

Monday, 11 November 2024

(10.30 am)

PROFESSOR SIR STEPHEN POWIS (continued)

LADY HALLETT: Yes, Ms Nield.

MS NIELD: My Lady, I believe there are questions for Professor Powis from some of our core participants.

LADY HALLETT: Certainly.

Who is going first? Mr Jory. You're over there.

Behind you, but if you can make sure your answers go into the microphone, Sir Stephen.

Questions from MR JORY KC

MR JORY: Thank you, my Lady.

Good morning, Professor. I ask questions on behalf of the Independent Ambulance Association. I have two areas to ask you about, please, and the first is this -- and please make sure when you answer -- I know it seems very unnatural -- that you swivel back and speak into the recording device, thank you.

In your fourth witness statement to Module 3 you set out details of the 11 NHS ambulance trusts, their structure and their interrelationship with the Association of Ambulance Chief Executives.

And you go on to set out NHS England's role in providing national leadership for the ambulance service.

Now, despite the NHS investing in excess of half

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As you will know from my statement and from the oral evidence of Anthony Marsh, who leads on our behalf NHS England on ambulance service matters, the 11 ambulance services are independent statutory organisations. We do rely on them. They have their own individual systems and processes, although clearly there's a commonality in the overall approach they use.

As I outlined in my previous evidence, we did in a level 4 and a level 3 incident go into much more direct command and control. Anthony Marsh explained that in his oral evidence. But I'm not sure whether in normal times, although as I say I neither agree nor disagree whether setting up more permanent structures for that particular sector of ambulance services and patient transport, whether the benefits would outweigh the disbenefits. But certainly something worthy of consideration.

Q. Thank you. Can I move on then to my second question, which concerns lessons learnt in future guidance. And again my focus is on the ambulance service. Last Thursday Ms Nield touched upon the question of who should be consulted, and you mentioned Anthony Marsh, who gave evidence previously to the Inquiry and mentioned the role of the independent ambulance sector. Can I ask you this, however, looking for your opinion,

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a billion pounds a year in non-emergency patient transport services and that this service could not operate without the assistance of the independent ambulance sector, which provides about 50% of the service, this activity is the only area involving such significant investment within NHS England that doesn't have a permanent national team providing oversight and leading or co-ordinating the work.

So, after that rather long introduction, my question is this. Do you agree that the creation of a permanent body or team within the NHS, specifically addressing the challenges of providing non-emergency patient transport and issues such as consistency and approach across the trusts, the commissioning of services, innovation, equality of access, procurement and value for money, would be both sensible and beneficial?

A. Thank you. Well, I think the honest answer is I neither agree nor disagree. It's not a topic that I've thought about in detail. I think the first thing to say is clearly we value the work of independent contractors in supporting the ambulance service and patient transport, and even more so during the pandemic, when everybody pulled together to provide the support and resource that was required.

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and I know you say that perhaps you're not the person who should be asked this question but, given the specific challenges that you know of from your experience because you have oversight of it in the ambulance sector, including the specific difficulties that paramedics and ambulance staff face, for example they're the first to come into contact very often with patients, they have a lack of information, they work by definition sometimes in very confined and constrained areas, do you agree that it would be helpful within any future guidance regarding working practices to include specific and clear guidance for the ambulance sector, addressing their unique challenges?

A. Well, in principle I absolutely agree that whether we are dealing with core NHS organisations or those in the independent sector that are supporting us, and that I think is across a range of independent sector provision, including independent hospitals, that working in consultation is a principle that we would want to keep to and working in partnership as much as possible, and so that does seem a sensible approach in normal times and of course even more so in pandemics.

But of course always recognising that as independent organisations, they will have a different set of constraints and a different set of aims, albeit

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1 that clearly in an emergency we all come together to
2 essentially do the right thing.

3 **MR JORY:** Thank you, Professor.

4 Thank you, my Lady, those are my questions.

5 **LADY HALLETT:** Thank you, Mr Jory, very grateful.

6 Now I think we have Mr Wagner over there.

7 **Questions from MR WAGNER**

8 **MR WAGNER:** Good morning Professor Powis, I act for
9 13 Pregnancy, Baby and Parent Organisations, and I want
10 to ask you with a single area, which is care for
11 miscarriage and ectopic and molar pregnancies.

12 You exhibit a graph in your fourth statement, at
13 paragraph 1185, and I'd like it to go on the screen,
14 please.

15 It's INQ000485652_323. Thank you.

16 So you can see there it goes from January 2017 to
17 May 2022, and it's:

18 "Inpatient episodes for miscarriages, ectopic or
19 molar pregnancies, or stillbirths ..."

20 And you can see there is a significant dip around
21 I think it begins in March -- it's around March 2020.

22 And in your statement you describe the graph as
23 showing a marked decline in inpatient admissions in
24 respect of care for miscarriage, ectopic and molar
25 pregnancies in March 2020. The graph also shows that

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1 a reduction in people attending hospitals for a range of
2 conditions. This is one set of conditions but we saw
3 similar dips in cardiac conditions, other conditions as
4 well. And of course that was, as I said earlier, very
5 concerning. There are likely a number of reasons for
6 it, as you have pointed out, and I've discussed, around
7 people not wanting to come into hospital because they
8 were fearful of hospital, where infections might be
9 higher, of trying to assist the NHS.

10 We would have preferred them to come, but quite
11 clearly some people felt that they should let the NHS
12 get on and manage Covid. And other reasons too, and we
13 talked about the Protect the NHS slogan and its
14 potential impact.

15 So I think there are multiple reasons.

16 We did not stand down emergency and acute
17 services, including maternity services during this
18 period, but of course there was a lot of disruption,
19 particularly during wave 1 where we were heading into
20 an unknown pandemic in the Alpha wave. The following
21 winter we obviously knew a lot more about the virus and
22 how to manage it. So I think there are a range of
23 reasons. But clearly this is something that was
24 worrying at the time. I spoke about it early in
25 generality about the need to come to hospital or need to

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1 these numbers remained lower than the pre-Covid figures,
2 or appeared to, well into 2022.

3 And you say in your statement the dip likely
4 reflects the preference of women to stay away from
5 hospital settings and changes in the RCOG guidance on
6 management of ectopic pregnancies.

7 Now, in May 2023, The Miscarriage Association
8 carried out a survey of women who experienced pregnancy
9 loss between April 2020 and 4 July 2021, and during that
10 period -- I appreciate it's slightly -- it's the end of
11 the second part of that period -- 40% of women and
12 pregnant people recorded they were not able to receive
13 their preferred management method for those
14 miscarriages, ectopic and molar pregnancies.

15 My question is this, if you excuse the long
16 introduction, do you agree that, in addition to the
17 possible factors that you mention in your statement,
18 that marked decline in the inpatient admissions could
19 also be reflective of the fact that many women were
20 unable to access what they preferred to be their
21 management method for their miscarriages and ectopic
22 pregnancies?

23 **A.** Thank you. And we discussed this in general in my
24 evidence in previous sessions. Clearly particularly in
25 the first wave, in March and April of 2020, we saw

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1 come to appointments.

2 And it's certainly a lesson for future pandemics
3 that we should watch out for this and ensure that the
4 public messaging is supporting people coming to hospital
5 or to healthcare settings.

6 **Q.** Thank you. And the second question, a shorter one, is
7 you refer in your statement to the All-Party
8 Parliamentary Group on Baby Loss calling, in
9 August 2020, for swift reinstatement of the provision of
10 choice for women facing pregnancy or baby loss in all
11 trusts, including treatment options and interventions
12 and options after bereavement to make memories or spend
13 time with their baby, babies.

14 Were any steps taken by NHSE to comply with that
15 recommendation at the time?

16 **A.** Well, we tried -- our intention was to get services
17 re-established as soon as possible particularly after
18 wave 1. As I said earlier, in wave 2, although services
19 were disrupted we did not stand down services to the
20 same extent. Of course, again, these were services that
21 were not stood down. And so the intention was to try
22 and get back to as near as normal as possible as quickly
23 as possible. But clearly we were still in a pandemic.
24 Clearly there were still infection risks, clearly we had
25 visitor guidance and other policies in place to protect

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1 patients, staff and the public.

2 So as I know we have discussed in previous
3 evidence, this is one of those tricky balances which
4 requires judgment. It will not necessarily be the same
5 judgment in one part of the country compared to another.
6 Estate is different. The underlying community
7 prevalence is different but the principle is to try and
8 get back to as near normal as possible as quickly as
9 possible albeit with those constraints.

10 **MR WAGNER:** Thank you.

11 **LADY HALLETT:** Thank you, Mr Wagner.

12 Mr Wolfe, who I think is behind the pillar.

13 **Questions from MR WOLFE KC**

14 **MR WOLFE:** My Lady.

15 Good morning, Professor Powis.

16 **A.** Good morning.

17 **Q.** I ask questions on behalf John's Campaign, The Patients
18 Association, and Care Rights UK, all of whom represent
19 people drawing on the health and social care, and their
20 families. My first question is about patient
21 participation and consultation.

22 At paragraph 53 of your witness statement you talk
23 about the way in which NHS England had regular forums
24 with the BMA, the royal colleges and medical providers.

25 Can I just ask you about that. To what extent did

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1 stages, that there is a need to get guidance out
2 quickly.

3 So, again, it's back to the theme of a difficult
4 judgment, a balance, a balance of risks to take that
5 changes over time. But the key principle is that as
6 much as possible we at NHS England would wish to consult
7 with public and patient groups.

8 **Q.** So my clients take the view that there might be some
9 specific benefits from having a patient consultation
10 focus included within those BMA and other dialogues.
11 You don't disagree with that, do you?

12 **A.** So I don't disagree in principle that it's important to
13 have those contacts and of course I would have other
14 meetings with charities representing various patient
15 groups. The particular meetings I was referring to were
16 quite tight discussions around transfer information and
17 so it might not be the most effective way of doing it,
18 so, in principle, no, I wouldn't object but there may be
19 better ways.

20 **Q.** So my further questions are about visitor guidance which
21 you talked about to some extent on Thursday.

22 Paragraph 240 of your witness statement, you recognise
23 that it can be more difficult to provide compassionate
24 one-to-one care and detect signs of deterioration in the
25 condition of a patient when there are no family members

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1 consultation with patients and potentially their

2 families feed into those conversations with the BMA and
3 others?

4 **A.** The consultations with the BMA and the royal colleges,
5 I think I discussed in the statement, I need to look at
6 the paragraph, paragraph 53, I think of my third witness
7 statement, correct? Perhaps not. Perhaps it's the
8 fourth. But those conversations were mainly
9 professional conversations that I had around informing
10 the colleges and BMA, things that we were doing at
11 NHS England but similarly from them concerns that they
12 had. So they were not specifically designed to involve
13 patients and the public, although some of the -- well,
14 many of the organisations on that of course do have
15 processes by which they themselves liaise with patients
16 and the public and are very strong advocates.

17 There are other mechanisms by which we gather
18 information and consult with patient groups and the
19 public. There are many organisations that advocate on
20 their behalf. As I discussed in previous sessions of
21 evidence, that became more challenging particularly in
22 the early part of the pandemic when you do not have the
23 time that you usually have to undergo that consultation.
24 That is regrettable but it is the nature of
25 a fast-moving pandemic, particularly in the early

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1 around. And my clients would agree with that.

2 To what extent was that taken into account in the
3 evolving flexibility that was introduced into the
4 visitor guidance?

5 **A.** Again, it was one of the reasons that we wanted to
6 become more flexible on visitor guidance as quickly as
7 possible. Again, a topic we discussed earlier and
8 again, one of those difficult balances in terms of
9 protecting staff, patients and visitors from high rates
10 of infection but at the same time providing that
11 flexibility to allow people to visit. So if you look at
12 the various iterations of the visitor guidance that came
13 out from March and subsequently, there is a principle
14 and a theme through all of them of trying to ensure that
15 they were more flexible and then as rapidly as possible
16 getting back towards where we were at the beginning
17 which was complete local flexibility around visitor
18 guidance.

19 **Q.** Any reason, then, why that type of situation couldn't
20 have been introduced as a specific exception along with
21 the others early on?

22 **A.** So I think we tried to put in as many exceptions as we
23 could as early as possible but clearly there is learning
24 for future pandemics in terms of ensuring that we do
25 that quickly and we extend that exceptionality as much

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1 as we possibly can.

2 **Q.** So, again, in terms of that evolving flexibility to what
3 extent was that flexibility, not just about patients and
4 families, but also about the reduced strain on staff and
5 the benefits that that would bring for the NHS itself?

6 **A.** Yes, and I think you have heard that in some of the
7 evidence that the Inquiry has been presented with.
8 Again, a balance. Absolutely, for many staff the strain
9 and the trauma of having to look after patients without
10 the benefit of having close family and relatives to aid
11 in that was really challenging but at the same time
12 staff were really worried about spread of infection,
13 they were really worried about catching Covid themselves
14 and about people that they cared for who didn't have
15 Covid and, of course, visitors and others catching
16 Covid.

17 So I think there was stress on, you know, in both
18 those areas, so staff felt a huge amount of stress about
19 a lot of things, and one of those things that is
20 difficult to reconcile and I think as one of the
21 witnesses who has given evidence said previously, it
22 would have been almost impossible to come up with
23 visitor guidance that would have satisfied everybody's
24 concerns equally.

25 **Q.** Final thought. In that evolving flexibility, do you not

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1 on healthcare workers, such as burnouts and Long Covid,
2 are a continuing barrier to the NHS recovery and,
3 therefore, to its resilience.

4 **A.** Thank you very much. And yes, I absolutely agree that
5 we have that ongoing impact of the pandemic and that our
6 staff, even though it's now nearly five years since the
7 start of the pandemic, though are still struggling and
8 remembering the impact of those waves and the moral
9 injury that we know they suffered. Which is why,
10 of course, we have continued to maintain a focus on
11 health and well-being, why we continue to give as much
12 support as possible and encourage local organisations
13 who were at the front of this, at the front-facing part
14 of this, to support their employers. Why, for instance,
15 you will have seen an emphasis, to give one example, in
16 resident doctors, our doctors in training and other
17 doctors, to help employers do as much as possible to
18 provide the support that means that they are feeling
19 satisfied in their work, enjoying the work they do.

20 Because our staff are everything in the NHS.
21 However much capital investment there is, however much
22 infrastructure we put in, at the end of the day this is
23 a people service and it's the staff of the service, as
24 you quite rightly say, that make it what it is.

25 **Q.** Thank you, Professor.

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1 think it would have been helpful to make the specific
2 point that the local trust policies needed to look at
3 the balance for the individual patient? This wasn't
4 just a generic flexibility it was about looking at risks
5 and benefits for individual patients, whether a human
6 rights focus or a public sector equality duty focus or
7 simply an NHS good practice focus?

8 **A.** I think that was implicit in the guidance but perhaps it
9 might have been more explicit.

10 **MR WOLFE:** Thank you, Chair.

11 Thank you, Professor Powis.

12 **LADY HALLETT:** Thank you, Mr Wolfe.

13 Mr Stanton.

14 Mr Stanton is behind you.

15 Questions from MR STANTON

16 **MR STANTON:** I ask questions on behalf of the BMA. The
17 first question I have is in the area of NHS resilience.

18 You refer to resilience challenges within your
19 statement, including that these challenges not only
20 affected the ability to respond to the pandemic but also
21 the ability to recover from it, and you made some
22 recommendations within your evidence last week about the
23 need for more capital investment and more staff.

24 Can I ask you about another aspect of resilience,
25 namely the extent to which the impacts of the pandemic

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1 Specifically in respect of Long Covid in
2 healthcare workers, you mentioned in your evidence last
3 week that the turning point in your recognition of
4 Long Covid was in a meeting with Long Covid SOS on
5 11 September 2020. And you also stated that one of your
6 earliest recollections of realising the impact of
7 Long Covid on NHS staff was the extent to which they
8 were accessing Long Covid clinics.

9 Please can I ask you at what point did you become
10 aware that healthcare workers were experiencing a higher
11 prevalence of Long Covid than in the general population?

12 **A.** So I can't remember exactly but it would have been
13 pretty early on. And to an extent it would not have
14 been unexpected because we knew that healthcare workers
15 were one of the groups that were experiencing a high
16 rate of infection per se and therefore it would be
17 logical that, unfortunately, they would also experience
18 a higher rate of Long Covid.

19 **Q.** Thank you, Professor.

20 Final question, still on the issue of workforce.

21 You have indicated that even in circumstances where we
22 are able to increase the number of staff within the NHS,
23 there will always be a need for surge capacity to deal
24 with a pandemic. And in this respect the Inquiry has
25 been provided with evidence that has indicated that the

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1 full potential of the returners programme was not
2 realised, despite the willingness of the staff or the
3 former staff.

4 Please could I ask you how do you think
5 NHS England and individual trusts could have
6 collaborated more effectively to have improved that
7 potential resource?

8 **A.** Yes, this is one of the areas where I think we have
9 reflected how we might have been able to provide more
10 support for those returners. Those individuals who had
11 recently retired or left the health service for other
12 reasons and who were willing to come back might have
13 been able to come back. And I think a lot of it is
14 around the support for local organisations to streamline
15 and undertake as efficiently as possible the sort of
16 processes that you need to bring staff back in.

17 And of course this is at a time when they are
18 trying to do a million other things because of the
19 pressures of the pandemic. There are other lessons on
20 this as well but I think it's -- to my mind, it is very
21 much around how we can think about providing that extra
22 support to make it as easy as possible for individuals
23 to come back into the health service.

24 **MR STANTON:** Thank you, Professor.

25 Thank you, my Lady.

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1 therefore sought to provide as much support as possible
2 to healthcare organisations to ensure that they
3 undertook those assessments and, again, you will recall
4 and it's in the statement, we heard also evidence from
5 Dame Ruth May on this, we were particularly focused on
6 supporting those trusts to undertake those risk
7 assessments in individuals from ethnic groups that we
8 knew were at high risk.

9 And I think an exhibit was shown earlier in my
10 evidence that showed that we saw a significant
11 improvement over the following weeks and particularly in
12 individuals from BAME groups and other ethnic
13 minorities.

14 So that's one example. There's a range of other
15 examples. In the statement there are examples around
16 how, for instance, we supported Filipino nurses. I know
17 Dame Ruth in her statement, in her evidence gave
18 examples of how she had supported particular groups and,
19 of course, when it came to things like vaccination
20 policies later on, again really targeted approaches,
21 really a lot of effort going in to particularly support
22 those individuals because, firstly, we knew that they
23 had higher risk and two, because it was really high up
24 on our agenda as a priority to provide that support.

25 **Q.** Just in relation to those initiatives, was there prior

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1 **LADY HALLETT:** Thank you, Mr Stanton.

2 Mr Thomas, if you could take us up to marking
3 Remembrance Day.

4 **Questions from PROFESSOR THOMAS KC**

5 **PROFESSOR THOMAS:** Good morning, Professor. My name is
6 Leslie Thomas and I am representing FEMHO, the
7 Federation of Ethnic Minority Healthcare Organisations.
8 And, as you know, these workers faced unique challenges
9 during the pandemic and we aim to better understand the
10 targeted support initiatives and protective measures
11 implemented for them.

12 So, with that in mind, you don't need to turn it
13 up but at paragraph 709 of your witness statement you
14 highlight targeted initiatives to support black, Asian,
15 and minority ethnic healthcare workers, acknowledging
16 their disproportionate impact during the pandemic.

17 Could you specify the types of initiatives that
18 were put in place?

19 **A.** Yes, and we talked about some of these, I think in the
20 previous session. So clearly the risk assessment
21 process that we put in place in the early phase of the
22 first wave, when these issues came to our attention, was
23 a really important process and I outlined how by the
24 time we had come to late June and early July we were not
25 satisfied with the progress that had been made and

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1 engagement with black, Asian, and ethnic minority
2 leaders before implementing them?

3 **A.** Yes, there was. Right from the start. So as soon these
4 issues came to our attention, and again this is in the
5 statement, the former Chief Executive of the NHS,
6 Lord Stevens, called for a summit which was held, I
7 think, on 15 April where healthcare leaders from ethnic
8 minority groups and other groups came together as
9 a starting point to discuss the issues that were being
10 raised and to start to formulate a plan going forward.
11 And I know my colleague, the Chief People Officer at
12 NHS England, who led this work spent a lot of time
13 engaging with staff from those backgrounds and,
14 of course, the Race and Health Observatory was also
15 established. I know the work had been ongoing prior to
16 the pandemic but that was another important point during
17 the pandemic where we supported and put in place another
18 bit of the system that would help support us in these
19 efforts.

20 **LADY HALLETT:** Mr Thomas, I am in your hands. I don't want
21 your question or the answer to be interrupted.

22 **PROFESSOR THOMAS:** Can I pause here.

23 **LADY HALLETT:** If that is convenient for you. I think we
24 will all just pause until we get the indication that we
25 should -- for those who wish and can stand, we will

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1 stand in a moment.

2 (2 minutes of silence observed)

3 **LADY HALLETT:** Mr Thomas.

4 **PROFESSOR THOMAS:** Professor Powis, we just looked in the
5 last question at what initiatives were taken, given the
6 disproportionate impact on black, Asian, and minority
7 ethnic; these initiatives, were they reviewed for their
8 impact and effectiveness?

9 **A.** There were a number of evaluations undertaken of the
10 programme of support we gave to staff. I've indicated
11 earlier that we'd be very happy to write to the Inquiry
12 with specific details over and above anything that is in
13 the statement, but our principle is to evaluate wherever
14 possible.

15 **Q.** All right, well, if so, and I take it from your answer
16 you're saying that they were evaluated for the impact
17 and the effectiveness, the follow-on question,
18 looking -- and I want to be forward facing not just
19 negative, what insights or lessons were gathered that
20 could guide more effective support and strategies for
21 ethnic minority healthcare workers in a future
22 healthcare crisis?

23 **A.** Well, I think there are many things that we are doing
24 and can do. So if I just pick on one or two of the core
25 things, I think we need our NHS leaders to be more

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1 So there are many things that we are doing and
2 many things that we can do and I should emphasise it is
3 of highest important for us in NHS England that we
4 address this.

5 **Q.** Can I turn to my final area. I want to look at
6 deployment decisions and risk factors. You see, it's
7 been reported that Asian, black, minority ethnic
8 healthcare workers were disproportionately assigned to
9 high risk areas during the pandemic, which elevated
10 their risk to exposure to Covid.

11 So, question: did the DHSC's recognition of race
12 and ethnicity as potential risk factors influence
13 deployment decisions for these healthcare workers?
14 Specifically, what measures were adopted to ensure that
15 these workers were not placed at increased risk?

16 **A.** So of course the intent of the risk assessments that
17 were undertaken was to identify those that were at the
18 highest risk and working in the highest risk
19 circumstances and, where appropriate, provide
20 redeployment. That was the intent. That was the
21 purpose of this exercise. And I'm sure that happened in
22 many, many cases but it may not have happened
23 everywhere. This, of course, is a responsibility for
24 local organisations, with NHS England, NHS employers and
25 others providing the guidance and the tools to do it.

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1 representative of the staff that the NHS employs as
2 a whole and of the communities they serve. We are
3 making some progress on that, if you look at the
4 percentage of individuals from BAME and other ethnic
5 backgrounds who are in senior positions within the
6 boards of NHS trusts for example. That proportion is
7 increasing.

8 If you look further down leadership in our
9 organisations, particularly at Agenda for Change higher
10 band 8s and band 9s, we have not got the representation
11 that we need and of course those are the grades that are
12 the precursors to moving up into the very senior
13 leadership positions.

14 We at NHS England are working hard to rectify
15 that, to support people, to mentor people, to get into
16 a position where they're in those senior roles and
17 I know many organisations across the NHS are doing
18 something similar. That is one example.

19 Another example I could give you is in our support
20 for staff networks, in our work to combat racism, and
21 again there has been a real focus on this recently but
22 I think, as you have heard, this needs to be constant
23 and not just occurring when there are issues in the
24 community that bring it to particular focus and
25 attention.

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1 We did see in the staff survey, again, as
2 I've mentioned, reporting from over the period
3 October 2020 that in the round staff felt their health
4 and well-being was more supported compared to previous,
5 although that dropped off again the year after. And
6 I think do think one of the lessons perhaps for us
7 specifically is around, in a future pandemic,
8 understanding more the impact of those assessments at
9 local level as well as just whether they were
10 undertaken.

11 **Q.** Okay, that very nicely brings me to my final question,
12 which is this, and you just touched upon it, and it's:
13 looking to the future, bearing in mind you've just
14 accepted that some areas or some of this impact may have
15 been missed, what systems or protocols can have been
16 established to prevent similar disproportionality in
17 deployment assignments so that ethnic minority
18 healthcare workers are adequately safeguarded during any
19 future health emergency?

20 **A.** So I did just touch on that. So I think clearly
21 ensuring that there is a risk assessment framework once
22 we understand the nature of the risk that any future
23 virus might cause. And of course that is not always
24 obvious at the start, but once that's understood I think
25 the lessons from this pandemic will set us in good stead

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1 for developing risk assessment processes and tools at
2 speed. But I think in addition to ensuring that they
3 are undertaken, doing more work around understanding
4 their impact and the nature of that impact and where
5 redeployment occurred and where it didn't I think would
6 be an important lessons on for the future.

7 **LADY HALLETT:** Thank you, Mr Thomas.

8 Mr Burton.

9 Mr Burton is over there.

10 **Questions from MR BURTON KC**

11 **MR BURTON:** Thank you, my Lady.

12 Good morning, Professor. On the question of
13 DNACPRs, in its final report the CQC concluded as
14 follows:

15 "Every area we looked at had taken steps to make
16 sure that services were aware of the importance of
17 taking a person-centred approach to DNACPR decisions
18 and advance care planning. However, we found that
19 providers had to cope with a huge amount of guidance
20 about all aspects of the pandemic that lacked clarity
21 and changed rapidly, leading to confusion."

22 I wondered if you agreed with that conclusion of
23 the CQC and, perhaps more importantly, whether you could
24 help the Inquiry with any recommendations about how in
25 the future NHS England could avoid or minimise confusion

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1 On the matter of DNACPRs, I think there were a lot
2 of recommendations in the CQC report which were very
3 helpful, and of course they have been acted upon.
4 I think we need to be aware that this is a potential
5 issue going into a next pandemic. There is clear
6 guidance, there has been guidance over many years from
7 professional organisations around the use of DNACPR as
8 one part of advance care planning. It is not the same
9 as advance care planning. And I don't think that
10 guidance necessarily needed to change but we need to be
11 aware that in times of emergency and stress it may be
12 used in a way that wasn't anticipated. And I think
13 that's the lesson, to be aware of that going into the
14 next pandemic and therefore acting early to ensure that
15 we remind people that the appropriate use of DNACPRs and
16 advance care planning is the thing that needs to remain
17 during the pandemic.

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

19 I have some discrete questions about visitor
20 guidance, if I may. You've explained how the guidance
21 evolved over the first sort of six months of 2020, and
22 in a more relaxed fashion, but you also came quite close
23 to conceding in your evidence last week that perhaps the
24 decision not to make allowances for people with learning
25 disabilities and autism sooner was a mistake.

27

1 about issues as important as DNACPRs.

2 **A.** On the general matter of too much guidance or too little
3 guidance, again this is something we discussed in the
4 earlier part of my evidence, and I'm pretty sure I said
5 that for every person who felt there was too much
6 guidance there may be somebody else who feels that
7 a specific bit of guidance was missing or should have
8 been issued when it wasn't. So this is a balance. It's
9 a balance, again, that changes during the course of the
10 pandemic. It changes according to the context. And in
11 a sense it's impossible to get it absolutely right.

