earlier but I just want to go over it if I may. Professor, in paragraph 34 of your statement you note that cancer symptom awareness tends to be lower in ethnic minority communities and suggest that targeted interventions could help to reduce this problem. Here is my question.

During the pandemic how can healthcare systems ensure that public health messaging and services are culturally tailored to meet the needs of ethnic minority communities particularly in relation to cancer care?
A. I think that's a really critical and good question. My

answer to that is tied into -- I would like to see relatively urgent research done that actually involves those communities in telling me and others how it should be done. I think if I try to create that type of messaging to communities I probably would not do a very good job because it will not be culturally and contextually specific enough.

So my answer is I would like to identify -- I think we need a research programme to identify community leaders who can create those contexts.

The other point is we've learned that one method will not match all different types of communities and the messaging will need to be different for each community and so it's really important we don't just paint this with one brush.

My opinion is that the only way to deal with that is through research response and we're lucky enough to have the NIHR in this country, the National Institute for Health Research, who have some of the world's best applied research pathways and I'd go as far as to say that's the only way that we're going to communicate more effectively with those populations.
PROFESSOR THOMAS: Thank you very much.

Thank you, my Lady.
LADY HALLETT: Thank you, Mr Thomas.

Questions from THE CHAIR

LADY HALLETT: Can I ask you a slightly different subject. You mentioned at the very beginning that you were redeployed at the beginning of the pandemic. You are a bowel cancer specialist, if you'll forgive my using "bowel" rather than "colorectal", and surgeon and you saved lives via intervention. Were you consulted about being redeployed?

A. As a department we made decisions and I was part of that decision-making process, and those decisions were that the older surgeons would go and do the elective operating -- it was considered to be a safer environment -- and the younger surgeons would take on the emergency work. So we made -- those decisions we made within our department. The redeployment decisions, no, those came from the top of the NHS.

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

LADY HALLETT: And where were you redeployed to?

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

through to blocked bowel through to people bleeding. There were a number of traumas coming through the doors as well because some people carried on with their activities and people were still driving cars, so the wider effects in the hospital, the wider emergency service was still in place and still needed a tremendous amount of support.

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

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

A. Thank you.

(The witness withdrew)

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

(11.04 am)

(A short break)

(11.20 am)

LADY HALLETT: Mr Fireman.

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

MS CHLOE SCOTT (affirmed)

PROFESSOR ANDREW JOHN METCALFE (sworn)

Questions from COUNSEL TO THE INQUIRY

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

PROFESSOR METCALFE: Not at all.

MS SCOTT: Not at all.

MR FIREMAN: Could you please give your full names.

PROFESSOR METCALFE: My name is Professor Andrew John Metcalfe.

MS SCOTT: Chloe Elizabeth Henderson Scott.

MR FIREMAN: Thank you.

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

If I may begin with your professional roles. Professor Metcalfe, you are a professor of orthopaedics at the University of Warwick and a consultant orthopaedic surgeon at the University Hospitals Coventry and Warwickshire NHS Trust; is that correct?

PROFESSOR METCALFE: That's correct.

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

MS SCOTT: That's correct.

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

MS SCOTT: Yes, that's correct.

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

PROFESSOR METCALFE: Yes, that's correct.

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

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

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

MS SCOTT: Ms Scott is fine.
MR FIREMAN: Whichever you prefer.
MS SCOTT: Ms Scott is fine.
LADY HALLETT: Surgeons are Mr, aren't they?
MR FIREMAN: Yes, I thought --
MS SCOTT: Yes, Ms.
MR FIREMAN: That was my understanding, yes. Just in case, worth clarifying.

If we could start with you. You explain in your report the way in which the hip socket works. It's a ball and socket joint, you describe, and there are a number of different conditions to it being worn out and a need for a total hip replacement.

If we could look at your report.

This is INQ000474262.

This is a picture that you have put in your report. Could you relatively briefly just explain what a total hip replacement involves.

MS SCOTT: Sure.

So the hip joint is one of the biggest joints in your body. It can wear out due to various different causes. Osteoarthritis of the hip is very common in an ageing population, so very common in the over 60s, but there are other reasons that your hip joint can wear out sooner than normal.

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

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

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

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

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

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

Your report describes several measures that are used to assess patient outcomes and patient experiences, and you have set these out, including -- I don't know if it's "PROMs", patient-reported outcome measures, the Oxford Hip Score, the EuroQol 5D score. Briefly, what is the value of these scoring mechanisms?
MS SCOTT: So hip replacements are very common, we do 100,000 of them a year normally in the UK. If you're doing that volume of something, you need to know if it works or not, so there are a number of validated, heavily validated in fact, patient-reported outcome measures within orthopaedics and particularly within hip and knee osteo -- well, hip and knee replacement and hip and knee osteoarthritis.

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

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

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

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

MS SCOTT: Almost. So it goes from minus 0.594, so 0.6, up to 1. So 1 is perfect health, 0 is supposed to be death, and the negative scores are termed as health-related quality of life state worse than death.

And that's not worse than death according to us as researchers or clinicians, and it's not that the patients say "Living with this pain is worse than death", it's that those scores have been given to the UK general population and they have been asked: if you had this score and these symptoms, how long would you be willing to carry on in that health state? And if the general population are not willing to carry on in that health state then it's one of these negative worse than death scores.

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

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

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

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

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

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

We then repeated our study, or a similar study but this time across ten centres, during the pandemic to see how people's health-related quality of life had changed during the pandemic when they were waiting for a total

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

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

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

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

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

In terms of the management for hip arthritis, when it's early on or when the symptom burden is not too significant, obviously simple painkillers, activity modification, physiotherapy, weight loss, things like that are what are initiated in the first instance.

The problem comes when those more conservative

treatments and walking aids and things like that aren't helping people live their life as they want to anymore, at which point a hip replacement is what would be considered.

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

MS SCOTT: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROFESSOR METCALFE: That's right.

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

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

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

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

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

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

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

And then:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So yes, it gives trusts a real focus and so,

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

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

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

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

front door is acute services, so the emergency department, and acute medical admissions, which of course at the time were very much overwhelmed.

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

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

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

response?

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

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

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

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

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

MS SCOTT: I think very much so unless you are a specific treatment centre.

Q. Turning back to you, Professor, and looking at Wales.

If we can go to a witness statement of Judith Paget. This is INQ000486014 and paragraph 630.

This sets out the way in which elective hip replacement was dealt with. It was -- it says here it was:

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

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

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

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

Wales?

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

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

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

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

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

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

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

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

PROFESSOR METCALFE: Yes, they're much less clear an

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

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

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

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

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

orthopaedic waiting patients.

Q. It says at the first bullet point here:

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

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

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

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

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

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

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

Q. That can come down.

Reflecting, then, on all of the four nations of the UK and their approaches you've sort of touched on it as you've gone along but are there any other comments you'd like to make about the way in which the countries compare in terms of their approaches to restoring elective surgery?

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

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

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

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

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

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

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

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

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

PROFESSOR METCALFE: Yes.

MR FIREMAN: We're looking at page 26.

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

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

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

MS SCOTT: Sure.

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

MS SCOTT: Yes.

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

MS SCOTT: Yes.

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

MS SCOTT: Less than a month.

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

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

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

MS SCOTT: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

pathway. Should I explain what a green pathway means?

