Thursday, 7 November 2024

(10.01 am)

MS HANDS: My Lady, good morning. May I please call Professor Simon Ball.

PROFESSOR SIMON BALL (affirmed)

Questions from COUNSEL TO THE INQUIRY

MS HANDS: Professor, good morning. You've produced a statement for us and that is our reference INQ000477597.

Professor, it's correct that you were the Chief Medical Officer for the University Hospitals Birmingham NHS Foundation Trust from January 2019 to January 2024, is that right?

A. That's correct.

Q. The questions I'm going to ask you today are focused on the Queen Elizabeth Hospital specifically and that is a hospital within that trust, is that right?

A. That's correct.

Q. Can you paint a picture for us of the hospital estate and how that may have benefited you or otherwise during the pandemic?

A. Yes, so the Queen Elizabeth Hospital, which I'll refer to as the QE if I may --

Q. You may.

A. -- is largely supported by a modern estate, so a large

hospital building with some historic buildings alongside it, that was opened in 2011, so a largely modern estate with around 46%, I think, single side-rooms, so with en suites and then in most of the rest of the rooms then four-bedded bays with, again, bathrooms associated with each four-bedded bay, so no open wards as such.

In addition to that, the hospital was designed with 100-bedded, capacity for 100 ICU beds of which 67 were funded so very, very large capacity for intensive care.

Q. I want to start with that topic of bed occupancy and capacity. On 17 March 2020, the NHS England discharge policy was issued. At that point it's right, isn't it, that the hospital had over 1,000 general and acute beds with approximately 960 occupied?

A. Yes, at that stage, yes.

Q. And of those 67 ICU bed you have just referred to approximately 40 were occupied?

A. By that stage, that's correct.

Q. So would it be accurate to say at that date there was some available capacity?

A. Yes, because we actually recognised the fact that the pandemic was coming in the year leading up to that, there was approximately 99% bed occupancy across the trust and similarly in the ICU.

Q. So is it right to say you took action before that policy?

A. That's correct.

Q. And did you take any further action once that policy had been issued to increase or to discharge patients from those beds?

A. So the NHS England policy was actioned on the 17th. It was apparent to the senior clinical leadership that the pandemic was going to significantly affect the country so we continued on the work that was -- already had been going on over the previous two weeks to reduce bed occupancy by expediting discharge and then from that point forward we stopped almost all active admission other than those that were urgent.

Q. And is it right that you expanded the ICU bed capacity, from the 67 you've just referred to, to 126 by April 2020?

A. That's correct, yes.

Q. Can you give us an idea as to how you went achieving that, at a practical level?

A. So I think the first thing that I should say is that part of -- much of this was delivered by senior responsible clinicians that we appointed at a hospital level, and who were leading the ICU response as well, so we changed our -- the way that we'd organised our

hospital and senior clinical management to be very much more site-based and across the hospitals and they played a major role in changing the way that we organised ourselves.

To give you a feel, to support 67 ICU beds you probably need around 450 nurses to provide one-to-one care so -- and when we topped out the following January we're talking about providing the equivalent of 1,000 ICU nurses. So --

Q. I want to stop you there for one moment. We will come on to look at the expansion of capacity in January when in fact it expanded further, didn't it --

A. It did.

Q. -- into 2021? I think you've said in your statement that in April 2020 the expansion would have required an additional 205 doctors and 429 nurses?

A. Yes.

Q. Does that sound right?

A. That sounds right. So the equivalent, getting on for 1,000 in total to provide that kind of level of support. And so that meant bringing in staff who were not currently working on ICU so that meant staff nurses that were working on the wards, we had support from across the -- what is now the ICS, then the system, so other hospitals within the Birmingham and Solihull system had

staff members redeployed.

And indeed we had other healthcare professionals, so we had some senior surgeons providing the one-to one care to patients all supervised at a level of pods of four beds, senior intensive-care-trained nurses so it was a matter of expansion and re-organisation of the way that we did things.

And I'll perhaps then come on to not only delivering that one-to-one care with high levels of supervision, with high levels of -- and early retraining and, of course, provision of clear protocols around Covid-19, but in addition to providing that one-to-one care that was closely supervised, we also set up teams to provide particular functions, such as inserting lines, or performing tracheostomies, or indeed proning, so that's where you ventilate patients on their front. So a whole team dedicated to simply supporting turning the patient, which if they are ventilated is a major undertaking.

So a complete re-organisation in the way that the intensive care was delivered and supported.

Q. And is it right that you created a reservist workforce, essentially the individuals you've referred to who were trained to support ICU when it was required?

A. Yes, it came to be known as the reservist workforce

later in the year but those that had had experience and had been trained became known as the reservist workforce because then when it came to redeployment we understood who had actually had experience, who had been trained and who had been developed in a way to support the ICU.

Q. And you've referred to some one-to-one care being provided by those that were deployed or redeployed. Is it correct that there was also a stretching of patient ratios during both waves of the pandemic, staff to -- sorry, nurse to patient ratios?

A. So that is not strictly true. I think it's actually the skill mix that changed rather than the ratio, so there was one-to-one nursing on ITU but the skill mix changed, so we would usually have an intensive-care-trained nurse per patient that -- they weren't always intensive-care-trained nurses but they were overseen at a kind of pod level of four by at least one intensive-care-trained nurse.

Q. In December 2020 the CQC carried out an unannounced inspection of the hospital and one area of improvement that they identified was the staffing levels to ensure that there was an adequate number and skill mix on each shift. Around that time there was, you said, a very high number of Covid-19 patients in the hospital and shortly following that in January 2021 ICU bed capacity

again increased from the 126 to 142. So, in light of that, was it possible to achieve the adequate number of staff with the right skill mix on each shift during that period?

A. So it was possible to achieve the right number of staff. The skill mix was, as I said a different matter. You would usually expect a one-to-one intensive care nurses so -- on intensive care, and I'll come back to wards if I may in a moment, but on intensive care absolutely we sustained 1:1 ratios, but not always of intensive-care-trained staff, but overseen by layers of supervision, both in pods of four, at section levels, it may be five or more pods or what have you. So that's really what we are talking about in terms of those ratios.

In terms of the wards, indeed there were challenges, and again we were re-deploying those nursing staff and indeed other allied health professionals into wards that had not had recent experience of acute medical inpatient care or purview, and again that required significant amounts of training, close support and supervision across groups of wards and what have you.

So I think, you know, the CQC inspection was indeed important in re-emphasising how we needed to keep

on addressing supporting those -- that particular differences in skill mix. So particularly, for example, if you had, overnight, two or three of the core staff on the ward, plus then others, then you'd want -- and perhaps those core members of staff were off -- went off sick, then that needed an urgent response from the site team, or the way that we organise ourselves was across floors, because there are seven floors in the QE.

Q. And did you always have an adequate number of staff, senior staff, to provide that supervision and support?

A. There were -- there was adequate provision of senior staff to provide that support, that's correct.

Q. And you have said in your statement that the lack of workforce capacity did lead to deficiencies in patient care and delays in transfers of patients from wards, is that right?

A. So that's correct. So the skill mix impact is around the efficiency in which care was delivered, so it may be in transfers of care, it may be that drug rounds were slower and less efficient, and that that kind of thing is -- are the areas that inevitably impacted upon by having a less experienced skill mix.

Q. Staying with the topic of transfers, you've said in your statement that due to the size of the hospital, it's more common for the hospital to receive transfers in,

and in fact you received 363 transfers in during the pandemic, is that right?

A. That's true, that's the intensive care -- I think you're referring to the intensive care transfers. So most of the QE's intensive care capacity meant that almost all of the transfers were in, and they were mostly in from other hospitals within Birmingham and Solihull, and that reflects the fact that there was such a high incidence of Covid-19 requiring ventilation across Birmingham and Solihull.

Q. There were some transfers out of the hospital, wasn't there; 43 of the 160 transfers out occurred during a 28-day period at the end of January 2021. Again, were they ICU transfers?

A. The paragraph you're referring to ICU, transfers co-ordinated by the national and regional co-ordination teams, and those were hugely appreciated, obviously by the teams, not only just the sheer numbers, but just feeling that they were being supported by -- across the nation, actually, and understanding of quite how intense the requirements for intensive care in the hospital were.

Q. What were the reasons for such a high number of transfers in that short period of time?

A. So in January 2021, across the trust, and we were

operating as a single trust in terms of provision of ICU care in particular, we peaked at more than 100 Covid-19 admissions in a day, so there were huge demands with regards to that peak of Covid-19 presentations requiring hospitalisation and of course a proportion of them requiring ventilation and on intensive care. So that was the reason that was -- and I think in our exhibits you can see this peak in ITU bed numbers around the 21st, I think, of January or so.

Q. You've said in your statement that during wave 2, so around this time, ICU was operating at 206% capacity but the ICU only came close to crossing the limit at which it would have been necessary to review criteria for ICU admission. We will come on to discuss the criteria, but can we assume from that that the hospital did not cross the limit?

A. You can, and it's difficult to know what that number actually is, but when you have 142 ventilated patients on a single floor ICU you are really looking for at the limits of capacity, but I think it's probably fair to say that if I'd have asked the teams when we first started, could we have ventilated 142 patients, they would have had their doubts. So it's difficult to know exactly where that limit was, but we didn't reach it.

Q. You've said in your statement, in short, maintaining the

basis for admission to ICU, benefiting the patient population and not altering the basis for admission in the face of the pandemic nevertheless came at significant, often personal cost, is that right?

A. I think that's true, and I think that there is no doubt that operating at the level of intensity even for experienced ITU nurses, dealing with such an influx of very acutely sick patients who often spent many, many weeks on intensive care to recover, as you know, a very high mortality particularly in that first wave came at significant personal cost in terms of individuals' well-being, I think that's entirely true.

Q. And I think you said in your statement that there was also an impact on the staff that were treating patients outside of ICU, as well.

A. I think it's easy to focus on ICU. I think we need to remember that the majority of patients were cared for on the wards, and again we were dealing with, even for staff members who were used to dealing in highly intense environments in populations with -- who were quite often very sick, this was a step up again, and then we were bringing in staff from across the hospital who weren't used to working in acute medical wards at that level of intensity, dealing with patients who were dying, and who were quite so acutely sick. So I think it's really

important that that's acknowledged as well.

Q. And can you provide some examples of how the hospital or the trust more widely supported staff not only working in ICU but also on those wards as well?

A. Yes, I mean, I think that -- I mean, the important thing to say is that our approach was multi-factorial. It involved local support and a significant amount of local support from the local managers but then broader approaches to maintaining and sustaining health and well-being, both using kind of national approaches, training staff as psychological first aiders and then kind of practical things just on a -- in terms of provision of food and provision of drinks and the like on a -- particularly at those peaks when we were actually separating, and ensuring that members of staff weren't meeting, that is to say they were meeting infection prevention and control guidelines.

And if I may just briefly dwell on that. I think that was particularly tough for staff because in those -- in the setting where you're dealing with something completely new and highly stressful then you normalise that by discussing those matters again with your colleagues, understanding what -- that you are not the only person who is going through that.

So in addition to this, the challenges around

maintaining good infection prevention and control almost took out those internal support networks, so we had to create those in many ways.

Q. On a slightly different topic but around capacity, did the hospital or trust discuss use of the Birmingham Nightingale hospital facilities to transfer patients in order to manage capacity?

A. So we did. So a team from the trust was responsible for standing up the Nightingale hospital. It was -- we tried to keep that team small and separate from those delivering the rest of the response within the trust and, you know, fortunately we did not need to use the Nightingale hospital but it was supported by the trust.

Q. Did it have any impact on the hospital's ability to care and treat patients by deploying staff members to the Nightingale that weren't then needed?

A. I guess I've kind of anticipated that question in a way by saying that it was a small number of staff and we separated out that responsibility, so there was no conflict at an individual level, which is often more difficult to manage than it is at a kind of organisational level.

Q. Turning then to ICU admission. You've said that the criteria for admission to ICU at the hospital did not change from usual practice and the senior ICU clinicians

supported decision-making around admission; is that correct?

A. That's true, yes.

Q. And how were those senior clinicians supported by the clinical support group and clinical ethics group that you've referred to in your statement?

A. So I think, if I can kind of expand on that a little bit. So the first thing to say is we deployed very large numbers of senior clinicians onto the wards 24/7; that they were involved in both determining escalation, or identifying patients that required escalation, but also having early discussions with patients around their prognosis and their preferences for escalation of treatment. So that's really important. We were conscious of the fact that those clinicians would be having many such discussions in the context of the pandemic at a very -- you know, at a very early stage of admission because we knew patients were deteriorating quite rapidly.

The clinical support group was set up to provide opportunity for clinicians making those decisions, particularly if they felt the discussions were particularly difficult, to seek support. As it happens -- so that was an offshoot of the clinical ethics group but was kept separate from the clinical

ethics group.

As it happens, most clinicians sought support from the other senior clinicians, including intensivists, respiratory physicians who were actually available across the floors within the Queen Elizabeth Hospital.

Q. And did you develop or disseminate any local guidelines to support that decision-making?

A. Yes, so a range of guidelines that were continuously updated and were supported by something called the medical and scientific advisory group that were responsible for reviewing all of the guidelines, ensuring they were kept up to date and publishing those and disseminating those.

Q. Did you receive any feedback from staff as to how useful or otherwise they were?

A. I think what was particularly appreciated was the microsite that we set up which provided easy access, easy searchable access to all of the guidelines and I think at its peak that was accessed 23,000 times in a day.

Now, I should say that we opened that microsite up not only within the trust but to the outside world because we felt that we were a very big centre with a great deal of experience, we felt that actually we wanted to share our experience and what have you, and

that microsite was accessed a total of 4 million times. So the feedback we've had was that the whole range of guidelines were really appreciated but actually particularly the ease of access and the ease of discovery of what the right guideline was.

Q. Can you recall when the microsite was made available to staff, firstly, and then to the public?

A. I think it was in April of 2020.

Q. 2020?

A. Yeah. I think it was stood up pretty quickly because it became apparent that we needed to rapidly disseminate information and email wasn't good when you had to search -- we needed to have something that was really easily searchable essentially.

Q. And in your statement you've referred to insights that were published during the pandemic. It's at paragraph 200. And one of those was in relation to the first wave of the pandemic on the impact from people -- on people from Asian communities was more likely to present with severe symptoms but no difference in duration of symptoms and they were more likely to be admitted to ICU. And then how that knowledge changed how you assessed severity in that population, including more close monitoring to identifying signs of deterioration and a lower threshold for ICU review.

So did those insights such as the one you've explained here inform the ICU admission criteria and the guidelines that were developed?

A. I think not so much -- ICU admission criteria but overall approach to treatment of patients, I think, around where your level of concern is and what have you. Yeah, I think that paper was published -- was based on data up to the end of April and we'd already admitted 2,200 patients at that point. So we were constantly learning from the data as it came through.

The QE in particular at the time benefited from an electronic healthcare record that had been developed in Birmingham over the previous 20 years that we were able to adapt and collect new information, new forms of data and at the same time also provide electronic clinical decision support based on those new insights, so creating bundles, investigation bundles or treatment bundles to ensure that people were getting absolutely the right treatment they were getting.

So yeah, I think those -- the thing that struck us was essentially young Asian men were presenting later than the rest of the population but with really quite serious disease and part of that was internal but it was also getting the message out externally across the population to not delay attending.

Q. And you've said that you did not reach the point of having to review the criteria for ICU admission but did you prepare for that eventuality?

A. So I think it was a debate that was going on nationally and it was particularly in that first month when the Ferguson modelling had -- if you extrapolated the Ferguson modelling, unmodified we were facing having to ventilate 500 patients across Birmingham and Solihull and that peak not being flattened, we would not have had enough ventilators to do that, let alone any of the other considerations around capacity.

So I think it was a national debate or a national discussion rather than one particularly locally, I think understood by the senior leaders but I think you need to be careful at which point you kind of change -- unknown to yourself change people's attitudes, and what have you, so we were quite careful not to and to emphasise that we will come to that and deal with it as and when it is necessary. Fortunately, it wasn't but it was a widespread discussion obviously in the context of the modelling.

LADY HALLETT: By the Ferguson modelling, you mean the Imperial College Professor Neil Ferguson?

A. Sorry, yes, I do.

LADY HALLETT: I know, obviously, from all the evidence I've

heard but for those watching.

A. My apologies.

MS HANDS: Staying on the topic of ventilators, you have explained in your statement how the supply of ventilators was a concern, particularly as you received unsuitable machines from the central supply but that that had been rectified by January 2021. Was there any point that you ran out of ventilators?

A. No. No, there wasn't and so what we're referring to with regards to the central supply was at the end of March 2020, and what have you, and I can tell you hours felt like days and days felt like weeks at the time and clearly at the time the effects of lockdown hadn't really kicked in, there were concerns with regards to the fact that we might, had the increase in requirements gone unmodified, but they didn't and, you know, over a matter of days then new extra supplies of ventilators were coming in. They were clearly needed across the nation and I think it was simply that the ventilators, one batch of ventilators that we received were really only suitable for transferring patients not managing patients on intensive care.

And I think that just -- we included that because we felt the whole issue around precision of procurement, I think is a potential learning for this in terms of any

future response.

Q. We will come on to discuss some of the issues you set out in your statement around PPE and RPE procurement and the supply. Were there any processes in which you could provide feedback about the quality and suitability of the equipment that you did receive?

A. So we have an excellent director of procurement who I am aware has provided evidence for -- or a statement for Module 5 and that feedback really went back through the director of procurement who had a role or had good lines of communication nationally, yes.

Q. Before we come on to that, I just want to finish the topic of escalation of care. In regards to any patient presenting at the hospital, is it right that the care escalation decisions were made when the patient was admitted and would be recorded in a Treatment Escalation and Limitation form?

A. That's correct, yes.

Q. Can you briefly explain what that form is and how it's used?

A. Yes, and many people will now understand that as a ReSPECT form that others may have heard. At the time that had initially been implemented historically in the electronic healthcare record as a Treatment Escalation and Limitation Form and it's an opportunity to determine

or to describe, I should say, the discussions that have gone on with a patient and around their preferences and around not only limitation but actually escalation. I think that's a really important point. So it may be not for escalation to -- for ventilator, so in face of treatment via ventilator or other invasive treatments, maybe not for cardiopulmonary resuscitation, or for those things, and I think what we did see during the course of the pandemic, we were encouraging that every single admission should have that recorded and we saw a significant increase in positive affirmation for these interventions not just not for these -- not for these escalations.

And those were -- those are then reviewed on a daily basis and, you know, you mentioned earlier some of our processes and protocols and for example, you know, one of the areas that we brought in very explicitly, although it was available in national guidance, was the importance of suspending non-resuscitation orders in certain settings that might -- that were easily -- that were associated with specific interventions, whereby one might -- that were easily reversible.

So if you are taking someone to theatre or they're having an endoscopy -- I'm a kidney specialist -- so

somebody undergoing dialysis who then loses their blood pressure it's perfectly appropriate and reasonable to intervene at that point. If they've had a sudden abnormal arrhythmia in the setting of a general anaesthetic it's very reasonable to intervene at that point despite a non-resuscitation order and that's discussed with the patients at the time, making the point that treatment limitation does not imply non-treatment and does not prevent sensible intervention in settings such as that.

Q. And did staff receive training during the pandemic on when and how to complete those forms, or if there was any changes?

A. So we were thought -- so the answer is that this is part of standard -- part of standard practice, is the first thing to say. The training really related to dealing with some of the specifics around timeliness of addressing those issues, and those specific questions that I've just alluded to that came up around ensuring that we were actually addressing all of the questions that members of -- that our patients may have brought up.

Q. You've explained in your statement that there was a drop in discussions involving family members of approximately 25%. What in your view led to that drop, and also,

again, did staff receive any training about how to communicate with family members in the circumstances of the pandemic?

A. So I think that -- so what you're referring to there is a paper that we published on resuscitation that identified, so usually -- that identified that 96% of patients were involved in that decision-making. The numbers of -- the amount of family engagement, I think, simply reflected difficulty in -- usually, you've got family members in, coming in with patients with them, and that discussion is happening at the time. So I think that reflects then during those initial discussions, then, difficulties in contacting and identifying family members, and engaging in those discussions relatively early in the admission because we were aware of the fact that patients were deteriorating quickly.

Q. And did you observe any changes in the number of DNACPRs?

A. So there was a small increase in the number of patients who were presenting from the community with DNACPRs across their reporting period, which increased from around, I think, 4% -- it depended on which population we looked at, but between 4% to 8%.

The total -- I don't actually have the data to

hand in terms of total DNACPRs. What we saw was an increased utilisation of the Treatment Escalation and Limitation form.

Q. And what support was put in place, and when, for patients with learning disabilities, dementia, mental health concerns or communication difficulties, if they couldn't be supported in decision-making by their family or carer?

A. So I think the first thing to say is that we went completely out of our way to identify those individuals, and to maintain a standard of practice as we possibly could, so we would usually look for a mental capacity advocate and what have you. But at the end of the day, there was -- ultimately there would be a best interest decision made by the clinicians caring for a patient, but not only in the event of having exhausted every opportunity for accessing next of kin, advocates and what have you.

Q. Moving on now to a different topic, infection prevention and control measures. The Inquiry's heard a lot of evidence about the national IPC guidance. From your perspective at a hospital level, was there parts of the guidance at national level that was more helpful for implementation at that level?

A. More helpful. I think -- I think that it was very

wide-ranging. It was -- at the end of the day it's you know it's always helpful because trying to synthesise the evidence yourselves is impossible and what have you. I think that there was a lot of it and it came through frequently, and if you asked the teams, they would probably say it felt like it kind of came through on a Friday evening, but I think that's probably perception by us rather than actuality, if I'm honest. The fact is that we had a team stowed up 7 days a week through most of the areas where the times where there was a lot of demand for them to change.