12 Clearly guidance is required not just from
13 NHS England but from other organisations, particularly
14 in the phase of a pandemic when evidence is fast moving
15 and gathering in its magnitude, quantity and what it's
16 telling us all the time. But clearly we are very
17 conscious that having too much guidance can cause
18 difficulties, it can be a distraction. It's a really
19 difficult balance to maintain. And I think I said
20 earlier that I think the most important thing is to be
21 aware that that balance needs to be addressed rather
22 than particularly trying to set it at one point or
23 another. It's being aware of it and being as careful as
24 possible to only issue guidance where it's absolutely
25 necessary.

26

1 My question is this: did NHS England consult any
2 disabled people's groups or otherwise carry out an
3 equality impact assessment in relation to the visitor
4 guidance? If the answer to that is no, the second
5 question is, had it done so, do you think those mistakes
6 would have less likely been made?

7 **A.** I would need to write to the Inquiry with the specific
8 information on that. We did correct this. I think it
9 was in the April guidance, so it was fairly soon into
10 the pandemic. And as I said in previous evidence, this
11 was, in a sense, new territory for us in that visitor
12 guidance had always been local guidance previously.

13 So undoubtedly there are lessons to be learnt for
14 next time in this area and, as I've said, the principle
15 of consulting is something that we hold dear at
16 NHS England and it would be a principle that I think
17 would serve us well in this area, as in many other
18 areas.

19 **Q.** Thank you. And my final question is just about data.
20 What steps are being taken in relation to improving data
21 collection and dissemination across the NHS in relation
22 to disability?

23 **A.** Again, something I would need to get back to you in
24 writing over the specifics. But we are constantly
25 trying to improve our data. I think the pandemic has

28

1 taught us there are some areas where we probably need
2 more data, but again, back to the discussion that we had
3 previously, we are very aware that putting too many data
4 requests on organisations can have a disbenefit, but
5 clearly in this area I think it's important that we
6 gather appropriate data wherever we can.

7 **LADY HALLETT:** Thank you, Mr Burton.

8 Ms Alexis, who's just behind you.

9 **Questions from MS ALEXIS**

10 **MS ALEXIS:** Thank you, my Lady.

11 Professor, my name is Fallon Alexis and I ask
12 questions on behalf of the Covid-19 alliance against
13 airborne transmission, CATA. My questions relate to the
14 topic of PPE, provision to healthcare workers, please,
15 in light of the routes of transmission, and I'd like to
16 ask you questions, please, in relation to a letter that
17 you co-signed with others.

18 Can I ask, please, for document INQ000130506 to be
19 displayed on the screen, please, to assist you,
20 Professor.

21 This letter, as we can see from the first page, is
22 dated 28 March of 2020 and if assists, it's covered in
23 your third witness statement, Professor, on page 109 at
24 paragraph 386. And what we can see is it's sent, if we
25 can just scroll down, please, just to the end on page 3
29

1 the supply, changes to the guidance and then the current
2 guidance, and my question, please, relates to page 3 of
3 5 of this document, under the heading "Comparison with
4 WHO guidelines".

5 We can see in this section, Professor, you've set
6 out what the UK recommends of FFP3 respirators when
7 caring for patients in areas where high risk
8 aerosol-generating procedures are being performed and
9 you've gone on there. My question is this, Professor,
10 if we read on, it says in the second paragraph:

11 "Consistent with WHO guidelines, full sleeve gowns
12 are recommended for high risk procedures (eg during
13 AGPs) or where there is a risk of extensive splashing of
14 blood and/or other body fluids. In all other settings,
15 the UK has a long-standing bare below the elbow policy
16 as part of our long-term strategy to manage
17 healthcare-associated infections. COVID-19 is not
18 airborne, it is droplet carried. We know the cross
19 contamination from gowns for infection can be carried by
20 the gown sleeves and the advice therefore is bare below
21 the elbows and you scrub your hands, your wrists and
22 your forearms."

23 Professor, please can you explain why you felt the
24 need to so confidently and assertively rule out airborne
25 transmission so early in the pandemic?

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1 and over to page 4 we can see, Professor, that it's
2 signed by yourself there as the Medical Director along
3 with, rather, the Medical Director and Director of
4 Health Protection at Public Health England and the chair
5 of the Academy of Medical Royal College.

6 And back up if we can, please, just to set the
7 scene. We are at 28 March of 2020 and this is a letter
8 that you've sent to the chief executives of all NHS
9 trusts and NHS Foundation trusts, the Clinical
10 Commissioning Group accountable officers, GP practices
11 and primary care networks and providers of community
12 care health services, and it comprises a list there of
13 who it was copied to, which obviously includes, as we
14 can see, the Royal College presidents, the BMA, the RCN,
15 NHS providers, along with others, including at the
16 bottom there NHS 111 providers.

17 Thank you.

18 And we can see in summary -- I'm not going to go
19 through all of it, but to help you with a question that
20 follows, Professor, you set out at the beginning of that
21 letter that you're grateful for the efforts of the NHS
22 colleagues and you hope that this letter clarifies your
23 current approach and next steps in relation to NHS PPE.

24 And if we could, please, just looking down, we see
25 that there are sections titled "Supply" where you cover
30

1 **A.** This letter was written in the context of the evidence
2 that was available at the time and IPC guidance at the
3 time. As you pointed out, in the letter it points out
4 that a further iteration of the IPC guidance was about
5 to be undertaken. I believe that was covered in
6 Professor Hopkins' evidence. So this is early in the
7 pandemic and represents the position then.

8 It was some time, of course, before the World
9 Health Organisation recognised Covid-19 as being
10 airborne and you have heard a lot of evidence around the
11 method of spread whether it's droplet, aerosol, and how
12 far droplets or aerosols are carried and how long they
13 stay in the air and the surroundings to an individual.
14 It's not an area in which I'm an expert. Others are
15 much more knowledgeable about IPC and transmission and
16 the mechanisms of transmission and the science of
17 transmission than I am, but this represented what we
18 knew at that time in late March.

19 **LADY HALLETT:** I think we have to leave it there, Ms Alexis,
20 I'm sorry.

21 **MS ALEXIS:** Thank you, my Lady.

22 **LADY HALLETT:** Thank you.

23 Ms Stone.

24 Ms Stone is just there.

25 **Questions from MS STONE**

32

1 **MS STONE:** Good morning, Professor. I ask questions on
2 behalf of Covid Bereaved Families for Justice UK, and
3 I want to ask you some questions, if I may, all relating
4 to NHS 111. Two areas, please. The first is triage and
5 comorbidities and the second is around meeting the needs
6 of a diverse patient group.

7 So, in terms of the first of those, please, can
8 I take you back to the HSIB report which you discussed
9 on Thursday in response to some questions, and that is
10 the report about 111's response to callers with
11 Covid-19-related symptoms during the pandemic.

12 Professor, you helpfully summarised the findings
13 of that investigation report in your fourth statement.
14 I don't think it needs to be called up but for your
15 benefit it's at page 223 of that statement should you
16 need to go to it.

17 But one of the findings that you set out there is
18 this. The HSIB report found that the CRS Covid Response
19 Service algorithm did not allow for assessment of
20 callers comorbidities to establish whether a clinical
21 assessment would be beneficial. So it's that that
22 I wanted to ask you about. And by way of context,
23 I think you said in your evidence, or at least it was
24 implicit, that 111 operators wouldn't have access to
25 medical records; is that also correct?

33

1 point though is that I think it's implicit in your
2 answer that it would be important ordinarily to consider
3 comorbidities; would that be right?

4 **A.** Well, I think it's important to introduce changes into
5 those algorithms and scripts based on robust evidence.
6 And I'm confident that there was a process in place to
7 ensure that what was introduced had been looked at
8 carefully and the evidence was felt to be strong enough
9 to introduce it.

10 So I think there is a difference between thinking
11 at the start there is reason to think that comorbidities
12 are going to be important versus getting strong enough
13 evidence to say: yes, we are certain enough to include
14 it in a set of scripts and algorithms.

15 But I think in any event that happened fairly
16 rapidly early on. I think that was acknowledged in the
17 HSIB report.

18 **Q.** You responded to some of those findings, including this
19 one, in your statement, and you say in the statement
20 that NHS England agrees that the system wasn't initially
21 designed to take into account specific comorbidities due
22 to limited knowledge of the virus, but you go on to say
23 that there were lots of updates as the evidence base
24 evolved, which I think touches on what you've just said.

25 But I wanted to ask you this, in respect of that

35

1 So, firstly, as a matter of principle, for triage
2 in respect of a respiratory infection like Covid, would
3 it be important to assess a caller's comorbidities to
4 optimise the advice given and in particular to consider
5 whether a clinical assessment is needed?

6 **A.** So the evidence around comorbidities was evolving at the
7 time when the service was initially stood up. We had
8 a very robust process involving expert clinicians to
9 consider any new evidence around the virus and its
10 impact before that was operationalised into 111, CRS and
11 other algorithms. That process did look at multiple
12 conditions as soon as the evidence started to emerge,
13 and then I think fairly rapidly did incorporate that in.
14 So, quite rightly, once the evidence was there it was
15 incorporated.

16 Again, as you've heard, there were many changes
17 made to those scripts and algorithms as the evidence
18 emerged, but I think it is an important principle to
19 ensure that you are confident in that evidence before
20 you introduce it, because then -- not in respect of
21 multiple conditions, but if you introduce a change to
22 the script which is not based on good evidence then
23 clearly there could be a disbenefit to that. So you do
24 have to go through that robust process.

25 **Q.** I understand that, Professor. I think the starting

34

1 evidence base, please. We know that work was done early
2 in the pandemic to identify particular groups who may be
3 more clinically vulnerable to Covid for the purposes of
4 developing the shielding programme. And by 18 March
5 latest there were lists of specific comorbidities which
6 identified groups considered to be clinically vulnerable
7 and clinically extremely vulnerable. So they had been
8 identified by that date.

9 Can I ask you this, should that analysis have been
10 translated across into NHS 111 triage and assessment
11 protocols, such that callers should have been asked
12 whether they had those specific comorbidities, thereby
13 informing the advice that they received?

14 **A.** So I think you heard from the Chief Medical Officer,
15 Professor Sir Chris Whitty, in his evidence that those
16 initial comorbidities and conditions were derived from
17 a set of first principles rather than necessarily
18 an evidence base at that point; in other words, as we
19 were just discussing, what you might reasonably expect
20 rather than what you absolutely knew as per published
21 evidence.

22 And so I think that is a difficult balance.
23 I think it's a perfectly legitimate question for you to
24 pose and for us to think about for future pandemics, and
25 clearly it is a balance between -- it comes back to the

36

1 point I was making about how certain you need to be
2 about the evidence, because you -- if you include
3 something before the evidence is certain, you also have
4 to acknowledge that there might be a risk that that
5 might be a disbenefit.

6 I think others who were more involved in the
7 shielding programme than I would make the same point in
8 principle around the shielding programme, that there is
9 always a downside as well as an upside. So a perfectly
10 reasonable for us to consider but not necessarily
11 a straightforward one to answer.

12 **Q.** Would you agree that in the context of a new respiratory
13 infection that you would -- that a precautionary
14 approach would be important and therefore that including
15 these conditions that were thought, from first
16 principles, as you've just said, to have potential for
17 rendering individuals particularly vulnerable, that that
18 favours an inclusionary approach as far as 111 was
19 concerned?

20 **A.** I prefer to think a benefit of risks, which again
21 highlights the point I've made that there are always
22 consequences to a decision and you have to be really
23 cognisant that sometimes those consequences can have
24 a disbenefit or result in a harm to some individuals,
25 even though although you are trying to derive a benefit.

37

1 handlers are following -- algorithms are not clinically
2 trained, they're -- getting that clinical input can be
3 very important.

4 **Q.** Turning to my second area, please, and that's the extent
5 to which 111 was able to ensure it could meet the needs
6 of a diverse population, particularly in the context it
7 found itself. I want to ask you about three factors,
8 please, the first being questions about lip and skin
9 colour, the second being communication barriers, and the
10 third being data.

11 So the first area, please. We know from the HSIB
12 report that among the red flags for Covid was blue lips
13 or face. I think you understand that, Professor, or
14 knew it from your own knowledge. And from family
15 members we represent, we understand that on occasion
16 questions were asked of them about them or their loved
17 ones which assumed that they were white, for example had
18 their lips turned blue or had their skin colour turned
19 blue. Would you agree there are dangers with that sort
20 of standardised approach to questions about lip and skin
21 colour without reference to the ethnicity of the caller?

22 **A.** So I think this is a general point which holds fast
23 outside of a pandemic as well, and I think the medical
24 profession and clinicians in general need to be more
25 attuned to some of the phrases that we've used and some

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1 So these are quite carefully nuanced decisions, and the
2 principle that you should only make changes once you are
3 assured the evidence is possible I think would hold.

4 But clearly you -- as was demonstrated in the
5 shielding programme, you can start off with a set of
6 possibilities that you think are the most likely things
7 that you need to focus on. But I think this is, again,
8 down to a balance of risks and a balance of judgment.

9 **Q.** Another of the findings was that callers would only be
10 transferred to a clinician or receive a clinical call
11 back if they were so ill that they've stopped doing all
12 of their usual daily activities. Would you agree,
13 Professor, that the imposition of such a high threshold
14 for transfer to clinical advice was inappropriate in
15 dealing with such a new and emerging infectious disease?

16 **A.** So, again, this is a balance of risks and again
17 a balance of what you can undertake operationally. In
18 principle, we endeavour to put as much clinical support
19 into our call services and into 111 as we can,
20 recognising that in doing that those clinicians are
21 unable to do other things that we also might wish them
22 to do. So, again, we're into trade-offs. But in
23 principle we would want to try to set the appropriate
24 threshold to get that clinical call initiated, because
25 we also know and we have discussed that the call

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1 of the terminology that we have used over the years.
2 And that change is definitely occurring at the moment
3 but I would agree with you that we need to be cognisant
4 of that.

5 **Q.** So would you agree there should have been express
6 provision whether within the protocol and/or the
7 training of those call handlers to ensure that
8 a caller's ethnicity was taken into account when
9 considering those sorts of clinical factors?

10 **A.** And I would say in all settings which are -- not just
11 call settings but in interactions that clinicians have,
12 on remote consultations, on a whole range of issues we
13 should be more cognisant that some of this terminology
14 has arisen from white skin rather than darker skin and
15 it's inappropriate.

16 **Q.** Language or communication difficulties, please,
17 Professor. Another concern that was raised within the
18 HSIB report was about communication with callers whose
19 first language wasn't English. Would you agree that
20 specific provision should have been made for call
21 handlers or operators to facilitate communication with
22 those callers?

23 **A.** So as much as possible I agree with the principle that
24 we should have in place -- and, of course, there may be
25 operational limitations particularly when you're

40

1 standing something up at speed -- around ensuring that
2 we can handle as wide a range of language, accent and
3 approach as possible.

4 **LADY HALLETT:** Thank you, Ms Stone.
5 Ms Hannett.

6 **Questions from MS HANNETT KC**

7 **MS HANNETT:** Professor Powis, I appear on behalf of the
8 Long Covid groups. I ask questions on two themes: data
9 and communication.

10 Can I just ask you about data first of all. You
11 acknowledged on Thursday that you're concerned about the
12 variation in non-Covid services. In addition to
13 variation between the services themselves, the
14 Long Covid groups have raised concerns about issues in
15 accessing those services across the board. Those
16 include difficulties in obtaining a referral and long
17 waiting times.

18 The Long Covid expert report indicates that
19 113,000 patients had been assessed by a specialist
20 Long Covid service and 125,000 referrals had been made
21 by early 2024. By comparison, the ONS figures from
22 March 2024 indicated there were over 2 million people,
23 including more than 55,000 children with Long Covid, so
24 it would appear that only a very small proportion of
25 individuals with Long Covid are accessing the care

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1 the local geographies and local configuration of
2 services that integrated care boards now are working
3 with.

4 On the point of data, yes, I am somebody who
5 believes that having more data is important and having
6 a good understanding of prevalence and incidence of
7 Long Covid in the population, as it would for any
8 condition, would aid us in commissioning.

9 There are a number of ways in which that data can
10 be established. It doesn't all have to be established
11 by NHS England, nor either by the ONS but in principle,
12 yes, understanding the prevalence of a condition does
13 aid us and our local commissioners in determining what
14 services are required.

15 **Q.** Thank you. I just turn, then, to my next topic about
16 communication. NHS England promoted a wide range of
17 Covid-19 healthcare advice and guidance for the public
18 which had been developed by other organisations and you
19 give a number of examples of that in your witness
20 statement, such as promoting a DHSC launch public
21 information campaign.

22 The Department of Health and Social Care developed
23 one video promoting public information on Long Covid
24 in October 2020. It's right, isn't it, that NHS England
25 didn't promote that campaign or indeed publish any

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1 available. And, indeed, Brightling and Evans, in their
2 expert report to this Inquiry were concerned that this
3 means that there is a big gap of people that aren't
4 getting the support that they need.

5 The ONS itself is no longer publishing data on
6 Long Covid and would you agree, therefore, that
7 NHS England would be assisted by national ongoing data
8 collection on both the prevalence of Long Covid in the
9 population and data on the impact of its severity in
10 order to allow the NHS to take a more accurate stocktake
11 of need and to ensure that the right services are put in
12 place to meet the demand?

13 **A.** Yes, and if I give some context. And again, this is in
14 my statement. We were very aware of the ONS work as we
15 were developing Long Covid services. In fact, the
16 demand that we saw was less than we anticipated for the
17 reasons that you said, around that gap, although you are
18 quite right that that -- it still meant that there was
19 waiting times for Long Covid services and as I touched
20 on in my evidence in the previous session, there is
21 variation around the country in terms of waiting times.
22 Of course, you will see that in a variety of conditions,
23 it's not just the case in Long Covid, and in part it
24 reflects the fact that these services are locally
25 commissioned and the particular context and nuances of

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1 public information on Long Covid via the NHS website?

2 **A.** I haven't got the details but I have no reason to think
3 that that's inaccurate.

4 **Q.** Looking back now, then, in hindsight do you agree that
5 using available channels such as the NHS website to
6 disseminate public information on Long Covid would have
7 helped individual understand and identify what they were
8 suffering from?

9 **A.** So, as you say, we did support a lot of communication
10 around Long Covid and I think we do through the NHS
11 website try and provide as much information as possible.
12 Getting that balance of how we provide enough
13 information but not too much information is important
14 and it's certainly something that I think we should keep
15 under consideration as these services develop and
16 evolve.

17 **Q.** And similarly, there's still no public health campaign
18 informing of the risk of Long Covid. Professors
19 Brightling and Evans recommend that to improve access to
20 Long Covid clinical care, the first step is to improve
21 the awareness of the general public around Long Covid,
22 and to enable people to recognise their ongoing symptoms
23 and encourage them to receive healthcare. Would you
24 agree there should be a public health campaign on
25 Long Covid so that sufferers aren't left to struggle

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1 without that information?
 2 **A.** Well, I agree like many other conditions it's important
 3 that the public is aware of Long Covid and symptoms but
 4 the way in which those campaigns work, and not all of
 5 them are undertaken by NHS England or, indeed, the DHSC.
 6 There are campaigns from other groups as well in a range
 7 of conditions, not just talking about Long Covid here.
 8 I think it's quite a complex matter but in
 9 principle I am in favour of doing as much as we possibly
 10 can to ensure that the public is well informed of a wide
 11 range of medical conditions and I would include
 12 Long Covid in that because, as you have outlined, there
 13 is clearly an ongoing need for Long Covid services.
 14 **Q.** Thank you. Final question, if I may, and that's on the
 15 NHS communication on symptomology of Covid-19. Until
 16 April 2022 NHS England's website continued to state that
 17 Covid was: short, mild and flu like with only three
 18 cardinal symptoms of fever, cough and shortness of
 19 breath, despite a significant number of people suffering
 20 from other symptoms.
 21 The CDC in the United States, in contrast, was
 22 updating their website regularly alongside updates and
 23 understanding of new symptoms. Why did the NHS England
 24 not update its website information with updated
 25 understanding of Covid symptoms?

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1 (11.39 am)

(A short break)

2 (11.55 am)

3 **LADY HALLETT:** Ms Carey.4 **MS CAREY:** The first witness, please, I'm going to call
5 today is Ms Amanda Pritchard.6 **MS AMANDA PRITCHARD (sworn)**7 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**8 **MS CAREY:** Ms Pritchard, your full name, please.9 **A.** Amanda Kate Pritchard.10 **Q.** I think you have in front of you two witness statements
11 that you've made, both dated 16 January of this year.
12 INQ000409250, which is 120 pages long, and INQ000409251,
13 which is 353 pages long.14 I'm going to start with a little background to
15 you, NHS England itself, and then delve into some detail
16 dealing with the pandemic.

17 May I start with you, please.

18 Is it right that you joined the NHS management
19 training scheme in 1997 and have held a range of roles
20 within the NHS since that date?21 **A.** That is correct.22 **Q.** I think it's right that you have no clinical experience
23 yourself. You were the Chief Executive Officer during
24 the pandemic of NHS England -- sorry, the
25

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1 **A.** I can't give you a specific answer. I would need to
2 write to the Inquiry on that point but in principle we
3 do aim to update our websites to ensure that they are up
4 to date with the evidence and contemporaneous and
5 of course I would -- you would expect me to agree that
6 that would be a really important thing to do.7 **MS HANNETT:** Thank you, Professor.

8 Thank you, my Lady.

9 **LADY HALLETT:** Thank you, Ms Hannett. I think we'll break
10 now.11 I think that completes the questions for you,
12 Sir Stephen. Thank you very much indeed for your
13 assistance. I'm not sure I'm going to thank you for
14 whoever in your office produced such lengthy statements,
15 but I promise to ensure that all material is taken into
16 consideration, obviously the oral evidence and the
17 written, but that file contains statements from you and
18 Ms Pritchard, so you have given us quite a lot of
19 material. And I do understand the burden we've placed
20 on you.21 **THE WITNESS:** I hope they will be useful.22 **LADY HALLETT:** Thank you very much for your help.23 **THE WITNESS:** Thank you.

24 (The witness withdrew)

25 **LADY HALLETT:** I shall return at 11.55.

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1 Chief Executive Officer of NHS England since
2 1 August 2021 but prior to that date had been the Chief
3 Operating Officer of NHS Improvement; is that correct?4 **A.** So yes I've been Chief Executive Officer for NHS England
5 and Improvement, merged into a single organisation,
6 that's exactly right, from August '21.7 Prior to that, from 2019, from July 2019, I joined
8 as Chief Operating Officer for NHS England and
9 Chief Executive for NHS Improvement. They were working
10 as one organisation at that time.11 **Q.** We've basically been using "NHS England" as a catchall,
12 albeit covering both NHS England and NHS Improvement, as
13 then was?14 **A.** Yeah.15 **Q.** And prior to your roles in NHS England and Improvement,
16 you were the Chief Executive Officer of Guy's and Saint
17 Thomas' NHS Foundation Trust from January 2016 to
18 July 2019?19 **A.** That's right.20 **Q.** Can I ask you, please, at the outset, are you able to
21 give us an overview of the size of the NHS in England as
22 at around March 2020, in terms of budget, staffing
23 numbers, numbers of hospitals, that kind of thing?24 **A.** Yes, of course. And that is an important distinction
25 between the NHS in England and NHS England.

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1 So the NHS in England at that time had a budget of
2 about 1.248 billion -- so 124 billion, sorry, let me get
3 that right, 124 billion. We had 123 trusts, but that
4 includes acute trusts, ambulance trusts, community,
5 mental health, 6,771 GP practices organised into about
6 1,250 primary care networks. The NHS operated at that
7 time out of about 17,000 buildings, and overall we had
8 about 1 million, 1.2 -- actually, nearly 1.3 million
9 staff employed in a range of different roles, as well as
10 a whole number of staff employed through contractual
11 arrangements to provide additional services for the NHS.

12 **Q.** We are talking vast sums, a vast amount no doubt on your
13 plate.

14 Can I just ask you about this. The
15 17,000 buildings, they're not all hospitals, are they?
16 That would include other premises that are required by
17 the NHS to operate?

18 **A.** Yes, so a community trust might have literally hundreds
19 of different buildings, ranging from, you know, small
20 local services through to much bigger centres with beds
21 in them. Equally, we've got GP practices, I've already
22 mentioned, but a whole number of other -- ambulance
23 centres, et cetera, et cetera.

24 **Q.** Understood. All right, that just gives us an indication
25 of the scale of your job in running NHS England.

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1 Health and Social Care that sets the strategy and the
2 funding levels for NHS England, and it's NHS England
3 that commissions the services but does not make the
4 political decisions; is that correct?

5 **A.** That's correct.

6 **Q.** It does not set the health policy.

7 **A.** That's correct.

8 **Q.** And it does not provide patient services itself?

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

10 **Q.** And it is the workforce of trusts that are not employed
11 by NHS England but by the trusts themselves?

12 **A.** Yes, that's exactly right.

13 **Q.** And if we could just look at some of numbers of trusts,
14 you've given us an indication.

15 Can we have up on screen, please, pages 18 of
16 statement ending 250. Thank you.

17 I hope you've got on screen, Ms Pritchard, the
18 position as at March 2020: 74 trusts, 149 foundation
19 trusts, 6,700-odd GP practices, and approximately 11,800
20 community pharmacies.

21 Jump forward two years to March 2022, 69 trusts,
22 144 foundation trusts, nearly 6,500 GP practices and
23 a drop again of about 300 community pharmacies.

24 Now, the trusts changed sometimes their locations
25 and what -- the geographical boundaries. I'm not

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1 And can I also ask to be put on screen, please,
2 INQ000409251_336.

3 I just want to remind ourselves of some of the
4 waves and the numbers of patients involved across our
5 relevant period. And we can see there during the first
6 lockdown the weekly patients in hospital are indicated
7 by the blue line, so approaching, in early 2020, up
8 towards the 20,000 number of patients.

9 If we just stick with the blue line again as we
10 come to the second lockdown and into 2021, it goes up to
11 nearly 35,000 patients, and then drops down and then
12 various peaks and troughs as we go through 2021 into
13 2022. And you've helpfully indicated on there the
14 weekly patients in mechanical ventilation beds is
15 somewhere between 0 and 5,000, with slightly less steep
16 curves throughout the various waves.

17 So, on any view, significant pressures on the NHS
18 in England around winter 2020 into 2021, and we're going
19 to look at some of those pressures in more detail.

20 That's just as an overview.

21 Can I start, please, with your first witness
22 statement, ending 250 -- and I will try, Ms Pritchard,
23 not to jump between the two statements but it may be
24 necessary at times.

25 Is this the position, that it's the Department of

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1 interested in those but the drop in GP practices, are
2 you able to help whether that is related to the impact
3 of the pandemic?

4 **A.** Actually in both circumstances it's generally a similar
5 thing that's going on, which is that not that individual
6 locations are changing but that the governance around
7 them is. So this is predominantly mergers we are seeing
8 happening here.

9 **Q.** Right.

10 **A.** So, for example, where I used to work, Guy's and
11 St Thomas', was formed of two previous organisations,
12 Guy's and Saint Thomas's and Saint Thomas', which came
13 to form one new organisation some years ago, and that
14 has happened quite a bit over the last few years.

