Tuesday, 12 November 2024

(10.00 am)

LADY HALLETT: Ms Carey.

MS CAREY: Good morning, my Lady, the first witness today is Sir Christopher Wormald.

LADY HALLETT: Welcome back, Sir Chris.

THE WITNESS: Thank you.

SIR CHRISTOPHER WORMALD (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

MS CAREY: Sir Christopher, good morning. I know it's not your first time at Dorland House, I dare say it won't be your last. You are the permanent secretary to the Department of Health and Social Care and have been since May 2016; is that correct?

A. That is correct. And if I could start, as I always do, by putting on record the department's sorrow for everyone who suffered during the Covid pandemic, and particularly pertinent to this module, our ongoing thanks to our amazing staff in the health and care system who helped us all through.

Q. Thank you. Sir Christopher, you know I have a number of questions to ask you spanning five statements that have been prepared by the department. I think you are the signatory to the first and the final statement, and then a number of your colleagues have assisted with parts B, C, and D.

Clearly you may not be able to speak to all of them with direct knowledge, but can I ask that you do your best to assist us with the questions I have for you this morning?

A. Yes, of course, and I'll answer to the best of my abilities. There may be occasions when I have to say I'm sure the department knows and I'll go and check because unlike my previous two appearances, I'm answering on things I didn't directly witness so I've been briefed on or read about, as opposed to, as I say, previously when I normally had direct experience but I will answer as fully as I can.

Q. Thank you. Fully and shortly, please, if I may make that --

A. As shortly as I can.

Q. Thank you.

All right. As permanent secretary, as you set out, you are responsible for ensuring ministers receive advice on strategy and objectives for the health and social care system. You are the department's CEO, setting standards and managing risk and assurance and you are the department's accounting officer as well and I think before joining the department you were the permanent secretary of the Department for Education and the Director General within the Cabinet Office before that?

A. Yes.

Q. We will deal briefly, if I may, with the role of the department, which is set out in your first statement which I hope you've got in front of you.

I ought to say for the record there are five statements, INQ000369658, INQ000389241, INQ000472172, INQ000469724, and INQ000473872, all of which will be published later today.

And I think you say this, that in broad terms it's the department's role to support and advise the government's health and social care ministers by shaping policy, assisting in the setting of strategic direction, and implementing agreed policy.

You support the Secretary of State, Mr Hancock and Sir Sajid Javid, who were the relevant secretaries at the time, and the department secures funds for the NHS, and I think you're aware we heard from the CEO Amanda Pritchard yesterday?

A. Yes.

Q. In relation to pandemics, it may be easiest if we could have on screen INQ000369658 at page 39 and you've helpfully provided there a document which I showed in opening setting out in broad terms the structure and the responsibilities in a pandemic. Clearly, at the time preparations, were for a flu-like pandemic and at the top there is the Department of Health. Under them the Pandemic Influenza Preparedness Board, and sitting under that PHE, NHS England and NHS Improvement, as it then was, we're just calling it NHSE for now?

A. Yes, that's correct. So this is a, I thought a very good document in fact produced by the National Audit Office as part of one of their reports but we thought it summarised the different roles, as you say, for a flu pandemic exactly but actually it's true of -- well, it's true of day-to-day business of the NHS.

The only thing I would add is some of these things are administrative arrangements, some of them are statutory.

Q. Right.

A. So the role of NHS England and clinical commissioning groups and NHS providers, is all set out in the governing legislation and the relationship between the department and them is set by the legislation. Other things are non-statutory and therefore are at the discretion of the department as to how we set them up, such as expert advisory committees and boards.

Q. I understand. I think, in fact, I wasn't going to go through the statutory responsibilities, they're set out

in the statement, but we can see there that Public Health England are responsible for managing the pandemic flu stockpile?

A. Yes.

Q. Can you help us with that. Is it their responsibility to buy in the items of PPE or does that rest with the Department of Health?

A. So Public Health England is an agency of the department, so they are civil servants directly responsible to the Secretary of State albeit with an independent voice at the time on clinical matters. So things like what should be in the stockpile and how it is managed is a joint responsibility carried out by PHE but, as I say, they are an agency of the department not a statutory body.

Q. Is this the position that initially it was the Department of Health that was the lead government department, I think, until later on overall responsibility was taken over by No. 10 and the Cabinet Office. Can I ask you this, what does it actually mean in practice to be the lead government department in a pandemic?

A. I'll say a couple of things about this and of course the Inquiry has looked into some of these issues before in other modules.

So the lead government department means that it is overall your responsibility to both prepare for emergencies and then run emergencies in those areas when you -- when they occur.

Now, in practice, as we discovered in this pandemic, there is a point which is not set out formally but clearly happens when something is so big that it becomes clearly a whole government response and therefore the responsibility of the Prime Minister and the entire government and entire cabinet.

Now, we've put that point at the point when the first press conference is when the Prime Minister was clearly leading the response as being that point when we moved from, as it were, being -- this being a health issue to it being a whole government issue.

Q. So in your statement you say that you were the lead role until 2 March 2020, when the Prime Minister began to chair the COBR meetings before that --

A. As I say, that was not a thing that was set out in guidance pre, but in practice, once the Prime Minister is chairing COBR and leading press conferences, it's quite clear that the ultimate decisions are then whole-government decisions as opposed to something we could decide within the Department of Health and Social Care.

Q. Well, let me ask you this, did it make it more or less onerous for the department when you were no longer the lead government department?

A. To be honest, it made very little difference to the work of the department. Obviously in terms of there being a whole-government response it is very helpful, every department and the centre focused on this issue. And also, of course, in the situation we were in, just an inevitability: when it was the overriding issue of public debate and concern of course it was going to be prime ministerially led.

As I hope we've got over in our various statements, we focused very much on what was it that -- the things that the department could do, as set out in our battle plan and, regardless of whether we're the lead the department or elsewhere, trying to focus relentlessly on delivering those things, as it were. So if you asked a member of staff in DHSC, I suspect they wouldn't have noticed, they'd say, "My job was to work on battle plan 4, we were in the PPE cell", or whatever it was, and they were focused on the day job.

Q. We looked at the battle plan in fact in the opening. I'm not going to ask you much about that. Can I take you one stage back. On 10 February the Secretary of State requested the department to develop

an action plan.

A. Yes.

Q. Which I think was published in due course on 3 March.

A. Yes.

Q. And in that plan it was, and I quote:

"The UK is well prepared for disease outbreaks ..."

If I transposed "UK" for "the Department of Health", would you agree, Sir Christopher, or not whether the department was well prepared for --

A. I think partially yes and partially with the benefit of hindsight there were things we could have done better. So I --

Q. What's that?

A. So I would say a mixed picture.

Q. In what ways do you say the department was well prepared?

A. So -- well, if you look at where the UK did "well" compared to other countries in Covid, it was all the areas where we were strong prior to Covid. Very good science, research, a lot of which the department funded. The development of testing done by PHE was, in the early stages, world leading. The NHS response, is somewhere where there was a lot to commend. The overall government's financial response. So a whole series of

areas where we were strong pre-pandemic, and what the pandemic showed was we were very strong -- our use of the military would be another example. We have excellent armed forces, who helped us a lot. So there's a whole series of things at which we were strong before the pandemic and that showed up.

Q. All right.

A. There were then a series of areas where we were weak prior to the pandemic, which -- and this will be a theme of my evidence -- which the pandemic shone a spotlight on and magnified.

So it is not a secret that there were considerable challenges in the social care sector prior to the pandemic. It's not a secret -- and I would commend Lord Darzi's review of the NHS to the Inquiry -- that there were aspects of the NHS that were very challenged at the point of going into the pandemic.

It's not a secret that our colleagues in local government had faced some very, very difficult decisions around austerity which had left them not able to respond, and LRFs not -- sorry, you already know what LRFs are --

Q. Local resilience forms?

A. Yes, we had local resilience forums not able to respond as they were. And what we found in the pandemic was,

again, just like the areas where we were strong, excelled, those areas that were weaker, international supply chains would be another area and the underlying health of the nation would be another area, all those areas which were weak prior to the pandemic, the pandemic, as I say, shone a light on and highlighted.

Q. If I pause you there.

A. Yes.

Q. A little slower if you would, please, Sir Christopher.

A. Oh, sorry. I'm sorry.

Q. A number of those areas where you have accepted there were weaknesses are not all necessarily laid at the door of the Department of Health. If there were one that you acknowledged was a department weakness, what would that be?

A. Well, so of things, and the Inquiry has had my list several times of the five things we think we would want to do better in future, it's difficult to choose -- we thought very carefully about what those five were and they're built on the excellent technical report, that I know the Inquiry has, written by Professor Whitty, Professor Vallance and many others, so it's a proper -- proper piece of work. It's difficult to pick one of the five. If I had to pick one where we were challenged, it was the whole area of surge.

Now, this is obviously personal opinion, but I think the first-up response was very good, including, as I've said, developing some of the first tests anywhere in the world. And once we had got the full force of the state focused on the challenges we had, we delivered some quite extraordinary things, including the vaccine roll-out and, indeed, sourcing enormous quantities of PPE.

Q. Can I ask you about that, please.

A. I'll finish on your question.

Q. Please do.

A. So the most challenging question was getting up from the first-up response to the full weight of the state where we -- and I think Professor Whitty has spoken about this too, surging from one to the other is something we would want to be better at in future.

A lot of good things were done. As I've said before, I'm incredibly proud of what my colleagues in the NHS and in DHSC and in PHE did, but if we were looking at something we wanted to be better at in future it's that surge from one to another out of the five areas that I have talked to you about.

Q. Do you consider that the department had sufficient supplies of PPE as we entered the pandemic?

A. Well, so the question for PPE is supplies for what? So

we had about 420 million items in the PPE stockpile, which we believed at the time was sufficient not only for an influenza outbreak but also a sort of MERS/SARS-style outbreak.

As the Inquiry knows from previous modules, the pandemic we got was very different and required us to put PPE into far more settings than we were anticipating.

Now, where your question goes to, however, is would it have been possible to have a different stockpile.

Now, we ended up using I think somewhere around 15 billion items of PPE. I don't think anyone believes you could reasonably stockpile that number of items, and indeed the department worked out for that to be value for money you'd have to have a pandemic about once every ten years for it to do so.

So it goes back to my surge point, and this is how we're looking at stockpiles now, is do we have enough to get us through the initial period so that you can get your supply chains in line.

Now, the PIPP stockpile that we had --

Q. I am going to pause you there because I want to be clear. Although you're very familiar with this, those that are following Module 3 may be less so.

A. Yes.
Q. There are a number of different ways that PPE is procured by the NHS so I just want to back up if I may.
A. Yes, let me explain. So --
Q. Can I just ask the question and then you can answer it.
A. Sorry, yes.
Q. Is this right, that there was a stockpile of PPE held centrally known as the PIPP stockpile?
A. That's correct.
Q. Right. NHS trusts procured their own supplies as well, one of those providers being the NHS Supply Chain?
A. Yes, so not as well. So the business as usual position is that NHS trusts, and indeed care providers and everyone, is responsible for buying their own PPE, just as they're responsible for buying their own medicines, procuring their own -- so in the normal course of events this is not something that government is involved in. And exactly as you say, SCCL is one supplier. The majority supplier but one supplier.

We then hold an emergency stockpile of PPE at -- for emergencies, as we hold a number of stockpiles of other things, antivirals and some other things.

Q. SCCL is in fact, I think, a government company, government-owned company. We've been calling it the NHS Supply Chain --

A. Yeah, it is --
Q. It's one and the same thing?
A. Yes, yeah, but -- it is a supplier into a market along with other suppliers, but it does have the majority, so it's a very significant thing.
Q. And is this the position, primary care at the start of the pandemic were responsible for procuring their own supplies of PPE from private suppliers?
A. Yes.
Q. And that changed during the pandemic?
A. So in the pandemic clearly, and this is set out in our various statements, there was of course a world scramble for PPE. Somewhere around 80% of all PPE on the planet is made in China which was of course disrupted -- well, it was (a) disrupted because that's where the pandemic started, and (b) everyone was trying to buy from the same place. We therefore took the decision that we would have to do it nationally as various other countries were doing, and I'm sure the Inquiry has seen there are very similar stories from across the world about difficulties in buying PPE and the expense of doing so.

So we, like other countries, went buying centrally and then distributing for free not just to hospitals but to the other settings, including care homes where PPE

was required. And it was very, very hard. It was -- do you want me to go on?
Q. Pausing there. I want to look at the stockpile and then the other supplies that were required of PPE and do it in that order.

In relation to the PIPP stockpile, is it correct that in June of 2019 NERVTAG advised the department to add gowns to the stockpile for use in aerosol-generating procedures?
A. That is, indeed, correct and at the time of the pandemic broke out we were in the very early stages of that procurement, it having followed an entirely normal procurement process in peace time.
Q. The reality is, though, as you set out in your statement, as at 18 February -- can we have a look on screen, please, at INQ000389241_0057.

Having been advised in June '19 to get gowns, as at 18 February there was not a single surgical gown, was there, in that stockpile?
A. No, absolutely. No, that's completely true. We were seeking to buy somewhere around 20 million gowns for the stockpile. As I say, it was following, and this was in peace time an entirely normal government procurement process which was ongoing at the time that the pandemic started out. So given when the recommendation was made,

it is entirely unsurprising that that number is at zero.
Q. Sir Christopher, does it take eight months for the Department of Health to buy a sufficient supply, not necessarily 20 million, not even 100,000 gowns, as at the time we enter the pandemic?
A. Well, by normal government procurement, yes. So what happens in that period, you get an initial view from NERVTAG that we need gowns. You then have to specify exactly what type of gown and where from and then you have to run procurement processes which as you know are in normal circumstances will take months and months and months to do.
Q. All right.
A. So --
Q. Do you think it was too slow?
A. Well, the -- as I say -- well, there was nothing slow about this procurement. Can you argue that government procurement is very slow compared to other ways of doing it, yes, you can and many people do. What I will say, though, is there is a tradeoff here. So government procurement has huge checks and balances in it to ensure both value for money and fairness between suppliers. Of course what we did in the pandemic was we massively accelerated those things, raised our risk profile and then, as I think we'll come on to in a different module,

you face a whole series of different challenges about what is the quality of what you receive and et cetera. So the government does face this tradeoff.

Q. And no one is suggesting that on 17 June when NERVTAG said, "Go and buy some gowns", they were going to be procured on the 18th, I follow that. But once it was obviously the pandemic was coming down the track from January 2020, why is it still as of 18 February there is not a single gown in the PIPP stockpile?

A. Sorry, by the --

Q. 18 February.

A. By 18 February? Well, so what we did, so the procurement we were running for the 20 million was not going to deliver at that speed. We activated a whole series of what are known as sleeping contracts which was the other way which we procured -- planned to procure PPE in the pandemic and, again, as we have covered in a previous module, that is one of the bits of preparation that did not work, categorically did not work. And it's -- there was very little, I'm not quite sure what the right word is, nationalism that went on in the pandemic. We managed to procure large numbers of tests from abroad with one --

Q. I'm not asking you about tests.

A. No, sorry. The point I am making is PPE was about the

only area where a large number of national governments acted to prevent trade.

Q. Okay.

A. So we were not able to buy from the sources that we expected to buy because a whole series of countries had put restrictions on the export of PPE because of the world scare, so and I'll say I've been completely upfront about this, we -- our planning expected us to be able to buy at speed via the contracts we had signed and we were not able to do that.

Q. The NERVTAG recommendation was for -- one for gowns for use in AGPs as this would bring the stockpile in line with standard infection control procedures for seasonal flu. And so putting the fact that no one knew back in June that the pandemic was coming down the track, by winter that year you still didn't have gowns for an ordinarily predicted flu outbreak?

A. Yeah, well, I mean, so -- I mean, the government acts on the professional and clinical advice it receives.

Q. Yes.

A. So we had not received that advice from NERVTAG previously for reasons I completely understand and, as I say, it was following a completely normal government procurement process.

So, no normal government procurement process would

have delivered gowns for that winter and it was not planned on that basis.

I mean, as I said before, there are many critics of how government does procurement from many points of view including its timeliness so I can't disagree with your general point. What I'm saying is there was nothing particularly different about this procurement as opposed to what the government does normally.

Q. Right. Can I look at the position outside of the PIPP stockpile for a moment because I think in January 2020 NHS England requested a supply chain cell to be set up and is this right, that in February the department asked the supply chain cell to buy body bags, masks, FFP3 masks and gowns?

A. Well, the detail is set out in the department's statement so I think that is -- but as I say I'd refer to -- I think we set this out in some considerable detail in our statement so I'd refer you to that. But that's -- I think you're basically right.

Q. Is this for supply of PPE outside of the PIPP stockpile?

A. Yes. So as I say, the plan came in two parts. One, what you stockpile to get yourself through the initial period and then, two, speed buying because, as I say, no one can stockpile for everything you will need in an emergency, so this was the second part, as it were.

So you're using up the PIPP stockpile -- what's supposed to happen you're using up your stockpile as you put in place the long-term supply. Now, as I say, the PIPP stockpile played a huge part in keeping us going. The building up supply chains for the various reasons I've already explained was far harder than we anticipated and was a huge difficulty.

Now, it was not the only difficulty, as we discussed before. There were two challenges for us in PPE: one, getting the stuff into the country nationally; and then two, and actually more difficult and more challenging and I know this caused huge worry and concern to many healthcare workers, the distribution of it within the country when we got it. And as I say, most of our biggest problems were on -- the first one was very, very challenging and we were some time, as you'll have seen in our evidence, very close to the wire. The second was very difficult indeed and caused huge concern, rightly, amongst our --

Q. Pause there because I want to look at how close --

LADY HALLETT: Sorry, just before you go to that.

I am so sorry, I just wanted to go back. You said the sleeping contracts hadn't worked. Was that -- were they contracts where you hoped that British manufacturers would step in?

A. No, no. So there are almost no British manufacturers. As I say, 80% of world PPE is made in China.
LADY HALLETT: But there are people who otherwise might make --
A. No. So it was from traditional PPE suppliers. We did in the pandemic look at domestic supply but you have the issue of does the raw materials come from, which cannot be in the UK either, so it's a huge help to manufacture but it doesn't solve the problem and it's also, bluntly, much more expensive in peace time.
LADY HALLETT: So the sleeping contracts were international.
A. Were with international -- and as I say, every country in the world was doing this because very few people make PPE or have the raw materials.
LADY HALLETT: Sorry, Ms Carey.
MS CAREY: No, not at all.
Sir Christopher, may we look at how close to the wire we came by reference to a table set out in your statement INQ000389241_0063. Just whilst that's being brought up on screen, to help you, on 3 March the Secretary of State was made aware that NHS Supply Chain had introduced demand management measures, as it's called, to prevent over-ordering of stock and was planning to release the PIPP stock to maintain continuity of supply.

amounts of equipment, and et cetera, we normally have some supply issues in peace time at any point. A good example would be in 2018, I'm sure you remember there was a world shortage of Epipens.
Q. PPE, please, if you could focus --
A. Well, no, sorry, I'm just explaining the ... so the things that you do when you are short are exactly what you do here. You look for alternative supplies. You look to prioritise the supplies that you've got. You look for alternatives to things you run out with. And you demand-manage in the way you've described.
Pretty much exactly what we did for Epipens as to what we do with PPE, but on a much, much bigger scale, as it were, but the techniques used to manage what do you do when you have a shortage of a key medical product are no different in the pandemic than before or after the pandemic just on a much bigger scale.
So that was why demand management was put in. It's part of the standard playbook of what the health services do when they're short of a critical item.
Q. But there is, on any view here, a significant undersupply of gowns as judged against the reasonable worst-case scenario, isn't there?
A. Yeah, and, of course, fortunately the reasonable worst-case scenario was never reached.

