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

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.

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,

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

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

MR JORY: Thank you, Professor.

Thank you, my Lady, those are my questions.

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

Now I think we have Mr Wagner over there.

Questions from MR WAGNER

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

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

It's INQ000485652_323. Thank you.

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

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

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

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

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

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

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

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

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

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

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

So I think there are multiple reasons.

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

come to appointments.

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

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

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

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

patients, staff and the public.

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

MR WAGNER: Thank you.

LADY HALLETT: Thank you, Mr Wagner.

Mr Wolfe, who I think is behind the pillar.

Questions from MR WOLFE KC

MR WOLFE: My Lady.

Good morning, Professor Powis.

A. Good morning.

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

At paragraph 53 of your witness statement you talk about the way in which NHS England had regular forums with the BMA, the royal colleges and medical providers. Can I just ask you about that. To what extent did

consultation with patients and potentially their families feed into those conversations with the BMA and others?

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

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

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

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

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

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

Q. So my further questions are about visitor guidance which you talked about to some extent on Thursday. Paragraph 240 of your witness statement, you recognise that it can be more difficult to provide compassionate one-to-one care and detect signs of deterioration in the condition of a patient when there are no family members

around. And my clients would agree with that.

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

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

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

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

as we possibly can.
Q. So, again, in terms of that evolving flexibility to what extent was that flexibility, not just about patients and families, but also about the reduced strain on staff and the benefits that that would bring for the NHS itself?
A. Yes, and I think you have heard that in some of the evidence that the Inquiry has been presented with. Again, a balance. Absolutely, for many staff the strain and the trauma of having to look after patients without the benefit of having close family and relatives to aid in that was really challenging but at the same time staff were really worried about spread of infection, they were really worried about catching Covid themselves and about people that they cared for who didn't have Covid and, of course, visitors and others catching Covid.

So I think there was stress on, you know, in both those areas, so staff felt a huge amount of stress about a lot of things, and one of those things that is difficult to reconcile and I think as one of the witnesses who has given evidence said previously, it would have been almost impossible to come up with visitor guidance that would have satisfied everybody's concerns equally.
Q. Final thought. In that evolving flexibility, do you not

think it would have been helpful to make the specific point that the local trust policies needed to look at the balance for the individual patient? This wasn't just a generic flexibility it was about looking at risks and benefits for individual patients, whether a human rights focus or a public sector equality duty focus or simply an NHS good practice focus?
A. I think that was implicit in the guidance but perhaps it might have been more explicit.
MR WOLFE: Thank you, Chair.

Thank you, Professor Powis.
LADY HALLETT: Thank you, Mr Wolfe.

Mr Stanton.

Mr Stanton is behind you.

Questions from MR STANTON

MR STANTON: I ask questions on behalf of the BMA. The first question I have is in the area of NHS resilience. You refer to resilience challenges within your statement, including that these challenges not only affected the ability to respond to the pandemic but also the ability to recover from it, and you made some recommendations within your evidence last week about the need for more capital investment and more staff.

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

on healthcare workers, such as burnouts and Long Covid, are a continuing barrier to the NHS recovery and, therefore, to its resilience.
A. Thank you very much. And yes, I absolutely agree that we have that ongoing impact of the pandemic and that our staff, even though it's now nearly five years since the start of the pandemic, though are still struggling and remembering the impact of those waves and the moral injury that we know they suffered. Which is why, of course, we have continued to maintain a focus on health and well-being, why we continue to give as much support as possible and encourage local organisations who were at the front of this, at the front-facing part of this, to support their employers. Why, for instance, you will have seen an emphasis, to give one example, in resident doctors, our doctors in training and other doctors, to help employers do as much as possible to provide the support that means that they are feeling satisfied in their work, enjoying the work they do.

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

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

Please can I ask you at what point did you become aware that healthcare workers were experiencing a higher prevalence of Long Covid than in the general population?
A. So I can't remember exactly but it would have been pretty early on. And to an extent it would not have been unexpected because we knew that healthcare workers were one of the groups that were experiencing a high rate of infection per se and therefore it would be logical that, unfortunately, they would also experience a higher rate of Long Covid.
Q. Thank you, Professor.

Final question, still on the issue of workforce. You have indicated that even in circumstances where we are able to increase the number of staff within the NHS, there will always be a need for surge capacity to deal with a pandemic. And in this respect the Inquiry has been provided with evidence that has indicated that the

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

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

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

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

MR STANTON: Thank you, Professor.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Stanton.

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

Questions from PROFESSOR THOMAS KC

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

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

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

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

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

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

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

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

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

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

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

PROFESSOR THOMAS: Can I pause here.

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

stand in a moment.

(2 minutes of silence observed)

LADY HALLETT: Mr Thomas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you, Mr Thomas.

Mr Burton.

Mr Burton is over there.

Questions from MR BURTON KC

MR BURTON: Thank you, my Lady.

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

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

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

about issues as important as DNACPRs.

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

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

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

Q. Thank you very much, Professor.

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

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

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

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

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

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

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

LADY HALLETT: Thank you, Mr Burton.

Ms Alexis, who's just behind you.

Questions from MS ALEXIS

MS ALEXIS: Thank you, my Lady.

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

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

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

MS ALEXIS: Thank you, my Lady.

LADY HALLETT: Thank you.

Ms Stone.

Ms Stone is just there.

Questions from MS STONE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you, Ms Stone.

Ms Hannett.

Questions from MS HANNETT KC

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

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

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

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

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

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

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

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

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

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

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

public information on Long Covid via the NHS website?

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

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

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

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

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

A. I can't give you a specific answer. I would need to write to the Inquiry on that point but in principle we do aim to update our websites to ensure that they are up to date with the evidence and contemporaneous and of course I would -- you would expect me to agree that that would be a really important thing to do.
MS HANNETT: Thank you, Professor.
Thank you, my Lady.
LADY HALLETT: Thank you, Ms Hannett. I think we'll break now.
I think that completes the questions for you, Sir Stephen. Thank you very much indeed for your assistance. I'm not sure I'm going to thank you for whoever in your office produced such lengthy statements, but I promise to ensure that all material is taken into consideration, obviously the oral evidence and the written, but that file contains statements from you and Ms Pritchard, so you have given us quite a lot of material. And I do understand the burden we've placed on you.
THE WITNESS: I hope they will be useful.
LADY HALLETT: Thank you very much for your help.
THE WITNESS: Thank you.
(The witness withdrew)
LADY HALLETT: I shall return at 11.55.

(11.39 am)
(A short break)
(11.55 am)
LADY HALLETT: Ms Carey.
MS CAREY: The first witness, please, I'm going to call today is Ms Amanda Pritchard.
MS AMANDA PRITCHARD (sworn)
Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3
MS CAREY: Ms Pritchard, your full name, please.
A. Amanda Kate Pritchard.
Q. I think you have in front of you two witness statements that you've made, both dated 16 January of this year. INQ000409250, which is 120 pages long, and INQ000409251, which is 353 pages long.
I'm going to start with a little background to you, NHS England itself, and then delve into some detail dealing with the pandemic.
May I start with you, please.
Is it right that you joined the NHS management training scheme in 1997 and have held a range of roles within the NHS since that date?
A. That is correct.
Q. I think it's right that you have no clinical experience yourself. You were the Chief Executive Officer during the pandemic of NHS England -- sorry, the

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

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

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

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

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

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

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

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

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

So, on any view, significant pressures on the NHS in England around winter 2020 into 2021, and we're going to look at some of those pressures in more detail. That's just as an overview.