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

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

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

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

they're already in dedicated units.
Q. It seems that you need, in fact, an alignment between the repurposing of spaces and also the availability of staff?
PROFESSOR METCALFE: Indeed.
Q. Did, in fact, the restoration of elective care necessarily align with the ending of things like redeployment or the provision of care being given in different spaces to -- they were previously?
PROFESSOR METCALFE: It was hugely variable around the country, is the simple answer to that. So, you know, we have a growing number of elective-focused sites, and in specialist orthopaedic hospitals, which are effectively elective-focused sites, they are able to redeploy relatively quickly, and clearly some of their staff had redeployed to other hospitals. But those were mostly restored. And of course they had the physical space and the ability to deliver those pathways.
Other units found it very, very difficult, both from a physical space -- physical structure organisation sense but also from a staffing sense.
And I think that explains the really quite marked variability even within individual regions.
Q. We're going to look now at the geographical variation, and if we could look at your report and look at

figure 12, please, on screen.
We have here what's described as a "Heat map of proportion of pre-pandemic total hip replacements performed in 2020". It might help if you just describe what we can see in terms of the key with the colours there.
PROFESSOR METCALFE: Yes. So we've used data on hip replacement volumes -- actually we received it per month but we've obviously used 2020 data -- looked at 2019 data and then divided it by region. So each individual region we've looked at: did they -- what did they achieve as a percentage of their pre-pandemic volume? If they're blue, they're achieving above 100% and if they're sort of yellow they're achieving a bit below, if they're pink they're achieving quite a bit below, and if they're red they're way below.
Q. So if we come back and look at it in the round, what is the message that we can see from this diagram?
PROFESSOR METCALFE: Well, the first message it's really patchy and variable. This, and then I'm sure we'll come to a 2021 version, we'll see actually there are more -- the reduction in services was more marked in Wales, Northern Ireland and Scotland, and then across England very variable.
Even when looking at this we have to be quite

careful. So in my region there were really marked differences, to the point that now there is probably a difference in waiting times of a year whether you drive half an hour down the road or not, between different hospitals. So you can really have quite marked disparities even in small regions, often because one hospital is set up one way and one is set up another.
Q. In terms of national differences --
PROFESSOR METCALFE: Yes.
Q. -- can we derive any messages from looking at the map here?
PROFESSOR METCALFE: Yes, indeed. From this map, and indeed from multiple of the figures presented in the report, we see that, in general, England was better able to restore, but variable -- very variable across the country but better able to restore its activity. Scotland less well so but had some pockets of excellence, pockets of real success. Wales less so again. And in fact there's -- multiple figures show that the delivery of restoration of elective care in Wales was really, you know, quite a long way behind, and Northern Ireland even more so.
Q. If we go over the page we can look at 2021. It's figure -- it should be slightly further on.

PROFESSOR METCALFE: Indeed, yes. And I think this is telling both because of how red Wales is and -- but also, interestingly, Scotland is quite interesting because there's a patch that did really very well, in the centre of Scotland, and that was representative of one specific trust, I believe, who were much more able to restore their activity using a sort of elective care hub model.
MS SCOTT: So one health board, in Forth Valley, did prioritise the delivery of elective care and actually exceeded their previous volume of work in terms of elective surgery. They've subsequently also become a national treatment centre. So that was happening in the background that they were expanding.
The Golden Jubilee Hospital, as well as a kind of national treatment centre for Scotland, obviously was protected as well.
So those two units have kind of driven this but the rest of Scotland remained pretty dire. Certainly locally we had until not very long ago four and a half thousand people waiting for hip and knee replacements in my hospital alone. So it is very patchy.
And interestingly as well, the centre that did prioritise elective over the front door had significant front door issues as a consequence and problems with the

emergency department and the acute medical unit.
Q. Is it right that that hospital, I think it's the Golden Jubilee Hospital, it does take patients -- sorry --
MS SCOTT: So, no, that dark blue there, that is Forth Valley.
Q. That's Forth Valley.
MS SCOTT: Yes.
Q. And the Golden Jubilee Hospital --
MS SCOTT: The Golden Jubilee is its own health board and it's based in Glasgow, and it does take -- it takes patients from the whole of Scotland but different health boards have different arrangements with it. So it doesn't take patients from across Scotland based on some national waiting list, it takes patients based on X health board sends 100 a month to the Jubilee, that kind of arrangement, rather than a national waiting list.
Q. That can come down.
But is it right that during your research you identified that actually there was a correlation between the areas of greatest deprivation and the highest deficit in terms of restoration of hip surgery?
PROFESSOR METCALFE: Yes. That was not -- the figure shows a small but definite change -- effective deprivation on the waiting times for surgery -- or, sorry, our ability

to restore elective surgery.
And I would also comment that the sort of central guidance allowed some of that -- allows it -- it prevents inequalities because it allows the trusts that are most suffering with pressures, because of their sort of demographic, to best deal with -- to address elective care priorities as well. So otherwise those centres that are most under pressure from their acute side then also deliver more delay to care in the elective side, which worsens the problem of inequality.
Q. Is there also a link between the types of patients who may seek care for hip osteoarthritis?
PROFESSOR METCALFE: I'm sure that's true. It's a thing we don't -- I couldn't say we have strong data on, but I'm sure there is lots of evidence across healthcare that those who are more socioeconomically deprived have a lower rate of healthcare seeking and lower rates of healthcare engagement, and I'm sure that would be true.
Q. Finally on restoration of care. Professor, do you consider that the independent sector was sufficient utilised to restore this type of care?
PROFESSOR METCALFE: Well, I would say Professor Bhangu quite rightly said that it was used largely for cancer care, and he felt that it was well mobilised for that and I'm inclined to agree with him from what I've heard.

It wasn't really used for orthopaedic care. There was only so much capacity, of course, and it was pretty quickly returned to its original functioning in the independent sector care, in which case they resumed activity as they would normally do so. But in terms of NHS delivery of care in the independent sector it wasn't really used for orthopaedics at all. With very small numbers it was but at a very small rate.
Q. Next, the impact of the delays which were caused by the pandemic and the decision to suspend elective care. If I start with another passage of your report on screen, please, section 2.3, page 19, where you set out here the targets.
Yes, here we go.
In England the key target we see here is for elective care such as hip replacement to have a referral to treatment time of 18 weeks and all care to be completed by 52 weeks.
Then we go to Wales and we can see there that 95% of patients should have a referral to treatment of 26 weeks. No patients waiting longer than 36 weeks.
Go down to Scotland. And we can go through it, again, 90% of people should not wait longer than four weeks from referral by a GP to be seen by an allied health professional. And then Northern Ireland, there

weren't specific targets but the current ministerial waiting time targets state that 50% of patients shall wait no longer than 9 weeks for a first outpatient appointment, with no patient waiting longer than 52 weeks.
The first thing arises from looking at this is it appears that there are various different ways in which the nations are measuring their ability to perform total hip replacements; is that right?
PROFESSOR METCALFE: Yes, that's absolutely right. Yes.
Q. If we can take that down.
Is it right that actually this lack of consistency in terms of the data and the way in which nations are measuring their success in terms of performing orthopaedic care makes it very difficult to actually assess and compare the impact of the pandemic?
PROFESSOR METCALFE: Yes, it does. I mean, actually it's very hard to get referral for treatment times for hip replacements at all. We haven't been able to provide that data. There are -- so the way it is measured, it also tends to be collected in aggregate by specialty. But if you think of the specialty of trauma orthopaedics, it's hugely diverse. So, you know, carpal tunnel operations, you could do a lot of those in the pandemic because you didn't need an anaesthetic and you

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

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

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

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

And we see that, I think, in -- so to compare in

there was a 46% reduction, consistent with about 50,000 people -- less people having hip replacements in 2020 compared to 2019. You can ascertain how long you would expect that recovery to be to bring them back to previous standards, to bring them back to the sort of waiting times people were achieving. We know that's going to be a number of years.