A. Yes, that is correct. What I'll say about this --
Q. Pause, because I want to let people take in what it shows. Clearly we've got there different types of PPE, what is available at the time, what is available subject to clearance and testing and the like, what's on order, that's confirmed, presumably a degree of confidence it was coming, and then column D what was on order but you don't know really whether you're going to get it or not, and what the reasonable worst-case scenario was suggesting should be on hand and then, as we come to, the red and green and amber, where we got to?
A. Yes.
Q. And it's the red, understandably, I want to concentrate on.
A. Yes.
Q. Help us with this table, please.
A. So this was one of the tables we -- I mean we produced thousands of them, so this is but an example, we were monitoring, I think the cell was looking at the numbers sort of two or three times a day and, as I said, we were very close to the wire on a number of these things.
Now, the arrangements that were put in to ensure that we didn't run out nationally are nothing new but on a much bigger scale. So bluntly, the NHS, which uses, I think, something like 14,000 drugs and enormous

Now, the reason we plan on reasonable worst-case scenarios is to be safe. It's basically the rough percentage is the thing that's 10% likely to happen. So in 90% of cases of scenarios, the reasonable worst-case scenario will be more than you expect. We plan on it for safety purposes and the numbers here speak for themselves, that's why we were focusing on those items and why they are marked red is because we were very worried about them.
Q. I understand that but in relation to gowns do you consider, Sir Christopher, that the failure to have gowns in the stockpile as advised in June 2019 came at a significant economic cost?
A. Well, so, as I say, the procurement was -- it depends at which way you look at your question. If we had had gowns in the stockpile that would quite clearly have helped. There's no doubt about that. Would it have solved the whole problem, even if we'd had 20 million, I think we used about 100 million gowns across the pandemic so it would have met a proportion. Would I have expected, given the June 19 recommendation, to have gowns in the stockpile? No, I wouldn't for the reasons that I said. But obviously the basis of your question, would it have helped if we had had gowns in the stockpile? The answer is quite clearly yes.

Q. A gown in 2019 I understand was 33p and between February and July 2020 that rose to £4.50.
A. Yes.
Q. So that failure, whether it's systemic or naturally the slowness of the government machine procurement process, came at a significant financial cost, didn't it?
A. Well, so, I don't accept your word. I accept your description of the situation. I don't accept the word failure to --
Q. How would you describe it?
A. It was the playing out of normal government process. I accept, of course, your general point that the more things you have bought before the stockpile -- you have in the stockpile the cheaper the thing. But government faces a balancing act here and I'd refer you to the evidence that George Osborne gave in Module 1 that there is a choice between how much money you spend on preparation, and there is a lot you can spend on preparation, and having secure finances that allow you to deal with whatever crisis it is when you deal -- and that is a choice government faces.
Q. All right.
A. Now, the UK government chooses, and I think various witnesses have said this already, to run its health services with very little spare capacity. That is

a choice. It saves money in peace time, it gives us a huge challenge, but it does mean, as I say, as George Osborne pointed out, that you have resilient finances that allow you -- given you don't know what crisis is coming -- so I agree with you to the extent that that is a choice that governments make.
Q. All right. Now, put the economics to one side if you may. But do you consider the department's inability to purchase gowns for the PIPP stockpile is likely to have contributed to the acute shortages IPC guidance that was published on 17 April 2020?
A. As I say, had we -- it is self-evident that had we had 20 million gowns in the stockpile at that point, you know, say, the pandemic had happened later, that would have significantly improved our position. But as I say, you cannot and I don't think anyone argues that you can stockpile your way out of these challenges. It makes the surge bit much easier. We would still have had to buy 80% of the gowns that we needed on the markets at the price that you say. So it would have eased the position, quite clearly, couldn't argue with your analysis at all on that. It would have eased the position had we had gowns. Would it have "solved the problem"? No, it would not.
Q. The question I asked you was, do you consider the

department's inability to purchase those gowns is likely to have contributed to the need for that acute shortages IPC guidance?
A. Well, as I say --
Q. It's a "yes" or a "no", Sir Christopher.
A. I don't accept the word "inability", it was following a normal process. The question, had we had gowns would that have been better? The answer is clearly "yes".
Q. Had we had gowns, do you think we would have needed the acute shortages guidance that came into being on 17 April?
A. I don't know, is the straight answer. As I say, it would clearly have improved our position but would it have solved the problem? Well, I say, there's no counterfactual so I can't really tell you. But as I say, the basis of your question is of course correct. If we had had gowns in the stockpile that would have been better.
Q. We know that England had to receive 25,000 gowns from Northern Ireland the day after the acute shortages guidance came out and the Chief Nursing Officer was clear that that guidance caused real distress to the nurses on the front line who were made to reuse or sessionally use gowns.
A. Yes.

Q. Can I just ask you whether, on reflection, you think that the purchasing of gowns is evidence that the DHSC was well prepared for the disease outbreak?
A. No, I hope I've been quite blunt about what we think went well and what didn't go well. We have certainly reviewed how we do stockpiling since the pandemic, given what we have learned. When I ask myself the question, is there an individual who should, should rather than could, done something different with the recommendation we received from NERVTAG on that date, I couldn't say that there is an instance where I say there is a person or there is a decision that should have been done differently. As I say, your general point of would it have been better quite clearly stands.
LADY HALLETT: I think we've heard enough on procurement. I have a module dedicated to it.
MS CAREY: No, my Lady, I was going to move on save for one aspect, if I may.

Clearly you've acknowledged there was a supply issue with gowns.
A. Yes.
Q. And on 10 April there was a PPE plan published by the Department of Health.
A. Yes.
Q. And can we have up on screen, please, INQ000050008_14.

This was published on 10 April and in that plan at paragraph 1.24 it says:

"The UK was well prepared with a national stockpile of PPE which had been reserved for our preparations for an outbreak of pandemic influenza and no-deal Brexit."

Given that we've looked at the short supply of gowns and for the reasons you've outlined, do you think that was an accurate statement?

A. Yeah, I think it's -- I looked at this when the Inquiry sent this piece of evidence. The -- sorry, before I say, there was something I wanted to say about your previous question quickly. You pointed towards the distress that frontline workers felt, and we feel that profoundly, and nothing that I've said about what we've done, what we did, as I say, which I can defend in certain process terms, should be taken at all as we fully felt and understood the extreme distress that many frontline workers felt on this instance and it's obviously a matter of huge regret and sorrow to us, so I did want to make that point that I'm not trying -- you know, people were very concerned about PPE for very good reasons.

On this particular sentence, which, as I say, I looked at in advance of this hearing, I think it's

true but not sufficient. So the words on the page are true because it relates to pandemic influenza and no-deal Brexit.

With hindsight we had not planned, as is well-known, for an asymptomatic disease that required the level of PPE use that was made. Now, of course, on the date this was published we did not know the full significance of asymptomatic transmission as the Inquiry has heard from many witnesses. So in retrospect I think this sentence while true was too decisive.

So given what we at that time didn't know, as I say, while this is true there ought to have been more doubt because we didn't know enough about the disease to know that our stockpile was going to be sufficient, as it were. So I don't object to it having been written, as I say, I think it's a true statement on the day it was written. Looking back on it I think it was too decisive a statement.

Q. Can I look at some steps, please, that were taken to try and alleviate the supply chain problems and I think you say in your second statement that there was a national supply distribution response hotline set up on 16 March and initially, I think it was Monday to Friday, but it became a 24-hour service five days later on 21 March?

A. Yes. So this was something that existed already. We

had created it as part of our Brexit preparations and it was repurposed for Covid and it was exceptionally useful.

Q. It received between January 2020 and the end of July 2020 -- so the first wave in essence, coming to the end of that -- 36,277 calls. On any view, a phenomenally large number of calls?

A. Oh, exactly. And as I said in my previous answer, the levels of concern out in the system, both from individuals and institutions, is entirely understandable. So that is a huge number but -- huge but unsurprising in the circumstance.

Q. Are you able to help with what practically happened when a trust rang up the helpline and said, "We're running out of X PPE or Y PPE"? What actually happened and how quickly were they able to receive the missing item --

A. Yes, so what the helpline would do is it would basically triage. So it would work out what is the level of urgency compared to other people and then what is the requirement and then where could we fulfil that requirement for ...

Now there is a natural dynamic here where, if you are running an institution, it doesn't matter whether a care home or a hospital or -- et cetera, you want to be very sure that your PPE supplies are adequate, you

would want days' worth. Looking nationally, it was sometimes not able -- we were not able to supply days' worth, so we focused on the people who were going to run out most quickly, so if you were within 24 hours we were doing daily drops to most people. And there was, therefore -- even if we were doing, as it were, the right thing, you know, delivering to the most urgent and no one ran out, nevertheless if you were, as I say, either a healthcare worker or somebody running an institution, that would cause you huge anxiety, you know, because you're looking at your PPE stockpile and you're waiting for the next delivery.

So it was doing the right thing but, as I said, it's fully understandable why there were such levels of anxiety and concern. And we would if we were in those people's situation.

Now, obviously hospitals was what the system was designed to deliver. We had an entirely different set of problems -- I don't know if you're going to come on to this -- in other settings, care homes and GPs.

Q. We will.

A. Where were there a whole series of different challenges, which I'm sure you'll ask me about.

Q. Right. So can I just be clear, people calling in to the hotline were from a variety of different settings --

A. Yes.
Q. -- healthcare, primary care, social care.
A. Yes.
Q. Understood. So they're not all hospitals ringing saying: we need PPE --
A. No. And, of course, hospitals are big players, they have their own supplies and they're big institute -- and they're able to do the kind of compensatory measures that we did. Obviously much more difficult if you're an individual care home, much smaller scale, not used to doing these things.
Q. Can you help, how many call handlers were there, do you know, operating the NSDR?
A. I don't know. It may well be in our statements. I don't have the number. I can find out the number.
Q. Thank you.

I ask you that because could we have up on screen, please, INQ000339335_01.

There are what are called the hotline Covid-19 disruption reports. This is the one from 26 March at 1 o'clock. You can see there a large number of detail provided in the report, but it's the NSDR call data that I'd like to ask you about, where we can see on this date, at this time, what the position was for the preceding few days. And calls arrived approaching 2,000

by 19 March but it's the calls abandoned that I wanted to ask you about, Sir Christopher.

Clearly there's approaching 500 calls abandoned on or around 19 March. Was there any work done to ascertain whether there was sufficient numbers of staff manning the hotline to try to reduce the number of calls that were abandoned?
A. The whole reason this data exists is because of the very careful monitoring that was being done by the PPE cell. This is exactly the kind of management data you would want and expect to see at -- and particularly, as you have done, to identify calls abandoned.

Now the interesting thing about this graph is -- so most calls abandoned, the people actually call back, as it were.
Q. How do you know that?
A. Well, I mean, that is -- well, so that is a very fair question. I don't know for a fact --
Q. No. One would assume they would call back, but --
A. Now, the interesting thing about this is -- so you get a call spike, the first call spike, which leads to a number of calls abandoned. There's then a second spike, 23 March, where you will see the calls abandoned remains absolutely flat.

So, not managing the cell, I'm not a manager of

the call centres, but if I was looking at that data I would say a problem was identified and before the next spike it was dealt with, as it were. So obviously best is it never is identified -- it never -- but the whole point of management data like this, if you're leading an organisation, is to see if -- have you identified the problems and are they dealt with?

Now, this chart suggests that did happen, because, as I say, the next peak, which is actually longer, more calls, the calls abandoned line stays absolutely flat around zero.

So would it be better if you never got the calls abandoned in the first place? Yes, of course. But if you were leading an organisation you would see that as: management saw a problem and clearly had dealt with it by the time of the next spike.
Q. Pause there. Two things. It's my own fault for asking the question. I think I asked you how many advisers you had logging the calls and it actually says at the bottom of the page. As at 19 March there were 65. So that gives us an indication of the numbers --
A. Yes.
Q. -- potentially involved.

But can I ask you, in your capacity as permanent secretary, how often were you receiving reports of the

demand on the disruption report hotline?
A. Sorry, on this -- so I wouldn't not -- I mean -- so, as you know from our evidence, we have, you know, thousands of types of charts like this, monitoring different types of thing. So what I would expect as permanent secretary, and indeed what happened, is not that I would review these charts myself and second guess the leadership of the individual (unclear) ... far more than I do. I would expect, and this happened on a number of occasions in PPE, for the people who were leading the cell to, when there were problems, to escalate them to the extent of telling me about them.

Not normally because it would then be for me to deal but because I and ministers and indeed, in many cases, the Prime Minister needed to know where there were problems, partly for public explanation and also to see if we could help, as it were.
Q. Right.
A. So I would expect, and I think you would find this from any leader of any sort of organisation, that they wouldn't be viewing this level of detail themselves --
Q. No, I wanted to get a sense of at what stage are you brought in to sort out the problem.
A. Well, so, yes -- so brought in -- so -- and this is particularly -- it's true of any organisation but it's

particularly true of health and care. The biggest leadership question is who is best placed and has the knowledge and competence to deal with this problem best. Is it a clinician? Is it an expert in the area or whatever? And then what things do need national escalation to somebody else, as it were.

So the chances of me better knowing how to run a call centre than people whose expertise it is to run the call centres is zero. Can I ring up -- and I did this on I think one occasion -- ring up an organisation that also runs call centres in government, I think it was either DWP and HMRC, and say "Can you help us?"; that I can do, if you see what I mean.

Q. Right.

A. What I don't want to suggest there is some magic about being permanent secretary that means you have better solutions than the people who actually know how to --

Q. No, it wasn't that, I wanted just to get a sense of when it is that you're brought in to help --

A. Yeah, so it's --

Q. -- not in relation to this --

A. Yes, so what I did, so I had a daily meeting of all my key leaders around the organisation, and I would expect them to tell me in that meeting where there were issues that went beyond the sort of normal challenge.

Q. All right.

A. You know, "We've got a particular problem with X, Y and Z", and we moved resources around as a result of that meeting, depending upon where the spotlight was. So that would've been my main mechanism for knowing, and obviously I did look at a lot of data, but the main thing is do the leaders in that area escalate the problems.

Q. I'm not going to ask you about the parallel supply chain that was set up as well --

A. Yes.

Q. -- but I do want to come on in time to June 2020. And if it helps you, I'm at paragraph 236 in the second statement.

Could we have up on screen, please, INQ000389241_74.

I want to ask you about the halting of the buying of PPE stocks because I want to be clear about what was halted, when and why.

And in the statement you say:

"Once we were confident we had sufficient PPE supplies on order to create a ... four-month supply stockpile [by] mid-June ... the purchase of most categories of PPE was halted. The dates buying was halted for each type of PPE were: ..."

As set out in the table on our screen.

Halted for how long?

A. In some cases we haven't started rebuying yet.

Q. Right.

A. So the way this was done, so we established a reasonable worst-case scenario. In this case the reasonable worst-case scenario was in fact a multiplier of how much Covid and then on Covid usage, so we had, as it were, two worst-case scenarios multiplied together. And as it says in the statement, they worked out a four-month number for that reason -- those reasonable worst-case scenarios. And that was taken -- as I say, there was a lot of professional input to this taken as, you know, that being a safe amount where you could reasonably say we're very unlikely to run out.

Now, what happened in practice, of course, is we got nowhere near the reasonable worst-case scenarios, as you would in 90% of cases. That is, of course, excellent. And that is why, and you will have read the reports, we actually ended up a with large amount of PPE at the end that we had to store at considerable cost and have been disposing of.

Now, bluntly, I would much rather be answering questions about why we ended up with too much PPE --

Q. Than too little?

A. -- than other questions.

Q. All right. Can you help me in relation to FFP3 masks, were they -- was the buying of that reinstituted perhaps around the winter of 2020 into 2021?

A. I think it's set out in our statement. I can't remember off the top of my head the date. I think we did and I think you're referring to the bit of the statement where it says that we did.

There were two things on FFP3 masks: one is the absolute number and the second was diversifying the types.

Q. That's what I wanted to come on to, actually, because in September of 2020 the PPE strategy was set out, and in that DHSC said they were committed to understanding the needs of individuals using PPE and improving their user experiences. And there was reference then to the difficulties that women had with wearing PPE --

A. Yes.

Q. -- people who were black, Asian or of minority ethnic origin --

A. Yes.

Q. -- and indeed some others. So can we just focus on that for a moment.

Are you aware of how diverse or otherwise the PPE stockpile for FFP3 masks was to enable FFP3 masks within

the A&E --
A. Yeah, so it was -- it had diversity in it but not enough, and that is why we took the actions that you describe. So -- and how it's been explained to me and, as I say, this is not my professional expertise, so how it's been explained to me: masks, very, very different from any other PPE because it requires the fit test. No one should be deployed to a high-risk area without that fit test having been completed and them having a mask that suits them.

So what should have happened in accordance with the rules is, if there wasn't a mask available that fitted your face type because of your gender or your ethnicity, you shouldn't have been deployed to a high profile -- a high-incidence area.

Again, I know because lots of people have told us, this causes considerable stress in the system both for institutions and individuals, who would understandably worry about that position.

Now what we did, I think we had four different -- and this is from memory so if I get the numbers wrong I'll correct them afterwards. I think the original stockpile had four different types of FFP3 mask and we expanded that I think to about 20 --
Q. Yes.

A. -- particularly, and the cell looked at this in considerable detail, around the ethnicity questions. So again, with hindsight, obviously the sooner we had done that the better, but we did it in response to the concerns that were raised with us. It would obviously have been better had we done it quicker.
Q. And the current stockpile, does that have a sufficiently diverse range of masks to cater for gender, ethnicity?
A. I think so. Again, I will check exactly how -- what -- because it's been constructed slightly differently -- yeah, I'm 99% certain yes, but I'll just check the last per cent for you.
Q. One of the things you say in your statement is that the department set up what are called engagement -- customer engagement panels through staff groups with protected characteristics, including those from different ethnic backgrounds. And obviously in those forums PPE provision was discussed.
A. Yeah.
Q. When were those engagement panels set up, do you know?
A. I can't remember when they were set up, but --
Q. Was it pre-pandemic or during the pandemic?
A. It was -- well, the -- I think the ones you're -- so we do a lot of consultation anyway and we -- and then we of course set up a whole load of things specifically for

Covid. I think the specific groups you're talking about were specific to Covid. But the issues had been identified very early. So the Chief Medical Officer, as you know, asks for the Kevin Fenton report on the effects of ethnic minorities on -- of Covid, not just of PPE but more generally, and those issues were identified and that's why that thing was set up.

On medical equipment, this is another area where there were concerns pre-Covid which were massively highlighted. So as a --
Q. I want to come on to pulse oximeters and other medical equipment in a moment --
A. Well, I was going to make a more general point because it does apply to PPE. Through the Whitehead report we did find, which was -- had not put -- been put together in the way -- and we think we are the first people in the world, along with the Americans, to have done such a study, we did find this bias in medical equipment generally, including PPE, that had been there for quite some time. And as I say, Covid shone a spotlight on it but there quite clearly was a problem with how medical equipment is designed, tested, researched and provided that has biases in it.
LADY HALLETT: Sir Christopher, if I could ask you to slow down or I'm going to have the stenographer going on

strike.
A. I'm terribly sorry.
LADY HALLETT: Also if you could wait for Ms Carey's question, because otherwise what happens is if the two of you are speaking at the same time it's a nightmare --
A. I'm sorry, I will slow down.
LADY HALLETT: Thank you.
MS CAREY: Let me try as well.

Before we come to biases in the equipment and the like, can I just finish with the PPE.

Can we have on screen, please, INQ000389241, page 85. I just want to deal with the engagement panels, because in March 2021 -- it will just be coming up now. There you are, at paragraph 290:

"Further to the engagement panels, in March 2021, the Department commissioned the CO Covid-19 Taskforce Field Team to consult directly with health and social care frontline workers ... [the] engagement highlighted the following key themes:

"i. Some staff felt that they had been given lower priority than others in PPE provision."

And it sets out some examples of that.

The other theme was:

"ii. A lack of confidence in some to raise concerns or a feeling that they would not be listened

to."

And if we go over the page:

"iii. Reports that the fit of the PPE should have been better, the range more varied, and a request for approved clear masks."

And then:

"iv. Requests for greater agility in future emergencies ..."

Those concerns having been raised in the engagement panels or in the work of the task field team, what did the Department of Health do to address each of those four concerns?

A. Well, so the first thing to say is none of that would have surprised us. Many of these issues existed pre --

Q. Okay, well, let me ask you, then: if it's not new, why wasn't something done to try to address it before we got to this stage?

