

Thursday, 7 November 2024

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2 (10.01 am)
3 **MS HANDS:** My Lady, good morning. May I please call
4 Professor Simon Ball.
5 **PROFESSOR SIMON BALL (affirmed)**
6 **Questions from COUNSEL TO THE INQUIRY**
7 **MS HANDS:** Professor, good morning. You've produced
8 a statement for us and that is our reference
9 INQ000477597.
10 Professor, it's correct that you were the Chief
11 Medical Officer for the University Hospitals Birmingham
12 NHS Foundation Trust from January 2019 to January 2024,
13 is that right?
14 **A.** That's correct.
15 **Q.** The questions I'm going to ask you today are focused on
16 the Queen Elizabeth Hospital specifically and that is
17 a hospital within that trust, is that right?
18 **A.** That's correct.
19 **Q.** Can you paint a picture for us of the hospital estate
20 and how that may have benefited you or otherwise during
21 the pandemic?
22 **A.** Yes, so the Queen Elizabeth Hospital, which I'll refer
23 to as the QE if I may --
24 **Q.** You may.
25 **A.** -- is largely supported by a modern estate, so a large

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1 **Q.** So is it right to say you took action before that
2 policy?
3 **A.** That's correct.
4 **Q.** And did you take any further action once that policy had
5 been issued to increase or to discharge patients from
6 those beds?
7 **A.** So the NHS England policy was actioned on the 17th. It
8 was apparent to the senior clinical leadership that the
9 pandemic was going to significantly affect the country
10 so we continued on the work that was -- already had been
11 going on over the previous two weeks to reduce bed
12 occupancy by expediting discharge and then from that
13 point forward we stopped almost all active admission
14 other than those that were urgent.
15 **Q.** And is it right that you expanded the ICU bed capacity,
16 from the 67 you've just referred to, to 126 by
17 April 2020?
18 **A.** That's correct, yes.
19 **Q.** Can you give us an idea as to how you went achieving
20 that, at a practical level?
21 **A.** So I think the first thing that I should say is that
22 part of -- much of this was delivered by senior
23 responsible clinicians that we appointed at a hospital
24 level, and who were leading the ICU response as well, so
25 we changed our -- the way that we'd organised our

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1 hospital building with some historic buildings alongside
2 it, that was opened in 2011, so a largely modern estate
3 with around 46%, I think, single side-rooms, so with
4 en suites and then in most of the rest of the rooms then
5 four-bedded bays with, again, bathrooms associated with
6 each four-bedded bay, so no open wards as such.
7 In addition to that, the hospital was designed
8 with 100-bedded, capacity for 100 ICU beds of which 67
9 were funded so very, very large capacity for intensive
10 care.
11 **Q.** I want to start with that topic of bed occupancy and
12 capacity. On 17 March 2020, the NHS England discharge
13 policy was issued. At that point it's right, isn't it,
14 that the hospital had over 1,000 general and acute beds
15 with approximately 960 occupied?
16 **A.** Yes, at that stage, yes.
17 **Q.** And of those 67 ICU bed you have just referred to
18 approximately 40 were occupied?
19 **A.** By that stage, that's correct.
20 **Q.** So would it be accurate to say at that date there was
21 some available capacity?
22 **A.** Yes, because we actually recognised the fact that the
23 pandemic was coming in the year leading up to that,
24 there was approximately 99% bed occupancy across the
25 trust and similarly in the ICU.

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1 hospital and senior clinical management to be very much
2 more site-based and across the hospitals and they played
3 a major role in changing the way that we organised
4 ourselves.
5 To give you a feel, to support 67 ICU beds you
6 probably need around 450 nurses to provide one-to-one
7 care so -- and when we topped out the following January
8 we're talking about providing the equivalent of 1,000
9 ICU nurses. So --
10 **Q.** I want to stop you there for one moment. We will come
11 on to look at the expansion of capacity in January when
12 in fact it expanded further, didn't it --
13 **A.** It did.
14 **Q.** -- into 2021? I think you've said in your statement
15 that in April 2020 the expansion would have required
16 an additional 205 doctors and 429 nurses?
17 **A.** Yes.
18 **Q.** Does that sound right?
19 **A.** That sounds right. So the equivalent, getting on for
20 1,000 in total to provide that kind of level of support.
21 And so that meant bringing in staff who were not
22 currently working on ICU so that meant staff nurses that
23 were working on the wards, we had support from across
24 the -- what is now the ICS, then the system, so other
25 hospitals within the Birmingham and Solihull system had

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1 staff members redeployed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 and in fact you received 363 transfers in during the
 2 pandemic, is that right?
 3 **A.** That's true, that's the intensive care -- I think you're
 4 referring to the intensive care transfers. So most of
 5 the QE's intensive care capacity meant that almost all
 6 of the transfers were in, and they were mostly in from
 7 other hospitals within Birmingham and Solihull, and that
 8 reflects the fact that there was such a high incidence
 9 of Covid-19 requiring ventilation across Birmingham and
 10 Solihull.
 11 **Q.** There were some transfers out of the hospital, wasn't
 12 there; 43 of the 160 transfers out occurred during
 13 a 28-day period at the end of January 2021. Again, were
 14 they ICU transfers?
 15 **A.** The paragraph you're referring to ICU, transfers
 16 co-ordinated by the national and regional co-ordination
 17 teams, and those were hugely appreciated, obviously by
 18 the teams, not only just the sheer numbers, but just
 19 feeling that they were being supported by -- across the
 20 nation, actually, and understanding of quite how intense
 21 the requirements for intensive care in the hospital
 22 were.
 23 **Q.** What were the reasons for such a high number of
 24 transfers in that short period of time?
 25 **A.** So in January 2021, across the trust, and we were

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1 basis for admission to ICU, benefiting the patient
 2 population and not altering the basis for admission in
 3 the face of the pandemic nevertheless came at
 4 significant, often personal cost, is that right?
 5 **A.** I think that's true, and I think that there is no doubt
 6 that operating at the level of intensity even for
 7 experienced ITU nurses, dealing with such an influx of
 8 very acutely sick patients who often spent many,
 9 many weeks on intensive care to recover, as you know,
 10 a very high mortality particularly in that first wave
 11 came at significant personal cost in terms of
 12 individuals' well-being, I think that's entirely true.
 13 **Q.** And I think you said in your statement that there was
 14 also an impact on the staff that were treating patients
 15 outside of ICU, as well.
 16 **A.** I think it's easy to focus on ICU. I think we need to
 17 remember that the majority of patients were cared for on
 18 the wards, and again we were dealing with, even for
 19 staff members who were used to dealing in highly intense
 20 environments in populations with -- who were quite often
 21 very sick, this was a step up again, and then we were
 22 bringing in staff from across the hospital who weren't
 23 used to working in acute medical wards at that level of
 24 intensity, dealing with patients who were dying, and who
 25 were quite so acutely sick. So I think it's really

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1 operating as a single trust in terms of provision of ICU
 2 care in particular, we peaked at more than 100 Covid-19
 3 admissions in a day, so there were huge demands with
 4 regards to that peak of Covid-19 presentations requiring
 5 hospitalisation and of course a proportion of them
 6 requiring ventilation and on intensive care. So that
 7 was the reason that was -- and I think in our exhibits
 8 you can see this peak in ITU bed numbers around the
 9 21st, I think, of January or so.
 10 **Q.** You've said in your statement that during wave 2, so
 11 around this time, ICU was operating at 206% capacity but
 12 the ICU only came close to crossing the limit at which
 13 it would have been necessary to review criteria for ICU
 14 admission. We will come on to discuss the criteria, but
 15 can we assume from that that the hospital did not cross
 16 the limit?
 17 **A.** You can, and it's difficult to know what that number
 18 actually is, but when you have 142 ventilated patients
 19 on a single floor ICU you are really looking for at the
 20 limits of capacity, but I think it's probably fair to
 21 say that if I'd have asked the teams when we first
 22 started, could we have ventilated 142 patients, they
 23 would have had their doubts. So it's difficult to know
 24 exactly where that limit was, but we didn't reach it.
 25 **Q.** You've said in your statement, in short, maintaining the

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1 important that that's acknowledged as well.
 2 **Q.** And can you provide some examples of how the hospital or
 3 the trust more widely supported staff not only working
 4 in ICU but also on those wards as well?
 5 **A.** Yes, I mean, I think that -- I mean, the important thing
 6 to say is that our approach was multi-factorial. It
 7 involved local support and a significant amount of local
 8 support from the local managers but then broader
 9 approaches to maintaining and sustaining health and
 10 well-being, both using kind of national approaches,
 11 training staff as psychological first aiders and then
 12 kind of practical things just on a -- in terms of
 13 provision of food and provision of drinks and the like
 14 on a -- particularly at those peaks when we were
 15 actually separating, and ensuring that members of staff
 16 weren't meeting, that is to say they were meeting
 17 infection prevention and control guidelines.
 18 And if I may just briefly dwell on that. I think
 19 that was particularly tough for staff because in
 20 those -- in the setting where you're dealing with
 21 something completely new and highly stressful then you
 22 normalise that by discussing those matters again with
 23 your colleagues, understanding what -- that you are not
 24 the only person who is going through that.
 25 So in addition to this, the challenges around

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

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

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

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

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

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

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1 ethics group.

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

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

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

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

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

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

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1 supported decision-making around admission; is that
2 correct?

3 **A.** That's true, yes.

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

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

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

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

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

8 **A.** I think it was in April of 2020.

9 **Q.** 2020?