LADY HALLETT: But the content, Professor.

A. The content. I mean yeah I think from our perspective it was helpful. I'm trying to think of a specific example that you may be thinking of where it might not have been helpful. So -- I think the volume was the thing, of actually turning that into a simple message, and I think we gave some examples of infographics that we used to actually say -- take relatively complex advice into a simple message that is to be delivered by the individual. Because at the end of the day IPC is around -- a lot of it is around individual behaviour as much as anything else, if that makes sense.

MS HANDS: Can you give an example of the part of the guidance that you did translate into infographics in

order to make that message simple to understand, and then pass on.

A. Yes, I think we've given a few examples there, one of which is how to use face masks. In the early days of course there was a proliferation of different face masks being used and what have you. Again, infographics, but also working with individuals around the importance of maintaining your face mask wherever you were in the hospital. Info -- I think I alluded to it earlier, there was a real -- there was an understandable desire to be able to share your experience with other members of staff and what have you, but actually focusing on limiting your exposure to your colleagues, particularly in those early months before we were able to be screening not only patients, but members of staff for the presence of Covid-19 virus.

Q. And you've described fit testing for staff as being slow in your statement, and that there was a period in which frontline staff had to be prioritised.

A. Yes.

Q. How long did that persist for and were you able to expand the team to meet demand?

A. So there are two elements to that, one of which we stood up a fit testing team that was dedicated to that, but there were also consumables that were required in order

to be able to fit test individuals and then combined with that something else that we alluded to is then consistency of supply. So your fit testing is only -- only applies to the make and model of the mask that you've been tested on, and clearly, when supplies were stretched and what have you, we might be receiving supplies of a different form of FFP3 mask. So that's again if at an organisational level and therefore at an individual level you can maintain that consistency, that would have improved the efficiency of what we were undertaking.

Q. And how did you mitigate some of those supply issues around the PPE or RPE that was received?

A. So, I mean, the procurement team took pride in their ability and working with local providers, one, but also access to a very large number ultimately of hoods which are suitable across for a wide range of individuals. Whereas the masks are more dependent upon (a) fit testing and (b), you know, whether you can actually get a mask to fit you.

Q. And can you briefly explain what the impact was on staff of some of these PPE supply issues?

A. Yeah, I mean, I think -- we think about this in terms of were they protected or not, but actually it's -- I think that the most important thing is that members of staff

felt that they were being given the best level of protection that was available, and so that's -- it's a subtly different point that I'm making. We would never have put people into a position where they weren't protected, but they wanted to feel that they were getting good levels of supply and certainty of supply rather than thinking what happens if this supply isn't -- doesn't come through a day from now or two days from now. So it was an additional uncertainty on top of everything else everybody was having to deal with was the source of concern. Hopefully that answers your --

Q. Did staff feel like they were receiving the best level of protection from the PPE that you could supply them?

A. I think they felt that they were using the best PPE that was available, but they would have been aware of, at times, frustrations around, ultimately, equipment that had to be discarded, for example, or that they felt that really turned out to -- ended with feedback had to be discarded. So masks where -- you know masks where the kind of ear connectors keep falling off, or simple plastic gowns where the ties tended to break. You just don't want that, and at the end of the day we received feedback, we took those out of circulation to ensure that our staff were protected. But it's a really important part of the psychology of supporting your

staff through challenging times.
Q. In terms of Covid-19 testing, did you have any problems accessing a sufficient number of Covid-19 tests for staff during the early stages of the pandemic and did it improve?
A. So I mean, the answer is, yes. But I think, if I could add, I think the speed at which testing was developed and ultimately implemented was pretty impressive in fact. Of course yes, in the first month or two after the pandemic, yes, it led to particular challenges around getting staff -- identifying that staff were positive or negative and then planning with regards to deploying staff and what have you. But in truth, knowing about how long it usually takes for tests to come into being then it was pretty impressive actually how quickly it was achieved.
Q. Moving on to nosocomial transmission. You've set out in your statement that the hospital experienced 73 Covid-19 outbreaks from 1 September 2020 to June 2022 and that's defined as two or more cases linked in place and time. In your investigation of those experiences, were you able to establish any significant repeat contributory factors to the rates of transmission?
A. So I think the first thing to say is that before the availability of regular testing of staff and of patients

then, you know, that was clearly a significant contributory factor. I think, if I may, I'd also say that the rates at the QE were really relatively low and I think benefited from the estate that I've just referred to. It was, you know, the estate was very different in our other hospitals, some of which in are, kind of, late 19th/early 20th century estate, much more crowded, beds that are closer together than the very wide-spaced-out beds on the wards of the QE, corridors that you can't fit two beds down which you can at the QE, so I think that comes back to the estate question.
Q. Moving on to vaccination as a condition of deployment. You have very helpfully set out in your statement all of the actions that the hospital and the trust took in order to prepare for that being introduced. You've described it as time-consuming and difficult due to access to data being variable.

What was the impact on staff of the prospect of this being introduced?
A. So there's the impact on the staff who were kind of directly affected, I think it's fair to say, and then there's the impact on the staff who had been vaccinated because, you know, they had colleagues who were being affected who had stood by them during the course of the pandemic and I think that that was a clearly widespread

concern.

I think that what we did was to try and work with those members of staff to provide them with as much information as possible both with regards to addressing any concerns with regards to vaccination, but also being, you know, supporting them if they had chosen not to be vaccinated as to actually what would -- what the outcome would be, how one could adapt things, etc. I think in that we were hugely supported by our staff-side representatives who were, you know, very, very helpful in that regard.
Q. What would the impact have been if you had lost those staff members due to the policy being introduced?
A. I'm not sure that we've actually quantified that, if I'm honest, because obviously that policy was then changed. I think it would have been significant but I think it would have been even more significant in terms of the, you know, concerns of their close colleagues and their perception of the fairness of their contribution to the Covid pandemic response having been acknowledged.
Q. Briefly on the topic of visiting guidance, the Inquiry has heard a lot of evidence about visiting guidance so I just want to ask you about two discrete topics in this regard. The first is in regard to what local guidance and discretion was in place during the pandemic to allow

for visitors to attend in specific circumstances and whether that changed?
A. So the local guidance around discretion was effectively in a number of areas one of which was end of life, one of which was -- and the other predominant one was those with difficulty communicating, so patients with dementia, with learning disability, autistic spectrum disorder, and then particularly as -- for those with prolonged admissions, those whose mental health was really significantly suffering from -- in the context of a prolonged admission. So those were the opportunities for -- or the guidelines around particularly appropriate room for discretion.
Q. And again in your statement you very helpfully set out in detail the role of the ICU family liaison team that the hospital introduced. Can you briefly tell us what that team did and whether it was successful?
A. It appeared -- I'll answer the last question first. It appeared to be very successful. The ICU liaison team, so it became clear that, you know, that a lot of the role of an ICU nurse or a part of the role of an ICU nurse is talking to family and liaising with family. It's incredibly stressful to have a family member on ICU. That was simply not possible in the settings of levels of protection from aerosol-generating procedures.

So we set up a family liaison team largely, not entirely, but largely staffed by medical students overseen by retired intensivists led by the intensive care doctor who every day phoned a family member to give them an update on the patient, on the patient on ITU using a kind of summary that was in the electronic healthcare record so that they were able to receive that on a day-by-day basis.

There was a lot of positive feedback, both from family but also from the intensive care nurses who felt that they weren't delivering the level of care that they would usually hope to by not being able to speak to or talk to the family. So that was a good thing.

Do I have any regrets? It may be that perhaps, you know, could we have extended that even further I think.

Q. When you say extend it further, do you mean outside of ICU?

A. Outside of ICU I mean, yeah.

Q. Moving on to the topic of Long Covid. You have said in your statement that 36 staff members have Long Covid but it's had a minimal impact on overall staffing levels. When did you start collecting data on staff members suffering from Long Covid?

A. I actually don't have that to hand. I'll happily

provide that --

Q. Not a problem. Are you able to help us with when the staff network forum and the trust-wide Long Covid lead guidelines were introduced?

A. So across, I think -- across -- middle of 2021 and then onwards from there so that in -- obviously there was a change with regards to sick leave guidance in 2022 with regards to Long Covid.

Q. Yes, national guidance to support managers and leaders with staff suffering from Long Covid was published in February 2022. Would it have been helpful to have had that guidance any earlier?

A. February 20 -- I think a number of months earlier but we were in the middle of the, if we think about the peaks of the pandemic and what have you, really latter part of 2021 might have been useful. I think it's, you know, I'm just thinking about our ability to respond to the guidance, and what have you, would really have been -- would really have come along in mid-2021 onwards.

Q. Thank you. Professor, you've provided a number of recommendations and lessons learnt at the end of your statement and I would encourage anybody interested to look at those in detail but are there any that you wish to particularly bring to her Ladyship's attention?

It's 253 to 262 of your statement if that assists.

A. You will have heard, I think, around or you will hear around ICU capacity across the country and it's not simply a -- and how that compares to European comparators, for example, but also there is significant within-nation variation in ICU capacity which is probably important to consider.

I'm conscious of time. I think that those are probably -- and then I think, broadly speaking, the importance of the build environment in our ability to respond. We've talked about the Queen Elizabeth Hospital. The learning in many ways is the compare and contrast to a modern-built hospital to older infrastructure that we saw across the trust. I think that's probably -- and I think we benefited from the ability to adapt our electronic healthcare record in ways that generated useful data that contributed to the national understanding of Covid-19 but also that improved the care that we were able to deliver patients by delivering consistent advice to the clinicians, caring for patients.

I'll probably stop there. I can see the clock across there.

MS HANDS: I'm grateful, my Lady. Those are my questions.

LADY HALLETT: Thank you, Ms Hands.

Ms Jones, Jessica Jones. Behind the pillar at the

back.

Questions from MS JONES

MS JONES: Thank you.

Professor Ball, I ask questions on behalf of Care Rights UK, John's Campaign, and The Patients Association, all of which are organisations who represent patients and those receiving health and social care along with their loved ones.

The questions that I want to ask you today are about the visiting guidance. You've already said this morning that there were certain categories in which NHS guidance allowed for local discretion to permit continued visits, so for some patients with dementia, communication difficulties, learning disability, autism or whose mental health was deteriorating.

Can I ask, on a practical level, how were those patients identified and how were continued visits for them supported by the hospital?

A. Yes, so the level at which discretion was exercised was at a ward level and a ward leadership level, but I think in our evidence we also mentioned a very significant increase in the capacity of the vulnerabilities team, and we identified, actually before the pandemic, the need to develop a team that were dedicated to supporting -- not delivering care, but to supporting --

wards to ensure that reasonable adjustments were made in various settings.

So that team more than quadrupled in size across the pandemic, and they were able to support each of the -- every ward around patients with dementia, with learning disability, with autistic spectrum disorder. And so, I think, as time went on and as that team grew in size, then again they were able to act as combined advocates, as it were, in addition to the family and loved ones.

Q. And visiting was generally restricted, your evidence says, to one visitor. Was any distinction made between those who were there as visitors per se and those who might have been there as familiar carers providing healthcare to people with those conditions?

A. I don't think there was, I think it was -- I think -- in fact on infection prevention and control grounds, it was kept to a single visitor.

Q. Again, in terms of how the exceptions worked in practice, was it your view that they did work and was there any opportunity for you to feed back to NHS England about how guidance might be broadened or changed to be more effective?

A. So I think that on the whole they -- the feed become that we got was often positive, but sometimes I mean --

but sometimes there were concerns brought forward, but those concerns tended to be addressed, as it were. So, rather than as a source of data, they were treated as an opportunity to try and address with the individuals, with the family members -- usually family members -- their specific concerns and what have you. So I think that's important. I think we were -- it was an -- as you appreciate it was an extremely challenging time trying to balance infection prevention and control, and what we knew about the importance of visiting with regards to individuals mental health and indeed their physical recovery. You know we all will be aware, you will personally particularly be aware in terms of mobilisation, in terms of nutrition, etc, the role that family take.

It's an incredibly difficult balance to get right, if I'm honest, and I think the point that organisations like yours make is incredibly valuable because it's easy to become focused on the numbers, as it were. So increasing numbers of infection what have you so combining quantitative and qualitative information is a challenge, but it's really important that that qualitative information is brought forward.

Q. Thank you. Just to clarify on that, you have given a helpful answer there about what the hospital did in

those circumstances.

A. Yes.

Q. Was there any opportunity for dialogue with NHS England about how guidance might be broadened or be more helpful to avoid those issues?

A. So there's continuous feedback through the regional teams and through regional -- so this would have been led by the Chief Nursing Officer at the time and there was a chief nursing officer's forum and feedback through that so I would imagine that it would have been handled through that, but I didn't have personal experience of that.

Q. You're not aware whether or not any concerns were in fact fed back or not fed back?

A. Not the specifics, but I know that was a very active topic of feedback into the hospital.

Q. Thank you. And then lastly from me, do you think that the visiting guidance should have taken into account the impact of the healthcare staff of whether visitors were allowed to be present or not?

A. By which I think you mean that the care delivery would have been improved by the presence of --

Q. We've heard a couple of things, so first, yes, that care delivery can be improved because the presence of a familiar carer can actually help in the delivery of

healthcare to a patient, but also we've heard a lot about the moral distress that healthcare staff suffered in having to facilitate end-of-life contact, for example, virtually, or not being able to involve family members and loved ones in decisions about a patient's care.

A. Yes, I mean, I think that the answer is that -- the straightforward answer is this is what we usually do, and we usually do it, because it's of benefit to patients and, you know, would address that question of degrees of -- various degrees of moral injury that you refer to.

So I think that the answer to that is yes, and that's why we -- that's part of our normal practice. Again, it comes down to this business about balance. We had relatively low levels in some of the wards in Birmingham and Solihull relatively low levels of vaccination, for example, and so there continued to be relatively high levels of transmission across the population. I think we all acknowledge it's a challenge but, yes it would have been, of course.

MS JONES: Thank you.

Thank you, my Lady.

LADY HALLETT: Mr Jacobs.

Questions from MR JACOBS

MR JACOBS: Professor, just a couple of follow-up questions on behalf of the Trades Union Congress on vaccination as a condition of deployment.

A. Yes.

Q. You've described the extensive and time-consuming processes in relation to trying to introduce the policy. You've described the impact on staff both vaccinated and unvaccinated. Given those factors, was it a worthwhile policy?

A. So I think I'll turn my back to you if I may.

So I think that we have implemented it for new members of staff coming online so I think that in terms of protecting our patients then clearly we've got -- we would understand that to be a valuable exercise. In the context of -- in the context of staff who had been through the pandemic I think that one has to accept that there are challenges in the way that -- in the way that that's communicated. I think if -- my position is it was a worthwhile policy in the sense of if we had not attempted to implement it somebody else would be asking us the question of why we had not attempted to implement it. So hopefully that gives you some feel of the dilemma that of course we all feel in terms of enforcing a specific treatment or -- on staff members who are, many of whom had contributed significantly to the Covid

response.

Q. And you describe in your statement, and I think you have given a sense of this in your evidence, in a sort of different way to vaccination as a condition of deployment various approaches of encouragement rather than enforcement, provision of credible information, discussion groups, psychological support, and what have you. Do you think those means of encouragement were effective?

A. I think they were. Not completely, as we know. I think the one thing specific that I would probably bring out is how important information was, because we found that our information was incomplete around those who had been vaccinated or not, and it's really important not to engage in those discussions based on incomplete information. I think that's the other thing I'd add.

Q. I think it's right, isn't it, Professor, that once the government dropped its vaccination as a condition of deployment policy, as a trust you reverted to approach of encouragement rather than --

A. Correct.

Q. And in the context of a pandemic and the sacrifice that had already been made by healthcare workers, is it acknowledged from your trust's perspective, do you think, that discussing the value of vaccination with

staff who were concerned, providing support, and so on, is preferable to and actually probably more effective than saying: take it or you'll be dismissed?

A. Yeah, I think it's really important to make -- if I could address the latter point.

The concept that this would have been about "take it or you'll be dismissed" is not one that we would recognise. It was very much about working with our employees and our staff site representatives to minimise the chances of that happening, accepting the fact that could conceivably be an ultimate sanction but that was never in our mind.

MR JACOBS: Thank you very much.

LADY HALLETT: Thank you, Mr Jacobs.

Ms Munroe, please.

Questions from MS MUNROE KC

MS MUNROE: Good morning, Professor. My name is Allison Munroe and I ask questions on behalf of Covid-19 Bereaved Families for Justice UK.

My Lady, may I start actually with my last two topics because these are of particular importance to many of the families that we represent.

NICE guidance. Was the NICE guidance which was published in March 2020 -- and which I think from your statement you say was being used by QE -- was it being

used to inform discussions or decisions in relation to any of the following, escalating care, such as access to ICU treatment, Treatment Escalation and Limitation, the TEAL forms, and DNACPR notices?

A. So it was part of the information that we were providing to our healthcare professionals to have individualised decisions and discussions, I should say, around those decisions with staff members -- sorry, I'm perseverating from the previous question -- with patients.

And I think I come back to a point that I made earlier, that a lot of our efforts were around deploying very senior members of the clinical staff on to the ward so those in large numbers so that there was sufficient time for those discussions to be had in an individualised way.

Q. Still on the topic of NICE guidance. Notwithstanding what you said about deployment of senior staff, the clinicians, was any consideration given to the risk that as a result of the NICE guidance, clinicians may or could perhaps overestimate, for example, CFS scores and associated factors such as age or pre-existing health conditions when making those important considerations of whether a patient was eligible for ICU admission, ventilation etc at a time and context is really important here of course, this is all at a time when

there are severe constraints on resources, capacity, and just the mental and emotional toll that has been taking by the staff themselves?

A. Yes, so if I could first of all say we spent a lot of time communicating with our staff around the importance of not simplifying decision-making down into a simple score -- and I think you're referring to the Clinical Frailty Score there --

Q. Yes.

A. -- and that that, being very specific in our communication that no decision should be made on using a score that had not been validated for that purpose, for starters.

Secondly, I come back to, really, the profound efforts of the intensive care response in our hospital to eventually more than double capacity to allow us to continue, and to communicate that the importance of maintaining standard decision-making and what have you.

And there was a third point I was going to make which has just gone out of my mind but I think that's, you know, that's the essence. And I think, in my evidence, I kind of touched on it, which was importance of whilst acknowledging there were huge pressures and what have you, not jumping the gun, as it were -- so there were discussions going on nationally about what

happens if we end up with the Neil Ferguson modelling coming to pass during the course of April, but it was really important, and we really emphasised this in our communication, not to conflate that with current decision-making. And that was a really important part of the work that we did across the senior leadership and cascading down. Hopefully that answers your question.

Q. It does, thank you. Then the next topic -- related, ICU admission and decisions on escalation of care. Was QE or the trust able to collect and collate patient data, for example age, to understand if there were any changes in the characteristics of patients admitted to ICU during the pandemic?

A. So we would be able to provide you with that, with those data. Of course, this is a particular disease so it was a unique disease in many ways. It's not often -- we don't admit many patients with viral pneumonitis and so you'd have to then compare that with an equivalent patient group, as it were, so it's a question that's got subtleties within it.

Q. And then finally on this topic, and it again relates back to an earlier part of your evidence, Professor, where you were asked about the increase in 2020 and 2021 in the number of patients for whom there were DNACPR notices in place on arrival or admission to ICU compared

to 2019. You refer to an increase of -- from 2 to 4% and I think your statement actually, there was some differential between ethnicity, 2.6 to 4.2% increase for south Asian patients and 4.8 to 8.4 for white British patients. I think those were the figures that you gave.

A. Thank you.

Q. Just to assist. And in terms of the TEAL forms, there was an increase, I think again from your statement, from 20% prior to the pandemic to a peak of 60%?

A. Yes.

Q. So that's quite a big increase there, or is it? I don't know.

A. The point is we were encouraging people to fill in a TEAL form for everybody.

Q. Right.

A. That does not apply treatment limitation. In fact, I think we saw a three-fold increase in the affirmation for all active treatment for example. So, you know, there is a strong argument to encourage that every admission should have a TEAL form or a ReSPECT form completed so that we -- it's absolutely -- so that it takes away from this lack of clarity, this conflation of determining patient preferences from a specific set of decisions around cardiopulmonary resuscitation. So that's what we're talking about.

Can I just, if I may, just touch on the differences, the ethnicity differences.

So that was for patients coming in from the community, as they came in from the community had they had a DNACPR. And, of course, there's a very big difference in our population in the age distribution according to ethnicity. So our south Asian population is much younger than our white population across Birmingham and Solihull.

Q. I suppose a question that I have arising out of that increase. On the one hand one could say well, the increase -- there's many more people coming into ICU that could explain the increase in the percentages. But from particularly the perspective of the relatives, and who are not, you know, having that contact, not having that opportunity to discuss with the senior clinicians, would you agree that at least there could be -- those figures -- that increase could give rise to concerns that DNACPR and other decisions to limit care may have been influenced by the severe constraints on resources and capacity rather than strict clinical decisions, particularly, as I say, from the perspective of their relatives?

A. I can understand by that -- those concerns may exist and of course that particularly reflecting that early period

in March and April 2020 when, you know, there were fears that -- I mean, we watched the news together of, you know, what was going on elsewhere around the world, what was going on in north Italy, for example, so I can absolutely understand why that might be a source of concern, and it's why information and the use of data is so important in, you know, providing the evidence as you've alluded to and we'd be very happy to look in any way that we can at any specific questions that you might have.

Q. Thank you very much, Professor.

My question, then, going back to the topics, my Lady, my question on supply of ventilators, that's been answered.