A. And I can send you more information on this. I mean, there were things being done pre-Covid and I think all those issues, the challenge is they hadn't worked. Now, in Covid particularly on the ones that relate to staff consultation, of course during Covid while a lot of effort was put in to this area, we of course -- we were doing things at enormous speed and we weren't consulting as much as we would normally. And that was -- it's (a)

a big problem and (b) a fact of life. So, as I say, it doesn't surprise me.

A lot of these issues are about -- are within the NHS, and I know you spoke to Amanda Pritchard about them yesterday and I won't add to what she's said, other than to say, as I say, they are long-standing difficult issues that haven't been cracked yet.

Q. I understand the acknowledgement or concession, call it what you will, that this is nothing new. But why --

A. No, sorry, if --

LADY HALLETT: Wait, wait, wait. Please.

MS CAREY: The question I wanted to know is what is the department doing, for example, to try and address the concern that some staff felt they had been given lower priority than others in PPE provision?

A. Well, so I didn't mean to sound in the way that you described me that this is nothing new, these are incredibly important issues. What I'm saying is they are long-standing and very, very difficult issues.

Now, as we've set out in our statements, we took a whole series of actions, particularly around the provision of PPE for ethnic minority staff not just to reassure people but to actually change what we were providing in the way that I've already described.

Now, clearly and, entirely understandably,

a number of staff felt particularly early in the pandemic that these issues and, you know, we couldn't do anything about those retrospectively so I'm clear we took a lot of action that improved the situation, that's entirely --

Q. Can you give some examples?

A. I've given you some. The clearest one is the change of policies on the types of FFP3 masks. There are a number of others which I can supply but that's a very clear example. But as I say, I don't want to diminish the issue just because it had been long-standing, nor does the fact that we dealt with it later we change people's perceptions of what happened. Those are all -- this is stuff we have to crack and people's concerns are entirely reasonable and understandable.

Q. Can I ask you about, please, a request for approved clear masks, and I think you say in a different document that DHSC was piloting clear face masks with the NHS and indeed social care. The idea was that you could see through, they would be anti fogging, and obviously aid communication for those that require lip-reading or are better assisted. Are you able to help with what was the result of the pilot?

A. This is something that as I understand -- so two things. So, as it has been explained to me, because it is not

one of the areas I know or have witnessed myself, the supply in the pandemic was simply not available. So -- and lots of people wished, including us, wished to buy clear masks but there were none to buy. Bluntly. So which I think is why we were piloting it and I'll check the exact position now and come back to you. I think progress is being made but I'll check exactly what and come back to you.

Q. Thank you. Can I come back to the biases in medical equipment and in particular ask you about pulse oximeters.

A. Yes.

Q. You set out in the statement from the department that you were aware of the concerns that were raised that the accuracy of pulse oximeters detecting oxygen in people with darker skin was questionable, to say the least.

A. Yeah.

Q. Can you help now, were you aware of these concerns prior to the pandemic? I say "you", the department?

A. So I certainly wasn't. There had been -- it had been raised by people, not specifically with the department, and it was known about publicly. So to that extent everyone knew. It was not an issue that, as far as I'm aware, the department was dealing with or taking action on prior to the pandemic.

Q. Right.
A. I wouldn't particularly have expected the department to, you know, prior to the pandemic we were an organisation of, I think, 1600 people. These are operational questions and would be one of a number of operational questions. But as I say, I'm not aware the department was taking any action on that issue.
Q. Now, we are aware that NHS Race and Health Observatory published, I think in March 2021, a Rapid Review about pulse oximetry primarily and racial bias, and it made a number of recommendations and then in November 2021 the department conducted its own independent review. Can I just ask you, was the department's independent review anything to do with the recommendations made by the Race and Health Observatory?
A. As I remember it wasn't a direct recommendation, so this was -- it was something that the then Secretary of State Sajid Javid made a sort of personal mission. He was very concerned about the situation. He, as I remember, discussed it with his American counterpart and launched the review as a result which, as I say, I think is the first such review done anywhere and the findings were -- well, you can read the review as well as me -- stark.
Q. I'm going to come on to the findings. The terms of

reference for the review ask that consideration be given as to how the UK should drive forward, their words not mine, international standards on health equity in medical devices. And so is there any work ongoing to collaborate internationally to ensure that future devices don't have an inbuilt ethnic bias?
A. Yes, and as I said, it started, as I remember with the Secretary of State discussing it with his American counterparts who, of course, drive a huge quantity of the market. It does have to be -- this is a world market, as I describe, so it has to be a world change, but there are big things that the UK can do unilaterally.

The biggest single thing is the change that the MHRA I understand has made to make the approval of medical devices one of the questions being about the inclusiveness and the research base on a variety of different characteristics, before they approve.

So we've made, and I say this is probably the biggest thing, a specific regulatory change about those devices that we regulate. But as you say, the world market will have to change to actually solve the problem.
Q. The review was announced in November 2021. I think it was completed certainly in late 2023 and then the

government published it in March 2024.
A. Yes. So the government took the decision, and this was an explicit decision that it wished to publish the report at the point it was ready to respond. So to set out what the government would do as well as the problem definition that -- the report, and that took till that time. I should say although, as I say, the issues were highlighted by the pandemic, I don't think there was ever any suggestion that the review and its consequences would have any effect upon the course of the pandemic because timescales are much too long. So this was seen as a long-term piece of work not as a -- it was caused by the pandemic but it was not part of the response.
Q. It wasn't the solution to the problem that had been identified. But do you think, Sir Christopher, that a review being announced in November 2021 not in fact being published until March 2024 is too long a time to wait for such an important review?
A. Well, again, and I can't argue with you, all these things it's better -- the quicker the better.

I completely understand the government's wish to be able to say what it was doing about it and some of those things are very complicated, regulatory changes are very complicated, and obviously supply considerations and market considerations are a very complicated thing to

do. You can take the view that you publish the review as it is and the government responds some time later or you can do it this way. The choice --
Q. Do you know why it wasn't done, that the review came out when it was ready and the government quickly followed?
A. As I say, you'd have to ask the ministers in question but I think they wished to be able to set out not just the problem but what the government was actually going to do about it and the action it was going --
Q. Can I ask you about one of the recommendations.

Could we have on screen, please, INQ000468614, and perhaps when I have finished this, my Lady, it might be a convenient moment for a break.

But recommendation 1 of the review was that:

"Regulators, developers, manufacturers and healthcare professionals should take immediate mitigation actions to ensure existing pulse oximeter devices in the NHS can be used safely and equitably for all patients groups across the range of skin tones."

And the government response is set out:

"The government is committed to ensuring that pulse oximeters are safe and effective for all patients. Work is already underway to mitigate any inaccuracy in these devices fulfilling many of this recommendation's sub-recommendations."

Can you help with, Sir Christopher, as to what work is already underway to mitigate the inaccuracies?

A. Well, and this was done during the pandemic as well. Well, the first thing to say this is a clinical device so it's mainly a clinical matter for doctors and I know -- so I am reporting what I have been told not my professional expertise.

Theme one is simply doctors knowing and other medical staff knowing. So if you have somebody, you have a pulse oximeter reading, and they have a dark skin, knowing that the reading will not be the same as a white person is obviously very important. One of the things that was emphasised by, I think it was the NHS, during the pandemic is that one of the most crucial pieces of data from an oximeter and, as I say, this is not my professional expertise, I simply repeat, is the change in the reading rather than the absolute level. So it is not the case that an oximeter is not useful for people with different skin tones but you have to understand that the base level will be different and look at the changes over time as being crucial.

So there are -- as I say, you should mainly ask the doctors involved but there are medical practices you can take that mitigate the base problem that these devices do not work properly for people with dark skin

as they do with people with lighter skin.

MS CAREY: My Lady, would that be a convenient moment?

LADY HALLETT: Yes, certainly. I shall return at 11.30.

MS CAREY: Thank you very much.

(11.13 am)

(A short break)

(11.29 am)

LADY HALLETT: Ms Carey.

MS CAREY: Sir Christopher, a number of different and discrete topics I would like to cover you during the remainder of your evidence, and I think in your department's statement number 4 you make it clear that NHS England is and was during the relevant period responsible for operational delivery of NHS healthcare and it's the department that holds NHS England to account.

A. Yes. Now, that is the formal legal position and very important that we stick to it. It was there -- they are both the people with the legal duty to run the NHS and also, of course, the people with the expertise, as you will have seen from Amanda Pritchard and Steve Powis and many others in the course of the Inquiry's work.

Our job formally is to hold them to account. In practice what happened during the pandemic was we were in constant discussion with NHS England and they would

be consulting us, as they would consult many other people on what they were doing. So things remain their statutory duty but they will have been discussing it with the department. We would have been making our point of view clear -- ultimately their decision on how to run the NHS. Some discrete areas which are set out in the statement where it is the department's decision or the wider government's decision, for example around funding.

So the strict legals was not quite how we worked in the pandemic for reasons you'll understand.

Q. Understood. Can I ask you about NHS 111.

A. Yes.

Q. The department is not directly involved in commissioning the services of 111 or their operation, but the Inquiry has heard considerable amount of evidence about 111 calls going unanswered, indeed the Healthcare Safety Investigation Branch found as such. Professor Snooks, who we've heard from, told us, I think, at one stage there was 1.1 million calls unanswered.

Did the department play any role in monitoring the performance of NHS 111 and in particular the sheer volume of unanswered calls?

A. Not specifically, no. I am sure those issues will have been discussed, would have been identified by

NHS England and discussed with the department. We would have known about them but in terms of monitoring and activity that would be for the NHS.

Q. And does it follow, therefore, from that last answer that you're not aware that the department had to step in and ask either NHS England or Public Health England to review the performance of NHS 111?

A. Not that I recollect, no.

Q. Can I ask you about shielding, please. In the statement it sets out that letters were the main form of communication for those who ended up on the Shielding List. Can I ask you this. In the current climate was any thought given to the use of email as a way of communicating with those who were shielding?

A. So this was a programme, as you know, that was the lead responsibility of my colleagues in the Ministry of Housing, Communities and Local Government, we were a significant contributor, but the issue you raise is one that the NHS faces all the time.

We do give consideration to email. Of course not everyone has an email --

Q. No.

A. -- and, in particular, many elderly and vulnerable people do not, which is why we continue and they continue to use letters because you normally have the

address frequently not the email and you don't know whether it's checked, as it were.

So I understand the difficulties here though it wasn't our decision.

Q. Understood. All right. The statement says that text messages were also sent when shielding was extended in late June 2020.

A. Yeah.

Q. The Inquiry has in fact heard of text messages being sent much earlier, back in March when the shielding programme was got up and running. Are you aware of why there is potentially only reference to texts being sent in June if in fact people were receiving them much earlier?

A. No, I don't think I can explain that.

Q. In February 2021, the National Audit Office published a report on protecting the clinically vulnerable. Some of the recommendations by that report were for the department --

A. Yes.

Q. -- and I'd like us just to look, please, at INQ000059879_27 to start with.

This was taken from the report which sets out the various data that went into creating the shielded patient list --

A. Yes.

Q. -- coming from various source, hospitals, GPs, medicines data, maternity data, and the like. And then in due course the National Audit Office recommended that the department ensured that healthcare data systems could allow easy but secure access to healthcare data. Is work ongoing in that regard and if so --

A. Oh, yes, a huge amount of work although it's very -- sorry, the first thing I should say is that we signed off the National Office Audit report as being accurate and we did a Public Accounts Committee hearing on it and we thought it was a very strong report and gives a very clear statement of what went well and what could be better.

Now, data sharing is a colossal issue in the NHS. Three interrelated reasons: one, legal and we have some powers to do things about that and authorise data transfer, which we did during the pandemic.

One, correctly, privacy concerns, that a large number of the public are concerned about how their personal data is used both by the NHS and others and we always have to be mindful of that.

And third, entirely practical, which is can the systems talk to each other and you will, I'm sure, have seen the reports about the NHS's creations of --

apologies for the jargon -- the federated data platform work which is all about that and other programmes making the practicalities of data sharing easier.

Now, in this particular case the privacy one is very pertinent because obviously to identify an individual who needs shielding you have to be sharing very personal data. So that was obviously -- even in a pandemic that is a matter of obvious concern.

Q. So given that the National Audit Office recommended the department should ensure the data systems allow the access, if we were to have a pandemic at the end of this year, how confident are you, Sir Christopher, that perhaps some of the data problems would in fact be much better this time around?

A. It would be better but not good enough for us yet. So with data generally, not personal data, we made huge strides which we have maintained post the pandemic in -- particularly data in social care on which we held very little -- of course they're private businesses -- so we made a huge step forward in data about social care.

And, as I say, the NHS -- you know, within those very important constraints that I described as major programmes around data sharing. So it would be -- it would definitely be better but I don't think anyone, I don't know if you asked your NHS witnesses, no one

would say it is right yet.

Q. Can you help with a timescale for when you think it will be good enough?

A. No, not really because it's one of those circumstances where technology and the world moves on at such pace that the challenge is continually evolving. So if you take an example like genomic data, very, very important in the treatment of disease, could not be more personal and people are, entirely understandably, very concerned about the sharing of their genomic data, vital for health care.

So as that becomes -- they -- our challenge will change and I'm sure there will be technological advances both in IT and in the medical world that will continue throwing up those challenges. Wearable tech is obviously creating a lot of data; how is that shared, et cetera.

So, I don't think it will ever be perfect. We are trying to get continuous improvement here.

Q. Is this an area that requires legislation?

A. I don't actually think that it does. Well, it might do. I think the winning of the public debate and I have said this before in public, so I will say it again, I don't think either government or health or technology industries have done enough to recognise people's

concerns about privacy and to deal with them, and to explain, bluntly, that there are some tradeoffs here. You know, if you are prepared to give up some privacy we can give you better healthcare but it's your choice, as it were.

Q. Right.

A. So I don't think -- I think winning that public debate and reassuring people about the use of data, I think that's more important than legislation. There may need to be legislation that follows, and the government is doing some legislation, as you will know, but in health specifically it's the winning of the argument and then bringing the legislation and regulatory regime up to date with where public opinion is as opposed to believing we could pass a law and solve the problem.

The challenges are the tradeoffs in the public mind between two public goods, as it were, one privacy, one for better healthcare through data.

Q. Can I ask you, please, about DNACPRs.

A. Yes.

Q. In your --

A. Sorry, DNRCPR --

Q. DNRs -- we call them DNACPRs, do not resuscitate orders or notices.

A. Yes.

Q. The statement from the department sets out that during the early stages of the pandemic there were concerns raised that there was blanket use or inappropriate use. And when you say "early stages", are you able to help, Sir Christopher, as to when the department became aware of potential --

A. I think there was very --

Q. -- inappropriate use --

A. -- very -- well, so there were -- so, there's a clear regime on do not resuscitate orders that existed prior to the pandemic, in particular focusing on informed consent of individuals and their loved ones, and there was a low level of concern, of which everyone was aware prior to the pandemic, that the good practice was not always followed. So this was not a brand new issue. Again, like other areas, highlighted and spotlighted by the pandemic and made much bigger.

I think it was very early indeed, I think in -- sorry, March/April 2020, and a series of actions as set out in the statement by various bodies were taken, which -- I mean, all they do is re-emphasise the existing position that blanket DNRs are totally unacceptable, that they have to be individual clinical choices and based on the good practice and the consent.

Q. Right.

A. Now, when -- and various people have looked at this -- there is much more evidence of bad practice in consent than there are of actual blanket arrangements having been put in place. And --

Q. Can I pause you there, because I'm going to come on to look at what steps were taken potentially by the CQC and the like.

A. Yes.

Q. In your statement you said that the department did not receive inappropriate or evidence of inappropriate and blanket use of DNACPRs. Did the department ever ask for such evidence?

A. Well, we set up the CQC reviews to find out the exact thing. And it's not surprising that things wouldn't come to the department. The police is -- if you are concerned about do not resuscitation orders, your first ports of call would be the regulator, the CQC and NHS England. You wouldn't expect people to decide to raise things with the department.

But as I --

Q. That's not what I asked. I didn't ask whether they raised it with you, I'm asking whether the department --

A. I don't --

Q. -- ever asked for evidence of it.

A. Well, so we asked for the CQC review.

Q. Yes. That was in October 2020.

A. Yes.

Q. If concerns are coming in March and April or early --

A. Well, we had heard of concerns and we had discussed them with NHS England, and the guidance that was put out was -- well, you know, obviously it wasn't the department that did it but we were part of the discussions that led to -- so action was taken.

I'm not aware the department received any specific examples of the blanket use, as opposed to general inappropriately used, evidence, but we certainly asked NHS England.

Q. Now you made the point in an answer a moment ago that the letters were sent out by CMOs and the like reiterating the position across, indeed, the entire UK --

A. Yes.

Q. -- that DNACPRs should only be imposed on an individual basis.

A. And in line with the good practice.

Q. Quite. Absolutely. But come the autumn, and in the lead-up to the department commissioning the CQC to conduct its report, there were an increasing number of reports again of inappropriate or blanket use.

A. Yeah.

Q. And can I ask, please, that is put on screen INQ000478907. Could we go to the final page, page 3 of that document, please.

Because here we are now in September of 2020. And it's -- is the "MSC" the minister for social care?

A. Yes.

Q. "... MSC has ... requested that we have a method of assessing the scale of inappropriately applied DNACPRs. This is to include any data on the scale of the problem and what we are doing to monitor ... this ..."

And the minister wanted a submission setting out what the position was.

A. Yeah.

Q. And if we go back then to page 2, I think in short there were questions being raised in Parliament about it.

A. Yeah.

Q. And there was an issue, in short, with not being able to quantify the extent of the problem.

And could we go to page 1, please.

"Thank you for this information. To further add to the commission to sub below - to provide different options for assessing the scale of ... DNACPRs ... please see the readout ... from the Quad Meeting ..."

A. Yeah.

Q. "[Secretary of State] ..."

Is that?

"... raised the issue of blanket DNRs. Simon Stevens [the then COO NHS England] asked for details ... as this should not be happening."

A. Yes.

Q. "Chris Wormald noted that we need to be able to say publicly and in Parliament that this is not happening."

A. Yeah.

Q. Did you know whether it was happening?

A. No, sorry, that was my whole point and the whole point of this conversation. So it's the NHS's job to deal with this issue, as the presence of Simon Stevens makes clear. My view here is not controversial and was widely held there ought to be a total zero tolerance and that that's what Parliament and the public would expect, that we had a complete zero tolerance of any blanket bans. And then Simon Stevens makes his slightly caveated point. But it was an issue for the NHS to take away and deal with and you would have -- expect Simon Stevens to do so. And as I say, the NHS, as I understand it, took a series of very important actions in this area.

Q. If you didn't know whether it was or was not happening, can you account for why this note of the meeting doesn't say that in terms?

A. Well, the whole point of the meeting, as I think your --

you've now taken down the previous page -- was held because questions had been raised about whether it was happening. That was the point of the meeting at all.

Q. Some might read this as you being more worried about being able to say it wasn't happening, irrespective of whether it was or it wasn't, that the optics were what you were worried about --

A. No, no, not at all.

Q. -- Sir Christopher, not the actual reality on the ground.

A. No, not at all. We are required, ministers and we are required to tell the truth, and in particular tell the truth to Parliament. My point was that Parliament and the public would expect there to be a zero tolerance to this and that it shouldn't be happening and that we needed to get to the position where we could truthfully, in line with our requirements under the Ministerial Code and the Civil Service Code, truthfully say to Parliament that it wasn't happening.

Simon Stevens then correctly sets out a slightly more caveated position, but I don't think -- well, you could ask him, but I don't think Simon would disagree with my position, which I think was a general position, that there ought to be complete zero tolerance of this and that the public and Parliament would expect the

government to be able to say that.

Q. So this was not a concern by you more of appearance than --

A. No, we had huge concerns. I mean, so -- I mean, you'd have to ask clinicians, because obviously this is a clinical thing. My lay reading is that the guidance given is very clear indeed about what good practice and not good practice is. And just like every other area of clinical practice, you would expect clinicians to be following the guidance. And reports that they were not doing were taken incredibly seriously -- as I say, you have a Secretary of State meeting here with the Chief Executive of the NHS. That was its level of seriousness. Everyone was very, very concerned about the situation indeed.