15 **Q.** So, in relation to the differences in figures 63 and 64,
16 one should not jump to the assumption that that is
17 a pandemic-related reduction but perhaps more a result
18 of mergers of trusts, practices and indeed pharmacies?

19 **A.** I think that's right. I mean, certainly we have seen
20 more at-scale GP practice provision as well. Though,
21 saying that, I think there is no doubt that some smaller
22 organisations, and this applies to primary care as well,
23 did struggle in the pandemic, and therefore moving
24 towards larger-scale structures may well have been
25 something that was -- happened a bit more quickly

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1 because of those pressures.

2 **Q.** Can I ask you about primary care, because in your
3 statement at paragraph 249 you say that:

4 "Primary care has seen a gradual reduction in the
5 number of full-time equivalent GPs per patient, as
6 part-time working and early retirements offset increased
7 recruitment of young doctors into GP training."

8 Demand has increased with numbers of registering
9 in practices.

10 So do I take it there that there has been a fall
11 in GPs numbers?

12 **A.** So the overall number of GPs is now actually rising
13 again but the point is an important one which is that
14 the more experienced, often partners, as they are
15 retiring newer-trained GPs are joining the workforce but
16 they're often joining in a way that is more, you know,
17 reflective of local -- of personal circumstances which
18 means it's more part-time. At the same time the needs
19 of the population are rising and the number of the
20 population is rising so the numbers mean certainly that
21 you would, as a, kind of, GP, be feeling a great deal of
22 pressure on your work right now.

23 **Q.** Can I ask you this. Just stand back for a moment
24 from -- and take the mergers out of it for one second.
25 Has NHS England got any sense of the impact of the

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1 of starting point, if I can put it like that.

2 And that really brings me on to the resilience of
3 the NHS pre-pandemic and I think you have set out, if it
4 helps you, Ms Pritchard, at paragraph 197 onwards, the
5 definition in the EPRR framework of resilience and it
6 might be useful to up on screen, please, page 52,
7 paragraphs 197 and 198.

8 But there we can see reference to the 2015 EPRR
9 framework which define resilience as "the ability of the
10 community, services, area or infrastructure to detect,
11 prevent and, if necessary, to withstand, handle and
12 recover from disruptive challenges".

13 And then a little more detail given to that in
14 paragraph 198, "withstand, handle and recover" requires
15 a stable platform, ideally headroom or the means to
16 create headroom.

17 And there can be no two ways about it,
18 Ms Pritchard, is this right, that entering into the
19 pandemic, the NHS had historically low bed numbers? Is
20 that right?

21 **A.** Yes.

22 **Q.** High bed occupancy levels particularly when compared
23 with other G7 and European countries. And was it your
24 assessment that coming into 2020, therefore, there was
25 little flexibility in the existing capacity to respond

55

1 pandemic on numbers of staff who have burnt out, left
2 through stress and the like? Are you able to give us
3 an overview at the outset of what kind of impact the
4 pandemic has had on your staff availability?

5 **A.** Yes, we've got -- two things have happened that are
6 really noticeable since the pandemic. One is actually
7 we have a lot more staff than we had pre-pandemic and
8 that was partly because there was, I think, so much of
9 that sense that NHS staff have of the vocation being
10 about wanting to make a difference that many staff who
11 might have otherwise retired, stayed on a bit and there
12 was a real surge in the number of people applying to
13 become nurses, doctors, et cetera, which has begun to
14 flow through to the workforce. So we have about 70,000
15 more staff now than we did.

16 The big "however" is that we are, though, still
17 running at a higher rate of sickness than we were
18 pre-pandemic. So that has -- it went up a lot during
19 the pandemic, partly driven, of course, by Covid
20 infection. It has come down since then but it is still
21 higher than it was and the main, sort of, single reason
22 people are off sick, actually was pre-pandemic and still
23 is now, mental ill health, anxiety, depression, stress.

24 **Q.** We're going to look at some of the figures a little
25 later on in your evidence but that's helpful as a sort

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1 to a rapid and significant surge in demand?

2 **A.** Yes, that's right and I know this Inquiry in previous
3 modules has very helpfully gone into this in some detail
4 but the NHS was running at a very high level of
5 occupancy, so there were real pressures pre-pandemic and
6 I think certainly the challenge of not having that
7 headroom, which is described in this section of my
8 statement, meant that there were certain consequences to
9 how we had to respond in a pandemic that did make it
10 particularly challenging.

11 **Q.** May I put it in this way, and please correct me if you
12 think I'm wrong. Everyone had to surge during the
13 pandemic but it's a question how much you had to surge
14 and as far as the NHS is concerned, because of those low
15 numbers, it had to surge even greater?

16 **A.** Yes, and also how quickly you got into surge territory.
17 So I think the thing that perhaps other countries were
18 able to do was to have a bit of a buffer before you had
19 to enter that sort of extraordinary surge phase. We
20 didn't, so that rapid adaptation of estate, of what
21 staff were doing, et cetera, was necessary, for the
22 first step rather than, if you like, for the second step
23 of response.

24 **Q.** We have, I think you've probably been told, looked a lot
25 at critical care capacity but I just would like to look

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1 at more general availability of beds, and three
2 documents, please.
3 Could we have on screen, please, INQ000113287_6.
4 And, Ms Pritchard, if you have tabs it's tab 3 but
5 it might just be easier to use the screen.

6 **A.** Yes.

7 **Q.** This is a Health Foundation document and set out there
8 was hospital admissions and available beds. Beds is
9 represented by the blue line at the bottom, beds have
10 fallen by 5% over the -- 2010 onwards, coming up to the
11 end of 2019, and we can see there admissions rising much
12 more steeply.

13 And if we go, please, to page 11, acute hospital
14 beds in OECD countries and we can see there that per
15 thousand, as at 2018 England had two per thousand, and
16 you see the comparisons with Japan, with 7.8, to the
17 lowest there, being Colombia at 1.6.

18 Again, that's just hospital beds, and if we look
19 at hospital bed occupancy on page 12, please, running at
20 high occupancy there at 89.6% in England in 2018,
21 Israel, highest at 92.3, and United States the lowest
22 there 64.3%.

23 We'll look at critical care in particular,
24 I suspect, but that gives us an overview now of critical
25 care beds and indeed acute hospital beds.

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1 a stronger position if we had another pandemic. For
2 example, we have a data infrastructure which is much
3 more sophisticated now than it was back at the beginning
4 of the pandemic. We have better -- we talked about beds
5 but we have a lot more community infrastructure around
6 things like remote services, virtual wards, thing that,
7 again, were developed at pace in the pandemic. But at
8 the sort of core of your question which I think is also
9 about estate and do we have the -- is the estate in
10 a better place to withstand a pandemic, clearly the
11 government made a commitment to increase capital
12 expenditure with the 40 new hospitals programme that has
13 begun, and very welcome additional funding for capital
14 announced in the recent budget, but it will take some
15 time for that to feed through into actually putting the
16 state of the NHS into the kind of place that you would
17 want to be to see that headroom built in.

18 **Q.** Well, that very neatly brings me onto two things
19 I wanted to ask about which is, very briefly, funding
20 and then actually the estate itself.

21 Can I start with funding, please, and I just
22 wanted to look through you, if I may, at your
23 paragraph 231 which shows where the money goes -- that's
24 the title of the figure not a name that I have
25 attributed to it.

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1 I suspect you would always want to have more beds
2 and a lower rate of occupancy going into a pandemic, and
3 that may be outwith her Ladyship's ability to make
4 a recommendation, but can I ask you this. Having
5 entered it now in the position that we've just looked
6 at, are we in any better position now in 2024 were there
7 a pandemic in the next month or two?

8 **A.** So I think it's worth saying that we are very much still
9 in recovery. So in relation to that original definition
10 of resilience, and I think it's actually really
11 important that it has the word "recover" -- it has the
12 phrase "recover from disruptive challenges". So where
13 we stand today clearly not only do we still -- it's
14 worth saying, obvious point really, but we still have
15 Covid patients in hospitals now. We also have a very
16 significant job of recovery to do, both to do with care
17 that was disrupted during the pandemic but actually
18 recovery for our staff. So the point we've just made
19 about sickness, for example.

20 We also have a wider challenge across our nation
21 because the health of the nation is poorer as a result
22 of the pandemic. And we have new challenges like
23 Long Covid which is really significant both for patients
24 and a significant issue for staff.

25 We have some things that I would say put us in
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1 It's at page 64 of Ms Pritchard's statement, and
2 if we just go on one page, there should be a table.
3 There we are.

4 This is -- sets out where the money went as at,
5 I think it was 20 September, or thereabouts, in 2020.
6 The funding comes clearly, if we look, from the
7 Department of Health, 87% of which goes to NHS England
8 and we can see 4.3% to public health and 5.3% to NHS
9 activity support. And then from there that 87% gets
10 spread out into a number of different services, the bulk
11 of it going to clinical commissioning groups as they
12 then were. And we can see there 1% is to directly
13 commissioned services. 4% to other primary care. And
14 then various allocations to specialised services,
15 general practice, community health, acute care, mental
16 health.

17 That's probably an over-simplification of the
18 position, I don't doubt, but it's helpful for us to have
19 a sort of structure in mind.

20 But I think you say this in your statement that in
21 due course when the pandemic struck funding initially
22 was not an issue because the NHS received the funding it
23 needed at the start of the pandemic; is that right?

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

25 **Q.** And are you able to help, how much money was given to
60

1 the NHS?

2 **A.** I think we were initially allocated -- well, actually,
3 it changed fairly frequently over the course of the year
4 but the initial allocation was, I think, in the realm of
5 about 19 billion in the end. Not all of that was
6 actually needed or spent. But that's the point about
7 the support was there, had it been required.

8 **Q.** So it's not a question that the decisions were made
9 because there wasn't the money to enable anything to
10 happen, there's a resource issue in terms of having the
11 staff, having the beds, having the buildings --

12 **A.** Yes.

13 **Q.** -- to scale up, not necessarily a financial issue. I'm
14 not trying to minimise it.

15 **A.** Exactly.

16 **Q.** All right. Was there any difference in the way you were
17 able to operate during the pandemic in the way that
18 funding was given to you? Were you effectively given
19 a blank cheque, and said: spend it how you want?

20 **A.** No, what was agreed that was different was budgets that
21 were based on, if you like, a much greater level of
22 uncertainty about what would actually be required but
23 the process then of agreeing spend was, if you like,
24 much more normal and that was between NHS England, the
25 Treasury, the Department of Health, so there was a -- it

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1 much more important but less urgent repairs.

2 **Q.** So do I take it from what you've said that there were,
3 going into the pandemic, urgent repairs and then the
4 various priorities perhaps going down the scale of
5 importance, and I think you set out at your
6 paragraph 254 those 17,000 buildings, 12% of those
7 pre-date the founding of the NHS in 1948, 17% is over
8 60 years old, and 44% is between 30 and 60 years old.
9 So an aged estate on any view.

10 You mentioned the plan for 40, I think, was it 40
11 new hospitals the government announced? The aim was to
12 deliver six, was it, by 2025? Do you know whether we
13 are on track with that six?

14 **A.** So I know you haven't quite asked me this question, but
15 just -- I will get to your point about the new hospitals
16 programme, but I think you've made a really important
17 point about the age of the estate and the implications
18 of that.

19 So just worth saying there are service
20 interruptions every day because bits of the NHS estate
21 fail. So, you know, a plant stops working, you have to
22 close the theatre, you have to shut some beds. But
23 there are also real efficiency issues when you're
24 working in old estates.

25 So that graph we looked at where it shows beds

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1 was never anything like a blank cheque but what there
2 was, was the reassurance that if there were legitimate
3 calls that met our, you know, our delivery of government
4 policy then there would not be a financial constraint to
5 being able to follow through on those.

6 **Q.** Looking at the estate, and it's at your paragraph 251,
7 you make the point that a well-maintained estate that is
8 fit for purpose can improve the efficiency and capacity
9 of the healthcare system.

10 That probably speaks for itself but you say that
11 the maintenance backlog was growing year on year and by
12 2019/2020 it stood at 9 billion which was larger than
13 the total capital budget. So can I just try and
14 translate into what it meant on the ground. Did it mean
15 there were things that needed to be done to hospitals
16 and the like that hadn't been done and were awaiting
17 repairs, improvements, and the like?

18 **A.** Yes, there's a process every year for organisations to
19 assess their backlog maintenance and it's categorised
20 into kind of critical backlog maintenance and then less
21 urgent, and what that would cover is everything from
22 a known risk, where there is, for example we have some
23 hospitals that still have RAAC concrete in them, so that
24 would count as critical risk given the level of, well,
25 the well-understood risk around RAAC concrete through to

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1 coming down, actively -- sometimes if you're able to
2 work, for example, in -- which the New Hospital
3 Programme does -- single rooms, that can allow you to
4 have a lower length of stay, appropriately, because
5 patients are getting the care they need in
6 an appropriate modern environment, with the right
7 technology, et cetera, et cetera, and we know there is
8 really good evidence around that. So actually, part of
9 getting the estate right is partly to stop service
10 interruptions but partly to allow us to work really
11 efficiently and be able to deliver safely some of the
12 care required.

13 Similarly, of course, it allows you to adapt
14 an estate much more easily. So with the New Hospital
15 Programme, it builds in all of those things to the
16 specifications. And whilst a number of the schemes that
17 were in flight have now been fully completed, others are
18 still -- others are in flight.

19 In practice, that programme has needed to be
20 reprioritised a number of times. It's a government-led
21 programme, but they have had to review it a number of
22 times, partly to make sure it had fully reflected the
23 urgency of dealing with the hospitals with the RAAC
24 planks. And those are much bigger endeavours because in
25 some cases they require a rebuild of an entire hospital

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1 rather than just parts of it.

2 **Q.** Right. I wanted to ask you about the estate, because
3 one of the implications an ageing estate has on --
4 certainly this pandemic was the ability to properly
5 implement infection prevention and control measures.
6 And I suspect you wouldn't disagree that it's much
7 harder to do in an estate where there's poor
8 ventilation, large walls, no single rooms, no decent
9 breakout rooms for the staff to change. It has
10 implications across all of those things and, not least
11 of all, patients who are 12 to a ward rather than
12 a single or a double room. We'll perhaps look at some
13 of the implications in a moment.

14 Can I start then, please, with the pandemic
15 in 2020 and a number of letters that were sent by
16 NHS England, the first one being the -- effectively
17 discharge letter, the stopping of elective care letter
18 on 17 March.

19 And perhaps if we can call it up on screen
20 INQ00087317.

21 This is quite a long letter -- I won't go through
22 it all but it is signed by you and Sir Simon Stevens,
23 17 March, just before we went into lockdown, to all
24 chief executives and everyone else listed there --
25 effectively urging the recipients of the letter to free

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1 care, I think even our best case scenario at this point
2 is about 11,000 patients who would need critical care
3 capacity. So that far outweighed what would have been
4 possible to do.

5 But our view going into this was very much that it
6 was absolutely imperative that we try to do everything
7 possible, not least because there was so many unknowns
8 with the modelling. We were obviously all very hopeful
9 that we would be wrong and it would be overstating just
10 how difficult it was likely to be, and there were sort
11 of non-pharmaceutical interventions being considered by
12 government at this point as well. So this reflected, if
13 you like, a bottom up view that said what would be the
14 maximum possible from the combination of things set out
15 in this letter, which included, as you say, discharge,
16 elective, working in partnership with the independent
17 sector, et cetera, so that we could go in in the best
18 possible -- in the best possible place to respond to the
19 need of patients.

20 **Q.** And so to achieve that 30,000 there was the postponement
21 of all non-urgent elective operations from 15 April.
22 Why was it delayed potentially to 15 April?

23 **A.** So what the letter said was that people should, as it
24 says on the third line, have "local discretion to wind
25 down elective activity". That was partly because at

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1 up the maximum possible inpatient and critical care
2 capacity, to prepare for the anticipated large numbers,
3 to support their staff.

4 And if we just go over the page, I think there it
5 is set out that the aim was to expand critical care
6 capacity to the maximum and free up 30,000 or more of
7 the NHS in England's 100,000 general acute beds.

8 Can I ask you this. What was the 30,000 based on?
9 Is that some kind of modelling that was done?

10 **A.** So that -- there were two things happening here. There
11 was the production of the reasonable worst case scenario
12 modelling and, at this point, also early data really
13 from hospital admissions about what we were seeing
14 happen in practice, and then there was, which is
15 actually where this letter comes from, I mean, rapid
16 work but nonetheless sort of bottom up work to work out
17 what we thought the maximum operational possible was.

18 So the reasonable worst-case scenario at this
19 point was telling us -- it changed quite a lot over the
20 days, and I know, again, the Inquiry has looked at this
21 in some detail, but that we would have at one point, you
22 know, 400,000 patients requiring admission. Even at
23 this point in the mitigated scenarios it's still saying
24 we could have, you know, more patients in hospital than
25 we had physical beds for. And, again within critical

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1 this point there actually still weren't that many
2 patients in hospital with Covid. So it was difficult
3 judgment.

4 All of this was dealing with lots of unknowns and
5 uncertainty but what we didn't want to do was oversteer
6 in either direction and have patients who could have
7 been treated not being because we'd stood down too
8 quickly. Equally, we didn't want to be in a situation
9 where we'd maintained non-urgent activity to the
10 detriment of being able to treat Covid patients. And
11 that was really the point about local discretion,
12 because we could give a national direction but it could
13 only be interpreted in a sensible way by local leaders.

14 **Q.** And that was hoped to free up between 12,000 and 15,000
15 hospital beds by that postponement of non-urgent
16 elective. There was the urgent discharge of all
17 hospital inpatients who are medically fit, which would
18 potentially free up 15,000 acute beds currently occupied
19 by patients awaiting discharge or with lengths of stay
20 of over 21 days, and there was the use, in addition to
21 that, of the independent hospitals.

22 Can I ask you this, that 30,000 that was the aim
23 to free it up, by when or over what time frame was it
24 hoped that that 30,000 would be made available?

25 **A.** Well, I mean, again, sort of -- given where we were in

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1 the, sort of, reasonable worst-case scenario and the way
 2 you could see the numbers going up, at that point it was
 3 suggesting that there was likely to be a peak of demand
 4 somewhere around the middle of April. So we thought we
 5 had probably, you know, a couple of weeks, ideally, to
 6 get this to be enacted in order to give the maximum
 7 chance to deal with what was coming. And in under
 8 a level -- under a level 4 EPR situation, which we were
 9 in -- I mean, this was a completely unprecedented set of
 10 things for us to be doing. Obviously followed
 11 government agreeing that package of policy measures of
 12 which these were part, but to send a letter like this
 13 saying, "We are now going to reshape the way the NHS
 14 works, sort of within a matter of days", would have only
 15 been possible in a level 4 situation and it really did
 16 mean immediate action.

17 **LADY HALLETT:** In relation to discharging the medically fit,
 18 as members of the public we're often told that it's
 19 a continuing problem in the NHS that you have people in
 20 hospital that are medically fit to be discharged but
 21 can't be for a wide variety of the reasons. Why was
 22 this package or policy going to work when obviously it's
 23 a problem you're confronting every working day of your
 24 life? So why is this going to work when it doesn't work
 25 in normal times?

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1 So the speed of this was completely unprecedented,
 2 and again lots of learning I'm sure we'll talk about
 3 related to that, but the actual model was based on what
 4 was already happening in some parts of the country and
 5 working very well. So the question was, with those two
 6 policy initiatives that were new and were accompanied by
 7 quite significant funding from government, would that
 8 allow e to put those arrangements in place?

9 I don't know, we might want to talk about impact
 10 in a moment, but in practice there was variation in how
 11 quickly that was able to be done, largely based on where
 12 relationships were already strong and arrangements were
 13 already in place that followed that kind of model. But
 14 overall we did see a very significant reduction in the
 15 length of stay for patients who were medically fit as
 16 a consequence of those two policy initiatives.

17 **Q.** I would like to ask you about the impact of the measures
 18 from the phase 1 letter because I think you set that out
 19 at your paragraph 558 onwards in statement ending 251.

20 And could we have up on screen, please, page 150
 21 of INQ000409251.

22 And then I want to come back to one other aspect
 23 of the letter, but is this the position that case
 24 NHS England did an initial assessment of the impact of
 25 that letter over the -- on patient flow over the course

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1 **A.** Yes. so we -- so, first of all, absolutely recognise the
 2 complexity of discharge and that is an ongoing challenge
 3 for the NHS, for social care, for patients, for carers.
 4 But in this case there were two important policy
 5 decisions that had been made to support discharge. One
 6 was to pause or suspend at that point continuing
 7 healthcare assessment. Which is a process for -- it's
 8 really a financial decision rather than a clinical
 9 decision but can be one of the things that causes delay
 10 because sometimes that process just delays people moving
 11 to the next stage of their care.

12 But the other thing was the agreement, again
 13 government agreement, to fund the first part of
 14 someone's post acute care, sort of regardless of that
 15 assessment of eligibility, which allowed investment then
 16 to go to -- well, a combination of colleagues and social
 17 care and others to -- including NHS staff and local NHS
 18 community staff, to provide intermediate care,
 19 domiciliary care, care home places, in a model which we
 20 now refer to as discharge to assess, which means you are
 21 able to move somebody immediately out of the acute
 22 environment when they no longer need to be there and
 23 undertake the appropriate -- the rehabilitation and
 24 assessment when someone is in a place that's actually
 25 more likely to be suitable for their needs.

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1 of wave 1 of the pandemic, conducted by the discharge
 2 cell towards the end of April 2020 and it was presented
 3 to the NIRB -- was that the Incident Response Board?

4 "While the analysis noted a significant
 5 variation ..."

6 Which I think is the point you were just making:
 7 "... the data indicated an overall significant
 8 reduction in long length of stays in hospital. Since
 9 the introduction of the hospital discharge requirements
 10 in March 2020 ..."

11 And we can see set out there daily numbers of
 12 occupied beds for over seven days dropped from
 13 42,000-odd to just under 20,000. Those that were in
 14 hospital for 14 days dropped from 25,000 to 10,500, and
 15 all regions achieved significant reductions of between
 16 62 and 72% in hospital long length of stays of over
 17 21 days.

18 And so do I take it from that analysis, about the
 19 length of time people were staying in hospital for,
 20 certainly that did help to free up some of the beds that
 21 were needed for the influx of patients in later March
 22 and into April 2020?

23 **A.** Yes, absolutely. It's worth just -- if you don't mind
 24 just for one second, the reason length of stay is such
 25 an important way of looking at discharge is because

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1 every day there are new patients coming into hospital as
 2 well as patients going home, so it's a constant flow, as
 3 you say, of coming in and going out. So, actually, the
 4 length of time people are in hospital, you can sort of
 5 do the maths and convert that into beds but it's not
 6 a static group of people who are in those beds every
 7 day, they change every day. So what we could see from
 8 this was that there had been a very swift impact of the
 9 measures, as you say, variation, significant variation,
 10 largely dependent on where those relationships were good
 11 and arrangements were, broadly speaking, in line with
 12 this model of working.

13 But it is probably also worth saying that we saw,
 14 which wasn't predicted, when we wrote the letter,
 15 a significant drop off in the number of people coming to
 16 hospital. So the other factor that played into the
 17 availability of beds was the fact that, sort of, as
 18 I say, in an unplanned way we'd seen such a reduction in
 19 people actually presenting through A&E and then going on
 20 to being admitted.

21 **Q.** Can I just pick up on that. Are you saying there in
 22 fact there was fewer people coming in -- certainly fewer
 23 people coming into A&E than you had thought, and we've
 24 seen that borne out in various bits of data that we've
 25 already looked at.

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1 disaggregate what those different elements meant in
 2 terms of the overall impact but, as I say, those two big
 3 policy changes, the funding that then supported that,
 4 particularly that sort of first period of care, post the
 5 acute phase, did enable to us do something, my Lady, as
 6 you say, that we haven't managed to do really before or
 7 in the same way since, which was to get to a place where
 8 those who were medically fit were able to leave hospital
 9 in a more timely way.

10 **Q.** Let me ask you this. If there were similar predictions
 11 in the event of a future pandemic, would there still be
 12 the need now for there to be a discharge policy of sorts
 13 brought in to free up the kind of capacity in the tens
 14 of thousands that we are looking at in that letter?

15 **A.** There is a piece of work that we did that evaluated,
 16 later on actually, in 2021, the overall impact of what
 17 we were then calling the discharge to assess model. And
 18 what that suggested was that over the course of the
 19 programme it had allowed us to release, sort of, well
 20 over six and a half thousand beds and actually 11,000
 21 staff worth of time. So our, sort of, findings at the
 22 time on quality were also that -- and again, just to be
 23 clear, this was the latter part of -- this is nearly
 24 a year on from this time, but from a quality perspective
 25 the feedback was that that was actually leading to lower

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1 Can I just understand, then, if we stand back, had
 2 this discharge policy not been brought in what do you
 3 think the impact would have been on people seeking
 4 hospital care in the NHS and England? Effectively did
 5 it work?

6 **A.** So the discharge policy, for the stated aims at the
 7 time, which was, you know, back to we thought we were
 8 going to have this extraordinary influx of patients for
 9 Covid who would need hospital care, therefore pulling
 10 every lever to try and, you know, safely, as in the sort
 11 of based on existing best practice that we knew worked
 12 in other places, could we get to a place where people
 13 who really did not need to be in hospital anyway, so who
 14 delayed leaving, could get out in order to make space
 15 for people who we had anticipated would require
 16 inpatient care. Then it certainly made a huge
 17 contribution.

18 Again, one of the things we were aware at the time
 19 was, lots of individuals and families didn't want to be
 20 in hospital because there was a, you know,
 21 understandable fear as well about being in a place where
 22 we were expecting an awful lot of people who arrive with
 23 this infection. So I think that -- difficult to
 24 quantify what the different elements of all of these
 25 things meant, rather, I should say, difficult to

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1 admission rates, though I don't know that -- readmission
 2 rates, sorry, although I haven't actually seen any
 3 really clear research evidence on that, but certainly
 4 from social care colleagues that it was also allowing
 5 patients to have an appropriate period of rehabilitation
 6 that meant that when they then went on for ongoing care,
 7 actually it could be well calibrated rather than on the
 8 basis of the acute phase where, actually, you don't get
 9 necessarily the best clinical assessment.

10 So our view at the time was, from a quality and
 11 from an impact on the NHS perspective, and benefit for
 12 patients, the discharge to assess model seemed to be
 13 doing what we had hoped and so it remains the core of
 14 our approach today.

15 Obviously, the funding arrangements have changed,
 16 so it's a bit more now down to local systems to
 17 implement that in the way that they can within their
 18 existing envelopes and, of course, in partnership with
 19 social care.

20 **Q.** Can I just pause you there. You're obviously
 21 a signatory to the discharge letter but were you
 22 personally involved in some of the detail of how many
 23 beds it was hoped to free up and how that was going to
 24 be achieved? Or was it done by those that work under
 25 you, as it were?

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1 **A.** So my role at this time was to chair -- you have already
2 mentioned it -- the National Incident Response Board
3 which we -- which comprised of all the, we call them
4 cell leads, so the people who were running the national
5 cells of which there was one on discharge, as well as
6 regional colleagues, colleagues from government,
7 colleagues from PHE, the focus being very much, just to
8 be clear, on the operational response. So we weren't
9 doing, as you say, the government business which was
10 much more of the complex work of cross-government
11 co-ordination, this was very much looking into the NHS
12 but with a range of different, particularly clinical
13 voices around the table to make sure that we were
14 co-ordinating appropriately from a national, regional
15 and local perspective.