Just briefly on masks, then, FFP3 masks. Again, you've touched on this in your evidence already, Professor. We've heard evidence during the course of this module, quite a lot of evidence about masks and fit testing and some of the problems that anthropomorphic differences about --

A. Yes.

Q. -- genders and ethnicities and how that could influence the inadequacy of masks for staff. Did the trust have access to a range of sizes and models of mask to ensure that staff across the board, women, black and minority

staff, who may have failed fit testing were able to be provided with alternatives? And, if not, were there situations or scenarios where staff were being asked to work with masks that weren't fitted properly?

A. So the answer to the last question is "no". And the reason, actually, is that our procurement team did, and I think it is in the evidence somewhere, we managed to procure over 1,000 of the hooded -- ventilated hoods so if you were not able to work with a mask then you were provided with a hood that provided you with protection pretty much whatever your anthropomorphic differences or other differences.

Q. This is for another module but it would seem from a number of your answers, Professor, that the procurement team, certainly at the QE, in your trust, were able to work and resolve quite a lot of the difficulties that potentially were there around supply?

A. I think they'd probably say some of them.

Q. Then finally in the time left, just one or two points in relation to general concerns about supply of PPE, ventilators and CPAP equipment. Was it your understanding that PPE that was provided from central supplies had not been quality checked in some instances or inadequately checked prior to arriving in the trust hospitals? And, if so, did that impose an additional

burden on the hospitals within the trust?

A. I mean, I couldn't say whether it had or it hadn't. I think that our procurement team would say that some of the PPE that arrived wasn't fit for purpose, and what have you. You can understand in the -- it's difficult for me to take myself back but at the levels of pressure and drive to get kit out, I can understand why that might have happened, but it's certainly our observation that on occasion that the quality control wouldn't have met -- well, didn't meet our in-real-life testing.

MS MUNROE: Thank you very much, Professor.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Munroe.

I think that completes the questions we have for you, Professor Ball. Thank you very much indeed for all that you did obviously during the pandemic to try to make sure your hospitals were well equipped to serve your local community, and thank you for all the help you have given to the Inquiry.

THE WITNESS: Thank you, my Lady.

(The witness withdrew)

LADY HALLETT: Very well, I shall return at 11.40.

(11.24 am)

(A short break)

(11.42 am)

LADY HALLETT: Ms Nield.

MS NIELD: My Lady, I would like to call, please, Professor Sir Stephen Powis.

PROFESSOR SIR STEPHEN HUW POWIS (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I hope we haven't kept you waiting too long, Sir Stephen.

A. Not at all, thank you.

MS NIELD: Can you give your full name, please.

A. Stephen Huw Powis.

Q. Professor Powis, you have given several witness statements to this Inquiry and for Module 3 you've provided two witness statements which we will be focusing on today.

This is INQ000412890, that's 282 pages long, it's dated 7 February 2024, and that's your third witness statement to this Inquiry and that's how I will be identifying it. And INQ000485652, dated 9 July 2024, which is your fourth witness statement to this Inquiry and it runs to 591 pages.

Can I check, please, that you have both of those statements accessible to you?

A. I do.

Q. Professor Powis, you're the National Medical Director of NHS England and you have been in that role, I think,

since early 2018; is that correct?
A. Correct.
Q. And you're also a professor of renal medicine at University College London?
A. Yes, I have an honorary chair. I was a substantive professor until I left for NHS England and then I was given an honorary chair.
Q. And you were previously Medical Director and, latterly, Group Chief Medical Officer of the Royal Free London NHS Foundation Trust from 2006 to 2018, is that right?
A. That's correct.
Q. And you were not, I think, in clinical practice during the pandemic?
A. No, I stood down from clinical practice temporarily a couple of years before I left the Royal Free. We had additional work to do that required me to do that. And then when I left to come to NHS England, because of the nature of my clinical work, which was looking after long-term transplant patients, I didn't feel it was going to be possible to do that to the satisfaction of staff and patients and therefore I elected to stay out of clinical practice.
Q. Thank you. I think during the relevant period you held a number of roles and responsibilities which you've set out in your witness statement but perhaps I can

summarise them in this way.
You were an NHS England board member?
A. Yes.
Q. A member of the National Incident Response Board. You deputised for Lord Stevens the former Chief Executive of NHS England at government meetings. You attended SAGE meetings regularly. And I think you were also the interim Chief Executive Officer of NHS Improvement between 1 August 2021 and 31 July 2022 on which date NHS Improvement was abolished and legally became part the NHS England; is that right?
A. All correct.
Q. You have explained that NHS England is an executive non-departmental public body sponsored by the Department of Health and Social Care but is it correct that that has a degree of autonomy from the Secretary of State?
A. We have a degree of autonomy as what's commonly known as an arm's length body but clearly we work very closely with the Department of Health and Social Care and with the Secretary of State.
Q. And could you please briefly outline for us the role of the NHS England in the NHS system in England.
A. So NHS England is fundamentally a commissioner of services although with the merger of other organisations such as NHS Improvement, NHS Digital, and Health

Education England more recently, it has taken on a wider role, for instance it has some regulatory powers as well.
But fundamentally it's a commissioner and a co-ordinator of healthcare across England and also has an oversight role in ensuring that healthcare services are delivered.
The government gives us a mandate regularly, asking the -- indicating to the NHS what it wishes the NHS to focus on and, for example, each year we will translate that into operational planning guidance which is then provided to NHS organisations.
Q. And is it right to say that NHS England therefore does not provide healthcare services but rather commissions them or oversees commissions?
A. Yes, as I'm sure you know, the NHS is an ecosystem of many, many organisations many of which are their own statutory organisations and, of course, when it comes to primary care and general practice they are independent businesses with whom we have a contractual relationship. So we don't provide those direct services. We provide a few patient-facing services, particularly since NHS Digital has come into NHS England, but that was after the relevant period.
Q. Thank you. Your third witness statement sets out that

NHS England is a Category 1 responder under the Civil Contingencies Act and maintains an emergency preparedness resilience and response plan to enable it to respond to a wide range of incidents and emergencies such as a pandemic. And you've also set out that throughout the relevant period of this module, which is 1 March 2020 to 28 June 2022, NHS England was operating at an NHS incident level 4 or level 3 at different points throughout that relevant period.
Could you please explain to us what level 3 and level 4 meant in operational terms?
A. So level 4 is the point at which NHS England takes a much more direct command and control role within the system. So, for instance, that means much greater oversight of data collection, much greater operational input, much greater control and oversight of supply chains for example, more involvement in issuing guidance through to healthcare providers and healthcare systems, and that is co-ordinated at a national level.
Level 3 you could think of as very similar but the co-ordination is at regional level rather than national level and is most suited to when there are regional variations in the incident or the incidents that are occurring within a single region.
Q. And when we say at regional level, I think it's right

that NHS England has divided England into, I think is it seven different regions?

A. Yes, over the history of NHS England there have been a number of different configurations, but I think from the start of pandemic and currently there are seven NHS England regions.

Q. And can you help us with this. How would NHS England operating at either incident level 3 or 4, how would that affect individual hospital and the clinicians working within them in terms of how they were able to work during the pandemic?

A. So it would mean that we would have a much more co-ordinated and collaborative response. So, clearly, level 4 gives us a greater degree of direction but I think it's also important to say that clearly, that direction occurs through also giving individual organisations a flexibility to respond how they need to respond in terms of their local context, their local geography and local population, that's particularly relevant in a pandemic when infection rates might be different in different parts of the country.

So I would characterise it as bringing the healthcare system much more together as a single entity than you might normally see in normal times.

Q. So there's less local discretion in terms of how, as you

say, infection prevention and control measures might be applied or visiting restrictions?

A. Yes, potentially, although I think it's important to say that we would always want to give local discretion because local circumstances are always different, and there is never one-size-fits-all. No guidance or instruction can perfectly fit into every individual setting.

Clearly, at the height of the pandemic, at waves, then we are likely to be giving guidance that is more uniform and more directional, but at other times it's quite right to give local systems more flexibility to reflect those local contexts -- and I've given one example: when infection rates are different in different parts of the country.

Q. We may come back to that level of local discretion in relation to --

A. Yes.

Q. -- some of the specific topics that we're going to address, if we may.

Can you help us with this. How was your role as national medical director, how did that change during the pandemic? Perhaps you can start with outlining how that role operates in business as usual?

A. Well, as business as usual my role is to advise the

board of NHS England predominantly on clinical and professional matters, but not just that; as part of a collective unitary board, then I obviously have a collective role within the board on all matters that NHS England might need to consider.

I have a particular professional role as a doctor, the most senior doctor within the NHS. I have some statutory roles around professional regulation. There are a number of programmes that I run within my directorate in NHS England, around cardiovascular disease, stroke prevention, diabetes, for instance, that's in normal times. And of course that is useful in a pandemic because that's where that expertise sits.

But during the pandemic, I was much more pulled into, for instance, advice to government and advice to ministers, much more pulled into media and public-facing tasks. You will be aware that I did over 30 Downing Street press briefings, for example, and obviously pulled in to assisting with the overall operational role.

I had a particular role around data and modelling. There was a cell that looked after that, and I was a senior sponsor there.

I was a member of the Senior Clinicians Group which, you will have heard from other witnesses, was

a group of senior doctors and other clinicians that came together across England but then across the four nations.

I was a member of SAGE from late February, as you outlined at the start, SAGE was often meeting twice a week and there was obviously proprietary work to be done and occasional papers to take to SAGE. So the change for the pandemic was much more -- almost exclusively into those pandemic-facing tasks.

Another role I should mention was around working and co-ordinating with our partners and stakeholders, so the Royal Colleges, the BMA, others at charity sector, I would meet with all of those on a much, much more regular frequency and cadence than in normal times. So at times I would be meeting with the Royal College presidents twice a week for a flow of information both ways.

Q. You mention there your role in relation to data and data modelling, and I wondered if we could now come on to NHS England's access to information during the pandemic and how it collected data from the system.

A. Yes.

Q. So if we can go back to the early days of the pandemic, at the beginning of March 2020, when information was emerging from China about the novel coronavirus, when

Italy was experiencing high numbers of severely ill patients with Covid-19. What were NHS England's sources of clinical information on Covid-19 and how it affected patients, and how that was likely to affect the healthcare system of the UK?

A. So we had a number of sources of information in the period between January and coming up to March. So one of those would be through colleagues in Department of Health and Social Care, for instance the Chief Medical Officer and the deputy CMOs; their role is much more internationally-facing than my role and the role of NHS England, for instance, liaising with the World Health Organisation. So that would be one source of information.

We would have -- get information from our national clinical directors and national specialty advisers, so they are senior clinicians who we part employ within NHS England. They also work in their host organisations and they have expertise in areas such as respiratory medicine, critical care, end-of-life care. And, as respected and experienced individuals within their specialties, they will be gathering information from specialty societies, for instance, and from colleagues.

If I can give a personal example. I'm a kidney doctor by background. Throughout the pandemic,

I maintained membership of the International Society of Nephrology, the American Society of Nephrology, the American Transplant Society, so I would on a daily basis be seeing information coming through on emails, on webpages from those specialist organisations. So that played a key role and that information was transmitted to NHS England.

Then, of course, there's the published literature. And papers in the literature started to be published shortly after the pandemic started, so we would be paying attention to those as well.

So there were multiple sources of information. Our job at NHS England was to collect that information and operationalise it. It was not our primary responsibility to be in contact with people overseas, although we did have some contact on occasions; we would much more be sourcing that data from colleagues both in other departments and organisations UKHSA -- sorry, Public Health England would be another that I would mention, and also from clinical colleagues throughout the system.

Q. When you talk about --

LADY HALLETT: Can I ask you to slow down, please.

A. Certainly.

MS NIELD: When you talk about operationalising that

information or that data, how did you or how did NHS England disseminate that evolving clinical knowledge about Covid-19 and how it affected patients and the clinical support that they would require, how was that information disseminated to clinicians working on the frontline?

A. So very early on we had a conversation with NICE around the dissemination of clinical guidance. As an organisation, we do clearly disseminate guidance, but we don't regularly and typically disseminate best practice guidance in the way that NICE has a particular role. But it was clear from the outset that this was going to be a period where it was going to be very important to provide clinical guidance, and therefore we stood up the machinery, the mechanism to do that, and we agreed with NICE that we would essentially lend a hand and take part responsibility for issuing that guidance.

So I think we issued about 67 or so clinical guidance documents, often more operational than best practice, and NICE similarly issued guidance as well.

As wave 1 started to -- as infections came down at the end of wave 1, we handed that particular responsibility back to NICE. But during the first wave we were producing guidance on quite a frequent basis. And if you wish, I can talk about some of the pros and

cons of that approach.

Q. If we can come on to guidance, I think, a little later --

A. Certainly.

Q. -- if we may. You've given an example in your witness statement of how very specific information was cascaded to the system using the central alerting system --

A. Yes.

Q. -- which I think is managed by the MHRA --

A. Correct.

Q. -- the Medicines and Healthcare Products Regulatory Agency, and you give the particular example of using the CAS to alert clinicians to the effectiveness of dexamethasone in June 2020.

A. Yes.

Q. And you explain there that NHS England cannot post alerts directly but has to go through the Chief Medical Officers' office. Do you think it would have been beneficial if NHS England had had direct access to that system?

A. Not particularly, because we work very closely with the Chief Medical Officer and his office, and there's no delay in getting a CAS alert out, so I don't think it would make a great difference. And, of course, CAS alerts are very important particularly in directing very

specific information to the attention of clinicians, but there are a whole range of other ways in which we communicated out information, as I've set out in the statement, so that would be through webinars which we undertook frequently, it would be through letters to healthcare providers and healthcare systems. It would be through bulletins that we stood up increasingly. I had my own medical directors bulletin that went out to medical directors regularly. It would be through those conversations with the Royal Colleges, the BMA, and other important partners. So there wasn't one route of communication, there were multiple routes of communication, all of which had benefit and could be used for different purposes and potentially different audiences.

Q. So some of those channels of communication, and indeed some of those bodies that you have mentioned are England-only?

A. Yes.

Q. And some of them are national bodies, for example, the Royal Colleges. So can you help us with this: was there any means by which this sort of clinical knowledge and evolving understanding about Covid-19, was there any way that that could be shared by NHS England with healthcare systems in the devolved administration?

A. Yes, that would predominantly happen through the Chief Medical Officers who, of course, meet regularly as the four Chief Medical Officers of the four nations of the UK.

But also, as you rightly say, the colleges are UK-wide and the Scottish colleges were members of my webinar as well, they have many English members as well as Scottish members, and on occasions we can talk directly to colleagues in the devolved administrations, but you're quite correct, the focus of NHS England of course is primarily within England.

As a general principle, and I think the Chief Medical Officer may have given this in previous evidence, we would want to align clinically between the four nations as much as possible, and I think from the senior clinicians in those four nations that was the aim. Of course, we have to recognise that they are four different political systems and health is devolved, and therefore there is that context. But as much as possible, we were trying to align clinically.

Q. Thank you. If we can keep with the topic of information but move on slightly to information about the NHS system itself and the data that was collected. Is it right to say that in order to co-ordinate the national response, NHS England needed to greatly increase its data

collection about the capacity of NHS hospitals in terms of bed numbers, occupancy rates, staff availability, medical equipment and so on?

A. Correct, and if I could give some additional context. As you would expect, because of its role, NHS England does regularly collect and publish healthcare data from healthcare systems and healthcare providers. We collect information on the amount of elective care that is undertaken, on performance in A&E departments, you will see that published every month on a regular basis.

Many of those collections have a lag on them, in other words they are collections that are made many days or weeks after the patient episode, and there is good reason for that, because that gives us clarity on the diagnosis on the treatment and the management.

We have some collections, and the urgency and emergency care collection was the collection we had begun a few years earlier that took more realtime data to give us a more realtime understanding of what was going on in the emergency pathways within the NHS, but you will understand that having a lag on data is not optimum in a pandemic where things are changing on a daily and hourly basis and so we had to move to a much more -- to a system that was much more realtime and therefore we developed a sitrep, a specific sitrep which

collected data every day.

In addition to that there were lots of individual data collections for particular purposes which I'm sure we can discuss.

Q. So if we can look at sitreps, please. I think there were several sitreps that were collected on a number of different aspects of the healthcare system and I think, if we can focus on the NHS Provider daily sitreps at this point.

A. Yes.

Q. I think it's right that this changed over time to collect data on different categories, for example of bed types, in order to reflect the understanding of the clinical support that Covid patients in particular were going to require; is that right?

A. Yes, clearly our principle is only collect data if it's going to be useful and operationally useful because we understand the burden of data collection that we place upon organisations and individuals and we can discuss that later if you so wish.

But the data collection evolved over time, it evolved firstly as we learnt more about the virus. That necessitated more collection. Secondly, it evolved as we began to understand the operational challenges and so some of the things that we collected over time,

information on staff absences for example, which obviously would have an operational impact; on nosocomial infection we collected data, specifically on that as well.

Q. It might assist here if we can go to the statement of your colleague Amanda Pritchard, the Chief Executive Officer of NHS England, page 106, because she sets out here a timeline of the evolving changes to the NHS daily Provider sitrep. And so we can see here at (b):

"Between 10 and 16 March 2020, NHS England's existing sitrep reporting was expanded to include the numbers of patients in hospital with Covid-19 and of these how many were in [high dependency unit] or [intensive treatment unit] beds."

Is that the difference between level 2 and level 3 care? Yes. And those figures were shared with the Department for Health and Social Care.

Can we go over the page, please, and we can see at (e) that on 26 March sitreps were expanded to specify the number of patients receiving oxygen, non-invasive and mechanical ventilation and also including reporting from independent sector providers on how many NHS patients were being treated there in critical and non-critical care beds.

Looking at that expanded data on oxygen,

non-invasive and mechanical ventilation, if we can go down to (f) we see that these were then specified as O, O+ and V. So would non-invasive ventilation include CPAP, we have something about?

A. Yes, it would. So non-invasive ventilation is essentially O+ and it would include CPAP. It's where a patient does not require to be intubated, in other words a tube put into their trachea and sedated in order to provide ventilation --

Q. Mechanical ventilation would require --

A. That is mechanical ventilation. Non-invasive ventilation typically is a tight-fitting mask through which oxygen is delivered, typically at a higher pressure.

Q. And oxygenated support, would that be oxygen without a mask?

A. Well, it would be through a mask or through nasal tubing but it would be, what you would routinely see as giving people extra oxygen, so simply increasing the oxygen concentration.

Q. So that wouldn't have to be provided in either an HDU or --

A. So O, simple oxygen can be provided in many settings, it would typically be provided in wards, but it obviously can be provided in high dependency units and critical

care units, level 3 units. Typically, if a patient only required simply oxygen and increase in oxygen concentration that would not be a reason for moving to an HDU or a critical care unit. The patient would need additional support in order to make that escalation.

Q. And so why was it so important to specify the beds or divide them up in this way, O, O+ and V?

A. Because the operational requirements around those different forms of treatment are very different. For patients who are ventilated, clearly those are the sickest patients, they will need a very high input from staff, they will typically need to be managed in critical care facilities although they could be managed in surge areas and increasingly that happened as we provided the equipment and the support to do that.

At the other end of the spectrum, as I've said, simply oxygen through a face mask can be provided on a normal ward, it doesn't require any particular additional equipment other than the mask and, of course, the piping to provide the oxygen, and it doesn't require the sort of intensive staff oversight and monitoring that obviously somebody who is intubated, sedated and has -- is undergoing mechanical ventilation requires.

So it gives us an indication of the necessary deployment of resource and staff and depending on the

proportions of patients in all of those groups, that would have a very different impact on the workforce and on the resources that we had to deploy.

And, indeed, if I give you an additional bit of context, particularly in February, as the risk of the pandemic occurring and coming to the UK was obviously increasing substantially, we undertook a lot of work to try and model and predict what proportion of patients would be in each of those categories, because clearly that was going to have an impact on the services that we needed to provide.

Q. Thank you. If we can go down to point (h), please, here. Sorry, point (j). We see there that in October of 2020 the daily sitrep collection expanded to including reporting breakdowns by reference to ethnic background, more granular age brackets.

We have heard that data collection or data coding on ethnicity in the NHS system is often missing or inadequate and that the grouping of ethnicities tends to be very broad and lacking in granularity. Were there any data collection or coding issues that were apparent when this data collection for the sitreps began?

A. Not that I recall although I'm very happy to check for you, but we did feel it was -- and you are quite correct, there are challenges around collecting

ethnicity data and we are always striving to do better.
Q. Has that changed? Have there been any changes made to the way that ethnicity data is now collected or coded in the NHS system?
A. I think the focus is on collecting the data and filling the gaps rather than necessarily simply changing the underlying coding and collection. But, again, very happy to check and give you further information on that.
Q. Thank you. We can take that down now, thank you.
So the sitrep data was collected by NHS England, it was sent in by individual trusts or hospitals. Is it, then, to some extent relying on the accuracy and the timeliness of those sitrep requests being completed and sent back?
A. Yes, absolutely. And, of course, there are pros and cons of collecting data in essence in realtime. So as I said earlier, in those data collections that take longer to collect, there is an opportunity to validate the data, there's an opportunity to check the data so it is as accurate as possible.
When you are collecting data, as we were in the sitrep that is collected in organisations at 8 o'clock in the morning and is essentially made available across key decision-makers and across the system by lunchtime, the opportunity to verify the data, the opportunity to

check its accuracy is very limited and if you looked in detail at those datasets, that sitrep, you would see from time to time an obvious error where a hospital has entered a number of patients. It is clearly different, vastly different from the day before or the day after, and clearly somebody has entered a wrong number. But the principle was that the benefit of getting that data as quickly as possible outweighed any disbenefit from the occasional error in the data because it was designed to give us a system-wide overview and the small errors that occurred in individual organisations did not impact upon that.
Q. Can we look briefly, please, at that system-wide overview. Can we see one of the -- thank you. This is, I think, a dashboard. This is from collating the daily sitrep data?
A. In fact I believe this data was collected separately from the sitrep, this is data, I think, from the Alpha wave in January 2021, 23 January 2021. And this was data that came direct from critical care units in order to assist with the process of delivering mutual aid to organisations that were running out of capacity.
Q. So that would be if a patient had to be transferred to a critical care unit?
A. Yes, but the principles are the same, in that the data

would be collected in realtime, and of course it would be the same sort of data in terms of bed numbers and patients in beds that would be collected through the sitrep.
Q. Can we have a look then at some of the categories of data. Plainly, 23 January 2021 was a time when the system was under considerable pressure. We see a lot of red on this dashboard, but if we can look in particular at the kind of information that's collected and how that's been presented. We see at the top "Baseline beds". Does that mean the number of beds that were not considered to be surge capacity but the number of beds that we started from?
A. I believe so, but I can't give you the exact information on when that baseline collection was made. But, yes you are right that would be baseline core capacity.
Q. And we see "Beds within ACC"; "adult critical care"?
A. I believe so.
Q. "Surge Beds", so these are over the baseline?
A. These are beds that we would have surged into other areas as part of the surge plan, so that would typically be theatre recovery areas, even theatre spaces, spaces where it is possible to provide critical care but requires an increased effort and they're not designed to do that on a permanent basis.