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

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

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

A. That's correct.

Q. It does not set the health policy.

A. That's correct.

Q. And it does not provide patient services itself?

A. Yes, that's correct.

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

A. Yes, that's exactly right.

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

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

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

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

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

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

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

Q. Right.

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

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

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

because of those pressures.
Q. Can I ask you about primary care, because in your statement at paragraph 249 you say that:
"Primary care has seen a gradual reduction in the number of full-time equivalent GPs per patient, as part-time working and early retirements offset increased recruitment of young doctors into GP training."
Demand has increased with numbers of registering in practices.
So do I take it there that there has been a fall in GPs numbers?
A. So the overall number of GPs is now actually rising again but the point is an important one which is that the more experienced, often partners, as they are retiring newer-trained GPs are joining the workforce but they're often joining in a way that is more, you know, reflective of local -- of personal circumstances which means it's more part-time. At the same time the needs of the population are rising and the number of the population is rising so the numbers mean certainly that you would, as a, kind of, GP, be feeling a great deal of pressure on your work right now.
Q. Can I ask you this. Just stand back for a moment from -- and take the mergers out of it for one second. Has NHS England got any sense of the impact of the

pandemic on numbers of staff who have burnt out, left through stress and the like? Are you able to give us an overview at the outset of what kind of impact the pandemic has had on your staff availability?
A. Yes, we've got -- two things have happened that are really noticeable since the pandemic. One is actually we have a lot more staff than we had pre-pandemic and that was partly because there was, I think, so much of that sense that NHS staff have of the vocation being about wanting to make a difference that many staff who might have otherwise retired, stayed on a bit and there was a real surge in the number of people applying to become nurses, doctors, et cetera, which has begun to flow through to the workforce. So we have about 70,000 more staff now than we did.
The big "however" is that we are, though, still running at a higher rate of sickness than we were pre-pandemic. So that has -- it went up a lot during the pandemic, partly driven, of course, by Covid infection. It has come down since then but it is still higher than it was and the main, sort of, single reason people are off sick, actually was pre-pandemic and still is now, mental ill health, anxiety, depression, stress.
Q. We're going to look at some of the figures a little later on in your evidence but that's helpful as a sort

of starting point, if I can put it like that.
And that really brings me on to the resilience of the NHS pre-pandemic and I think you have set out, if it helps you, Ms Pritchard, at paragraph 197 onwards, the definition in the EPRR framework of resilience and it might be useful to up on screen, please, page 52, paragraphs 197 and 198.
But there we can see reference to the 2015 EPRR framework which define resilience as "the ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges".
And then a little more detail given to that in paragraph 198, "withstand, handle and recover" requires a stable platform, ideally headroom or the means to create headroom.
And there can be no two ways about it, Ms Pritchard, is this right, that entering into the pandemic, the NHS had historically low bed numbers? Is that right?
A. Yes.
Q. High bed occupancy levels particularly when compared with other G7 and European countries. And was it your assessment that coming into 2020, therefore, there was little flexibility in the existing capacity to respond

to a rapid and significant surge in demand?
A. Yes, that's right and I know this Inquiry in previous modules has very helpfully gone into this in some detail but the NHS was running at a very high level of occupancy, so there were real pressures pre-pandemic and I think certainly the challenge of not having that headroom, which is described in this section of my statement, meant that there were certain consequences to how we had to respond in a pandemic that did make it particularly challenging.
Q. May I put it in this way, and please correct me if you think I'm wrong. Everyone had to surge during the pandemic but it's a question how much you had to surge and as far as the NHS is concerned, because of those low numbers, it had to surge even greater?
A. Yes, and also how quickly you got into surge territory. So I think the thing that perhaps other countries were able to do was to have a bit of a buffer before you had to enter that sort of extraordinary surge phase. We didn't, so that rapid adaptation of estate, of what staff were doing, et cetera, was necessary, for the first step rather than, if you like, for the second step of response.
Q. We have, I think you've probably been told, looked a lot at critical care capacity but I just would like to look

at more general availability of beds, and three documents, please.

Could we have on screen, please, INQ000113287_6.

And, Ms Pritchard, if you have tabs it's tab 3 but it might just be easier to use the screen.

A. Yes.

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

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

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

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

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

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

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

We have some things that I would say put us in

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

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

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

It's at page 64 of Ms Pritchard's statement, and if we just go on one page, there should be a table. There we are.

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

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

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

A. Yes, that's right.

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

the NHS?
A. I think we were initially allocated -- well, actually, it changed fairly frequently over the course of the year but the initial allocation was, I think, in the realm of about 19 billion in the end. Not all of that was actually needed or spent. But that's the point about the support was there, had it been required.
Q. So it's not a question that the decisions were made because there wasn't the money to enable anything to happen, there's a resource issue in terms of having the staff, having the beds, having the buildings --
A. Yes.
Q. -- to scale up, not necessarily a financial issue. I'm not trying to minimise it.
A. Exactly.
Q. All right. Was there any difference in the way you were able to operate during the pandemic in the way that funding was given to you? Were you effectively given a blank cheque, and said: spend it how you want?
A. No, what was agreed that was different was budgets that were based on, if you like, a much greater level of uncertainty about what would actually be required but the process then of agreeing spend was, if you like, much more normal and that was between NHS England, the Treasury, the Department of Health, so there was a -- it

was never anything like a blank cheque but what there was, was the reassurance that if there were legitimate calls that met our, you know, our delivery of government policy then there would not be a financial constraint to being able to follow through on those.
Q. Looking at the estate, and it's at your paragraph 251, you make the point that a well-maintained estate that is fit for purpose can improve the efficiency and capacity of the healthcare system.

That probably speaks for itself but you say that the maintenance backlog was growing year on year and by 2019/2020 it stood at 9 billion which was larger than the total capital budget. So can I just try and translate into what it meant on the ground. Did it mean there were things that needed to be done to hospitals and the like that hadn't been done and were awaiting repairs, improvements, and the like?
A. Yes, there's a process every year for organisations to assess their backlog maintenance and it's categorised into kind of critical backlog maintenance and then less urgent, and what that would cover is everything from a known risk, where there is, for example we have some hospitals that still have RAAC concrete in them, so that would count as critical risk given the level of, well, the well-understood risk around RAAC concrete through to

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

You mentioned the plan for 40, I think, was it 40 new hospitals the government announced? The aim was to deliver six, was it, by 2025? Do you know whether we are on track with that six?
A. So I know you haven't quite asked me this question, but just -- I will get to your point about the new hospitals programme, but I think you've made a really important point about the age of the estate and the implications of that.

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

So that graph we looked at where it shows beds

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

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

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

rather than just parts of it.
Q. Right. I wanted to ask you about the estate, because one of the implications an ageing estate has on -- certainly this pandemic was the ability to properly implement infection prevention and control measures. And I suspect you wouldn't disagree that it's much harder to do in an estate where there's poor ventilation, large walls, no single rooms, no decent breakout rooms for the staff to change. It has implications across all of those things and, not least of all, patients who are 12 to a ward rather than a single or a double room. We'll perhaps look at some of the implications in a moment.
Can I start then, please, with the pandemic in 2020 and a number of letters that were sent by NHS England, the first one being the -- effectively discharge letter, the stopping of elective care letter on 17 March.
And perhaps if we can call it up on screen INQ00087317.
This is quite a long letter -- I won't go through it all but it is signed by you and Sir Simon Stevens, 17 March, just before we went into lockdown, to all chief executives and everyone else listed there -- effectively urging the recipients of the letter to free

up the maximum possible inpatient and critical care capacity, to prepare for the anticipated large numbers, to support their staff.
And if we just go over the page, I think there it is set out that the aim was to expand critical care capacity to the maximum and free up 30,000 or more of the NHS in England's 100,000 general acute beds.
Can I ask you this. What was the 30,000 based on? Is that some kind of modelling that was done?
A. So that -- there were two things happening here. There was the production of the reasonable worst case scenario modelling and, at this point, also early data really from hospital admissions about what we were seeing happen in practice, and then there was, which is actually where this letter comes from, I mean, rapid work but nonetheless sort of bottom up work to work out what we thought the maximum operational possible was.
So the reasonable worst-case scenario at this point was telling us -- it changed quite a lot over the days, and I know, again, the Inquiry has looked at this in some detail, but that we would have at one point, you know, 400,000 patients requiring admission. Even at this point in the mitigated scenarios it's still saying we could have, you know, more patients in hospital than we had physical beds for. And, again within critical

care, I think even our best case scenario at this point is about 11,000 patients who would need critical care capacity. So that far outweighed what would have been possible to do.
But our view going into this was very much that it was absolutely imperative that we try to do everything possible, not least because there was so many unknowns with the modelling. We were obviously all very hopeful that we would be wrong and it would be overstating just how difficult it was likely to be, and there were sort of non-pharmaceutical interventions being considered by government at this point as well. So this reflected, if you like, a bottom up view that said what would be the maximum possible from the combination of things set out in this letter, which included, as you say, discharge, elective, working in partnership with the independent sector, et cetera, so that we could go in in the best possible -- in the best possible place to respond to the need of patients.
Q. And so to achieve that 30,000 there was the postponement of all non-urgent elective operations from 15 April. Why was it delayed potentially to 15 April?
A. So what the letter said was that people should, as it says on the third line, have "local discretion to wind down elective activity". That was partly because at

this point there actually still weren't that many patients in hospital with Covid. So it was difficult judgment.
All of this was dealing with lots of unknowns and uncertainty but what we didn't want to do was oversteer in either direction and have patients who could have been treated not being because we'd stood down too quickly. Equally, we didn't want to be in a situation where we'd maintained non-urgent activity to the detriment of being able to treat Covid patients. And that was really the point about local discretion, because we could give a national direction but it could only be interpreted in a sensible way by local leaders.
Q. And that was hoped to free up between 12,000 and 15,000 hospital beds by that postponement of non-urgent elective. There was the urgent discharge of all hospital inpatients who are medically fit, which would potentially free up 15,000 acute beds currently occupied by patients awaiting discharge or with lengths of stay of over 21 days, and there was the use, in addition to that, of the independent hospitals.
Can I ask you this, that 30,000 that was the aim to free it up, by when or over what time frame was it hoped that that 30,000 would be made available?
A. Well, I mean, again, sort of -- given where we were in

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

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

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

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

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

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

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

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

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

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

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

Which I think is the point you were just making:

"... the data indicated an overall significant reduction in long length of stays in hospital. Since the introduction of the hospital discharge requirements in March 2020 ..."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. No.