16 So the discharge cell were the people who were
17 doing the detailed work on discharge and, as I say, it
18 was led, particularly in this case on discharge, by the
19 Department of Health and Social Care because of the
20 social care element. So it was their lead but our team
21 working hand in hand.

22 **Q.** Can I go back to the letter and just ask about one
23 matter, please. It was INQ000087317, and page 4 of that
24 document. And paragraph 3(b), please, Ms Pritchard.
25 Clearly back in the middle of March 2020 there was

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1 from Guy's and St Thomas' a few months previously, I was
2 still talking very regularly to colleagues across the
3 NHS and previous colleagues.

4 So one of the things we were hearing from staff
5 and, again, some extraordinary stories, I know you've
6 heard some very powerful testimony of this, of people
7 who were saying, "Well, actually, I want to work and
8 I want to make a contribution and I don't want to have
9 to isolate because somebody who lives in my house who
10 may be Covid positive, I don't think I am", so we were
11 very keen to find ways of supporting that.

12 **Q.** Do you know, and it may be that you can't tell me today,
13 but do you know how many staff actually took up the
14 option of staying in hotel accommodation during that
15 first wave of the pandemic?

16 **A.** I don't have numbers I'm afraid. I'm sure we can come
17 back to the Inquiry on that though.

18 **Q.** All right. Can I move on then to the second letter,
19 phase 2 letter, on 29 April and it's behind your tab 6,
20 and it's INQ000087412.

21 Perhaps the eye of the storm has passed to some
22 extent but clearly we're not in the summer when things
23 were opened up a little more.

24 **A.** No.

25 **Q.** And this letter really urged the restarting of some

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1 limited testing capacity, and it increased as the week
2 and months wore on, but it says there:

3 "... we are ... asking Public Health England as a
4 matter of urgency to establish NHS targeted staff
5 testing for symptomatic who would otherwise need to
6 self-isolate for 7 days. For those affected by PHE's 14
7 day household isolation policy, staff should ... be
8 offered the alternative option of staying in NHS
9 reimbursed hotel accommodation ..."

10 Do I take it from that obviously you wanted to
11 know if the staff member had Covid to send them home and
12 keep them away from the hospital. If, however, they
13 were isolating with someone in their house but did not
14 have it, get them back to work? Was that the aim of
15 this paragraph?

16 **A.** Yes, so the important bit of this, I think is this line
17 "on an entirely voluntary basis" but we were hearing
18 from staff -- the way that -- again, sorry, just to take
19 a tiny step back, but the way the National Incident
20 Response Board worked, the way that I worked was we were
21 having literally multiple conversations a day with
22 colleagues on the front line, so I had a WhatsApp group
23 with every chief exec in the country, so we were in
24 really regular direct dialogue with colleagues, and
25 obviously because I had literally only just stepped away

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1 non-urgent elective care and you set out there on the
2 first page some of the work that's been done, some of
3 the achievements that have been experienced. But it's
4 the urging at this stage, at the end of April, do you
5 think perhaps asking chief executives of trusts and the
6 like to restart some non-urgent elective care was too
7 soon, given what they had been through in the previous
8 six weeks?

9 **A.** So I think at this point, the letter -- in fact I don't
10 think, I know, the letter is really focused in that --
11 I think, again, you're right to say it is a long letter
12 and there's a lot in it so it's -- there are probably
13 actually bigger sections on Covid, staff support, et
14 cetera, than there is on the stepping back up of
15 non-Covid services, but the focus of this letter is
16 actually on stepping up non-Covid urgent services. So
17 there is a reference in it that says if there is local
18 capacity, it is absolutely appropriate to be thinking
19 about those non-urgent services but at this point the
20 feedback that we were getting, particularly from --
21 well, we were looking at our own data but from clinical
22 colleagues, was that there had been more of an impact
23 on, for example, cancer care than -- despite the best
24 efforts of everybody locally --

25 **Q.** Pause there, Ms Pritchard, I'll help you and I'll put

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1 that bit of the letter up -- it's on page 5 of this
2 document -- so we can see what you're referring to. And
3 it's the paragraph that effectively begins with the
4 underlining:

5 "This means we are now asking all NHS local
6 systems and organisations working with regional
7 colleagues fully to step up non-Covid 19 urgent
8 services as soon as possible over the next six weeks."

9 Then it goes on to ask them to make judgments
10 whether they have further capacity for routine
11 non-urgent elective care.

12 I am sorry to have interrupted you but that's
13 where the letter gets to --

14 **A.** Yes.

15 **Q.** -- in terms of its request of the trust and the clinical
16 commissioning groups and the like.

17 Why, from your perspective, were you asking the
18 recipients of this letter to get on with this work now
19 at the end of April 2020?

20 **A.** So you're right, this letter was written a little
21 earlier than we had anticipated because in the letter of
22 17 March we give an indication that we expect that first
23 phase to last for longer but at this point, two
24 important things were happening. One is that the data
25 was showing really clearly that we were coming out of

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1 tell people to step them up. Why?

2 **A.** I think in practice it was harder for local -- so,
3 again, probably worth saying two things. One is
4 an obvious point, and I know the Inquiry has heard,
5 again, really powerfully about this, but the level of
6 uncertainty about what was happening in that first wave
7 and that sense of we're just pulling out all the stops,
8 and colleagues locally just doing kind of everything
9 they could to respond to the needs of patients, meant
10 that, with the best will in the world, some services
11 like screening services, even though they weren't
12 formally stood down in practice, that just hadn't been
13 able to be maintained.

14 But the second thing is, and I know we'll talk
15 more about it, but it was that need to redeploy staff in
16 order to be able to meet the areas of greatest need
17 meant that some of the staff who would routinely have
18 been, say, cancer clinics or cancer surgery had been
19 asked to do really important work to support intensive
20 care and to support urgent emergency care flows. So
21 this was not, I think, to be clear, because anyone had
22 done anything wrong, quite the opposite, but it was
23 really about reminding people that: okay, we are now
24 coming down from that peak. It is time to look again
25 alter how staffing is working locally, how services are

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1 that peak, so we've gone -- you put it up on the screen
2 earlier on, but we've gone over the peak, we are coming
3 back down the other side. There were 13,000 patients in
4 hospital with Covid at this point, so that was important
5 contextual information which is very different to where
6 we'd been with the 17 March letter.

7 The second thing, and I think, again, this is one
8 of the things that felt important about doing this
9 letter, is we were being asked to provide clear
10 direction to the NHS from colleagues, as I say, through
11 these, sort of, daily conversations, through the
12 conversations that Professor Powis was having with royal
13 colleges, from others, because we were in that level 4
14 environment. So it was important, I think, that we were
15 able to respond to that.

16 It wasn't out of the blue, this letter. It wasn't
17 unexpected, we were working with colleagues in advance
18 to say: this is now new circumstances, here is a new set
19 of things that we're asking colleagues to do, which then
20 allowed, through the EPR structures, people to kind of
21 get on with, at this point, a sort of importantly
22 different emphasis to their work.

23 **LADY HALLETT:** Sorry to interrupt again. The message in the
24 first letter was: carry on urgent non-Covid services.

25 Yet it seems as if that wasn't happening, if you had to

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1 working locally and make sure that those urgent services
2 are fully restored.

3 **LADY HALLETT:** That wasn't really the point of my question.

4 **A.** Sorry.

5 **LADY HALLETT:** Don't worry, I probably didn't make it
6 sufficiently clear. The point of my question is Covid
7 is potentially lethal, cancer is potentially lethal, and
8 you'd told people to carry on with cancer screening
9 amongst other urgent non-Covid conditions. So why were
10 trusts not implementing that direction and why were they
11 moving people from cancer screening programmes or cancer
12 clinics?

13 **A.** Sorry, my Lady, I think it was just -- it's trying to --

14 I guess, stepping back, we do set direction, and in this
15 case, in level 4, we were giving much clearer direction
16 than we normally would, and certainly than we would do
17 now. But it was still very much up to local
18 organisations then to interpret the information we were
19 giving, the instruction we were giving, and work out how
20 to do it locally and what they were or weren't able to
21 locally. Because you can set a framework nationally but
22 I know, as -- over the years of working in a trust and
23 being in the operational side, you know, you can only do
24 some of this when you know what staff you actually have,
25 what your estate looks like, what the level of demand is

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1 in your place.

2 So the way we work always has to be very much,

3 kind of, with that understanding that, you know, we set

4 the framework, but then we work really closely with

5 local organisations but who, ultimately, still have to

6 take responsibility for the implementation locally and

7 for interpretation locally. And in this case I think we

8 what we were seeing, what we were hearing, was a level

9 of pressure some organisations -- it's not uniform but

10 the level of pressure some organisations were under,

11 they had really struggled to maintain those

12 non-urgent (sic) services because they didn't have the

13 resilience, particularly in staffing, to be able to run

14 multiple things at once and they had had to put all of

15 their effort into responding to Covid. So even though

16 this is only, you know, relatively -- as per your

17 question, this is a little bit sooner than we had

18 expected to do a second letter, it was really important

19 for us to signal to everybody it was now time to make

20 sure that if they had had to make those local decisions,

21 they needed to go back and make sure that they had now,

22 sort of, looked again at how staff were being deployed

23 to make sure that those non-Covid urgent services were

24 fully restored, as you say.

25 **LADY HALLETT:** I think in the middle of your answer you said

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1 **A.** So there were some parts of the country that actually

2 hadn't been terribly badly affected by Covid. So if

3 I think about the south-west, for example, in wave 1.

4 So they were able to restore the non-urgent work

5 actually more quickly than some of the parts of the

6 country that had been very, very much more affected.

7 **Q.** Can we look at the phase III letter because there's

8 a slightly different language adopted in the phase III

9 letter, which was issued on 31 July.

10 Can I have up on screen, please, INQ000051407,

11 thank you very much.

12 And it's at your tab 7, Ms Pritchard. But here we

13 are now at the end of July and the third phase letter

14 obviously starts by thanking everyone, updates them on

15 various Covid alert levels, the priorities, the

16 financial arrangements. I don't want to get into that,

17 but if we could go to page 2, "NHS priorities from [the

18 following month]", and one can see there at A:

19 "Accelerating the return to near normal levels

20 of non-Covid health services, making full use of the

21 capacity available in the 'window of opportunity'

22 between now and winter."

23 And then preparing for winter demand pressures,

24 and then dealing with lessons learned.

25 Can I ask, the winter demand pressures, was it

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1 "non-urgent", but you've just, at the end, said

2 "non-Covid" --

3 **A.** Sorry, non-Covid urgent, yes, sorry.

4 **MS CAREY:** Can I put back up on screen page 5 of that

5 letter. It may make sense if one looks at the paragraph

6 beginning:

7 "In addition, you should now work across local

8 systems and with your regional teams ... to make

9 judgments on whether you have further capacity for at

10 least some routine ..."

11 It was more, can I put it this way, aspirational

12 than mandatory in its tone: if you can do it, please try

13 to restart non-urgent elective care.

14 Was that really the message you were trying to

15 send out there, Ms Pritchard?

16 **A.** The primary function of this letter was -- well, as

17 I say, was to, sort of -- we are now in the next phase,

18 there are a range of things that would be distinctly

19 different to what we were doing in phase 1, so

20 particularly in relation to elective care it was

21 reminding everybody that it was hugely important to

22 fully restore any services that have been disrupted that

23 were urgent in nature. But on the non-urgent work, as

24 you rightly say, this was permissive.

25 **Q.** All right.

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1 envisaged we may have a flu pandemic in winter 2020 into

2 winter 201 or was there still a worry that there may be

3 resurgence of Covid, as in fact happened.

4 **LADY HALLETT:** I don't think you meant pandemic, do you?

5 **MS CAREY:** Did I say "pandemic"? I meant a flu outbreak.

6 Sorry, it's my fault.

7 Yes, was it envisaged that the preparation for

8 winter demand pressures was ordinary winter flu, for

9 want of a better phrase, or was there still concern that

10 there would be a resurgence of Covid-19.

11 **A.** Yeah, we were absolutely concerned that what we would

12 have would be a combination of normal winter pressures

13 and, as it says here, further probable Covid spikes

14 locally and possibly nationally. And so we were

15 anticipating a potential second wave at this point at

16 a time of year that would be more pressured anyway

17 because of the normal winter pressures.

18 So, you're absolutely right, this letter is

19 different in focus because this is really reflecting the

20 fact that now, when this letter was written, we had 900

21 inpatients with Covid, so very different to the context

22 of that the second letter was written in, and we foresaw

23 that we would have this, as it sort of phrases it here,

24 window of opportunity over the back end of the summer

25 and into autumn before we hit that winter period with

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1 a potential further Covid wave.
 2 **Q.** Now, if we go, please, to page 3 of the letter. The --
 3 accelerating the return of non-Covid health services
 4 included the restoration of the full operation of all
 5 cancer services. That work to be overseen. And if we
 6 could go to the bottom of that page as well:
 7 "[Recovering] the maximum elective activity possible
 8 between now and winter".

9 And if we go to page 4, there was various targets
 10 set out that ought to be achieved:

11 "In September at least 80% of ... last year's
 12 activity for both overnight ... and for
 13 outpatient[s] ..."

14 Then there was reference to "90% of ... last
 15 year's MRI/CT scans, and 100% of ... last year's
 16 activity for first outpatient attendances and
 17 follow-ups ..."

18 So a much clearer steer to the recipients of the
 19 letters to what was now expected. But I think you are
 20 aware, are you, Ms Pritchard, that certainly there's
 21 been some criticism of this letter. NHS Confederation
 22 described the letter as being extremely challenging,
 23 naive, unachievable and ultimately demotivating, it
 24 coming on the back of an incredibly intense period of
 25 work by all of NHS staff.

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1 also hearing loudly from many leadership colleagues
 2 across the NHS that it was -- now was the time and that
 3 they wanted to use the window of opportunity to make
 4 sure that we were doing what we needed to do for all of
 5 our patients, and that meant recovery.

6 In practice, actually, there was a massive
 7 increase in non-urgent elective activity over this
 8 period. Didn't hit the targets that are described here
 9 but if I just, you know, just as a headline, elective
 10 day cases went from roughly 60% to 80% over that period.
 11 Similarly, you know, CT scanning, 80% to 100%.

12 So, actually, the NHS responded remarkably to the
 13 ask of it to recover services.

14 And it's -- but it's absolutely true that there
 15 was some local representation where we were hearing
 16 people expressing understandable concern and, you know,
 17 the NHS Confederation, as one of the, sort of, trade
 18 bodies representing those voices, did their job which
 19 was to represent that to us so that we could try and
 20 make sure that in planning for this letter which
 21 involved, I should say, sort of seven roadshows with
 22 leaders in the weeks running up to it, we had a working
 23 group of 20 or so folk also working in detail with us as
 24 well as clinical groups, patient groups and others that
 25 we did get that balance right, which was reflecting the

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1 Why was it felt that in July NHS England could be
 2 so directive about how much resumption of work there
 3 could realistically be, given how, no doubt, absolutely
 4 exhausted everyone was having been through wave 1?

5 **A.** So your point about the pressure staff were under is
 6 really important, however, I think it's worth saying
 7 that -- sort of as a -- again, it's an obvious point,
 8 but one probably worth making anyway, is that the NHS is
 9 fundamentally here for patients. So everything that was
 10 done by colleagues across the NHS in the pandemic was
 11 patient first and people put themselves into the most
 12 extraordinary positions to do what they could.

13 And at this point we were hearing loud and clear,
 14 particularly from clinical colleagues across the NHS,
 15 that -- and again, it goes back to your definition right
 16 at the beginning of pandemic response -- that the
 17 recovery phase was now critical. Because the potential
 18 impact from having had to pause non-urgent work was now
 19 becoming really problematic for patients and that we
 20 were in danger of not doing enough to recover those
 21 incredibly important services for patients, with
 22 detriment arising.

23 So we were hearing loudly from the patient groups
 24 we were working with, we were hearing loudly from
 25 clinical groups we were working with, we were actually

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1 extraordinary things that NHS staff had done over the
 2 previous months but that absolute need to put patients
 3 first.

4 **Q.** Can I pause there and perhaps ask a couple of questions
 5 before lunch, if I may, my Lady.

6 You mentioned a number of times "we were hearing".
 7 And you -- in answer to that last question you said
 8 there, "There was patient groups, clinician groups".
 9 Were you yourself involved in hearing from any patient
 10 groups directly or was that left to others in
 11 NHS England?

12 **A.** That's a very good question that I would need to just
 13 confirm absolutely which meetings I was personally in
 14 and where I was hearing it from those cell leads, but
 15 certainly through representatives like the -- well, like
 16 Healthwatch or The Patients Association. I was involved
 17 in some of those meetings. There were far more going on
 18 though, I know, that other colleagues like
 19 Dame Ruth May, Professor Stephen Powis were leading and
 20 then reporting back in.

21 One of the things I was personally doing was
 22 making sure though that I was having direct
 23 conversations with my NHS Chief Executive and other,
 24 kind of, leadership colleagues so that we would pull all
 25 of those different sources of conversation --

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1 **Q.** Well, that's what I wanted to ask you, just this, before
2 we perhaps break.

3 I understand you can't be in every meeting and you
4 have to rely on your colleagues to report back. You've
5 told us about your liaison with the chief executives but
6 what about at ground level, Ms Pritchard? Did you
7 yourself ever go to a hospital or engage with nurses and
8 doctors working on the ground during the pandemic?

9 **A.** Yes. I was very fortunate, I suppose, still to have
10 particularly relationships back with Guy's and
11 St Thomas' which meant it was easy to pop in and speak
12 to people who also knew me in a slightly different role,
13 so I thought were -- they certainly didn't feel,
14 I think, under any compulsion to tell me anything other
15 than the direct truth because you can do that when
16 you know someone well. But I visited -- I visited every
17 Nightingale. I only did visits when it was appropriate
18 and when I could.

19 I think we did every region within those first
20 few months -- I'd have to check the exact dates -- but
21 certainly they were, and I still do visits every, at
22 least, every couple of weeks because I find that to be
23 a hugely valuable source of insight because there is
24 nothing that will compare with just standing in a place
25 talking to colleagues who are living and breathing some

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1 I think you go on to say in the statement that the
2 request for the funding for those beds was not approved
3 by Her Majesty's Treasury. No doubt something of
4 a disappointment to you but why was it felt at that
5 stage in that summer that as many as 10,000 extra beds
6 were going to be needed?

7 **A.** Thank you. We had done some modelling work over the
8 summer to look at -- again, recognising there was a huge
9 range of possible scenarios, but just looking at, from
10 a sort of best estimate, what it would take to be able
11 to run with a sort of constant number of patients in the
12 service who were Covid-positive, create the necessary
13 headroom then to respond to, as we were saying
14 previously, normal winter pressures over and above that
15 but, crucially, also to have the space to do the not
16 just urgent but also non-urgent, non-Covid work, so that
17 we would be able to do that recovery work that we'd
18 begun to start in the summer.

19 **Q.** And I think the Prime Minister's private office was
20 involved in the decision to refuse, and said effectively
21 they wanted more use to be made of Nightingales, the
22 independent sectors to go back to discharging patients
23 if necessary, using flu vaccinations to hopefully deal
24 with any flu upsurge there would be, and that there
25 would be -- capacity would be looked at in the spending

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1 of the very real, both pressures and constraints, but
2 also solutions and ideas to be able to feed back into
3 any of the data or the other, sort of, aggregate
4 conversations that are going on.

5 **MS CAREY:** We may return to that topic a little later this
6 afternoon.

7 Would that be convenient, my Lady?

8 **LADY HALLETT:** Certainly. I shall return at 2.05. We will
9 definitely complete your evidence today, Ms Pritchard.

10 **THE WITNESS:** Thank you.

11 (1.03 pm)

(The short adjournment)

13 (2.05 pm)

14 **LADY HALLETT:** Ms Carey.

15 **MS CAREY:** Thank you, my Lady.

16 Ms Pritchard, I want to examine with you this
17 afternoon the build-up to wave 2 and the winter 2020 to
18 2021 pressures and look at the Nightingales as well and
19 a couple of other discrete areas. We have quite a lot
20 to get through.

21 Can I start, please, with asking you about the
22 lead-up to winter 2020, and in your statement at
23 paragraph 630 onwards you set out that in July of 2020
24 NHS England sought 10,000 non-temporary beds to deal
25 with recovery and the potential future surges, and

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1 review, which I assume would be at the end of the
2 financial year of 2021; is that correct?

3 **A.** Yes, in -- autumn 2021.

4 **Q.** What were the consequences of that 10,000-bed request
5 being refused, from your perspective?

6 **A.** It was, as you say, very disappointing, because what it
7 meant in practice was where we could now be in, I think,
8 a very different position on elective recovery, if we
9 had had that capacity we could certainly have treated
10 thousands more patients if we had had that additional
11 headroom, as well as being more resilient going into
12 the second wave and into winter more generally.

13 So, subsequent to the pandemic there has been some
14 steps taken to increase kind of core bed capacity, but
15 clearly we could have done with that capacity at the
16 time, and I think we'd be in a quite different position
17 now.

18 **Q.** This might bring you to your paragraph 633 in your
19 statement ending 251, Ms Pritchard, because you say:

20 "Given the additional pressure faced during winter
21 months, NHS England has reduced other investments ... to
22 prioritise marginal funds and capital to make available
23 4,000 extra permanent beds in the acute sector to
24 increase capacity to deal with emergency care."

25 Help me about this 4,000 beds, how does that fit

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1 in with the 10,000 refusal, if at all?
 2 **A.** So that's from January 2023, so leading into the
 3 financial year 2023-2024 as part of, again, the
 4 government-supported Urgent and Emergency Care Recovery
 5 Plan, which had a combination of a number of different
 6 actions, one of which was to increase acute bed core
 7 capacity, another of which was to increase virtual ward
 8 beds in the community.

9 The impact of that investment and all of those
 10 different initiatives meant that last year -- and I know
 11 it's something other witnesses have talked about, the
 12 pressure on ambulance services, but we did see ambulance
 13 response times for what's called Category 2 responses
 14 reduce from 50 minutes to 36 minutes. So it made a big
 15 difference last year. But of course that was some
 16 considerable period after we had asked for the
 17 10,000 beds, which was at that early stage of the
 18 pandemic.

19 **Q.** So if I understand you correctly, the 4,000 beds has had
 20 a positive effect since 2023 onwards but back as at the
 21 time of the request in July 2020, was essentially
 22 NHS England reliant on discharges, Nightingales, surging
 23 within its own capacity to try to find additional beds
 24 in the event of a pandemic striking again in the
 25 winter -- or re-emerging, perhaps is a better way of

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1 a quick indication of it, INQ000409251_0134, your
 2 paragraph 501, Ms Pritchard.

3 But here we are as at New Year's Eve, in 2020,
 4 1,050 additional critical care beds had been opened and
 5 national occupancy for critical care had passed 100% of
 6 the standard. So baseline had been met; is that
 7 correct, we were now into using upsurge capacity?

8 **A.** Yes.

9 **Q.** 3% of critical care patients across the country were
 10 being cared for in surge capacity. But London, east of
 11 England, and south-east were particularly affected, they
 12 all had to use their surge. Look at London there, 28%
 13 critical care patients were in surge. 22% and 14% in
 14 the south and the east of England respectively.

15 Critical care units in the east were at 100%
 16 capacity. In the Midlands 21 critical care unoccupied
 17 bed across the entire region of the Midlands, only four
 18 of the 28 units had less than 100% occupancy.

19 Clearly, to try and deal with those pressures
 20 regions were taking steps to facilitate intraregional
 21 transfer to balance the load, for instance moving
 22 patients from Cumbria to Newcastle in the north east and
 23 Kent was being actively decompressed by sending patients
 24 to Oxford.

25 Now, Ms Pritchard, one takes the point that it's

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1 putting it, in the winter?

2 **A.** Yes. So we could foresee clearly that we were going to
 3 have to live with Covid for some considerable period of
 4 time, so that would create, if you like, a sort of
 5 ongoing pressure on the NHS, and we could see even back
 6 in July, and in fact of course had written about it in
 7 the phase 3 letter, that the recovery job would be hard.
 8 So those two things, the ability to continue to deal
 9 with further waves of Covid and the ability to deliver
 10 recovery, would have been massively enabled by that
 11 investment.

12 **Q.** Did you get any extra beds between July 2020 and the end
 13 of our relevant period in June 2022?

14 **A.** We did get some additional funding to support
 15 developments within critical care specifically, so
 16 about -- well, around about a quarter of a billion,
 17 which was invested partly in additional capacity but
 18 partly in the fabric of the estate around critical care
 19 units to make them more robust, more resilient to
 20 improve some of the environment.

21 **Q.** Can I jump forward then in time to winter 2020 and into
 22 2021, and in your statement you make clear that that was
 23 a period of extreme pressure on the NHS over that
 24 winter.

25 Can we have a look on screen, please, just as

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1 better to have a bed somewhere than nowhere but Kent to
 2 Oxford is, what, 140 miles or so, three hours in
 3 an ambulance. We've heard that the fact of transfers
 4 themselves are risky --

5 **A.** Yes.

6 **Q.** -- for both the patient and the staff that have to care
 7 for them. Can you help as to how it is we ended up in
 8 such a dire state of affairs come New Year's Eve 2020
 9 into January 2021?

10 **A.** Yes, thank you. I think if you don't mind there are
 11 three things worth saying. One about the preparations
 12 that we'd been made, one about the wave 2 experience,
 13 and then one about specifically critical care.

14 So firstly, it is community prevalence that drives
 15 what is going on and of course at this point in time,
 16 importantly, we did have community prevalence data which
 17 we didn't have in wave 1. So at this point when the
 18 community prevalence data starts showing that there
 19 is -- that the numbers are going up, we have an early
 20 warning system which allows us to see where some of the
 21 peaks of pressure are likely to be geographically
 22 because they happen in different times in different
 23 places which becomes important when we're then thinking
 24 about critical care transfer. But fundamentally, it's
 25 not within the NHS's control what happens with the virus

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1 in the community and therefore what the demand is made
2 on the NHS.

3 But because, sort of, second point, we had
4 foreseen that there might be a second wave and indeed
5 even back in August I think our modelling even then was
6 saying it was likely to be, if it did happen, at least
7 as bad, at least as challenging as wave 1, there were
8 a number of things that we, NHS England and the NHS had
9 done, as well as wider partners. So we talked a bit
10 about that investment in critical care.

11 **Q.** Yes.

12 **A.** Obviously at this point we have more ventilators, we
13 have more -- a more robust supply chain around things
14 like PPE. We have the Nightingales on standby. We also
15 have, at this point, about 50,000 more staff in the NHS
16 which is, as I said earlier, partly, you know,
17 extraordinary just contribution of people choosing not
18 to retire as well as people coming back and also joining
19 from overseas.

20 We have the partnerships with the independent
21 sector still live and also at this point with the
22 hospice sector, so we have access to additional beds
23 through that route. But the crucial thing at this point
24 is we also have new treatments and we have a vaccine on
25 the horizon. So we have dexamethasone, which -- I think

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1 greater volume at this point than anything you would
2 normally see, and a systematic approach to
3 cross-regional transfers. That is unusual.

4 So to transfer patients anything like this
5 distance you would only do in a circumstance where
6 clearly there was not the capacity locally to absorb the
7 pressure. But partly because we have the early warning
8 system we could see at this point there were other parts
9 of the country that were less badly affected, so it did
10 mean we could relieve some of those local pressures but
11 at the price of having to take patients some
12 considerable distance at times.