Q. And we've also heard that means a stretched staffing and nursing ratio as well.
A. Absolutely.
Q. Yes. And then we see "Total Beds", "Beds up in 48 hours", does that mean beds that can be made operational --
A. I believe that would be a prediction of the beds that are likely to become available based on local knowledge of patients who are likely to be discharged from ITU.
Q. We can see, moving down, "Occupancy against Baseline beds", so at this point all the baseline beds are occupied, 100%, and 51.6% above base, 42.4% above beds within adult critical care. So does this mean that 51.6% of the surge capacity was being utilised?
A. Well, I think what it means is that there were 51.6% above baseline. I am not sure that it would give you on this dashboard -- I'd need to do the maths to work out how it relates to the actual surge beds available, but what it clearly shows is that there's pressure, as you would expect at this point in the pandemic when we were at or close to a peak, and that critical care units were operating above their core capacity.
Q. And we can see there "Occupancy against Total Beds" is 90% --
A. Yes, yes --

Q. -- so that tends to suggest that --
A. -- that is a figure that --
Q. -- taking baseline and spread capacity together --
A. Yes, correct, correct.
Q. -- 90% of those total beds were occupied?
A. That is -- yes, correct. That would be the figure for that.
Q. And if we can look quickly at the coloured numbers, pastel-coloured numbers on the right-hand side of this black panel, we can see that Covid suspected, or Covid-positive patients, on invasive ventilation, the numbers are given there. Non-Covid patients on invasive ventilator, Covid-positive or suspected patients on non-invasive, you have explained that would include measures such as CPAP.
A. Yes.
Q. Similarly for non-Covid patients on non-invasive ventilation, and then we have HFNO patients, is that high flow nasal oxygen?
A. I believe so, yes.
Q. And for both Covid and non-Covid patients, and then patients that are on some other form of support.

We can take that down -- one final thing we should probably look at here, if we can scroll down a little bit, please, we can see that there are a number of

hospitals listed there. We don't need to go all the way down because this is a spreadsheet that goes on for a long way, but we can see that the CRITCON score, 3A, 2A, 2B, is recorded there and the nursing ratios, and the total number of patients, and then we can see the declared available beds, 0 or 1 for a lot of those hospitals?
A. And I think this gives you a real insight into the sort of granular data we were collecting and had to collect in order to perform our duty and responsibility under a level 4 incident, and this, as I said at the start of this particular exhibit, was giving our central team, in cooperation with regional teams, the information that they needed to understand which hospitals required the most support, and were either at the point where they needed mutual assistance, in other words, assistance from other hospitals, or were getting close to it.

I mean, clearly, that is the purpose of the CRITCON score; if you heard from other expert witnesses, you will know that CRITCON 3 is a position where people are getting close to the point that they need that mutual aid, and it needs to be considered.

You will see there are no CRITCON 4s there that are at the point at which they have absolutely run out of capacity, and it's a mix of 2 or 3.

Q. Thank you. Perhaps we can take that down now.

In terms of the CRITCON levels, we have -- the Inquiry has heard evidence from Professor Kevin Fong who undertook a peer support programme going into critical care units that were under a great deal of pressure, and he referred to the fact that the data collection forms, at least at first, were very onerous. And he said that it was clear that those units under the most stress provided the poorest data returns, indeed until the point that they became so operationally stressed that they provided no returns at all. So those that you wanted to know the most about were the least likely to return in the first wave. Now, he was speaking CRITCON reporting rather than sitreps, but were there any issues that you were aware of, with those trusts under the most pressure not sending in sitrep data?
A. So every day on the sitrep there was a list of missing trusts where data had not been submitted. I looked at that sitrep every day and the list of missing trusts was usually small, often none, and typically I think less than five.
Q. Thank you.
A. We can provide that detailed analysis, I'm sure, but from the sitrep information, I certainly didn't get the impression that trusts were not submitting data,

although I recognise absolutely, and we recognise at NHS England that this was an onerous task for trusts, and, as ever, it's a balance between getting -- ensuring you're getting the information which of course then benefited those organisations in turn, because that's what it was being used for, but not placing too much of an onerous task on them at a time when they were clearly stretched as Professor Fong had said, and clearly very busy.
Q. Do you have any reflections now, with the benefit of hindsight, on how NHS England could improve data collection on these sort of categories, in the event of a future pandemic where it's going to be important to have accurate realtime data, so that it's possible to get good quality data without overburdening the staff who were providing care?
A. Yes, and I think this is a comment in data collection in general, because we collect a lot of data when we're not in a pandemic, and that data is really important and useful clinical information that guides clinical treatments and improvements in clinical care. So over time I would hope that we could extract that data directly from electronic patient record systems, and therefore it would not require paper entrants or separate systems to enter it on to a computer, as part

of filling in a sitrep spreadsheet.

I think we are making progress toward that, but of course that requires a lot of technical infrastructure, it requires every organisation to have an electronic patient record that could do that, and to capture the information that we would require.

That will be a long journey, but that is the destination that I would like to reach.

Q. Thank you. One final point, please, on data collection.

The Inquiry has heard from Professor Sir Chris Whitty previously who emphasised how important it is to have data on healthcare worker deaths during a pandemic. Am I right that there was a lack of clarity or some disconnect over the way healthcare worker deaths were counted during the pandemic between the Office of National Statistics data and the NHS England records?

A. So we did collect healthcare worker deaths. It was not a trivial task in getting that information and absolutely defining everybody who was a healthcare worker. We put a considerable amount of effort into doing that.

Q. And how was that data obtained? Was it obtained anecdotally from --

A. It would be -- no, it would be obtained from collecting -- we set up a specific reporting system to

report both patient and staff deaths in the first wave. That data is available. I can't give you the exact details, but I would suspect it is different from the way the ONS collates data. ONS typically collates through death certification, for instance. We would be collecting the data directly from organisations.

Q. Perhaps we can have a look. There's a table at your witness statement page 230 -- thank you. I think it goes over the next page. So this is a table of all the NHS England recorded deaths --

A. Yes.

Q. -- of NHS staff. We can see that the total there is 559 people who died during the pandemic from Covid.

And we can see that there's a breakdown there by ethnicity. And I think you've explained in your witness statement that it wasn't easy to record those deaths because there hadn't been a formal system in place previously.

Are you satisfied that there's now a suitable system in place for capturing data on the deaths of healthcare workers and particularly in relation to race and ethnicity data?

A. Well, I think there's a better system in place, and as I've said, we put a lot of effort into standing up this particular collection of data, and it wasn't without its

challenges. I'm sure that there is more that we could do to perfect that, but I think we have learnt a lot from doing this.

Q. Thank you. We can take that down. Thank you.

So moving on from data issues, if we may, can we look at NHS England's role in clinical guidance, both in drafting it and in disseminating it. You mentioned earlier that you took a role that NICE would normally perform at the beginning of the pandemic.

I think you produced both clinical guidelines for the management of Covid-19, and also assisted NICE in developing some specialty guides as well. Can you explain why it is that you took over that role from NICE before handing it back, as it were?

A. Because we recognised that in a healthcare emergency such as a pandemic, with a virus which had previously been unknown, where the evidence base of the impact of the virus was developing rapidly that there was a need to try and inform clinicians of how clinically they might best respond to that, and what best practice looked like, and it goes back to my earlier comments around our role in assimilating the information that we're getting from colleagues, from the published literature, from overseas, and synthesising that both in terms of how to manage a patient but also in terms of

the operational requirements to fulfil that management. If I give you two examples.

So it became clear to us at the start of the first wave that there was -- it was probably better to try and manage patients with non-invasive ventilator than always proceeding to mechanical ventilation. That was information that was coming out of colleagues in Italy and other places that were managing the pandemic, and so we were transmitting that information through to clinicians into the system.

Another example in my own specialty in kidney disease, it wasn't apparent at the start of the pandemic that many of the patients who developed severe Covid would also develop kidney failure, acute kidney failure, which would require dialysis treatment to manage that. That became obvious as we went into March and into April, and therefore we communicated that out to clinicians, we worked with our national clinical director or equivalent for renal medicine, and the renal community, the kidney community, to ensure that we had the stocks in place, the consumables in place, and the ability to deliver acute kidney care which sometimes did require mutual aid as well.

Q. If we can focus on the guidelines particularly that were published by NHS England. You've explained that you had

to adapt or adopt a new process for developing those at pace. Can I ask whether any part of that process of developing guidelines involved any stakeholder consultation or consultation with, for example, disability groups or was there not time to do that in the --

A. As much as possible but, again, this is a recognition of balances. Clearly there are pros in developing guidance quickly particularly, as I have said, in an emerging pandemic where the need to get information out rapidly is paramount but clearly there are also downsides. You can develop guidance too quickly and you can equally develop guidance too slowly. The benefits of doing it over a longer time frame which is typically what NICE do, they take many weeks, is that you are able do that consultation, that verification. So that was compressed.

Q. So is the short answer to that "no"?

A. The short answer is we did what we could but there is a trade-off between getting guidance out rapidly and doing the consultation that you would want do under normal circumstances. It's a set of lousy choices often but you have to make that judgment. Of course, at different times of the pandemic there is an opportunity to take longer over guidance.

Q. But focusing on that early period --

A. On that early phase, particularly when everything, to an extent, was unknown, the need to get guidance out rapidly took precedent over the luxury of being able -- not the luxury, but our desire to ensure that we spent an appropriate amount of time consulting and developing guidance in partnership.

Q. Thank you. Can I ask you this. Were any of the clinical guidelines that were developed by NHS England prior to NICE resuming that role, was there any process by which they were disseminated to or for the benefit of any of the devolved administrations?

A. I cannot recall whether we would have directly sent them as a matter of process, but there was no particular issue in their availability and of course once we had distributed them they would be accessible to anybody who wanted them actually throughout the world. So clearly colleagues in the devolved administrations would have availability to them.

Typically we would not have developed them -- with directly with colleagues in the devolved administrations, although it may well be that clinicians who were developing them might have spoken to colleagues in some examples but as I said at the start, we're in NHS England, we start this from an English perspective

although we did want to do things as collaboratively as possible.

Q. Thank you. If we can move on, please, to a very specific aspect of clinical guidance. I think it's correct that in March 2020 you were involved, together with the four Chief Medical Officers and others in work to commission national clinical prioritisation guidance and specifically to develop a decision-making tool to be used in the event that demand for critical care exceeded capacity. And I think a draft was put together and made available for NHS England to review on 28 March 2020.

Were you made aware that there were clinicians who wanted national guidance on this topic?

A. Yes, at the time and subsequently, and clearly you have heard that from expert witnesses that have given evidence to the Inquiry. I think this was a really difficult issue. I've reflected on it a lot. I'm very happy to discuss it in detail with you.

Q. Can we look, please, at the finalised version, I think, of the draft tool which is INQ00087353, thank you.

We can see that there are three different factors, areas, that are ascribed on this tool a numerical score. So first of all we have age and a number of points given. Greater number of points for older patients. We see the Clinical Frailty Scale and a number of points

given depending on where a person sits on the Clinical Frailty Scale.

And if we can go back, please, to the -- thank you.

And we also see the third box there is comorbidities and certain specific comorbidities are also given a particular score. And then if we can see the final tool, the total is the sum of the three domains above plus taking off one point if the patient is female.

Do you know whether at this point, at the end of March when this tool was being finalised, there were any caveats on the use of the Clinical Frailty Scale in terms of it not being applied to patients with stable long-term disabilities, learning disabilities, autism?

A. So I think separate to this decision tool we were very clear that the Clinical Frailty Scale was not relevant to people with disability alone. Disability -- NICE had issued some guidance earlier in the pandemic, a few weeks earlier which had included the Clinical Frailty Scale. They withdrew that and we wrote out at the time to inform people that it should not be used, it's not appropriate. But in terms of this decision tool, which was never authorised, it was never officially released, I -- it is exactly as you see in

front of you. It didn't go beyond this stage other than the group that developed it subsequently published a version of it in an Intensive Care Society set of principles around decision-making.

Q. I think we'll come on to look at that shortly. I think the impetus for this had come from -- it was the Department of Health and Social Care who had made enquiries to get this tool developed but then I think on 28 March directed that it shouldn't go ahead. What was the reason --

A. So it would be useful if I gave you some context. Clearly this was at a point, in March, where cases of Covid were rapidly increasing. The strategy that the NHS and government had taken was, on the one hand, to put in social distancing messages -- social distancing, in other words lockdown, to reduce the rate of transmission and within the NHS our job was to surge capacity. But at that point in March the number of patients with Covid in ITU beds was doubling every five to seven days. We couldn't see, because there was no community testing at the time, what was likely to come ahead. It was not clear whether the public would respond to lockdown. They did wonderfully but that was not clear.

Frankly, I was personally terrified, terrified

that the NHS was going to be overwhelmed and doctors were going to be placed in a position, and other clinicians, where they would not be able to make the professional judgment that they usually make in terms of treatments and escalation. And in those circumstances, as I had said to the Health Select Committee earlier in March, we and -- I and my clinical colleagues, the CMOs, felt that we should begin to explore a decision tool such as this.

Q. If I can stop you there because I think we understand the context in which this was being discussed. What I would like to know is the context in which it was halted.

A. So it was halted, I think, because a number of us, the Chief Medical Officer, myself, with input from the Chief Executive of NHS England came to the conclusion that it should not be released. For me, and I have said this in the statement, the main reason was at this point when it had got to this form, it was becoming increasingly clear to me that the peak of the pandemic was approaching and therefore it would not be needed because we would not breach capacity.

This, as you've heard, is a CRITCON 4 situation and it became very apparent to me that it was not going to be needed and I had a fear that if it was released it

might be used when it would not need to be used.

Q. Was there not also a great deal of concern within the Department of Health and Social Care that this tool was going to be very controversial and risk a poor reaction from the public?

A. Yes, and I had that concern too and it goes back to the discussion we have just had about developing guidance rapidly and the inability to consult and the inability to take in a broader set of views.

Now, this is not a criticism of the group of clinicians who worked on this, they did a magnificent job, they were asked to do something that nobody ever wants to do, is develop this sort of tool, and they had to do it rapidly, but it became absolutely clear to me that this was going to be controversial, that it hadn't had the opportunity to be discussed more widely with patient groups, with the public, and so my recommendation to the Inquiry is that we should absolutely in future not try and develop one of these tools in the midst of a pandemic. This is a discussion that has to occur in normal times.

In my view it's a discussion that shouldn't be government led, it shouldn't even be led by the profession, it needs to be located within society. I think that is similar to what you have heard from

other expert witnesses, Dr Suntharalingam and Professor Summers, I think made a similar point. This is too hard a task to do at the height of a pandemic.

LADY HALLETT: Can I just ask -- sorry to interrupt -- it probably doesn't take us very far in the course of the Inquiry but I'm just fascinated. Looking at number 1 of the Clinical Frailty Scale, you add a point for someone who is very fit? I'm just not sure. How does that work?

A. So I think you are pointing out the difficulties in this scale. And again, without any criticism of those who developed it because they did a fantastic job in getting this far, you can see, if you go back to the tool, that greater than 8 is a cut-off point between escalation. You can arrive at that adding somebody who is 80 to somebody who is well and has hypertension, high blood pressure.

So it is a useful aid and in a sense it reflects what clinicians do, which is they never take age into consideration alone, they always take into consideration other conditions, whether the patient is frail, that holistic approach, but to try and simplify it into a scale I think takes away all the nuances and complexities that come out from the care and interactions between a professional clinician and

a patient.

And I think that goes to the heart of the debate because I did hear, and I continue to hear and it was in evidence that you have heard, that doctors, if we did get to -- or clinicians, if we did get to CRITCON 4, would be uncomfortable around making those very difficult prioritisation decisions without some sort of framework, some sort of authority from government.

On the other hand, at the opposite end of that spectrum is the view that the last thing we want to do is to take away that judgment and that knowledge in those decision-makers from individual decision-makers. It becomes too simplistic. We will get on to DNACPR, I'm sure, and there might have been inappropriate use of DNACPR. There is a danger that there might be inappropriate use of a simple tool that takes away from that professional judgment and professional relationship.

So this is a very difficult area where there are, in a sense, contradictory and competing views that are hard to reconcile but it does, in my view, require a debate in society if it is going to be taken further rather than a debate within the profession or a debate within government.

MS NIELD: Do you think there's an element in which the

halting of this tool at that particular time, because of concerns about how it was going to land, and we can go to the emails within the Department of Health and Social Care if that's necessary, but do you think there's an element to which broader political concerns about public reaction perhaps trumped or overrode clinicians' legitimate concerns about being put in an impossible position, and do you think that was the correct balance to strike to give a certain primacy to the anticipated public reaction rather than the concerns and views of frontline clinicians?

A. Well, fortunately we didn't need it because, as I said, we were reaching the peak of the pandemic so in a sense we didn't have to have that debate, very difficult debate. I think -- as I've outlined, I think there is a range of legitimate views here. Another view which you could have on this is it's a form of government-imposed rationing if it's taken forward, if it comes from the government. So I think this is a really difficult area. I've reflected on it a lot --

Q. Do you think the balance was right?

A. I think it was right to stand it down, I think it was right to stand it down because we didn't need it and it could have been used inappropriately.

Q. Can I bring you back on that because at that point, as

you say, you've reached the peak of wave 1 but it was also, wasn't it, foremost in everyone's minds there was quite likely to be a second wave and it may be worse in wave 2, so it may be there was going to come a point in the relatively near future where critical care may be overwhelmed?

A. So I have reflected on that as well. And the first point I'd make is the authors or the group who undertook the work, as I've said, subsequently published it in a set of principles and I thought that was actually a good position to reach for the pandemic. It included a version of this but without the scoring and it focused much more on the principles of how you would make those decisions.

I thought that was a good point to reach in the Covid-19 pandemic --

Q. Did you think it was preferable, then, if I can just pick up on that. Did you think this was preferable without the numerical scoring?

A. I still think there are difficulties in using a tool even without the scoring but I think we reached a reasonable position in the Intensive Care Society publishing a set of principles around this and how CRITCON is used.

Between waves we were still in a pandemic and

I still think that to do this sort of thing, if it does need to be done, require -- it is one of those things that I think would require months of consideration and not in the midst of a pandemic.

Q. In terms of removing the numerical score, because we know that's, I think, the Intensive Care Society tool that was published and was published in Wales, as well as in England, remove the numbers, does that also bring with it a risk that this is going to be interpreted or applied in an inconsistent way in the sense that if a numerical score isn't given to each one of these, one clinician might see -- might accord greater significance to age alone, or might accord greater significance to the Clinical Frailty Scale score or, indeed, a comorbidity? So isn't there a risk of inconsistent decisions being made if you don't have a numerical scoring system?

A. Those are all potential risks but I think what we are highlighting in this discussion is the difficulties of this sort of tool and which is why I think it requires further discussion and that discussion needs to be a broader discussion and needs to be done at a time when we are not in the middle of an emergency.

Q. And with the tool that was eventually published by the ICS, do you know to what extent that adapted version of

this tool was utilised in intensive care units in England?
A. I can't give you information on that, the Intensive Care Society might need to. I think within that guidance, which of course is Intensive Care Society guidance, it's not NHS England guidance, so in a sense it's come from a professional society rather than a government agency I think the emphasis was an awful lot more on the principles of managing patients and escalation in a pandemic rather than necessarily simply the use of a tool.
Q. Do you consider that at times when ICUs were under pressure and anticipating an imminent surge in demand, so not all their beds are necessarily full yet, but is it possible that a sort of preemptive rationing could come into play? So decisions being made about which patients to admit to intensive care, to avoid the situation where all the beds are already full, and then the peak of the wave hits?
A. That would be the wrong way around in my view because the CRITCON system and the principles behind it are that clinicians should continue to make the usual judgements that they make and, of course, those judgments flex according to the circumstance. I know that from my time as a clinician. But, in essence, the object is to

ensure that clinicians continue to make the usual decisions that they would make outside of a pandemic until the point at which you are at CRITCON 4 which fortunately we never reached as a system.
Q. Can we move on, please. You mentioned briefly DNACPRs --
A. Yes.
Q. -- and I wonder if we might move to that topic now, and the role of NHS England in publishing guidance around DNACPRs during the pandemic.

I think you've set out in your third witness statement that prior to the pandemic, as a result of the 2019 Learning Disability Mortality Review which found that in some of the cases, the DNACPR notices that they reviewed -- which would have been put in place in 2018 -- learning disabilities had frequently been cited as a reason for a DNACPR notice being placed on a patient's files.