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

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

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1 So did those insights such as the one you've
2 explained here inform the ICU admission criteria and the
3 guidelines that were developed?
4 **A.** I think not so much -- ICU admission criteria but
5 overall approach to treatment of patients, I think,
6 around where your level of concern is and what have you.
7 Yeah, I think that paper was published -- was based on
8 data up to the end of April and we'd already admitted
9 2,200 patients at that point. So we were constantly
10 learning from the data as it came through.

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

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

17

1 heard but for those watching.

2 **A.** My apologies.

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

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

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

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

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

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

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

24 **A.** Sorry, yes, I do.

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

18

1 future response.

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

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

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

18 **A.** That's correct, yes.

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

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

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

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

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

21

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24

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

12 **LADY HALLETT:** But the content, Professor.

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

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

25

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

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

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

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

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

27

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

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

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

20 **A.** Yes.

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

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

26

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

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

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

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1 staff through challenging times.

2 **Q.** In terms of Covid-19 testing, did you have any problems
3 accessing a sufficient number of Covid-19 tests for
4 staff during the early stages of the pandemic and did it
5 improve?

6 **A.** So I mean, the answer is, yes. But I think, if I could
7 add, I think the speed at which testing was developed
8 and ultimately implemented was pretty impressive in
9 fact. Of course yes, in the first month or two after
10 the pandemic, yes, it led to particular challenges
11 around getting staff -- identifying that staff were
12 positive or negative and then planning with regards to
13 deploying staff and what have you. But in truth,
14 knowing about how long it usually takes for tests to
15 come into being then it was pretty impressive actually
16 how quickly it was achieved.

17 **Q.** Moving on to nosocomial transmission. You've set out in
18 your statement that the hospital experienced 73 Covid-19
19 outbreaks from 1 September 2020 to June 2022 and that's
20 defined as two or more cases linked in place and time.
21 In your investigation of those experiences, were you
22 able to establish any significant repeat contributory
23 factors to the rates of transmission?

24 **A.** So I think the first thing to say is that before the
25 availability of regular testing of staff and of patients

29

1 concern.

2 I think that what we did was to try and work with
3 those members of staff to provide them with as much
4 information as possible both with regards to addressing
5 any concerns with regards to vaccination, but also
6 being, you know, supporting them if they had chosen not
7 to be vaccinated as to actually what would -- what the
8 outcome would be, how one could adapt things, etc.
9 I think in that we were hugely supported by our
10 staff-side representatives who were, you know, very,
11 very helpful in that regard.

12 **Q.** What would the impact have been if you had lost those
13 staff members due to the policy being introduced?

14 **A.** I'm not sure that we've actually quantified that, if I'm
15 honest, because obviously that policy was then changed.
16 I think it would have been significant but I think it
17 would have been even more significant in terms of the,
18 you know, concerns of their close colleagues and their
19 perception of the fairness of their contribution to the
20 Covid pandemic response having been acknowledged.

21 **Q.** Briefly on the topic of visiting guidance, the Inquiry
22 has heard a lot of evidence about visiting guidance so
23 I just want to ask you about two discrete topics in this
24 regard. The first is in regard to what local guidance
25 and discretion was in place during the pandemic to allow

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1 then, you know, that was clearly a significant
2 contributory factor. I think, if I may, I'd also say
3 that the rates at the QE were really relatively low and
4 I think benefited from the estate that I've just
5 referred to. It was, you know, the estate was very
6 different in our other hospitals, some of which in are,
7 kind of, late 19th/early 20th century estate, much more
8 crowded, beds that are closer together than the very
9 wide-spaced-out beds on the wards of the QE, corridors
10 that you can't fit two beds down which you can at the
11 QE, so I think that comes back to the estate question.

12 **Q.** Moving on to vaccination as a condition of deployment.
13 You have very helpfully set out in your statement all of
14 the actions that the hospital and the trust took in
15 order to prepare for that being introduced. You've
16 described it as time-consuming and difficult due to
17 access to data being variable.

18 What was the impact on staff of the prospect of
19 this being introduced?

20 **A.** So there's the impact on the staff who were kind of
21 directly affected, I think it's fair to say, and then
22 there's the impact on the staff who had been vaccinated
23 because, you know, they had colleagues who were being
24 affected who had stood by them during the course of the
25 pandemic and I think that that was a clearly widespread

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1 for visitors to attend in specific circumstances and
2 whether that changed?

3 **A.** So the local guidance around discretion was effectively
4 in a number of areas one of which was end of life, one
5 of which was -- and the other predominant one was those
6 with difficulty communicating, so patients with
7 dementia, with learning disability, autistic spectrum
8 disorder, and then particularly as -- for those with
9 prolonged admissions, those whose mental health was
10 really significantly suffering from -- in the context of
11 a prolonged admission. So those were the opportunities
12 for -- or the guidelines around particularly appropriate
13 room for discretion.

14 **Q.** And again in your statement you very helpfully set out
15 in detail the role of the ICU family liaison team that
16 the hospital introduced. Can you briefly tell us what
17 that team did and whether it was successful?

18 **A.** It appeared -- I'll answer the last question first. It
19 appeared to be very successful. The ICU liaison team,
20 so it became clear that, you know, that a lot of the
21 role of an ICU nurse or a part of the role of an ICU
22 nurse is talking to family and liaising with family.
23 It's incredibly stressful to have a family member on
24 ICU. That was simply not possible in the settings of
25 levels of protection from aerosol-generating procedures.

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

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

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

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

19 **A.** Outside of ICU I mean, yeah.

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

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

33

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

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

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

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

24 **LADY HALLETT:** Thank you, Ms Hands.

25 Ms Jones, Jessica Jones. Behind the pillar at the

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1 provide that --

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

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

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

13 **A.** February 20 -- I think a number of months earlier but we
14 were in the middle of the, if we think about the peaks
15 of the pandemic and what have you, really latter part of
16 2021 might have been useful. I think it's, you know,
17 I'm just thinking about our ability to respond to the
18 guidance, and what have you, would really have been --
19 would really have come along in mid-2021 onwards.

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

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

34

1 back.

2 Questions from MS JONES

3 **MS JONES:** Thank you.

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

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

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

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

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

3 So that team more than quadrupled in size across
4 the pandemic, and they were able to support each of
5 the -- every ward around patients with dementia, with
6 learning disability, with autistic spectrum disorder.

7 And so, I think, as time went on and as that team grew
8 in size, then again they were able to act as combined
9 advocates, as it were, in addition to the family and
10 loved ones.

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

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

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

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

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1 those circumstances.

2 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 **MS JONES:** Thank you.

23 Thank you, my Lady.

24 **LADY HALLETT:** Mr Jacobs.

25 **Questions from MR JACOBS**

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

4 **A.** Yes.

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

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

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

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

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

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

13 **MR JACOBS:** Thank you very much.

14 **LADY HALLETT:** Thank you, Mr Jacobs.
15 Ms Munroe, please.

16 **Questions from MS MUNROE KC**

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

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

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

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1 response.

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

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

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

21 **A.** Correct.

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

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

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

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

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

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

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

9 **Q.** Yes.

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

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

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

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

6 **A.** Thank you.

7 **Q.** Just to assist. And in terms of the TEAL forms, there
8 was an increase, I think again from your statement, from
9 20% prior to the pandemic to a peak of 60%?

10 **A.** Yes.

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

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

15 **Q.** Right.

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

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

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

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

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

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

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

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

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

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

11 **Q.** Thank you very much, Professor.

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

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

21 **A.** Yes.

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

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1 burden on the hospitals within the trust?

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

11 **MS MUNROE:** Thank you very much, Professor.

12 Thank you, my Lady.

13 **LADY HALLETT:** Thank you, Ms Munroe.

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

20 **THE WITNESS:** Thank you, my Lady.

21 **(The witness withdrew)**

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

23 **(11.24 am)**

24 **(A short break)**

25 **(11.42 am)**

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

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

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

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

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

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1 **LADY HALLETT:** Ms Nield.

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

4 **PROFESSOR SIR STEPHEN HUW POWIS (sworn)**

5 **Questions from COUNSEL TO THE INQUIRY**

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

8 **A.** Not at all, thank you.

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

10 **A.** Stephen Huw Powis.

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

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

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

23 **A.** I do.

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

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1 since early 2018; is that correct?

2 **A.** Correct.

3 **Q.** And you're also a professor of renal medicine at

4 University College London?

5 **A.** Yes, I have an honorary chair. I was a substantive

6 professor until I left for NHS England and then I was

7 given an honorary chair.

8 **Q.** And you were previously Medical Director and, latterly,

9 Group Chief Medical Officer of the Royal Free London NHS

10 Foundation Trust from 2006 to 2018, is that right?

11 **A.** That's correct.

12 **Q.** And you were not, I think, in clinical practice during

13 the pandemic?

14 **A.** No, I stood down from clinical practice temporarily

15 a couple of years before I left the Royal Free. We had

16 additional work to do that required me to do that. And

17 then when I left to come to NHS England, because of the

18 nature of my clinical work, which was looking after

19 long-term transplant patients, I didn't feel it was

20 going to be possible to do that to the satisfaction of

21 staff and patients and therefore I elected to stay out

22 of clinical practice.

23 **Q.** Thank you. I think during the relevant period you held

24 a number of roles and responsibilities which you've set

25 out in your witness statement but perhaps I can

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1 Education England more recently, it has taken on a wider

2 role, for instance it has some regulatory powers as

3 well.

4 But fundamentally it's a commissioner and

5 a co-ordinator of healthcare across England and also has

6 an oversight role in ensuring that healthcare services

7 are delivered.

8 The government gives us a mandate regularly,

9 asking the -- indicating to the NHS what it wishes the

10 NHS to focus on and, for example, each year we will

11 translate that into operational planning guidance which

12 is then provided to NHS organisations.

13 **Q.** And is it right to say that NHS England therefore does

14 not provide healthcare services but rather commissions

15 them or oversees commissions?