I mean, generally and personally -- I mean, anyone I think can probably put themselves in the shoes of someone who has a relative who has an inappropriate do not resuscitate order and how you would feel. And then of course, in terms of national policy, the position, as I say, was very, very clear and people should have been following it.

Q. The interim report from the CQC identified that there was evidence of unacceptable and inappropriate DNACPRs being made at the start.

A. Yeah.
Q. And indeed concluded it was possible in some cases DNACPR -- inappropriate DNACPRs remained in place. Once the CQC had published their interim findings, can you help with what action the department took to address the concerns raised by the CQC?
A. Well, of course, the biggest action we took was to commission the report in the first place, and it is in the end a matter for the regulator, the CQC, to regulate the system. That is their statutory responsibility.

So the most important follow-ups are for the CQC and for the NHS itself -- and the medical professions, because, as I say, this is a clinical matter. Our job, and you said at the beginning, holding people to account, is to continually press for action and updates on this issue.

As I say, I don't think there was anyone I am aware of in the national system, be it CQC or NHS England or anyone else, who didn't take this issue incredibly seriously. So I don't -- my recollection is it's not something the department had to press people to action on. It was making sure that action was effective and, as I say, that there was zero tolerance of bad practice.
Q. In due course the CQC's final report was published in

March 2021, and that resulted in a ministerial oversight group being set up.
A. Yeah.
Q. And the terms of those we can read for ourselves but I'm asked to ask you, did the department take any steps once the CQC's final report had been published to ensure that DNACPRs were being made on an individual basis?
A. Well, the actions are as set out in the CQC report, importantly, as you say, with a ministerial oversight group, the actions of which are set out in our statements. I wouldn't repeat them. And that was the action that fell to us.

As I said before, I detected absolutely no lack of willpower on the basis of anyone working in the centre to deal with this issue. I haven't met anyone, clinical or otherwise, who doesn't have the same view that bad practice in this area is unacceptable. And certainly, as far as I could see, everyone was doing -- you know, putting their shoulder to the wheel to deal with the issue. Which isn't to say there aren't terrible cases where it doesn't -- where it continues to happen, but I don't think that is due to the lack of willpower from any of the national bodies.
Q. Okay. New topic, please, the life assurance scheme that was announced on 27 April. This is in your third

statement from the department.

The scheme was announced I think on 27 April 2020. It provided, in short, a £60,000 lump sum for the families of those who had -- recovered by the scheme -- who had contracted Covid at work.
A. Yeah.
Q. And included in that I think were pharmacies, if the pharmacist was based in a hospital or a GP setting. Do you see it follow therefore that community pharmacists were not initially included in the scheme?
A. So I'd like to say something general about these sorts of schemes, if I may, before I start.

So these are always incredibly difficult because you're dealing with human beings in terrible circumstances and government schemes always, as you know, work by criteria and rules, and there are always people who are very deserving who fall outside of those. That is just an awful problem with government schemes of these sorts, that regardless of where you draw the line there are people just the other side of it, and you have to feel for those people. So it's always an incredibly difficult issue, this one.

How it was dealt with in this case. So the starting point was to replicate what the NHS pension scheme does for NHS employees for returning staff. It

was actually originally the suggestion of the BMA. They raised this issue with us.
Q. That community pharmacists should be included?
A. No, no, no, the original scheme.
Q. I see, thank you.
A. So if you are a returning worker, so you've retired, you've taken your pension, you return to work in the NHS, you're then not covered by the life insurance bit of the pension scheme.
Q. Right.
A. The BMA raised this with us. As you know, we don't agree with the BMA on everything but in this case they made a hugely valid point. So we started with can we replicate for returning workers.

Ministers then decided they wished to extend the scheme beyond what we do in peace time, extended it to care workers.

You then have the question that you've raised about where do you draw the line on people who are not the employees of the NHS, and what ministers decided on was that on top of, as it were, the people who qualified automatically, there would be discretion --
Q. Right.
A. -- for other people and a number of pharmacists were covered by a ministerial decision.

Q. Pausing there, Sir Christopher --
A. So they're not in the main scheme but there was a discretionary scheme to allow people not just pharmacists to be included.
Q. Right. Pausing there, please.
Can we have a look at an email chain, INQ000050020_3.
Bearing in mind the background you set out, there was then discretion to add groups in.
A. Yes.
Q. If one looks at the email at the top of the page which is 11 April 2020:
"Apologies for the delay getting this back to you.
"[Secretary of State] has considered and made the following decisions:
"All pharmacy staff are to be included."
A. Yes.
Q. A very clear steer there from Mr Hancock as it would be at the time, that all pharmacy staff are to be included.
And if we go to page 1 of the email, indeed I think the Minister for Social Care:
"We have now had a discussion with minister" -- is that right, MS(C)?
A. Yeah.
Q. "... to go through the outstanding issues ...

"[The minister] set out the rationale for preferring the ... lump sum ...
"We ran through the further work we have done on the case for including pharmacy staff given [Treasury's] concerns. The rationale is based on pharmacies having a 30% increase in workload with a higher likelihood of seeing COVID patients than in other retail environments. Pharmacy staff also have to go close to give advice and also see patients in their consultation spaces where social distancing is not possible."
Given what on any view is a pretty clear steer from both Mr Hancock and, indeed, the Minister for Social Care, when the announcement was made it was not clear, was it, that this included community pharmacists?
A. No. So as I understand it, that position was not agreed by the Treasury and therefore there wasn't a blanket inclusion of community pharmacies. That was then part of the discretionary scheme that I've just described where a number of pharmacists who sadly died were included in the scheme, community pharmacists.
Q. We have heard from the chair of the National Pharmacy Association who told us the scheme having been announced, I think on 27 April, on 30 April Mr Hancock tweeted to say that community pharmacies or pharmacists were included and whilst he acknowledged the quick

turnaround, he said it was demoralising and demotivating for that not to have been clear from the start. Is the problem here lying with the Treasury not agreeing funds or a miscommunication on what it is?
A. I think a bit of both. So we could have -- so I think -- so the first thing to say is I think that, as I say, wherever you draw the line there are terrible cases where you morally think we should pay on the other side of that line. So having a discretionary scheme that allowed you to pay money to people who didn't qualify, I think is a very good idea. Not just for this scheme but generally for the reasons that I described at the beginning.
And I think as I'm not -- I don't think I've read the Tweets in question and I don't think they were in my evidence pack.
Q. No, they're not, I just summarised them for you.
A. Yes.
Q. In short, there was a turnaround that included pharmacists.
A. Yes, I mean, if Mr Hancock believes it could and should have been communicated better I wouldn't disagree with him but, as I say, I haven't viewed the Tweets myself. And I reiterate the point, this was a much more generous scheme than the thing we did normally. That still,

because you draw a line, means there are people the other side of the line and these sorts of, you know, very difficult stories and that does make it also very difficult to communicate.
Q. Can I move to GPs and the number of appointments that were face to face, home visits via remote consultation. This is set out in your fourth witness statement.
Could I have up on screen, please, INQ000469724_6.
Sir Christopher, the department acknowledges the pandemic led to unprecedented changes to the work and behaviour of GP practices, and then has set out there the various numbers of appointments. Is this UK-wide or England only?
A. I would imagine -- I think -- I'll check but I think this is England only. I mean, GP services are a devolved matter --
Q. They are.
A. -- in the other three so I believe these are England and it may say in the footnote but ...
Q. I don't think it does but we can check that.
A. I'm not -- again 99%. I'll check for you but I'm pretty certain this is England only.
Q. If we look at the early stages of the pandemic, we can see there in February we went from 19.2 million face-to-face appointments down to 15.9 the following

month and then in April a significant drop to 7.4 and 7.7, with increasing rises -- well, sorry, decreases in home visits and then increases in telephone appointments.

A. Yes.

Q. Was that part of a particular policy that the department was involved in?

A. Well, involved -- so it's the responsibility of NHS England to contract for GP services, as we've described previously. As I described previously, this will have been discussed with the department. We could have raised objections if we'd wanted to but it's a decision, well, of individual GPs, of clinical commissioning groups, and then of NHS England but of course the department is involved in everything in the way that you've described.

Q. What I wanted to ask, really, was: we know that there are a number of reasons why people may have wanted to avoid making face-to-face appointments with GPs. Not overloading the NHS for one, not contracting the virus for another reason, and general concern about what was going on. I just want to understand, what did the department do to try and ensure that people sought face-to-face appointments if they felt they needed a face-to-face appointment?

A. Well, as I say, that is mainly an issue for NHS --

Q. Why is that not an issue for the department, though, generally?

A. Well, because this is a -- it's one of the biggest NHS services, it is run by NHS England in the way that I've described. The NHS's message was exactly as you say and the department supported that message.

I don't think the communications, certainly as played out in the national media, worked that well. This ought to be all about balance. Many people -- there are many people who prefer online appointments and many people that don't. There are many people who don't need a face-to-face appointment and there are many people who do, and if the system were working, like, absolutely properly by reducing the burden on GPs by doing online appointments for those who either positively prefer or don't need, you ought to be freeing up GP time for the people who do need, you know, a physical examination or are in a state of vulnerability where they wish to talk face to face and the system should have, if it were working perfectly, that should have been the perception of it.

Clearly, certainly in the national media it was not a perception so I couldn't say that the communications that the NHS did and we supported worked

and my overall view is that we need to rebalance this argument more about what sort of appointment suits which people as opposed to face-to-face good, online bad, or vice versa.

Q. Can I broaden the issue because it's not just GP appointments, I think you are aware in the department of a drop in people attending A&E, for example?

A. Yeah.

Q. The Healthcare Safety Investigation Branch were concerned in their report that people weren't seeking medical advice if they couldn't get through to 111, for example. So it permeates a number of aspects of the healthcare system's response.

What role, if any, did the department have in the public messaging that said: come to us if you need us, come to A&E, in the face to ... (*inaudible words: multiple speakers)*

A. Again, it's -- now, obviously, national government as a whole was very active on public communications, press conferences and the various slogans that I know you've debated, so obviously it was a big issue for national government and the department was one of the people who were part of the discussion about what those messages should be but not the decision-maker.

In terms of what was the impact, well, you asked

my dear colleague Professor Whitty this question and I completely agree with what he said.

Q. You said in answer to a question a moment ago that we need to rebalance this argument. Can you think of any practical ways in which one might do it differently in the event of a future pandemic?

A. Well, so ideally, and there is a lot of work going on on this subject, in -- and it's not the phrase but it sort of captures what I mean. In peace time, ie not in a pandemic, ideally we would be striking the kind of balance I am describing in the business as usual activities of the NHS, that those people who want to access it digitally via the app or via other digital services can do so, that that reduces pressure on face-to-face services, which can then focus on those people who need face-to-face services.

Now, so, my view -- I mean, obviously, we learned a lot in the pandemic on this subject and so did the NHS. But if we can get those sorts of balances right in peace time that will put us in a better position when the system comes under pressure in a crisis whether that's a pandemic or any other sort of crisis.

Q. Can I move to your final statement, please, Sir Christopher, and what is termed the "lessons learned" statement by the department.

A. Yes.
Q. And in that statement you say the department has identified five themes within which it has learned lessons and made changes in respect of pandemic preparedness, and I'd like to ask you about each of them. We may have covered some of them as we've been through your evidence this morning.

The first of those was theme 1, was to have a toolkit of capabilities that can be adapted to any future novel disease or public health risk, and you say that that includes equipment, skilled people, infrastructure, and research capability.

May I ask you this. Please don't take this rudely. We hear very big, broad themes but I want to know what actual work is being done to create a toolkit of capabilities by the Department of Health?
A. So it's completely central to what we do. As I said in Module 1, not only were we over-focused on an influenza plan, but we were over-focused on plans, period. It's incredibly difficult to plan for a crisis where you don't know what the disease is or how it will spread or any of those things, so the more you can have capabilities you can use for any crisis, the one you don't know about as opposed to specific, the better.

So -- and there are some very specific things. So

my colleagues at UKHSA, I don't know if they were questioned about this, have a lot more PCR testing capability available now than they did before the first pandemic. Probably the biggest single intervention we've made is on the on-shoring of a vaccine platform with Moderna, not just for Covid vaccines but for other vaccines and for that to be on-shore.

In PPE we are taking the approach, the surge approach, item by item of how long will it take us to get overseas stuff and therefore how much do we need to hold on particular things.

Again, of vital importance, continued investment in the science and research base --
Q. I want to come on to that because a number of witnesses have commended to her Ladyship the need for ongoing investment into research programmes and is --
A. Yes, that's -- *(inaudible words: multiple speakers)*
Q. -- it the department in part that funds the NIHR?
A. No, the NIHR is entirely funded by the department. So there are three types of -- we are blessed in the UK with one of the finest research capabilities in the world and we need to keep it. It is funded in three ways -- actually, four ways.

There is obviously considerable private investment by particularly the pharmaceutical companies. There are

some very significant charities with endowments who invest in research. And then publicly there is the General Medical Council, part of UKRI, that invests in, as it were, pure research and then the department, and we're reasonably unique in government in doing this, we invest through NIHR in translational research.
Q. What does that mean?
A. So pure research is the discovery of things. Translational research is how you turn those discoverables into things that -- so we do the bit, the, sort of, in R&D the D end of: here we have a new thing, a vaccine or whatever, how do we get that used in hospitals and in health. We spend about 1 billion a year and, as I say, I think we're reasonably unique in government in providing this. And the great strength of our research base in this area is the diversity of the funding in different things from those four sources.

So if you think of it as an ecosystem which has those four components, add to that we are, again, lucky to have some of the absolute finest universities in the world in this field, Cambridge, Oxford, Imperial, UCL, a lot of others, which are again a vital national asset in science, and maintaining that ecosystem of research is (a), very good economically, not the issue for this Inquiry but it is. But in pandemic or indeed any other

emergency preparation, having that science-base that can turn itself to anything is absolutely vitally important.

So obviously the AZ vaccine, developed in Oxford, that didn't appear out of the blue. That was a platform partly funded by NIHR and others. That it existed, that it was already researching Coronavirus vaccines gave us a colossal head start and would have saved many, many lives around the world.

So that is what I mean by a capability.

So again, and many of my answers in this area will be the same, there is a lot of progress. Are we where we would want to be? No, it is a continuing thing. But as I say, the science base, absolutely key.
LADY HALLETT: Can I just ask a question. I appreciate I'm going to be having a Test and Trace module. So forgive me if this question comes out of the blue. At the very beginning of your evidence you said one of the strengths was testing.
A. At the research --
LADY HALLETT: Exactly. You meant producing the tests.
A. So very specifically --
LADY HALLETT: Just pause for the question.
A. Sorry.
LADY HALLETT: I do understand.

You mean the fact we developed a test. But one of

the problems when the pandemic struck was that we didn't have the Test and Trace capability that could be scaled up quickly. Public Health England could only do so many tests a week and in a pandemic you need to do thousands a day.

A. Yeah.

LADY HALLETT: So what are you doing to make sure that we have the capability to be scaled up with Test and Trace?

A. Yes, this is mainly a question for my colleagues at UKHSA. I don't know if you discussed this with --

LADY HALLETT: We didn't probably because the team thought -- because I have a separate module but as you raised it earlier I thought I'd pursue it.

A. Right, well -- yes, we might stick it up.

So there is: what's your initial testing capacity. This is assuming that you can actually develop a test for whatever it is. So in the last pandemic, HIV, it of course took years and years to develop a test. So the first thing, you can't assume that just because we were able to test for Covid quite quickly that that would be the case in the next pandemic. And then you have the general and the specific test. So PCR tests are used for many different diseases --

LADY HALLETT: If you could -- I am so sorry to interrupt, but everyone has limited time so I mustn't allow too

much time for myself. If you could just focus on what are we doing about having the necessary infrastructure to be able to put into place swiftly a scaled-up system of Test and Trace? Assume we've got the test.

A. Right, so immediately, UKHSA has reported to me that they can do around 10,000 PCR tests a day as opposed to 1,000 that we could do pre the pandemic. That's obviously a very big difference. I'll confirm the numbers with -- as I say, my UKHSA colleagues are the experts.

And then they are working with industry about how you scale up from there. Because obviously -- I think we got up to about 2 million tests a day which, as I say, no one can stockpile for and that is about industry capacity to create LFD tests of the type that we all took.

Now, there are lots of steps in that which may not be possible in a future pandemic. We may not have a test, you may not be able to create an LFD test or whatever, but it's the work done by my colleagues on UKHSA both on their initial testing capacity and that surge bit that I would point you to.

LADY HALLETT: Thank you.

Sorry to take you to a different module.

MS CAREY: Not at all.

Theme 2, as identified by the department, was to ensure that there was underlying resilience of the system because that was considered by the department to be central to pandemic preparedness in terms of estate, facilities, equipment, workforce, security and medical supplies, pretty much across the board in terms of the healthcare system's response.

And you make the point in the statement that the NHS was operating at high occupancy for general acute beds, high occupancy for critical care beds. And in fact when we compare ourselves with other OECD departments, the UK runs at very little spare capacity.

A. That's true.

Q. And in short, if that is the decision taken by the politicians to run it in that way, do you consider, as permanent secretary, that undermines the ability of the healthcare system to be prepared ahead of the next pandemic?

A. So, as you say, it's a political choice.

Q. Quite.

A. And it's a political choice with consequences for how much tax we pay and what we spend on other public services. Obviously, we spend far more on health than any other public service. So there were some big political, rightly, political choices in there which

I won't comment on.

Clearly, how much spare capacity you have in your system is important when you have a crisis but then so, as I was describing earlier, is a resilient economy.

The key bit of work, of course -- the two key bits of work that the current government -- obviously not the government that was there for the pandemic -- has done. One, as I mentioned before, is the Darzi review, which gives you a very clear and stark description of what the state of the NHS is and what the causes of that were, which are not all financial but you can -- as I say, you can read the report as well as I can. Lord Darzi is very clear. And then the process that the government is currently running to develop its ten-year plan for the NHS, including -- and this goes to some of your previous questions -- I think we would say a much higher level of public and non-public sector engagement than when we have done these exercises before with civil society and with the general public and with NHS staff. And clearly what is then in the ten-year plan on these subjects becomes the government's answer to these questions, including that very difficult trade-off that we've just described between, you know, current performance, spare capacity, impact on other public services and impact upon the taxpayer.

Q. One of the matters you raise, obviously, clearly, is the resilience of the workforce.
A. Yes.
Q. And acknowledging as we do that you don't employ the NHS workforce, I would like to know nonetheless what recommendations the department has got to try to help the resilience of the workforce. Not NHSE's plan or the various devolved nations' plans but the department itself.
A. So I would refer you to the NHSE's workforce plan that the department was very, very closely associated with, and I think it was even co-branded, I'll check, but that sets out for the first time a long-term projection not just of the total workforce size but the individual specialities and how we need to develop the workforce. So that is the department's answer in that area.

And there's a general theme here that, as I say, it goes with the what's the resilience of the system, that you have to build this thinking into how we run the health and care service day to day as opposed to saying: we do that and then here's a separate pandemic plan that we take off the shelf.

So if we deliver the workforce plan and have a much more resilient workforce, that doesn't have the kind of workforce gaps in it that we see at the moment,

we do that because that's how you get a great NHS, it has the corollary that you are better prepared for emergencies of all types, as opposed to the way of thinking that goes "We need a separate emergency plan", as opposed to saying what we need is, you know, a properly staffed, properly skilled NHS workforce with the right technology.
Q. Theme three, as identified, was the ability to scale up staffing and equipment quickly as that is considered essential. And we've heard from a number of witnesses in the ways in which that was achieved, so I'm not going to ask you about it, Sir Christopher.

But the theme four was an acknowledgement that diagnostics and data are crucial in a pandemic response. And we've touched on that in your evidence but can I ask you this: is the Department of Health doing any work to monitor the deaths of healthcare workers in the event of a future pandemic?
A. Well, I mean, that's crucial the death of healthcare workers for whatever reason is monitored.