And as a response to those findings, NHS England in 2019 issued communications to the system to make it clear that DNACPRs applied generically to patients with long-term conditions such as learning disabilities are entirely inappropriate; is that correct?
A. That's absolutely correct. I wouldn't necessarily say it was frequently, I'd need to look at the detail of the

report, but it was -- there were sufficient numbers for us to become concerned, and therefore necessitate writing to remind people that this was completely inappropriate.
Q. And that might sometimes be referred to as a "blanket DNACPR decision", so a decision made on an inappropriate basis. And the Inquiry has heard evidence of a number of concerns particularly of some of the core participants to this module that blanket DNACPR decisions were being made in healthcare settings. Were any concerns of that nature brought to the attention of NHS England during the pandemic? I'm talking about outside of media reports, but specific instances.
A. Yes, we heard this through a variety of sources and I think I've outlined in the statement at the end of March and early April, and we took immediate action. We wrote out and communicated on a number of occasions during the pandemic to state that the use of blanket DNACPRs is completely inappropriate.
Q. You mentioned earlier that the NICE guidance -- if we can get up, please, the letter that you issued on 3 April, which makes some reference to the NICE guidance. It's INQ000216427. So explain there that you're writing to colleagues:

"... to ensure that there is clarity in relation

to the use of the Clinical Frailty Scale ... and the use of ... (DNACPR) with younger patients ... with a stable long-term physical need, learning disability or autism."

And there's reference to your letter of May 2019, which we've already heard about, that:

"... 'learning disability' and 'Down's syndrome' should never be a reason for issuing a DNACPR order or be used to describing the underlying, or only, cause of death. ... Learning disabilities are not fatal conditions."

And there's then reference to the NICE guidance rapid guidance on admission to hospital and to critical care, and the guidance made reference to assessments using the Clinical Frailty Scale.

"The guidelines were amended on the 25th March to make clear that:

'The [Clinical Frailty Scale] should not be used in younger people ... [and those] with long-term disabilities ... learning disability or autism. ...'"

So were there concerns at that point that the guideline, before it had been amended, may have misled clinicians to assume that the Clinical Frailty Scale might also be applicable to younger people when they making DNACPR decisions? Was that the risk --
A. Clearly, that was the risk that we wished to address

with this letter, I think this was a letter written by my colleagues referencing my original letter which, to be clear, the original 2019 letter was in response to both learning disabilities being used as a reason for DNACPR orders, but also being placed on death certificates as a primary cause of death, both of which are not acceptable.

But yes, that was the risk we were addressing, that that guidance might be used inappropriately.

And of course, going back to our early discussions, I think -- and again this was NICE guidance so I don't know the detail, but I suspect that if there had been a longer time to produce this guidance and more -- the ability to have more consultation and more scrutiny, this would have been picked up.

So, again, it's back to that, you know, the benefits of rapid guidance, but also there are some disbenefits and some risks in producing rapid guidance.

Q. Can I ask you briefly, after this letter was sent on 3 April I think you wrote again on 7 April in relation to blanket DNACPRs being inappropriate on the basis of simply a medical condition, a disability, or age.

After those two letters had been sent out on 3 and 7 April, did NHS England at that point undertake any sort of follow-up to establish whether that guidance was

being appropriately implemented?

A. Not that I recall at the time. You will know that the CQC were commissioned to undertake a report on this, and I don't believe that this was in widespread use, but there were enough anecdotes and information coming to us through a variety of channels that we felt it was important to address, and we did so again, on a number of occasions, to emphasise that this approach was inappropriate, and also if we heard that there was anecdotal information.

But I think this was an issue mainly at the very start of wave 1, around March and April. As I say, I don't believe it was widespread, I think the CQC report reflected that, but clearly we had heard enough examples for it to be concerning.

MS NIELD: My Lady, I don't know if that might be an appropriate time to break for lunch.

LADY HALLETT: Yes, certainly.

I hope you were warned to not only that you would be -- the whole of this afternoon but have to come back on Monday. I hope that is going to be all right for you.

THE WITNESS: I think it will be fine.

LADY HALLETT: I'm really grateful.

Very well. I shall return at 1.50.

(12.52 pm)

(The short adjournment)

(1.50 pm)

LADY HALLETT: Ms Nield.

MS NIELD: My Lady.

Professor Powis, on the subject of DNACPRs, I think there were two further communications with the system. On 11 May 2020, a primary care bulletin reiterated the importance of appropriate DNACPRs and not imposing them in or drafting them in inappropriate circumstances, and then again on 4 March 2021. Were there any particular triggers for these repeated notices to the system?

A. I can't recall that there were. I'm very happy to provide you with information if there was. As I said earlier, I think this was predominantly brought to our attention at the very start of wave 1 at the end of March and early April 2020.

Q. In terms of some steps that were taken by NHS England in relation to this issue, I think you explain in your witness statement that on 4 September 2020, the guidance, the quality outcomes framework for GPs was amended. They were asked to restore proactive annual health checks for people with learning disabilities and autism, and to review all DNACPR decisions and confirm

that they were determined appropriately and continued to be clinically indicated.

Can I ask you this: was it intended that general practitioners, in conducting that sort of review of their patients' notes, should report any inappropriate DNACPRs to NHS England, and were NHS England notified of the outcomes of any such reviews?

A. Not that I'm aware, and I think it was -- so QOF is an incentive scheme for general practitioners where they have additional incentives, financial incentives, to target particular areas of work. In fact, that work would have been disrupted, and I'm not confident it was fully implemented, because in the following period, once again we had to suspend QOF to redeploy general practitioners, so the QOF system was not operating as it normally would outside of pandemic times because of the requirements at times to release general practitioners to assist in other activities such as the vaccination programme.

Q. Can I ask you this, normally if it was part of the QOF framework to review patients' notes in terms of monitoring diabetic patients or medication or anything else, would it normally be the case that that sort of patient record review would result in a notification to NHS England, was it usually reported on or was it more

of an internal process?
A. It depends a little bit on the QOF indicator. So we would have information on which practices had undertaken the particular QOF indicator or the response to it, and if that QOF indicator required the generation of data, then there may be ways that we could collect that data, so for instance, a QOF indicator incentivising measuring -- monitoring blood pressure, identifying new cases of high blood pressure, we would be able to get the data in terms of how many patients had their blood pressure identified or treated to optimum standards.
Q. But so far as you are aware in relation to this DNACPR -- *(Unclear: multiple speakers)* --
A. No, and --
Q. -- it doesn't appear that that data was -- *(Unclear: multiple speakers)* --
A. No, and because of the operational disruption as to whether it actually got as far as being a QOF that was used in practice. But very happy to provide further information.
Q. Thank you. Related matter. You explain in your witness statement that I think in response to the recommendations of the Care Quality Commission report which you've referred to earlier, which was published in March 2021, I think that's right, NHS England

developed an advance care planning document; is that correct?
Would it be right to say that the document that was developed there, I think it was called the Universal Principles for Advance Care Planning, was a broad statement of principles to be applied rather than a document to record those conversations between patients and clinicians? Would that be correct?
A. Correct.
Q. So not analogous to the ReSPECT form which the Inquiry have heard something about?
A. The ReSPECT form would be one implication of those six principles.
Q. Did you consider that the ReSPECT form, in its current form, could comply with those universal principles for -- (*Unclear: multiple speakers)* --
A. Yes, I'm sure it would. As part of the production of that document, my understanding is there were discussion -- well, there were discussions subsequent to that document as to whether we should have a single form or a single process, and the view of NHS England colleagues at the time was that the overriding priority was to have the six principles embedded rather than mandating that a particular tool or a particular form or a particular process should be used.

As you know, the ReSPECT form is used in many parts of the country but there are other processes in place in order to apply those principles, and our view, as I've discussed with you earlier, is that we do like to allow local flexibility so that local healthcare systems can determine what is best for their populations and patients.
Q. The Resuscitation Council UK who developed that ReSPECT form made a recommendation to the Inquiry that it would be better for reasons of consistency, and for other reasons, for other practical reasons, if there was a uniform, universal form of documentation to record patients' wishes, advanced care plans, including DNACPR wishes, that should be applied across all four nations of the UK, whether that be the ReSPECT form or a different form.
What are your views on that recommendation on the utility and benefits of having a uniform single document across the UK?
A. So I can certainly see the value of that approach, and I read the evidence from the Resuscitation Council. As I said, when it was discussed at NHS England our view was that it was the principles that were important and not necessarily having a standardised form that is currently the position but I absolutely see that there

is some merit in standardisation.
Q. So on a related note, if we can move on, please, to palliative care and end-of-life care --
A. Yes.
Q. -- in hospital for Covid-19 patients. In your third witness statement you said:
"As the pandemic developed, NHS England was not aware of a system issue with capacity for end of life hospital care and provision was available to those who wanted and needed it."
You have been provided with the witness statement of the president of the Association of Palliative Medicine, that's Dr Sara Cox, I don't think we need to get that witness statement up, but it's INQ000257329. Dr Cox has noted in her witness statement five main issues that she has identified in relation to palliative care during the pandemic, and perhaps I can summarise them in this way before I invite you to comment on those.
First of all, she says that there were not enough palliative care specialists to see everyone who was affected and concludes that that will have resulted in gaps in care for some.
That there was unclear, conflicting, and constantly changing guidance on visiting restrictions,

which made the situation difficult for families and loved ones.

That the relatives of patients from ethnic minority communities were disproportionately impacted by those restrictive visiting practices because they were unable to fulfil religious and culturally prescribed responsibilities around the end of life and death.

And there were communication challenges for families who did not have English as their first language because of the limited availability of telephone interpreters and the restrictions on visiting.

And she says that all of those factors together resulted in a degree of psychological trauma for staff involved in palliative care.

I'd like to ask whether you accept those points made by Dr Cox, and whether NHS England was made aware of those problems in palliative care at the time.

A. Yes, so I, with the caveat that I will come to in a minute, I think we would accept that the palliative care service and palliative care teams were under significant pressure, as were many other members of staff particularly during the peaks of the pandemic, they were having to treat many more or care for many more patients. The settings in which they had to do that were more difficult, and indeed this was

undoubtedly one of the most traumatic parts for staff and of course for patients and relatives of all of the pandemic, and I don't underestimate how difficult it was. And I'd like to obviously pay tribute to our palliative care teams, both specialists and generalists because I think they did a fantastic job with the really difficult circumstances, having to support staff in adapting to the way in which end-of-life care could be managed, but, you know, it is correct that they were stretched, as you have seen in Dr Cox's statement.

The one issue that I might caveat a bit, and we may come to this, is on visitor guidance, which goes back to the discussion that we've had on the pros and cons of issuing guidance.

We did issue visitor guidance. In fact, we had not got national visitor guidance prior to the pandemic, and that went through, I think, three iterations in wave 1 at least. The principle was to try and make it more flexible as we progressed, as we learnt more about the virus, and certainly later on in the pandemic, as testing became more available, as PPE more available, as treatments more available, then the direction of travel was clearly to try and relax those, the guidance.

Clearly the guidance is a balance between the risks of nosocomial infection prevention and spread, and

allowing people to visit.

And, of course, as I've said earlier, the principle is to try and give flexibility to local organisations, I think you heard from Professor Ball some of the flexibilities that they applied in Birmingham because no estate is the same, no staff are the same in terms of the number of staff and the configuration and skills of staff. So you do have to allow that flexibility for local leaders to apply these -- the guidance as best possible in their circumstances.

Q. Coming back specifically to end-of-life and palliative care, and we're going to deal -- we'll come on next, if we may, to visiting restrictions which obviously were not only in place in relation to palliative care patients.

A. No.

Q. But in terms of some of the issues that are brought out by Dr Cox, aside from just those visiting restrictions, do you think that there's an extent to which it is inevitable in a pandemic that there is going to be an impact and a greater demand on the palliative care service, and do you think that NHS England could have done more or would in a future pandemic do things differently in relation to making provision for those

inevitable changes and impacts upon the palliative care service?

A. Well, this comes to the resilience point that we may talk about later. So, clearly, the more staff we have, the better, and we are understaffed within the NHS in many of the professional specialty areas compared to our OECD comparators. That is why the long-term workforce plan that was published 18 months ago by the previous government is so important for us because it will allow us to build up resilience in all disciplines and all professions, so there is no doubt we would want to be more resilient in palliative care as we would in other areas, intensive care would be a good example, as we go forward.

But even with that resilience, in a pandemic where you have to, by necessity as you've indicated, surge and stretch beyond your normal capacity, I don't think we can ever fully mitigate the challenges that people are faced with and of course that will depend upon a virus, a virus that predominantly affected children, for instance, would bring with it a whole different set of challenges.

So I think we will prepare as well as we can. We should be more resilient but we also have to be able to adapt and flex to the exact nature of the issue that

we're dealing with.

Q. Thank you. Can we move on then, please, to the role of NHS England in visiting restrictions for hospital visiting. And I think you referred briefly perhaps to the role that NHS England played. I think it's right that initially between 25 March 2020 and 6 June of that year there was national, a national visiting policy, national visiting restrictions that were published by NHS England.

I think if we can go to your third witness statement, page 179, at paragraph 685, you summarise in the final sentence what was permitted under that national policy:

"The rules explained that visiting would be limited to ... one visitor per patient, apart from in the case of a child (where both parents could visit), when a patient was receiving end-of-life care, when a partner and birthing partner were accompanying a woman in labour, or if the visitor required another person to assist them."

And if we could go on, please, to paragraph 686, you then explain that the visiting -- the only circumstances where visiting was permitted from 25 March was for one immediate family member to visit when a patient was either a child or receiving end-of-life

care or a woman in labour. And:

"The rules advised on making greater use of phone and video calls to stay in touch with loved ones."

There was then a revision to the guidance on 9 April to include an additional circumstance where visiting would be permitted to support someone with a mental health issue such as dementia, a learning disability or autism where not being present would cause the patient to be distressed.

We can take that down now, thank you.

Do you think it was an error in the initial guidance when it was published on 25 March not to have permitted expressly visiting for people with dementia, learning disabilities or autism, not to have included that exception in the initial guidance?

A. Well, I can make a few points on this. Firstly, as I think I've said already, this was new territory for us, we had not got national visitor guidance in place before so it was not something that we had national experience at. Visitor guidance has always been local. And so there was inevitably a learning curve for us in terms of providing guidance.

So, on reflection, I think it is possible that we should have done -- made that clearer earlier.

I give you another example which we clarified in

later iterations of the guidance, I think in May, was whether chaplains, faith leaders, whether carers should be included as members of the healthcare family or as visitors. And our view was that they should be included as, in essence, as part of the healthcare family and not counted as a visitor. We clarified that later. But that was I think part of our learning process in producing guidance in an area that we had not previously had experience.

But as I've said, the principles were that we wanted, and I acknowledge this was one of the toughest areas of the pandemic and it was another area of difficult choices and the pain it gave to staff and public, I fully recognise, we fully recognise as NHS England, getting that balance right was really difficult. But we wanted to be as flexible as we could and increasingly flexible as we learnt more, as we were able to put in more measures to protect staff, to protect patients and visitors.

And there were areas such as end-of-life care and birthing and labour, in particular, where we, from the outset, were clear that we wanted to make exceptionality.

But I think you have raised a good point and I think as part of our reflective process, then, that is

something that we would think about.

Q. I think it's right that on 5 June 2020, NHS England then published revised guidance on visiting which set out the guiding principles but granted discretion to local NHS trusts to formulate their own policies.

A. Yes.

Q. And can we have a look briefly, please, at that guidance. Thank you.

This is "Visiting healthcare inpatient settings during the COVID-19 pandemic". It explains that this replaces the previous visitor guidance that was the national policy.

"The national suspension on visiting imposed under that guidance is now lifted. Visiting shall instead be subject to local discretion by trusts and other NHS bodies ...

"This guidance provides advice on how NHS organisations may choose to facilitate visiting across healthcare inpatient settings ..."

And if we can go further down, please.

There are some practical considerations that are set out there. And principally:

"The number of visitors at the bedside is limited to one close family contact or somebody important to the patient ... where it is possible to maintain social

distancing throughout the visit, a second additional visitor could be permitted in circumstances including partners of women in labour and a family member for individuals receiving end-of-life care."

We can take that down. Thank you.

Some of the Inquiry's core participants have reported that there was significant variability of approach to visiting in 2020 following the granting of that discretion to trusts and, in particular, that some families who were carers for their loved ones were not able to visit because it was interpreted so strictly that even where they were carers the local discretion was that they should not be able to visit.

Was that something that NHS England was aware of at the time, this level of local variability, sometimes really in contradiction of the guiding principles?

A. So we were certainly aware of the variation. And as I've said, giving local systems discretion is important because their local circumstances change, not least if the prevalence of the virus is particularly high in one community but not in another it would be reasonable to have a different approach to visitor guidance. And, of course, that guidance was issued as we were coming out of the first wave and the prevalence in the community was lower.

As we went into a second wave, again local leaders had to begin to make decisions as to how in their particular context they would have to apply that flexibility.

And I fully acknowledge that that would lead to variation and from the public and patients' perspective that would look odd, bizarre, that in one setting this was allowed; in another setting that something else was allowed.

But it did reflect the requirement to enable those local leaders to look at their estate, to look at their particular circumstances, to look at their staff mix, and say, actually, at this particular point we think this needs to be in place, whereas in another point something else needs to be in place.

It's a balance, isn't it, between the one-size-fits-all approach which has its disadvantages, as I said earlier, and allowing that flexibility which brings with it a criticism that you get the variability. That balance changes according to where you are in the pandemic, it changes according to where you are in the country, so I think it's right that we give local flexibility. I would expect local leaders to use it and use it wisely and, of course, we would expect them to do it within the principles.

Q. Can we have a look, please, particularly at the restrictions on visitors and supporters for women who were accessing maternity services --

A. Yes.

Q. -- during the pandemic. I think it's right that the initial guidance that was in place classed a birthing partner or the partner of a woman in labour as a visitor rather than an essential support partner or partner in care.

A. Yes.

Q. I think it was on 14 December 2020 that the guidance published by NHS England on visiting in maternity services defined co-parents, if I can put it in that way, as partners in care rather than visitors and drew a distinction between visitors to whom restrictions may apply and support partners in maternity services, and I'd like to ask again, do you consider that it was an error in the initial guidance not to define birthing partners and co-parents?

A. So our reflection, I think, would be that we could have been clearer, and I think this is a lesson for next time, if there is a next time, in making those distinctions as to who is part of the healthcare support team if you wish, faith leaders, carers, birthing partners, and who is a visitor. And I think you saw

that in the guidance as we iterated it, but I absolutely agree that one of the reflections that we would have coming out is to do that sooner and be clearer.

Q. That was looking at -- we've already heard about the partner of a woman in labour. In terms of how visiting restrictions in maternity services might apply to people accompanying a woman to an antenatal appointment or a scan, you have referred again in your third witness statement to efforts to produce guidance together with the Royal College of Obstetricians and Gynaecologists and also the Royal College of Midwives, and there was a framework to support visiting and maternity services jointly published I think on 8 September 2020 by those two organisations, NHS England and also the Society and College of Radiographers -- I think that's right -- and that guidance enabled partners to also attend antenatal and postnatal appointments. And I think that guidance was developed by those stakeholder organisations, who then asked NHS England to badge it, effectively, and to disseminate that framework.

You've been provided with emails -- I don't think we need to get to them now -- between NHS England and Jo Tanner from the Royal College of Midwives -- a month before that framework was published in August, where there was some concern and frustrations being expressed

by the Royal College of Midwives that the guidance has been drafted and it's been sitting for some time with NHS England. What was the reason for the delay in NHS England signing off that guidance?

A. Because we have an approvals process to go through, and as we discussed earlier, you can rush out guidance too quickly and it doesn't go through the appropriate scrutiny. We discussed that in terms of the NICE guidance in clinical frailty, so it is right that there is a process of approvals and scrutiny, and at that stage in the pandemic, to an extent, where we were not at a peak, that approvals process didn't need to go quite as quickly as it did at the start.

So that is an important set of balances, but I would agree that on that particular occasion, I think we could have been quicker.

Q. Thank you. So looking at the balance that you've referred to in terms of visitor restrictions, and the competing concerns that have to be weighed, so far as you are aware, was there any clear data or is there now any clear data on the extent to which visitors were contributing to nosocomial transmission rates in hospitals?

A. So there's a fair amount of information on nosocomial transmission rates, and as you would work out, I guess,

from first principles, that there is patient-to-patient transmission, and I think the evidence is that that was probably the predominant route of transmission. There is staff-to-staff transmission, staff-to-patient, patient-to-staff and of course hospitals, by their very nature, are areas where there will be a higher volume of virus because they are treating people with Covid or people with Covid are coming to hospitals. So I can't recollect if we have specific data on visitor-to-visitor or visitor-to-staff data, but clearly the risk of transmission occurring between any group in a hospital environment is going to be higher than it would be in a setting, particularly when there are lockdown measures in place.

Q. Can I ask you this: do you think more emphasis on other infection prevention and control measures for visitors, such as testing visitors, social distancing, mandating face coverings for visitors, could have substantially mitigated that risk rather than taking a very restrictive approach to visiting per se?

A. Yes, and they did, but of course, in March, some of those things were not in place.

So we had no testing capacity to do that in March, and when testing capacity came onstream, and obviously visitors would be able to self-test at home and know

whether they had Covid or not, then clearly that is a benefit. And I think the move away from a national mandated set of guidance to more local flexibility, as I think I've stated already, in part reflected that those changes that were coming onstream, the move to universal masking in various settings in the late spring, I think it was June 2020, again, all of these things absolutely would help mitigate that.

But right at the very start, when a lot of that was not available or in place, and of course when knowledge of the virus was at a comparatively early stage, the right thing I think to do was to say at this point we have to be firmer and we have to be more restrictive.