16 **A.** Yes, as I'm sure you know, the NHS is an ecosystem of

17 many, many organisations many of which are their own

18 statutory organisations and, of course, when it comes to

19 primary care and general practice they are independent

20 businesses with whom we have a contractual relationship.

21 So we don't provide those direct services. We provide

22 a few patient-facing services, particularly since

23 NHS Digital has come into NHS England, but that was

24 after the relevant period.

25 **Q.** Thank you. Your third witness statement sets out that

55

1 summarise them in this way.

2 You were an NHS England board member?

3 **A.** Yes.

4 **Q.** A member of the National Incident Response Board. You

5 deputised for Lord Stevens the former Chief Executive of

6 NHS England at government meetings. You attended SAGE

7 meetings regularly. And I think you were also the

8 interim Chief Executive Officer of NHS Improvement

9 between 1 August 2021 and 31 July 2022 on which date

10 NHS Improvement was abolished and legally became part

11 the NHS England; is that right?

12 **A.** All correct.

13 **Q.** You have explained that NHS England is an executive

14 non-departmental public body sponsored by the Department

15 of Health and Social Care but is it correct that that

16 has a degree of autonomy from the Secretary of State?

17 **A.** We have a degree of autonomy as what's commonly known as

18 an arm's length body but clearly we work very closely

19 with the Department of Health and Social Care and with

20 the Secretary of State.

21 **Q.** And could you please briefly outline for us the role of

22 the NHS England in the NHS system in England.

23 **A.** So NHS England is fundamentally a commissioner of

24 services although with the merger of other organisations

25 such as NHS Improvement, NHS Digital, and Health

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1 NHS England is a Category 1 responder under the Civil

2 Contingencies Act and maintains an emergency

3 preparedness resilience and response plan to enable it

4 to respond to a wide range of incidents and emergencies

5 such as a pandemic. And you've also set out that

6 throughout the relevant period of this module, which is

7 1 March 2020 to 28 June 2022, NHS England was operating

8 at an NHS incident level 4 or level 3 at different

9 points throughout that relevant period.

10 Could you please explain to us what level 3 and

11 level 4 meant in operational terms?

12 **A.** So level 4 is the point at which NHS England takes

13 a much more direct command and control role within the

14 system. So, for instance, that means much greater

15 oversight of data collection, much greater operational

16 input, much greater control and oversight of supply

17 chains for example, more involvement in issuing guidance

18 through to healthcare providers and healthcare systems,

19 and that is co-ordinated at a national level.

20 Level 3 you could think of as very similar but the

21 co-ordination is at regional level rather than national

22 level and is most suited to when there are regional

23 variations in the incident or the incidents that are

24 occurring within a single region.

25 **Q.** And when we say at regional level, I think it's right

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

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

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

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

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

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

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

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

14 But during the pandemic, I was much more pulled
15 into, for instance, advice to government and advice to
16 ministers, much more pulled into media and public-facing
17 tasks. You will be aware that I did over
18 30 Downing Street press briefings, for example, and
19 obviously pulled in to assisting with the overall
20 operational role.

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

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

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

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

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

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

18 **A.** Yes.

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

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

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

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

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

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

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

22 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

22 **Q.** When you talk about --

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

24 **A.** Certainly.

25 **MS NIELD:** When you talk about operationalising that

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1 cons of that approach.

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

4 **A.** Certainly.

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

8 **A.** Yes.

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

10 **A.** Correct.

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

15 **A.** Yes.

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

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

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

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

19 **A.** Yes.

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

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

4 **A.** Correct, and if I could give some additional context.

5 As you would expect, because of its role, NHS England
 6 does regularly collect and publish healthcare data from
 7 healthcare systems and healthcare providers. We collect
 8 information on the amount of elective care that is
 9 undertaken, on performance in A&E departments, you will
 10 see that published every month on a regular basis.

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

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

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

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

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

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

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1 collected data every day.

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

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

10 **A.** Yes.

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

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

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

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

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

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

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

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

25 Looking at that expanded data on oxygen,
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1 care units, level 3 units. Typically, if a patient only
2 required simply oxygen and increase in oxygen
3 concentration that would not be a reason for moving to
4 an HDU or a critical care unit. The patient would need
5 additional support in order to make that escalation.

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

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

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

24 So it gives us an indication of the necessary
25 deployment of resource and staff and depending on the
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1 non-invasive and mechanical ventilation, if we can go
2 down to (f) we see that these were then specified as O,
3 O+ and V. So would non-invasive ventilation include
4 CPAP, we have something about?

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

10 **Q.** Mechanical ventilation would require --

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

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

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

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

23 **A.** So O, simple oxygen can be provided in many settings, it
24 would typically be provided in wards, but it obviously
25 can be provided in high dependency units and critical
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1 proportions of patients in all of those groups, that
2 would have a very different impact on the workforce and
3 on the resources that we had to deploy.

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

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

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

23 **A.** Not that I recall although I'm very happy to check for
24 you, but we did feel it was -- and you are quite
25 correct, there are challenges around collecting
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1 ethnicity data and we are always striving to do better.
 2 **Q.** Has that changed? Have there been any changes made to
 3 the way that ethnicity data is now collected or coded in
 4 the NHS system?

5 **A.** I think the focus is on collecting the data and filling
 6 the gaps rather than necessarily simply changing the
 7 underlying coding and collection. But, again, very
 8 happy to check and give you further information on that.

9 **Q.** Thank you. We can take that down now, thank you.
 10 So the sitrep data was collected by NHS England,
 11 it was sent in by individual trusts or hospitals. Is
 12 it, then, to some extent relying on the accuracy and the
 13 timeliness of those sitrep requests being completed and
 14 sent back?

15 **A.** Yes, absolutely. And, of course, there are pros and
 16 cons of collecting data in essence in realtime. So as
 17 I said earlier, in those data collections that take
 18 longer to collect, there is an opportunity to validate
 19 the data, there's an opportunity to check the data so it
 20 is as accurate as possible.

21 When you are collecting data, as we were in the
 22 sitrep that is collected in organisations at 8 o'clock
 23 in the morning and is essentially made available across
 24 key decision-makers and across the system by lunchtime,
 25 the opportunity to verify the data, the opportunity to

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1 would be collected in realtime, and of course it would
 2 be the same sort of data in terms of bed numbers and
 3 patients in beds that would be collected through the
 4 sitrep.

5 **Q.** Can we have a look then at some of the categories of
 6 data. Plainly, 23 January 2021 was a time when the
 7 system was under considerable pressure. We see a lot of
 8 red on this dashboard, but if we can look in particular
 9 at the kind of information that's collected and how
 10 that's been presented. We see at the top "Baseline
 11 beds". Does that mean the number of beds that were not
 12 considered to be surge capacity but the number of beds
 13 that we started from?

14 **A.** I believe so, but I can't give you the exact information
 15 on when that baseline collection was made. But, yes you
 16 are right that would be baseline core capacity.

17 **Q.** And we see "Beds within ACC"; "adult critical care"?

18 **A.** I believe so.

19 **Q.** "Surge Beds", so these are over the baseline?

20 **A.** These are beds that we would have surged into other
 21 areas as part of the surge plan, so that would typically
 22 be theatre recovery areas, even theatre spaces, spaces
 23 where it is possible to provide critical care but
 24 requires an increased effort and they're not designed to
 25 do that on a permanent basis.

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1 check its accuracy is very limited and if you looked in
 2 detail at those datasets, that sitrep, you would see
 3 from time to time an obvious error where a hospital has
 4 entered a number of patients. It is clearly different,
 5 vastly different from the day before or the day after,
 6 and clearly somebody has entered a wrong number. But
 7 the principle was that the benefit of getting that data
 8 as quickly as possible outweighed any disbenefit from
 9 the occasional error in the data because it was designed
 10 to give us a system-wide overview and the small errors
 11 that occurred in individual organisations did not impact
 12 upon that.

13 **Q.** Can we look briefly, please, at that system-wide
 14 overview. Can we see one of the -- thank you. This is,
 15 I think, a dashboard. This is from collating the daily
 16 sitrep data?

17 **A.** In fact I believe this data was collected separately
 18 from the sitrep, this is data, I think, from the Alpha
 19 wave in January 2021, 23 January 2021. And this was
 20 data that came direct from critical care units in order
 21 to assist with the process of delivering mutual aid to
 22 organisations that were running out of capacity.

23 **Q.** So that would be if a patient had to be transferred to
 24 a critical care unit?

25 **A.** Yes, but the principles are the same, in that the data

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1 **Q.** And we've also heard that means a stretched staffing and
 2 nursing ratio as well.

3 **A.** Absolutely.

4 **Q.** Yes. And then we see "Total Beds", "Beds up in
 5 48 hours", does that mean beds that can be made
 6 operational --

7 **A.** I believe that would be a prediction of the beds that
 8 are likely to become available based on local knowledge
 9 of patients who are likely to be discharged from ITU.

10 **Q.** We can see, moving down, "Occupancy against Baseline
 11 beds", so at this point all the baseline beds are
 12 occupied, 100%, and 51.6% above base, 42.4% above beds
 13 within adult critical care. So does this mean that
 14 51.6% of the surge capacity was being utilised?

15 **A.** Well, I think what it means is that there were 51.6%
 16 above baseline. I am not sure that it would give you on
 17 this dashboard -- I'd need to do the maths to work out
 18 how it relates to the actual surge beds available, but
 19 what it clearly shows is that there's pressure, as you
 20 would expect at this point in the pandemic when we were
 21 at or close to a peak, and that critical care units were
 22 operating above their core capacity.