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

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

PROFESSOR METCALFE: Absolutely, yes.

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

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

Q. Can we get that on screen, please.

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

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

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

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

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

PROFESSOR METCALFE: Say that again, sorry --

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

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

Thank you.

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

MS SCOTT: 24.

Q. So page 62.

MS SCOTT: Figure 24.

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

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

Q. Just the top one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR FIREMAN: Thank you very much.

Those are my questions, my Lady.

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

Questions from THE CHAIR

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

PROFESSOR METCALFE: Of course.

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

PROFESSOR METCALFE: Do you want to go first?

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

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

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

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

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

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

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

PROFESSOR METCALFE: No, no, very challenging. Very challenging.

LADY HALLETT: Mr Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good morning, Professor -- good afternoon --

PROFESSOR METCALFE: Good afternoon.

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

In paragraph 136 of your report you discuss health

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

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

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

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

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

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

PROFESSOR METCALFE: That's a very interesting question.

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

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

PROFESSOR METCALFE: So we know there was a relationship with social deprivation and we know that both ethnic minority -- proportions of ethnic minorities and social deprivation are two interlinked -- are often interlinked, so it is likely that there was. We don't have data on that and perhaps similar to the point that was being discussed earlier about granularity of data, then actually granularity of data in terms of ethnicity,

gender, social deprivation, would be valuable if there was a way of making that available and that would improve our ability to -- because ultimately the availability of data allows you to act in a --

Q. In a more targeted way?

PROFESSOR METCALFE: In a more targeted way and motivate change, so I think that sort of granularity of data would be really valuable.

Q. Let me come on to my last question. From your perspective how can healthcare providers improve cultural competence throughout hip replacement care pathway from diagnosis through to post-operative recovery to ensure that ethnic minority patients receive equitable and culturally sensitive care?

PROFESSOR METCALFE: Do you want to start?

MS SCOTT: So I think part of the barrier often is a lack of diversity within orthopaedics itself and actually if orthopaedics itself could have a more diverse workforce then it may help more diverse individuals whether -- regardless of the reason for their diversity, it might make them more confident in accessing healthcare for their joint problems. So that's certainly something that is in the spotlight at the moment and definitely needs work, but lots of people are working to try and improve that.

PROFESSOR METCALFE: Yes, I would agree and again I would follow on from Professor Bhangu's suggestion that there really should be much more research in this area. I think we recognise it as something we could do better at, and I think as clinicians and in fact our clinical bodies recognise that this is an important issue we need to improve on. I don't think we're there yet in terms of our ability to do that well and I think we could be a lot better and we probably do need to invest in research that focuses on that.

PROFESSOR THOMAS: Thank you very much. Those are my questions.

LADY HALLETT: Thank you, Mr Thomas. I think that completes the questions for you. Thank you both very much indeed, Professor Metcalfe, Ms Scott, for all your help in preparing the report, for making it understandable and for all your help today. I'm really grateful to you.

PROFESSOR METCALFE: Thank you very much.

MS SCOTT: Thank you.

(The witnesses withdrew)

LADY HALLETT: 1.40.

(12.37 pm)

(The short adjournment)

(1.40 pm)

LADY HALLETT: Ms Nield.

MS NIELD: My Lady, may I call, please, Julie Pashley.

MS JULIE PASHLEY (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I hope you haven't been hanging around for too long.

THE WITNESS: No, thank you.

MS NIELD: Ms Pashley, could you give your full name, please.

A. Julie Pashley.

Q. You've provided a witness statement to this module of the inquiry dated 20 June 2024, that's INQ000486003, which sets out the experiences of your daughter who was a young person detained in hospital, in a children and young persons mental health services inpatient unit, between March 2020 and June of 2021; is that right?

A. Yeah.

Q. I think when your daughter was first admitted she was 16 years of age; is that correct?

A. That's correct.

Q. I think you are a mother of two children in fact?

A. Yeah.

Q. We're not going to name your daughter today. We are going to refer to her by the initials CB --

A. Yeah.

Q. -- if that's all right?

LADY HALLETT: Sorry to interrupt. Given that you've given your name, which is now public, is your daughter all right for you to talk about her?

A. Absolutely.

LADY HALLETT: I just wanted to check, because obviously people will be able to identify her even if we don't name her.

A. Yes.

MS NIELD: Thank you, my Lady. I think your daughter was first admitted to a tier 4, that's inpatient, mental health unit at the end of January 2020; is that right?

A. Yes.

Q. And she was admitted as a voluntary patient, so she wasn't admitted under the Mental Health Act; is that correct?

A. That's correct.

Q. And what was her diagnosis at that time?

A. So she was depressed, anxious, at risk of suicide, risky behaviour and diagnosed autistic at that point.

Q. Thank you. When your daughter was first admitted to that tier 4 inpatient ward, you say in your witness statement that most things seemed to function properly within the unit. How would you describe the culture or

the atmosphere on the unit at that point?
A. It was really warm, friendly, open. It was designed to feel like home from home. It was -- families were involved, families were welcomed on to the ward, we were part of the care and that continuity of care.
Q. Thank you. And then I think towards the end of February or beginning of March you say that things changed on the ward as everyone was becoming more aware of Covid-19 and its risks. Can you tell us what changed on the unit at that point?
A. So we were no longer allowed on the unit. We could go to the family room. We had to wear a mask, we obviously had to use hand sanitiser. All the staff had to wear scrubs, they were also wearing masks. So we kind of lost that connection, I suppose, with the ward, so it became a gap between us and them.
Q. And how were those new rules communicated to families?
A. Randomly, as and when they were brought in I suppose. As soon as something changed we were told relatively quickly, but it wasn't consistent. It was constantly changing I suppose.
Q. I think there was an incident on 18 March 2020 where staff believed that your daughter had swallowed a blade?
A. Yeah.
Q. And you were contacted I think by the unit to explain

this. What were you asked to do then at that point?
A. So we were asked to take her to A&E to be assessed.
Q. I think that was in a different hospital?
A. Yeah, in a physical health hospital, not a mental health hospital.
Q. And were you told whether you could bring your daughter back to the inpatient unit after you had been to A&E?
A. We were told we couldn't take her back to the unit because she was a risk, Covid risk, to the patients and staff on the ward of the mental health unit.
Q. So the concern at that point was while she was in the A&E department she could have contracted Covid?
A. Yeah.
Q. All right. And how long were you told she would have to stay away from the unit for?
A. Two weeks.
Q. I think, given that, you made attempts to persuade the staff at the Accident & Emergency Department to undertake a Covid test?
A. Yeah, it wasn't -- testing wasn't routine at that point and hospitals weren't testing on arrival, so we managed to persuade them -- I'm not entirely sure, my husband managed to do that persuading -- we managed to persuade the doctor to test our daughter for Covid, so that we would at least get the result if we needed a negative

result.
Q. And did you get a negative result?
A. We did.
Q. And so at that point you took CB, your daughter, back to the ward. Was she taken back in, was she readmitted?
A. No.
Q. Did they explain why?
A. Just -- I don't think we'd had the negative result actually at that point so they weren't prepared to take her back, because they were taking a number of -- well, probably over 24 hours to get the results at that point. So, yeah.
Q. And how did you feel about taking your daughter home with you at that stage?
A. Absolutely petrified. She was obviously in a risk-taking mood, she had potentially swallowed a blade so therefore she was clearly quite unstable, and we had to take her home and have her at home with us in our care for potentially two weeks or at least hopefully until the negative result had come through.
Q. Had she had any home leave during her inpatient stay at that point?
A. I think she'd had one or two one-night stays at home.
Q. Did you explain your concerns about her risky behaviour and the risk she posed to herself?