But the principle always was to be less restrictive and more flexible as we learnt more about the virus, as other mitigations came into place.

Q. We've touched there on nosocomial infection rates, and could we move on to look at NHS England's role in monitoring and responding to nosocomial infections in England.

I think NHSE had established its own nosocomial infections programme; was that in existence prior to the pandemic?

A. Not in that form. Nosocomial infection, which is spread

of infection within hospital, within healthcare settings more generally, is, of course, something that happens outside of pandemics. We're getting to winter at the moment and norovirus, which circulates in the winter, is a good example of where spread can occur in hospitals. So hospital teams are well used to, through the IPC measures, to deal with nosocomial infection, and to try and prevent it. So that experience was in place. But we didn't have a dedicated team around Covid in particular. That was set up actually as a subgroup of SAGE initially, the HOCI group, which you've probably heard about, and then within a fairly short period of time came in with the governance structures of NHS England, and the nosocomial programme essentially was over seen by HOCI, and was part of the same programme of work.

So we recognised, very early on, at the end of March, that nosocomial infection was a problem, it was highly likely to be a problem, was with something as infectious as Covid-19 and we very rapidly put in the oversight mechanisms to design approaches to try and reduce it, and also to support individual trusts in their approaches to reduce nosocomial infection.

Q. What did the nosocomial infections programme identify as the main factors driving hospital-acquired Covid?

A. Well, the absolutely main factor was the prevalence in the community which, in a sense, might seem obvious, but it was the case that the more infection that there was in the community, that was a time at which we saw the most nosocomial infection in hospitals.

Q. But how was it particularly spreading once it got into the hospital?

A. Well, as I've said, I think the evidence is it could be spread through a variety of routes. A lot of spread was patient-to-patient, but it could also be staff-to-staff, and of course staff meet together in lots of environments. It's not possible, when you're working, to separate completely even with social distancing rules in place. So staff-to-staff could be a problem. We've talked about visitor-to-staff. So every possibility you can think of. And of course there were mitigations for all of those, but you will never, in my view, be able to completely mitigate nosocomial infection.

Of course, the other thing to say in this context is the nature of the hospital estate is really important. So many of our hospitals are older and they have more open wards and few single rooms. I have said in public that I think, and I think here as a recommendation for the Inquiry, that future hospitals should be predominantly single rooms. There are

a number of reasons for that but one of those is around infection prevention and control. That is the case among other countries around the world.

Ventilation is important. There is a whole host of things in terms of our estate that will reduce the risk of nosocomial infection.

Q. Is it right that testing of both patients and staff was also identified as a key measure?

A. Sorry, I missed the start.

Q. Is it right that testing --

A. Yes, correct.

Q. -- patients and staff was identified as a key measure?

A. Yes, it is correct, and when testing became available in more, in higher quantities, we first introduced testing of all patients in hospital at various points as a way of identifying patients who had got nosocomial infection who may not have come in or -- and then brought -- possibly come in with an infection from the community. I think later on we introduced staff testing on a regular basis, once we had the capacity.

Q. If I can introduce, I think this is right in terms of the timings, I think it was in June 2020 that a policy of testing all emergency admissions was introduced, and then testing all -- and also testing all inpatients on day 3 of their admission was introduced on

17 November 2020, so if those patients may have developed Covid whilst they were in hospital?

A. Yes. So that's correct. So of course we had to determine how often to test in hospital and so colleagues at Public Health England helped with us that sort of modelling and we iterated our thoughts on that as to the most effective time after a patient had been admitted to test, so that was the evolution of that approach, and also of course testing was becoming more available as we went through into the latter months of 2020.

Q. I think regular testing of asymptomatic staff was introduced at the time of greater availability of lateral flow devices in early November 2020, is that right?

A. That's correct, and indeed that was a game changer, if I can use the term "game changer", because it was the availability of lateral flow tests in volume that allowed to us have the quantity of testing that we would need to test all NHS staff.

Q. Notwithstanding the various measures that were taken, you've identified that in summer of 2021, probable or definite hospital onset cases averaged 10% of all hospital Covid-19 admissions in England. So does that mean that 10% of all patients in hospital with Covid at

that point had acquired that infection in hospital?

A. Yes, correct.

Q. And you've also noted that nosocomial transmission increased notably with the more transmissible variants. Could we have a look, please, at paragraph 464 of your third witness statement, page 127. Thank you. You explain that:

"[The] rate increased with the emergence of the more transmissible Omicron variant ... In the first months of 2022, the [percentage] rate of probable and definite nosocomial infections increased to between 25% [to] 35%. This was due to a combination of Omicron's increased transmissibility, its vaccine and immune escape properties, and greater numbers of non-Covid-19 patients in hospitals allowing more infection transmission opportunities for the virus."

And if we can go on, please, to paragraph 465.

"... Omicron's comparatively lower impact on morbidity and mortality meant that the return to enhanced IPC measures as seen in previous waves of Covid-19 was not required and not implemented."

That may seem to some a rather relaxed approach to increased nosocomial transmission rates, given that the Omicron virus still proved fatal for some patients?

A. And this is a balance of risks and, as stated in those

paragraphs, by the time we got to Omicron it was clear that, through a combination of the immunity that had come from the vaccination programme and prior infection and potentially Omicron being less -- having less clinical impact, part of the properties of that variant, it was really clear that Omicron was not causing the degree of harm to the population as a whole or to individuals as the Alpha wave and the original Wuhan wave.

So at that point we had IPC measures that had evolved and again flexibility for local systems to adapt their IPC measures and the decision at the time was that that would be the appropriate stance to keep to give that flexibility to local systems.

But there is always a balance here between understanding what the virus is doing and the potential consequences and the impact of IPC measures.

And IPC measures, of course you have an impact, they have an impact on the ability to flow patients through the hospital because you have to separate patients out so you lose bed capacity. So all these measures are not without downsides and risks and that's why it is always best thinking about this as a balance of risk.

Q. Thank you.

We can take that down, thank you.

New topic, please. Pulse oximetry to monitor Covid-19 patients and particularly the NHS England COVID Oximetry@home programme. I think it's right that that programme was run through general practitioners providing pulse oximeters that had been supplied by NHS England to patients with Covid-19, and it was available to patients who tested positive, were symptomatic, and were aged over 65 or clinically extremely vulnerable; is that right?

The Inquiry has heard about concerns that pulse oximeters may not be accurate in patients with darker skin pigmentation and I think those concerns were first raised during the pandemic after an article had been published in the British Medical Journal on 21 December 2020 which was itself based on an American journal report?

A. Yes.

Q. Is it right that NHS England published a COVID Oximetry@home operational update on 23 December 2020 in relation to those concerns?

A. Yes, correct, immediately we heard of those concerns we responded to it.

Q. And what was the advice given in that update?

A. Well, the advice was to note that these concerns had

been raised, to emphasise that pulse oximetry should be used in the context of other things, so symptoms, signs, other signs that the patient might be displaying of deterioration, that absolute readings of oxygen levels through oximeters were maybe not as important as looking at a trend, so a falling trend in readings rather than an absolute trend. This is information that had gone out at the time start of the programme but we felt it was important at that stage to acknowledge that concerns had been raised but also to emphasise that oximetry purely on its own, in other words taking a single absolute reading, was only part of the Oximetry@home programme and there had to be a wider view of the patients as well.

And, of course, for the patient to take account of other things that were happening rather than just the oximeter reading.

Q. So is it right, then, that even if there had been a degree of inaccuracy in terms of the reading that was given by the device, if there was a drop in oxygen saturation levels, blood oxygen saturation levels, the device would pick up on that?

A. Yes, that was our view and our risk was that people amongst communities with darker skin would be put off from enrolling in this programme at all and therefore

would not get any benefit from it because they may be worried about inaccurate readings where, in fact, what we wanted was a programme that was more holistic than simply a reading of a single oxygen or a set of absolute oxygen levels.

So that was the balance and that was the fear and that was why we issued that guidance to ensure that our clinicians and patients using this understood that there was a constellation of things that you needed to take into account.

Q. So if we can move on a few months from NHS England publishing that update in December of 2020. Towards the end of March 2021, the Race and Health Observatory published their rapid evidence review on the potential for inaccuracies in pulse oximeter readings, and they raised this concern that: given the increased mortality amongst ethnic minority patients during the Covid-19 pandemic, it is possible that the differential accuracy of pulse oximetry is a contributing factor to this health inequality.

In other words, that reliance on inaccurate pulse oximetry readings could have led to higher mortality rates from Covid-19. What are your views as to whether that is possible, that that inaccurate, potential inaccuracy could have led to increased mortality?

A. I understand the potential risk but I don't -- I haven't seen any evidence and I think others have not seen evidence either. I think this was mentioned in the report that was commissioned from the Secretary of State into the use of pulse oximetry and other devices, that we have no evidence that any actual harm has resulted from this.

Q. Has anyone looked for any evidence? Has there been any evaluations of the programme?

A. Well, there are ongoing clinical studies at the moment. We -- in one of the very first pilots that we did way prior to December of 2020, we targeted for inclusion individuals from those communities because we knew they had a higher risk of Covid and we didn't see any adverse outcomes. So I don't believe that we have seen any adverse outcomes. But clearly ongoing research is needed in this area. There is ongoing research. I'm also aware of some concerns around the methodology of some of those original articles. NIHR are undertaking some research at the moment to try and replicate the data and bring it more up to date.

So this is an area of ongoing research where I think there is still some uncertainty.

Q. You mentioned the briefing note that was prepared for the then Secretary of State for Health and Social Care

that was Sir Sajid Javid at that time.

Can we go to that document, please, it's INQ000470551.

Did you have input into this?

A. I don't think I did.

Q. We can see that there's -- a summary has been prepared there:

"We are not aware of any evidence that pulse oximeter inaccuracy in people with COVID and darker skin has contributed to excess deaths. The Medicines and Healthcare products Regulatory Agency ... is not aware of any incidents where skin colour has had an adverse effect on the use of pulse oximeters when providing effective clinical care."

And it references the NHS guidance about monitoring trends and asks -- says it has asked the National Institute for Health Research to commission rapid further research.

Is that the research that's not yet --

A. Yes, I have checked on that recently and the end date of that research study was due in August this year. I understand that the team have been granted a short extension so we are still awaiting the output of that research.

Q. At point 6 it says:

"We are concerned some media messaging risks increasing numbers of people with darker skin who decline pulse oximetry services, thereby exacerbating inequalities."

And if we can go down, please, to point 8:

"There are some research reports that pulse oximeters may not work as well in people with darker skin."

Is this the concerns that you mentioned about the quality of that research, reports involve old, out-of-date oximeters and/or there's no detail on the specific models used; they involve relatively low numbers of patients; no studies have involved Covid patients; they involve reading levels unrelated to the ranges set out by NHS COVID Oximetry@home, significantly lower, which would mean the patient would likely be hospitalised; and there are questions over the validity of testing based on commonly accepted methodology, so time delays between comparing the oximetry readings with, I think it says below -- can we scroll down, please.

A. Yes, those are the methodological issues that have been raised. But this is clearly an important area. I mean, it's one that we absolutely need research on and we absolutely need to ensure that our -- the devices we use

within medicine, not just pulse oximetry, are fit for uses in all people.

Q. Can we go to the second page of that document, please.

I think we can take that down now.

Subsequently, I think on 21 November 2021, the Secretary of State for Health and Social Care expressed concerns on the Andrew Marr show about these inaccuracies and said he thought it was possible that black and ethnic minority people may have died from Covid-19 as a result of relying on inaccurate pulse oximetry readings.

Can I ask you what your views were at the time of how helpful those comments were from the Secretary of State.

A. Well, I can't recall exactly at the time. I mean, clearly we were concerned because, of course, the reason for putting this programme in place was we were worried with silent hypoxia, worried about patients deteriorating without symptoms, that was the rationale right at the start, and therefore we were worried that if people didn't take up this offer they could deteriorate more quickly than would become apparent from their symptoms.

I think he, on reflection I wonder whether he based those comments on the Race and Health Observatory

comments, but I do note in his evidence statement to this module that he has noted that there has been no evidence and that the commissioned piece of work that he asked for states that there is -- there has been no evidence of harm.

I should also probably note in this respect that there were a number of evaluations and there have been a number of subsequent research studies into the use of pulse oximetry at home -- this is in all populations. Those studies are fairly mixed in their conclusions but they tend towards either a neutral effect or a positive effect, and I don't think any of them have determined that harm came from this programme.

Q. So this is in relation to using pulse oximetry to monitor Covid patients?

A. Yes, at home, yeah.

Q. Thank you. So some have shown, I think, some benefit in reduced mortality figures and some have shown no difference one way or another.

A. Yes, but I think none have shown harm.

Q. Thank you.

If we can move on, please, to 111 services and telephone triage for Covid-19 patients. What was the involvement of NHS England with the 111 service? What's its role in relation to it?

A. We oversaw the 111 service during the pandemic. 111 services are commissioned locally, but this is an area where we took a more direct role as part of our level 4 response.

Q. Is it right to say that particularly at the beginning of the pandemic, the 111 service was struggling to respond to the volume of calls it was receiving?

A. As we got into late February and March, we had particular trouble responding. That was at a time where there was a lot of concern around, obviously, what was going on in northern Italy, the likelihood that the pandemic would come here, although there weren't many cases at the time, there was a lot of public interest and a lot of desire for information, so we were seeing requests coming through, both asking for general information about Covid but also specifically around worries that an individual might have symptoms of Covid-19.

And so a variety of different services were stood up. Important to remember in this respect that in a sense 111 is a number, and there are a set of different services that can be flexed that sit behind that number. So 111 itself is the telephone number; what you are directed to afterwards is -- can be a variety of different services, and they can flex and

change depending on the context.

Q. Can we go to a graph that you have provided at page 216 of your witness statement. This is the number and percentage of calls answered within 60 seconds. The dotted line at the top, I think, is the target rate --

A. Yes.

Q. -- and we can see that calls received are in green, and there's a big spike in March of 2020. Calls answered, in light blue is calls answered. And in dark blue, calls answered within 60 seconds, and we can see there's a corresponding dip in March of 2020 in relation to the number of calls answered.

You've explained that, I think, additional call agents were added to the call resource in, first of all, February 2020, another 150 call agents, and then another 117 full-time equivalents were agreed in March of 2020.

How long would it have taken for those additional staff members to be recruited and to take up their posts?

A. Well, the training for the 111 service takes a number of weeks, I think five weeks. And so very early on, I think in February 2020, we took the decision to stand up a standalone service to deal with patients and individuals calling in with concerns about Coronavirus, and that was the Covid-19 response service, the CRS.

And one of the reasons for doing that was because we could ensure that that service was really just targeted on Covid-19 rather than the complete range of conditions that anybody might call 111 about. It meant that the individuals that we recruited to that service didn't require the length of training that they would to get -- to become part of the general 111 service.

So, rather than knowing that it would take time to train people to deal with all circumstances, rather than focus on expanding the 111 service, we set up a separate service that could deal specifically with Covid, and that had the advantage that the training was shorter. Remember, the call handlers in 111 and indeed the CRS are basically running to algorithms and scripts, they're not clinicians, they are asking a set of questions which will lead to a particular action in terms of advice to the patient, or whether the patient is referred on to 999 or to a clinician.

And so the algorithms that are needed just to deal with a single set of symptoms and a condition, Covid-19, is far less complex than the algorithms that are required for the whole range of conditions that anybody could phone at 111 about.

Q. So --

A. That was the rationale.

Q. And those additional staff that I've mentioned in February and March 2020, were they recruited to the core 111 service --

A. 111, yes --

Q. -- rather than the CRS?

A. -- but the reason we didn't expand beyond that was because we focused our efforts on expanding the Covid-specific Covid Response Service.

Public Health England had also set up a helpline which was predominantly around giving general advice around Covid, and I think you will probably see, you might show me an exhibit in a minute, that there came a point where that service was essentially doing the same as the Covid Response Service and so we asked PHE if we could merge the two services into one.

Q. Perhaps we can get up that document. It's INQ000348589. This is a briefing document dated 26 March 2020 from Public Health England following discussions about that merging that you've mentioned. Can we go to page 3, please.

"In response to a request from [NHS England]/NHS111 for aid, [Public Health England] sourced an additional 1,000 call handers at 24 response."

Is that the CRS?

A. I believe that's the CRS, yes.

Q. So that is an additional 1,000 call landers sourced at that point?

A. So this is essentially merging the PHE helpline which, at this stage in late March, I think calls had moved from general advice around Covid to more specific advice about individual circumstances, which actually was the role of the CRS, and therefore the functions -- what practically was happening in those two call services was essentially duplicative and therefore it made sense simply to combine it into a single service.

Q. Can we go to page 2 of that document, please. There's a graph there at the bottom if we can see the green and orange graph. Thank you. And this covers the period 27 February 2020 to 24 March 2020 so it's a snapshot really of the daily figures over a period of about a month early in the pandemic. And it's the core service --

A. Yes.

Q. -- calls offered and answered. And I think we can see there that the green bars show the number of calls that came in and the red bars are the number of those calls that were answered at all, even after 60 seconds.

And so we can see that performance as the number of calls comes in, actually the performance, the number

of calls being answered is declining really from 7 March and declining throughout that month. The orange line, solid line there, I think, demonstrates the calls answered within 60 seconds, so that's at times dipping very low.

So, looking at that snapshot, it seems that the system was struggling to meet demand at that time. Was the problem therein sufficient call handlers?

A. Well, the problem was the level of demand. It was obviously a mismatch between supply and demand. It was one of those occasions that a part of the service did absolutely face a situation where supply was -- sorry demand was greatly exceeding supply. This is the granular detail I think behind the chart that you showed earlier and in March we were seeing double the number of volumes of calls into 111 that we would've done in an equivalent month pre-pandemic, so there's no doubt there was a huge amount of pressure coming on, and it was really difficult to cope.

The mitigations were to produce that -- to instigate that Covid Response Service which we at the time felt was the most effective and quickest way of taking some of the pressure off 111.

In time we also put in place a clinical -- a Covid Clinical Advice Service which provided clinical support

into the call handlers, so there were a number of mitigation strategies, but there is no doubt that the NHS and NHS 111, in this particular period, was under extreme pressure and it's reflected in these graphs.

Q. If we can come back to this graph. We're not seeing a constant level of the number of calls answered through this month and so when we get to 16, 17, 18 to 20 March, the numbers have dropped to well below 20% of calls being answered altogether. And when we see the numbers of calls down the side, it seems that fewer calls are being picked up, doesn't it, not just that demand is increasing, but --

A. Yes, well, we're heading into peak -- you know, numbers of -- peak prevalence of Covid in the community in wave 1, so 111 was incredibly busy at that time. And this reflects the pressure. I can't reflect on why one day was significantly different from another --

Q. Perhaps we can --

A. -- but I think the overall picture, as you showed in that earlier graph, was that this was the period where we had sustained pressure on 111, as did other -- the devolved administrations as well in their services.

Q. I think we can take that down now, thank you. Perhaps we can move on from the statistics to the quality of the calls.

A. Yes.
Q. I think it's right that the Healthcare Safety Investigation Branch undertook an investigation into concerns about patient safety issuers --
A. Yes, they did.
Q. -- in response to callers to the 111 service. That report was published in late September 2022.
A. Correct.
Q. And it noted that the clinical staff recruited to work in the Covid-19 Clinical Assessment Service reported to HSSIB that they had received very little in the way of clinical training, and they'd established informal networks to try to share knowledge of the virus. Was NHS 111 aware of those difficulties with the level of training that had been offered?
A. Yes, we were, and there was a strategy behind this which was, we -- so the clinicians recruited into that service, the Covid Clinical Advice Service, were mainly GPs, active GPs or recently retired GPs, and the intent was to provide a clinical support for the call handlers. The intent was not to recruit a group of clinicians and then train them in additional clinical skills because what we wanted to use was their general skills, which they already had, around patient -- identifying patients who were deteriorating, patients who might have

conditions that were other than Covid-19.

So our view was that we didn't need to train them in a set of clinical skills that they already had; what we did need to train them in was telephony, and how to work in a call centre, whether it was home or wherever and in the 111 service.

So the training was short, it was telephony-specific. If there were updates to the way Covid-19 was being managed, then that was communicated, but it was deliberately not the intent to spend a large amount of time training them in a set of skills that we felt they already had, which was the reason for bringing them in the first place.

Q. In retrospect and with the benefit of hindsight, do you think there might have been some benefit in -- given that these are trained clinicians, if they were given some targeted training around the clinical presentations of Covid?
A. I believe they were, but obviously you've heard those reflections in the HSSIB report that not everybody felt it was what they needed, so I think that is definitely a reflection for the future, but it was definitely the strategy to bring in a group of clinicians to use their existing clinical skills, which would be generalist skills, around identifying patients who were

deteriorating, patients who had a set of symptoms, that might or might not be Covid-19. So yes, of course we always reflect on these things, but the strategy was to bring them in for their skills, to give them the additional telephony training, not spend weeks teaching them something we felt they already knew and was the reason we were bringing them in the first place.
Q. That report from the Healthcare Safety Investigations Branch made a number of recommendations directed at various bodies. One of those recommendations was that NHS England should review the risks associated with increased use of telephone triage services during a national healthcare emergency, and I wanted to ask how NHS England has progressed with that.
A. So I think that work is being undertaken with colleagues at UKHSA. I haven't got an output for you at the moment, but we have been looking at those recommendations.