We put this one in because -- I mean, you could say it's a subset of some of the other ones but it was so crucial -- the diagnostics question that I was discussing with the chair was clearly very crucial and when -- we discussed data earlier and the improvements

we need to make in data sharing. So that was the purpose of that. But as I say, we take all deaths in service seriously.
Q. No, and I understand that, but the question I ask is: is the department actually doing any work to monitor the deaths of healthcare workers?
A. Oh, sorry, NHS England does, as a piece of day-to-day business. For a future pandemic it would be very, very difficult to do, just because of how many different types of pandemic you have. And I'll draw your attention again to the difference between the HIV pandemic and Covid in terms of who it affected, what its effects on healthcare workers are and what you need to do about it, well, they are self-evident.
Q. Do I take it from that answer that in fact you say that's the responsibility of NHS England to monitor the deaths and collate the data?
A. Yes.
Q. Right. And what about Long Covid in healthcare workers, is that a departmental matter or a matter for the NHS --
A. So -- well, so Long Covid amongst NHS staff would be an NHSE matter.
Q. All right.
A. As you know from our statements, there is a number of things the department has done and the NHS has done on

the question of Long Covid more generally which also impacts on, so the research we do on Long Covid is just as relevant to NHS staff as it is to anyone else.
Q. The fifth and final theme identified by the department was that preparedness should be along the five routes of disease transmission.

Clearly we've been concentrating on the respiratory virus. Who does Department of Health say should be responsible for preparing along the five different routes?
A. Well, everybody. So UKHSA is absolutely key and they are looking at all five routes. The NHS also needs to think about these things. And not just for pandemics. So there was a lot of publicity about Mpox, which spreads in a very different way and requires very different health response. We need, as they do, our NHS colleagues to be thinking about all five routes. But the actual -- the lead responsibility is with our colleagues at UKHSA.
Q. If you could reflect on this finally, Sir Christopher. Is there any one single recommendation that you would urge upon her Ladyship which would improve the healthcare system's response in the event of a future pandemic?
A. It's incredibly difficult to pick one. I hope I've

highlighted --
Q. I know.
A. -- some of these. The science base and research I think is absolutely vital. I think the capabilities over plans, capabilities and resilience over plans is absolutely vital. I've already talked about the vital importance of surge. So I would particularly highlight those ones, as I have in my evidence.

I can't remember if I said earlier, all this is built on the technical report that Chris Whitty and Patrick Vallance and others did, and I would say commending that to future scientists and clinicians, we will certainly be doing that, so that would be the other thing on my list.

I don't think I can pick one. You know, getting down from everything in the technical report to those five, that was a considerable effort, so, beyond what I've already said about the importance of things, I don't think I can pick one, sorry.
Q. Don't worry, we have the technical report well in mind.

Sir Christopher, they are all the questions but I know there are some questions, my Lady, from core participants.
LADY HALLETT: There are, please.

Now, is it Ms Iengar today?

Questions from MS IENGAR
MS IENGAR: My Lady.

Sir Christopher, I ask questions on behalf of the Long Covid groups, and following on the theme of recommendations, my two very brief questions look forward to the future of Long Covid services.

The experts to the Inquiry, Professor Brightling and Dr Evans, describe Long Covid services as the foundation, the bedrock, as it were, to finding solutions for people living with Long Covid. And they raise concern that a number of the existing Long Covid services were already under threat and noted that there is likely to be shrinking of the clinical services next year.

Sir, do you agree that Long Covid, both the prevention of Long Covid and the provision of Long Covid healthcare, are matters of ongoing public health priority?
A. Yes, I do agree. Obviously -- and the service provision questions are for my colleagues at NHS England. As you will know, there are a lot of health priorities that they have to maintain but I would agree with your question, Long Covid is extremely important. Obviously for the people who have -- sadly are afflicted by Long Covid, including some NHS staff, and actually

future research is very important, services are very important, and public understanding I think is very important.
Q. And the Inquiry has had sight of a recent joint letter. I wouldn't take you to it but, my Lady, for reference, it's INQ000498103. It's a letter from the Clinical Post COVID Society and the British Society of Physical & Rehabilitation Medicine, and they raise similar concern that the ICBs were reallocating funding intended for Long Covid to other services while there is a significant unmet need for Long Covid patients. And the letter continues to forewarn that depriving adults of those services can lead to more serious chronic health and, for children, deprivation of services stunted biophysical development.

And my second and final question is this, simply, do you agree with the experts and the clinicians in this field that there is a need for ongoing and adequate funding for Long Covid healthcare to ensure the sustainable provision of Long Covid services?
A. In principle, yes. I can't comment on the letter because I don't think I've seen it. And I don't know whether ICBs are doing what you -- doing what you describe. I mentioned the ten-year plan process for the NHS, which I say is deliberately a very open process

where we are taking views from everybody about what the priorities and the services of the NHS should be. I know Long Covid will be a part of that and I hope that your -- the groups you represent are full participants in that, and I'm making the point -- and I -- not just about how much money but what are the services that most improve the lives of people with Long Covid.

And as I hinted at in my previous answer, the research in this area is very, very important. This is obviously a very new condition and we don't know enough yet about how it is best managed and treated, so the underlying research which allows us to make improvements in both the services and further areas, those are very important as well.

Final point, of course, ICS is -- the point of them is to make difficult trade-off decisions based on their own local populations about services. So, to the extent that -- are they taking it in? Of course they are. That is their job. I would hope that, as with many other conditions, ICSs are well informed about Long Covid needs as they take those very difficult decisions locally about what services to provide and how to provide them.
MS IENGAR: Thank you, Sir Christopher. Thank you, my Lady.
LADY HALLETT: Thank you very much.

Mr Burton.
Mr Burton is in a similar position.

Questions from MR BURTON KC

MR BURTON: Thank you, my Lady.
Good afternoon, Sir Christopher.

A. Hello.

Q. At paragraph 25 of your statement ending 3872 you mention the importance of having good data and that during the pandemic ONS data was used.

A. Yeah.

Q. Are you aware that the only way the ONS was able to compile any data on disability was by using the 2011 census?

A. I couldn't answer on exactly how the ONS compiles its data. I -- if you're telling me that's the case, I'll believe you.

Q. Well, perhaps if I could ask you -- the follow-on question, really, was this then. I mean, do you believe during the pandemic the department had sufficient data available to it about the prevalence and relevance of disability?

A. Probably not. And it was not alone in this area. We have some of the most fantastic data in the world on many, many issues of health. It's one of the advantages of a single payer system.

I won't repeat the challenges but very frequently the data exists but it's very difficult to share and sometimes for very good reasons. I mean, people care about their privacy as I described.
What we found in the pandemic generally on data was very frequently the data was there, difficult to compile on a comparable basis for some of the reasons I've described, often with too great a lag. Not till 2011, in terms of NHS data, but still it tells you what happened three months ago.
And then the crucial bit, which your question points to, is there's quite a danger that you spend all your time observing data as opposed to taking decisions that help people. So that's the real challenge in this area: there is an awful lot of data, but how you get to "it is this data set that actually allows us" -- to your question -- "to plan services for people with disabilities better in a place."

Q. Was your previous answer just now generic about data or specific about --

A. Generic, but I would say it will apply to data of all types. So I'm sure in the NHS as a whole there will be enormous quantities of data about individuals with disabilities. It's the ability to bring that together and then take useful decisions about service planning,

which very often is about place.
So, going back to the discussion of ICSs I was having with your colleague, "Can an ICS plan services in an area that are better" is much more important than whether nationally we can observe something.

Q. I understand that.
I'm now very much focused, with two quick questions, on the future. Are any improvements being made or pursued by the department at the moment in terms of collation and deployment of disability-related data, as far as you're aware?

A. So I refer you to my answer earlier about federated data platforms, which would also cover this area. So I'm not aware of a specific initiative but that general "can we have systems in the NHS that allow us to share data and draw conclusions better", you would hope. Well, the intention of it is that everyone benefits and that the people in most need of services benefit most. So that would cover ...

Q. And my final question related to that, the department's own research demonstrates that there were very significant disparities in terms of mortality between disabled people and non-disabled people --

A. Yes.

Q. -- and I'm sure you're aware of that, but what I really

want to ask you is this. By way of an example, the department's reports highlight that even where one controls for factors like age, et cetera, in relation to people with a learning disability they were at least two more times likely to die of Covid than people who were not disabled and this remains unexplained.

A. Yes.

Q. Do you feel that the department has done enough to understand why the disparities for disabled people in relation to mortality occurred?

A. No, not yet, and we need more research. And this is not just true of the area you're describing, it's true of every area. Where something is unexplained we need our wonderful researchers that I described earlier, a number of them funded by the department, to move it into the category of explained and then to move it into the category of what are we going to do about it.

Q. Well, exactly, Sir Christopher.

A. So, no, and it's, I'll say not just about your area, and I don't know if you asked these questions of the Chief Medical Officer but he would be even stronger than I. The whole purpose of medical research is to move things from being unexplained to explained and then to: can we do something about it that makes people's lives better?

Q. So insofar as it's not currently explained, you would be

anticipating that efforts will be made to explain it in due course?

A. Exactly. And, as I say, both the government, the department, the private sector and the voluntary sector put huge resources into research, entirely rightly, for exactly the kind of reason that you are describing.

MR BURTON: Thank you very much, Sir Christopher.

That's the end of my questions, my Lady.

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

Mr Stanton.

He's behind you. If you could make sure your answers go into the microphone.

THE WITNESS: Yes, I will turn back.

Questions from MR STANTON

MR STANTON: Good afternoon, Sir Christopher.

I ask questions on behalf of the British Medical Association. I just have one question area to cover with you which relates to an issue you were discussing earlier with Ms Carey around the stop order on items of PPE, specifically the stop order in relation to FFP3 masks which was put in place on 30 June 2020. You might recall that particular section of your statement was brought up on screen, I don't think there's any need to go back to it unless you --

A. No, no.

Q. What I'd like to explore with you is the basis on which FFP3 stock was deemed to be sufficient at that time. And I'm hoping this is one of the areas where you'll feel able to agree with the BMA.

Just a brief amount of context. You're obviously aware FFP3 masks are an important piece of protective equipment and that they provide significantly greater protection than other forms of masking. You'll also be aware that knowledge about the risk of aerosol transmission developed quite significantly between March 2020, when the main route was thought to be droplet, and to a position in September, when the Inquiry's expert, Professor Beggs, has stated that there was at that point enough evidence of moderate certainty to strongly suggest that Covid was transmitted by the airborne route.

And you yourself in your 12th statement, at paragraph 58, show some insights into this issue. I'd like to take you briefly to that passage. We can bring it up on screen if it would help you or I can read the relevant passage.

A. No, this one, I don't think it was in my evidence pack so if you could bring it up on screen.

Q. Certainly. So that reference is INQ000473872 at page 23. Paragraph 58. And you'll see there you say:

"The department considers that evolving knowledge emergency of routes of transmission constituted an important feature of, and learning from, the healthcare system's response to COVID-19, particularly in relation to IPC measures. It is essential that the healthcare system is properly equipped to deal with all routes of disease transmission as it is impossible to predict what type of pathogen a future pandemic may involve."

And so my first question, Sir Christopher, is, in June when the decision was taken to stop ordering FFP3 masks were you aware that the evidence for airborne transmission and therefore the potential significance to the supply of FFP3 respirators was evolving?

A. So I'll answer this in two parts. So in terms of were we aware that knowledge of the disease was evolving? Yes. And in a whole range of areas not just that one and I think my colleague Professor Whitty has covered that in considerable detail and all my knowledge comes from his and his peers, so I will not add any lay views.

In terms of the decision, I don't think I have any knowledge to add to what I said earlier about that decision. And as the chair noted, we've got a whole module to do on this --

Q. Yes.

A. -- so I think it would probably be better to answer that question there with somebody more expert in that specific part of the decision than I.

Q. Can I then just try and address this issue towards the IPC guidance.

A. Yes.

Q. I appreciate you would have had no involvement in setting the IPC guidance. You're not responsible for that. However, provision of FFP3 respirators to healthcare workers in general healthcare settings was limited by reason of the IPC guidance because the guidance specified the use of those respirators in high risk areas such as ICU and for specific procedures such as AGPs.

This had real-life profound consequences for healthcare workers and the Inquiry has heard from witness -- just two weeks ago an Inquiry witness spoke about the circumstances in which she became infected as a physiotherapist dealing with or providing care to a person with Covid-19 in circumstances where she had wanted an FFP3 mask but was not provided with one because the guidance didn't specify.

Again, I appreciate that's not your area of responsibility but the rationale or any insights you can give for the rationale for stopping FFP3 mask orders

might give some insight into the basis of that guidance.

For example, some of the IPC cell members have suggested that the guidance was based on sciences; others have suggested it's based on supply.

So I wondered at what point did it become clear to you that there was a significant risk of aerosol transmission?

A. To me, personally, I cannot recall. I know it was raised with me by the clinicians. But on your general point -- so, the IPC guidance is written by clinicians and it is based on the science. And they've always been very clear that while you also have to write plan Bs based on what is available, as we did, as we have been discussing -- sorry, I'm not talking into the microphone, am I?

The core guidance, very frequently based on WHO and other recommendations, is written by clinicians based on the science.

So on -- is the guidance right, either then or now, I think is something that BMA ought to discuss clinically, about is that guidance right, and as I said earlier, on a whole range of things, including a lot of clinical things, we have good relations with the BMA so I would hope that those discussions were productive.

In terms of the stop, that was based on -- well,

the clinical advice, the modelling and the level of supply and I don't think there was any relationship between the drafting of any clinical guidance and what we had -- and that stop decision. That was, as I understand it, that was entirely clinically led, based on the science, as you would expect, and then we modelled based on the clinical advice we had received, what four months' supply would look like and made our buying decisions accordingly.

I am -- certainly, that is what I have been informed is it was that way around. The rest of those questions, as I say, would be better discussed with your clinicians.

Q. Understand. May I very quickly ask you about the modelling. Was the modelling based on the need to supply FFP3 masks across the whole range of healthcare settings and therefore the only limiting factor was the IPC guidance, or was the modelling based on only needing enough supply in ICU settings and for AGP procedures?

A. As I understand it, but I will have to check and maybe better it's done in Module 5, I think, as I understand it, it's based on the clinical guidance and then the reasonable worst-case scenarios as I described earlier in this hearing.

So, I don't think there was a different

clinical -- as I say, I will check for certain because I haven't asked this question in the terms that you say it, I don't think there was a different clinical definition of what was required that went into the modelling than the published IPC guidance. I will check for certain but that's my understanding of the position.

MR STANTON: Thank you, Sir Christopher.

Thank you, my Lady.

LADY HALLETT: Can I just a question. You said, Sir Christopher -- I thought you preferred being called Sir Chris.

A. No, I actually prefer being called Chris without the "Sir" but ...

LADY HALLETT: Well, you can't have that. You shouldn't have accepted the knighthood if that's your preference.

A. Oh hear. I walked into that.

LADY HALLETT: Can I ask you a question. You say that you understood the guidance was written by clinicians.

A. All our -- so, clinical guidance is written by clinicians.

LADY HALLETT: I know, but you were being asked by Mr Stanton about IPC guidance. Do you understand IPC guidance to be written by clinicians?

A. Yes, yes.

LADY HALLETT: By clinicians, do you mean medically

qualified doctors?

A. Normally, yes, though of course nurses and others are also very important in this area.

LADY HALLETT: But you understood that it was doctors who were helping to write the guidance?

A. Not helping, to -- writing it.

LADY HALLETT: Writing it. Medically qualified doctors?

A. Yes, well -- not just medically -- well. So, clinical guidance should be written by people who are not just doctors but are clinically expert in the area that the guidance is concerned with. Now, I think, from memory, in the case of infection prevention and control that would certainly, I think, have included the Chief Nursing Officer and nursing, as you know, is very central to infection.

LADY HALLETT: No, my point is -- I appreciate the nurses. My point is, did you understand that medically qualified doctors were writing the guidance along with many of the experts in IPC and any of the chief --

A. Yes, so clinical, if something is described as clinical guidance, as opposed to any sort of other guidance, it has been written by clinicians.

LADY HALLETT: I don't know if you want to pursue that, Mr Stanton, or are you content?

MR STANTON: No, my Lady, I'm happy to leave it there.

Thank you.
LADY HALLETT: Thank you.
Sir Chris, I appreciate you may wish to get away but you were prepared to come back this afternoon. There is still about half-an-hour's worth of questions, so if you don't mind, the stenographer has had quite a tough morning, we will break now --
A. No, I am at your disposal all day. I'm not going anywhere until the questions have finished.
LADY HALLETT: Don't worry. You'll be gone by this afternoon, mid-afternoon. 1.45, please.
(12.45 pm)
(The short adjournment)
(1.45 pm)
LADY HALLETT: Who was next? Is it Ms Sen Gupta? It is, she is on her feet.
MS SEN GUPTA: It is, my Lady, thank you.
Questions from MS SEN GUPTA KC
MS SEN GUPTA : Good afternoon, Sir Christopher.
I represent the Frontline Migrant Health Workers Group. Our client's members are outsourced non-clinical workers largely from ethnic minority and migrant backgrounds and clinical nursing and healthcare assistant staff, all of whom are from a migrant background.
Ms Carey asked you about the life assurance

scheme. That scheme applied to what the DHSC described as frontline workers. How did the department define frontline?
A. Well, in exactly the way I described when I was discussing this with lead counsel. So there were people who were defined because they were employees of the NHS, then there were people who were defined because they were employees in social care, and then, as I said, we had the additional discretionary scheme on top of that for people who were frontline workers but weren't in either of the previous two categories.
Q. And in your answer you've again that used that term "frontline workers" and that's what I would like you to define for me, please?
A. No, I said NHS employees. So there were people who were working as employees of the NHS who would normally be in the NHS pension scheme. As I say, then there were social care workers, and then there was the discretionary element for people who were not in those two categories but were still deserving of a payout. And this is all in the context of the -- I'm not quite sure what the right word is -- dilemma -- problem with government schemes of this type is you always draw a line somewhere and there are always deserving cases on the other side of that line.

Q. And it was the third category, using your definition, that I was asking you about. Is there anything else you want to add in relation to that, rather than there's a third category?
A. No, as I say, this scheme was very unusual. Well, (a) in it was extended beyond NHS employees in the first place. That was its first unusualness. And the second was we had this discretionary element which -- well, I'm sure you'll ask the ministers who did it when they are here, but they were conscious that there were going to be cases that were very deserving that didn't fit within the scheme criteria, and therefore they wanted discretion to be able to make payments to people who they thought were deserving who were not in the defined categories.
So -- and that -- as we know --
Q. I'll move on.
A. -- that's unusual for schemes of this type.
Q. Sir Christopher, I'll move on. I'm conscious of time. Moving on to my next question. Did the scheme apply to workers who worked at private hospitals caring for NHS patients?
A. Not in the defined categories. Again, I think anyone could be in the discretionary category. I'm not -- I don't know whether anyone was in that circumstance and

tragically died, but if they had done I'm pretty sure they would've been able to apply under the discretionary element.
Q. Sir Christopher, in respect of migrant healthcare workers, what efforts were made to ensure that their overseas families were aware of the scheme and could apply?
A. I'd have to go -- I know efforts were made to publicise the scheme. On that specific point I'll need to go away and check for you what was done.
Q. Thank you.
Moving on, then, to the risk reduction framework referred to by Matthew Style in his statement. That's inquiry reference INQ000472172, page 91, paragraph 322.
Mr Style refers to the framework having been sent to NHS trusts, who have a duty of care towards their directly employed NHS employees. To what extent was the framework sent to subcontracted employees of hospital workers to ensure that outsourced staff had the same level of protection as their NHS staff colleagues?
A. Again, I am going to have to go and check for you. So my knowledge is what is in the statement we have submitted on this topic, so I'll go again -- at that level of detail I'd need to go away and check for you, which I will do.

Q. And perhaps at the same time you could check this further question, please: to what extent was the risk reduction framework sent to private hospitals who were caring for NHS patients?

A. Yes, that would be the same answer.

MS SEN GUPTA: Thank you.

My Lady, thank you.

LADY HALLETT: Thank you very much, Ms Sen Gupta.