Q. And this letter really urged the restarting of some

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

LADY HALLETT: Sorry to interrupt again. The message in the first letter was: carry on urgent non-Covid services. Yet it seems as if that wasn't happening, if you had to

tell people to step them up. Why?

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

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

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

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

A. Sorry.

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

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

in your place.

So the way we work always has to be very much, kind of, with that understanding that, you know, we set the framework, but then we work really closely with local organisations but who, ultimately, still have to take responsibility for the implementation locally and for interpretation locally. And in this case I think we what we were seeing, what we were hearing, was a level of pressure some organisations -- it's not uniform but the level of pressure some organisations were under, they had really struggled to maintain those non-urgent (sic) services because they didn't have the resilience, particularly in staffing, to be able to run multiple things at once and they had had to put all of their effort into responding to Covid. So even though this is only, you know, relatively -- as per your question, this is a little bit sooner than we had expected to do a second letter, it was really important for us to signal to everybody it was now time to make sure that if they had had to make those local decisions, they needed to go back and make sure that they had now, sort of, looked again at how staff were being deployed to make sure that those non-Covid urgent services were fully restored, as you say.

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

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

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

MS CAREY: Can I put back up on screen page 5 of that letter. It may make sense if one looks at the paragraph beginning:

"In addition, you should now work across local systems and with your regional teams ... to make judgments on whether you have further capacity for at least some routine ..."

It was more, can I put it this way, aspirational than mandatory in its tone: if you can do it, please try to restart non-urgent elective care.

Was that really the message you were trying to send out there, Ms Pritchard?

A. The primary function of this letter was -- well, as I say, was to, sort of -- we are now in the next phase, there are a range of things that would be distinctly different to what we were doing in phase 1, so particularly in relation to elective care it was reminding everybody that it was hugely important to fully restore any services that have been disrupted that were urgent in nature. But on the non-urgent work, as you rightly say, this was permissive.

Q. All right.

A. So there were some parts of the country that actually hadn't been terribly badly affected by Covid. So if I think about the south-west, for example, in wave 1. So they were able to restore the non-urgent work actually more quickly than some of the parts of the country that had been very, very much more affected.

Q. Can we look at the phase III letter because there's a slightly different language adopted in the phase III letter, which was issued on 31 July.

Can I have up on screen, please, INQ000051407, thank you very much.

And it's at your tab 7, Ms Pritchard. But here we are now at the end of July and the third phase letter obviously starts by thanking everyone, updates them on various Covid alert levels, the priorities, the financial arrangements. I don't want to get into that, but if we could go to page 2, "NHS priorities from [the following month]", and one can see there at A:

"Accelerating the return to near normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter."

And then preparing for winter demand pressures, and then dealing with lessons learned.

Can I ask, the winter demand pressures, was it

envisaged we may have a flu pandemic in winter 2020 into winter 201 or was there still a worry that there may be resurgence of Covid, as in fact happened.

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

MS CAREY: Did I say "pandemic"? I meant a flu outbreak. Sorry, it's my fault.

Yes, was it envisaged that the preparation for winter demand pressures was ordinary winter flu, for want of a better phrase, or was there still concern that there would be a resurgence of Covid-19.

A. Yeah, we were absolutely concerned that what we would have would be a combination of normal winter pressures and, as it says here, further probable Covid spikes locally and possibly nationally. And so we were anticipating a potential second wave at this point at a time of year that would be more pressured anyway because of the normal winter pressures.

So, you're absolutely right, this letter is different in focus because this is really reflecting the fact that now, when this letter was written, we had 900 inpatients with Covid, so very different to the context of that the second letter was written in, and we foresaw that we would have this, as it sort of phrases it here, window of opportunity over the back end of the summer and into autumn before we hit that winter period with

a potential further Covid wave.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Would that be convenient, my Lady?

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

THE WITNESS: Thank you.

(1.03 pm)

(The short adjournment)

(2.05 pm)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

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

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

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

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

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

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

A. Yes, in -- autumn 2021.

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

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

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

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

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

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

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

The impact of that investment and all of those different initiatives meant that last year -- and I know it's something other witnesses have talked about, the pressure on ambulance services, but we did see ambulance response times for what's called Category 2 responses reduce from 50 minutes to 36 minutes. So it made a big difference last year. But of course that was some considerable period after we had asked for the 10,000 beds, which was at that early stage of the pandemic.
Q. So if I understand you correctly, the 4,000 beds has had a positive effect since 2023 onwards but back as at the time of the request in July 2020, was essentially NHS England reliant on discharges, Nightingales, surging within its own capacity to try to find additional beds in the event of a pandemic striking again in the winter -- or re-emerging, perhaps is a better way of

putting it, in the winter?
A. Yes. So we could foresee clearly that we were going to have to live with Covid for some considerable period of time, so that would create, if you like, a sort of ongoing pressure on the NHS, and we could see even back in July, and in fact of course had written about it in the phase 3 letter, that the recovery job would be hard. So those two things, the ability to continue to deal with further waves of Covid and the ability to deliver recovery, would have been massively enabled by that investment.
Q. Did you get any extra beds between July 2020 and the end of our relevant period in June 2022?
A. We did get some additional funding to support developments within critical care specifically, so about -- well, around about a quarter of a billion, which was invested partly in additional capacity but partly in the fabric of the estate around critical care units to make them more robust, more resilient to improve some of the environment.
Q. Can I jump forward then in time to winter 2020 and into 2021, and in your statement you make clear that that was a period of extreme pressure on the NHS over that winter.

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

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

But here we are as at New Year's Eve, in 2020, 1,050 additional critical care beds had been opened and national occupancy for critical care had passed 100% of the standard. So baseline had been met; is that correct, we were now into using upsurge capacity?
A. Yes.
Q. 3% of critical care patients across the country were being cared for in surge capacity. But London, east of England, and south-east were particularly affected, they all had to use their surge. Look at London there, 28% critical care patients were in surge. 22% and 14% in the south and the east of England respectively.

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

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

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

better to have a bed somewhere than nowhere but Kent to Oxford is, what, 140 miles or so, three hours in an ambulance. We've heard that the fact of transfers themselves are risky --
A. Yes.
Q. -- for both the patient and the staff that have to care for them. Can you help as to how it is we ended up in such a dire state of affairs come New Year's Eve 2020 into January 2021?
A. Yes, thank you. I think if you don't mind there are three things worth saying. One about the preparations that we'd been made, one about the wave 2 experience, and then one about specifically critical care.

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Could we have up on screen, please, INQ000474486_7.

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. No.

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

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

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

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

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

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

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

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

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

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

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

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

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

What can be done in the future to try to ensure

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

A. So I'm not saying for a moment that I can possibly speak for every clinical decision in every hospital. I obviously can't. But I think what we -- so the bit we can do though is a combination of looking at what the data is telling us about what happened, what the lived experience was around trying to relieve pressure in transfers, and the logic of trying to surge, locally surge, then regionally surge, nationally was the one that allowed the NHS to continue to function.

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

But what -- your question, which is about future

resilience, I think probably goes back to some of what we were discussing earlier. Because a bed is not a bed; a bed is a physical space, yes, but it is only a bed if it's got staff, if it's got medicines, if it's got equipment; and all of those things are part of what I think forms that future resilience narrative and that future resilience ask, which clearly, you know -- well, I've already said, we didn't have headroom going into the pandemic, and that has not materially changed as we stand now.

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

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

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

A. No.
Q. -- but do you think there is a real danger that NHSE over-relies on the data and how do you think you can better understand the frontline pressures than perhaps had been in place during the pandemic?
A. I don't agree. Throughout the whole pandemic there was a combination of information that we were relying on, data was -- it was part -- it was an important part but it certainly wasn't all of it.