A. Yes.
Q. Did you explain that to the inpatient staff?
A. Yeah.
Q. And what was their response?
A. "We cannot take her back."
Q. Were you given any documentation to explain why she was being sent home at that point?
A. No.
Q. Did there seem to have been a formal risk assessment undertaken?
A. Not that we were aware of.
Q. Did they give you any what's sometimes called safety netting advice, did they give you any advice about where you could go or what you could do or who to contact if any of your fears were realised?
A. We could always contact I think it was a crisis team number, but I'm not even sure they were 24 hours a day.
Q. How did your daughter respond to being told that she wasn't able to go back on to the unit? What were her views?
A. She was anxious, she knew she wasn't safe. She didn't want to come home. We tried really hard to make it as pos -- possible -- and easy for her as possible to try -- we were quite sort of: it'll be fine, we'll all be fine, we'll get through it, it'll be okay. We spent

that evening playing games and trying to entertain and distract her from her own thoughts and feelings I suppose.

Q. If I can just take you back then to that point where the unit were saying they were not going to take CB back because of the Covid risk, the potential Covid risks, and CB was not feeling ready to go home at that point. Do you know whether CB communicated her views about her own state of mind and her own risks to the unit staff at that point?

A. She wasn't given the opportunity at that point.

Q. So, I'm sorry, I had moved you back from that evening when she was discharged, so I think that was 18 March.

A. Yes.

Q. And you tried to distract her that evening. I think the following day or the following evening your daughter did actually leave the home at night after you'd all gone to bed; is that right?

A. Yeah, yeah.

Q. And I think you were able to, once you realised that she was missing -- I think you heard the front door closing --

A. Yeah, my husband heard the front door go. I didn't, I was asleep, but he woke me up. And of course we panicked.

Q. And were you able to track your daughter?

A. Yeah. Thankfully, we've always had an app on our phones that we could -- we can track both of our children wherever they are.

Q. And so you were able to locate her?

A. Yeah, we could see where she had gone.

Q. And where had she gone?

A. She'd gone half a mile up the road to a bridge.

Q. And what were your concerns then?

A. That she was going to jump off the bridge.

Q. I think fortunately you were able to find her?

A. Yeah.

Q. And I think the police were also called and arrived shortly after you'd found her; is that correct?

A. Yes. So my husband arrived first and pulled her back off the bridge because she'd climbed over the barriers at that point and then the police arrived around about the same time. They'd gone under the bridge first. She had called them to say, "You're going need to pick me up off the road so that no motorists will be hurt by my body."

So the police arrived and -- at that time and they were obviously quite concerned about her mental health, and we explained the situation that we'd had with the unit and they called the unit to try to get her taken

back there. That's where they wanted to take her back and they were prepared to hold her under a section 136.

Q. What was the initial response of the hospital?

A. "No, we can't take her back."

Q. So I think you explain that it was when the police mentioned section 136 of the Mental Health Act which enables them to hold a patient until they're assessed by a medical professional; is that correct?

A. Yeah.

Q. And at that point --

A. They gave in and said, "Okay, we'll take her back."

Q. The unit took her back.

A. Yeah.

Q. Thank you.

Did the unit explain why they were reluctant to take her back?

A. It was still around the risk of spreading Covid.

Q. And was there any discussion about isolation rooms, that she could be put in isolation when she came back onto the unit?

A. We asked if she could go into an isolation room and they said, "No, they're for children who can't go home, who don't have homes to go to."

Q. Once the hospital eventually agreed to admit her and to conduct a mental health assessment I think the following

day, in fact 20 March, your daughter again expressed suicidal thoughts --

A. Yes.

Q. -- whilst she was on the unit and asked to leave the unit.

A. Yeah, she wanted to leave the unit in order to end her life.

Q. But I think it wasn't until the following Monday, until after the weekend that your daughter was formally admitted --

A. Yeah.

Q. -- under the assessment provisions of the Mental Health Act, section 2 of the Mental Health Act?

A. Yeah.

Q. Which allowed her to be detained --

A. For up to 28 days, yes.

Q. -- pending an assessment?

A. Yeah.

Q. Did you have a conversation with a consultant at the unit about that assessment process and the likelihood of when she was going to be discharged from that?

A. Yeah, so we -- her usual consultant said she was too unwell to be sent home so she would be detained for as long as it was necessary to ensure her safety, and to start the right treatment, which was a relief, a huge

relief that actually she might get what she needed, and we wouldn't have to have her at home for a while. And then we moved on to, I think it was, 26 December (sic), was it, lockdown, the day, or the day after?

Q. I think she was formally discharged on 26 March, day 2 of lockdown; is that right?

A. Yeah. So on the Monday, which I think was the 25th, 24th or 25th of March, I can't remember, the Monday she was -- we were told that she wouldn't be discharged. And then it was something like 24 hours later when a different consultant, one that didn't know her, said, "No, she needs to be discharged, we need the beds for crisis."

Q. And did you challenge that discharge decision?

A. Yeah. Yep.

Q. Presumably that challenge --

A. Got nowhere.

Q. -- made no difference?

A. No.

Q. I think you've explained that the discharge note dated 26 March stated that your daughter was extremely vulnerable, showed risky and impulsive behaviour?

A. Yeah.

Q. And went on to explain that the hospital had justified the decision to discharge her on the basis that your

daughter had asked to go home --

A. Yeah.

Q. -- and that they were taking steps to limit exposure to Covid-19 on the unit, is that right?

A. Yeah.

Q. How did you feel after you read those discharge notes?

A. A bit sick really. Again really anxious, thinking: could we keep her safe at home again? Yeah, I think it was just dread, absolute dread.

Q. Was there any care planning put in place for providing care to your daughter in the community when she'd been discharged?

A. I can't remember if it was that time or the next one, the next discharge.

Q. I think you describe it in your witness statement as "limited care planning --

A. That's right, yeah.

Q. -- in place", and the only support that she in fact received in the community was over the phone?

A. Yes, that was, yeah, the things were still quite tricky at that point with regards to community services. She -- it was phone calls so we could get a phone call from the community team but that was it.

Q. How beneficial would you say that support over the telephone was for your daughter in particular, given her

autism diagnosis?

A. Absolutely useless.

Q. And how did this second discharge from inpatient services seem to impact on your daughter and her attitude and trust in the mental health services system?

A. I think she'd lost all trust by that point. I guess she felt that nobody cared, that nobody was willing to look after her. She couldn't get the treatment she needed, the support that she needed. She just felt really let down. I think we all felt really let down.

Q. And do you think that had an impact on her mental health at the time?

A. Absolutely.

Q. In the first few months after she was discharged in March how was CB coping?

A. She wasn't too bad at home. We managed to not have any significant incidents for a couple of weeks, which was really positive. She wasn't great and she was definitely deteriorating from that point.

Q. Was she able to engage with any community mental health services?

A. Not at that point.

Q. I think CB was admitted again to inpatient mental health services, again as an informal or voluntary patient on 15 May, 2020?

A. Yeah.

Q. And you noted in your witness statement that it was immediately clear that the rules around infection prevention and control were more rigid but also more consistent.

A. Yes.

Q. Is this to the same unit that she'd been at previously?

A. Yeah, yeah.

Q. And this was a short admission with 72 hours' crisis support on the ward, is that right?

A. Yeah. Yeah.

Q. And then I think your daughter made good progress during that admission?

A. Yeah, I mean, I think she'd felt so let down, there was an element of she'd just hit crisis again quite quickly and was taken back, supported, and realised that actually she'd rather be at home and she could manage at home. But with the right support at home, which seemed to materialise at this point.