23 **Q.** And we can see there "Occupancy against Total Beds" is
 24 90% --

25 **A.** Yes, yes --

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1 Q. -- so that tends to suggest that --
 2 A. -- that is a figure that --
 3 Q. -- taking baseline and spread capacity together --
 4 A. Yes, correct, correct.
 5 Q. -- 90% of those total beds were occupied?
 6 A. That is -- yes, correct. That would be the figure for
 7 that.
 8 Q. And if we can look quickly at the coloured numbers,
 9 pastel-coloured numbers on the right-hand side of this
 10 black panel, we can see that Covid suspected, or
 11 Covid-positive patients, on invasive ventilation, the
 12 numbers are given there. Non-Covid patients on invasive
 13 ventilator, Covid-positive or suspected patients on
 14 non-invasive, you have explained that would include
 15 measures such as CPAP.
 16 A. Yes.
 17 Q. Similarly for non-Covid patients on non-invasive
 18 ventilation, and then we have HFNO patients, is that
 19 high flow nasal oxygen?
 20 A. I believe so, yes.
 21 Q. And for both Covid and non-Covid patients, and then
 22 patients that are on some other form of support.
 23 We can take that down -- one final thing we should
 24 probably look at here, if we can scroll down a little
 25 bit, please, we can see that there are a number of

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

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1 hospitals listed there. We don't need to go all the way
 2 down because this is a spreadsheet that goes on for
 3 a long way, but we can see that the CRITCON score, 3A,
 4 2A, 2B, is recorded there and the nursing ratios, and
 5 the total number of patients, and then we can see the
 6 declared available beds, 0 or 1 for a lot of those
 7 hospitals?
 8 A. And I think this gives you a real insight into the sort
 9 of granular data we were collecting and had to collect
 10 in order to perform our duty and responsibility under
 11 a level 4 incident, and this, as I said at the start of
 12 this particular exhibit, was giving our central team, in
 13 cooperation with regional teams, the information that
 14 they needed to understand which hospitals required the
 15 most support, and were either at the point where they
 16 needed mutual assistance, in other words, assistance
 17 from other hospitals, or were getting close to it.
 18 I mean, clearly, that is the purpose of the
 19 CRITCON score; if you heard from other expert witnesses,
 20 you will know that CRITCON 3 is a position where people
 21 are getting close to the point that they need that
 22 mutual aid, and it needs to be considered.
 23 You will see there are no CRITCON 4s there that
 24 are at the point at which they have absolutely run out
 25 of capacity, and it's a mix of 2 or 3.

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

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1 of filling in a sitrep spreadsheet.

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

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

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

10 The Inquiry has heard from Professor Sir Chris
11 Whitty previously who emphasised how important it is to
12 have data on healthcare worker deaths during a pandemic.

13 Am I right that there was a lack of clarity or some
14 disconnect over the way healthcare worker deaths were
15 counted during the pandemic between the Office of
16 National Statistics data and the NHS England records?

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

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

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

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

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

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

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

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

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1 report both patient and staff deaths in the first wave.

2 That data is available. I can't give you the exact
3 details, but I would suspect it is different from the
4 way the ONS collates data. ONS typically collates
5 through death certification, for instance. We would be
6 collecting the data directly from organisations.

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

11 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **Q.** But focusing on that early period --

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

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

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

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

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

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

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

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

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

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

5 **Q.** I think we'll come on to look at that shortly. I think
6 the impetus for this had come from -- it was the
7 Department of Health and Social Care who had made
8 enquiries to get this tool developed but then I think on
9 28 March directed that it shouldn't go ahead. What was
10 the reason --

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

25 Frankly, I was personally terrified, terrified
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1 might be used when it would not need to be used.
2 **Q.** Was there not also a great deal of concern within the
3 Department of Health and Social Care that this tool was
4 going to be very controversial and risk a poor reaction
5 from the public?

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

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

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

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

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

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

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

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

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

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

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

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1 a patient.

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

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

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

25 **MS NIELD:** Do you think there's an element in which the
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1 you say, you've reached the peak of wave 1 but it was
2 also, wasn't it, foremost in everyone's minds there was
3 quite likely to be a second wave and it may be worse in
4 wave 2, so it may be there was going to come a point in
5 the relatively near future where critical care may be
6 overwhelmed?

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

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

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

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

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

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

21 **Q.** Do you think the balance was right?

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

25 **Q.** Can I bring you back on that because at that point, as
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1 I still think that to do this sort of thing, if it does
2 need to be done, require -- it is one of those things
3 that I think would require months of consideration and
4 not in the midst of a pandemic.

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

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

24 **Q.** And with the tool that was eventually published by the
25 ICS, do you know to what extent that adapted version of
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1 this tool was utilised in intensive care units in
 2 England?
 3 **A.** I can't give you information on that, the Intensive Care
 4 Society might need to. I think within that guidance,
 5 which of course is Intensive Care Society guidance, it's
 6 not NHS England guidance, so in a sense it's come from
 7 a professional society rather than a government agency
 8 I think the emphasis was an awful lot more on the
 9 principles of managing patients and escalation in
 10 a pandemic rather than necessarily simply the use of
 11 a tool.
 12 **Q.** Do you consider that at times when ICUs were under
 13 pressure and anticipating an imminent surge in demand,
 14 so not all their beds are necessarily full yet, but is
 15 it possible that a sort of preemptive rationing could
 16 come into play? So decisions being made about which
 17 patients to admit to intensive care, to avoid the
 18 situation where all the beds are already full, and then
 19 the peak of the wave hits?
 20 **A.** That would be the wrong way around in my view because
 21 the CRITCON system and the principles behind it are that
 22 clinicians should continue to make the usual judgements
 23 that they make and, of course, those judgments flex
 24 according to the circumstance. I know that from my time
 25 as a clinician. But, in essence, the object is to

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1 report, but it was -- there were sufficient numbers for
 2 us to become concerned, and therefore necessitate
 3 writing to remind people that this was completely
 4 inappropriate.
 5 **Q.** And that might sometimes be referred to as a "blanket
 6 DNACPR decision", so a decision made on an inappropriate
 7 basis. And the Inquiry has heard evidence of a number
 8 of concerns particularly of some of the core
 9 participants to this module that blanket DNACPR
 10 decisions were being made in healthcare settings. Were
 11 any concerns of that nature brought to the attention of
 12 NHS England during the pandemic? I'm talking about
 13 outside of media reports, but specific instances.
 14 **A.** Yes, we heard this through a variety of sources and
 15 I think I've outlined in the statement at the end
 16 of March and early April, and we took immediate action.
 17 We wrote out and communicated on a number of occasions
 18 during the pandemic to state that the use of blanket
 19 DNACPRs is completely inappropriate.
 20 **Q.** You mentioned earlier that the NICE guidance -- if we
 21 can get up, please, the letter that you issued on
 22 3 April, which makes some reference to the NICE
 23 guidance. It's INQ000216427. So explain there that
 24 you're writing to colleagues:
 25 "... to ensure that there is clarity in relation

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1 ensure that clinicians continue to make the usual
 2 decisions that they would make outside of a pandemic
 3 until the point at which you are at CRITCON 4 which
 4 fortunately we never reached as a system.

5 **Q.** Can we move on, please. You mentioned briefly
 6 DNACPRs --

7 **A.** Yes.

8 **Q.** -- and I wonder if we might move to that topic now, and
 9 the role of NHS England in publishing guidance around
 10 DNACPRs during the pandemic.

11 I think you've set out in your third witness
 12 statement that prior to the pandemic, as a result of the
 13 2019 Learning Disability Mortality Review which found
 14 that in some of the cases, the DNACPR notices that they
 15 reviewed -- which would have been put in place in
 16 2018 -- learning disabilities had frequently been cited
 17 as a reason for a DNACPR notice being placed on
 18 a patient's files.

19 And as a response to those findings, NHS England
 20 in 2019 issued communications to the system to make it
 21 clear that DNACPRs applied generically to patients with
 22 long-term conditions such as learning disabilities are
 23 entirely inappropriate; is that correct?

24 **A.** That's absolutely correct. I wouldn't necessarily say
 25 it was frequently, I'd need to look at the detail of the

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

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

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

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

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

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

20 So were there concerns at that point that the
 21 guideline, before it had been amended, may have misled
 22 clinicians to assume that the Clinical Frailty Scale
 23 might also be applicable to younger people when they
 24 making DNACPR decisions? Was that the risk --

25 **A.** Clearly, that was the risk that we wished to address

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

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

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

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

19 **Q.** Can I ask you briefly, after this letter was sent on
20 3 April I think you wrote again on 7 April in relation
21 to blanket DNACPRs being inappropriate on the basis of
22 simply a medical condition, a disability, or age.

23 After those two letters had been sent out on 3 and
24 7 April, did NHS England at that point undertake any
25 sort of follow-up to establish whether that guidance was

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1 (12.52 pm)

2 (The short adjournment)

3 (1.50 pm)

4 **LADY HALLETT:** Ms Nield.5 **MS NIELD:** My Lady.

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

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

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

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1 being appropriately implemented?

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

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

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

18 **LADY HALLETT:** Yes, certainly.

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

23 **THE WITNESS:** I think it will be fine.

24 **LADY HALLETT:** I'm really grateful.

25 Very well. I shall return at 1.50.

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

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

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

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

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1 of an internal process?

2 **A.** It depends a little bit on the QOF indicator. So we
3 would have information on which practices had undertaken
4 the particular QOF indicator or the response to it, and
5 if that QOF indicator required the generation of data,
6 then there may be ways that we could collect that data,
7 so for instance, a QOF indicator incentivising
8 measuring -- monitoring blood pressure, identifying new
9 cases of high blood pressure, we would be able to get
10 the data in terms of how many patients had their blood
11 pressure identified or treated to optimum standards.