13 **Q.** I understand all of the things that are in place but
14 what may get lost there is the toll that wave 1 had
15 taken on the ability of the staff to care in the same
16 way that they did at the outset of the pandemic. And
17 was there any plan in place for asking them again to
18 redouble their efforts to try and deal with this
19 January 2021 surge?

20 **A.** So in my experience staff did not need to be asked to do
21 the extraordinary things that they did throughout the
22 pandemic. The thing that we were more concerned about
23 was the health and well-being and safety of staff. So
24 at this point we've also rolled out and, again, I know
25 you have heard from other witnesses on this, the risk

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1 we rolled it out, the new guidance, in a day, in July
2 because it made such a difference, and the vaccine, the
3 first vaccination 6 December.

4 We had begun to do a bit of that recovery that
5 I talked about although not as much as we would have
6 liked to be able to do if we had had more capacity, and
7 we do have staff testing at this point.

8 So we go into the second wave in a very different
9 place to the way we went into the first wave. But as
10 you say, and this is coming on to your specific point
11 here, the level of community prevalence, combined with
12 the severity of the variant meant that in practice the
13 peak of demand on the NHS was actually considerably
14 greater than it was in the second wave.

15 So the whole approach to surge was to say the best
16 thing for patients was to maximise the available
17 capacity in situ before you then start to have to either
18 move patients or to open new facilities such as the
19 Nightingale.

20 So at this point what we're seeing is individual
21 organisations absolutely hitting not just their sort of
22 baseline capacity but their surge capacity, triggering
23 then local transfers, which are going on, I should say,
24 they go on today, there will be patients being
25 transferred between critical care units but at a much

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1 assessment process for staff that are known at this
2 point to be at greater risk. We've also put in a whole
3 range of health and well-being offers nationally to
4 support local staff and, actually, at this point we're
5 working with colleagues like Professor Fong, who I know
6 you've heard from, to look particularly at the needs of
7 critical care staff because whilst there were enormous
8 efforts made by all staff, critical care staff really
9 were in the eye of the storm. So things like the
10 professional nurse advocate programme is borne out of
11 a particular concern for this group of staff who are
12 once again without being asked, doing the most
13 extraordinary things to try and make sure that they can
14 provide care.

15 **Q.** I want to pick up on something Professor Fong told us in
16 a moment but can I just ask you about CRITCON 4
17 declarations.

18 Now, I appreciate, Ms Pritchard, that it's not
19 coming from a clinician's perspective.

20 Could we have up on screen, please,
21 INQ000474486_7.

22 Ms Pritchard, the Inquiry has seen this document
23 before but it is the CRITCON declarations across the
24 relevant period. And if, with the assistance of the
25 document handler, can we highlight the black, which is

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1 to represent CRITCON 4 declarations. They're very
2 difficult to see. They run at the top of the screen.
3 And remind ourselves that CRITCON 3 is described as
4 being at full stretch. And CRITCON 4 is described as
5 being an emergency where resources are overwhelmed,
6 possibility of triage by resource or withdrawal of
7 critical care due to resource limitation is being
8 considered.

9 And there's a little black during, I think it is
10 the beginning of the pandemic in March and then in the
11 middle ringed section we are between January and
12 about April 2021.

13 And could we just go back out and look at the
14 document again.

15 We've got the blacks there that are difficult to
16 see but if you look at that section from January '21
17 to April '21', there's a significant amount of red,
18 CRITCON 3 on there, notwithstanding the 4s.

19 May I ask you this then. I know that we have
20 a statement from Mr Prentice who sets out that some of
21 the CRITCON 4 declarations may have been made in error
22 but at least two of them have not been made in error.
23 And I just want to ask you, do you not think the fact
24 that the hospital is declaring itself at CRITCON 4, even
25 if technically they are not, is an indication of the

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1 really means, which is it means actively and
2 systematically limiting care.

3 **Q.** So when you say we were very close or right on the edge,
4 to use your words, does that mean running out of beds in
5 any particular hospital and indeed region?

6 **A.** Yes.

7 **Q.** If I suggested to you we were on the brink at times in
8 January 2021, would you disagree, Ms Pritchard?

9 **A.** No.

10 **Q.** In your statement you made clear that there were three
11 occasions where you were concerned that critical care
12 would exceed capacity, February/March 2020, winter
13 2020-2021, and indeed you say in winter 2021-2022
14 because Omicron was a slightly unknown entity, certainly
15 at the beginning, but in fact, clearly, because you'd
16 got increased people attending A&E, they having
17 decreased in 2020, in fact there was a real pressure in
18 2021-2022 as well.

19 Now, one thing you say in your statement, you say
20 at your paragraph 484(b):

21 "Everyone who needed to be create treated in
22 a critical care bed had been given a critical care
23 bed, but this precipitated a need for patient
24 transfers between hospitals and regions to balance
25 demand ..."

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1 pressures that the NHS was under back in January
2 to April 2021? Even just looking at the red, it tells
3 us that, doesn't it?

4 **A.** Yes. So I actually think on this it's an incredibly
5 effective way of illustrating exactly the point you've
6 just made, which is -- and I guess I'm making as well --
7 which is that wave 2 in many ways was actually more
8 challenging than wave -- in other ways less, because of
9 all the things we knew that we didn't have before and
10 obviously the hope of the vaccine, but in terms of what
11 we actually saw of the peak of demand and the level of
12 pressure, wave 2 was completely terrifying at times.

13 You know, I was talking to people who were in
14 hospitals, in intensive care units, who were describing
15 some of the same things you've heard from witness
16 testimony and, you know -- and we were very close at
17 times, very close. So the fact there are so few blacks
18 on your graph that do, I think, illustrate also what we
19 were doing, which was when trusts were -- and they were
20 often -- getting to the peak, where they were right on
21 the edge, there was the ability, because of the small
22 number of times we see it flip over to level 4, to be
23 able to relieve the pressure in that local place such
24 that we didn't get to the position where there was
25 widespread CRITCON 4 or, indeed, you know, what that

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1 And can I ask you, on what evidence is it that you
2 rely to be able to make the assertion/claim that
3 everyone who needed a critical care bed got it?

4 **A.** So I think on reflection it is a clumsy statement. It
5 really is intended to make the point that I've already
6 made, which is, at a -- as a combination of having two
7 things, which were hard data, which is partly what we're
8 looking at on screen, as well as other data sources, but
9 also, crucially, that everyday conversation that is
10 going on both through EPR and directly, we were aware
11 nationally of where we were reaching that point of,
12 you know, absolutely maximum capacity locally. Such
13 that there was an ability then to relief local pressure
14 either through that local transfer or further afield.
15 Or indeed moving equipment, moving staff, you know, to
16 support those places that were really under maximum
17 pressure. Such that we never got to the point
18 nationally where, if you like, the philosophy that we
19 always had in the NHS through all of the pandemic, which
20 was we try to treat every patient to the best
21 possible -- within available resources, such that that
22 became impossible and we were then talking about,
23 you know, systematic limiting of access to treatment.

24 That does not mean, though, that it did not feel
25 completely overwhelming to staff at this time in those

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1 places, and it does not mean that the kind of care that
2 was being provided was anything like normal. And it
3 also, you know, doesn't mean that this looked like, sort
4 of, you know, in any way how you would think of as our
5 sort of normal way of providing critical care services
6 in particular.

7 **Q.** It is not my intention to criticise any clumsy or
8 slightly overoptimistic drafting, but you bring me to
9 the point I wanted to make, which was: the data tells us
10 so much. One only need to look in your statement -- if
11 anyone wants to, at pages 127, 128, 129 -- there clearly
12 were some spare beds available throughout most of the
13 pandemic, depending on which setting you're looking at,
14 but the point that we have heard a number of witnesses
15 say, it's not just about the bed, it's about the quality
16 and the detail of care that is provided.

17 And so do you think perhaps, Ms Pritchard, there
18 was an overreliance on the data presenting a rosier
19 picture than actually was portrayed on the ground for
20 those particularly in critical care units?

21 **A.** I'm confident in saying there wasn't for us, and in all
22 of the conversations we were having with government we
23 were really clear about what people were actually
24 experiencing, and certainly colleagues of mine were
25 inviting in and making arrangements for journalists to

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1 there is more critical care capacity in the event of
2 a respiratory pandemic like Covid?

3 **A.** So I'm not saying for a moment that I can possibly speak
4 for every clinical decision in every hospital.

5 I obviously can't. But I think what we -- so the bit we
6 can do though is a combination of looking at what the
7 data is telling us about what happened, what the lived
8 experience was around trying to relieve pressure in
9 transfers, and the logic of trying to surge, locally
10 surge, then regionally surge, nationally was the one
11 that allowed the NHS to continue to function.

12 What I think the data tells us from ICNARC --
13 I've looked carefully at what Professor Rowan and
14 Dr Matteo have said, and I think they're right to be
15 cautious about drawing conclusions, and certainly
16 they're right, clearly, not to dismiss any of that data
17 and what it might tell us, but in terms of being able to
18 draw a direct causality I think I would share their view
19 that we'd have to be careful about jumping to
20 conclusions, and clearly there's a need, I guess, to
21 understand a bit more about what the therapeutic options
22 around vaccination, dexamethasone, other forms of
23 oxygen, allowed to happen outside of that traditional
24 ICU space, which also feeds into this.

25 But what -- your question, which is about future

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1 film in our critical care units and in our hospitals, to
2 try to help the public understand what staff -- what
3 extraordinary lengths staff were going to. And I know
4 we will have all seen colleagues at -- whether at the
5 daily press conferences or elsewhere knocking down
6 systematically any suggestion that the NHS was not
7 pulling out all the stops and under enormous pressure,
8 actually not just in wave 2 but certainly wave 1 and
9 other times as well.

10 **Q.** Notwithstanding the acknowledgements you've made about
11 the pressure on the NHS, do you accept that there were
12 a proportion of people it looks like weren't in fact
13 taken into critical care or ICU units?

14 We heard, for example, from Kathy Rowan of ICNARC
15 who said potentially some of the data suggests that
16 elderly patients were not being admitted into ICU. We
17 also have had research conducted by the Inquiry where
18 a number of staff have spoken about difficulties in
19 escalating people into critical care. So the assertion
20 that we all got a bed if we needed it is only true to
21 the extent if you were in it, but we've heard there's
22 a great number of people being treated outside of
23 critical care that would normally been treated within
24 it.

25 What can be done in the future to try to ensure
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1 resilience, I think probably goes back to some of what
2 we were discussing earlier. Because a bed is not a bed;
3 a bed is a physical space, yes, but it is only a bed if
4 it's got staff, if it's got medicines, if it's got
5 equipment; and all of those things are part of what
6 I think forms that future resilience narrative and that
7 future resilience ask, which clearly, you know -- well,
8 I've already said, we didn't have headroom going into
9 the pandemic, and that has not materially changed as we
10 stand now.

11 **Q.** There's clearly decisions made about whether one gets
12 into critical care or ICU. What about the actual level
13 of care provided once in it? Professor Fong told us of
14 a visit that he conducted at the end of December 2020
15 where he described the ICU unit as "bursting at the
16 seams" and he went on to outline the number of patients
17 that were in ICU, in A&E and emergency department
18 waiting to get into ICU, a patient in an ambulance
19 waiting to get into the hospital that died before he
20 could even get into the hospital, and he said this:

21 "It is genuinely the closest I have ever seen
22 a hospital to a state of collapse in my entire
23 career."

24 Now, if one looks at the data that is not, nor
25 could it ever be, portrayed in the data --

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1 A. No.

2 Q. -- but do you think there is a real danger that NHSE
3 over-relies on the data and how do you think you can
4 better understand the frontline pressures than perhaps
5 had been in place during the pandemic?

6 A. I don't agree. Throughout the whole pandemic there was
7 a combination of information that we were relying on,
8 data was -- it was part -- it was an important part but
9 it certainly wasn't all of it.

10 So Professor Fong went out to do those visits
11 partly at the request of my colleagues in the EPR team
12 because they valued so highly that firsthand feedback.
13 Similarly, I have to say I was in the room with very
14 senior politicians relaying exactly those kinds of
15 stories and describing in a way that I think was very
16 clear -- in fact we've got notes I know were released to
17 another module of the Cabinet Office discussions and
18 meetings Covid-O in January '21, where some of the
19 language there clearly says that we were very clear
20 about the state of pressure in the NHS and that was
21 widely understood and well understood.

22 Q. What plans are there in the event of a future pandemic
23 to have something like the peer support programme that
24 Professor Fong undertook? Is there anything like that
25 that is ready to go, as it were, in the event we need it

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1 A. Yes, which is why we never would.

2 Q. Can I ask you about one other matter in relation to the
3 data and it's the way in which capacity in critical care
4 units was communicated.

5 Could I show on screen, please, INQ000474255_22,
6 and at the same time, if able, underscore 39.

7 And whilst that's being put up, Ms Pritchard,
8 we've heard from two intensivists,
9 Professor Charlotte Summers and Dr Ganesh
10 Suntharalingam, that in England critical care bed
11 occupancy is reported as a proportion of not only the
12 existing capacity but of the surge capacity and to that
13 extent it is different from how the other nations report
14 their capacity.

15 And I've just put up on screen two of the graphs
16 that we used when those experts gave evidence and it's
17 really this: I understand why NHS England would want to
18 know how much of the surge there is left before you hit
19 peak capacity. If we look at the figure on the right
20 side of the screen, this was taken from Northwick Park,
21 one can see that their baseline there I think was 24 --
22 22 beds. They were then operating considerably in
23 excess of that throughout a lot of the pandemic. But
24 there was some capacity, as represented by the grey
25 boxes that we can just about make out. If you look at

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1 again?

2 A. Yes, there's a set of things particularly around
3 supporting staff which I think have been, if we were
4 looking for learning, I would have liked to start with
5 them rather than develop them through the pandemic. So
6 it would have been very useful to have been able to
7 switch them on sooner and where it's been appropriate
8 we've maintained those, so things like the professional
9 nurse advocates' network still exists.

10 We are doing at the moment a review of staff
11 support, partly to make sure that we have properly and
12 systematically looked at where national initiatives make
13 the biggest difference and how they can most usefully
14 support, you know, what will always be primarily local
15 responsibility to support local staff. But absolutely
16 relevant, absolutely right.

17 Q. Do you think that looking at the quantity of data is not
18 really sufficient for measuring the strain on critical
19 care units?

20 A. Do you mean the CRITCON data?

21 Q. Yeah, the CRITCON data or any of the other -- we have
22 got various sitreps that show us the pressures that the
23 critical care units were under. Do you think that that
24 just doesn't accurately convey the strain on critical
25 care units by just looking at the data itself?

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1 5 April, it's almost all full and they have exceeded at
2 least double their usual baseline capacity.

3 Scotland mark it differently. They had up to, I
4 think it was 575-odd beds available. 175 normally.
5 They just exceeded baseline capacity some time in March
6 to April 2020.

7 From the public's perspective do you think that
8 conveying capacity by reference to both baseline and
9 surge perhaps misrepresented how truly bad it was for
10 a hospital like Northwick Park to be running at over
11 double their baseline?

12 A. So I think you've, really importantly, identified that
13 data is used for different purposes. So the way that --
14 I should say it was, obviously, just in the pandemic
15 that it was done like this but the way that the data was
16 reported against maximum surge was for the operational
17 purposes to identify when a unit was reaching its
18 maximum capacity and therefore might need transfers or
19 other support.

20 So, actually, you can see, as you rightly say,
21 that that happened a number of times over this period
22 with Northwick Park and bearing in mind this is a --
23 I think it's an 8 am date stamp on this. Obviously
24 there will be more activity flowing in to a unit over
25 the hours so it's a snapshot in time. I think the

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1 Northwick Park data you would expect to see quite a high
2 number of transfers with this kind of profile because
3 they're clearly showing that they're very near or indeed
4 at or over capacity a lot of the time. So from
5 an operational perspective, that's the important thing
6 to know.

7 From a "does the public understand from the data
8 only?", then I think it's a very sensible suggestion to
9 say both putting in a baseline and surge probably makes
10 that clearer. But I suppose that's where what I would
11 come back to is, we certainly would never rely,
12 certainly in our communication with government, our
13 internal decision-making, or the way that my colleagues
14 were talking to the public in the opportunity they did
15 have, on only data telling the story and, really
16 importantly, things like having some incredibly brave
17 journalists actually going in and spending time in units
18 reporting from them directly, I suspect told a much more
19 powerful story than data alone.

20 **Q.** In the event of a future pandemic, what are
21 NHS England's plans for the way it communicates ICU
22 capacity? Is it going to do baseline and surge or
23 revert to the way Scotland does it? Are you able to
24 help?

25 **A.** I can say I don't think we've actually formally

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1 about "both and" hopefully would allow a reassurance on
2 the operational view that there still was capacity to
3 treat people, along with those messages, strong messages
4 about please come forward if you need help, whilst also
5 avoiding any misunderstanding about the level of
6 pressure that the NHS was under.

7 **Q.** May I change topic completely, please, Ms Pritchard and
8 turn to Nightingales. And I think you set that out, if
9 it helps you, at pages 259 onwards in your statement
10 ending 251.

11 But you set out there that as at about 20 March,
12 so just before we went into lockdown, it was felt that
13 London might be the first to be hit with the real
14 effects of the pandemic. Modelling suggested that 4,000
15 beds might be needed when London had 800 at that time
16 and that it was over the weekend of 21, 22 March that
17 the Nightingales were conceived. And were you involved
18 in the conception of the Nightingale units? Were you in
19 meetings that weekend discussing this?

20 **A.** I was in meetings the entirety of that weekend, yes.

21 **Q.** You say there that nightingales were conceived:

22 "Inherent in the Nightingale assumption was that
23 they would need to be 'right-sized', to enable
24 flexibility regarding staffing models, and able to be
25 built at speed."

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1 concluded what the right answer would be. I suspect
2 the Inquiry will have a view, but my personal view would
3 be that in order to make sure we're doing the "both and"
4 of reporting the data that's operationally most useful
5 but also telling a clearer story with the data, the
6 "both and" would be a sensible way of doing it.

7 **Q.** You don't want to scare people off from going to ICU
8 because that comes with it a whole different set of --
9 or attending A&E certainly, a different set of
10 difficulties, but certainly the public perception may --

11 **A.** Agree.

12 **Q.** -- have been that it looked like there was more capacity
13 than if fact there was because they would have been
14 running at staffing ratios of way in excess of 1:1 by
15 the time they were dealing with 50, 60 patients in their
16 ICU?

17 **A.** And I think you're right that the balance is really
18 important because we, if I take a step back again, we
19 were really anxious that people were not coming forward
20 for care and actually there was a survey done early on
21 which said 1 in 10 people, if they had a new lump, a new
22 mole, wouldn't bother the health service with it even if
23 it didn't go away, and just looking at the number of
24 people that didn't come to A&E, that was an increasing
25 concern as the pandemic went on. But I think your point

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1 What did you mean by "right-sized"?

2 **A.** So at the time, if I go back to that period, as you say,
3 the data was telling us on the reasonable worst case
4 scenario, and really crucially the doubling rate of the
5 number of patients who were in hospital. Because, I
6 mean, just some simple months, 1, 2, 4, 8, 16, 32, you
7 get a lot of people very fast and at that time we were
8 actually modelling a double rate of three days.

9 Now, it wasn't as bad as that. It actually ended
10 up being more like five to six days but the rate of
11 increase meant we did not think at this point that there
12 was going to be a scenario where they would not be
13 needed. So we thought we were building something that
14 we would have to open and really fast.

15 **Q.** And I think you say that on 23 March you, Sir Simon and
16 a number of other officials attended a meeting with the
17 Prime Minister, Matt Hancock and other government
18 ministers and officials, and I think essentially there
19 the go-ahead was given to be able to start the
20 Nightingale programme, starting with, I think, the ExCeL
21 centre in London, but at the same time recognition that
22 there would need to be Nightingales across all the other
23 regions of NHS England.

24 Now, to help you, and I hope her Ladyship, can
25 I have up on screen INQ000474444.

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1 Which is a schedule of the Nightingales, when they
2 were approved, when they became operational, the
3 activity that they saw during wave 1, the activity they
4 saw during wave 2, and indeed the setup, running and
5 decommissioning costs. And I should say we're grateful
6 to those who represent you for their help in preparing
7 this schedule.

8 If one takes London as a starting point, it was
9 approved, as we just looked at, on 23 March. It went
10 operational on 3 April. But during wave 1, 57 patients
11 were admitted. It was open for admissions from April to
12 May 2020, then on standby, and during wave 2 it was not
13 used to admit Covid-19 patients but 71 non-Covid-19
14 patients were treated, and we can see there that from
15 11 January 2021 it was used as a mass Covid-19
16 vaccination centre until late June 2021.

17 Setup, 77 million. 49 million to run. Just over
18 5 million to decommission. Total cost, 132 million.

19 And I'm not going to go through each and every
20 different Nightingale, but to take a different example,
21 slightly later, Harrogate: approved 15th, set up
22 six days later. It was opened on standby. No patients
23 were admitted. As the region managed within its
24 existing capacity it was able to be reactivated to admit
25 patients within 7 days. And then it sets out there how
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1 hospital at the time, so it was much more uncertain than
2 it became later on, when we could predict much more
3 accurately what was likely to happen. But the doubling
4 rates looked like we were going to be in a situation
5 where we would hit the kind of maximum operational, even
6 with the surge, that we've talked about, capacity.

7 And if we had not had this kind of facility
8 available at that time, this Inquiry would be having
9 a very different kind of conversation if we had ended up
10 in that kind of scenario, where we would have been
11 unable to treat potentially many, many thousands of
12 patients.

13 So at the time -- and I think just worth saying
14 perhaps that date of approval on this chart is the date
15 of the formal assurance approval, the actual decision
16 date was that early conversation that we've talked about
17 with the Prime Minister, because obviously this, again,
18 is a government decision that we're then
19 operationalising, and actually the formal decision on
20 the later ones, with the exception of Exeter, is
21 1 April. So these are the sign-off of the assurance
22 processes.

23 So at that point, when the wave is still going up
24 we don't know where it's going to end at that point.

25 So the first wave is in lots of ways -- I'm back
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1 in fact it ended up being used because it had clinical
2 imaging equipment and it was able to provide CT scans.
3 Again it was ready to be used in wave 2. Total cost
4 32 million.

5 Exeter was the last. May I ask you about
6 Birmingham though. 10 April it was approved.
7 Operational, 16th. On standby. No patients admitted.
8 And again no patients admitted in wave 2 nor indeed any
9 other indication that it provided vaccinations or
10 imaging or stand-down facilities for those seeking
11 rehab, at a cost of 50 million.

12 I suspect you know what I'm going to ask, but at
13 a grand total nearly 358.5 million, do you think,
14 Ms Pritchard, that that was a useful resource that was
15 available to the NHS, albeit one that was very little
16 used to treat Covid-19 patients?

17 A. Yes is the simple answer. And let me tell you why I say
18 that. And it's because when we were at the beginning of
19 this process, making decisions about opening these
20 unprecedented field hospitals, because that's what we're
21 talking about, we went into this -- and I think you've
22 heard from Simon Ball from Birmingham about this as
23 well -- expecting to need them. Because we didn't have
24 community prevalence data, we only had the data which
25 was the rear-view mirror about patients who were in
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1 to the sort of it was terrifying. It was really -- it
2 was one of -- it's those moments like at that weekend
3 where I was in the London office with loads of clinical
4 colleagues and others and we -- we thought we were about
5 to do something that we'd seen in China, where they
6 opened field hospitals, and we thought we were doing it
7 to avoid a northern Italy situation. So the fact we
8 didn't actually need to open them at scale in the first
9 wave was a sort of huge relief.

10 Some of them, as you say, were open. So London
11 opened actually slightly ahead of where -- so they were
12 designed -- London specifically was designed only really
13 to be used once every other bit of capacity had been
14 exhausted. So we were assuming at this point everywhere
15 would be working at a 1:6 ratio, from trained staff
16 to -- to other staff, so 1:1 one from a staffing point
17 of view but not from a specialist skill point of view.
18 And when London opened we were not at that point but the
19 clinicians, rightly in my view, thought it would be
20 safer to open it a bit earlier to have a sort of
21 couple of weeks of trying to test it out before
22 potentially it would then have to be opened at the sort
23 of scale that we were looking at at that time. And in
24 fact, of course, that never happened, so it never had to
25 be opened at that sort of scale.
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1 Q. Pausing there. I take your point that, as you say, this
2 was a contingency we never wanted to use. Thankfully,
3 you would say, you never had to use, certainly not in
4 the way it was envisaged. But how was it envisaged it
5 was going to staff it? If you take London as
6 an example, they're already operating at ratios of 1:6.
7 Who was going to staff the Nightingale if we'd needed it
8 for Covid-19 patients?

9 A. Well, so, thankfully, London wasn't -- I mean, nowhere
10 was 1:6 for any extended period of time, but the
11 guidance had said that is where -- thinking about surge
12 and how you would step up, the guidance gave, kind of,
13 clear, if you like, sort of permission/cover to do that.

14 Some places I should be clear, again, did hit
15 those sorts of ratios for periods of time, but
16 certainly 1:4, what -- we saw that in a number of
17 places, so -- but other places didn't have to get that
18 far.

19 What that model -- I know you've talked to
20 Dame Ruth about this, but that model had a -- a model
21 where there would be one specialist nurse looking after,
22 effectively, a group of patients, with then other less
23 experienced, less skilled members of staff from other
24 clinical fields supporting that, and groups of
25 volunteers. So for London, for example, we had made

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1 have reached that point where it would have been
2 unrecognisable for the kind of care even that was
3 provided during that first wave.

4 Q. Yes. So if I follow you right, we would have had such
5 significant dilutions in the hospital, within their own
6 surge, breaking out operating theatres, repurposing
7 other wards, and then you would have had significant
8 dilution of care in the Nightingales as well?

9 A. Yes, so the Nightingale model was a military field
10 hospital model. So we had military colleagues,
11 invaluable military colleagues working with us
12 throughout the whole of the pandemic but particularly
13 supporting the Nightingale project, and it was part of
14 their thinking how do you do this in a real, live
15 situation that informed the staffing models, and indeed
16 the whole approach to Nightingales.

17 But it might be worth saying that -- I talked
18 about that date of approval was the sort of formal
19 assurance, and the formal assurance process included the
20 sign-off of plans and -- plans for staffing and the
21 staffing model.

22 Q. We have heard evidence though from both Professor Fong
23 and indeed Dr Suntharalingam that the devil in intensive
24 care is in the detail, and once you dilute the detail
25 you're actually providing a different form of care, was

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1 plans to train airline staff, who were at that time
2 available and keen to help, to be part of that volunteer
3 workforce. But you would not have reached the point of
4 opening a Nightingale, theoretically -- certainly in
5 London's case, although, as I say, it did open a bit
6 earlier as a test, or an early trial I guess -- unless
7 everywhere had got to that extremist level. And it
8 never did, so we never needed to get to that place.

9 Q. I note -- but that comes back to the question I'm
10 asking, which is: who was going to staff it then had we
11 got to that level?

12 A. So that would have freed up -- so if everywhere was
13 running at a 1:6, that would have allowed staff both
14 from -- to be released to support the Nightingale. But
15 also that's where the volunteers become crucial. And
16 even in this very early phase of thinking about London,
17 it was clear that there were parts of the country that
18 were under less pressure. So it would have been
19 difficult to move staff from other parts of the country
20 but actually there were hotel facilities that had
21 been -- you know, had been secured as part of the model
22 for London such that people could have been accommodated
23 if we had reached that point.