Q. I think she was discharged then on 1 June 2020?

A. Yeah.

Q. So just a two-week admission period?

A. Yeah.

Q. How was the care planning prior to that discharge and the community support that she received?

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

Q. And how did that support seem to affect your daughter?

A. Positively. It was a real positive step forward.

Q. I think then was your daughter planning to try to resume her education then in September?

A. Yes, which was a huge progress for her. She was totally against education for a while and didn't see the point in any future planning at all so we were really positive that she wanted to go to college.

Q. I think she did have some concerns about the impact of her disrupted education.

A. She did. She did. So although she was quite excited to go, as soon as she could think: oh, my GCSE results are coming, what if I can't get to college, what if I don't have the grades that I need to get into college? Because it was all teacher assessed and she'd missed most of year 11, so that sent her back down into

a spiral.

Q. And I think unfortunately her mental health deteriorated to the point that she was admitted again to inpatient care?

A. Yeah.

Q. This time on 4 August 2020?

A. Yeah.

Q. Still Covid infection rules in place on the unit. At that time there were some loosening of restrictions in the community but not on the inpatient unit, is that right?

A. Yeah, that's right.

Q. And so whenever your daughter had a home visit from --

A. Yeah, when she could come home, yeah.

Q. She was having to then isolate when she went back on to the unit, is that right? And how long was she having to isolate for at that time?

A. In theory it should have been about 24 hours but it was about 72 by the time -- so they would test -- so if she went back on a Sunday night, for example, they wouldn't test until Monday morning, then that test would take at least 24 hours to come back, so it wasn't until they'd had a negative test that she could actually resume activities on the ward and leave her room.

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

in a room --

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

Q. And how did your daughter find those periods of isolation?

A. Soul destroying probably, I think that's fair to say. I can't even begin to imagine what it must be like as a healthy teenager to be stuck in a room on your own for that length of time, never mind a mentally unwell teenager to be stuck in a room on your own with all your own thoughts and all those things that have led you to be in that place in the first place, so I -- yeah, it wasn't great.

Q. I think outside of the periods of isolation, at that time on that unit your daughter did have access to some outside spaces and some green spaces?

A. Yeah.

Q. And she had access to her mobile phone and other communications devices at that point?

A. Yeah.

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

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

Q. Another thing that you have noted at that time in terms of changes on the unit from pre-pandemic times was that staff were wearing PPE and in particular face masks and I wanted to ask how that affected your daughter particularly given her neurodivergence?

A. So if she can't see someone's face -- she struggles with facial expressions anyway but if you're wearing a mask she has no idea what mood somebody is in, if they're asking something, what that tone is, you know, she struggles quite significantly with that sort of communication. And she struggles to make connection with people anyway so being able to see someone's face is really, really important to her and being able to hear their voice and yeah, it's just -- I think, again, it was quite isolating I suppose.

Q. So it was impacting on her ability to form a trusting --

A. Form any relationship.

Q. -- relationship or rapport with the therapeutic staff?

A. Yeah.

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

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

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

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

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

and I think at that point she wanted to live in supported accommodation; is that correct?
A. Yeah, she wanted to live in -- on her own. She didn't want to come back home, it was too traumatic for her to be in the house.
Q. And what was your view of her moving into supported accommodation? Were you happy for that to happen?
A. I suppose it's a -- it's a tricky one. You never want them to leave, but knowing her vulnerability, allowing her to live on her own was for us quite risk taking, but we were assured that she would have supported living and that there would be support in place for her.
Q. I think because she had been detained under the Mental Health Act, she then has a right to quite an extensive aftercare support package; is that right?
A. Yeah, so section 117 aftercare, funded by Health and Social Care.
Q. So did it appear -- were you assured that that package was in place?
A. Yeah.
Q. And was that the responsibility of social services?
A. The accommodation was, yeah. The accommodation was responsible for -- I think it was children services, because she was still a child at that time.
Q. And so your daughter's discharged, you're told there's

a care package available. I don't think she went immediately into any supported accommodation though?
A. No. So we got home and I had a phone call from social services to say there was no placement, there was nowhere for her to go, she would have to stay at home. At that point, I mean, we didn't want her to be discharged because we didn't want her to not go into supported living -- we wanted her at home -- we'd have -- you know, if she'd wanted to come home we'd have had her home, there is no question. But she didn't want to come home and we knew pushing her into that situation of coming home would cause her distress and an escalation of distressed behaviour.
Q. Was there ever an explanation of why that care package which had been agreed to in principle didn't materialise?
A. Because she was about to be an adult so it would be adult social services' problem.
Q. I think, in fact, your daughter effectively ended up homeless?
A. Yeah.
Q. And between September and December 2021 you did not know her location, you did not know where she was?
A. No, she cut communication to us completely at that point, which was upsetting but understandable given that

she just wanted to live on her own. She didn't want to be with us so she -- I think in her mind it was: right, if I cut off communication with them, somebody will have to do something.
Q. So at that point I think was there any support in place from social services?
A. No. Well, she did have a social worker. She did have a social worker. But he didn't provide any support.
Q. Did there appear to be any communication or cooperation between the children's mental health service or children social care and adult social services?
A. No. So she was discharged from CAMHS services, in principle to adult services. Adult services were not available for her because they didn't feel -- she didn't sit with -- she couldn't access what they were going to offer, which was group therapy online. So she couldn't access that because of being autistic.

So social services -- so she had nothing, mental health support wise, and the communication between children services and adult social services was adult services saying: we have to reassess, we have to do a full new assessment, nothing children services said -- no longer counts.
Q. I think your daughter did eventually have access to a supported flat with a low level of support in

December 2021 but it wasn't providing the level of support that she required at that point?
A. No. So she went into -- she had a crisis in December, when she finally got back in contact with us. And she was put into 24/7 support in a flat for -- which was one-to-one, for a couple of months, and then she went into a low-level flat after that.
Q. And I think at that point when she was in a low-level support flat you explain that in fact her flat ended up being cuckooed by a drug dealer, who was using the flat to deal drugs, sexually assaulted your daughter and beat her over a 3-week period?
A. Yeah.
Q. She became addicted to heroin and cocaine in that time?
A. Yeah.
Q. There was no one from the community mental health team visiting to check on her and in fact it was when she went to the police herself to explain what was happening that that situation was brought to an end. After that point she continued to ask for help.
A. Yeah.
Q. And I think it wasn't until June of 2023 when your daughter jumped from a bridge and broke her spine in three places that she was provided with the support that she needed from adult mental health services and social

care services, is that right?
A. Yeah. Yeah.
Q. Can I ask you, please, Ms Pashley, what's your overall assessment of the impact of the Covid restrictions and rules on the care and treatment that your daughter received and her experiences as an inpatient during the pandemic?
A. I think it potentially delayed any progress in her mental health, any benefit, really, I suppose, of her getting any better, being looked after both as well as she perhaps could have been. I think if she'd come out into the community with the services that were available previously then maybe again we would have seen a better progress, a better prognosis, I suppose.