So Professor Fong went out to do those visits partly at the request of my colleagues in the EPR team because they valued so highly that firsthand feedback. Similarly, I have to say I was in the room with very senior politicians relaying exactly those kinds of stories and describing in a way that I think was very clear -- in fact we've got notes I know were released to another module of the Cabinet Office discussions and meetings Covid-O in January '21, where some of the language there clearly says that we were very clear about the state of pressure in the NHS and that was widely understood and well understood.
Q. What plans are there in the event of a future pandemic to have something like the peer support programme that Professor Fong undertook? Is there anything like that that is ready to go, as it were, in the event we need it

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

We are doing at the moment a review of staff support, partly to make sure that we have properly and systematically looked at where national initiatives make the biggest difference and how they can most usefully support, you know, what will always be primarily local responsibility to support local staff. But absolutely relevant, absolutely right.
Q. Do you think that looking at the quantity of data is not really sufficient for measuring the strain on critical care units?
A. Do you mean the CRITCON data?
Q. Yeah, the CRITCON data or any of the other -- we have got various sitreps that show us the pressures that the critical care units were under. Do you think that that just doesn't accurately convey the strain on critical care units by just looking at the data itself?

A. Yes, which is why we never would.
Q. Can I ask you about one other matter in relation to the data and it's the way in which capacity in critical care units was communicated.

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

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

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

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

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

From the public's perspective do you think that conveying capacity by reference to both baseline and surge perhaps misrepresented how truly bad it was for a hospital like Northwick Park to be running at over double their baseline?
A. So I think you've, really importantly, identified that data is used for different purposes. So the way that -- I should say it was, obviously, just in the pandemic that it was done like this but the way that the data was reported against maximum surge was for the operational purposes to identify when a unit was reaching its maximum capacity and therefore might need transfers or other support.

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

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

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

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

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

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

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

A. Agree.

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

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

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

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

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

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

Q. You say there that nightingales were conceived:

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

What did you mean by "right-sized"?

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

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

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

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

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

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

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

And I'm not going to go through each and every different Nightingale, but to take a different example, slightly later, Harrogate: approved 15th, set up six days later. It was opened on standby. No patients were admitted. As the region managed within its existing capacity it was able to be reactivated to admit patients within 7 days. And then it sets out there how

in fact it ended up being used because it had clinical imaging equipment and it was able to provide CT scans. Again it was ready to be used in wave 2. Total cost 32 million.

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

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

A. Yes is the simple answer. And let me tell you why I say that. And it's because when we were at the beginning of this process, making decisions about opening these unprecedented field hospitals, because that's what we're talking about, we went into this -- and I think you've heard from Simon Ball from Birmingham about this as well -- expecting to need them. Because we didn't have community prevalence data, we only had the data which was the rear-view mirror about patients who were in

hospital at the time, so it was much more uncertain than it became later on, when we could predict much more accurately what was likely to happen. But the doubling rates looked like we were going to be in a situation where we would hit the kind of maximum operational, even with the surge, that we've talked about, capacity.

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

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

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

So the first wave is in lots of ways -- I'm back

to the sort of it was terrifying. It was really -- it was one of -- it's those moments like at that weekend where I was in the London office with loads of clinical colleagues and others and we -- we thought we were about to do something that we'd seen in China, where they opened field hospitals, and we thought we were doing it to avoid a northern Italy situation. So the fact we didn't actually need to open them at scale in the first wave was a sort of huge relief.

Some of them, as you say, were open. So London opened actually slightly ahead of where -- so they were designed -- London specifically was designed only really to be used once every other bit of capacity had been exhausted. So we were assuming at this point everywhere would be working at a 1:6 ratio, from trained staff to -- to other staff, so 1:1 one from a staffing point of view but not from a specialist skill point of view. And when London opened we were not at that point but the clinicians, rightly in my view, thought it would be safer to open it a bit earlier to have a sort of couple of weeks of trying to test it out before potentially it would then have to be opened at the sort of scale that we were looking at at that time. And in fact, of course, that never happened, so it never had to be opened at that sort of scale.

Q. Pausing there. I take your point that, as you say, this was a contingency we never wanted to use. Thankfully, you would say, you never had to use, certainly not in the way it was envisaged. But how was it envisaged it was going to staff it? If you take London as an example, they're already operating at ratios of 1:6. Who was going to staff the Nightingale if we'd needed it for Covid-19 patients?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

whatever million?
A. So.
LADY HALLETT: Take away the word "wasted".
A. Yes, thank you.
LADY HALLETT: You would say it's properly preparing, sorry, you haven't spent it without needing it.
A. So that's right. I mean, on cost, I know -- it's perhaps just worth thinking -- and again it's an illustration that these were not normal hospitals, because a normal bed costs -- to build a modular bed costs about half a million pounds, and actually this worked out, across all of the beds we opened, sort of -- as in spent the money on being able to open, would have been more like 88,000 per bed. So they're not comparable, as in they're not the same, and I think that illustrates the point. But Exeter, because it was later, they were able to work with their, you know, local partners to identify a building that could be kept.

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

time, but has been able to be massively useful for the recovery effort longer term.
MS CAREY: Before I leave this spreadsheet, Birmingham is something of an outlier in that it didn't receive any patients in wave 1 or wave 2 or, on the basis of the information we've set out here, be repurposed for another use. Why, do you know, was Birmingham not used to do something in wave 2 for standing down patients, being used as a vaccination hub, what was the particular problem that meant 50 million was spent on a facility that was never used at all?
A. So each of these -- having visited all of them. Each of them was in a very different -- had very different physical constraints. So, actually, one of the things that we haven't talked about was the difference between the sort of wave 1 model of care and the wave 2 model of care because one of the things that happened between the two is absolutely where it was -- where the physical building meant it was possible to be used for other purposes, whether that was CT scanning or day cases or, indeed, in Exeter's case they also used it for training nurses, for example, training overseas nurses, that happened but they were also adapted so that in wave 2 the model of care would have been different because wave 1 given what we were looking at at the time had to

be done really fast.

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

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

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

which was a much better model of care for patients. And the physical facility just didn't lend itself to be adapted for other purposes in the way some of the others did for wave 2 and beyond.
Q. One of the things you say in your statement is there was a concern, certainly initially, that the Nightingales would not have enough ventilators to treat the anticipated number of Covid patients.

Now, I appreciate at the beginning everyone thought everyone would need a ventilator --
A. Yes.
Q. -- and as it turns out, Covid is a multi-organ disease --
A. Yes.
Q. -- so we have got that in mind. But can I just ask you about ventilators. You said this in your statement, that it was for the trust to purchase their own ventilators so there was no central inventory at the start of the pandemic as to how many ventilators there was.

And what I'd like to know is, is there such a central inventory now?
A. The short answer to your question is there is not but there are plans to create one. So, NHS Supply Chain is currently working on an asset register. They're

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. So when you say it enabled people to go out and say -- well, NHS England say, "What can we do to help you?" What kind of responses were being given? I appreciate they might want 10 more staff on a given day.
A. Yes.
Q. Putting sort of the practicalities of adding some more bodies into the mix, what else was being relayed to you as the ways in which NHS England could help where there was significant episodes of absence?
A. So -- yeah. So in the early days testing was a really big ask. So we had lots of completely understandable requirements or desire for access to staff testing, particularly where there were high levels of absence. So that was one of the things we worked really closely with Public Health England, as well as with our own sort of sub-cell on testing to try and make sure if -- as and when capacity became available it was targeted most effectively.

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

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

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

And then there were a range of things, as I recall, thinking back, where I think it was a bit more specific, so for example my recollection is there was a request from Filipino staff for some targeted and more bespoke bereavement support because that was something that they'd been particularly at the front line of dealing with. So everything from, if you like, the sort of very much this is for that -- might have heard it from particular groups of staffs but it was relevant to the whole of the NHS. And then others that were a bit more specific to particular staff groups or particular places.
Q. You told us that generally speaking in pre-pandemic the -- there was a high proportion of sickness absence due to anxiety, stress, depression and other psychiatric illness. It spiked then, I think in July 2020, where there was 32% of absences due to anxiety, stress, depression, before it dropped back to 23% in 2022, to 2023. It's still a significant proportion, Ms Pritchard, of the workforce off due to anxiety, stress or depression. One can understand why it peaked as it did in July 2020, everyone having just gone through wave 1, but now in 2022, 2023, back down at 23%.

What is in place to try and support staff and try and mitigate as best you can the effects of stress, anxiety, burnout, depression, when those staff are on the front line trying to deal with the pandemic?
A. So we had an -- I know this is one of the things you've talked to other witnesses about so forgive me if I don't have as comprehensive a response. But my recollection is that because we had an Expert Advisory Group that was chaired by Carol Black and had a range of other really, really knowledgable and insightful people, we were hearing a clear story which was that the emphasis had to be on, if you like, supporting local employers to support their own staff because that was -- all the evidence said that's the most powerful and the most helpful thing you can do.

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

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

But I think their advice was that there was also

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

So a whole range of things that were particularly designed to support that local offer.
Q. And finally this then. In the event of a future pandemic, is there any sort of planning for how to support NHS staff to try and reduce or minimise the number of people that are off sick with the stress, the depression, the anxiety?
A. Yes, I think the -- so there's -- the staff treatment access review that's going on at the moment is really about occupational health services and what, again, are the -- so we tried lots of things in the pandemic and we tried them at pace. One of the things that we did through the sort of two years was to constantly try to reflect on what was working, what the feedback was,

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

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

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

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

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

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

MS CAREY: Thank you very much, my Lady.