24 But your substantive point is right that this
25 is -- if we had hit this point then I think we would

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1 how Dr Suntharalingam put it. Or as Professor Fong,
2 once you start diluting the detail it kind of stops
3 being intensive care, is what he said.

4 There may be no easy answer to this but would you
5 advocate for the establishment of Nightingales again if
6 we had a pandemic like we did back in March 2020?

7 A. So I would start I think honestly with the -- you
8 wouldn't want to rule that out before you knew exactly
9 what the circumstances were of a further pandemic. But
10 this is a "What's the alternative?" question. So we had
11 done surge. This is super-surge. So this would have
12 meant -- again, you're absolutely right, this is not
13 critical care as we understand it. This would be
14 something -- this is field hospital medicine. And the
15 alternative is that you do not treat people at all.

16 LADY HALLETT: I see that Exeter didn't have to be
17 decommissioned because it was used for other purposes.
18 If you were planning for any future disaster on the
19 scale of this pandemic, what about a system whereby you
20 could -- you spent a lot of money, many millions of
21 pounds, but then you could repurpose the unit thereafter
22 for -- there are all sorts of the things, I've heard
23 about elective hubs and that kind of thing. Is there
24 any thought going into whether that would be an option,
25 so, in other words, you hadn't wasted the 300 and

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1 whatever million?

2 **A.** So.

3 **LADY HALLETT:** Take away the word "wasted".

4 **A.** Yes, thank you.

5 **LADY HALLETT:** You would say it's properly preparing, sorry,
6 you haven't spent it without needing it.

7 **A.** So that's right. I mean, on cost, I know -- it's
8 perhaps just worth thinking -- and again it's
9 an illustration that these were not normal hospitals,
10 because a normal bed costs -- to build a modular bed
11 costs about half a million pounds, and actually this
12 worked out, across all of the beds we opened, sort of --
13 as in spent the money on being able to open, would have
14 been more like 88,000 per bed. So they're not
15 comparable, as in they're not the same, and I think that
16 illustrates the point. But Exeter, because it was
17 later, they were able to work with their, you know,
18 local partners to identify a building that could be
19 kept.

20 So as a model for the future that is very
21 different to the conference centre -- clearly, the ExCeL
22 want it back. So I would definitely agree with you,
23 my Lady, the Exeter model has huge advantages, because
24 it was both big and at scale to do what was needed,
25 potentially -- or what we thought would be needed at the

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1 be done really fast.

2 By the time we got to wave 2, there was sufficient
3 greater knowledge about the virus and how it worked to
4 know that you would really not want to ventilate
5 patients in a field hospital, you would absolutely want
6 to keep them on a hospital site, hence the model of
7 transfer and national transfer if required.

8 So they were remodelled to be much more step-down
9 facilities but not step down in the sense of people
10 waiting to be discharged from hospital because putting
11 a frail older person in an open plan environment with no
12 privacy and limited access to bathrooms was clearly not
13 appropriate, but in Manchester's case it was a good
14 example of where it was adapted to be a genuinely
15 helpful resource, I think for them, to be able to
16 relieve pressure from an intensive care perspective so
17 they could then bring more patients through.

18 So for Birmingham, and I know again you've taken
19 evidence from Simon Ball on this, Birmingham actually
20 stretched the capacity within the hospital site for
21 intensive care such that they took enormous numbers of
22 patients from their local area, but actually more widely
23 across the Midlands, and that was the -- so they didn't
24 need to use their facility for intensive care because
25 they had stretched the capacity within their own site

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1 time, but has been able to be massively useful for the
2 recovery effort longer term.

3 **MS CAREY:** Before I leave this spreadsheet, Birmingham is
4 something of an outlier in that it didn't receive any
5 patients in wave 1 or wave 2 or, on the basis of the
6 information we've set out here, be repurposed for
7 another use. Why, do you know, was Birmingham not used
8 to do something in wave 2 for standing down patients,
9 being used as a vaccination hub, what was the particular
10 problem that meant 50 million was spent on a facility
11 that was never used at all?

12 **A.** So each of these -- having visited all of them. Each of
13 them was in a very different -- had very different
14 physical constraints. So, actually, one of the things
15 that we haven't talked about was the difference between
16 the sort of wave 1 model of care and the wave 2 model of
17 care because one of the things that happened between the
18 two is absolutely where it was -- where the physical
19 building meant it was possible to be used for other
20 purposes, whether that was CT scanning or day cases or,
21 indeed, in Exeter's case they also used it for training
22 nurses, for example, training overseas nurses, that
23 happened but they were also adapted so that in wave 2
24 the model of care would have been different because
25 wave 1 given what we were looking at at the time had to

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1 which was a much better model of care for patients. And
2 the physical facility just didn't lend itself to be
3 adapted for other purposes in the way some of the others
4 did for wave 2 and beyond.

5 **Q.** One of the things you say in your statement is there was
6 a concern, certainly initially, that the Nightingales
7 would not have enough ventilators to treat the
8 anticipated number of Covid patients.

9 Now, I appreciate at the beginning everyone
10 thought everyone would need a ventilator --

11 **A.** Yes.

12 **Q.** -- and as it turns out, Covid is a multi-organ
13 disease --

14 **A.** Yes.

15 **Q.** -- so we have got that in mind. But can I just ask you
16 about ventilators. You said this in your statement,
17 that it was for the trust to purchase their own
18 ventilators so there was no central inventory at the
19 start of the pandemic as to how many ventilators there
20 was.

21 And what I'd like to know is, is there such
22 a central inventory now?

23 **A.** The short answer to your question is there is not but
24 there are plans to create one. So, NHS Supply Chain is
25 currently working on an asset register. They're

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1 prioritising diagnostic equipment like CT and MRI but
2 next year the plan is that that would then expand to
3 include equipment like ventilators.

4 In this case there had been an exercise in 2017 to
5 do a sort of rapid piece of work around ventilator
6 capacity so there was a baseline which was broadly
7 right, actually, going into the pandemic. It was
8 repeated as a quick exercise in February 2020, and
9 I think it's just -- I absolutely agree an asset
10 register is a sensible thing to have but I still think
11 if we were in a similar situation you would want to do
12 that stocktake again anyway because part of what was
13 happening on the ground in February is, you know,
14 clinicians were telling me about, were literally taking
15 kit out of cupboards, testing it, saying what if we
16 attach this to it, and that to it, could you repurpose
17 it for this?

18 So you'd still, I think, need to do that sort of
19 realtime testing to see what kind of stretch capability
20 and what state some of that equipment was in.

21 **Q.** Your statement sets out in great detail the efforts made
22 to increase ventilator capacity, capacity for CPAP and
23 the like, and I think it gets to the position that by,
24 certainly, September there was over 31,400 mechanical
25 ventilators, I should say in September 2020, when we had

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1 one that you would want to use on an ongoing basis. So
2 I know some of those -- I believe, actually, because it
3 doesn't sit with us, it sits with the department, but
4 I believe some of those you wouldn't have wanted to
5 bring into normal use anyway.

6 **Q.** Can I move from equipment to people because one of the
7 things you said before lunch was to tell us about the
8 absence rate of staff and in particular due to anxiety,
9 stress and depression, and I think you set out in your
10 statement that NHS England established a workforce cell
11 in March 2020 to support and mitigate what was thought
12 was likely to be a 20 to 30% absent rate across its
13 workforce. Was that because -- taking into account
14 Covid-related absences as well as stress, other
15 illnesses and the like? Where does the 20, 30% absence
16 rate come from?

17 **A.** Yes, thank you. So that was a piece of modelling work
18 based on the reasonable worst case scenario that was
19 specifically Covid-related -- so it was a total sickness
20 number but driven predominantly by some assumptions
21 about what was happening with the virus.

22 **Q.** You say in your statement at paragraph 858, if it helps
23 you, Ms Pritchard, that the NHS does not use a single
24 staffing computer system across all settings. Gathering
25 consistent and reliable data required a bespoke sitrep

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1 started out with significantly less than that at the
2 beginning of the pandemic.

3 What -- I suppose what I want to know is what's
4 happened to the additional ventilators that were managed
5 to be sourced and how ready are they to be wheeled out
6 again in the event of a future respiratory pandemic?

7 **A.** The story on ventilators, I think, is both a success
8 story of rapid procurement and manufacture but also
9 a sort of important caution about what lends itself to
10 stockpiling and what doesn't. Because ventilators,
11 unlike PPE, have parts that degrade. So actually
12 keeping a stockpile is a different task to, say, PPE
13 where there's a constant call-off of PPE that's then
14 brought to use and then it's replaced by new stuff so
15 you have a constant rolling ability to keep a live
16 stockpile.

17 With ventilators that doesn't quite work because
18 they would need maintenance and they would need to be,
19 you know, constantly replenished with some of the parts
20 that would degrade. So there was a ventilator stock
21 held by the Department of Health. I believe that has
22 now closed and those that were able to be usefully used
23 were distributed. Some that were purchased, were
24 purchased, I think, in the early days in particular
25 for -- to a specification that actually wouldn't be the

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1 to be established which essentially then began to tell
2 you how many staff were absent on the previous day
3 across all settings.

4 And that sitrep being established, what did you
5 what did NHS England do once armed with the data about
6 the people that were absent from work the day before,
7 how did it help?

8 **A.** So I think it was useful in a number of ways. One goes
9 back to the point we've been discussing about a bed is
10 not a bed if it hasn't got staff. So if we were
11 thinking about what's creating pressure on the NHS, that
12 workforce data was a really important part of
13 understanding what was going on locally along with all
14 the other things we've talked about.

15 It was also important in the early days when we
16 had really limited access to tests. So being able to
17 identify places that were hot spots, where they had
18 outbreaks for targeting support with staff testing, that
19 sort of thing was useful.

20 The other thing that was valuable was really being
21 able to identify again where we were seeing pressure
22 points that meant you would just go and ask, what can we
23 do to support? So some of that led into people working
24 with our cell lead in particular, on the health and
25 well-being programme.

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1 Q. So when you say it enabled people to go out and say --
 2 well, NHS England say, "What can we do to help you?"
 3 What kind of responses were being given? I appreciate
 4 they might want 10 more staff on a given day.

5 A. Yes.

6 Q. Putting sort of the practicalities of adding some more
 7 bodies into the mix, what else was being relayed to you
 8 as the ways in which NHS England could help where there
 9 was significant episodes of absence?

10 A. So -- yeah. So in the early days testing was a really
 11 big ask. So we had lots of completely understandable
 12 requirements or desire for access to staff testing,
 13 particularly where there were high levels of absence.
 14 So that was one of the things we worked really closely
 15 with Public Health England, as well as with our own sort
 16 of sub-cell on testing to try and make sure if -- as and
 17 when capacity became available it was targeted most
 18 effectively.

19 One of the big asks which was later was really
 20 about access to asymptomatic staff testing, which came
 21 in November with lateral flow.

22 Other things that were asks at the time -- there
 23 was a really, again, important request around risk
 24 assessment for staff and support with that and with
 25 appropriate frameworks for redeployment and for

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1 What is in place to try and support staff and try and
 2 mitigate as best you can the effects of stress, anxiety,
 3 burnout, depression, when those staff are on the front
 4 line trying to deal with the pandemic?

5 A. So we had an -- I know this is one of the things you've
 6 talked to other witnesses about so forgive me if I don't
 7 have as comprehensive a response. But my recollection
 8 is that because we had an Expert Advisory Group that was
 9 chaired by Carol Black and had a range of other really,
 10 really knowledgeable and insightful people, we were
 11 hearing a clear story which was that the emphasis had to
 12 be on, if you like, supporting local employers to
 13 support their own staff because that was -- all the
 14 evidence said that's the most powerful and the most
 15 helpful thing you can do.

16 So one of the things we asked was that everybody
 17 had health and well-being conversations with line
 18 managers in place and then that was rolled out with
 19 health and well-being champions to oversee that at board
 20 level support.

21 So that was one big area of focus, how do we as
 22 NHS England set the guidance, set the expectation,
 23 provide the right support for local leaders to do the
 24 things that are going to be most impactful.

25 But I think their advice was that there was also

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1 reasonable adjustments for staff who were at greater
 2 personal risk from the pandemic.

3 And then there were a range of things, as
 4 I recall, thinking back, where I think it was a bit more
 5 specific, so for example my recollection is there was
 6 a request from Filipino staff for some targeted and more
 7 bespoke bereavement support because that was something
 8 that they'd been particularly at the front line of
 9 dealing with. So everything from, if you like, the sort
 10 of very much this is for that -- might have heard it
 11 from particular groups of staffs but it was relevant to
 12 the whole of the NHS. And then others that were a bit
 13 more specific to particular staff groups or particular
 14 places.

15 Q. You told us that generally speaking in pre-pandemic
 16 the -- there was a high proportion of sickness absence
 17 due to anxiety, stress, depression and other psychiatric
 18 illness. It spiked then, I think in July 2020, where
 19 there was 32% of absences due to anxiety, stress,
 20 depression, before it dropped back to 23% in 2022, to
 21 2023. It's still a significant proportion,
 22 Ms Pritchard, of the workforce off due to anxiety,
 23 stress or depression. One can understand why it peaked
 24 as it did in July 2020, everyone having just gone
 25 through wave 1, but now in 2022, 2023, back down at 23%.

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1 some ways in which nationally we could supplement what
 2 was available locally in a way that would be helpful.
 3 So, for example, the mental health hubs that were set up
 4 during the pandemic were specifically in response to the
 5 point you've made about staff experiencing high levels
 6 of mental ill health, stress, anxiety as a result of
 7 what they had experienced in the pandemic as well as
 8 other factors. And things like, you know, the helplines
 9 that we put in, some of which were targeted to
 10 particular staff groups, the website had over a million
 11 uses -- a million views.

12 So a whole range of things that were particularly
 13 designed to support that local offer.

14 Q. And finally this then. In the event of a future
 15 pandemic, is there any sort of planning for how to
 16 support NHS staff to try and reduce or minimise the
 17 number of people that are off sick with the stress, the
 18 depression, the anxiety?

19 A. Yes, I think the -- so there's -- the staff treatment
 20 access review that's going on at the moment is really
 21 about occupational health services and what, again, are
 22 the -- so we tried lots of things in the pandemic and we
 23 tried them at pace. One of the things that we did
 24 through the sort of two years was to constantly try to
 25 reflect on what was working, what the feedback was,

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1 iterate change, a bit like what we've talked about with
2 the Nightingales. But I think now, in the sort of --
3 you know, beyond the -- when we've slightly got the
4 ability to just step back and reflect properly, actually
5 the reason we've chosen to do this more formal review
6 around health and well-being support and what the
7 national support could best be for local delivery as
8 well as looking at what the occupational health offer of
9 the future could look like is because I think there is
10 a recognition that there is no doubt things that could
11 be better now as well as things that we would want to
12 have in place for a future pandemic.

13 **Q.** Do you think the NHS workforce is more resilient now,
14 less resilient now? Where are we at now as of 2024?

15 **A.** So, on the one hand we do have more staff now than we
16 did going into the pandemic, so 70,000 more staff. So
17 numbers-wise we have more, which is fantastic. From
18 a how do staff actually feel and the level of resilience
19 to even think about having to do anything like this
20 again, I would say there is a long recovery journey
21 ahead.

22 **MS CAREY:** My Lady, I've got about 5 or 10 minutes more of
23 questions for Ms Pritchard. I don't know whether you
24 want to take a break or make me push on, as it were, and
25 then take a break before the core participants'

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1 anything, is being done to improve ventilation in the
2 older estates. Can you help with that at all?

3 **A.** Yes, you're right to point to the challenge with the
4 existing estate rather than the obvious opportunity with
5 new estate. At the moment we have an estates'
6 maintenance backlog of, I think, now approaching
7 14 billion. So the works to improve ventilation sort of
8 by necessity have to line up with a number of other
9 competing demands on the capital budget. Where there
10 are remedial works to existing trusts -- I was talking
11 to a colleague who runs a trust that has had to do quite
12 a lot of work on their maternity unit. That is
13 an obvious opportunity to then take into consideration
14 those guidance -- those updated HEM guidance and
15 instructions in fact about what the estate needs to look
16 like.

17 So where those opportunities arise it is being
18 considered as part of that work. But what we do not
19 have is an ability at the moment to do a comprehensive
20 review of all of the existing estate, with a view to
21 bringing the existing estate up to that standard.
22 However, clearly the guidance does talk about those
23 opportunities to use devices like HEPA filters,
24 UV devices, where the estate is not good enough to be
25 able to meet the ventilation requirements. So that

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1 questions. I'm in your Ladyship's hands.

2 **LADY HALLETT:** We'll take a break now. I shall return just
3 after 3.30.

4 **MS CAREY:** Thank you very much, my Lady.

5 (3.16 pm)

(A short break)

6
7 (3.30 pm)

8 **LADY HALLETT:** Ms Carey.

9 **MS CAREY:** Thank you, my Lady.

10 Can we turn to some lessons learned and
11 recommendations, please.

12 I think you can confirm that in June 2023
13 NHS England published a nearly 150-page document of
14 lessons learned from Covid-19. I'm not going to go
15 through, nor does time allow me to do so, all of them,
16 but I would like to ask some discrete matters.

17 In that document you make the point in relation --
18 or I should say NHS England makes the point that
19 effective ventilation and air quality is important in
20 NHS buildings, and the report says that lessons have
21 been learned during the pandemic, have led to additional
22 guidance being published relating to ultraviolet devices
23 for air cleaning and HEPA filters, as indeed we've got
24 in Dorland House here.

25 I'm particularly keen to know about what more, if

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1 would be clearly part of a future pandemic plan.

2 **Q.** I think you said this morning that the backlog as at
3 2019/2020 stood at 9 billion. Do I understand now it's
4 got worse to the tune of 5 billion as a result of the
5 pandemic and no doubt just the age and wear and tear --

6 **A.** Yes, that's --

7 **Q.** All right. So the backlog has got worse, making it all
8 the more problematic for you to deal with. How does
9 that feed in to the resilience or otherwise of the
10 estate in the event that we had a pandemic next year?
11 It sounds like we're in a worse position.

12 **A.** So, yes -- I mean, they are two slightly different
13 things, in the sense that the estate backlog points to
14 a whole number of things that aren't necessarily about
15 ventilation, single rooms, et cetera. But your
16 fundamental point is right, the estate is ageing and
17 every year that we are not renewing it, it is getting
18 older, and old estate is not just inefficient, it's also
19 much less adaptable and less -- you know, less able to
20 be brought up to the standards that we would now
21 recognise as the standard you would be building into
22 new-build.

23 **Q.** Different topic, please. We know that there were
24 a number of deaths of healthcare workers during the
25 pandemic, and there are -- there is concern about the

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1 ways in which it's recorded. But I'd just like to ask,
2 from NHS England's perspective you set out that there
3 was as you entered the pandemic no systematic national
4 mechanism to capture staff deaths. And in the lessons
5 learned report, and it's at page 93 if anyone who wishes
6 to look at it, you say:

7 [As read] "There is work done at national,
8 regional and local organisation levels that provides
9 a foundation to build upon should this be needed in
10 fewer pandemics or other emergencies."

11 Can you help us, briefly if you can, with what
12 work has been done to help reliably capture the number
13 of deaths of healthcare workers?

14 **A.** Yes, so the process was set up, as you say, from scratch
15 at the beginning of the pandemic and was a sort of
16 parallel process with two different ways of reporting.
17 That was streamlined mid-pandemic to be a single way of
18 doing it and it has been further reviewed and
19 strengthened more recently but the -- so that's the
20 positive. Something exists. It has been reviewed.
21 There's a version of it now which I think is more
22 robust, more resilient than we had before.

23 The tricky bit is always a combination of both,
24 kind of, individual, sort of, data protection privacy
25 arrangements around how you would -- how exactly you
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1 to you on that.
2 **Q.** NHS England in July of this year published a framework
3 for managing the response to pandemic disease and no
4 doubt that will be your blueprint if there were
5 a pandemic in the next reasonably foreseeable future.
6 It is -- it identifies the issues, but if I may put it
7 like this, it might be said that it's light on concrete
8 proposals as how to achieve better leadership, better
9 staffing resilience, better data capture, all the things
10 we have been talking about. Is there any other work
11 that's going on to do a, for example, respiratory virus
12 pandemic plan as opposed to a blood-borne virus pandemic
13 plan?

14 **A.** So to be clear, clearly we felt it was really important
15 to have both a continuous process of lessons learned and
16 a way of updating the framework as we went along. My
17 expectation is that that will be further iterated and
18 developed pending the outcome and advice of the Inquiry.
19 But you're quite right, having something ready to go,
20 should there be a more immediate need, felt important.

21 From one of the things that the EPR framework does
22 as it currently stands and I've, unfortunately, had the
23 experience of being on the other side of this in
24 a number of major incidents back in my previous roles as
25 well, is it sets a framework for you to make decisions
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1 would use data in a way that was appropriate about
2 individuals, the way that we in NHS England, kind of,
3 dealt with that was to make sure any reported death was
4 validated by an employer or by a CCG, if it was
5 a colleague in primary care, and I know there have been
6 some concerns that that has under-reported the data
7 because the other -- the ONS source looks at death
8 certificates where somebody is identified as
9 a healthcare worker. Obviously that is harder to
10 validate because one of the things that we put in place
11 was a set of criteria including how recently you were
12 actually at work, whether you were there in a voluntary
13 capacity which is included in the data, or you were
14 an outsourced member of staff, also included in the
15 data.

16 But really understanding what the discrepancy is
17 between the, sort of, what we can validate by those
18 official sources versus what's the self-reported does
19 remain an outstanding area, and part of the review
20 that's happened has been to look at that but I think
21 that still hasn't been satisfactorily resolved.

22 **Q.** Does the review look at whether the data will capture
23 the ethnicity of a healthcare worker that has died?

24 **A.** I don't know, but the way it was reported during the
25 pandemic did. So I imagine it would but I can get back
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1 depending on the specific circumstance you find yourself
2 in. So, for example, a major incident in a trust, it
3 doesn't try and say what happens if it's a train versus
4 a car, versus a plane landing on Heathrow, but it gives
5 you the right questions to ask, the structures to use
6 and, if you like, the sort of signposts for: here's
7 where we've learnt stuff in the past, this is what you
8 would want to go to and pull from to help you make
9 decisions in this specific circumstance.

10 So, as it stands at the moment, the EPR framework
11 we would expect that to remain an overarching pandemic
12 framework but then be able to signpost to the sorts of
13 learning from, as we have in the past, for example from
14 MERS and SARS, which led to things like the HCID
15 network, but also the learning from the most recent
16 Coronavirus pandemic to be able to say: right, there's
17 a set of things you would do in this circumstance, which
18 might, as you say, be different if it were, say,
19 blood-borne or something else.

20 **Q.** Finally this. From your perspective as CEO, if there
21 were a recommendation, one or two, that you would urge
22 on her Ladyship, what would they be that would genuinely
23 help those on the front line in the event of a future
24 pandemic?

25 **LADY HALLETT:** Remembering the art of the possible.
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1 **A.** Yes, thank you. So one of the things I would strongly
 2 say is the importance of the community prevalence data
 3 and the testing so that we could properly understand
 4 what was going on with the virus, and put the NHS
 5 locally as well as nationally in a position to be able
 6 to be front-foot on response, and better able to protect
 7 ourself, better able to understand what was actually
 8 likely to come over the next week, two weeks,
 9 three weeks, beyond. It's absolutely critical and it
 10 made such a difference going into the latter part of the
 11 pandemic that we had that. So maintaining that
 12 infrastructure and that ability to be able to respond
 13 then at pace with testing and community prevalence data,
 14 crucial.

15 Probably unexpectedly, given my job is the NHS,
 16 but actually I would say don't forget social care.
 17 I know this Inquiry won't, to be clear, but we can only
 18 do what we can do in the NHS if we've got an equally,
 19 you know, if we've got that strong partnership with
 20 social care, so the staffing, the resourcing, all of the
 21 questions you've rightly asked me, I would say that
 22 would be a crucial underpinning for our resilience in
 23 any future pandemic.

24 And then, if I was allowed a third, it is this
 25 resilience point. So yes, buildings. Equally staff,

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1 **MS CAREY:** My Lady, those are my questions. Thank you.

2 **LADY HALLETT:** Thank you.

3 Ms Polaschek. I don't know how much of your
 4 thunder Ms Carey has stolen.

5 **MS POLASCHEK:** A little and I will try not to repeat
 6 anything, my Lady.

7 **Questions from MS POLASCHEK**

8 **MS POLASCHEK:** I ask questions on behalf of Clinically
 9 Vulnerable Families and I'm just going to pick up on a
 10 couple of the points you were just making in respect of
 11 ventilation in the NHS estate.

12 So, Professor Beggs, who is the IPC expert to the
 13 Inquiry has set out a number of the challenges in
 14 relation to ventilation in the NHS and one of the key
 15 issues he identifies is that the NHS Health Technical
 16 Memoranda, which I think you've just referred to
 17 earlier, that govern ventilation and healthcare
 18 facilities, were written prior to the pandemic, and are
 19 what he calls in urgent need of updating. And for
 20 example, he notes that they fail to address the risk of
 21 airborne spread of Covid outside of specific high risk
 22 environments and they don't give any guidance on the use
 23 of HEPA filters.

24 Do you accept, or does NHS England accept, that
 25 the HTM guidelines are out of date and need to be

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1 and the data infrastructure and our ability to do things
 2 like support remote working, that we have a strong
 3 community infrastructure that doesn't rely on having to
 4 pull people into physical buildings like hospitals would
 5 be the other really big piece of the jigsaw for me for
 6 a future pandemic.

7 **Q.** And that latter recommendation lies, does it not, with
 8 NHS England itself. I was conscious that prevalence
 9 data may come from UKHSA -- as it now is -- social care
 10 department, and I was thinking about, what does
 11 NHS England want and can achieve? Is it the data itself
 12 that you're responsible for?

13 **A.** Yes, so we've got things like the federated data
 14 platform, but we're supported enormously by things like
 15 the setting of standards, the interoperability that mean
 16 that systems are designed to talk to each other rather
 17 than having to be joined up through a third party.

18 Some of the arrangements that we've also got in
 19 place now for things like virtual wards, it's home
 20 monitoring, it's remote testing, not just for the virus
 21 but for other things as well. So yes, absolutely, plans
 22 in place, but continuing to make the investment in that
 23 technology and in the data infrastructure such that it's
 24 there when we need it next time with the right policy
 25 wraparound I think would be invaluable.

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1 updated and is there a plan for doing so?

2 **A.** Thank you.

3 To be honest, I was a bit confused by that
 4 reflection from Professor Beggs because the HTM was
 5 updated in June '21, and of the working group who were
 6 involved in that and the expert advisers, he was one of
 7 them. So I absolutely understand the point about HEPA
 8 filters and UV devices and that's why subsequent they
 9 have been added to the HTM as two additional documents
 10 but it's clear that the intention is you have to read
 11 the whole thing together.

12 So I am hopeful that we have actually done the
 13 thing that he was asking for because that is --
 14 that June '21 HTM plus the advice on HEPA filter devices
 15 and UV devices is now -- has now been thoroughly
 16 reviewed and -- 'in light of learning from the pandemic.