I'd like to think we wouldn't have gone down the road we'd gone down and she would never have jumped off the bridge, she would never have been cuckooed, she wouldn't have had to have all those horrific experiences that she suffered and us as a family, I think. The trauma that the whole two years, three years, put on our family was horrific.
MS NIELD: Ms Pashley, I have no more questions for you, thank you very much.
A. Thank you.
LADY HALLETT: Ms Pashley, I have to ask, how is she doing

now?
A. Much better than she was. We still have a long way to go. There's a lot of still stuff to unpick. There's a lot of trauma still that needs to be -- that's sort of happened in the process of where she was, so -- but she is much better than she was. I feel, touching wood, that we're not at risk of loss of life anymore.
LADY HALLETT: I'm sure we all hope that. I don't know if you were dreading coming along or whether you wanted to talk about it or whether you felt it was a terrible thing to do but you've been really helpful.
A. It's been a privilege, actually.
LADY HALLETT: Well, it has been our privilege to listen to you even though it's an extremely sad and distressing story. Anyway, with your support we all hope that she makes as good a chance at her life as she can, as best a chance as she can. Thank you very much indeed.
A. Thank you.

(The witness withdrew)

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

DR GUY NORTHOVER (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I hope you have not been waiting a long time.
THE WITNESS: No.

MS NIELD: Dr Northover, could you give your full name, please.
A. Dr Guy Northover.
Q. Dr Northover, you have provided an expert report on inpatient child and young persons mental health services for module 3 of this Inquiry, co-authored with Dr Sacha Evans, it's dated 23 July 2024, and it has a reference number INQ000474300.

Do you have a copy of that report in front of you?
A. Yes, I do.
Q. And you're familiar with it?
A. Yes.
Q. Dr Northover, you are a consultant child and adolescent psychiatrist and I think you took up your first consultant post in 2010; is that correct?
A. Yes.
Q. And you're presently working at Berkshire Healthcare NHS Trust in the children and young people psychosis and mania pathway; is that right?
A. Yes, that's correct.
Q. I think you've been the trust's lead clinical director since 2016 and you have extensive experience working within and designing child and adolescent mental health crisis services?
A. Yes.

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

Could you please summarise for us the Getting It Right First Time programme?
A. Yes, absolutely. So the Getting It Right First Time programme is a national quality improvement programme that uses -- it's a data-driven approach to identify across the country areas of variation and that's followed up by clinical visits to sites to understand whether the variation is warranted or unwarranted and then based on understanding whether it's warranted or unwarranted it's providing support and recommendations to specific units or trusts on how they might improve, and that's been followed up by the creation of a national report with national recommendations.
Q. Thank you.

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

clinical reference group to us, please?
A. Absolutely. So that's a clinical reference group which was supporting the specialist commissioning team for child and adolescent inpatient services. So it's a group of clinicians whose professional opinion was listened to to help shape the specialist commissioning team's direction of travel.
Q. Thank you. And I mentioned earlier that you've co-authored this report with Dr Sacha Evans who is currently based at the Mildred Creak unit at Great Ormond Street Hospital, and that's a specialist unit treating children aged 8 to 13 years; is that correct?
A. Yes, that's correct.
Q. If we can move briefly to the methodology of your report, and the sources of information that you've drawn upon to produce that report. You've explained in paragraphs 26 to 29 of your report that you've obtained both quantitative, numerical, data and qualitative data to prepare the report and I think it's right that whilst you've included statistical data where possible from all four nations of the UK, you observed that the amount of data available from England was considerably greater than that available from the devolved nations, is that right?
A. Yes, that's absolutely right.

Q. And you've also observed that the number of Child and Adolescent Mental Health Services inpatients in the devolved nations is a small number and sometimes those small numbers means it can be identified difficult to identify whether a trend is statistically significant from that data. But nevertheless is it correct that in your view there's been no obvious divergence or difference in the trends observed between the four nations of the UK?
A. Yes, I think that was absolutely the interpretation we took from the data we were able to see.
Q. Thank you.

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

future pandemics.

Can we begin also with some terminology because we've heard "children and young people's mental health services" and "child and adolescent mental health services"; is there a difference between the two?
A. There isn't, and of course there's the third terminology as well, "children and young people mental health", and it is confusing but they all mean the same thing. It's just where it's used in different policy teams and within different trusts, and I probably have to apologise in advance to say that I will be shifting between the three terminologies myself without realising it.
Q. Well, for ease of reference I'm probably going to be saying CAMHS because it's less of a mouthful than the other acronyms.

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

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

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

We can see also there are low secure and medium secure units there; is that for forensic units, as they're called?
A. It is. It's slightly different within child and adolescent services to how it is within adult services. So a medium secure unit is what you'd think of as similar to a secure unit in adult services where young people within a medium secure unit will have a court order to be within that unit, so due to their mental illness they will have committed a crime that requires them to be within a safe environment.

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

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

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

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

Q. Is that a psychiatric intensive care then?

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Can we move on now, please, to the pandemic period and first of all to look at admissions during the pandemic. You've identified in your report that the data shows a decline in the number of admissions, the number of young people admitted across all nations of the UK during the pandemic. What were the reasons for that decline in the number of admissions in your view?

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

So the decrease in beds would have caused

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

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

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

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

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

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

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

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

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

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

Q. Once a decision was made then to admit a young person, in pre-pandemic times how long would it usually take on

average between that referral decision and the young person arriving on the unit?

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

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

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

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

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

Within child and adolescent mental health services, young people are being admitted -- you quite

often find there are young people being admitted who have significant social deprivation and social challenges, and in those circumstances sometimes identifying a social care alternative is a better therapeutic approach than a mental health inpatient approach. And understanding that prior to an admission can sometimes take a long time to resolve.

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

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

Q. And you explain in your report that whilst -- some of these children whilst they were waiting to be admitted to a CAMHS inpatient unit would have been kept on an adult ward, an adult psychiatric ward; is that right?

A. So, again, we did see an increase in the number of young people who were being admitted to an adult psychiatric inpatient unit prior to going to a child and adolescent unit. And that was a double whammy of challenge, because the young person would be in an inappropriate environment, because they'd be in an adult environment, where they would have to self-isolate. And then once a bed became available they would then have to move to a child and adolescent unit, where they would have to self-isolate again.

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

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

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

So when Covid wasn't an issue you would usually find that a CAMHS therapist would come from the

community to support the young person whilst on an adult ward, however during Covid that was something that was far, far less likely to happen.

Q. Thank you.

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

A. Yes.

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

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

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

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

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

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

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

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

The second part of it is if you have a mental

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

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

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

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

Do the observations of Dr Lockhart, repeating the

concerns of members of the Royal College, correlate with what you heard from CAMHS inpatient staff that you spoke in compiling your report?

A. Yes, absolutely, yeah.

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

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

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

Q. At which point they were at a crisis point?
A. Yes.
MS NIELD: Thank you.
My Lady, I'm about to move to a new topic.
I don't know if that's a good point to take a break?
LADY HALLETT: Certainly. I shall be back at 3 o'clock.
I hope you were warned we take breaks.
THE WITNESS: Yes.
(2.50 pm)
(A short break)
(3.00 pm)
MS NIELD: Dr Northover, can we move on, please, to look at changes to discharge from CAMHS inpatient care during the pandemic, and could we go to page 31, figure 10, in your report. We can see there plotted, for England, monthly discharge rates from CAMHS inpatient services.
We can see there a rapid spike, a rapid rise in monthly discharges at the onset of the pandemic in around March 2020, and you attribute this in your report to the NHS directive to free up bed capacity at that time.
Was that directive directed, so far as you are aware, to mental health units as well as to acute hospital?
A. So whilst the directive may not have been directly as