12 **Q.** But so far as you are aware in relation to this
13 DNACPR -- (*Unclear: multiple speakers*) --

14 **A.** No, and --

15 **Q.** -- it doesn't appear that that data was -- (*Unclear:
16 multiple speakers*) --

17 **A.** No, and because of the operational disruption as to
18 whether it actually got as far as being a QOF that was
19 used in practice. But very happy to provide further
20 information.

21 **Q.** Thank you. Related matter. You explain in your witness
22 statement that I think in response to the
23 recommendations of the Care Quality Commission report
24 which you've referred to earlier, which was published
25 in March 2021, I think that's right, NHS England

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1 As you know, the ReSPECT form is used in many
2 parts of the country but there are other processes in
3 place in order to apply those principles, and our view,
4 as I've discussed with you earlier, is that we do like
5 to allow local flexibility so that local healthcare
6 systems can determine what is best for their populations
7 and patients.

8 **Q.** The Resuscitation Council UK who developed that ReSPECT
9 form made a recommendation to the Inquiry that it would
10 be better for reasons of consistency, and for other
11 reasons, for other practical reasons, if there was
12 a uniform, universal form of documentation to record
13 patients' wishes, advanced care plans, including DNACPR
14 wishes, that should be applied across all four nations
15 of the UK, whether that be the ReSPECT form or
16 a different form.

17 What are your views on that recommendation on the
18 utility and benefits of having a uniform single document
19 across the UK?

20 **A.** So I can certainly see the value of that approach, and
21 I read the evidence from the Resuscitation Council. As
22 I said, when it was discussed at NHS England our view
23 was that it was the principles that were important and
24 not necessarily having a standardised form that is
25 currently the position but I absolutely see that there

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1 developed an advance care planning document; is that
2 correct?

3 Would it be right to say that the document that
4 was developed there, I think it was called the Universal
5 Principles for Advance Care Planning, was a broad
6 statement of principles to be applied rather than
7 a document to record those conversations between
8 patients and clinicians? Would that be correct?

9 **A.** Correct.

10 **Q.** So not analogous to the ReSPECT form which the Inquiry
11 have heard something about?

12 **A.** The ReSPECT form would be one implication of those six
13 principles.

14 **Q.** Did you consider that the ReSPECT form, in its current
15 form, could comply with those universal principles
16 for -- (*Unclear: multiple speakers*) --

17 **A.** Yes, I'm sure it would. As part of the production of
18 that document, my understanding is there were
19 discussions -- well, there were discussions subsequent to
20 that document as to whether we should have a single form
21 or a single process, and the view of NHS England
22 colleagues at the time was that the overriding priority
23 was to have the six principles embedded rather than
24 mandating that a particular tool or a particular form or
25 a particular process should be used.

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1 is some merit in standardisation.

2 **Q.** So on a related note, if we can move on, please, to
3 palliative care and end-of-life care --

4 **A.** Yes.

5 **Q.** -- in hospital for Covid-19 patients. In your third
6 witness statement you said:

7 "As the pandemic developed, NHS England was not
8 aware of a system issue with capacity for end of life
9 hospital care and provision was available to those who
10 wanted and needed it."

11 You have been provided with the witness statement
12 of the president of the Association of Palliative
13 Medicine, that's Dr Sara Cox, I don't think we need to
14 get that witness statement up, but it's INQ000257329.
15 Dr Cox has noted in her witness statement five main
16 issues that she has identified in relation to palliative
17 care during the pandemic, and perhaps I can summarise
18 them in this way before I invite you to comment on
19 those.

20 First of all, she says that there were not enough
21 palliative care specialists to see everyone who was
22 affected and concludes that that will have resulted in
23 gaps in care for some.

24 That there was unclear, conflicting, and
25 constantly changing guidance on visiting restrictions,

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1 which made the situation difficult for families and
 2 loved ones.
 3 That the relatives of patients from ethnic
 4 minority communities were disproportionately impacted by
 5 those restrictive visiting practices because they were
 6 unable to fulfil religious and culturally prescribed
 7 responsibilities around the end of life and death.

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

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

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

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

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1 allowing people to visit.

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

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

17 **A.** No.

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

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

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

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

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

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1 inevitable changes and impacts upon the palliative care
 2 service?

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

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

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

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1 we're dealing with.

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

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

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

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

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

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

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

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

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1 care or a woman in labour. And:

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

4 There was then a revision to the guidance on
5 9 April to include an additional circumstance where
6 visiting would be permitted to support someone with
7 a mental health issue such as dementia, a learning
8 disability or autism where not being present would cause
9 the patient to be distressed.

10 We can take that down now, thank you.

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

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

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

25 I give you another example which we clarified in

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1 something that we would think about.

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

6 **A.** Yes.

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

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

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

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

20 And if we can go further down, please.

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

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

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

5 We can take that down. Thank you.

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

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

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

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

4 **A.** Yes.

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

10 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

24 **A.** So there's a fair amount of information on nosocomial
 25 transmission rates, and as you would work out, I guess,
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1 whether they had Covid or not, then clearly that is
 2 a benefit. And I think the move away from a national
 3 mandated set of guidance to more local flexibility, as
 4 I think I've stated already, in part reflected that
 5 those changes that were coming onstream, the move to
 6 universal masking in various settings in the late
 7 spring, I think it was June 2020, again, all of these
 8 things absolutely would help mitigate that.

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

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

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

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

25 **A.** Not in that form. Nosocomial infection, which is spread
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1 from first principles, that there is patient-to-patient
 2 transmission, and I think the evidence is that that was
 3 probably the predominant route of transmission. There
 4 is staff-to-staff transmission, staff-to-patient,
 5 patient-to-staff and of course hospitals, by their very
 6 nature, are areas where there will be a higher volume of
 7 virus because they are treating people with Covid or
 8 people with Covid are coming to hospitals. So I can't
 9 recollect if we have specific data on visitor-to-visitor
 10 or visitor-to-staff data, but clearly the risk of
 11 transmission occurring between any group in a hospital
 12 environment is going to be higher than it would be in
 13 a setting, particularly when there are lockdown measures
 14 in place.

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

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

23 So we had no testing capacity to do that in March,
 24 and when testing capacity came onstream, and obviously
 25 visitors would be able to self-test at home and know
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1 of infection within hospital, within healthcare settings
 2 more generally, is, of course, something that happens
 3 outside of pandemics. We're getting to winter at the
 4 moment and norovirus, which circulates in the winter, is
 5 a good example of where spread can occur in hospitals.
 6 So hospital teams are well used to, through the IPC
 7 measures, to deal with nosocomial infection, and to try
 8 and prevent it. So that experience was in place. But
 9 we didn't have a dedicated team around Covid in
 10 particular. That was set up actually as a subgroup of
 11 SAGE initially, the HOCl group, which you've probably
 12 heard about, and then within a fairly short period of
 13 time came in with the governance structures of
 14 NHS England, and the nosocomial programme essentially
 15 was over seen by HOCl, and was part of the same
 16 programme of work.

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

24 **Q.** What did the nosocomial infections programme identify as
 25 the main factors driving hospital-acquired Covid?
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1 A. Well, the absolutely main factor was the prevalence in
2 the community which, in a sense, might seem obvious, but
3 it was the case that the more infection that there was
4 in the community, that was a time at which we saw the
5 most nosocomial infection in hospitals.

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

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

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

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1 17 November 2020, so if those patients may have
2 developed Covid whilst they were in hospital?

3 A. Yes. So that's correct. So of course we had to
4 determine how often to test in hospital and so
5 colleagues at Public Health England helped with us that
6 sort of modelling and we iterated our thoughts on that
7 as to the most effective time after a patient had been
8 admitted to test, so that was the evolution of that
9 approach, and also of course testing was becoming more
10 available as we went through into the latter months of
11 2020.

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

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

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

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

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

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

9 A. Sorry, I missed the start.

10 Q. Is it right that testing --

11 A. Yes, correct.

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

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

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

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1 that point had acquired that infection in hospital?

2 A. Yes, correct.

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

8 "[The] rate increased with the emergence of the
9 more transmissible Omicron variant ... In the
10 first months of 2022, the [percentage] rate of probable
11 and definite nosocomial infections increased to between
12 25% [to] 35%. This was due to a combination of
13 Omicron's increased transmissibility, its vaccine and
14 immune escape properties, and greater numbers of
15 non-Covid-19 patients in hospitals allowing more
16 infection transmission opportunities for the virus."

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

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

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

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

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

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

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

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

25 Q. Thank you.

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

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

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

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

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1 We can take that down, thank you.

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

11 The Inquiry has heard about concerns that pulse
12 oximeters may not be accurate in patients with darker
13 skin pigmentation and I think those concerns were first
14 raised during the pandemic after an article had been
15 published in the British Medical Journal on
16 21 December 2020 which was itself based on an American
17 journal report?

18 A. Yes.

19 Q. Is it right that NHS England published
20 a COVID Oximetry@home operational update on
21 23 December 2020 in relation to those concerns?

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

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

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

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

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

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

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

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

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

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

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

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

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

5 And if we can go down, please, to point 8:
 6 "There are some research reports that pulse
 7 oximeters may not work as well in people with darker
 8 skin."

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

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

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1 that was Sir Sajid Javid at that time.
 2 Can we go to that document, please, it's
 3 INQ000470551.
 4 Did you have input into this?

5 **A.** I don't think I did.