17 **Q.** I don't want to speak too much for Professor Beggs but
 18 I think the way he puts it in his report is that the
 19 additional notes on HEPA filters are what he describes
 20 as an "add-on response" and so they aren't part of the
 21 mandatory guidance under the HTM, but that may be
 22 something that he has misunderstood.

23 **A.** I can certainly double-check that it is clear that that
 24 has to be read as a package. That is my understanding,
 25 is that now sits as a package of HTM plus those

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1 additional points.

2 **Q.** Thank you, Ms Pritchard. In respect specifically of
3 HEPA filters, again Professor Beggs described these as
4 the low-hanging fruit of fixing some of the ventilation
5 problems and as you've alluded to, of course, it is
6 expensive to upgrade ventilation in the ageing NHS
7 estate all at once.

8 Aside from that guidance, for forward-looking
9 work, what work is being done currently to put in place
10 more access to HEPA filters in the NHS estate?

11 **A.** I'm afraid I would need to probably get back to you with
12 more specific feedback on that. As I've said to counsel
13 a moment ago, what I am aware of is where there are
14 works going on, where there's an opportunity to upgrade
15 the ventilation of estate, that is being taken, as well
16 as, as you say, being built into kind of future estate
17 planning.

18 On the specific use of devices, I mean, that
19 guidance has now gone out, the expectation is that is
20 going to be then considered appropriately by estates and
21 clinical professionals and used appropriately but, as
22 I say, I would just need to come back with more
23 information as to whether there's a sort of formalised
24 programme around that because I'm not aware of the
25 detail.

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1 I think it is, in the current environment, it is
2 probably difficult to go much further than that.

3 **MS POLASCHEK:** Thank you, my Lady. Those are my questions.

4 **LADY HALLETT:** Thank you very much for your help.
5 Mr Wolfe.
6 He's behind the pillar, as far as you're
7 concerned.

Questions from MR WOLFE KC

9 **MR WOLFE:** Hello, Ms Pritchard.
10 So I ask questions on behalf of John's Campaign,
11 Care Rights UK and The Patients Association, and the
12 theme of my brief questions is the way in which NHS
13 systems, by working with families involved in the care
14 process, by talking to patients as well, can improve the
15 outcomes for patients and their families and indeed for
16 the NHS itself. So that's the context of the questions.

17 **A.** Thank you.

18 **Q.** My first questions about patient experience departments
19 or sometimes called patient experience teams. Our view,
20 John's Campaign's view, is involving them can be very
21 helpful in helping to advocate for and create dialogue
22 between patients and their families and the NHS. And
23 I imagine that that is something you would agree with.
24 It's not something you mention in your witness
25 statement. Is there any significance in that?

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1 **Q.** Thank you. And just the final question. Of course
2 accepting that there's a need for prioritisation of
3 capital spending, we also know that clinically
4 vulnerable patients face greater risks than others
5 entering healthcare settings due to the impact to them
6 if they contract Covid-19. So in light of that, would
7 you accept that there is an urgent need for those
8 patients to make it safe for them to access healthcare
9 now and in any future pandemic?

10 **A.** So absolutely understand the importance of us making
11 sure that all patients are safe in NHS facilities of
12 whatever kind. I think the reality, though, as you say,
13 about just the level of backlog maintenance and the
14 urgency of some of the pressure on the estate and the
15 age of the estate, does make it very hard, and you're
16 making constant risk-based decisions about what to spend
17 money on locally and is it, you know, that concrete roof
18 that is about to -- not about to, I'm exaggerating,
19 sorry, where there's a risk it might crack at any time
20 or this, where there's a water leak or that, where
21 there's another problem.

22 So I would certainly absolutely agree that this
23 needs to take its appropriate place within the
24 prioritisation that is going on locally about how to
25 spend the capital resource to upgrade the estate but

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1 **A.** No. I mean, my witness statement answered the Rule 9
2 questions given by the Inquiry. So, no, I certainly
3 wouldn't want you to read into that any more than that.

4 It's absolutely my personal experience from having
5 worked in the NHS for now many, many years that that
6 partnership with patients is invaluable when you're
7 designing and delivering services.

8 **Q.** One of our concerns is that the role of the patient
9 experience teams appeared to diminish during the
10 pandemic. Again, is that consistent with your
11 experience and something that should be a matter of
12 concern?

13 **A.** I -- it's a good question. I mean, it's difficult --
14 one of the themes of this discussion today to some
15 extent has been, I think, what is the national and what
16 is the local. So, talking to colleagues who were more
17 in the front line than I was during the pandemic,
18 I think it's probably right to say there was variation,
19 and there was certainly some teams that I think were
20 really pulling in their patient experience teams to work
21 with them, and certainly it's something we would
22 encourage, but I think there were others where probably
23 it's fair to say there were just other competing
24 operational pressures that meant -- and that perhaps
25 didn't have the level of attention that it did elsewhere

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1 or could have done.

2 **Q.** So in a future pandemic you would want to encourage
3 everyone, all the different providers and trusts, to
4 follow that better practice of involving the patient
5 teams?

6 **A.** Yes.

7 **Q.** Different theme if I may. A couple of paragraphs of
8 your witness statement, paragraphs 532 and 537, you talk
9 about -- and we completely agree with this -- the way in
10 which longer hospital stays can generally lead to worse
11 health outcomes.

12 One of the ways in which we see that could be
13 mitigated is by the involvement of family carers in
14 supporting the professional health teams. Again, is
15 that something you would generally support?

16 **A.** Yes.

17 **Q.** Then, in terms of the position of discharge, you talk,
18 at paragraph 519 of your statement, about the process of
19 accelerated discharges in December 2021. One of the
20 things that we think can support those kind -- well, any
21 discharges but particularly accelerated discharges, is
22 a real focus on recognising the value that family carers
23 provide in supporting the ongoing delivery of health
24 care once somebody returns home. Again, is that something
25 you're supportive of?

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1 I think we did very much try to build on the best
2 practice that was already in place in the NHS and then
3 encourage everywhere to adopt that way of working at
4 pace. And absolutely I think that is what we've done
5 since then, in a whole range of different ways. So --
6 you know, whether it's elective recovery or it's
7 tackling delayed handovers, certainly discharge -- you
8 know, I would be seeking to do the same again, which is
9 learn from where it's working well and then try to
10 support that to become much more, you know, common
11 practice across the NHS.

12 **MR WOLFE:** Thank you, Ms Pritchard.

13 Thank you my Lady.

14 **LADY HALLETT:** Thank you, Mr Wolfe.

15 Mr Stanton.

16 He's behind you. Please make sure though that if
17 you look at him when he asks the questions that you turn
18 to the microphone --

19 **A.** Right.

20 **LADY HALLETT:** Thank you.

21 **Questions from MR STANTON**

22 **MR STANTON:** Good afternoon.

23 I ask questions on behalf of the British Medical
24 Association. I'd like to initially, if I may, pick up
25 on an issue you were discussing with Ms Carey, which is

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1 **A.** Yes, completely, and I think all of our -- all of the
2 guidance on discharge both within the -- both issued in
3 the pandemic and subsequently reinforces the point that
4 actually that joint -- you know, we've already
5 mentioned, I'll be the first to accept, it doesn't
6 always work as well as it should, but actually having
7 a good joint understanding of the needs of the person
8 who is being discharged and in this case has been
9 delayed for whatever reason, such that when they do get
10 discharged, you know, plans are in place to support them
11 to get the care they need once they're not in an acute
12 environment any more, you know, we know all the evidence
13 says that that involvement of families and carers is
14 crucial.

15 **Q.** So involvement in families and carers not in just in
16 planning that process but also recognising the role that
17 they very often, indeed perhaps generally, have in
18 supporting and indeed delivering healthcare back at
19 home?

20 **A.** Absolutely.

21 **Q.** And so, again, insofar as there was mixed experience
22 last time, looking forward to the next pandemic should
23 we get one, you presumably would encourage that best
24 practice approach being adopted across the board?

25 **A.** Yes. I mean, as I was saying earlier on, discharge,

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1 about whether enough is being done to support healthcare
2 workers with their mental health and well-being.

3 And I just wondered if I could bring to your
4 attention some data I'm sure you're aware of, but before
5 the Inquiry Professor Fong has talked about the levels
6 of severe depression in ICU staff, which he referred to,
7 at 52%. He also mentioned ICU staff -- this is from
8 a survey, sorry, around January 2021 -- ICU staff also
9 experiencing severe anxiety and 44% of staff
10 experiencing that. And those figures are echoed by
11 the Inquiry's intensive care experts who refer to 50% of
12 staff meeting the criteria for a mental health disorder.

13 Just against that backdrop, and obviously having
14 regard to the issue that you've recognised -- you
15 referred to the fact that mental health and well-being
16 was the number one issue for staff absence -- do you
17 think enough is being done within the NHS to support
18 healthcare workers?

19 **A.** Thank you -- should I look back here? It does feel
20 a bit odd.

21 So, thank you. So, is enough being done? I think
22 one of the things that -- well, so one of the things
23 that we start from is, again, that recognition of just
24 what staff did during the pandemic and the extraordinary
25 lengths that people went to to try and support patients.

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1 And it does have both a short-term and long-term impact.
 2 So specifically for doctors we do have a programme,
 3 which is called the Practitioner Health programme, which
 4 is -- it's actually not just for doctors but it's been
 5 predominantly for doctors, I'm sorry, I should have just
 6 corrected that -- that is something we get incredibly
 7 positive feedback about. And, you know, last year there
 8 was a suggestion we might move away from it, but it was
 9 absolutely clear that would have been the wrong thing to
 10 do. So not only have we recommitted to that programme
 11 but the review that is happening now is very much about
 12 saying: okay, well, if that's what best practice looks
 13 like, how do we make sure there's some learning about
 14 what we can do more broadly to make sure that all staff
 15 are accessing that kind of high value support.

16 But whatever is done nationally can only ever
 17 support what's done locally. So I think it's this
 18 importance of occupational health services and both
 19 being clear about what we're asking of them but also
 20 what support is required, such that -- you know, I was
 21 very fortunate in my previous organisation we had
 22 a superb occupational health service, which was -- which
 23 I think really enabled staff to access support. Which
 24 I know is not universally available. And that's the
 25 kind of thing I think this review that we're currently

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1 So, yes, I agree NHS England should be seeking to
 2 lean into this, and hence the guidance and the review,
 3 but I also think that all our learning tells us that
 4 what really makes a difference is what's happening
 5 locally.

6 So a good example would be flexible working
 7 arrangements. That's the kind of thing that we know --
 8 particularly if you've been off sick, you want to return
 9 to work, a graduated return to work programme is the
 10 kind of thing that can really make the difference. But
 11 that's not something that we can nationally do, that --
 12 ultimately, you know, we can give guidance, but it has
 13 to be done in discussion between a local employer and
 14 an individual to really work out what the right model is
 15 going to be for them.

16 **Q.** Thank you. Just picking up on the point you mention
 17 there about support for healthcare workers returning.
 18 The expert report and oral evidence of
 19 Professors Brightling and Evans, who are the inquiry's
 20 experts in Long Covid, made reference to the fact that
 21 flexible individualised phased returns appear to be
 22 better managed in the private sector, and they suggested
 23 that the NHS as a large employer has quite a fixed
 24 process.

25 What do you think is needed for the NHS to provide

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1 undertaking is seeking to understand and seeking to get
 2 a clear review of what we could be doing in the future.

3 **Q.** Thank you. I appreciate what you say about supporting
 4 employers at a local level to support their staff.
 5 I just wonder, given the levels of sickness and the
 6 figures that I brought to your attention, do you not
 7 think we're now at a point of crisis and that
 8 NHS England needs to take more of a lead in this area?

9 **A.** Do you mean crisis in relation to workforce mental
 10 health?

11 **Q.** Yes.

12 **A.** Thank you. So our data at the moment tells us that
 13 sickness is running at a higher level than it was
 14 pre-pandemic, but it's only about 1% higher. So
 15 actually if you translate that into numbers of staff,
 16 that's big numbers of staff bearing in mind how many
 17 people work in the NHS, but I think it would be --
 18 probably -- I absolutely respect what people are
 19 describing about personal experiences and the level of
 20 pressure they feel under. I think our focus has been to
 21 say we can see that a proportion of those people are not
 22 able to continue to work, so hence the level of sickness
 23 increase. However, we can see that a lot of people are
 24 still finding that they can work, so how do we support
 25 them best to be able to continue to stay at work.

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1 the same level of support as in the private sector and
 2 how can it improve?

3 **A.** I suspect that there is -- in fact, I know there is some
 4 very good practice in the NHS and there are places that
 5 are -- aren't systematically adopting that best practice
 6 to the same extent. So one of the things that we did as
 7 part of the Long Term Workforce Plan -- which was
 8 a really big moment for the NHS, first time we've ever
 9 had a long-term workforce plan -- was to include in it
 10 the evidence from, if you like, the sort of trailblazer
 11 sites that had been working on the retention programme.
 12 But the retention programme was actually a whole range
 13 of different initiatives, again supported by
 14 NHS England, run locally, to try to put in place a whole
 15 series of different things to help staff feel valued and
 16 appreciated, able to work in a way that worked for them
 17 with their work life balance and other commitments, but
 18 also retained them not only within the NHS but also
 19 within that local organisation. And what we could see
 20 from that data was that that really did make
 21 a difference.

22 So retention rates, higher. Satisfaction higher.
 23 And that is something that we are now rolling out across
 24 the whole of the NHS. So to try to recognise that
 25 variation does exist but that it is also quite a big ask

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1 and quite complicated to put in place that big package
2 of staff support. Which many trusts, as I say, do and
3 do well, but for others they've got more work to
4 implement it. So that's the kind of thing where I would
5 say recognise definitely that there is potential to do
6 better on things like flexible working. It's really
7 important. But we have, I think now, a way of
8 approaching that more systematically to take the best
9 practice that exists from different places and from the
10 private sector and to try to support that to be
11 introduced in a much more systematic way across other
12 organisations as well.

13 **MR STANTON:** Thank you, Ms Pritchard.

14 Thank you, my Lady.

15 **LADY HALLETT:** Thank you, Mr Stanton. Very grateful.

16 Mr Pezzani.

17 He's over there.

18 **Questions from MR PEZZANI**

19 **MR PEZZANI:** Good afternoon, Ms Pritchard. I ask questions
20 on behalf of Mind, the mental health charity.

21 The first topic I wish to ask you about, if I may,
22 relates to planning. The children and young people's
23 mental health inpatient experts appointed by
24 the Inquiry, Drs Northover and Evans, say at page 41 of
25 their report that:

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1 example, the impact of school closures, or the impact
2 of, you know, that level of disruption on children and
3 young people specifically.

4 So in the context of the planning we are back to
5 there being -- it's -- the framework that then needs to
6 be looked at in the context of whatever the specific
7 thing is that you are actually facing at that time.

8 I think there is, though, sort of two things, if
9 I may. No doubt that actually the impact on children
10 and young people has been profound, particularly from
11 a mental health perspective. And that gives us, sort
12 of, I suppose, my third point and, my Lady, I should
13 have said this when I was given the opportunity earlier
14 so if I may just link them.

15 My other big reflection is planning for recovery
16 right from the start. So we now are in a place where we
17 are still on a very significant recovery journey.

18 I think that is absolutely the case for children and
19 young people's mental health services and children and
20 young people's services more broadly.

21 But it is equally the case, if I look at things
22 like elective work, where my Lady you mentioned the
23 value of things like surgical hubs, elective centres,
24 that ability to keep services separated such that they
25 can keep going but also quickly come back onstream,

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1 "In relation to planning there is no evidence to
2 suggest that the UK healthcare systems had specific
3 plans for mental health inpatient services in the event
4 of a pandemic beyond those for all healthcare inpatient
5 services. Prior to the Covid-19 pandemic it does not
6 appear that the UK's preparedness and response
7 capabilities considered mental health illness, either
8 adult, community, child or inpatient."

9 And then at paragraph 164, they say:

10 "Pandemics can have a significant negative impact
11 on child and adolescent mental health. The Covid-19
12 pandemic exposed young people to known risk factors for
13 mental illness such as disrupted schooling, social
14 isolation, health anxiety and economic instability."

15 In that context, Ms Pritchard, can I ask first,
16 would you agree that the potential for a significant
17 effect of a pandemic on the mental health of children
18 and young people was foreseeable and that NHS England
19 had no specific plans for children and young people's
20 mental health inpatient services in the event of
21 a pandemic?

22 **A.** So was the impact foreseeable? I think I'd probably go
23 back to every pandemic is different and I don't think,
24 to be fair, there was a plan existing across government
25 or, indeed, in the NHS that specifically looked at, for

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1 aware that absolutely would be one of my standout
2 recommendations from an elective perspective. That
3 would also be what I would come back to saying, in
4 a future pandemic plan, the importance of recovery
5 covering mental health as well as covering physical
6 health, I think I would be equally clear about the
7 importance of that.

8 **Q.** Thank you. Would you agree, Ms Pritchard, that we now
9 have sufficient evidence from the Covid pandemic to
10 conclude that a pandemic and associated infection
11 control measures are likely to, may well, whatever
12 language you like, have a significant impact and
13 a negative impact on children and young people's mental
14 health and that all future pandemic preparedness
15 planning should now include the likely consequences for
16 children and young people's mental health services?

17 **A.** Yes, I would agree.

18 **Q.** Thank you. In a different context, in paragraph 248 of
19 your first witness statement, you quote a briefing dated
20 15 November 2018 which was jointly published by the
21 Health Foundation and The King's Fund and The Nuffield
22 Trust and it was about workforce challenges facing the
23 health service.

24 In relation to mental health, on page 11 of that
25 briefing, it says:

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1 "Long-standing objectives to reach parity of
2 esteem between physical and mental health will fail if
3 the NHS cannot overcome the existing deep shortages in
4 mental health staffing."

5 In the 15 or so months to March 2020, can you
6 assist on what progress was made in overcoming those
7 deep shortages in mental health staffing, please?

8 **A.** On specifics, if I may, I'll come back to you because we
9 will have exact data that I can share.

10 I do know that over the period that we're
11 discussing up till now, in the same way as we've seen
12 increases in the number of staff that we now employ
13 across the NHS that has also been true for mental
14 health, but it is still one of the areas where we
15 experience the greatest staff shortages. And whilst we
16 have seen, again, a very significant increase in the
17 number of people with mental health conditions who have
18 been able to access treatment, that has been far
19 outstripped by demand, and that is both true for adults
20 and for children and young people.

21 And clearly the provision of services is entirely
22 dependent on people, so the ability not just to recruit
23 and retain but to train staff has been baked in to the
24 work that my colleagues in the mental health team do
25 nationally right from the period you're talking about

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1 home area increases the likelihood that a child or young
2 person that is assessed as needing inpatient attention
3 is going to be placed on age-inappropriate, in the other
4 words, adult wards and/or out of area, particularly
5 during surges in demand, for example during the
6 pandemic?

7 **A.** There's a lot in that question. So one of the things
8 that we've been trying to do over recent years is
9 obviously move to much more of a community delivered
10 model. But -- and saying that recognising there will
11 likely always be a need for inpatient care for some
12 people. So access to inpatient beds for children has
13 been an issue for some places for some period of time.

14 I'm not aware of cases where children have been
15 placed in adult mental health settings but I am aware
16 that we have, and there have been periods, I mean even
17 now, where we have children who are in acute beds, so
18 they're in a physical health hospital bed because
19 they're waiting for a placement in a specialist mental
20 health bed, and I think that is clearly an area where if
21 you're then placed out of area, you've got a particular
22 challenge about making sure that the appropriate family
23 access, wraparound support is in place.

24 **LADY HALLETT:** I think we are moving beyond Covid-19.

25 **A.** Sorry, we are. My apologies.

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1 was reinforced in the Long Term Workforce Plan.

2 As I say, I know we are continuing to make
3 progress but in terms of being able to give you exact
4 figures, I will undertake to make sure we come back to
5 you on that.

6 **Q.** Thanks. Just to clarify one point, when you say far
7 outstripped by demand, what period are you talking
8 about?

9 **A.** So post-pandemic particularly, we have seen an increase
10 in activity -- I'm thinking particularly of your
11 question about children and young people --

12 **Q.** Yes.

13 **A.** -- but the level of demand for new referrals into
14 services has gone up much more steeply. So that speaks
15 to your point about the impact of the pandemic on
16 children and young people's mental health but it is
17 also -- we've also seen a steep increase in demand for
18 adult services but it is particularly noticeable for
19 children and young people.

20 **Q.** Thank you.

21 And just in relation to those difficulties created
22 by asymmetries between demand and staffing capacity,
23 supply in particular, would you agree that a lack of
24 capacity on age-appropriate wards for children and young
25 people or local wards in children and young people's

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1 **LADY HALLETT:** It's not your fault, but I think we are
2 moving beyond Covid-19.

3 So thank you very much, Mr Pezzani.

4 **MR PEZZANI:** Thank you, my Lady.

5 **LADY HALLETT:** Ms Hannett.

6 Ms Hannett is behind ...

7 **Questions from MS HANNETT KC**

8 **MS HANNETT:** Good afternoon, Ms Pritchard, I ask questions
9 on behalf of the Long Covid groups.

10 May I start, please, by asking you a question
11 about the data on the impact of Long Covid on the
12 workforce. You explain in your witness statement that
13 the NHS workforce is its greatest asset and the Inquiry
14 has heard evidence from multiple sources, including
15 Professor Powis, of the ongoing and debilitating impact
16 that Long Covid has on the NHS workforce.

17 We know from minutes from a Long Covid oversight
18 board meeting in October 2021 by that point no specific
19 data relating to workforce absences due to Long Covid
20 was identified.

21 My question is, is NHS England collecting data now
22 on the number of healthcare workers, both clinical and
23 non-clinical, who are absent from work due to
24 Long Covid?

25 **A.** So the simple answer to your question, I'm afraid, is

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1 "no". But there is a process which is currently
2 underway to re-procure the electronic staff record
3 system which I think does give us a chance to look at
4 the sickness coding that is embedded in that system.
5 They've committed, the team who are doing it, which is
6 led by the BSA, but in partnership with NHS England and
7 many others, to have wide stakeholder involvement in
8 that process.

9 So, again, speaking personally, rather than on
10 behalf of the organisation, I think that is a very good
11 and important opportunity for us to look at making sure
12 we have got that coding in place.

13 **Q.** Yes, of course, because you said this morning that
14 Long Covid is really significant for both patients and
15 staff. And would you accept that in order to understand
16 the impact of Long Covid on the NHS workforce and to
17 ensure that there are adequate preventative and
18 protective measures in place, you do need to collect
19 that type of data?

20 **A.** Yes, so, again, I'm very aware that this is an area
21 where locally, if we asked every trust, I'm sure they
22 would be able to, through their occupational health
23 units, give us some very useful insight but it does feel
24 to me that that is a fairly obvious thing for us to try
25 and build into the next iteration of ESR, is an ability

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1 same territory, is that they have said there is
2 variation in what they're seeing across the country and
3 without wishing to pass at the moment any judgment
4 what's behind that, some of that might be good because
5 some local services may well have developed a more
6 sophisticated model that we would want to learn from and
7 spread; actually, some of it might not be, so there is
8 a stocktake going on at the moment looking at what is
9 happening across all of those Long Covid services.

10 **Q.** Thank you. Related, what has NHS England done to
11 increase public awareness of the availability of
12 Long Covid services?

13 **A.** So I suspect that that is, without again having the
14 absolute data in front of me, something that we wouldn't
15 really do as a national step. If it's about local
16 services and local service access, that would be done by
17 local commissioning teams working in partnership with
18 providers to make sure however they're communicating to
19 their local populations and patients is -- as well as,
20 of course, GPs and others who might be referring in to
21 the service -- is sufficiently clear.

22 **Q.** And would the stocktake you've just referred to be
23 a good opportunity to check that local Long Covid
24 services are communicating their existence appropriately
25 to their local population?

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1 to collect that data more easily nationally.

2 **Q.** Thank you, Ms Pritchard.

3 My next questions concern Long Covid services. You
4 wrote the foreword to the NHS priorities for 2022-2023
5 and that document recommends an increased number of
6 patients be referred into Long Covid services. Can
7 I ask, please, what NHS England has done to improve
8 rates of referral into the Long Covid services?

9 **A.** Yes, so I know you talked to Professor Powis in some
10 detail about Long Covid services which he's been
11 championing for some time, but the way that planning
12 guidance works is it is our, if you like, sort of, in
13 a non-pandemic context it's the way that we would
14 issue out to the NHS the priorities for the coming year
15 and the expectations, if you like, that government has
16 agreed with us that we're then translating into a set of
17 operational actions for the NHS. So everything that
18 goes into that is then followed up, sometimes very
19 intensively by support teams on the ground, sometimes by
20 data collection, sometimes by a mix of the two.

21 So in this case the Long Covid leadership team or
22 the team which have that in their portfolio, will be
23 keeping routinely an eye on what is going on and
24 actually what they have said subsequently, I think you
25 may have covered this so forgive me if I'm covering the

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1 **A.** That seems like a very good idea.

2 **Q.** Turning then, in terms of analysing the data from
3 Long Covid services, in Wales the Adferiad reports,
4 published every six months, give an analysed narrative
5 picture of Long Covid patients, and they analyse, for
6 example, the ethnic and social demographics impact of
7 Long Covid on the general quality of life.

8 Do you agree that a regular, detailed, analysed
9 picture of the data from Long Covid services would
10 assist NHS England in approving its Long Covid
11 healthcare?

12 **A.** It might. I think we would need to just look at what
13 that data is then used for and how that then feeds into
14 future commissioning or -- future commissioning
15 arrangements or plans for provision. I'm conscious that
16 we do run a range of national audits within England and
17 it may well be that that's something that would be
18 better seen, you know, as part of that more structured
19 audit programme, but I don't know enough about how they
20 do it in Wales probably to be able to say exactly what
21 model would work best.

22 I mean, certainly looking at the data, we have
23 teams at NHS England Professor Powis oversees who do
24 that and who are currently doing the stocktake, and I'm
25 certainly happy to say -- or to pass back that that

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1 might be a question again that we could ask that team to
2 pick up as part of that work.

3 **Q.** Yes, it's the regularity and the qualitative aspect of
4 it that's of concern to my clients certainly.

5 I'm grateful. Thank you, Ms Pritchard.

6 Thank you, my Lady.

7 **LADY HALLETT:** Thank you, Ms Hannett.

8 Mr Thomas.

9 Mr Thomas is over there, behind you again,
10 I'm afraid.

11 **Questions from PROFESSOR THOMAS KC**

12 **PROFESSOR THOMAS:** Good afternoon, Ms Pritchard.

13 I represent FEMHO, the Federation of Ethnic
14 Minority Healthcare Organisations.

15 In paragraph 164(c) of your statement, you mention
16 that NHS England's Chief People Officer convened
17 national meetings with black, Asian and minority ethnic
18 staff network leads and EDI leads across the NHS after
19 observing the disproportionate impact of Covid on these
20 communities.

21 Would you say that this engagement was a reactive
22 measure to the disproportionately high death rates or
23 was it part of a pre-existing strategic intervention
24 aimed at supporting ethnic minority staff. And if the
25 latter, if you're saying it was pre-existing, when were

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1 **A.** I don't know, is the honest answer to that. In my
2 National Incident Response Board we had an eye right
3 from the beginning about making sure we had diverse
4 representation, so not just only overly clinically
5 represented but making sure we were bringing into the
6 room that inequalities lens -- staff and equalities as
7 well as patient inequalities lens.