Mr Thomas.

He's behind you.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Sir Christopher.

A. Hello.

Q. I'm representing FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.

Pulse oximeters. In paragraph 125 to 127 of the statement from Matthew Style, Jonathan Marron and Lucy Chappell, it's noted that -- evidence suggesting that the pulse oximeters were less than accurate in darker skin patients, potentially contributing to health inequalities.

Can we agree on this, that that evidence on this disparity was and is now well established?

A. Well, I'll answer the question on what was known before the pandemic previously. So, yes, agree there was

just us, it needs every country in the world making the same -- and then, as you pointed to in your question, the research that NIHR and a lot of other people are doing on this issue is very important too.

And if I can add a point that's not in your question, it's unbelievably important that people go on raising this and talking about it and discussing it, both in terms of how do we mitigate in the short-term, how do you use devices best but also how do we get those world markets to change.

What we can't have is this was an issue in the pandemic, some things were then, and then it goes away. What the report I quoted points to is this sort of systemic thing that your clients and others and us and everyone has to go on raising and ensure we're not in the same position again.

Q. Thank you for that. Let me move on because I just want to touch upon my next question, and you may have answered it. And it is simply, do you foresee any barriers to ensuring that more equitable medical devices such as these pulse oximeters can be rapidly integrated into NHS operations and what steps will be done to address these barriers?

A. Yes, so there clearly are barriers or the situation wouldn't have arisen in the first place. And I think

evidence --

LADY HALLETT: Could you make sure --

A. Oh, sorry. It's very difficult not to look at someone when you're answering. So I'd refer you to that answer.

In terms of the situation now, I'd refer you to the Whitehead report that we were discussing earlier, which clearly shows that not only in this case but across a range of medical equipment there is a bias in how devices are created by world markets and tested, which is to the disadvantage of people with darker skin.

PROFESSOR THOMAS: Following on from that. What immediate steps have been taken to address this issue in the short-term before the completion of the NIHR study in autumn 2024?

A. Yes, so the previous one I think I referred to in previous evidence, which is the change in the regulatory system, so that the MHRA, as I understand it, specifically asks about the application of devices to different ethnic groups before a new product would be licensed.

So that hardwiring into the regulatory system, that's the most important thing the UK can personally do on this very, very important issue that you raise.

And as I think I said earlier, then generally you need world markets to respond, which obviously is not

the biggest barrier, and it goes to the points I made in relation to your previous question, is you have to move the whole world market on how these things are designed, manufactured, tested --

Q. But the UK can be a leader.

A. Yes, and I've set out the biggest thing that the UK has done of putting it in the regulatory system.

Q. Right.

A. So then we new -- so we need to deal properly with existing products. We need new products and then exactly as you say, the NHS, and others, needs to make sure it uses those new products and does so in the proper way, which is a big operational issue for the NHS.

Q. Thank you. Let me move on. PPE and fit testing.

A. Yes.

Q. In paragraph 280 it's mentioned that if an individual fails an FFP3 test they should be redeployed or provided with alternative protection.

A. That's correct.

Q. And the Inquiry has revealed evidence that this protocol was not followed for many ethnic minority healthcare workers. Question: what steps were taken to ensure that black, Asian, minority ethnic staff who may have faced challenges with standard-fit masks were not

disproportionately redeployed into less safe or higher risk roles?

A. Yes, so I think I covered most of my answers previously. But to recap. So it shouldn't have happened. It was against the guidance. Under operational pressures, very, very difficult both for institutions and for individual staff members and we appreciate the distress that issue caused.

Q. Sir Christopher --

A. Then as I described in my previous answers, there was first the review that the CMO ordered of how ethnic minorities --

Q. Can I just jump in a second. You're right, you did cover it earlier. So let me ask you a question that follows on from that so you're not just repeating yourself. And the question is this. Bearing in mind the difficulties that you've just highlighted and you highlighted earlier, question: what monitoring mechanisms were in place to ensure that redeployment decisions for minority ethnic staff were equitable in line with the guidance?

A. Sorry, during the pandemic?

Q. Yes.

A. That's a matter for NHS England so it is -- it's immediately a matter for the individual trust. They are

the employer and they have the duties of care.

Q. You had no oversight?

A. And then we would expect NHS England in its oversight capacity to be doing so. It's not something the department would have done directly.

Q. Are you unaware of what those mechanisms were?

A. Well, the NHS -- NHSE has, and I'm sure Amanda Pritchard described this yesterday, has a range of oversight arrangements and responsibilities and it would have been part of that. I can go away and ask for details from NHSE of exactly what they did but it's not something the department would have done.

Q. Let me move on. In paragraph 286 it states that fit testing outcomes from NHS staff have been recorded centrally since June 2022. Question: how has this data been used to inform future procurement decisions especially regarding the PPE needs of black, Asian, and minority ethnic healthcare workers?

A. So that would be initially an issue for individual trusts, because we are now in a business-as-usual position where individual trusts procure PPE. I won't repeat what I said about the central stockpile and how we diversified that. And then, again, I'd have to check with NHS England on exactly what they do with the data you're describing.

Q. Okay, well, if you're able to assist me on this question. Can we expect any adjustments in the types of PPE procured to reflect the fit challenges faced by ethnic minority workers?

A. Yes, and as I described earlier, we have already done that --

Q. Okay.

A. -- which is not to say that there is more --

Q. That can be done?

A. -- to do, yes.

Q. In paragraph 288 it's mentioned that customer engagement panels were established to hear from staff groups with protected characteristics including black, Asian, and minority ethnic workers. Question: could you provide more detail on the frequency and the scope of these discussions and how much feedback from ethnic minority workers was specifically incorporated into the PPE provision decisions?

A. Again, I'll have to go away on the extra detail. I know what is in the statements so I can come back on that. I know that the whole issue was taken very, very seriously indeed by the PPE cell and that they adjusted their procurement as a result of not just the feedback from the staff panels but a lot of other feedback. I'll come back to you on the details --

Q. When you come back can you also come back on the next question which is, and what specific changes, if any, were implemented as a result of these discussions? Will you do that for us, please?

A. Yes, and I've already quoted one around the fit masks and I'll give you what else we have.

Q. Let me come to my final question. In Module 1 of this Inquiry it was noted PPE that would fit minority ethnic staff was purchased in smaller quantities. One question, one word: why?

A. Well, I think as you say, we covered this in Module 1 and it's played out in the questions of this module. And all the changes that we made on this area and the reviews that we carried out were to deal with that issue. Behind your question, would it have been much better if those things had been done before --

Q. No, no, no, no, no.

A. Yes, it would.

Q. No, sorry, that wasn't my question. I'm going to repeat it. It's a simple question. Why were they purchased in smaller quantities for minority ethic staff? Help us, please.

A. What we appreciated during the pandemic as a result of the feedback and what we've seen, brought to light these challenges which we had underestimated previously. We

sought to put that right but it doesn't change the fact that by the entire system they were underestimated previously.

Q. Structural problems, would you agree?

A. So as I've said to a number of questions, there were lots of issues in the pandemic of which this is one and in terms of why it happens across medical equipment, as I say, I'd refer you to the Whitehead report which covers this in considerable detail and the biases that were built into the system. And like in a lot of other areas, this shone a big spotlight on problems in the system that existed already and magnified them. So this was another area where we learned a lot.

Q. You say structural biases; we say racism inbuilt into the system.

A. Well, as I say, we agreed with the Whitehead report on this. It's very clear on biases and the --

Q. Why are you afraid to use the word "racism"?

A. Sorry, I am quoting the report directly. So it is very clear on the biases and the ethnic origins. What words people want to attach to that is up to that is up to --

Q. Well, words are important.

A. I quote the report we had done.

Q. Words are important, aren't they?

A. Yes, they are.

PROFESSOR THOMAS: My Lady, that's all I ask.

LADY HALLETT: Thank you.

Ms Munroe, who is just there.

MS MUNROE: Thank you, my Lady.

Questions from MS MUNROE KC

MS MUNROE: Good afternoon, Sir Christopher, my name is Allison Munroe. I ask you questions on behalf of Covid-19 Bereaved Families Justice for UK.

My Lady, if I may, I'm going to take the questions in reverse order, having prioritised them, and start with the question on end of shielding.

LADY HALLETT: Of course.

MS MUNROE: Sir Christopher, we are under limited time so I'll try to keep my questions as specific and concise as possible and would be grateful if your answers were likewise, thank you.

End of shielding. Now, the DHSC submission dated 23 July 2021 regarding the end of the shielding programme stated as follows.

"It could be difficult to get the messaging of any correspondence right in order to avoid criticism that the most vulnerable group was being abandoned particularly at a time of rising case rates."

Now, given the cumulative impact of the end of the lockdown rules, the advice for those shielding and the

end of the shielding programme itself, do you accept that abandoning the most vulnerable group was exactly what did happen?

A. No, not at all. So what we did here, we were replacing shielding with the QCovid tool which allowed -- shielding, being a very blunt weapon and as I'm sure you will have heard, in some ways, damaging to the people who were shielded -- we were replacing that with the QCovid tool which allows individual clinicians to assess the individual in front of them and work out what is the best solution for that individual and was technically miles ahead of what we did in shielding and took account of individual risk factors.

So we were moving from a generalised blunt weapon to a specific assessment of vulnerable people and what they needed to do. That was the basis of the decision.

Q. Topic two. Blanket and inappropriate use of DNACPR. You've already been taken to an email dated September 2020 that refers to a Quad meeting and some of my questions in relation to this email have already been addressed. So I ask you this, Sir Christopher. In answering questions from Ms Carey King's Counsel, arising from this email, you said:

"Inappropriate and blanket use of DNACPRs shouldn't be happening. We needed to get to the

position to say to Parliament that it wasn't happening."

You never got to that position, did you?

A. Sorry?

Q. You never got to that position, did you?

A. It has to be -- so in any zero tolerance environment, and there were lots of things where we say we have a zero tolerance of something, that has to remain the objective even if there is only one case. In most cases where we say we have zero tolerance of X, we do never get to zero. But the point is that the mindset everyone has to have is that not one example is acceptable. And this is one of those cases where there is no acceptable level of failure. We should always be aiming for zero.

Can we, and this is, I think, at the heart of Simon Stevens' comment after mine, can we guarantee that nowhere in a system covering 10% of the economy and 1.2 million people is somebody not following the rules, is incredibly difficult to do but nevertheless our mindset ought to be not one case is acceptable.

Q. But isn't part of the problem that during the pandemic there was no data that could actually record the scale of the problem?

A. Well, so it's always a challenge -- when people are breaking rules it is always a challenge to collect data

on who is doing it because obviously they're not going to admit it. That is one of the reasons why we asked for the CQC study that has been referenced already, was for the regulator on this subject to make an assessment of how widespread it was and what we should do about it. But as I say, when people are either deliberately or accidentally breaking the rule that has been set, it's incredibly difficult to have precise data on how many.

Q. But there continues to be no centralised data which would enable monitoring of this issue. Why is that and does that not concern you at all?

A. Well, if we could have data -- it's just like any other rule-breaking, if you can have data on exactly how much of it there is, that will obviously be better. Our problem is a practical one of how you do that. Now, it's in the remit of the regulator. This is why one of the reasons that we have a CQC and a medical regulator is to assess are the rules being followed and then take action when they're not and that is the approach taken.

I mean, I should say -- I mean what I say about zero tolerance, everyone is appalled where this goes wrong and it's hugely, hugely damaging for individuals so I do -- we do all appreciate the levels of concern that these issues raise and as I said before, I haven't met anyone at the centre who believes it's acceptable to

have this bad practice in this area and is not trying their hardest to deal with it.

Q. If I may just ask you a follow-up from that. You've described this as rule breaking but it's a little bit more nuanced than that, isn't it, because during the pandemic, you know, we are talking about clinicians working in extremis, people's own clinicians and nursing and other medical staff, their own mental health being pushed to the limits, mistakes can happen, it's also a matter of training and people having consistent guidance, consistent messaging. It's not simply about rule breaking, is it?

A. I agree with all of those points. And while -- so things can be -- when clinicians are working as we know they did in the pandemic in this incredible way doing extraordinary things and when you're doing things under intense pressure and at speed mistakes get made. That's not the same as saying you accept that situation.

It may well be, and a previous Secretary of State, Jeremy Hunt, was always talking about this, that it's not about blame it's about putting it right, as it were. So it may be that we need better training, better guidance, all the things that you listed. That doesn't make it okay that the guidance wasn't followed. So there was a rule and it was broken. The right answer to

that may, exactly as you have said, be better training and those sorts of things, but as I say, I'm a lay reader of the guidance, it's clinical guidance for clinicians, but it seems to me very clear what should be done and therefore very clear when that rule is not followed.

Q. Then my last question on this topic. Again, from your evidence before the luncheon adjournment you said that in relation to blanket or inappropriate use of DNACPRs "our job is to hold people to account and press for action and updates ..."

A. Yeah.

Q. "... making sure that action is effective and zero tolerance."

Now, considering the evidence, and I'm sure you've been following the Inquiry carefully when you can, considering the evidence that the Inquiry has heard on DNACPRs and those families that we represent, something in the region of 422 of them, of our bereaved families have raised concerns about inappropriate DNACPR use, would you accept that the problem is potentially far more widespread than your department had recognised at the time and perhaps still recognise -- don't recognise now?

A. Well, we accept the CQC report on this subject --

I won't summarise it for you because everyone can read it themselves -- that there was definitely a problem, more on the inappropriate side in terms of individual consents than the blanket, as I described earlier, and the regulator continues to look at this issue.

So it is a very important issue. It was recognised. A lot of action was taken but of course the fundamentals of your question is correct. That there is that level of concern and that we needed to do those things shows that there was a problem.

Q. Thank you. And my final topic, NHS 111.

Firstly, quality assurance. Now, I accept, of course, Sir Christopher, that while the DHSC delegated responsibility for the commissioning of the 111 service to NHS England, do you accept that overall responsibility in terms of the adequacy, and functioning of the service lay with the department?

A. No, so it wasn't delegated. It's never been delegated. The functions of NHS England commissioned services are set out in the statute, in this case the governing legislation was the 2012 Act, and in statute NHS England, and the various other NHS bodies concerned, are responsible for the commissioning and delivery of services, not the department. We hold them --

Q. So what's the department role?

A. The department -- well, again, it is set out in the legislation.
Q. If you can just very briefly tell us. In relation to NHS 111, then, what do you see as the department's role?
A. It is exactly the same as in relation to any other NHS service and the department's role is as I described to lead counsel.
Q. So do you not feel that you have -- the department has any role in terms of oversight?
A. We hold -- as set out in legislation, we hold NHS England to account for all the services that are covered by the NHS, acute services, primary care services, community services, 111. It is one of the services that we hold the NHS to account for but it is their duty to deliver the service.
Q. Perhaps you can assist me with this question then, still on the issue of quality assurance. Did the department or are you aware of whether or not there were any quality assurance mechanisms in place or were the department -- in any way did you satisfy yourselves as to the quality and operational functioning of the NHS 111 service?
A. We will have discussed the service with the NHS. We will have assured ourselves, and I know they do this, that they have quality assurance measures both for the

service and the quality of service.

Lead counsel showed earlier one of the reports generated that allows for that oversight. But our responsibility is to ensure that the NHS has systems. As I say, it is set in -- it's just the law but it is their responsibility to run the service and to quality control it.

Q. All right. Then, finally, on the question of capacity then during the first wave, NHS 111 service. The DHSC policy in messaging in March 2020 was that individuals should contact 111 rather than attending A&E departments or other health settings.

For reference, that's part B statement INQ000398241, paragraphs 148-150, and 153.

Now, Sir Christopher, I'm going to suggest that it's common sense and entirely predictable that in the circumstances of an ensuing pandemic that we would see the level in demand of the NHS 111 service saw. So my question is this, that given the advice that the department was handing out in March 2020, what steps did the department take to ensure that there would be capacity within NHS 111 to cope with the increased demand?
A. We'd have discussed that with NHS England, who, as I've said, are the statutorily responsible body. But in

the context of all NHS services were under colossal pressure. Hospitals were under colossal pressure, GPs, community services. The pandemic put, as this Inquiry well knows, pressure across all NHS services --
Q. I know that. Sir Christopher, the question is specifically what steps -- not what discussions you had -- what steps did the department take to ensure that there would be capacity, bearing in mind what I've said, it was inevitable that there would be --
A. I come back to the same answer. It is the NHS's statutory responsibility to manage those things. The department discusses those issues with the NHS but it is their responsibility to manage capacity in all their services, of which 111 is an example.
Q. My final question, again Ms Carey King's Counsel took you to some figures about NHS 111, and I believe it's right that in fact at the peak in the first wave, after March 2020, half of all calls went unanswered. Firstly, do you accept that level is completely unacceptable and that, secondly, for many people, the service simply failed them?
A. Sorry, I don't -- I don't not recognise but I'm not aware of the number you've just quoted or where that was in the evidence, so I can't really comment. I'll come back to you on that question.

Q. Do you accept that the service though was not -- it failed many people because there were so many calls unanswered?
A. I'm not going to accuse anyone in the NHS -- and the NHS 111 is an NHS service just like all the others. I think the staff of the NHS performed wonders during the pandemic to help people, and I think that is true of our doctors, our nurses, our support staff and our staff who work on NHS 111. Now, of course there were challenges in all those services and that's been widely acknowledged and described to this Inquiry, but I'm never going to say that the staff of the NHS -- well, I'm not going to use the "failed" word in relation to any NHS staff.
Q. It's not about the staff, it's about the system and the services that are put in place. It's not about staff and how wonderful they are and how hard people work. We know that. We've heard that from them themselves. It's about the systems that were put in place and whether they were actually working.
A. Well, so, as I've said, and as this Inquiry has heard from lots of witnesses, all aspects of the NHS were under huge pressure and did the best they could in very, very difficult circumstances. I wouldn't pick 111 out as being different from the challenges that were across

the NHS in many services that this Inquiry has heard about.

MS MUNROE: Thank you very much.

A. As I say, some of my answers on 111 --

LADY HALLETT: That's fine. Thank you, Sir Christopher.

A. I was going to say, I will come back on the questions I couldn't answer.

MS MUNROE: Thank you.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Munroe.

MS CAREY: My Lady, for the record, can I say this.

The HCIB report made findings that half of 111 calls went unanswered. That was in tab 10 at INQ000320204 --

A. Sorry. Yes.

MS CAREY: -- not at all -- page 7 and 8. And it was also attested to by Professor Snooks in her report at page 17. I just say that so that anyone who is following can understand where the evidence base was that underpinned, no doubt, Ms Munroe's questions.

A. Yes, thank you very much.

LADY HALLETT: Thank you very much.

Thank you, Sir Christopher, that completes our questions for you. I've said it before but I shall say it again, I do understand the demands that this Inquiry

and, I suspect, other public inquiries make upon your department. You're used to implementing the decisions of politicians. Well, that's what I'm doing.

A. Yes.

LADY HALLETT: I'm implementing the decision to set the terms of reference as wide as they have. So please thank your colleagues in the department for the help they've given.

A. That's very generous of you.

LADY HALLETT: And that they will continue to give.

A. Yes, well, it is our duty to provide the information the Inquiry needs. And it's fully -- I fully appreciate the comments that you've made. That's very kind of you.

LADY HALLETT: Thank you.

(The witness withdrew)

LADY HALLETT: Ms Hand.

MS HANDS: My Lady, if I may call Dr Philip Kloer.

DR PHILIP KLOER (affirmed)

Questions from COUNSEL TO THE INQUIRY

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

A. No, thank you.

MS HANDS: Dr Kloer, good afternoon.

You've produced a witness statement for this module. That is INQ000475209.

Dr Kloer, you are the formal medical director of

Hywel Dda University Health Board and current interim chief executive of that board. I'm going to ask you about the Glangwili General Hospital, which is a hospital within that board; is that right?

A. That's correct. I have just been appointed as the chief executive.

Q. Thank you.

Can you start by painting a picture for us of the age and infrastructure of the hospital estate.