6 **Q.** We can see that there's -- a summary has been prepared
 7 there:
 8 "We are not aware of any evidence that pulse
 9 oximeter inaccuracy in people with COVID and darker skin
 10 has contributed to excess deaths. The Medicines and
 11 Healthcare products Regulatory Agency ... is not aware
 12 of any incidents where skin colour has had an adverse
 13 effect on the use of pulse oximeters when providing
 14 effective clinical care."
 15 And it references the NHS guidance about
 16 monitoring trends and asks -- says it has asked the
 17 National Institute for Health Research to commission
 18 rapid further research.
 19 Is that the research that's not yet --

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

25 **Q.** At point 6 it says:

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

3 **Q.** Can we go to the second page of that document, please.
 4 I think we can take that down now.
 5 Subsequently, I think on 21 November 2021, the
 6 Secretary of State for Health and Social Care expressed
 7 concerns on the Andrew Marr show about these
 8 inaccuracies and said he thought it was possible that
 9 black and ethnic minority people may have died from
 10 Covid-19 as a result of relying on inaccurate pulse
 11 oximetry readings.
 12 Can I ask you what your views were at the time of
 13 how helpful those comments were from the Secretary of
 14 State.

15 **A.** Well, I can't recall exactly at the time. I mean,
 16 clearly we were concerned because, of course, the reason
 17 for putting this programme in place was we were worried
 18 with silent hypoxia, worried about patients
 19 deteriorating without symptoms, that was the rationale
 20 right at the start, and therefore we were worried that
 21 if people didn't take up this offer they could
 22 deteriorate more quickly than would become apparent from
 23 their symptoms.
 24 I think he, on reflection I wonder whether he
 25 based those comments on the Race and Health Observatory

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

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

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

16 **A.** Yes, at home, yeah.

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

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

21 **Q.** Thank you.

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

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1 change depending on the context.

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

6 **A.** Yes.

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

13 You've explained that, I think, additional call
14 agents were added to the call resource in, first of all,
15 February 2020, another 150 call agents, and then another
16 117 full-time equivalents were agreed in March of 2020.

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

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

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

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

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

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

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

8 So, rather than knowing that it would take time to
9 train people to deal with all circumstances, rather than
10 focus on expanding the 111 service, we set up a separate
11 service that could deal specifically with Covid, and
12 that had the advantage that the training was shorter.
13 Remember, the call handlers in 111 and indeed the CRS
14 are basically running to algorithms and scripts, they're
15 not clinicians, they are asking a set of questions which
16 will lead to a particular action in terms of advice to
17 the patient, or whether the patient is referred on to
18 999 or to a clinician.

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

24 **Q.** So --

25 **A.** That was the rationale.

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1 Q. And those additional staff that I've mentioned
 2 in February and March 2020, were they recruited to the
 3 core 111 service --
 4 A. 111, yes --
 5 Q. -- rather than the CRS?
 6 A. -- but the reason we didn't expand beyond that was
 7 because we focused our efforts on expanding the
 8 Covid-specific Covid Response Service.
 9 Public Health England had also set up a helpline
 10 which was predominantly around giving general advice
 11 around Covid, and I think you will probably see, you
 12 might show me an exhibit in a minute, that there came
 13 a point where that service was essentially doing the
 14 same as the Covid Response Service and so we asked PHE
 15 if we could merge the two services into one.
 16 Q. Perhaps we can get up that document. It's INQ000348589.
 17 This is a briefing document dated 26 March 2020 from
 18 Public Health England following discussions about that
 19 merging that you've mentioned. Can we go to page 3,
 20 please.
 21 "In response to a request from
 22 [NHS England]/NHS111 for aid, [Public Health England]
 23 sourced an additional 1,000 call handlers at 24
 24 response."
 25 Is that the CRS?
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1 of calls being answered is declining really from 7 March
 2 and declining throughout that month. The orange line,
 3 solid line there, I think, demonstrates the calls
 4 answered within 60 seconds, so that's at times dipping
 5 very low.
 6 So, looking at that snapshot, it seems that the
 7 system was struggling to meet demand at that time. Was
 8 the problem therein sufficient call handlers?
 9 A. Well, the problem was the level of demand. It was
 10 obviously a mismatch between supply and demand. It was
 11 one of those occasions that a part of the service did
 12 absolutely face a situation where supply was -- sorry
 13 demand was greatly exceeding supply. This is the
 14 granular detail I think behind the chart that you showed
 15 earlier and in March we were seeing double the number of
 16 volumes of calls into 111 that we would've done in
 17 an equivalent month pre-pandemic, so there's no doubt
 18 there was a huge amount of pressure coming on, and it
 19 was really difficult to cope.
 20 The mitigations were to produce that -- to
 21 instigate that Covid Response Service which we at the
 22 time felt was the most effective and quickest way of
 23 taking some of the pressure off 111.
 24 In time we also put in place a clinical -- a Covid
 25 Clinical Advice Service which provided clinical support
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1 A. I believe that's the CRS, yes.
 2 Q. So that is an additional 1,000 call handlers sourced at
 3 that point?
 4 A. So this is essentially merging the PHE helpline which,
 5 at this stage in late March, I think calls had moved
 6 from general advice around Covid to more specific advice
 7 about individual circumstances, which actually was the
 8 role of the CRS, and therefore the functions -- what
 9 practically was happening in those two call services was
 10 essentially duplicative and therefore it made sense
 11 simply to combine it into a single service.
 12 Q. Can we go to page 2 of that document, please. There's
 13 a graph there at the bottom if we can see the green and
 14 orange graph. Thank you. And this covers the period
 15 27 February 2020 to 24 March 2020 so it's a snapshot
 16 really of the daily figures over a period of about
 17 a month early in the pandemic. And it's the core
 18 service --
 19 A. Yes.
 20 Q. -- calls offered and answered. And I think we can see
 21 there that the green bars show the number of calls that
 22 came in and the red bars are the number of those calls
 23 that were answered at all, even after 60 seconds.
 24 And so we can see that performance as the number
 25 of calls comes in, actually the performance, the number
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1 into the call handlers, so there were a number of
 2 mitigation strategies, but there is no doubt that the
 3 NHS and NHS 111, in this particular period, was under
 4 extreme pressure and it's reflected in these graphs.
 5 Q. If we can come back to this graph. We're not seeing
 6 a constant level of the number of calls answered through
 7 this month and so when we get to 16, 17, 18 to 20 March,
 8 the numbers have dropped to well below 20% of calls
 9 being answered altogether. And when we see the numbers
 10 of calls down the side, it seems that fewer calls are
 11 being picked up, doesn't it, not just that demand is
 12 increasing, but --
 13 A. Yes, well, we're heading into peak -- you know, numbers
 14 of -- peak prevalence of Covid in the community in
 15 wave 1, so 111 was incredibly busy at that time. And
 16 this reflects the pressure. I can't reflect on why one
 17 day was significantly different from another --
 18 Q. Perhaps we can --
 19 A. -- but I think the overall picture, as you showed in
 20 that earlier graph, was that this was the period where
 21 we had sustained pressure on 111, as did other -- the
 22 devolved administrations as well in their services.
 23 Q. I think we can take that down now, thank you. Perhaps
 24 we can move on from the statistics to the quality of the
 25 calls.
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1 A. Yes.

2 Q. I think it's right that the Healthcare Safety
3 Investigation Branch undertook an investigation into
4 concerns about patient safety issues --

5 A. Yes, they did.

6 Q. -- in response to callers to the 111 service. That
7 report was published in late September 2022.

8 A. Correct.

9 Q. And it noted that the clinical staff recruited to work
10 in the Covid-19 Clinical Assessment Service reported to
11 HSSIB that they had received very little in the way of
12 clinical training, and they'd established informal
13 networks to try to share knowledge of the virus. Was
14 NHS 111 aware of those difficulties with the level of
15 training that had been offered?

16 A. Yes, we were, and there was a strategy behind this which
17 was, we -- so the clinicians recruited into that
18 service, the Covid Clinical Advice Service, were mainly
19 GPs, active GPs or recently retired GPs, and the intent
20 was to provide a clinical support for the call handlers.
21 The intent was not to recruit a group of clinicians and
22 then train them in additional clinical skills because
23 what we wanted to use was their general skills, which
24 they already had, around patient -- identifying patients
25 who were deteriorating, patients who might have

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1 deteriorating, patients who had a set of symptoms, that
2 might or might not be Covid-19. So yes, of course we
3 always reflect on these things, but the strategy was to
4 bring them in for their skills, to give them the
5 additional telephony training, not spend weeks teaching
6 them something we felt they already knew and was the
7 reason we were bringing them in the first place.

8 Q. That report from the Healthcare Safety Investigations
9 Branch made a number of recommendations directed at
10 various bodies. One of those recommendations was that
11 NHS England should review the risks associated with
12 increased use of telephone triage services during
13 a national healthcare emergency, and I wanted to ask how
14 NHS England has progressed with that.

15 A. So I think that work is being undertaken with colleagues
16 at UKHSA. I haven't got an output for you at the
17 moment, but we have been looking at those
18 recommendations.

19 There were a number of other recommendations as
20 well around call recording, if I reflect correctly,
21 which we have also been -- well, on the call recording
22 that was implemented pretty immediately but there are
23 a number of other reflections in that HSSIB report we're
24 working on.

25 Q. Apart from the HSSIB report, I think you have been made

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1 conditions that were other than Covid-19.

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

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

14 Q. In retrospect and with the benefit of hindsight, do you
15 think there might have been some benefit in -- given
16 that these are trained clinicians, if they were given
17 some targeted training around the clinical presentations
18 of Covid?

19 A. I believe they were, but obviously you've heard those
20 reflections in the HSSIB report that not everybody felt
21 it was what they needed, so I think that is definitely
22 a reflection for the future, but it was definitely the
23 strategy to bring in a group of clinicians to use their
24 existing clinical skills, which would be generalist
25 skills, around identifying patients who were

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1 aware of a report in the Guardian from October 2020
2 referring to what was called an internal audit --

3 A. Yes.

4 Q. -- of 111 that noted that up to 60% of calls handled by
5 the Clinical Assessment Service within 111 were rated as
6 "not safe", and what steps NHS England took in relation
7 to that.