useful to mental health inpatient units, I think at the time there was a consideration that the reduction in discharging patients wasn't just around freeing up bed capacity, it was around the potential risk of staffing issues and within mental health units would we be able to maintain all of the beds that we presently had at that time.
Q. Thank you.
And then after that spike we see very rapid drop in the number of discharges, in April of 2020, and then a more gradual trend of decline throughout 2021 and 2022.
This graph is based on data from England. Is it right that that trend of declining discharges was in fact consistent across the four nations of the UK?
A. Yes, as far as I'm aware, yes.
Q. Have you identified any evidence that young people were being discharged during that spike too early and whilst still unwell in order to -- either to free up beds or for any other reasons?
A. Yeah, and in contact with the units that I spoke to there was a concern that some young people were being discharged when perhaps their treatment hadn't been completed and at a time when potentially the community intensive support teams were not in a place to manage

all of the young people who might have been referred on to their services.
Q. If a young person's discharged effectively too soon before their therapeutic stay has really completed, what's the likely future consequences of that?
A. The most likely future consequence is they need to be readmitted into an inpatient unit. And I think that's what we see when we look at this graph, because we see a drop off then we see a slight rise again, when we think, okay, potentially we're seeing some of those young people who were initially discharged being readmitted again at that point.
Q. Can we look, please, at the figure that appears on that page but below figure 11.
This is the average length of stay. We can see a gradual increase throughout the relevant period. Again, we have it in the mean and the median length of stay here.
Is it right that this increased length of stay for patients was correlated to the decline in monthly discharges?
A. It does appear to be, yes. Yes, I think certainly we can say that one of the reasons for the increase -- the decrease in discharge is an increased length of stay. The other reason is likely, as I said earlier, that

there were less beds available.
Q. And you identify in paragraphs 95 and 96 of your report that the rules about self-isolation impacted discharge and length of stay, particularly in relation to trial periods of leave prior to discharge.
Could you enlarge upon that, please, and explain how trial periods of leave were generally utilised prior to discharging a patient.
A. So, as we all know, children and young people are rarely discharged into a flat on their own. They are almost always discharged back into family or into carers. And that shift from an inpatient unit back into the family or carers environment is something -- it's difficult to predict how that will go. So you often have periods of extended leave where a young person will go back home, will spend a night, maybe two nights with the family, and then come back into the unit to have an assessment of how that went, and that's -- that gives an opportunity to then adjust the discharge plan to make sure that it's most appropriate for the young person and the family.
Q. So it's effectively a trial period back at home but before formal discharge has taken place?
A. Yes, it's a little bit more than a trial period, it's part of the treatment plan but it can absolutely be seen

as a trial period.
Q. In terms of the impact of longer stays on the unit on the outcomes for patients, Dr Lockhart has stated in her witness statement that prolonged admissions are associated with poorer outcomes. Could you enlarge upon that for us, please.
A. So, again, this was some data which came out of the GIRFT report as well, which is the longer you spend in a CAMHS inpatient unit the worse your long-term outcome is, when you look at that young person's trajectory over months or years.
Q. That seems perhaps a little bit surprising because clearly it's supposed to be a therapeutic environment that they've gone into, so what's the reason for that?
A. There's a number of reasons. So, first of all, if it takes you longer to recover you have probably got a more severe presentation in the first place, so that could be one of the reasons why it takes longer to recover.
The second part behind it is because of the restrictive nature of inpatient units. So when you are in an inpatient unit as a young person you don't have the freedoms that you would usually have, as I previously mentioned. You don't have the opportunity to leave the unit when you want to, you don't meet your friends, you get separated a little bit from your

family, and the longer you're in an inpatient unit in that way the -- I'm trying to avoid using the word "institutionalised" because that's not what I mean, but the longer you are within an inpatient unit, the more challenging it appears to go back into the environment that potentially was part of the reason that you got admitted in the first place.
Q. So children were spending longer in inpatient units before discharge. Can we look now at some of the changes that they would have been experiencing whilst they were staying in the inpatient unit and how that might have impacted on inpatients and their progress.
First of all, there were some changes to staffing during the pandemic and overall a reduction in the number of staff that were available; is that right?
A. Yes. So staff sickness did lead to an increased use of agency staff and decreased staff levels on the units. And agency staff may not know the unit as well as regular staff and the young person may find it more difficult to establish those therapeutic relationships if you have a continually changing staff member who is trying to support that young person.
Q. In terms of the numbers of staff that were available during the pandemic, you set out the NHS benchmarking network data on average staffing numbers, so they're

quite intensively staffed --
A. Yes.
Q. -- inpatient units. On average 35.2 staff per 12 beds and in an eating disorder unit 33.7 staff per 12 beds. In terms of reduction of the number of staff who are available then, whether that's due to illness or self-isolation rules, what would the impact be of a unit being understaffed?
A. So an understaffed unit is unlikely to be able to have meaningful activities going throughout the day. So if we're looking at meaningful activities, if you're a young person and you're admitted into an inpatient unit, staying in your bedroom continuously isn't going to be the type of intervention that's going to help you, so you need to have these structural activities throughout the day which may be therapeutic in some circumstances, such as group therapies, may be trips and visits out of the unit and other circumstances but may also be things such as having sporting activities, having other sort of activities that the young people can get involved with as a group that are not necessarily overtly therapeutic. If you don't have the staffing levels for that, then you end up in a situation that you might be able to maintain some of those therapeutic activities, but in between those there might

be very little for the young person to do which, in itself, can lead to a less beneficial inpatient admission.
Q. That's an impact on the quality of care really for the patients at the time. Are there potential impacts on patient safety from understaffing?
A. So for staffing levels to get to the point that it has an impact on safety, it does have to be quite extreme. So that would be at the point where a unit feels that it's no longer able to provide one-to-one staffing for young people who require to be under that constant level of observation.
What we did see within England is when staffing levels started to get to the point that there was a concern around safety, a trust might have made the decision to say, okay, we're going to close one of our units so we can ensure that we've got enough staffing level on another unit.
Q. Can we perhaps have a look at the graph that shows that.
That's figure 7, page 26 of your report.
And we can see that between -- in 2020, between two and seven units were closed at any one time. However, you have observed that the units -- the CAMHS inpatient units in the devolved nations remained open throughout. Do you know why there was this discrepancy

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

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

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

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

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

Q. And you set out in the report one independent provider unit which reported that its staffing contingency plan was to provide basic training for the reception and administrative staff to provide cover on the ward if that was required. What were your views about the appropriateness of that arrangement?
A. Thank goodness it never had to be implemented.
Q. If we can move on to deal with the impact of infection prevention and control measures in inpatient CAMHS units

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

Is it right that throughout the UK during the relevant period there were isolation rules for all new admissions on to inpatient CAMHS units?
A. Yes.
Q. So that meant that the young person had to isolate for between seven and 14 days at various points throughout the pandemic?
A. Yeah.
Q. What was the impact of a period of isolation on a young person's mental state?
A. I was very fortunate to be able to hear the evidence provided by the impact witness earlier and I think I -- it's just building on what she said, it is a terrible time for a young person to be placed in isolation when they're at their most distressed from a mental illness that means they can no longer be at home. So to be placed in isolation at that time with a mental health nurse outside your room inevitably had an impact in terms of the distress on that young person but also the time that it would have actually taken to get them the appropriate therapeutic input and also for them to be able to be engaged within that therapeutic milieu within the unit.

Q. You have also set out that because of the self-isolation rules there were restrictions on the number or frequency of visits from friends and family. What are the importance of -- what is the importance of family visits for mental health inpatients?
A. It's crucial, family and carers. Some young people may be admitted where actually they haven't got family or don't have access to their family, but I think family and carers is absolutely crucial. I think any mental health presentation within a young person doesn't just affect the young person, it affects the family and carers as well. So it's about how the treatment needs to involve those systems and not just an individual. So delaying or not enabling that to happen has a negative impact on the therapeutic delivery of care.
Q. So it's not just that it's nice for the inpatient to have some visits and someone come along and keep them company but it actually very much impacts on the therapeutic progress. Is it right that in pre-pandemic times family therapy would be part of the inpatient treatment and take place on the unit often?
A. Yes, absolutely, and I would have to go and check the staffing numbers but every child and adolescent inpatient unit should have a family therapist.
Q. You've also identified that because of the social

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

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

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

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

Was there an observable effect or impact on

children and young people from not being able to access group therapy?