There were a number of other recommendations as well around call recording, if I reflect correctly, which we have also been -- well, on the call recording that was implemented pretty immediately but there are a number of other reflections in that HSSIB report we're working on.
Q. Apart from the HSSIB report, I think you have been made

aware of a report in the Guardian from October 2020 referring to what was called an internal audit --
A. Yes.
Q. -- of 111 that noted that up to 60% of calls handled by the Clinical Assessment Service within 111 were rated as "not safe", and what steps NHS England took in relation to that.
A. So this related to nurses who were a small, very small part of that overall cohort of clinicians. As I said, the clinicians in the Covid Clinical Advice Service were predominantly GPs. The service, if I remember, was hosted by SCAS, South Coast Ambulance Service, the audit, I believe it was an audit they undertook relatively small sample size, raised those concerns around the quality of information provided by nurses that was raised with NHS England, and we took the decision that we would remove nurses from that pool of clinicians.
Q. Thank you.
A. Can I just add, because I should have added this, there were a number of other clinical advice services for dentistry for example that were stood up, and of course the clinicians in those services were -- had the clinical skills relevant to the particular service. So, obviously, in the dentistry clinical advice service, it

was dentists, and again we didn't feel that we needed to re-teach dentists a set of skills that the dentists already had, that was the reason for bringing them in at the first place.

LADY HALLETT: I'm sorry, I didn't follow your answer. Ms Nield put to you that a large percentage of the calls were found not to have been answered satisfactorily, and I think it was 60% of the uptake?

MS NIELD: Up to 60%.

LADY HALLETT: And then your answer was: that related to nurses who formed a small part of the team.

A. No --

LADY HALLETT: Could you explain what you meant?

A. So this relates to a report in the Guardian that there was a quality issue in the Covid Clinical Advice Service amongst the cohorts of clinicians that were nurses. It was a small number of nurses in that service in that cohort of clinicians mostly GPs and I think the audit had undertook an audit of a small number of them, but it showed that there was, I think, 60% -- there was an issue of like 60% of incorrect advice or incorrect process, and as a result we decided it would be best to remove nurses from that pool. But the majority of that pool of clinicians were GPs.

So a quality issue was raised, we responded to it

appropriately.

MS NIELD: But the quality issue was only raised in relation to the quality of advice given by nurses rather than clinicians.

A. Because I think that was what the audit -- that was what the audit -- that was where the concern had raised, yes.

Q. Thank you. If we can move on, please, from 111 to care for maintaining care for conditions other than Covid-19 during the pandemic.

You've explained that -- in your witness statement that some core services such as maternity care, urgent and emergency care were never paused, but the delivery of those services was adapted or reorganised for the pandemic, is that right? And you give the example of ambulance services which established alternative pathways to ensure that frontline ambulance resources were optimised for the most seriously ill and injured patients.

I'm asked to ask you or clarify with you whether that meant that the 11 NHS ambulance trusts relied upon independent ambulance providers to provide some services particularly in relation to non-emergency patient transport -- *(Unclear: multiple speakers)* --

A. There was --

Q. -- played a bigger role.

A. There was some use of the independent sector -- as there was generally.

Q. And, given the greater reliance on the independent ambulance sector during the pandemic, do you consider that in any future pandemic, independent ambulance providers should be consulted prior to the final formulation of measures and guidance that affect the ambulance sector?

A. Yes, ambulance service is not my area of expertise. I believe you have taken evidence from my colleague Anthony Marsh. I would think that would be sensible but, again, not my area of expertise.

Q. Thank you. Maternity care you mentioned as one of those core services that could not be paused but had to be reorganised to some extent during the pandemic. Can I ask you this in relation to maternity services specifically: to what extent you consider that maternity care professionals should not be redeployed to other services during a pandemic and, firstly, because maternity care is an essential service and, secondly, because training in maternity care is highly specialised?

A. I agree with that.

Q. Your statement makes clear that during the pandemic discharges from maternity units were more rapid,

discharges of new mothers were more rapid, with shorter postnatal stays on average. Do you consider that those shorter stays could have resulted in a reduced quality of care and support provided to women immediately after childbirth?

A. Well, I would assume and hope that the clinicians who were discharging women after birth were doing so safely and were expediting the discharge process without taking undue risk. There's many ways in which you can expedite discharge without causing harm. I have no evidence that harm was caused but I would have thought, I would expect that clinicians would not want to discharge somebody unless they felt it was reasonable for them to be discharged and/or they had the appropriate support in home that meant some of the support they might have had in hospital could have been replicated at home.

Q. You've set out in your witness statement the way that the maternity care service did change in a number of ways. Some midwife-led units were closed temporarily during the pandemic. Certain services weren't made available as they had been previously. Do you have any reflection on the changes to maternity care during the pandemic and any lessons that you would learn for future pandemics?

A. We've talked about visitor guidance, so we've covered

that off. We've talked about not re-deploying staff out of maternity units. I think it was right to look operationally at whether there were smaller units. Of course, one of the problems with smaller units is they have smaller numbers of staff so any outbreak of infection means that they are vulnerable to disruption or closure. So I think we would take that approach again.

Then I think you are into much more general issues around how we support staff and how we support patients in our services as a whole.

Q. If we can come on please to elective care. I think it's right that during the pandemic elective or planned care was paused from 17 March 2020 following which NHS England encouraged those trusts who were able to do so to consider resuming elective care in late April 2020, and then on 31 July 2020, NHS England instructed trusts to recover the maximum elective activity possible including using independent sector capability if that was necessary.

A. Yes.

Q. And you've set out some of the strategies that were adopted to maintain non-Covid care. I'd like to deal briefly, if I may, with each of those in turn.

Firstly, the increased use of technology in

primary and secondary care for patient consultations.

We've heard some evidence about the challenges of delivering remote consultations. Do you consider that NHS England provided sufficient guidance for clinicians to enable them to appropriately identify patients or symptoms which require direct in-person assessment?

A. So we did provide a lot of guidance and I think it's important to say that this was a direction of travel that pre-dated the pandemic. In the NHS long-term plan which was published at the beginning of 2019, we set an ambition to move, in the hospital sector, a number of outpatient appointments from face-to-face to remote appointments.

The reason for doing that is because technology is now at a stage where it's possible and of course where a face-to-face appointment, an examination is required then an appointment should be undertaken in a healthcare setting, but there are plenty of opportunities to do that remotely.

When I was a practising clinician, in my days looking after kidney transplant patients, I often reflected that sometimes I could have had a telephone call rather than bringing somebody into hospital because the discussion that we needed to have didn't need the examination, it was maybe a discussion of results that

had become available.

So that was a direction of travel and we were doing work on it.

Indeed, I well remember in the month, probably in the February of 2020 going to one of the major hospitals in London who were starting their programme of moving outpatient appointments more remotely, seeing a sea of sceptical faces and then two months later, somebody from the hospital saying: we actually did it all in a week when we had to in the pandemic. So there was a lot of ground work in advance. But clearly the move to it was very rapid, it had to be because of the circumstances, and there are some downsides of moving that rapidly within which I would include taking the public along with you in terms of the change of service. But it was the right thing to do under the circumstances.

In primary care, of course, we did the same. Again, there has been a move over the years to a mixture of face-to-face and remote appointments.

In general practice where, again, it's back to the issue of smaller healthcare settings with smaller number of staff, if there was an outbreak in that setting then the entire service goes down. We saw that in the early days of the pandemic where we had to close GP practices.

So this was, again, a balance of risks. We had made preparations in advance, we had to accelerate those, we issued a lot of guidance. Yes, we could always do more but it was, in my opinion, the right thing to do.

Q. You mentioned some of the downsides, which brings me on to my next question which is about the potential for some patients to be excluded from access to digital or remote engagement with healthcare.

Do you think that that risk or that downside was adequately addressed by NHS England?

A. So that is a concern in pandemic times and outside of pandemic times, that we don't digitally exclude individuals. We have to be very careful to ensure that we give patients routes to access that they want and that is appropriate. So it's very much on our mind. But, equally, I have always felt that the use of digital technology actually can be a benefit for more vulnerable groups because actually coming into hospital can be quite a challenge and the advantage of not having to come into hospital or a healthcare setting is often an upside as well.

LADY HALLETT: Is that a convenient moment?

MS NIELD: Certainly.

LADY HALLETT: 3.20.

(3.05 pm)

(A short break)

(3.21 pm)

LADY HALLETT: Ms Nield.

MS NIELD: Professor Powis, we were on the subject of elective care and strategies to maintain elective care during the pandemic and the Inquiry heard last week from Professor Aneel Bhangu, who's an expert in colorectal cancer, and also from Professor Metcalfe and Ms Scott in relation to hip replacement surgeries.

And all of those experts recommended an increased role for elective hubs that would be separate from hospitals with emergency departments and so on, which would enable protection of elective patients from the risk of hospital-acquired infections. Is that something that NHS England would support, the greater use of creation and use of elective hubs?

A. Yes, and they are correct and it is NHS England policy to do so at present. We had been doing that prior to the pandemic. Clearly the pandemic re-emphasised the importance of separating cold elective care, non-emergency care from emergency care, and we have been proceeding with that policy.

Q. Another of the strategies you've identified in your witness statement was the use of independent sector

facilities. And the Inquiry heard from Professor Bhangu that had been very successfully utilised for cancer patients. However, in relation to hip replacement surgery, Professor Metcalfe and Ms Scott explained that only very small numbers of orthopaedic surgery patients were treated in private hospitals.

So I'd like to ask whether you think that independent sector capacity was fully utilised during the pandemic, whether there was an issue about what type of care was prioritised for the independent sector and whether there were limitations on the use of the independent sector such as lack of staff?

A. Yes, it was right that we took the capacity of the independent sector during the pandemic. It provided that flexibility we required. It wasn't just the facilities of the hospitals, it was the staff, it was the equipment that became available too.

Clearly there were challenges, as you have said. It is quite right that often the same staff who are undertaking procedures in the independent sector are the NHS staff who are undertaking work in NHS hospitals and they clearly cannot be in two places at once and they may have been redeployed into Covid activity. So undoubtedly that was a challenge.

There was variable uptake across the country.

Very dependent on local configurations and local availability but, in general, we are very grateful to our colleagues in the independent sector who supported and lent their support. Clearly there were contractual underpinnings to this but we very much work closely with them and worked as one to address the challenges of the pandemic.

Q. Finally, on non-Covid care, screening or what Professor Bhangu referred to as ante-diagnostics. It was Professor Bhangu's recommendation that screening should continue and not be paused in the event of a future pandemic. Would you see any reason not to continue with cancer screening programmes in a future pandemic?

A. So we didn't at national level turn off or step down screening services but we are well aware that there were decisions made at local level to do that, quite understandably in the face of the pressures around the peaks and depending on the screening service redeployment of staff. So all services came under pressure and we tried to protect screening services as much as possible and then recover the lost ground as quickly as possible afterwards but, in general, I agree we would do as much as possible to preserve screening services during a future pandemic.

LADY HALLETT: So with cancer, you say you try to recover as soon as possible, but it could be too late.

A. Well, this is in respect of the screening services so there is a range --

LADY HALLETT: But if the cancer has progressed because o screening is --

A. Oh, absolutely, and that would be the reason for wanting to protect screening services. In fact, we recovered at various rates, depending on the particular screening programme. The screening programmes that probably gave the greatest challenge was endoscopy which we use in some of our follow-up to screening programmes. But, yes, in principle we will try and protect screening programmes as much as possible.

MS NIELD: In terms of the number of patients presenting for non-Covid care, including elective care, you've noted in your witness statement that the impact of the Stay at Home Protect the NHS messaging may have played a part in the significant decrease in people coming forward for healthcare.

What lessons do you think can be learned about balancing that sort of public health messaging and ensuring continued access to healthcare for individuals who need it?

A. Well, the Protect the NHS message which was

a Cabinet Office-developed communication strategy, I think was the best intent, it was to recognise that people were sacrificing, great sacrifices, in terms of social distancing and lockdown to ensure the transmission rate dropped and that that relieved pressure on the NHS and, of course, reduced deaths. But, of course, unfortunately some people might have interpreted that as "stay away from the NHS", which was absolutely not what we wanted, we were quite clear that if you had a condition that required NHS treatment you should come forward.

So early on we began to get worried about the risk of that happening. I raised it and spoke about it deliberately at a very early stage in one of the Downing Street press conferences, I think it was 4 April, or thereabouts. I stood up and -- and actually I remember getting an email from somebody afterwards saying: my husband has been sitting at home for a number of days, with chest pain, I think it was, and wouldn't go to hospital and they heard you on the television and he went. And they saved his life.

So I know it had an impact. I won't get emotional here but that was ...

LADY HALLETT: You are allowed to.

A. Yeah, so we were worried.

We communicated those concerns to Cabinet Office and we introduced the Help Us Help You campaign, which had a number of iterations around cancer symptoms, to remind the public that the NHS was there, please do come. But understandably, people were worried, they were worried about catching an infection in healthcare settings. They were worried about, you know, disrupting the work of healthcare professionals which, you know, they didn't have to be. We really wanted them to come forward. And that is a lesson learnt for future pandemics that we need to do as much as we can to ensure that people know and have the confidence to come forward.

LADY HALLETT: Were the NHS involved in developing the messaging, or was it just -- the communications or --

A. No, we weren't, and -- to my knowledge, we weren't. And as I said, we have no doubt it was done with the best intentions for good reasons, and it was an effective message in the sense of social distancing. But there is a -- there was a concern that people might be misinterpreting that. I think there were other -- there were a number of other reasons why people stayed at home, which they undoubtedly did. We saw falls in the number of admissions for a number of conditions. And of course we were very quickly on to trying to remind

people that you should come but it is one of the things to reflect upon for future pandemics.

MS NIELD: Do you think, picking up on her Ladyship's question, do you think if there had been some involvement of NHS England or senior healthcare system leaders when formulating that Cabinet Office messaging, that perhaps a slightly more nuanced message might have been possible?

A. Perhaps. But easy to look backwards in hindsight. I think the important thing is to think about it going forward.

Q. Can we move on then, please, to the role of NHS England in commissioning services for Long Covid.

You've set out the chronology of events in some detail in your fourth witness statement, so can I take you, please, just to some of these tee developments.

I think it's right that NHS England commissioned NICE to develop evidence-based guidelines and treatment options on 30 September 2020, and prior to that there was support available to people experiencing long-term impacts of Covid via the online portal Your Covid Recovery, which was launched in July 2020.

And then there was an interactive tool available on the same platform from 7 October 2020, is that right?

A. Correct.

Q. The Chief Medical Officer, Professor Sir Chris Whitty, suggested when he gave evidence at this Inquiry that we could have been swifter off the mark in spotting Long Covid as it emerged and in commissioning health services for people with Long Covid. I'd like to ask whether you agree with that, and whether you think NHS England could have acted sooner, for example, making the request to NICE prior to 30 September.

A. So my view is that we acted very quickly in terms of our response to Long Covid, and I absolutely acknowledge that from the perspective of those with Long Covid, it is never fast enough. But compared to other services that I've been involved in, standing up from a standing start, I think we acted quickly.

I became concerned, as others did, as we came out of wave 1 and into the summer of July 2020, that many individuals were reporting long-term effects and symptoms following Covid. This was brought to my attention by Long Covid SOS who wrote to me in early August and I met with them on 11 September 2020 I think was the date, and I'm really grateful to those from Long Covid SOS who attended that meeting, because it was a turning point for me in terms of Long Covid. I remember it in graphic detail, what they told me. They told me that they were having difficulty getting

clinicians to believe or understand their symptoms and whether this was actually a thing, a condition.

Sir Chris responded to this, and I agree, that at that early stage it's maybe not surprising that all clinicians didn't have the information they needed, but I absolutely understood the frustration of those who were suffering with Long Covid.

They also made a very important point to me as well, which was, for many people who had not been hospitalised, they didn't actually know for certain whether they'd had Covid or not, because of course the testing was not available. So there was the additional uncertainty of having a set of conditions which you thought was related to Covid but you couldn't be 100% certain.

They made it very clear to me that what they didn't want was to go pillar to post, from one service to another service, because they had a range of conditions affecting different parts of the body, they wanted a holistic, joined-up service. And they wanted this to be a specific service.

And so I went away, with colleagues within my team we developed the five point plan. I'd already been thinking about commissioning NICE to undertake a case definition. I wrote to them on 30 September, but

I never write to NICE commissioning them to do something without contacting them beforehand to tell them I'm going to do it and asking if they can, so the initial conversations would have been before 30 September. And, of course, I asked NICE to do it as quickly as possible, understanding the constraints. We discussed about doing something quickly particularly when the evidence base was still emerging.

And then we set about setting up a Long Covid task force, which my colleague Kiren Collison the deputy primary care medical director set up, and she did a magnificent job in bringing patients and others together to have input into the services, and we had 69 Long Covid clinics set up by December, which I think was faster than just about every country in the world. And although, back to what I said at the start, I know how incredibly frustrating this was and how quickly individuals wanted this to be done, but from my perspective we did move quickly on this, and I'm very proud of the team that I had who worked so hard, both nationally and regionally, to get these clinics established.

Q. You mention there by December 2020 there were 69 operational clinics across England. I think by November 2021, 19 Long Covid clinics and 14

paediatric helps for Long Covid.

A. Yes.

Q. And I think by November 2021 you've noted in your witness statement that patient feedback surveys showed high levels of satisfaction with Long Covid services, but there was still wide local and regional variation in both referral rates and waiting times, and the waiting list stood at over 12,000 with 33% waiting more than 15 weeks.

Are you aware of whether variation in services and barriers to access continue to be problems in England and, if so, are NHS England taking any steps in relation to that?

A. Yes, there are still problems around variation. Of course, as we've discussed earlier, it's quite right that we allow local healthcare systems to provide the services that they think are most appropriate for their patient population, their configuration of health services. That inevitably leads to variation in just about every service that we deliver.

We shifted at the end of the pandemic from a national approach to a locally commissioned approach, so we handed this programme over to local commissioners, integrated care boards. These are services that are in the range of services that should be locally

commissioned, and there's a technical reason too: they're not on the specialised commissioning list, which is a list of around 160 services that the Secretary of State designates as nationally specialised services.

But, there is variability. I do have a little bit of concern around whether that is too much variation, and we have asked colleagues in NHS England currently undertaking a stocktake of the existing service, so that we have a better sense of whether those services are.

I think those services need to evolve, as well. We have learnt a lot about the management of Long Covid and, of course, this sits within a general field of post-viral conditions and you will be aware that chronic fatigue syndrome, sometimes also referred to as ME, is another set of post-viral conditions, and I think, over time, there may be value in combining those services and of course that will give us more resilience going into a future pandemic if we have a service around post-viral conditions, long-term conditions that is already established.

So I would encourage ICBs to focus on this as an area. As you have said, there is still demand.

The demand amongst children, I think has dropped a bit and there's a little bit of consolidation in those

services but there is still demand amongst adults and it's important that we pay attention to that.

Q. Can I ask about Long Covid and healthcare workers.

Does NHS England currently collect data regarding the number, age, sex and ethnicity of healthcare workers and NHS staff who have been affected by Long Covid?

A. I don't believe nationally. We have issued guidance and support and help to staff -- to organisations in general as to how to support staff with Long Covid. Of course those staff have access to those clinical services and, indeed, one of the observations very early on, when some of those early services were set up, was that they were seeing colleagues, members of staff, who were coming forward. That was, I remember, one of my early recollections of realising the impact this was having on the NHS workforce.

Q. Do you think it would be useful to collect that data at a national level, to have a national picture?

A. Whether -- I would have to think about that because, of course, we can collect data on a lot of things and the question is ensuring there is a purpose to doing that at a national level rather than a local level.

Q. We've touched briefly on one impact of the NHS workforce. If we can broaden out our perspective on that, please, and turn to steps taken by NHS England to

protect and support staff during the pandemic.

If we could look, first of all, at steps taken to protect staff from Covid-19 itself before we go on to consider the support for staff that was co-ordinated by NHS England.

I think it's right that from 29 April 2020 there was a requirement for all NHS trusts to ensure that vulnerable staff had completed a risk assessment, a Covid-19 risk assessment and guidance was provided to trusts to enable them to carry out those risk assessments and identify risk factors. Was there a standardised risk assessment tool available to trusts at that point with a scoring system to quantify risks, or did that come later?

A. There was a risk assessment process set up with the help of NHS employers in, I think April or May of 2020, so whether that would be classified as a tool or not, I don't know. But there certainly was a standardised piece of advice that was distributed to trusts to help them in this process.

Q. So was there uniformity in terms of the risk factors that were -- specific risk factors that were identified?

A. I can't specifically recall if that was the case. But I am aware from other evidence there might have been a tool in use in Wales but I haven't been able to

ascertain whether there were similarities or differences yet, but I can certainly look at that.

Q. Professor Bamrah from the Federation of Ethnic Minority Healthcare Organisations suggested that the all-Wales risk assessment tool --

A. Yeah.

Q. -- which was a scoring tool and stratified risk according to that numerical score, it was suggested that that had been passed to NHS England and informed the tool devised for England that came out in September 2020, would that accord with your recollection?

A. When I saw that evidence I asked to see whether we could find a record of that, and we couldn't. That's not to say we won't keep looking. So at the moment I'm not aware that tool was passed through to us, but I can't completely rule it out and, of course, we will search on your behalf if you wish.

Q. Do you think NHS England could have acted more quickly to ensure that staff were being risk assessed?

A. We acted quickly, particularly when we started to understand the risk profile of Covid, particularly amongst colleagues from our BAME community but by the time we got to June and July I think it was apparent to us organisations were not rolling this risk assessment

tool or risk assessment process out as quickly as we would have liked.

Q. I think you undertook a compliance monitoring programme from --

A. From July, yes.

Q. We will come on to that shortly. Can I ask you this: was there any consideration given to ensuring that NHS trusts were undertaking risk assessments for outsourced staff, so non-employees? Was that supposed to apply equally to all workers?

A. So, again, my view would be that whoever is employing staff, they should, if they are working within the NHS community they should be within the NHS community. I can't give you the detail. Again, we can come back to you with this, if we have the detail, on how many trusts took that view and how many didn't. But my own personal view is that we should have a broad scope for individuals who are working within the NHS.