8 A. So this related to nurses who were a small, very small
9 part of that overall cohort of clinicians. As I said,
10 the clinicians in the Covid Clinical Advice Service were
11 predominantly GPs. The service, if I remember, was
12 hosted by SCAS, South Coast Ambulance Service, the
13 audit, I believe it was an audit they undertook
14 relatively small sample size, raised those concerns
15 around the quality of information provided by nurses
16 that was raised with NHS England, and we took the
17 decision that we would remove nurses from that pool of
18 clinicians.

19 Q. Thank you.

20 A. Can I just add, because I should have added this, there
21 were a number of other clinical advice services for
22 dentistry for example that were stood up, and of course
23 the clinicians in those services were -- had the
24 clinical skills relevant to the particular service. So,
25 obviously, in the dentistry clinical advice service, it

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

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

9 **MS NIELD:** Up to 60%.

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

12 **A.** No --

13 **LADY HALLETT:** Could you explain what you meant?

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

25 So a quality issue was raised, we responded to it
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1 **A.** There was some use of the independent sector -- as there
2 was generally.

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

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

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

23 **A.** I agree with that.

24 **Q.** Your statement makes clear that during the pandemic
25 discharges from maternity units were more rapid,
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1 appropriately.

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

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

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

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

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

24 **A.** There was --

25 **Q.** -- played a bigger role.
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1 discharges of new mothers were more rapid, with shorter
2 postnatal stays on average. Do you consider that those
3 shorter stays could have resulted in a reduced quality
4 of care and support provided to women immediately after
5 childbirth?

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

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

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

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

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

21 **A.** Yes.

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

25 Firstly, the increased use of technology in
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1 had become available.

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

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

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

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

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1 primary and secondary care for patient consultations.

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

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

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

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

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

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

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

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

23 **LADY HALLETT:** Is that a convenient moment?

24 **MS NIELD:** Certainly.

25 **LADY HALLETT:** 3.20.

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1 (3.05 pm)

2 (A short break)

3 (3.21 pm)

4 **LADY HALLETT:** Ms Nield.

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

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

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

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

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

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

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

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

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

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

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

25 There was variable uptake across the country.

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

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

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

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

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

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

25 **A.** Well, the Protect the NHS message which was

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

12 So early on we began to get worried about the risk
13 of that happening. I raised it and spoke about it
14 deliberately at a very early stage in one of the
15 Downing Street press conferences, I think it was
16 4 April, or thereabouts. I stood up and -- and actually
17 I remember getting an email from somebody afterwards
18 saying: my husband has been sitting at home for a number
19 of days, with chest pain, I think it was, and wouldn't
20 go to hospital and they heard you on the television and
21 he went. And they saved his life.

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

24 **LADY HALLETT:** You are allowed to.

25 **A.** Yeah, so we were worried.
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1 people that you should come but it is one of the things
2 to reflect upon for future pandemics.
3 **MS NIELD:** Do you think, picking up on her Ladyship's
4 question, do you think if there had been some
5 involvement of NHS England or senior healthcare system
6 leaders when formulating that Cabinet Office messaging,
7 that perhaps a slightly more nuanced message might have
8 been possible?

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

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

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

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

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

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

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

16 **A.** No, we weren't, and -- to my knowledge, we weren't. And
17 as I said, we have no doubt it was done with the best
18 intentions for good reasons, and it was an effective
19 message in the sense of social distancing. But there is
20 a -- there was a concern that people might be
21 misinterpreting that. I think there were other -- there
22 were a number of other reasons why people stayed at
23 home, which they undoubtedly did. We saw falls in the
24 number of admissions for a number of conditions. And
25 of course we were very quickly on to trying to remind
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1 **Q.** The Chief Medical Officer, Professor Sir Chris Whitty,
2 suggested when he gave evidence at this Inquiry that we
3 could have been swifter off the mark in spotting
4 Long Covid as it emerged and in commissioning health
5 services for people with Long Covid. I'd like to ask
6 whether you agree with that, and whether you think
7 NHS England could have acted sooner, for example, making
8 the request to NICE prior to 30 September.

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

15 I became concerned, as others did, as we came out
16 of wave 1 and into the summer of July 2020, that many
17 individuals were reporting long-term effects and
18 symptoms following Covid. This was brought to my
19 attention by Long Covid SOS who wrote to me in
20 early August and I met with them on 11 September 2020
21 I think was the date, and I'm really grateful to those
22 from Long Covid SOS who attended that meeting, because
23 it was a turning point for me in terms of Long Covid.
24 I remember it in graphic detail, what they told me.
25 They told me that they were having difficulty getting
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1 clinicians to believe or understand their symptoms and
2 whether this was actually a thing, a condition.

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

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

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

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

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1 paediatric helps for Long Covid.

2 **A.** Yes.

3 **Q.** And I think by November 2021 you've noted in your
4 witness statement that patient feedback surveys showed
5 high levels of satisfaction with Long Covid services,
6 but there was still wide local and regional variation in
7 both referral rates and waiting times, and the waiting
8 list stood at over 12,000 with 33% waiting more than
9 15 weeks.

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

14 **A.** Yes, there are still problems around variation.

15 Of course, as we've discussed earlier, it's quite right
16 that we allow local healthcare systems to provide the
17 services that they think are most appropriate for their
18 patient population, their configuration of health
19 services. That inevitably leads to variation in just
20 about every service that we deliver.

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

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

9 And then we set about setting up a Long Covid task
10 force, which my colleague Kiren Collison the deputy
11 primary care medical director set up, and she did
12 a magnificent job in bringing patients and others
13 together to have input into the services, and we had
14 69 Long Covid clinics set up by December, which I think
15 was faster than just about every country in the world.
16 And although, back to what I said at the start, I know
17 how incredibly frustrating this was and how quickly
18 individuals wanted this to be done, but from my
19 perspective we did move quickly on this, and I'm very
20 proud of the team that I had who worked so hard, both
21 nationally and regionally, to get these clinics
22 established.

23 **Q.** You mention there by December 2020 there were
24 69 operational clinics across England. I think
25 by November 2021, 19 Long Covid clinics and 14

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

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

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

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

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

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

3 **Q.** Can I ask about Long Covid and healthcare workers.
 4 Does NHS England currently collect data regarding
 5 the number, age, sex and ethnicity of healthcare workers
 6 and NHS staff who have been affected by Long Covid?

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

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

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

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

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

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

6 **A.** Yeah.

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

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

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

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

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

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

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

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

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

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

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

5 **A.** From July, yes.

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

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

19 **Q.** Thank you.

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

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

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

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

10 **A.** Yes, I agree.

11 **Q.** Can we get up, please, INQ000330885.

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

17 If we could go to page 3 there, we see the
 18 table showing national averages of when BAME staff were
 19 assessed, at-risk staff, and all staff. And we can see
 20 there's an improvement from window 1, window 2 and into
 21 window 3 with eventually 96% nationally of BAME staff
 22 having received a risk assessment by window 3, when only
 23 73% had been risk assessed in window 1.

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

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

7 We established a risk assessment delivery unit
 8 whose job it was or task it was to support, to spread
 9 best practice, to work with those organisation who, for
 10 whatever reason, were struggling. So we did put more
 11 targeted support and work into this during the summer of
 12 2020, exactly because we thought it was such
 13 an important thing to do.

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

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

I, obviously, and others, stayed in contact with

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

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

9 We can take that down. Thank you.

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

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

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

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

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

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

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

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1 undertaken in October --

2 **A.** Yes.

3 **Q.** -- the annual surveys that come out? Were there any

4 messages coming out from that survey that contradicted

5 or differed from the messages that you were getting from

6 the royal colleges, colleagues working on the frontline,

7 any of the other channels of communication you've

8 mentioned?

9 **A.** Not in general. I mean, you may be about to show me

10 some exhibits but we instigated a separate survey

11 I think the People Pulse survey which was a much more

12 regular survey and if you look at anxiety levels they

13 corresponded with the peaks of the two initial waves.

14 **Q.** Perhaps we could have a look at that. I think this was

15 a monthly survey --

16 **A.** It was a monthly survey so the --

17 **Q.** -- so it wasn't getting quite as many as the annual

18 survey --

19 **A.** No.

20 **Q.** -- but perhaps we can have a look at INQ000330944 on

21 page 2, please.

22 **A.** There we are.

23 **Q.** So we can see, plotted in blue, this is anxiety levels,

24 and in grey, this is the number of Covid-19 patients in

25 the UK, and so we can see at times of peaks in

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1 in a sense, more manageable, I think there was

2 another -- that wasn't as hard as it might have been.

3 So I think it very much depended upon the wave and the

4 stage of the pandemic you were in.

5 **Q.** Can we go to page 5 of this document, please, because

6 there's a graph there that sets out anxiety and

7 motivation. And we can see it's a mirror image. The

8 blue line the bottom line is anxiety. Reported anxiety

9 levels. And the orange line is motivation as reported

10 by staff. And we can see that anxiety rises, motivation

11 dips.

12 Can I ask you this: as a clinician, what do you

13 see as the potential clinical impact to the demotivated

14 workforce or section of the workforce?

15 **A.** So there is no doubt that for everybody, as I've often

16 said in public, who went through the pandemic, it was

17 the most challenging, the most difficult, or the most

18 stressful time of their professional careers. It's the

19 biggest health emergency in 100 years, the biggest

20 challenge crisis that the NHS has had to face since its

21 inception in 1948.