(3.16 pm)

(A short break)

(3.30 pm)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

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

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

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

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

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

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

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

would be clearly part of a future pandemic plan.

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

A. Yes, that's --

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

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

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

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

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

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

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

The tricky bit is always a combination of both, kind of, individual, sort of, data protection privacy arrangements around how you would -- how exactly you

would use data in a way that was appropriate about individuals, the way that we in NHS England, kind of, dealt with that was to make sure any reported death was validated by an employer or by a CCG, if it was a colleague in primary care, and I know there have been some concerns that that has under-reported the data because the other -- the ONS source looks at death certificates where somebody is identified as a healthcare worker. Obviously that is harder to validate because one of the things that we put in place was a set of criteria including how recently you were actually at work, whether you were there in a voluntary capacity which is included in the data, or you were an outsourced member of staff, also included in the data.

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

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

A. I don't know, but the way it was reported during the pandemic did. So I imagine it would but I can get back

to you on that.

Q. NHS England in July of this year published a framework for managing the response to pandemic disease and no doubt that will be your blueprint if there were a pandemic in the next reasonably foreseeable future. It is -- it identifies the issues, but if I may put it like this, it might be said that it's light on concrete proposals as how to achieve better leadership, better staffing resilience, better data capture, all the things we have been talking about. Is there any other work that's going on to do a, for example, respiratory virus pandemic plan as opposed to a blood-born virus pandemic plan?

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

From one of the things that the EPR framework does as it currently stands and I've, unfortunately, had the experience of being on the other side of this in a number of major incidents back in my previous roles as well, is it sets a framework for you to make decisions

depending on the specific circumstance you find yourself in. So, for example, a major incident in a trust, it doesn't try and say what happens if it's a train versus a car, versus a plane landing on Heathrow, but it gives you the right questions to ask, the structures to use and, if you like, the sort of signposts for: here's where we've learnt stuff in the past, this is what you would want to go to and pull from to help you make decisions in this specific circumstance.

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

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

LADY HALLETT: Remembering the art of the possible.

A. Yes, thank you. So one of the things I would strongly say is the importance of the community prevalence data and the testing so that we could properly understand what was going on with the virus, and put the NHS locally as well as nationally in a position to be able to be front-foot on response, and better able to protect ourself, better able to understand what was actually likely to come over the next week, two weeks, three weeks, beyond. It's absolutely critical and it made such a difference going into the latter part of the pandemic that we had that. So maintaining that infrastructure and that ability to be able to respond then at pace with testing and community prevalence data, crucial.

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

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

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

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

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

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

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

LADY HALLETT: Thank you.

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

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

Questions from MS POLASCHEK

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

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

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

updated and is there a plan for doing so?

A. Thank you.

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

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

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

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

additional points.
Q. Thank you, Ms Pritchard. In respect specifically of HEPA filters, again Professor Beggs described these as the low-hanging fruit of fixing some of the ventilation problems and as you've alluded to, of course, it is expensive to upgrade ventilation in the ageing NHS estate all at once.
Aside from that guidance, for forward-looking work, what work is being done currently to put in place more access to HEPA filters in the NHS estate?
A. I'm afraid I would need to probably get back to you with more specific feedback on that. As I've said to counsel a moment ago, what I am aware of is where there are works going on, where there's an opportunity to upgrade the ventilation of estate, that is being taken, as well as, as you say, being built into kind of future estate planning.
On the specific use of devices, I mean, that guidance has now gone out, the expectation is that is going to be then considered appropriately by estates and clinical professionals and used appropriately but, as I say, I would just need to come back with more information as to whether there's a sort of formalised programme around that because I'm not aware of the detail.

Q. Thank you. And just the final question. Of course accepting that there's a need for prioritisation of capital spending, we also know that clinically vulnerable patients face greater risks than others entering healthcare settings due to the impact to them if they contract Covid-19. So in light of that, would you accept that there is an urgent need for those patients to make it safe for them to access healthcare now and in any future pandemic?
A. So absolutely understand the importance of us making sure that all patients are safe in NHS facilities of whatever kind. I think the reality, though, as you say, about just the level of backlog maintenance and the urgency of some of the pressure on the estate and the age of the estate, does make it very hard, and you're making constant risk-based decisions about what to spend money on locally and is it, you know, that concrete roof that is about to -- not about to, I'm exaggerating, sorry, where there's a risk it might crack at any time or this, where there's a water leak or that, where there's another problem.
So I would certainly absolutely agree that this needs to take its appropriate place within the prioritisation that is going on locally about how to spend the capital resource to upgrade the estate but

I think it is, in the current environment, it is probably difficult to go much further than that.
MS POLASCHEK: Thank you, my Lady. Those are my questions.
LADY HALLETT: Thank you very much for your help.
Mr Wolfe.
He's behind the pillar, as far as you're concerned.

Questions from MR WOLFE KC

MR WOLFE: Hello, Ms Pritchard.
So I ask questions on behalf of John's Campaign, Care Rights UK and The Patients Association, and the theme of my brief questions is the way in which NHS systems, by working with families involved in the care process, by talking to patients as well, can improve the outcomes for patients and their families and indeed for the NHS itself. So that's the context of the questions.
A. Thank you.
Q. My first questions about patient experience departments or sometimes called patient experience teams. Our view, John's Campaign's view, is involving them can be very helpful in helping to advocate for and create dialogue between patients and their families and the NHS. And I imagine that that is something you would agree with. It's not something you mention in your witness statement. Is there any significance in that?

A. No. I mean, my witness statement answered the Rule 9 questions given by the Inquiry. So, no, I certainly wouldn't want you to read into that any more than that.
It's absolutely my personal experience from having worked in the NHS for now many, many years that that partnership with patients is invaluable when you're designing and delivering services.
Q. One of our concerns is that the role of the patient experience teams appeared to diminish during the pandemic. Again, is that consistent with your experience and something that should be a matter of concern?
A. I -- it's a good question. I mean, it's difficult -- one of the themes of this discussion today to some extent has been, I think, what is the national and what is the local. So, talking to colleagues who were more in the front line than I was during the pandemic, I think it's probably right to say there was variation, and there was certainly some teams that I think were really pulling in their patient experience teams to work with them, and certainly it's something we would encourage, but I think there were others where probably it's fair to say there were just other competing operational pressures that meant -- and that perhaps didn't have the level of attention that it did elsewhere

or could have done.
Q. So in a future pandemic you would want to encourage everyone, all the different providers and trusts, to follow that better practice of involving the patient teams?
A. Yes.
Q. Different theme if I may. A couple of paragraphs of your witness statement, paragraphs 532 and 537, you talk about -- and we completely agree with this -- the way in which longer hospital stays can generally lead to worse health outcomes.
One of the ways in which we see that could be mitigated is by the involvement of family carers in supporting the professional health teams. Again, is that something you would generally support?
A. Yes.
Q. Then, in terms of the position of discharge, you talk, at paragraph 519 of your statement, about the process of accelerated discharges in December 2021. One of the things that we think can support those kind -- well, any discharges but particularly accelerated discharges, is a real focus on recognising the value that family carers provide in supporting the ongoing delivery of health once somebody returns home. Again, is that something you're supportive of?

A. Yes, completely, and I think all of our -- all of the guidance on discharge both within the -- both issued in the pandemic and subsequently reinforces the point that actually that joint -- you know, we've already mentioned, I'll be the first to accept, it doesn't always work as well as it should, but actually having a good joint understanding of the needs of the person who is being discharged and in this case has been delayed for whatever reason, such that when they do get discharged, you know, plans are in place to support them to get the care they need once they're not in an acute environment any more, you know, we know all the evidence says that that involvement of families and carers is crucial.
Q. So involvement in families and carers not in just in planning that process but also recognising the role that they very often, indeed perhaps generally, have in supporting and indeed delivering healthcare back at home?
A. Absolutely.
Q. And so, again, insofar as there was mixed experience last time, looking forward to the next pandemic should we get one, you presumably would encourage that best practice approach being adopted across the board?
A. Yes. I mean, as I was saying earlier on, discharge,

I think we did very much try to build on the best practice that was already in place in the NHS and then encourage everywhere to adopt that way of working at pace. And absolutely I think that is what we've done since then, in a whole range of different ways. So -- you know, whether it's elective recovery or it's tackling delayed handovers, certainly discharge -- you know, I would be seeking to do the same again, which is learn from where it's working well and then try to support that to become much more, you know, common practice across the NHS.
MR WOLFE: Thank you, Ms Pritchard.
Thank you my Lady.
LADY HALLETT: Thank you, Mr Wolfe.
Mr Stanton.
He's behind you. Please make sure though that if you look at him when he asks the questions that you turn to the microphone --
A. Right.
LADY HALLETT: Thank you.