8 Do I think that made a difference in the response?
9 I think -- I mean, there are multiple factors,
10 including, I think, the speed with which it was spotted
11 that there was that disproportionate impact. And my
12 sense is that certainly Lord Stevens was very responsive
13 once he was made -- once it was drawn to his
14 attention -- he was the Chief Executive at the time --
15 in taking action.

16 As a broader point though, we absolutely see the
17 importance of representative and diverse leadership
18 within local bodies as well as national bodies and would
19 thoroughly support that. In fact, that is one of the
20 high impact actions that is in our equality and
21 diversity action plan that was published recently.

22 **Q.** Could I piggyback on what you've just said. How could
23 leadership diversity accelerate critical interventions
24 to protect these workers and can you suggest specific
25 measures to support a pipeline for ethnic minority

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1 these meetings planned?

2 **A.** So I believe that this particular meeting was part of
3 the work of the workforce -- sorry, the cell that had
4 been set up following a meeting which I think
5 Lord Stevens had had earlier in April which had then led
6 to him commissioning the Chief People Officer to lead
7 some work, which I think then meant that meeting you've
8 referred to I think -- as you say, it's 30 April, was
9 then part of the action that was taken by her in her
10 capacity leading the cell. So I think that's -- as
11 a specific action it was part of that work, but she was
12 already leading for NHS England on staff inequalities,
13 so things like the race equality scheme, the disability
14 scheme and a whole range of other actions and activities
15 that were -- taken nationally, were already part of her
16 portfolio.

17 So in her job that wasn't pandemic-related, she
18 would have been in, you know, regular contact with
19 leaders from staff networks, not just race but more
20 broadly as well.

21 **Q.** Let's stay on leadership representation. Would you
22 agree that having more black, Asian and minority ethnic
23 leaders in senior positions would probably have
24 influenced a response to the adverse outcomes
25 experienced by ethnic minority healthcare workers?

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1 leaders within the NHS?

2 **A.** So -- sorry, I've realised I'm looking in the wrong
3 direction, so I'm going to turn --

4 **Q.** You are still speaking in the microphone --

5 **LADY HALLETT:** There's a microphone to your right, so as
6 long as you --

7 **A.** Fine, okay, in that case I'll carry on looking this way.

8 So there is a -- I think you've perhaps -- tell me
9 if I've misunderstood the question, but there are,
10 I think --

11 **PROFESSOR THOMAS:** Do you want me to repeat the question?

12 **A.** -- two parts. So one of your questions -- one part
13 I think is pandemic-specific and then one part is future
14 focused.

15 So in terms of the pandemic, one of the things
16 that we heard pretty clearly in that summer period
17 in 2020 was that the risk assessment process was both
18 too slow and, in some cases, not resulting in
19 follow-through that was necessary to respond to the
20 things that have been identified in the risk
21 assessments.

22 So, again, I don't think I could say whether more
23 diverse leadership would have made the difference or
24 not. We haven't done enough systematic analysis of
25 where was doing it well and where wasn't. But there was

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1 certainly a need for us, I think from a national
2 perspective, to make sure that we were both very clear
3 about the importance of that risk assessment process but
4 also that we had provided the right guidance and
5 follow-through on what a good process looked like.

6 So in the end we actually set up a unit
7 nationally, again under the Chief People Officer's
8 leadership, to really support and get stuck in for
9 places that seemed to be finding it more difficult to
10 do, and that did lead to, I think, significant
11 improvement in certainly the number of risk assessments
12 that were undertaken.

13 On your point about sort of future pipeline, I'm
14 sort of -- I suppose both pre-pandemic, during the
15 pandemic and subsequently, we have a lot of different
16 work going on around equality diversity inclusion in
17 the NHS but one of those specific streamed themes is
18 around leadership and the pipeline developing future
19 leaders. So the talent management programmes that exist
20 in the NHS at the moment are oriented in that direction.
21 Certainly if we think about things like the aspiring
22 chief executive programmes, that's one of the things
23 that's explicitly considered. And indeed, as I say,
24 it's something that I've certainly given a lot of
25 thought to personally.

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1 that allow us to collate local data into a national view
2 at speed. I think that will be one of the things,
3 again, I've already said, I think for a future pandemic
4 that will be really useful.

5 But the early indication that there was
6 disproportionate impact on certain groups, actually the
7 initial thinking I know from scientists and from the
8 medical profession was pointing towards older people and
9 people with significant underlying health conditions,
10 including, for example, diabetes, so I think it's
11 probably fair to say the data originally pointed in that
12 direction, and then it was a few weeks later that it
13 became clearer that actually there was a real signal in
14 the data.

15 I don't think that was so much so from staff data,
16 I think that was coming more from the overall population
17 data that was suggesting there was a disproportionate
18 impact on people from black, Asian or ethnic minorities.

19 **Q.** The short point though. When that data was coming
20 through, the NHS moved a little slow; would you not
21 agree?

22 **A.** Well, I think Simon Stevens' meeting was 15 April, so if
23 we think about the sort of speed with which this was all
24 happening, the cell, I think was set up the following
25 day and then there's a whole set of actions that follow

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1 But the high impact actions that are set out in
2 our equality diversity action plan, they are about
3 making things different in a very practical way, and
4 that's the set of things that I signed up to, along with
5 our current lead for workforce training and education,
6 as being the important things that we are expecting not
7 just our own organisation but the whole of the NHS in
8 England to adopt and to deliver.

9 **Q.** I want to move on because I'm conscious of time. I want
10 to turn to timeliness of data collection.

11 Can we agree this, can we agree that if the
12 ethnic-specific data had been collated and collected
13 sooner, NHS leadership might have been able to respond
14 more swiftly, differently, systematically, to protect
15 minority ethnic healthcare workers? Can we agree on
16 that?

17 **A.** In what regard? Do you mean in relation to staff
18 deaths?

19 **Q.** Yes, and not just staff deaths, in terms of the impact
20 of Covid on staff, whether that be illnesses or death.

21 **A.** So I think we moved really quite quickly, I know we've
22 talked about it already, to stand up new data
23 collections, because there did have to be new, partly
24 because we didn't have -- we don't have -- it's much
25 better now and needs to continue to develop -- systems

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1 from it. So we had both, I think, written into the
2 29th April letter that expectation of risk assessment
3 and a clear signal about the fact that the data was now
4 saying that there looked like there was
5 a disproportionate impact, and we then had -- "then had"
6 is not quite right, but we had another programme of work
7 that was looking at the disproportionate impact on
8 patients and on communities also then feeding into
9 a whole set of actions that were written into future
10 asks of the NHS to adapt services to make sure it was
11 responsive.

12 **Q.** A couple more questions, and I want to take these
13 swiftly, if I may. When data on ethnicity had begun to
14 be gathered, how was this data used in NHS performance
15 monitoring and response efforts during the pandemic and
16 would you agree it made a difference when you started to
17 use the data?

18 **A.** Do you mean in relation to risk assessment?

19 **Q.** Yes, and the impact of the virus on ethnic minority
20 groups?

21 **A.** So yes, the point -- so, I think I've perhaps already
22 covered this a little bit when it became clear, as
23 I say, that we needed to ensure that risk assessment was
24 taking place, it was slower to get off the ground from
25 that sort of April 29 period and then we write again,

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1 I think on 24 June, and then there's the unit set up at
2 the beginning -- 5 July, to help support the delivery of
3 risk assessment across the NHS and, looking at the
4 compliance rate, it does get much better after July but
5 it has taken, I think we would all accept, too long to
6 get that in place.

7 So certainly, I think it was -- a learning point
8 for the future is that as soon as data becomes available
9 that tells us which particular new version of a pandemic
10 is going -- what it is going to do, then the ability to
11 react at pace and to have data systems around, that is
12 really important.

13 **Q.** I think we're agreed on this. Let me come onto -- I'm
14 nearly there. You refer to socioeconomic factors and
15 the role of multi-generational households in certain
16 regions as contributing to higher Covid rates among
17 ethnic minorities. How were these additional risk
18 factors captured in the NHS data collection efforts?

19 **A.** I don't think there was a mechanism of capturing that
20 data. What we did do was look at deprivation data which
21 isn't -- it's not -- it's a proxy, it can't give you the
22 whole story, but we were certainly seeing across the NHS
23 that those people who lived in more deprived communities
24 where there isn't a direct but there can be
25 a correlation with, then, poorer housing stock but also

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1 those who were disproportionately impacted, that was the
2 focus of my question. And minority ethnic healthcare
3 workers were disproportionately impacted. That's the
4 point.

5 **A.** Yes, and I suppose what I'm responding to is just
6 a recognition that all of our -- well, you can argue --
7 I'm taking the opportunity to say it because I don't
8 feel I have yet, but just to make sure we don't only
9 talk about doctors and nurses when we talk about --

10 **Q.** No, I understand that.

11 **A.** -- the things that colleagues did through the pandemic
12 but also acknowledging that actually making sure that as
13 an employer we are embracing what is a huge strength,
14 which is the diversity of our workforce, but also
15 recognising that actually the experience of our
16 workforce is not uniform -- in different places, in
17 different roles, but also where you have particular
18 issues that we must address for those --

19 (Unclear: multiple speakers)

20 **LADY HALLETT:** Thank you, Mr Thomas.

21 **PROFESSOR THOMAS:** Thank you, my Lady.

22 **LADY HALLETT:** Ms Pritchard, it's getting pretty late. It's
23 probably feeling pretty for you but it is just that they
24 have limited time.

25 **A.** I'm sorry.

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1 with -- actually, we should be clear, urban areas as
2 well. So there were other bits of data that were
3 becoming available that were certainly giving a sense of
4 where the greatest risks seem to lie.

5 **Q.** Finally this, and I'm just trying to wrap up and I want
6 to be forward thinking for the Inquiry. Given the
7 disproportionate impact of Covid on ethnic minority
8 workers and recognising the historic and structural
9 challenges they face, would you agree that this
10 experience has underscored the need for deeper
11 structural changes within the NHS to address
12 long-standing inequalities? Would you agree with that?

13 **A.** I absolutely agree that we need to continue to do -- do
14 you know what? Let me start again. I agree we need to
15 do more. And it has never, I think, been highlighted as
16 obviously as through Covid the importance of the
17 contribution all of our staff make to the NHS and our
18 absolute reliance on the people who do every job.
19 I haven't talked about it today but the work of our
20 engineering teams, the work of our estates teams, the
21 work of our porters, but the point for me is simple, if
22 you work for the NHS you have to feel fully valued by
23 the NHS and we need to do more to make that --
24 (Unclear: multiple speakers).

25 **Q.** Yes, I understand that, Ms Pritchard, but the point is

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1 **LADY HALLETT:** The advocates have sometimes quite -- very
2 restricted time, so if you could keep your answers
3 short, I know they would be very grateful.

4 **A.** Sorry.

5 **LADY HALLETT:** They don't like me jumping in.
6 Mr Jacobs.

Questions from MR JACOBS

8 **MR JACOBS:** Ms Pritchard, I have some questions on behalf of
9 the Trades Union Congress on a similar theme to
10 Mr Thomas.

11 Questions on the position of those healthcare
12 workers who work in outsourced services. Does
13 NHS England hold data on the proportion of staff in
14 outsourced services who belong to black, Asian, and
15 minority ethnic groups.

16 **A.** We don't hold data on outsourced staff.

17 **Q.** Does it not need to in order to consider the potentially
18 significant equality implications of commissioning
19 services in that way?

20 **A.** So we don't actually hold data. When I say we don't
21 hold data, I mean we don't hold any data on staff who
22 are employed by third-party outsourced providers.

23 So the way that it works at the moment is
24 NHS England as a sort of overarching commissioner passes
25 resource down through what were CCGs, are now ICBs, to

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1 local employers who then determine how they spend it.
 2 So the responsibility sits with the local employer, so
 3 if that's the trust, to make sure that then in their
 4 contract management, if you like, with the provider of,
 5 it's often hard or soft facility management services,
 6 that they are then working with that provider to ensure
 7 that the appropriate data but also the appropriate
 8 actions are taken.

9 **Q.** So that's at a lower level. So do we take from your
 10 answer that NHS England actually didn't see itself as
 11 having a role in terms of considering the equality
 12 implications of delivering some healthcare services
 13 through outsourced services?

14 **A.** So I think, just to be clear, I guess what I'm saying is
 15 we collect data on people who are NHS employees. So
 16 that, by its very nature, is never going to be a full
 17 picture of all of the colleagues across the country who
 18 are involved in healthcare services.

19 **Q.** I think that's an answer to a different question. The
 20 question is: does NHS England consider that it has
 21 a role in considering the equality implications of
 22 delivering certain healthcare services through
 23 outsourced services?

24 **A.** So we have an -- there are a set of things we are
 25 responsible for including quality -- actually, we're not
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1 compound some pre-existing inequalities. The Inquiry
 2 has heard accounts of workers have less access to sick
 3 pay, being less able to raise concerns, lower priority
 4 for PPE and so on.

5 Does NHS England share a concern that the
 6 conditions of those in outsource work is such as to
 7 compound pre-existing inequalities?

8 **A.** So I have personal experience of working in trusts with
 9 outsourced providers and insourced, and what I can say
 10 is they can both work really well and they can both work
 11 less well. So where a trust takes its responsibilities
 12 for working in partnership with but through
 13 a contractual arrangement with an outsourced provider
 14 and, you know, as where I used to work, which was not
 15 Guy's and St Thomas', somewhere else, did and that
 16 leadership team is part of the trust leadership team but
 17 it is absolutely -- staff are treated exactly as if they
 18 were members of the NHS workforce because they are, in
 19 practice, of course, members of that wider NHS family,
 20 it can work really well. And, actually, can work, you
 21 know, I could argue even better sometimes than the NHS
 22 trying to do it for itself because you often have people
 23 who have real genuine expertise in running those
 24 services and can be much more responsive to the needs of
 25 their staff. Equally, it can work badly.
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1 the quality monitor, that's the CQC. There is a set of
 2 things NHS England is responsible for in commissioning
 3 and then the follow-through to ensure that
 4 the commissioning is being done well and services are
 5 being provided as per expectations. So if a local
 6 employer has chosen to outsource a service, they're
 7 still responsible for the quality of the provision of
 8 that service --

9 **Q.** If I understand correctly, your answer is that the local
 10 employer is responsible for considering equality
 11 implications not NHS England?

12 **A.** But not in a different sense than in a sense for any
 13 other -- so we're not responsible for the provision of
 14 community pharmacy services or optometry services.

15 **Q.** Understood.

16 **A.** And nor are we responsible for the provision of services
 17 by voluntary sector partners, but we are responsible for
 18 setting standards that we then expect to be delivered
 19 through whether it is a contract mechanism or it's
 20 a direct employment mechanism.

21 **Q.** Yes. The Inquiry has heard evidence from those, for
 22 example, who talk about the importance of reducing
 23 precariousness of work, in reducing inequality of
 24 impact. My client and others are concerned about
 25 working conditions in outsource services that may
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1 So if your question is, which I don't know if it
 2 is, but it's something I've reflected on, should we
 3 have --

4 **Q.** Let me ask a follow-up question.

5 **A.** Yes, sorry.

6 **Q.** We have your personal experience that it can work well,
 7 it can work badly. We've certainly had personal
 8 experiences before the Inquiry of it working badly.
 9 Does NHS England not need to do some work, particularly
 10 with this concern about disproportionate impact, on
 11 truly looking at this issue and trying to understand it
 12 and trying to understand whether this is one area in
 13 which there needs to be some change?

14 **A.** So thank you for the question. And I have thought about
 15 this because I read the evidence given by previous
 16 witnesses on it. And on reflection I do think we should
 17 have been clearer about the expectation that everything
 18 that we were pushing out as guidance or as asked of --
 19 into the NHS, we should have been explicitly clearer
 20 that that needed to apply to outsourced staff.

21 So thinking about, say, risk assessment I now
 22 think we had taken the normal way of working as being
 23 the normal way of working and, actually, in a pandemic
 24 situation there is probably a need for greater clarity
 25 of expectations and that would be one of the points of
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1 learning I would take into a future pandemic.
 2 **Q.** And just finally, you said a moment ago if you work for
 3 the NHS you need to feel fully valued. Is NHS England
 4 confident that outsourced healthcare workers feel fully
 5 valued?

6 **A.** Well, that -- I am not confident at the moment that we
 7 are doing collectively as the NHS, as I just said to
 8 your colleague, enough to ensure that all our staff feel
 9 equally valued. So, again, I don't want to
 10 inappropriately suggest that's something that
 11 NHS England can fix because ultimately it has to be for
 12 local employers to lead, but can we support both in
 13 relation to NHS -- people in NHS contracts and with
 14 clear expectations about outsourced staff, I think
 15 we can.

16 **MR JACOBS:** Thank you.

17 Thank you, my Lady.

18 **LADY HALLETT:** Thank you, Mr Jacobs.

19 Ms Stone, I am sorry you have come at the very end
 20 of a long day. I would be grateful if you could focus
 21 on the main issues you wish to highlight.

22 **MS STONE:** My Lady, yes, I am conscious of the time, thank
 23 you.

24 Questions from MS STONE

25 **MS STONE:** Good afternoon, Ms Pritchard, I ask questions on
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1 still be in hospital but only those people who were
 2 medically fit to leave, so shouldn't have been needing
 3 to be in an acute environment.

4 The follow-up on quality was a couple of things.
 5 So there was monitoring going on through our National
 6 Incident Response Board, through very regular feedback
 7 on numbers but also feeding in the experience that was
 8 being relayed to us by partners in local government, by
 9 experience of local ICBs and trusts feeding back, but
 10 also, and this is the final bit of it, we were looking
 11 at readmission data, which is only a crude tool because,
 12 obviously, bearing in mind there were loads of other
 13 factors that can affect readmission, I wouldn't want to
 14 over-rely on it, but that did show, over the period,
 15 that readmission rates went up by 1%.

16 What we couldn't do is disaggregate from that how
 17 much of that was people catching Covid or other things
 18 going on that meant that they came back. But it was
 19 nonetheless just a sort of helpful additional piece of
 20 data to allow us to just keep an eye on whether or not
 21 this was leading to unintended consequences about people
 22 then needing to come back into hospital.

23 **Q.** And was there official review of that question, that
 24 exact question, ie are there unintended consequences?

25 **A.** On readmission rates?

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1 behalf of Covid-19 Bereaved Families for Justice UK, and
 2 two short topics, if I may, please.

3 The first relates to discharge from hospital
 4 during the pandemic. You told us about steps taken to
 5 promote discharge of medically fit patients during the
 6 course of the pandemic for reasons you explained and
 7 that we understand. It's an obvious point but it needs
 8 to be appropriate discharge because of the risks to
 9 patients associated with inappropriate discharge.

10 Can you tell us what additional measures
 11 NHS England introduced to ensure that the risk of
 12 inappropriate discharge was addressed, including
 13 monitoring and evaluation of discharge processes?

14 **A.** Yes, you're completely right to say that it must be
 15 appropriate discharge. So, I think it's probably worth
 16 saying that's why the guidance, which the Department of
 17 Health led on but we were absolutely co-signatories to,
 18 was very clear about the expectations around what good
 19 discharge would look like and it was based on, as I said
 20 earlier, the existing best practice but with
 21 an expectation that that would then be something that
 22 would be both enabled by those policy decisions that
 23 they made but implemented locally, and one of the things
 24 that I think we were, again, very clear about was this
 25 was focused not on people who had any medical reason to

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1 **Q.** Just generally. Of are there unintended consequences of
 2 the enhanced focus on discharge?

3 **A.** I'm not aware -- I mean, I'm sure there is, but I'm not
 4 aware of any research -- specific research that's been
 5 done -- sort of third party research on this.

6 We produced within NHS England our sort of own
 7 analysis of what had happened and did a learning report
 8 which I referred to earlier, which was one of the things
 9 that led to that conclusion about the number of beds,
 10 staff, and also that had been released through the
 11 measure but also the feedback about the discharge to
 12 assess model being the one that was preferred from both
 13 social care colleagues and also from the feedback that
 14 we were getting from the front line. But I suspect
 15 there are more independent sources of research which I'm
 16 not familiar with.

17 **Q.** And I think the report that you referred to earlier,
 18 you've just re-referred to it, that didn't specifically
 19 address, I don't think, correct me if I'm wrong, the
 20 question of inappropriate discharge?

21 **A.** Not on a sort of -- do you mean on an individual --
 22 sorry?

23 **Q.** Did you, NHS England, look at whether there was any
 24 adverse outcome, unintended outcome -- I can't remember
 25 the phrase that you used -- arising from the focus on

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1 discharge and, specifically, inappropriate discharge
 2 arising from that focus?
 3 **A.** Right, okay. So not in the sense that we were
 4 explicitly, I think, looking at -- so we didn't do any
 5 work to say: were people who were not medically fit for
 6 discharge discharged? And I hope -- so all of our
 7 analysis was based on, if you like, the local analysis
 8 which categorised patients as being medically fit for
 9 discharge.
 10 **Q.** Yes.
 11 **A.** So I don't think there was an audit done of whether that
 12 categorisation was appropriate. But of that group that
 13 were medically fit for discharge, that's where our -- so
 14 that is the bit that we then -- our analysis was based
 15 on, I suppose, that initial categorisation being
 16 appropriate.
 17 **Q.** And are you aware whether concerns have been raised with
 18 NHS England about the emphasis on discharge leading to
 19 inappropriate discharge?
 20 **A.** We didn't have concerns raised. To my knowledge.
 21 **Q.** Second topic, please, is the EPRR framework that you --
 22 **A.** I'm so sorry, I should have said I am conscious that
 23 we're not talking about discharge to care homes at this
 24 point though, are we? Because clearly there's a whole
 25 set of conversations about discharge to care homes, if
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1 about discharge to my knowledge, I am talking discharge
 2 to assess. So that is not including care home
 3 discharge, where I think there was -- there is, I know,
 4 a whole separate module that will focus on that, amongst
 5 other things.
 6 **Q.** So, just so that we're clear, your evidence is that, to
 7 your knowledge, there were no concerns raised about
 8 discharge to assess --
 9 **A.** Not as a policy, no.
 10 **Q.** -- during the pandemic; is that correct?
 11 **A.** No. There were definitely, and continue to be,
 12 individual examples of where discharge not go as well as
 13 it should do, but, in terms of a concern about that
 14 policy being moved to, that wasn't something that was
 15 raised, to my knowledge.
 16 **Q.** But there were concerns raised about examples of
 17 discharge that didn't go as it should have done which we
 18 might refer to as inappropriate discharge?
 19 **A.** I think there were -- well, so there were examples --
 20 I'm actually not sure I would use "inappropriate", but
 21 what I would say is there were certainly examples of
 22 where things like communication wasn't quite good enough
 23 or people felt they weren't, you know, quite clear about
 24 exactly that the arrangements were for who was going to
 25 come in to provide what care when. I mean, not outside
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1 you're asking about --
 2 **Q.** Yes, so there would be specific concerns and I think
 3 the Inquiry is well aware of --
 4 **LADY HALLETT:** That's a different module, you're absolutely
 5 right.
 6 **A.** Right, fine. That's just -- so I'm conscious I haven't
 7 answered that question. I was answering a slightly
 8 different question.
 9 **MS STONE:** Inappropriate in broad terms is what I was
 10 referring to for the purposes of that question.
 11 Moving on to the EPRR framework, please. You've
 12 told us it's recently been updated, this year. I just
 13 wanted to ask you about one aspect you refer to in your
 14 statement and that's health inequalities, please.
 15 At paragraph 182 of your second statement you
 16 note, Ms Pritchard, that the EPRR framework has been
 17 updated to confirm that specific guidance on managing
 18 health inequalities during a major incident is being
 19 developed and will be published in due course.
 20 So, do we infer from that that that specific
 21 guidance did not exist as we went into the pandemic?
 22 **A.** That is correct. There was no specific guidance on
 23 health inequalities. I know you want to move on but can
 24 I, just for the record, because I'm conscious this is
 25 formal, say when I said there were not concerns raised
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1 the -- I mean, I hate to say it, but sort of not outside
 2 the usual type of things that can not go as well as we
 3 would want them to from a discharge perspective, and
 4 certainly the speed with which some of the discharges
 5 were -- they were medically fit, they were delayed, they
 6 were expecting to leave hospital, but perhaps not quite
 7 as fast as they had previously thought. And I think
 8 that no doubt did create some pressure on the system, so
 9 drawing distinction between concerns about the policy,
 10 individual examples where -- you know, clearly, things,
 11 even today, don't always go as smoothly as we would
 12 want, and then a specific set of issues around care
 13 homes, which we haven't really talked about today.
 14 **Q.** I think that's understood, Ms Pritchard.
 15 Just coming back, please, to the EPRR framework.
 16 **A.** Oh, yes. So, no, there wasn't a specific --
 17 **Q.** That didn't exist as we went into the pandemic.
 18 Given that the scale and severity of health
 19 inequalities in the UK as a whole, and England in
 20 particular, were well-known, as was the likelihood of
 21 those inequalities being exacerbated in a major
 22 incident, and particularly a pandemic, shouldn't that
 23 specific guidance have already been in place as we went
 24 into the Covid pandemic in 2020?
 25 **A.** Back to what I feel I've -- apologies, but sort of said
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1 a couple of times, which is just -- so the EPR framework
 2 is effectively a sort of set of action cards of things
 3 to think about, and then it's adapted to the specific
 4 circumstances.
 5 So there was a huge amount of work going on
 6 pre-pandemic about reducing healthcare inequalities.
 7 It's written into the long-term plan, published in 2019,
 8 and there's a number of very specific programmes as well
 9 as a general focus. And in fact where we are now with
 10 the creation of ICBs and ICSs is -- actually at the very
 11 heart of that, that way of working is the partnership
 12 between local government, the NHS, voluntary sector,
 13 patients themselves, in order to address healthcare
 14 inequalities, amongst a range of other things.
 15 So should there have been a specific EPR framework
 16 that addressed healthcare inequalities? Well, I think
 17 that is definitely one of the bits of learning from the
 18 pandemic, which means we will now have one in the
 19 future. But it was, I think, something that, again,
 20 we've -- we've talked before about a flu -- you know,
 21 the planning was based largely on a flu pandemic in the
 22 past, and I think those shortcomings have been
 23 identified through previous modules.
 24 **LADY HALLETT:** I'm afraid it's not your fault, Ms Stone, but
 25 we have to leave it there, but given that I've given you
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1 permission for the questions, if any of the questions
 2 you haven't had the time to ask are ones upon which
 3 you'd like an answer, we'll ask Ms Pritchard to give us
 4 a written answer.
 5 **MS STONE:** I'd be grateful for that opportunity.
 6 Thank you, my Lady.
 7 **LADY HALLETT:** I hope that completes then the questioning.
 8 Sorry it's been such a long day for you.
 9 I don't know if you realise that a team at NHS,
 10 who have been helping us -- this is the statements from
 11 you and Sir Stephen. You probably saw me refer to them
 12 this morning. Anyway, thank you. I don't know how much
 13 you have been involved in getting the team together to
 14 answer all our questions and to provide help to the
 15 Inquiry, but I'm very grateful for all that your team
 16 have done, and obviously that you have done too. Thank
 17 you for your help.
 18 **THE WITNESS:** Thank you, my Lady.
 19 **LADY HALLETT:** Very well. 10 o'clock tomorrow, please.
 20 **(The witness withdrew)**
 21 **(4.54 pm)**
 22 **(The hearing adjourned until 10.00 am**
 23 **on Tuesday, 12 November 2024)**
 24
 25

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