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

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

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

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

A. Yes, absolutely. And, you know, the drawbacks and the benefits can vary from presentation to young person to type of therapy, so it's quite difficult to unpick. So certain therapies such as pyschoanalysis, psychotherapy or an art therapy, which is going to be much more difficult to deliver remotely than a manualised, structured cognitive behavioural therapy and then a young person with social communication difficulties

may find remote therapy easier or they may find it more difficult depending on the make-up of the young person. But absolutely it would have an impact.

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

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

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

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

Q. Staying then with the impact of IPC measures on inpatient wards. You've set out the possibility on

an inpatient ward and with these particular children and young people who may pose a risk to themselves that PPE could actually be used for self-harm?

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

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

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

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

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

Q. So you've identified in your report that the Covid rules in particular impacted on children and young people in

terms of reduced visits from families and carers, the self-isolation periods and reduction in staffing levels and less continuity of care. Were you able to identify any measures or guidance at a national level or indeed at a trust level that were aimed at mitigating those impacts?

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

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

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

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

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

I think Great Ormond Street was one example of this.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes. Yes.

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

A. No.

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you very much, Ms Nield.

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

microphone, I'd be grateful.

Questions from MR PEZZANI

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

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

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

Can I ask specifically in relation to eating disorders, please, Doctor. I am looking at part of your statement that deals with eating disorders at paragraphs 164 and 165, where you say at 164 what we've, I think, already established, that following an initial decrease, eating disorder presentations rose significantly during the Covid-19 pandemic.

And then at paragraph 165 you note that prior to the pandemic, eating disorder services had already been struggling to meet demand.

You also more generally report, at paragraphs 104 and 158, that the staff that you spoke to identified a feeling that there was decreased capacity across the

sector, and there were even ethics committees set up to meet the potential for reduced capacity and increasing demand causing crisis.

How then would you respond to an assertion that during the pandemic, in specific relation to children and young people's mental health services, demand never exceeded capacity?

A. Certainly I would -- so, again, the first part of the question is whether we're looking at inpatient care, because if we're looking at inpatient care in particular then you can manage your demand, because your demand is how many beds you've got.

So by seeing young people spending longer within inappropriate settings before they're admitting would suggest that we weren't meeting the demand for inpatient beds at that time.

I'm not sure whether that's entirely answered your answer (sic). And I'm just going to finish saying that and then turn around and look at you again.

Q. If you have anything that you wish to add then please do.

I did specifically mention eating disorders, and I wonder whether you would be able to comment specifically on the demand and capacity to meet that demand during the pandemic in relation to eating

disorders?

A. So, again, with eating disorders, one of the challenges with eating disorders, and the reason why we saw an initial drop off, is for young people staying in their family homes and the weight loss not being recognised in the first instance. So it may well not be that demand -- we could meet demand in terms of the young people being referred but that doesn't mean that we were being referred everybody who had an eating disorder.

So then once we got past that initial phase of young people deteriorating significantly within their -- basically within their bedrooms, that's when we suddenly saw an increase in demand, at which point I think all services were starting to recognise that they couldn't meet the demand for the referrals for eating disorders.

Q. The second topic that I would wish to raise has also been expressly asked of you already, and that's about what you say at paragraph 122 of your report about independent providers reporting greater challenges in developing staffing contingency plans because they were more isolated and not able to call on community mental health staff, community teams, to provide emergency cover. Are you able to explain what you mean by "isolation" though in that context? Do you mean

geographical isolation or isolation from NHS services, either inpatient or community or both?

A. So it's certainly not a geographical isolation. It is an isolation from the provision of other services. So if I look at the trust that I work in, Berkshire Healthcare, it employs nearly 6,000 people, so that's a large group of people that you can pull on and identify those who have got the expertise and the knowledge to support an inpatient unit if it's getting to the point that the sickness on that unit is not allowing enough safe staffing levels.

The independent units may have -- they may have more than one unit but they're likely to be spread over the country and you're not able to have that large resource of staff within close proximity or with the right level of skills to come in and support a unit. And that's why, as I mentioned in the report, some of these units were having to resort to looking at the staff they did have that they could pull in and how can we upskill those staff to the best of their abilities to provide the best care that they possibly could, which at that time may not have been what we would consider to be good during a time outside of a pandemic.

LADY HALLETT: I think we are going to have to leave it there, Mr Pezzani.

MR PEZZANI: Thank you, my Lady.

LADY HALLETT: Thank you very much.

That completes the questions we have for you, Dr Northover. Thank you very much for your help in producing your written report and for your help in giving evidence today. I'm very grateful.

THE WITNESS: Many thanks.

(The witness withdrew)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Before we conclude this week's proceedings, can I invite you, please, to publish a number of additional statements and documents at this stage. That includes three statements on behalf of royal colleges:

Dr Edward Morris, who is the former president of the Royal College of Obstetricians and Gynaecologists;

Dr Katherine Henderson, who is the president of the Royal College of Emergency Medicine; and Sir Andrew Goddard, the former president of the Royal College of Physicians.

In addition, there are four impact witness statements that we'd invite to you publish. They are from Vivienne Wilkes, who is a member of the Disability Charities Consortium. She is registered blind and was sent a shielding letter in inaccessible format during

the pandemic, and she speaks to that and other difficulties she had in accessing healthcare.

Kafeelat Adekunle is a community matron and a member of the RCN, and she describes the difficulties that she had with PPE and the impact of the pandemic.

Adrian Warnock, a member of the Clinically Vulnerable Families core participant group isolated from his parents during the pandemic and he attests to the impact of shielding on him.

And your Ladyship will recall yesterday hearing from Natalie Rogers. In addition to the -- speaking on behalf of the Long Covid core participant group she made an impact statement which sets out her own personal experience. I invite you to publish three chronologies provided by the Long Covid groups which sets out a number of documents they provided to government, work being done with their membership, and indeed other work they have undertaken to provide impact evidence to the Inquiry.

Can I also invite you to publish the expert report from Professor Christopher Gale and Dr Nadarajah, they are the experts in ischaemic heart disease.

And finally this, can I invite you to publish an additional statement from Professor Jonathan Wyllie. Your Ladyship will recall on 10 October he gave evidence

and was asked about whether the Resuscitation Council had received reports of inappropriate or blanket DNACPRs. He indicated he thought there had been reports of a trust behaving in this way and over the course of the two-week break the module 3 Inquiry legal team asked Professor Wyllie for further details about that evidence. He's provided an addendum in which he clarifies. The example he was talking about in fact related to a restrictive approach to the circumstances in which CPR should be administered and not in fact to an example about blanket or inappropriate DNACPRs.

Can I ask your Ladyship, in order to have his evidence in its proper context, for you to publish his statement which is INQ000474448.

LADY HALLETT: I authorise publication of all the statements.

MS CAREY: Thank you very much, my Lady.

LADY HALLETT: Thank you very much. That completes the hearings for this week. I'll see those who have to attend and those who are interested on Monday, 4 November at 10.30.

MS CAREY: Thank you.

(3.41 pm)

(The hearing adjourned until 10.30 am on Monday, 4 November 2024)

INDEX