Questions from MR STANTON

MR STANTON: Good afternoon.
I ask questions on behalf of the British Medical Association. I'd like to initially, if I may, pick up on an issue you were discussing with Ms Carey, which is

about whether enough is being done to support healthcare workers with their mental health and well-being.
And I just wondered if I could bring to your attention some data I'm sure you're aware of, but before the Inquiry Professor Fong has talked about the levels of severe depression in ICU staff, which he referred to, at 52%. He also mentioned ICU staff -- this is from a survey, sorry, around January 2021 -- ICU staff also experiencing severe anxiety and 44% of staff experiencing that. And those figures are echoed by the Inquiry's intensive care experts who refer to 50% of staff meeting the criteria for a mental health disorder.
Just against that backdrop, and obviously having regard to the issue that you've recognised -- you referred to the fact that mental health and well-being was the number one issue for staff absence -- do you think enough is being done within the NHS to support healthcare workers?
A. Thank you -- should I look back here? It does feel a bit odd.
So, thank you. So, is enough being done? I think one of the things that -- well, so one of the things that we start from is, again, that recognition of just what staff did during the pandemic and the extraordinary lengths that people went to to try and support patients.

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

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

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

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

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

Q. Yes.

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

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

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

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

What do you think is needed for the NHS to provide

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

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

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

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

MR STANTON: Thank you, Ms Pritchard.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Stanton. Very grateful. Mr Pezzani.

He's over there.

Questions from MR PEZZANI

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

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

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

And then at paragraph 164, they say:

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

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

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

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

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

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

My other big reflection is planning for recovery right from the start. So we now are in a place where we are still on a very significant recovery journey. I think that is absolutely the case for children and young people's mental health services and children and young people's services more broadly.

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

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

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

A. Yes, I would agree.

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

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

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

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

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

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

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

was reinforced in the Long Term Workforce Plan.

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

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

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

Q. Yes.

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

Q. Thank you.

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

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

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

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

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

A. Sorry, we are. My apologies.

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

So thank you very much, Mr Pezzani.

MR PEZZANI: Thank you, my Lady.

LADY HALLETT: Ms Hannett.

Ms Hannett is behind ...

Questions from MS HANNETT KC

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

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

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

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

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

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

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

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

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

to collect that data more easily nationally.

Q. Thank you, Ms Pritchard.

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

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

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

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

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

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

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

A. That seems like a very good idea.

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

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

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

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

might be a question again that we could ask that team to pick up as part of that work.

Q. Yes, it's the regularity and the qualitative aspect of it that's of concern to my clients certainly.

I'm grateful. Thank you, Ms Pritchard.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Hannett.

Mr Thomas.

Mr Thomas is over there, behind you again, I'm afraid.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Ms Pritchard.

I represent FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

In paragraph 164(c) of your statement, you mention that NHS England's Chief People Officer convened national meetings with black, Asian and minority ethnic staff network leads and EDI leads across the NHS after observing the disproportionate impact of Covid on these communities.

Would you say that this engagement was a reactive measure to the disproportionately high death rates or was it part of a pre-existing strategic intervention aimed at supporting ethnic minority staff. And if the latter, if you're saying it was pre-existing, when were

these meetings planned?

A. So I believe that this particular meeting was part of the work of the workforce -- sorry, the cell that had been set up following a meeting which I think Lord Stevens had had earlier in April which had then led to him commissioning the Chief People Officer to lead some work, which I think then meant that meeting you've referred to I think -- as you say, it's 30 April, was then part of the action that was taken by her in her capacity leading the cell. So I think that's -- as a specific action it was part of that work, but she was already leading for NHS England on staff inequalities, so things like the race equality scheme, the disability scheme and a whole range of other actions and activities that were -- taken nationally, were already part of her portfolio.

So in her job that wasn't pandemic-related, she would have been in, you know, regular contact with leaders from staff networks, not just race but more broadly as well.

Q. Let's stay on leadership representation. Would you agree that having more black, Asian and minority ethnic leaders in senior positions would probably have influenced a response to the adverse outcomes experienced by ethnic minority healthcare workers?

A. I don't know, is the honest answer to that. In my National Incident Response Board we had an eye right from the beginning about making sure we had diverse representation, so not jut only overly clinically represented but making sure we were bringing into the room that inequalities lens -- staff and equalities as well as patient inequalities lens.

Do I think that made a difference in the response? I think -- I mean, there are multiple factors, including, I think, the speed with which it was spotted that there was that disproportionate impact. And my sense is that certainly Lord Stevens was very responsive once he was made -- once it was drawn to his attention -- he was the Chief Executive at the time -- in taking action.

As a broader point though, we absolutely see the importance of representative and diverse leadership within local bodies as well as national bodies and would thoroughly support that. In fact, that is one of the high impact actions that is in our equality and diversity action plan that was published recently.

Q. Could I piggyback on what you've just said. How could leadership diversity accelerate critical interventions to protect these workers and can you suggest specific measures to support a pipeline for ethnic minority

leaders within the NHS?

A. So -- sorry, I've realised I'm looking in the wrong direction, so I'm going to turn --

Q. You are still speaking in the microphone --

LADY HALLETT: There's a microphone to your right, so as long as you --

A. Fine, okay, in that case I'll carry on looking this way.

So there is a -- I think you've perhaps -- tell me if I've misunderstood the question, but there are, I think --

PROFESSOR THOMAS: Do you want me to repeat the question?

A. -- two parts. So one of your questions -- one part I think is pandemic-specific and then one part is future focused.

So in terms of the pandemic, one of the things that we heard pretty clearly in that summer period in 2020 was that the risk assessment process was both too slow and, in some cases, not resulting in follow-through that was necessary to respond to the things that have been identified in the risk assessments.

So, again, I don't think I could say whether more diverse leadership would have made the difference or not. We haven't done enough systematic analysis of where was doing it well and where wasn't. But there was

certainly a need for us, I think from a national perspective, to make sure that we were both very clear about the importance of that risk assessment process but also that we had provided the right guidance and follow-through on what a good process looked like.

So in the end we actually set up a unit nationally, again under the Chief People Officer's leadership, to really support and get stuck in for places that seemed to be finding it more difficult to do, and that did lead to, I think, significant improvement in certainly the number of risk assessments that were undertaken.

On your point about sort of future pipeline, I'm sort of -- I suppose both pre-pandemic, during the pandemic and subsequently, we have a lot of different work going on around equality diversity inclusion in the NHS but one of those specific streamed themes is around leadership and the pipeline developing future leaders. So the talent management programmes that exist in the NHS at the moment are oriented in that direction. Certainly if we think about things like the aspiring chief executive programmes, that's one of the things that's explicitly considered. And indeed, as I say, it's something that I've certainly given a lot of thought to personally.

But the high impact actions that are set out in our equality diversity action plan, they are about making things different in a very practical way, and that's the set of things that I signed up to, along with our current lead for workforce training and education, as being the important things that we are expecting not just our own organisation but the whole of the NHS in England to adopt and to deliver.

Q. I want to move on because I'm conscious of time. I want to turn to timeliness of data collection.

Can we agree this, can we agree that if the ethnic-specific data had been collated and collected sooner, NHS leadership might have been able to respond more swiftly, differently, systematically, to protect minority ethnic healthcare workers? Can we agree on that?

A. In what regard? Do you mean in relation to staff deaths?

Q. Yes, and not just staff deaths, in terms of the impact of Covid on staff, whether that be illnesses or death.

A. So I think we moved really quite quickly, I know we've talked about it already, to stand up new data collections, because there did have to be new, partly because we didn't have -- we don't have -- it's much better now and needs to continue to develop -- systems

that allow us to collate local data into a national view at speed. I think that will be one of the things, again, I've already said, I think for a future pandemic that will be really useful.

But the early indication that there was disproportionate impact on certain groups, actually the initial thinking I know from scientists and from the medical profession was pointing towards older people and people with significant underlying health conditions, including, for example, diabetes, so I think it's probably fair to say the data originally pointed in that direction, and then it was a few weeks later that it became clearer that actually there was a real signal in the data.

I don't think that was so much so from staff data, I think that was coming more from the overall population data that was suggesting there was a disproportionate impact on people from black, Asian or ethnic minorities.