22 Staff were magnificent, they went the extra mile,

23 but that was at a cost and both at the time and both

24 with lasting effects, it has deeply affected members of

25 staff. We are very aware of that and that is why we are

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1 the number of patients, there's also peaks, and the high

2 point of anxiety there is 40.5 staff reporting that

3 they're feeling anxious, and that declines as to the

4 wave of patient numbers declines as well.

5 **A.** That's perhaps not surprising, but I think there was

6 a difference between wave 1 and wave 2, and I very much

7 heard that from staff. So in wave 1, where this was --

8 you know, this was the first time staff had had to deal

9 with Covid, there was a great sense of camaraderie,

10 a great sense of coming together and working out how it

11 should be done -- I think you might have heard a sense

12 of that from some of the impact witnesses.

13 Staff were redeployed into areas that they might

14 not have worked in for a while, but there was this real

15 sense, the public clapping and the public support.

16 I think by the time it came to the second wave or

17 the second big wave, the Alpha wave, there was a sense

18 of "Here we go again. This is going to be more

19 difficult. Yes, we have learnt to do this a bit better

20 because we knew we'd gone through it once, but we really

21 don't want to go through it again". And I think that

22 was reflected in what I was hearing from staff.

23 By the time you got to the Omicron wave, and again

24 you could see this I think in the anxiety levels in this

25 report, because that had less clinical impact and was,

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1 trying to provide ongoing support. That will take time

2 to get over, despite all the efforts. The risk

3 assessment process, all the support that we put on

4 really early, was to help local organisations who

5 of course are at the frontline of helping staff to

6 provide that support, but with an emergency of this

7 sort, you can't fully mitigate it.

8 I should also say, and you heard this very

9 graphically from Professor Fong, if the NHS had got to

10 the point where it was completely overwhelmed, it would

11 have been even worse. The moral injury would have been,

12 you know, orders of greater magnitude. But having said

13 that, even what we had to deal with had a huge impact on

14 staff.

15 **Q.** And I think you explain that the 2022 staff survey

16 indicated that 34% of staff said that they always or

17 often felt burnt out because of their work, and 37.4%

18 often or always found their work emotionally exhausting.

19 Is it right that that incidence of burnout amongst the

20 NHS workforce is reflected in difficulties recruiting

21 and retaining staff?

22 **A.** I think it certainly impacted on retention, although

23 actually we are doing reasonably well in term of staff

24 leaders at the moment, we are getting to a better

25 position. I think, in recruitment, we saw a real flush

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

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

24 **Q.** So can we move on and look at the support for staff that
 25 was provided for or co-ordinated by NHS England during
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1 aim, as you said, was to support local organisations who
 2 have prime responsibility as employers for their
 3 workforce, so, again, going back to being at a level 4
 4 incident, one of our tasks here is to provide that
 5 national resource to support those local organisations,
 6 and we did that entirely as you described, through
 7 a whole range of offers co-ordinated through our people
 8 directorate, as it was at the time, led by our chief
 9 people officer, in consultation, collaboration with
 10 a lot of organisations, including charities, including
 11 learning from other major incidents such as the
 12 Manchester bombings, using technology, you mentioned
 13 a number of apps that are now available to help people
 14 with psychological support.

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

21 **Q.** Can I ask you this. The Inquiry has heard from
 22 an expert in general practice about the levels of
 23 burnout amongst general practitioners in particular, and
 24 the kind of support that can be offered to assist in
 25 that regard. And Professor Edwards suggested that like
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1 the pandemic rather than currently.

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

5 **A.** Correct.

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

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

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

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

25 I think they were generally well received. The
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1 everything else in the NHS, mental health and well-being
 2 support for staff should be evidence-based, and that so
 3 there should be evaluations of programs to see what
 4 works, and what's most effective and efficient. And
 5 that more research, he suggests, is needed to establish
 6 what kind of support is effective.

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

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

24 **Q.** Can I move on then, please, to lessons learned and
 25 recommendations. And you've set out in your witness
 184

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

12 **A.** No.

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

16 We can see there that the report outlined
 17 90 lessons across a number of specific areas, including
 18 preparedness and resilience, caring for people with
 19 Covid-19, impact on other services -- does that mean
 20 essential services, non-Covid services?

21 **A.** Non-Covid services, yes.

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

25 I think it's right that in relation to the
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1 are made in that report are being embedded effectively
 2 into business as usual --

3 **A.** Yes.

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

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

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

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

24 **A.** So I think that's been a thread through pretty much
 25 everything that we have discussed today, that balance
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1 recommendations that were made within that report, those
 2 are being taken forward currently by NHS England?

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

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

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

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

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

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

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

25 **Q.** I think it's right that some of the recommendations that
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1 between the more directive approach and the guidance
 2 that, you know, is one-size-fits-all versus giving local
 3 organisations and healthcare systems the flexibility.
 4 We've discussed that in terms of Long Covid. We've
 5 discussed that in terms of visitor guidance. It's
 6 inevitably a balance and a set of judgments that will
 7 change during the course of an incident and will be
 8 contextual to the particular issue you're dealing with.

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

18 Those judgments won't always be the right
 19 judgments. In hindsight you will inevitably look back
 20 and say: we could have balanced it a little bit
 21 differently. But you have to make them and you have to
 22 make them in fast moving circumstances. You don't have
 23 the luxury often to wait a week or two; you sometimes
 24 have to make them in days. And you have to make them
 25 sometimes on the basis of the evidence not being
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1 available that you would like to have available.
 2 So I think it's right that we think about that and
 3 I said right at the start when I talked about the
 4 incident 4 level that although it gave us a command and
 5 control structure, it didn't mean that we didn't
 6 recognise the need for flexibility and local
 7 decision-making.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 "If Covid-19 teaches anything it is that relying

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

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

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

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

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

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1 we were able to do and we are now using that to bring
2 databases together to give us much more insight into
3 population health and into how we can run the health
4 service efficiently.

5 Having said that, and that will give us more
6 resilience, you would still need surge capacity in
7 a pandemic. And it is absolutely the case that even
8 those countries, France, Germany, the United States,
9 that have more doctors than we have per head of the
10 population, who have more modern up-to-date estates, got
11 to the point where they were struggling to meet demand
12 and running out of capacity, and they needed to put in
13 mutual aid.

14 So resilience will absolutely help us, it will
15 help us in recovery as well. One of the problems in
16 terms of recovering from the pandemic is that lack of
17 resilience. But we will still need to have those surge
18 plans in place. We can't simply rely on more staff,
19 better estate, we will need to do, as we did this time,
20 and have a surge plan which is where the importance of
21 planning for the right pandemic and having the EPRR
22 structures around incident responses and having them as
23 strong as possible are the things that will set us in
24 the best possible stead for a future pandemic.

25 **Q.** Thank you very much, Professor Powis, that's

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1 the NHS. So there is no doubt that a sustained capital
2 investment programme to bring NHS estate up to date to
3 make sure it's fit for purpose across all range of
4 health settings would give us more resilience.

5 More staff would give us more resilience.

6 I've talked about the long-term workforce plan. That is
7 an area where the previous government and this
8 government, who supported the approach in opposition,
9 obviously they will be looking at the plan themselves,
10 but that plan to expand, double the number of medical
11 school places, increase the number of nurses, increase
12 the number of GPs, simply having more staff and relying
13 less on agency staff for instance will make the NHS more
14 resilient.

15 Also having staff that have a more set of
16 generalist skills and they're not simply specialists
17 will help and we are making progress with the colleges
18 on ensuring that will happen.

19 Infrastructure, IT infrastructure. We've talked
20 about data collection, we've talked about the power of
21 data, having better IT systems, having systems that can
22 talk to each other, that can automatically generate the
23 data and, of course, the federated data platform which
24 we have rolled out after the pandemic has actually taken
25 the lessons of the pandemic in terms of the data sharing

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1 a comprehensive answer that you've given. I'd like to
2 ask you this: is there anything else, in addition to
3 what we've already discussed and the very comprehensive
4 answer that you have just given, are there any or key
5 recommendations for the healthcare system you'd like
6 the Inquiry to bear in mind, or do you think we've
7 covered all those points this afternoon?

8 **A.** I mentioned a few. A few I didn't mention would be with
9 respect to NICE, to consider whether they should be
10 a Category 1 responder, which would give them some of
11 the responsibility and capabilities to stand up -- I
12 mean they stood up magnificently, but I think being
13 a Category 1 responder focuses you to be able to respond
14 in a crisis.

15 I think I have probably mentioned a number of
16 other recommendations that you will have captured along
17 the way, and so I'm very happy to give you in writing
18 anything else that comes to mind other than what's in
19 the statement, but I think you've had a lot of
20 recommendations.

21 And the one thing I would say is, going back to
22 Long Covid, which I didn't tell you when I answered, is
23 that we do have a registry of Long Covid cases, and
24 I will go back and check whether it's in a format that
25 would allow to us say something about healthcare

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1 workers. So we will let you know on that one too.
 2 **MS NIELD:** Thank you very much. Professor Powis, I have no
 3 further questions for you.
 4 **LADY HALLETT:** If we could finish you tonight, Professor,
 5 I would carry on, but I'm afraid it's just over
 6 an hour's worth of questions from the core participants
 7 and you've had a long day so far, so although my
 8 ever-efficient ushers have been getting people ready
 9 with lecterns for questions, if everyone will forgive
 10 me, I think we will finish now and come back on Monday,
 11 10.30, 11 November, please, and we'll see you again
 12 then.
 13 **THE WITNESS:** It will be a pleasure to see you again.
 14 **LADY HALLETT:** Thank you.
 15 **(4.16 pm)**
 16 **(The hearing adjourned until 10.30 am**
 17 **on Monday, 11 November 2024)**
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