Q. Thank you.

LADY HALLETT: Sorry, your answer maybe wasn't that clear. So you're not saying it should be the outside employer but the NHS because they're part of the NHS community, is that right?

A. Well, I think you could probably, in practice, do it either way, but I wouldn't necessarily rule out doing it

one way or the other. I think it depends a bit on the relationship of the employer and there are -- staff that are outsourced are outsourced in a variety of different ways and circumstances and some of the outsourcing arrangements are closer to the NHS organisation than not.

MS NIELD: Perhaps it would be easier if the risk assessment is being conducted in the workplace by the line manager regardless of the employment status.

A. Yes, I agree.

Q. Can we get up, please, INQ000330885.

This is the compliance report, I think, that you were referring to earlier. I think there were three windows when compliance was assessed, I think in July, August and then September of 2020, if that's right.

If we could go to page 3 there, we see the table showing national averages of when BAME staff were assessed, at-risk staff, and all staff. And we can see there's an improvement from window 1, window 2 and into window 3 with eventually 96% nationally of BAME staff having received a risk assessment by window 3, when only 73% had been risk assessed in window 1.

I think it's right to say that there was also great variation in compliance noted between trusts.

I don't think it's in that document but if we can go to INQ000330972, and page 10 of that document, please.

This is within the London region and we can see there's -- it's a bar chart showing as much as 96% compliance in one hospital and as low as 14% compliance in another hospital in terms of risk assessing their staff.

We can take that down. Thank you.

And you've explained in your witness statement that this risk assessment compliance monitoring was a useful tool in covering a cultural gap amongst organisations and you noted that good practice emerged from organisations that deployed an empathetic, co-ordinated and risk-stratified approach targeting high-risk staff and work settings coupled with a strong communications effort. Conversely, the process also demonstrated some staff feeling targeted, redeployed without discussion, curtailment of training opportunities and in some instances being put on Statutory Sick Pay.

Did NHS England take any steps in relation to those negative experiences of risk assessments that had been reported?

A. So we had this focus, as I've said, and you saw that in

the data from end of June, early July onwards, to try and support organisations to undertake more risk assessments and you saw the result of that. As part -- and I know you discussed this with Dame Ruth around shortening the time, particularly for vulnerable staff in terms of our expectations.

We established a risk assessment delivery unit whose job it was or task it was to support, to spread best practice, to work with those organisation who, for whatever reason, were struggling. So we did put more targeted support and work into this during the summer of 2020, exactly because we thought it was such an important thing to do.

Q. Can we move on now, please, to look at how NHS England monitored and supported staff health and well-being during the pandemic. First of all, can you help us with this. How did NHS England hear from frontline staff during the pandemic and monitor their well-being?

A. Well, we heard through lots of routes. You know from other statements that a number of people who worked within NHS England worked shifts. Dame Ruth May, I think, described eloquently and passionately how she worked on the wards. I didn't, but I clearly had colleagues who did.

I, obviously, and others, stayed in contact with

many of my former colleagues who were working. I had regular meetings with the royal colleges, Dame Ruth had regular meetings with the Royal College of Nursing and others, so we had information coming back through other clinical leaders who were in touch with their members.

I met with the BMA regularly who also provided me with information. Of course we had staff surveys, as well, that I'm sure we will come on to. So there was -- and, of course, Professor Fong's visits, which you heard him describe a few weeks ago, which we supported as part of our EPRR response, those were all incredibly important and powerful ways of us getting information back.

And, of course, I undertook visits, as well, in the first wave. That was really difficult because of all the other work I was doing but increasingly I went out and I visited actually many vaccine sites, but many hospitals, and so that ability to talk directly to staff to just sit down, have a cup of coffee and relive the experiences or what they were concerned about, all of those routes in are important ways in which you get a sense of what is happening at the frontline of patient care.

Q. Can I ask you this. You speak about the different results that have come out in the -- I think it's

undertaken in October --
A. Yes.
Q. -- the annual surveys that come out? Were there any messages coming out from that survey that contradicted or differed from the messages that you were getting from the royal colleges, colleagues working on the frontline, any of the other channels of communication you've mentioned?
A. Not in general. I mean, you may be about to show me some exhibits but we instigated a separate survey I think the People Pulse survey which was a much more regular survey and if you look at anxiety levels they corresponded with the peaks of the two initial waves.
Q. Perhaps we could have a look at that. I think this was a monthly survey --
A. It was a monthly survey so the --
Q. -- so it wasn't getting quite as many as the annual survey --
A. No.
Q. -- but perhaps we can have a look at INQ000330944 on page 2, please.
A. There we are.
Q. So we can see, plotted in blue, this is anxiety levels, and in grey, this is the number of Covid-19 patients in the UK, and so we can see at times of peaks in

the number of patients, there's also peaks, and the high point of anxiety there is 40.5 staff reporting that they're feeling anxious, and that declines as to the wave of patient numbers declines as well.
A. That's perhaps not surprising, but I think there was a difference between wave 1 and wave 2, and I very much heard that from staff. So in wave 1, where this was -- you know, this was the first time staff had had to deal with Covid, there was a great sense of camaraderie, a great sense of coming together and working out how it should be done -- I think you might have heard a sense of that from some of the impact witnesses.

Staff were redeployed into areas that they might not have worked in for a while, but there was this real sense, the public clapping and the public support.

I think by the time it came to the second wave or the second big wave, the Alpha wave, there was a sense of "Here we go again. This is going to be more difficult. Yes, we have learnt to do this a bit better because we knew we'd gone through it once, but we really don't want to go through it again". And I think that was reflected in what I was hearing from staff.

By the time you got to the Omicron wave, and again you could see this I think in the anxiety levels in this report, because that had less clinical impact and was,

in a sense, more manageable, I think there was another -- that wasn't as hard as it might have been. So I think it very much depended upon the wave and the stage of the pandemic you were in.
Q. Can we go to page 5 of this document, please, because there's a graph there that sets out anxiety and motivation. And we can see it's a mirror image. The blue line the bottom line is anxiety. Reported anxiety levels. And the orange line is motivation as reported by staff. And we can see that anxiety rises, motivation dips.

Can I ask you this: as a clinician, what do you see as the potential clinical impact to the demotivated workforce or section of the workforce?
A. So there is no doubt that for everybody, as I've often said in public, who went through the pandemic, it was the most challenging, the most difficult, or the most stressful time of their professional careers. It's the biggest health emergency in 100 years, the biggest challenge crisis that the NHS has had to face since its inception in 1948.

Staff were magnificent, they went the extra mile, but that was at a cost and both at the time and both with lasting effects, it has deeply affected members of staff. We are very aware of that and that is why we are

trying to provide ongoing support. That will take time to get over, despite all the efforts. The risk assessment process, all the support that we put on really early, was to help local organisations who of course are at the frontline of helping staff to provide that support, but with an emergency of this sort, you can't fully mitigate it.

I should also say, and you heard this very graphically from Professor Fong, if the NHS had got to the point where it was completely overwhelmed, it would have been even worse. The moral injury would have been, you know, orders of greater magnitude. But having said that, even what we had to deal with had a huge impact on staff.
Q. And I think you explain that the 2022 staff survey indicated that 34% of staff said that they always or often felt burnt out because of their work, and 37.4% often or always found their work emotionally exhausting. Is it right that that incidence of burnout amongst the NHS workforce is reflected in difficulties recruiting and retaining staff?
A. I think it certainly impacted on retention, although actually we are doing reasonably well in term of staff leaders at the moment, we are getting to a better position. I think, in recruitment, we saw a real flush

of people wanting to come and work for the NHS during the initial phases of the pandemic, that has dropped off a bit and of course you can never know what the impact of having more people coming forward would have in the subsequent years, but obviously a happy workforce, a workforce that feels supported is a workforce that is likely to be stay and be retained, and that's why a big focus of our work at the moment is in supporting staff, a big part of the long-term workforce plan that I think I referred to earlier is around retention of staff and ensuring that we support staff and have the conditions to ensure that they stay -- and giving them flexibility of working, which of course is something that I think younger generations want much more now than perhaps people of my age wanted when we were going through careers.

The annual survey, the October 2021, did actually show an increase in people who felt supported in health and well-being. I think that was at the time we were doing the big push on risk assessments, difficult to know if it's cause and effect, but that was the case, and then it dropped off again in the October 2021 survey.

Q. So can we move on and look at the support for staff that was provided for or co-ordinated by NHS England during

the pandemic rather than currently.

I think it's right, normally, that sort of health and well-being support is provided at a local level rather than through NHS England.

A. Correct.

Q. But during the pandemic, NHS England did take a lead role in expanding provision of health and well-being support.

And you set out in your third witness statement that in terms of support for psychological well-being of staff, this took the form of mental health helplines, mobile apps, guides for managers on how to support their staff, the creation of virtual common rooms for staff to share their experiences and the provision of physical safe spaces and rest areas, and that included specific health and well-being support for BAME colleagues. And you give the example of Tagalog-speaking bereavement counsellors for Filipino staff.

What was the uptake of the health and well-being support that was offered, and what was the feedback of staff on the usefulness?

A. I don't have those figures in front of me. I can certainly provide them for you. They might be in my statement, I would need to have a look.

I think they were generally well received. The

aim, as you said, was to support local organisations who have prime responsibility as employers for their workforce, so, again, going back to being at a level 4 incident, one of our tasks here is to provide that national resource to support those local organisations, and we did that entirely as you described, through a whole range of offers co-ordinated through our people directorate, as it was at the time, led by our chief people officer, in consultation, collaboration with a lot of organisations, including charities, including learning from other major incidents such as the Manchester bombings, using technology, you mentioned a number of apps that are now available to help people with psychological support.

So, I think there are some figures in the statement, I just would need to look them up as to I think the number of people who took up some of those offers. So we have, I think, provided the details with you, but I would need to have a look at the appropriate page and paragraph.

Q. Can I ask you this. The Inquiry has heard from an expert in general practice about the levels of burnout amongst general practitioners in particular, and the kind of support that can be offered to assist in that regard. And Professor Edwards suggested that like

everything else in the NHS, mental health and well-being support for staff should be evidence-based, and that so there should be evaluations of programs to see what works, and what's most effective and efficient. And that more research, he suggests, is needed to establish what kind of support is effective.

And I'd like to know whether NHS England undertook any reviews or evaluations on the support that they provided, and whether you think it would be useful to have more research to know how best to provide support in the event of a future pandemic.

A. So in principle we agree that we should evaluate as many programmes as we possibly can, that we launch and provide. Again, I can't give you off the top of my head without looking back through the statement or giving you the details separately as to how many of the individual products had been evaluated. Of course, many of the apps we provided will have been independently evaluated as part of their development, but I would agree that more -- well, as an academic I will always agree that more research is better, and I definitely agree that evaluation is an important part of rolling out programmes.

Q. Can I move on then, please, to lessons learned and recommendations. And you've set out in your witness

statement and as we've progressed through evidence this afternoon, your views on various recommendations in particular specific topics. You've also explained that NHS England undertook an internal lessons learned review which reported on 20 June 2023, which I think was a process of pulling together various lessons identified from a range of activities throughout the pandemic, regional and national and local level, as well as some lessons learned exercises -- three lessons learned exercises subject conducted in 2020 and 2021. I'm not going to go through --

A. No.

Q. -- that report which runs to 150 pages in any detail, but can we look, please, at paragraph 1803 of your fourth witness statement.

We can see there that the report outlined 90 lessons across a number of specific areas, including preparedness and resilience, caring for people with Covid-19, impact on other services -- does that mean essential services, non-Covid services?

A. Non-Covid services, yes.

Q. Impact on the workforce. Vaccinations, inequalities and managing the incident, as well as the data-driven response, leadership, culture and innovations.

I think it's right that in relation to the

recommendations that were made within that report, those are being taken forward currently by NHS England?

A. Correct. We have action plans to take those forward.

Q. And those are largely internal recommendations for NHS England or are there any recommendations that are -- *(Unclear: multiple speakers)* --

A. They will be largely internal recommendations, but inevitably with these recommendations, some may extend to work with partner organisations.

Q. Were there any recommendations made, for example, to the Department for Health and Social Care?

A. So this report really focused on the internal workings of NHS England. We have contributed to other exercises in terms of lessons learnt, so I contributed, as did Dame Ruth and others, to the Chief Medical Officer's technical report that was published after the pandemic.

We have obviously contributed to select committee reports, so this is not the only way in which we are thinking about lessons learnt and working with other organisations to establish a set of recommendations that we think would be useful.

And of course, the Inquiry is very much part of that process in our mind, which is why it's important that I and others are here.

Q. I think it's right that some of the recommendations that

are made in that report are being embedded effectively into business as usual --

A. Yes.

Q. -- changes to services that can be implemented now, but I think it's right to say that some of those recommendations or changes are specific to a pandemic situation, and I think you've identified that there were some changes made to the EPRR structure within NHS England.

Regarding that framework, you've said this in your witness statement:

"There was a difficult balance to strike between enabling local responses to issues as they were seen ... on the frontline, and the need to co-ordinate resources, communication and actions across the whole country."

Can I ask you for your views or reflections as to the appropriateness of the timing in how NHS England moved between level 4 which you described to us at the beginning of your evidence and level 3, the regional level, and whether level 4 should have permitted more flexibility or a greater degree of local discretion, depending on the local levels of pressure or impact?

A. So I think that's been a thread through pretty much everything that we have discussed today, that balance

between the more directive approach and the guidance that, you know, is one-size-fits-all versus giving local organisations and healthcare systems the flexibility. We've discussed that in terms of Long Covid. We've discussed that in terms of visitor guidance. It's inevitably a balance and a set of judgments that will change during the course of an incident and will be contextual to the particular issue you're dealing with.

So I don't think there's a straightforward answer to that. You can't pre-specify it. I think you need to be aware of it and you need to ensure that you are thinking through whatever policy or whatever process you are involved in, what is, at this particular time, in this particular context, the right balance between a more rigid set of instructions versus the flexibility to do things locally? It's not black or white. It's not one or the other, it's a series of judgments.

Those judgments won't always be the right judgments. In hindsight you will inevitably look back and say: we could have balanced it a little bit differently. But you have to make them and you have to make them in fast moving circumstances. You don't have the luxury often to wait a week or two; you sometimes have to make them in days. And you have to make them sometimes on the basis of the evidence not being

available that you would like to have available.

So I think it's right that we think about that and I said right at the start when I talked about the incident 4 level that although it gave us a command and control structure, it didn't mean that we didn't recognise the need for flexibility and local decision-making.

And so equally, and I was in this position when I was a medical director of a hospital, you can be frustrated that you are being told to do something and on occasions you wish you were being told to do something. Both are true.

Q. In relation to the EPRR framework, I think you've noted that the section concerned with inequalities during a major incident has been updated and there's some specific guidance being developed. Can you assist the Inquiry with a little more detail about that.

A. So I think the framework is still in development. I think we have -- it has been -- it has been made available but it's still in development, so I think the sensible thing would be to be in touch with you when we are further down the line in terms of the development of that framework.

Q. One point you have made in relation to that is that digital exclusion should be seen as another lens within

health inequalities. Has digital exclusion been added, for want of a better word, to the inequalities framework?

A. Yes, and as we've discussed previously, I think, digital exclusion, or the use of digital technologies both has the potential to exclude but it also has the potential to include vulnerable groups and those who are disadvantaged. We see that outside of the pandemic in some of the digital services that we provide, where the uptake is greater in individuals who, for whatever reason, don't uptake offers in a more traditional sort of healthcare process.

Q. Data and information sharing. The Inquiry has heard from a general practitioner who described a deluge of guidance documents in general practice. Normally they would receive 10 to 20 documents in a year but in the first two years of the pandemic received over 400 documents, mostly related to Covid. You've noted in your witness statement that in deciding when and how to issue guidance, NHS England had to take into account the existing guidance and communication being placed on the system so as not to overwhelm the system and colleagues working within it.

Do you think the balance was right? Do you think there should have been more collaboration or cooperation

between royal colleges and other professional bodies to make sure there wasn't duplication and information overload?

A. So, again, it's a question of balance. You can give too much guidance, you can give too little guidance. For everybody who I hear from who says we gave too little guidance, there's probably somebody else who said, "I wish we'd had guidance in this area", and to an extent you will never get that balance right and nor should you expect to, but the principles, I think, as I've outlined a few times this afternoon, are that wherever possible we want to develop guidance in collaboration with partners in. That could be the royal colleges, it could be charities, it could be think-tanks, it could be a range of people and, of course, the public and patients in general.

There are limitations about how you can do that in the middle of a pandemic when you are trying to get guidance out quickly because there is a need to get it out quickly and that is a trade-off that inevitably you have to make but the principle is, wherever possible, do that in consultation and you can -- you have given some examples within maternity how the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives helped us.

We can and we do ask other parties such as the royal colleges to develop guidance on our behalf, so that occurs outside of pandemics and it certainly happened within the pandemic.

So it's not just about us, we can lean into guidance that other people are doing. We can badge guidance that others have produced, if we feel that's appropriate and that we can sign up to it.

But it's a question of balance and both testing the water in terms of whether people feel they are getting too much or whether they are getting too little, and it will vary from topic to topic.

So, again, it's one, I don't think where you can give a black or white answer. All you can say is you have to be tuned into it, you have to be aware of it, you have to take it into consideration. You will never it right for everybody but you try and get it right for as many people and many organisations as possible.

Q. Resilience of the healthcare system for future pandemics. And you've mentioned several times this afternoon the importance of having a resilient system with enough capacity in it. And in your witness statement you have quoted the former CEO of NHS England, Sir Simon Stevens. He said this:

"If Covid-19 teaches anything it is that relying

on just in time emergency response can end up being more dangerous and far more expensive than building adaptable and resilient capabilities ahead of time."

What would you identify, Professor Powis, as the key steps that need to be taken now to build resilient capabilities for a future pandemic?

A. I'd answer that in a number of parts.

The first is around investment is estate. Clearly much of the estate and the NHS in England is much older than it needs to be and that has a whole host of consequences. We haven't talked about it, but I know you will have heard how we had difficulty piping oxygen through to certain ward settings in older estate where the plumbing, the piping simply could not take the volumes of oxygen going through it. We talked about the issues of single rooms versus more open wards where infection spreads more easily. We haven't talked but we could talk about the problems of ventilating spaces adequately.

So that means capital investment in hospitals and also in other healthcare settings. You will, I'm sure, have noted that Lord Ara Darzi published an independent review of the NHS only a few weeks ago, who made exactly the point there has been an underinvestment, comparatively, in capital, ie in bricks and mortar, in

the NHS. So there is no doubt that a sustained capital investment programme to bring NHS estate up to date to make sure it's fit for purpose across all range of health settings would give us more resilience.

More staff would give us more resilience. I've talked about the long-term workforce plan. That is an area where the previous government and this government, who supported the approach in opposition, obviously they will be looking at the plan themselves, but that plan to expand, double the number of medical school places, increase the number of nurses, increase the number of GPs, simply having more staff and relying less on agency staff for instance will make the NHS more resilient.

Also having staff that have a more set of generalist skills and they're not simply specialists will help and we are making progress with the colleges on ensuring that will happen.

Infrastructure, IT infrastructure. We've talked about data collection, we've talked about the power of data, having better IT systems, having systems that can talk to each other, that can automatically generate the data and, of course, the federated data platform which we have rolled out after the pandemic has actually taken the lessons of the pandemic in terms of the data sharing

we were able to do and we are now using that to bring databases together to give us much more insight into population health and into how we can run the health service efficiently.

Having said that, and that will give us more resilience, you would still need surge capacity in a pandemic. And it is absolutely the case that even those countries, France, Germany, the United States, that have more doctors than we have per head of the population, who have more modern up-to-date estates, got to the point where they were struggling to meet demand and running out of capacity, and they needed to put in mutual aid.

So resilience will absolutely help us, it will help us in recovery as well. One of the problems in terms of recovering from the pandemic is that lack of resilience. But we will still need to have those surge plans in place. We can't simply rely on more staff, better estate, we will need to do, as we did this time, and have a surge plan which is where the importance of planning for the right pandemic and having the EPRR structures around incident responses and having them as strong as possible are the things that will set us in the best possible stead for a future pandemic.

Q. Thank you very much, Professor Powis, that's

a comprehensive answer that you've given. I'd like to ask you this: is there anything else, in addition to what we've already discussed and the very comprehensive answer that you have just given, are there any or key recommendations for the healthcare system you'd like the Inquiry to bear in mind, or do you think we've covered all those points this afternoon?

A. I mentioned a few. A few I didn't mention would be with respect to NICE, to consider whether they should be a Category 1 responder, which would give them some of the responsibility and capabilities to stand up -- I mean they stood up magnificently, but I think being a Category 1 responder focuses you to be able to respond in a crisis.

I think I have probably mentioned a number of other recommendations that you will have captured along the way, and so I'm very happy to give you in writing anything else that comes to mind other than what's in the statement, but I think you've had a lot of recommendations.

And the one thing I would say is, going back to Long Covid, which I didn't tell you when I answered, is that we do have a registry of Long Covid cases, and I will go back and check whether it's in a format that would allow to us say something about healthcare

workers. So we will let you know on that one too.

MS NIELD: Thank you very much. Professor Powis, I have no further questions for you.

LADY HALLETT: If we could finish you tonight, Professor, I would carry on, but I'm afraid it's just over an hour's worth of questions from the core participants and you've had a long day so far, so although my ever-efficient ushers have been getting people ready with lecterns for questions, if everyone will forgive me, I think we will finish now and come back on Monday, 10.30, 11 November, please, and we'll see you again then.

THE WITNESS: It will be a pleasure to see you again.

LADY HALLETT: Thank you.

(4.16 pm)

(The hearing adjourned until 10.30 am on Monday, 11 November 2024)

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