Q. The short point though. When that data was coming through, the NHS moved a little slow; would you not agree?

A. Well, I think Simon Stevens' meeting was 15 April, so if we think about the sort of speed with which this was all happening, the cell, I think was set up the following day and then there's a whole set of actions that follow

from it. So we had both, I think, written into the 29th April letter that expectation of risk assessment and a clear signal about the fact that the data was now saying that there looked like there was a disproportionate impact, and we then had -- "then had" is not quite right, but we had another programme of work that was looking at the disproportionate impact on patients and on communities also then feeding into a whole set of actions that were written into future asks of the NHS to adapt services to make sure it was responsive.

Q. A couple more questions, and I want to take these swiftly, if I may. When data on ethnicity had begun to be gathered, how was this data used in NHS performance monitoring and response efforts during the pandemic and would you agree it made a difference when you started to use the data?

A. Do you mean in relation to risk assessment?

Q. Yes, and the impact of the virus on ethnic minority groups?

A. So yes, the point -- so, I think I've perhaps already covered this a little bit when it became clear, as I say, that we needed to ensure that risk assessment was taking place, it was slower to get off the ground from that sort of April 29 period and then we write again,

I think on 24 June, and then there's the unit set up at the beginning -- 5 July, to help support the delivery of risk assessment across the NHS and, looking at the compliance rate, it does get much better after July but it has taken, I think we would all accept, too long to get that in place.

So certainly, I think it was -- a learning point for the future is that as soon as data becomes available that tells us which particular new version of a pandemic is going -- what it is going to do, then the ability to react at pace and to have data systems around, that is really important.

Q. I think we're agreed on this. Let me come onto -- I'm nearly there. You refer to socioeconomic factors and the role of multi-generational households in certain regions as contributing to higher Covid rates among ethnic minorities. How were these additional risk factors captured in the NHS data collection efforts?

A. I don't think there was a mechanism of capturing that data. What we did do was look at deprivation data which isn't -- it's not -- it's a proxy, it can't give you the whole story, but we were certainly seeing across the NHS that those people who lived in more deprived communities where there isn't a direct but there can be a correlation with, then, poorer housing stock but also

with -- actually, we should be clear, urban areas as well. So there were other bits of data that were becoming available that were certainly giving a sense of where the greatest risks seem to lie.

Q. Finally this, and I'm just trying to wrap up and I want to be forward thinking for the Inquiry. Given the disproportionate impact of Covid on ethnic minority workers and recognising the historic and structural challenges they face, would you agree that this experience has underscored the need for deeper structural changes within the NHS to address long-standing inequalities? Would you agree with that?

A. I absolutely agree that we need to continue to do -- do you know what? Let me start again. I agree we need to do more. And it has never, I think, been highlighted as obviously as through Covid the importance of the contribution all of our staff make to the NHS and our absolute reliance on the people who do every job. I haven't talked about it today but the work of our engineering teams, the work of our estates teams, the work of our porters, but the point for me is simple, if you work for the NHS you have to feel fully valued by the NHS and we need to do more to make that --

(Unclear: multiple speakers).

Q. Yes, I understand that, Ms Pritchard, but the point is

those who were disproportionately impacted, that was the focus of my question. And minority ethnic healthcare workers were disproportionately impacted. That's the point.

A. Yes, and I suppose what I'm responding to is just a recognition that all of our -- well, you can argue -- I'm taking the opportunity to say it because I don't feel I have yet, but just to make sure we don't only talk about doctors and nurses when we talk about --

Q. No, I understand that.

A. -- the things that colleagues did through the pandemic but also acknowledging that actually making sure that as an employer we are embracing what is a huge strength, which is the diversity of our workforce, but also recognising that actually the experience of our workforce is not uniform -- in different places, in different roles, but also where you have particular issues that we must address for those --

(Unclear: multiple speakers)

LADY HALLETT: Thank you, Mr Thomas.

PROFESSOR THOMAS: Thank you, my Lady.

LADY HALLETT: Ms Pritchard, it's getting pretty late. It's probably feeling pretty for you but it is just that they have limited time.

A. I'm sorry.

LADY HALLETT: The advocates have sometimes quite -- very restricted time, so if you could keep your answers short, I know they would be very grateful.

A. Sorry.

LADY HALLETT: They don't like me jumping in.

Mr Jacobs.

Questions from MR JACOBS

MR JACOBS: Ms Pritchard, I have some questions on behalf of the Trades Union Congress on a similar theme to Mr Thomas.

Questions on the position of those healthcare workers who work in outsourced services. Does NHS England hold data on the proportion of staff in outsourced services who belong to black, Asian, and minority ethnic groups.

A. We don't hold data on outsourced staff.

Q. Does it not need to in order to consider the potentially significant equality implications of commissioning services in that way?

A. So we don't actually hold data. When I say we don't hold data, I mean we don't hold any data on staff who are employed by third-party outsourced providers.

So the way that it works at the moment is NHS England as a sort of overarching commissioner passes resource down through what were CCGs, are now ICBs, to

local employers who then determine how they spend it. So the responsibility sits with the local employer, so if that's the trust, to make sure that then in their contract management, if you like, with the provider of, it's often hard or soft facility management services, that they are then working with that provider to ensure that the appropriate data but also the appropriate actions are taken.

Q. So that's at a lower level. So do we take from your answer that NHS England actually didn't see itself as having a role in terms of considering the equality implications of delivering some healthcare services through outsourced services?

A. So I think, just to be clear, I guess what I'm saying is we collect data on people who are NHS employees. So that, by its very nature, is never going to be a full picture of all of the colleagues across the country who are involved in healthcare services.

Q. I think that's an answer to a different question. The question is: does NHS England consider that it has a role in considering the equality implications of delivering certain healthcare services through outsourced services?

A. So we have an -- there are a set of things we are responsible for including quality -- actually, we're not

the quality monitor, that's the CQC. There is a set of things NHS England is responsible for in commissioning and then the follow-through to ensure that the commissioning is being done well and services are being provided as per expectations. So if a local employer has chosen to outsource a service, they're still responsible for the quality of the provision of that service --

Q. If I understand correctly, your answer is that the local employer is responsible for considering equality implications not NHS England?

A. But not in a different sense than in a sense for any other -- so we're not responsible for the provision of community pharmacy services or optometry services.

Q. Understood.

A. And nor are we responsible for the provision of services by voluntary sector partners, but we are responsible for setting standards that we then expect to be delivered through whether it is a contract mechanism or it's a direct employment mechanism.

Q. Yes. The Inquiry has heard evidence from those, for example, who talk about the importance of reducing precariousness of work, in reducing inequality of impact. My client and others are concerned about working conditions in outsource services that may

compound some pre-existing inequalities. The Inquiry has heard accounts of workers have less access to sick pay, being less able to raise concerns, lower priority for PPE and so on.

Does NHS England share a concern that the conditions of those in outsource work is such as to compound pre-existing inequalities?

A. So I have personal experience of working in trusts with outsourced providers and insourced, and what I can say is they can both work really well and they can both work less well. So where a trust takes its responsibilities for working in partnership with but through a contractual arrangement with an outsourced provider and, you know, as where I used to work, which was not Guy's and St Thomas', somewhere else, did and that leadership team is part of the trust leadership team but it is absolutely -- staff are treated exactly as if they were members of the NHS workforce because they are, in practice, of course, members of that wider NHS family, it can work really well. And, actually, can work, you know, I could argue even better sometimes than the NHS trying to do it for itself because you often have people who have real genuine expertise in running those services and can be much more responsive to the needs of their staff. Equally, it can work badly.

So if your question is, which I don't know if it is, but it's something I've reflected on, should we have --

Q. Let me ask a follow-up question.

A. Yes, sorry.

Q. We have your personal experience that it can work well, it can work badly. We've certainly had personal experiences before the Inquiry of it working badly. Does NHS England not need to do some work, particularly with this concern about disproportionate impact, on truly looking at this issue and trying to understand it and trying to understand whether this is one area in which there needs to be some change?

A. So thank you for the question. And I have thought about this because I read the evidence given by previous witnesses on it. And on reflection I do think we should have been clearer about the expectation that everything that we were pushing out as guidance or as asked of -- into the NHS, we should have been explicitly clearer that that needed to apply to outsourced staff.

So thinking about, say, risk assessment I now think we had taken the normal way of working as being the normal way of working and, actually, in a pandemic situation there is probably a need for greater clarity of expectations and that would be one of the points of

learning I would take into a future pandemic.
Q. And just finally, you said a moment ago if you work for the NHS you need to feel fully valued. Is NHS England confident that outsourced healthcare workers feel fully valued?
A. Well, that -- I am not confident at the moment that we are doing collectively as the NHS, as I just said to your colleague, enough to ensure that all our staff feel equally valued. So, again, I don't want to inappropriately suggest that's something that NHS England can fix because ultimately it has to be for local employers to lead, but can we support both in relation to NHS -- people in NHS contracts and with clear expectations about outsourced staff, I think we can.
MR JACOBS: Thank you.
Thank you, my Lady.
LADY HALLETT: Thank you, Mr Jacobs.
Ms Stone, I am sorry you have come at the very end of a long day. I would be grateful if you could focus on the main issues you wish to highlight.
MS STONE: My Lady, yes, I am conscious of the time, thank you.