A. Yes. Glangwili Hospital was the first hospital established under the NHS Act in Wales in 1949 and started off running from Nissen huts. The current building was opened by the Queen Mother in 1959, and so I think it's fair to say that it wasn't designed with modern healthcare standards in mind.

The core of the building still stands today and houses the medical wards and the surgical wards. And what we found in the pandemic was that there were a number of limiting factors that the estate provided us with.

Firstly, the lack of side rooms. There are only 20% side rooms available across our 388 beds. There's very poor ventilation and air exchange. We don't have air-conditioning or air filtration units across the site.

That was not only an issue for Covid and protecting people from Covid but was also an issue, we found, for oxygen levels on the respiratory ward. We found that oxygen levels when we were providing high-flow oxygen to our patients or CPAP on the respiratory wards, oxygen levels became very high. It was really worrying for us and for our staff. And this was during the second wave, when it was in the winter for us, and so whilst we needed to open the windows it made it cold for patients, so the staff were worrying about opening windows. Also concerned about opening doors because of Covid spread.

The other limitations were bed spacing and we had to -- the initial assessments, when we had the environmental guidance in the summer, were that we would lose around 113 of our 388 beds if we were to follow the exact guidance around the exact environmental guidance.

We -- as it was, we were creative, our staff were incredibly creative, and we put in studded walls, with perspex in the middle, and this meant the air flow was more than 2 metres, but it introduced other issues, with cramping of space between beds if we wanted to use equipment for patients. It also meant that we had to remove furniture.

Q. Thank you, Doctor. I'm going to stop you there and

I just want to pick up on your evidence there around there being 388 inpatient beds in the hospital.

You've said that there were -- on the 1 March 2020, 348 of those beds were in fact occupied, and all 11 of the level 3 funded ICU beds were also occupied; is that right?

A. That's correct.

Q. And was any action taken to discharge patients before the national discharge policy in April 2020?

A. There were a number of things that we put in place. I mean, first of all, I think the public were not attending hospital at the same rate, so we did see a huge drop in attendance, and I think that did mean that by May we saw a reduction to around 180 beds being occupied.

Also the announcements around suspensions of elective care had a big impact on us as well. We also knew that we -- looking at the challenges in Italy and Spain -- that we needed to act fast, we were being urged by colleagues in Italy and Spain to act fast and create space and retrain our staff in elective services to look after patients with Covid.

So we did try to prioritise investigations and assessments of acute patients to get people home as quickly as possible.

Q. And you expanded ICU capacity but only up to 16 level 3 beds within the escalation plans; is that right?

A. Yes, well, actually in the second wave it was the only time, for a short period in the second wave, that we exceeded our capacity in ITU. So in the second wave we were able to secure some agency staff and also use our theatre staff to support ventilation of patients in the recovery areas in theatres.

But that was only for a very short period of time and we never reached a moment where we had to prioritise one patient over another. We were always able to provide ITU care for people if they needed it.

Q. So you would provide that care but is it right, therefore, that they would be provided with that care outside of ITU during that period?

A. Yes. So there was that -- for a very brief period of time we used the theatre recovery area, so this is the area normally where after someone has had surgery they would have their -- they -- we would normally put people who have just had their surgery there but, actually, we used the experience of theatre staff, who are used to ventilating patients, in that theatre recovery area. But it was only for a very short period of time.

Q. You said in your statement that you maintained one-to-one nursing care for level 3 patients throughout

the pandemic; is that right?

A. That's correct.

Q. Was that the same ratio outside of ICU if they were receiving the treatment that you have just referred to?

A. Yes, so all ventilated patients requiring level 3 care received one-to-one nursing. For those requiring CPAP, they all received one-to-two nursing so we never had to comprise on our nursing ratios for those patients.

Q. You've provided a couple of examples already around how you increased your workforce capacity. Can you provide some further examples. I think you have done so in your statement but perhaps you could provide some of those that were most successful.

A. Sure. We were very successful in our recruitment campaign. We managed to recruit 1,100 people to work, mostly in our domestic services, also healthcare support workers and our family liaison officers who were mostly from the retail and hospitality industry. All of those were really important to help support the kind of wraparound -- the model we wrapped around our nurses. So when we received the guidance from the Chief Nursing Officer around interpreting the nursing Act in Wales early on in the pandemic it meant that we could stretch our nursing ratios on the medical wards whilst having that wraparound support.

We also, following the announcement of suspension of non-essential elective surgery, we redeployed 600 staff in -- across the health board from those areas. That was a challenge because many of our staff had chosen to work in those areas and not to work on acute wards so we had to have individual discussions with staff. But it did mean, again, that we were able to source additional staff for our acute wards and also for some staff source staff for the command centre that we'd set up.

Q. In terms of the nurse-to-patient ratio, I think you've said in your statement the health board expanded the national guidance on reducing that ratio. Can you recall what the ratios were expanded to and when?

A. So I don't have the specific details on that but what I do know is that in the nursing Act in Wales medical wards would normally have a really careful calculation of how many nurses you need for a medical ward. The Chief Nursing Officer's letter set out that this was a novel situation so that particular calculation didn't apply.

My understanding is that at times we had one registered nurse for the whole ward but there were a significant number of other staff there to support that nurse. And --

Q. Can I just stop you there. How many patients would be on that ward?
A. So there could be anything from around 20 to 24 people on the ward.
Q. So it would be one nurse, to 20 to 24 patients?
A. Registered nurse, my understanding is, but what I do understand, though, is that a lot of the tasks that those nurses would normally have been engaged with were then supported by other staff on that ward. So, for example, the family liaison officers were really important. They provided a bridge between the patients and their relatives. They -- also we had much more healthcare support workers, so a lot of the basic care was able to be provided by them. And we had more domestic staff to provide the enhanced cleaning because of our recruitment campaign.

Also, we directed a lot of our therapists to the wards who were not undertaking outpatients so there was quite a big team around the patients and in some of the areas like ITU, A&E, and some of the respiratory wards we also had specialist psychological support embedded on the ward so the nurse wasn't sort of left on their own.
Q. It's right, isn't it, that the hospital transferred 133 non-Covid patients to the local field hospital during wave 2. Were those patients medically fit patients?

A. So the vast majority of them were -- so they were medically fit patients and the vast majority had not had Covid.
Q. And did that hospital provide enough and the right kind of support around capacity for your hospital?
A. So it was quite incredible how we transformed a leisure centre and a bowling alley into a clinical environment with the support of our local authorities. When I visited them they looked exact and felt exactly like a hospital. The patients -- what our experience was that patients, quite a number of patients were asking to be transferred to the field hospital because they wanted to be out of the main hospital. And we also noticed -- the nursing staff noticed there that they tended to be more inclined to get up and mobilise than they were in the acute hospital. So from that perspective it was a success although, of course, the wave and the numbers of patients that we had envisaged at the start of the pandemic with the predictions that we had been given didn't actually materialise.
Q. And did the -- the field hospital impact on staffing capacity at GGH at all?
A. So relatively small numbers of staff who needed to staff the field hospital because it was small numbers, and they were staff members who generally needed to be

working in a more green area than the hospital so, actually, we don't feel it impacted significantly.

The worry was, though, that if we had had the wave that we were expecting in the numbers that we were expecting, our staffing would have been incredibly stretched if we'd had to staff all of the field hospital beds that we had provision for.
Q. The hospital undertook a survey of staff in June 2021 and I want to ask you about some of those responses received.

If we can please have on screen INQ000466548, page 7. Thank you.

This is at tab 2 of your bundle, should you wish to go to it.
A. Thank you.
Q. Some of the feedback reported that:

"In terms of physical safety ... [it] was felt unanimously whether interviewing frontline workers, domestics or office bound work force. Feeling unsafe in the workplace is the single largest work based stressor whether someone feels physically threatened or psychologically threatened the equal result is work based stress and the resultant absenteeism or presentism in its lesser form. Much rebuilding needs to be considered to allow people to feel safe again in

the work space."

What support did you put in place following that feedback?
A. So, first of all, we knew this was an unprecedented time, obviously, and we really wanted to capture the learning from the experience of our staff which is why we commissioned this report in June 2021, and I think there was rich learning for us. There was some positive aspects of it but clearly that's one of the elements there where people just felt so worried that they, for example, they wouldn't have the right PPE, they were worried they might catch Covid but also that they may spread it to their families.

From a physical perspective we really tried to make sure that we were risk assessing staff to make sure they were working in an area that was -- that fitted their risk assessment for Covid.

We also -- we never ran out of PPE. We tried to provide people with adequate PPE and we believe we always had that in place. And if someone -- if, for example, when we had challenges with FFP3 masks we always increased the PPE so we provided people with powered hoods, if we didn't -- if they weren't able to fit test for an FFP3 mask. But one of the biggest challenges that our staff faced was around psychological

well-being. We recognised that right at the start. We adapted our psychological well-being plans right at the start of the pandemic. And we really did put in some very practical support for staff.

Q. Thank you, Doctor, I'm going to stop you there.

There is one other quotation I wish to take you to on this page further down starting with:

"One member of staff had Covid-19 and said her mum and family caught it too, she is still feeling guilty. This same member of staff stated that she was told off for ordering visors for staff to use on the ward. She felt let down and not well protected ..."

Why were staff having to order their own PPE if there was sufficient supply of PPE in the hospital?

A. There was, I suppose, at the start of the pandemic there was huge anxiety around PPE and that was universal. Everybody was worried about that. We did have one moment where we had some challenges around visors but my understanding was we never ran out of visors. That's the information that I have.

I think one of the things that we did recognise was that when people were running out on a ward they sometimes didn't know how to access the PPE that we had in the storage, they didn't quite know who to ask, so I think one of the learnings that we noticed very early

in the pandemic was around communication with staff on wards. We put in place a local command centre which was led by a senior respiratory physician, a senior nurse and a junior doctor, and that was specifically for Glangwili, and I think that definitely improved communication with staff.

It's regrettable that people were told off and I can only imagine how stressful -- stressed that staff member would have been with the worry of not being able to access PPE and being told off. So I would very much regret that.

And part of the reason for this report was to make sure that we didn't just hear positive stories, that we learnt from all the difficult experiences of our staff as well and we try to be an open organisation so that we can learn.

Q. You said in your statement that there were critical levels reached of face masks in summer 2020. Is that the period of time in which you were short of visors? Is that what you're referring to there?

A. My understanding is it's about the same time but we always had a policy of having a two-week supply available.

Q. So what were the critical levels that were reached at that time?

A. So I don't have the specific details of that but -- and I can provide that to the Inquiry, if we have it, at a later date if that would be helpful. What my understanding is, though, we didn't go below the two weeks' supply, we got close to it. So for staff who felt that they weren't able to access PPE, my understanding is it was there; it was probably just the communication of how to access it within the stores.

Q. If we could go to page 10 of the staff feedback as well, please, and down to the working environment -- thank you. Staff feedback also included:

"The working environment was cited as being a source of work based anxiety. ... Quite a few staff took their breaks tat in their car in the carpark eating sandwiches with a flask of coffee.

"Staff reported not having enough adequate toilet facilities or donning and doffing areas. Along with the lack of side rooms and isolation rooms, unventilated waiting areas ..."

And some staff reported going to a cupboard under the stairs to have a cry.

Are some of those issues that are reported there representative of the issues around the hospital estate more generally that you started with in your evidence today?

A. Yes. So I mentioned some of those issues earlier, so I do recognise that. But in addition to what I mentioned earlier, there are, I think, compared to a really modern hospital there are less toilet facilities per bed, there are less changing facilities, less staff rest rooms -- in fact, we use the day rooms for staff rest rooms but they were not really adequate for what we would call a well-being space, whilst we worked on them for staff -- yeah, they weren't adequate for a well-being space and it was difficult to socially distance.

So some of these experiences are difficult to read because, you know, staff that were under incredible pressure at that time and speaking to them at that time it was a real worry and of course staffing -- our staffing was stretched particularly in the second wave. We were lucky in the first wave. So in the second wave, yeah, it was a real pressure for people and the environment at the hospital definitely had an impact on that.

Q. And you referred earlier to some of the psychological support that was put in place for staff and you've referred to that in your statement too. But you have said that less than 50% of the support for leaders was taken up. How did you encourage uptake of that support?

A. We communicated with all of our local leaders and it wasn't the only offer. There was also offers of joint group sessions who had been on leadership programmes with us in the previous years, and I suppose it's been an ongoing effort. This report that you have in front of you was in June '21. We commissioned a further report in December '23, and we received a report to board in -- earlier this year.

So our work around leadership development, compassionate leadership, continues. I think one of the learnings from the report was that some of our staff had a really excellent experience when leaders were just touching base, just small things like saying "thank you" and checking in on them, and just the importance of those very small basic things as a leader and instilling that into our leadership teams.

So we've got a range of programmes so this wasn't the only programme that we've run since then.

Q. And before we move on from this report -- it can come down now, thank you -- there was also feedback given in the survey on the topic of non-Covid care and treatment and around elective care and some staff reported that they felt anxious and frustrated due to the uncertainty at the start of the pandemic but then continuing at the time of the survey in June 2021 as to the plan of action

including recovery of services, and many described a "them and us" culture between frontline staff and administrative services and management.

So what lessons did you take from that feedback that was received in the survey?

A. I think, first of all, there was a really -- I mentioned the point about leadership and how that, you know, staff experienced that variably during the pandemic. I think also communication was a really strong feature in the report that we received, and the fact that you can never communicate too much, I think.

So I think a lot of the conversations that I've had with staff and a lot of the information within that report that I've read does come down to adequate communication, and visible leadership, something that I, you know, as the new chief exec, have been taking on board, as you can imagine, going forward.

I think the challenges around restart of elective services -- well, there are a few challenges. First of all, those 600 staff who were redeployed, it was really difficult for them because they knew there were patients waiting who wanted and needed their attention, so that was a significant difficulty for quite a few of those staff and for some of them it was difficult for them to understand why we couldn't get on with some of those

procedures or outpatients.

We tried to be creative. You will see in the evidence around some of the creativity around our cardiology and colorectal departments in keeping in touch with our patients, that was spread across many specialities. We did make use of the local private hospital but it only has 20 beds and it's a fairly small facility and was necessary but just wasn't sufficient.

And one of the difficulties for us was maintaining green areas where we could safely undertake the elective procedures, and the waves came one after another. So if we started up elective surgery sometimes we'd have to stop it. It was quite a fluid situation. But we were very, very aware that there was a growing backlog and we went to enormous efforts to try to get that up -- those services up and running again.

We did also put in place a waiting list support service so that patients on waiting lists, which in fact we've enhanced since then, were able to keep in touch with people on what were very long waiting lists.

Q. Thank you. I want to move on to the topic of decision-making around escalation of care. You have said in your statement that you developed treatment guidelines not to ration care but as a pathway for best medical practice perceived at the time. When and to

whom did those guidelines apply?

A. So we moved our respiratory ward -- just for context -- to the centre of the hospital to be near ITU and A&E. It meant our respiratory physicians and ICU clinicians worked closer together than ever before. They were working well together before but it was a really important relationship around escalation of decisions.

At the same time, at the start of the pandemic, we had an outreach team, in March 2020, we appointed an outreach team. So there were a number of things happening around escalation of care.

The guidance that was put in place we learnt from some of our staff who worked in a health board in the east of Wales and that was adopted by our staff. It was a guidance but what we found because we never had to -- we never had to consider one patient over another for our resources. Every single patient during the pandemic had an individualised decision, but made between the senior respiratory consultant and an ITU consultant. They'd have had those guidelines in mind but they made a very individualised discussion with the patient and their families.

Q. I want to pick up on one point you said there around every patient getting that individual treatment plan.

If we could please have on screen INQ000466549,

page 1, tab 3.

This is an ethics panel response to strategic ethical questions that were discussed at a panel meeting on 30 April 2020, and in this section on considering the principles of minimising the overall harm from the pandemic, bullet point 5 -- thank you -- the answer essentially to the question was:

"Comparing the two patients, who has the better chance of a good long-term outcome with critical care support?"

And the answer was, essentially:

"Using a validated survival indicator tool might be helpful, although these may be bias toward 'short-term' survival, whereas 'long-term' survival is more important to consider. It may be easier to consider this in terms of 'saving lives' and 'saving life-years', and even the quality of those 'life-years' can be considered."

To your knowledge, did such comparison take place within considering decisions on escalation of care or treatment decisions?

A. So, no, although the context is that at the start of the pandemic we -- it was predicted that we would need to ventilate 192 people at a time and we only had 11 funded beds and an 18-bedded ITU. So we set up the ethics

panel to -- right at the start of the pandemic, to consider really difficult situations.

It was difficult to even consider this as an ethics panel. We had ethicists, members of the clergy, legal team, equalities team, lay people, to consider what could have been an enormously difficult situation, and we tried to do that with -- to the best of our ability, and this was the best advice we could give to our gold command in the event that we needed to ration care, in the event that we had that kind of wave.

And we used the national principles, you'll see there, from the Moral and Ethical Advisory Group that was provided even earlier in the pandemic.

So this was never -- the short answer is: no, we didn't have to apply this, although I think what staff felt was that they needed to know what the ethical parameters would be if we ever ended up in this sort of situation. And there were a range of questions that the ethics panel considered. The ethics panel also had a separate function which was advice to clinicians if they needed an urgent decision and there was a 24/7 access to advice.

To my knowledge, that support and advice was never accessed, although, speaking to clinicians, they felt reassured that it was at least there for them to call.

Q. I think you've said in your statement that you did not formally consult with the ethics panel in the development of those guidelines; is that right?

A. So the guidelines that are being referred to there are just general -- so the ethics panel didn't have a role at the time in considering all of the guidance that came out and giving an ethical view on all the guidance.

Q. But in terms of this specific set of guidance?

A. Yes. This specific set of guidance was produced by the ethics panel in response to the question about making decisions about use of critical care resource in challenging situations.

So this was specifically considered by the ethics panel against all of those national principles. So it was a session of the ethics panel and they produced -- we produced this ethical guidance.

And this is only ethical guidance. There was other guidance that we followed around escalation of care. There was the guidance at the start of the pandemic in March, which was produced by ICU clinicians, which I referred to earlier, on their experience from working in a hospital in the east of Wales.

There was also the Welsh critical care and trauma network guidance that came out in April. Both of those were accepted by our clinicians, however, even with that

guidance, actually we -- any decisions where someone was thought to be appropriate for either CPAP or ITU were considered carefully by an ITU consultant and a respiratory physician.

Q. Moving on to the topic of DNACPRs. You have summarised a number of complaints and issues around the issuing of DNACPR notices that you were aware of during the pandemic in your statement. What action did you take in GGH once aware of those complaints?

A. So we had established guidance in place. In fact, DNACPR and end of life planning is something that is core to the training and education for all clinical professionals, particularly doctors and nurses. We adapted our guidance through -- through the pandemic.

On this particular issue in the spotlight hospital in February 2021, we became aware of this issue through a couple of routes, and it was a distressing issue that -- a junior doctor had attempted to apply a DNACPR form to somebody with learning disabilities. That was challenged by one of our nursing staff immediately and it was immediately rescinded.

Unfortunately the patient did deteriorate despite having very senior level support from a number of different specialty consultants and had a cardiac arrest and resuscitation was attempted and unfortunately they

died. So the application of the DNACPR form didn't in itself affect that patient's care. However, because of the basic principles and the concern over it, we undertook the detailed investigation and root cause analysis. We've shared the findings of that with our mortality and morbidity meeting, so with our whole clinical team. We have also shared it with our learning disabilities nurses who are responsible and support the education and training of clinicians around these issues.

So we know this is something that -- given the fact that we have new doctors and nurses coming every six months, and sometimes more frequently, we know this is something that requires continuous training.

Q. Was there any additional advice or guidance issued around communication with family members or carers in those discussions when perhaps they weren't able to be there in person due to visiting restrictions?

A. Well, part of the basic training for DNACPR decisions --

Q. Was there any additional guidance --

A. On top of that?

Q. Yes, during the pandemic specifically.

A. So, well, we received letters from the Chief Nursing Officer and Chief Medical Officer I think in the spring of 2020, April 2021 and April -- and spring of 2022 as

well, which we shared. So that was very clear about the importance of particularly learning disabilities but generally people with protected characteristics and issues around the Equality Act. But apart from that we didn't have any additional guidance, because actually it's just basic good medical practice.