Questions from MS STONE

MS STONE: Good afternoon, Ms Pritchard, I ask questions on

behalf of Covid-19 Bereaved Families for Justice UK, and two short topics, if I may, please.
The first relates to discharge from hospital during the pandemic. You told us about steps taken to promote discharge of medically fit patients during the course of the pandemic for reasons you explained and that we understand. It's an obvious point but it needs to be appropriate discharge because of the risks to patients associated with inappropriate discharge.
Can you tell us what additional measures NHS England introduced to ensure that the risk of inappropriate discharge was addressed, including monitoring and evaluation of discharge processes?
A. Yes, you're completely right to say that it must be appropriate discharge. So, I think it's probably worth saying that's why the guidance, which the Department of Health led on but we were absolutely co-signatories to, was very clear about the expectations around what good discharge would look like and it was based on, as I said earlier, the existing best practice but with an expectation that that would then be something that would be both enabled by those policy decisions that they made but implemented locally, and one of the things that I think we were, again, very clear about was this was focused not on people who had any medical reason to

still be in hospital but only those people who were medically fit to leave, so shouldn't have been needing to be in an acute environment.
The follow-up on quality was a couple of things. So there was monitoring going on through our National Incident Response Board, through very regular feedback on numbers but also feeding in the experience that was being relayed to us by partners in local government, by experience of local ICBs and trusts feeding back, but also, and this is the final bit of it, we were looking at readmission data, which is only a crude tool because, obviously, bearing in mind there were loads of other factors that can affect readmission, I wouldn't want to over-rely on it, but that did show, over the period, that readmission rates went up by 1%.
What we couldn't do is disaggregate from that how much of that was people catching Covid or other things going on that meant that they came back. But it was nonetheless just a sort of helpful additional piece of data to allow us to just keep an eye on whether or not this was leading to unintended consequences about people then needing to come back into hospital.
Q. And was there official review of that question, that exact question, ie are there unintended consequences?
A. On readmission rates?

Q. Just generally. Of are there unintended consequences of the enhanced focus on discharge?
A. I'm not aware -- I mean, I'm sure there is, but I'm not aware of any research -- specific research that's been done -- sort of third party research on this.
We produced within NHS England our sort of own analysis of what had happened and did a learning report which I referred to earlier, which was one of the things that led to that conclusion about the number of beds, staff, and also that had been released through the measure but also the feedback about the discharge to assess model being the one that was preferred from both social care colleagues and also from the feedback that we were getting from the front line. But I suspect there are more independent sources of research which I'm not familiar with.
Q. And I think the report that you referred to earlier, you've just re-referred to it, that didn't specifically address, I don't think, correct me if I'm wrong, the question of inappropriate discharge?
A. Not on a sort of -- do you mean on an individual -- sorry?
Q. Did you, NHS England, look at whether there was any adverse outcome, unintended outcome -- I can't remember the phrase that you used -- arising from the focus on

discharge and, specifically, inappropriate discharge arising from that focus?
A. Right, okay. So not in the sense that we were explicitly, I think, looking at -- so we didn't do any work to say: were people who were not medically fit for discharge discharged? And I hope -- so all of our analysis was based on, if you like, the local analysis which categorised patients as being medically fit for discharge.
Q. Yes.
A. So I don't think there was an audit done of whether that categorisation was appropriate. But of that group that were medically fit for discharge, that's where our -- so that is the bit that we then -- our analysis was based on, I suppose, that initial categorisation being appropriate.
Q. And are you aware whether concerns have been raised with NHS England about the emphasis on discharge leading to inappropriate discharge?
A. We didn't have concerns raised. To my knowledge.
Q. Second topic, please, is the EPRR framework that you --
A. I'm so sorry, I should have said I am conscious that we're not talking about discharge to care homes at this point though, are we? Because clearly there's a whole set of conversations about discharge to care homes, if

you're asking about --
Q. Yes, so there would be specific concerns and I think the Inquiry is well aware of --
LADY HALLETT: That's a different module, you're absolutely right.
A. Right, fine. That's just -- so I'm conscious I haven't answered that question. I was answering a slightly different question.
MS STONE: Inappropriate in broad terms is what I was referring to for the purposes of that question.

Moving on to the EPRR framework, please. You've told us it's recently been updated, this year. I just wanted to ask you about one aspect you refer to in your statement and that's health inequalities, please.

At paragraph 182 of your second statement you note, Ms Pritchard, that the EPRR framework has been updated to confirm that specific guidance on managing health inequalities during a major incident is being developed and will be published in due course.

So, do we infer from that that that specific guidance did not exist as we went into the pandemic?
A. That is correct. There was no specific guidance on health inequalities. I know you want to move on but can I, just for the record, because I'm conscious this is formal, say when I said there were not concerns raised

about discharge to my knowledge, I am talking discharge to assess. So that is not including care home discharge, where I think there was -- there is, I know, a whole separate module that will focus on that, amongst other things.
Q. So, just so that we're clear, your evidence is that, to your knowledge, there were no concerns raised about discharge to assess --
A. Not as a policy, no.
Q. -- during the pandemic; is that correct?
A. No. There were definitely, and continue to be, individual examples of where discharge not go as well as it should do, but, in terms of a concern about that policy being moved to, that wasn't something that was raised, to my knowledge.
Q. But there were concerns raised about examples of discharge that didn't go as it should have done which we might refer to as inappropriate discharge?
A. I think there were -- well, so there were examples -- I'm actually not sure I would use "inappropriate", but what I would say is there were certainly examples of where things like communication wasn't quite good enough or people felt they weren't, you know, quite clear about exactly that the arrangements were for who was going to come in to provide what care when. I mean, not outside

the -- I mean, I hate to say it, but sort of not outside the usual type of things that can not go as well as we would want them to from a discharge perspective, and certainly the speed with which some of the discharges were -- they were medically fit, they were delayed, they were expecting to leave hospital, but perhaps not quite as fast as they had previously thought. And I think that no doubt did create some pressure on the system, so drawing distinction between concerns about the policy, individual examples where -- you know, clearly, things, even today, don't always go as smoothly as we would want, and then a specific set of issues around care homes, which we haven't really talked about today.
Q. I think that's understood, Ms Pritchard.

Just coming back, please, to the EPRR framework.
A. Oh, yes. So, no, there wasn't a specific --
Q. That didn't exist as we went into the pandemic.

Given that the scale and severity of health inequalities in the UK as a whole, and England in particular, were well-known, as was the likelihood of those inequalities being exacerbated in a major incident, and particularly a pandemic, shouldn't that specific guidance have already been in place as we went into the Covid pandemic in 2020?
A. Back to what I feel I've -- apologies, but sort of said

a couple of times, which is just -- so the EPR framework is effectively a sort of set of action cards of things to think about, and then it's adapted to the specific circumstances.

So there was a huge amount of work going on pre-pandemic about reducing healthcare inequalities. It's written into the long-term plan, published in 2019, and there's a number of very specific programmes as well as a general focus. And in fact where we are now with the creation of ICBs and ICSs is -- actually at the very heart of that, that way of working is the partnership between local government, the NHS, voluntary sector, patients themselves, in order to address healthcare inequalities, amongst a range of other things.

So should there have been a specific EPR framework that addressed healthcare inequalities? Well, I think that is definitely one of the bits of learning from the pandemic, which means we will now have one in the future. But it was, I think, something that, again, we've -- we've talked before about a flu -- you know, the planning was based largely on a flu pandemic in the past, and I think those shortcomings have been identified through previous modules.

LADY HALLETT: I'm afraid it's not your fault, Ms Stone, but we have to leave it there, but given that I've given you

permission for the questions, if any of the questions you haven't had the time to ask are ones upon which you'd like an answer, we'll ask Ms Pritchard to give us a written answer.

MS STONE: I'd be grateful for that opportunity.

Thank you, my Lady.

LADY HALLETT: I hope that completes then the questioning. Sorry it's been such a long day for you.

I don't know if you realise that a team at NHS, who have been helping us -- this is the statements from you and Sir Stephen. You probably saw me refer to them this morning. Anyway, thank you. I don't know how much you have been involved in getting the team together to answer all our questions and to provide help to the Inquiry, but I'm very grateful for all that your team have done, and obviously that you have done too. Thank you for your help.

THE WITNESS: Thank you, my Lady.

LADY HALLETT: Very well. 10 o'clock tomorrow, please.

(The witness withdrew)

(4.54 pm)

(The hearing adjourned until 10.00 am on Tuesday, 12 November 2024)

INDEX