We do encourage our staff to challenge decisions when they don't feel they're appropriate, and I suppose I'm pleased that the nurse did challenge it. I suppose that's the kind of culture that I'd want in the organisation, that we do challenge that, because it's a very serious situation.

LADY HALLETT: Given it goes against all your medical training, which you obviously heard yourself, and all the guidance, did you ever discover how the doctor thought that it might be appropriate to do something like that?

A. No, well, it was clearly a learning experience for them. I haven't had any direct -- perhaps "learning experience" isn't strong enough, but I know it was discussed with them with their educational supervisor and explained to them. But I don't know -- it's a good point, I don't know why they felt that why that was appropriate. That was never fed back to me.

LADY HALLETT: And one theory, I can't remember if it was

put it a witness but it was floated and -- was that because of the stress your colleagues were under that people may have made inappropriate decisions going against what they'd normally appreciate was what they should do. But you haven't found out so far as --

A. Yeah.

LADY HALLETT: -- I'm asking you to speculate.

A. The only thing I would say is that we were fortunate not to be in a position to where we had to ration ITU or CPAP resource.

LADY HALLETT: So that shouldn't have been --

A. So -- no. So whilst people would have been understandably stressed, and they were, and there were some really harrowing accounts of what people were trying to manage, there shouldn't have been the stress to place DNACPR forms on people inappropriately. Of course we didn't want people to undergo futile DNACPR, we wanted people to have appropriate palliative care, but I don't feel there was a reason to put inappropriate DNACPR forms.

LADY HALLETT: Sorry to interrupt.

MS HANDS: Not at all, my Lady. I am about to move on to another topic so that may be a convenient time to break.

LADY HALLETT: Certainly.

MS HANDS: Thank you.

LADY HALLETT: There you go, my interruption has got you a break, Doctor. Quarter of an hour.

(3.00 pm)

(A short break)

(3.15 pm)

LADY HALLETT: Ms Hands.

MS HANDS: My Lady.

Doctor, I have a few topics to cover still with you this afternoon, starting, please, with infection prevention and control guidance.

You very helpfully at the start of your evidence spoke about some of the issues that you had around implementing that guidance because of the hospital estate.

So my question is whether it was helpful to have that national IPC guidance or whether guidance that perhaps could have been more flexible based on local conditions would have assisted?

A. I think it was important to have the national guidance, and our nursing director was very closely involved in the work nationally so I think we were connected to the development of that guidance.

Of course national guidance can't take account of every local situation, so inevitably we -- given the rapid changing situation we had to adapt locally. There

were times, I suppose, and there were some issues with the guidance. Of course I've described the estate issue, I won't go over that again. There were issues where there was inconsistency between bodies around IPC guidance. One of the important ones was around the Resuscitation Council and Public Health England around AGPs for CPR. That was extremely concerning. Junior doctors were contacting me as a worry. I know that got resolved to some extent, but that was a concern.

We had to purposefully implement the guidance on our site.

One of the issues was also that the guidance -- the timing of guidance. So Public Health England would produce guidance generally on a Thursday. Wales would have to assimilate that guidance and then produce the guidance on a Friday. That became difficult because whilst we could operationally implement some of the guidance over the weekend, if it needed posters or adaptation to the estate or videos or some other form of communication or talking to key people, that was really difficult to do on a Friday. And of course for staff -- this is probably the most important thing -- for staff, they were aware on Thursday about a potential change in guidance. So it was quite confusing and created anxiety for staff.

I think the last thing I'll say on that was that sometimes guidance felt like it was catching up with sort of knowledge on the ground. So we'd have been connected across the UK, across Europe sometimes, and I suppose -- so, one example of that was around the attention to large droplet spread versus aerosol spread and the kind of measures of IPC that we knew needed to be put in on the ground, but perhaps the direction was to focus more on a different measure, so -- but overall I think the national guidance was helpful and I think will be important in future pandemics.

Q. Thank you. You have explained in your statement that the health board was unable to implement the Welsh government recommends in regard to lateral flow testing for patient-facing staff in December 2020 due to a lack of supply and the manual reporting systems that were in place at the time which would have put additional stress on workforce capacity.

And you've explained in your statement that there was a phased approach to testing which in fact began at the start of February 2021 and was complete by the end of July 2021. Was that reported to the Welsh Government that -- those issues you were having and was any support provided to deliver that any sooner?

A. So this was a really difficult decision for us. And we

were in constant communication with Welsh Government because our testing lead was part of a national group so it would have -- they'd have been fully aware.

Our issue locally -- there was a number of issues at the same time. Firstly the vaccination programme had just been announced at that moment, so we had deployed a lot of our staff to the vaccination programme, I think understandably.

We were also worried about false negative and positive tests at a moment where we were right in the middle of the second wave of the pandemic. And paper was brought to our executive team on January 21st, I think, in 2021, outlining the balance of the decision, and the suggestion and recommendation that we go for phase testing.

It was difficult because we were worried we'd stall the vaccination programme if we diverted staff to the manual data collection for testing at that point in January and February. We were also worried that we'd have even more difficulty staffing our wards if we implemented that testing at that time.

So, on balance -- that's the balance decision we made at the time. We did, when we implemented -- started to implement it in February, we started with our most vulnerable staff first -- or staff caring for the

most vulnerable first, our oncology teams, about 80 of them, in February, and then in March we rapidly worked with our front-facing staff. So the majority of our front-facing staff were going asymptomatic testing by March, and we'd completed them by the end of May, and then the rest of our staff by -- at the end of July, August.

So whilst the phasing -- there was a phased approach, the majority of front-facing staff were undertaking it by the end of March. By that time we'd -- our mass recruitment campaign had supported our mass vaccination centres and we did have nearly a 90% uptake by our staff, for example. So I think that will have helped protect our patients.

So the balance decision around testing or vaccination at that moment was a really difficult one for our executive team because we knew both were really important.

Q. And you've described in your statement a series of nosocomial outbreaks at the hospital between October 2020 and January 2021. At that point in time what were the factors that were thought to be contributing to the outbreaks and did you make any changes to try and mitigate those risks?

A. There's a large community transmission at that time, in

the second wave, and I think the experience of most hospitals is that when there's large community transmission there's also hospital transmission. So we did have some significant challenges. We followed the Welsh Government guidance. We followed the 16-point plan. We were well supported in our outbreak meetings. Each of our hospitals had outbreak meetings. And with executive director of nursing oversight. We were also supported though by Public Health Wales, epidemiologists and health protection experts and microbiologists and we -- we had a huge focus on PPE and enhanced cleaning, using UV detection, and you'll see from the exhibit that we were meticulous in our approach with outbreaks.

In fact, in December we had six outbreak wards in Glangwili. In January, I understand there were four, and in February, two, and by March there were none. So the measures, I think, that we put in place were effective albeit that it did take some time for those outbreaks to clear.

Q. You mentioned earlier in your evidence that there was a predicted need for 192 ventilators but that you only received approximately one-third of the requested ventilators from NHS Wales, and those that were received were not in fact suitable. But it's right that there was no independent means available to you for purchasing

or securing equipment, isn't it?

A. Correct.

Q. So if that predicted 192 ventilators had come to fruition, is it right that you would have been significantly short without the means of procuring more equipment?

A. Definitely.

Q. You have also said in your statement that there was a realisation that the supply of oxygen and the flow rate and reserves would be insufficient to meet anticipated demand for ventilators and CPAP treatment. When was that realised and how did you manage that?

A. Can I just mention with ventilators, if we had received 192 ventilators we would have struggled to staff 192 patients on ventilators. There's no doubt we were struggling to staff 16, as you've said earlier. So 192 -- which is why that ethical guidance was -- we were trying to consider that almost impossible scenario which at the time we were worried might be real.

So on oxygen -- sorry to go back.

Q. Not at all.

A. On oxygen, right at the start of the pandemic we received the likely patients -- the likely predicted patients that we would get in our hospital and actually it was up to 240 patients a day that we might receive

with Covid so this is what we felt we might be facing in our hospitals. We considered how many ventilators we'd need, how much CPAP, how many people on oxygen, how much PPE. We had cells running for all those very, very early in the pandemic. So oxygen was considered very early on. And it was something that we'd never actually had to particularly consider before in terms of the flow rate.

And we worked out we would no way be able to provide the flow rate that would be required for all the people requiring high flow oxygen and CPAP. So very quickly we contacted BOC, British Oxygen Company, who helped us replace our vaporiser in April 2020, and also we did extensive maintenance and repair to our pipes to reduce leakages and, actually, that secured us the oxygen flow that would be required for our patients.

So we never had an issue -- oxygen -- around that. Our oxygen alarms never went off in our hospital and eventually we replaced our VIE in 2021 or BOC replaced it for us. Of course our oxygen alarms were going off because of the high levels of oxygen in our respiratory ward which I had talked about earlier which is a sort of separate issue.

Q. Thank you.

Moving on to a different topic now. The Inquiry

has heard a lot of evidence around visiting restrictions. So my questions are short but it's right, isn't it, that there were no formal written policies in the hospital for Covid inpatient visiting until February 2021?

A. Yes, we had an interim policy in February 2021 but we did have guidance, we followed national guidance throughout the period up until that point.

Q. Is it right that any discretionary decisions would be made by the ward sister on duty that day?

A. Yes. They had clear guidance nationally, you know, right at the start of the pandemic, and the guidance included the fact that right at the start of the pandemic that we needed to support people with end-of-life care, and we needed to support people when they had a child in hospital or on -- a mother having a baby, that they needed to have at least one visitor.

Of course the learning in April was that, following the letter from the Chief Nursing Officer, was that of course the importance of supporting people with learning disabilities or dementia or other reasons to have confusion. And I think later on, in August, we supported the provision for a partner to attend an anomaly scan, 20-week anomaly scan.

So our understanding of visiting increased but the

discretion was very much for the ward sister and I think, understandably, right at the start of the pandemic they were extremely worried about creating spread for the vulnerable patients that were on the wards. But we knew very early, at the start of the pandemic, in our gold meeting in early March that we were worried about the sort of moral support that visitors provide for patients but also physical support around feeding and so we knew that was an issue because it's very much part of healthcare.

Q. And was there any oversight to ensure that there was consistent decision-making when it was based on the ward sister's discretion?

A. The only information I had is that I know the executive director of nursing and the nursing teams were in constant conversation with our nurses about visiting and there would be information flows back and forth. And if there was any concern, the advice for the sisters was that they were able to contact the infection prevention and control nurse who were able to support them with their decisions, and they were available 24/7.

Q. Dealing briefly with some staffing issues. What action was taken to prepare for the introduction of VCOD, the vaccination as a condition of deployment?

A. Oh, okay.

LADY HALLETT: That will teach you to use an acronym.

MS HANDS: It did.

A. Sorry.

MS HANDS: My mistake.

A. It's normally doctors who do that.

So we really encouraged the vaccination programme and, as I said earlier, we got up to nearly 90% in the first and second wave of our staff being vaccinated and we were really flexible with appointments but we never instituted any vaccine as a condition of deployment. It wasn't within our gift to undertake a compulsory vaccination or vaccine on condition of deployment.

Q. Briefly, in terms of risk assessments for staff, when were they first introduced and what was the level of compliance with the local risk assessments when you introduced them?

A. So we instituted the government's Covid risk assessment right at the start of the pandemic and quite a lot of staff engaged with that but, you know, there was a point actually in April where we received a letter from BAPIO, British Association of Physicians of Indian Origin, which we were aware of these discussions, actually, before we had received the letter, and that was a worry because -- in fact, I remember doctors with BAME background talking to me about the worry, and I remember

talking to them and some of them not being worried enough, in my view, and so this risk assessment was really helpful, I think, and we -- what happened in May was the government combined the BAME risk assessment work of Aneurin Bevan Health Board into the Welsh Government's risk assessment and we therefore enacted that across our health board.

We tried to encourage as many people to complete that as possible. In June my understanding is that our figures were around 65%. I don't know -- I don't have the information on sort of the later figures. We did set up a BAME group in the health board in June, as well, and they set up a BAME network of about 70 people across our health board, which was really important in trying to encourage people to undertake the risk assessments but also to encourage people to have vaccination and also it was a two-way feedback because they were able to feed back to us information that was important. And it was chaired by a health board chair so by the most senior people in the organisation.

Q. Doctor, in terms of access to support for Long Covid, it's right, isn't it, that you introduced the Long Covid Syndrome Service in October 2021?

A. Yes.

Q. Was there any support for staff before that date?

A. So we didn't have the Long Covid service in place but we did have our occupational health team in place. We had an occupational health doctor who would have supported staff. And of course understanding was developing during that time, although, you know, the service was announced and the funding was announced in, I think, June time, in the -- in June 2021. So any support would have been through our occupational health doctor.

Q. Thank you. You have very helpfully set out a number of recommendations in your statement. Are there perhaps one or two that you wish to particularly draw to her Ladyship's attention?

A. So I think considering physical estate in future pandemic planning is important, given our experience. I think some of the risk -- the sort of statistical modelling around outbreaks for both -- the pandemic and non-pandemic issues I think would be important.

If I might be allowed two very quick other ones. Learning -- in our report we've been very open about our report on staff well-being, the positives and the negatives, and I think many of the hospitals will have undertaken similar work in learning what best supports staff well-being in these situations.

And lastly, I would say really much earlier awareness of the impact on vulnerable groups, so -- and

learning what support we should be applying very early on in a pandemic situation to any vulnerable group I think would be important.

MS HANDS: Thank you.

Those are my questions, my Lady.

LADY HALLETT: Thank you.

Ms Iengar.

Questions from MS IENGAR

MS IENGAR: Doctor, I appear on behalf of the Long Covid groups and I have some very short questions on the topic of the impact of Long Covid on the workforce, which follows nicely from the tail end of CTI's questioning.

Doctor, in your statement you say Long Covid did not appear to be a significant factor -- and that's paragraph 47 of your statement -- affecting staffing capacity, but you later in the same statement acknowledge the limitations of that sentence because, as you say, a complete dataset of staff absence due to Long Covid was not retained.

Was data on the number of staff with Long Covid being systematically recorded?

A. Thank you. I need to turn towards the microphone.

Q. Please do.

A. So we didn't have a way of recording Long Covid systematically, and so, as I set out in my statement,

I was -- we were concerned that that could represent an underreporting, and we did recognise just how significant Long Covid can be for people, taking people out of being able to work for quite a long period of time.

Our estimates were that we had about 10 people in Glangwili, as you'll see from the statement, between 2020 and 2022, but I think -- you know, your point about the data, we cannot completely rely on that data.

Q. Thank you. So those are estimates. So when you refer to the health board and GGH identifying the number of staff, those are estimates not recorded data?

A. They are estimates.

Q. And is that data now being collected, at either the HB or GGH level?

A. So actually I'm not sure of the latest data and how it's been collected. I think -- we do have -- we've launched a new service, so -- the reason I'm hesitating on this is we've launched a new service in Wales, we've followed national guidance around post-viral syndrome, and that incorporates both Long Covid as well as conditions like ME and chronic fatigue syndrome, and we have an MDT approach.

I can certainly check how we are collecting the data currently for that service -- because that service

started in October -- and provide any information that might be helpful to the Inquiry if it is.

Q. And a follow-on question, and the response may be that this is something you're able to follow up on. My first was in relation to healthcare workers with Long Covid. In relation to staff absences due to Long Covid, is that data being collected at the moment?

A. So, again, it's a similar answer. Because of the way the data is coded we've not got specific data on Long Covid. It's extrapolated data. So we have data on people who have Covid and we have data for how long people are off work, which is why we -- why the figure of 10 was produced. But -- so, yes, it's estimated data.

Q. And finally, Doctor, you lay out at paragraph 205 and also orally just now you laid out some of the supportive measures that GGH have put in place: the extension of contractual sickness pay of Long Covid, the creation of an injury allowance and bespoke phased returns to work.

My question is this. In order to continue responding to the impact of Long Covid on the workforce, would you agree that GGH would be assisted in collecting that data rather than simply using that extrapolated data or estimated data, as you say, perhaps by coding the number of staff referrals into the Long Covid

service that you just mentioned?

A. I do agree. And I think, you know, because it's a new service that we set up in October, this broader service I think we also need to collect data on it to establish effectiveness and learning from that service, because it's a new service. So I do agree with you.

MS IENGAR: Thank you, Doctor.

My Lady.

LADY HALLETT: Thank you very much.

Ms Munroe, who is just there.

Questions from MS MUNROE KC

MS MUNROE: Thank you.

Good afternoon, Professor. My name is Allison Munroe. I ask questions on behalf of the Covid Bereaved Families for Justice UK, and just a few questions for you, please.

I'm very grateful that, in fact, counsel to the Inquiry, Ms Hands, helpfully has taken you to the issue of DNACPR. Some of my questions have already been addressed, so just one point of clarification and two short questions.

In your paragraph 189-191, where you set out the examples and the instances of issues around DNACPR, just to clarify. There is an email on 14 February 2021 and that's from the learning and support assistant's raising

concerns, plural. Then a formal complaint, and that's the following year, 14 April 2022, on the issue of DNACPR. And that resulted in a joint letter from the CMO Dr Atherton to the CNO Sue Tranka, from them to the HB CEO. And then, thirdly, the incident concerning the junior doctor, and that's February 2021. So we're talking about three separate reports detailing a number of incidences; is that right?

A. Well, there were two instances, one in the spotlight hospital in February 2021 and then one in another hospital which was similar but not quite the same.

Q. And so the formal complaint that resulted in the letter from Dr Atherton and Ms Tranka, what does that relate to?

A. My understanding -- I'm trying to remember which -- I think that related to the one in the other hospital --

Q. I see.

A. -- rather than the spotlight hospital.

Q. Thank you very much for clarifying that.

Then the short question is this. The email of 14 February 2021, from the learning and support assistant, raised concerns that DNACPR notices were being issued by HB staff for Covid patients with learning disabilities without their consent.

Now, these are particularly vulnerable patients.

What if anything was done to follow up with the local learning and support assistants about their concerns about what sounds like multiple incidents?

A. Well, I've -- so, first of all, we undertook that very detailed investigation. My understanding is that they would have been involved in that and communicated with as part of that.

Q. A root and branch analysis?

A. Yes, the root cause analysis, which is a very detailed investigation and, as I described earlier, was shared widely, the learning from that was shared widely.

As you can see, we've tested at the time with our senior doctors as to whether -- who were involved with our rapid response acute illness group which oversees DNACPR as to whether were other incidences around DNACPR and Equality Act issues. We also had an outreach team in place who, as I described, came into being right at the start of pandemic and were overseeing best interest decisions and were there to draw people into ITU if it was appropriate, or into the respiratory ward, and none of those flagged a broad-ranging issue across Glangwili.

However, my, as I stated earlier, we do have new staff arriving, junior staff quite frequently and I don't think we can be complacent about this issue and we do have the learning disabilities nursing team there

who are there to support the education of junior doctors.

The other advice that we've given to staff is that these need to be reported as an incident.

So I think if it was a broad issue across our health board then we'd have seen that as an issue. The other point is we do have, whilst -- although audits were reduced and in some cases discontinued during the Covid period because of the challenges, we were undertaking audits in 2019 and in 2022 and they didn't identify a systemic issue.

Lastly, I know it's a long answer, but lastly we did have an HIW, Health Inspectorate Wales, I should say, inspection of one of our sites, not the spotlight hospital, one of the other sites, on our DNACPR processes and that actually suggested generally good practice.

So I think all of those things around the governance give us some reassurance but I wouldn't want to be complacent and, you know, I think it does need constant attention.

Q. Thank you, and I think a very detailed answer just now and what you had said earlier in answer to questions from Ms Hands very much deals with the majority of my question in relation to the incident with the junior

doctor, but if I may just ask you this. That DNACPR notice that that junior doctor tried to issue was on the grounds -- and again, a patient with learning disabilities, on the grounds of "poor quality of life". Bearing in mind the question that her Ladyship asked you and bearing in mind the grounds upon which that junior doctor was attempting to issue the notice, you didn't know the answer as to why he did, he acted in the way that he did.

Should that central question why not be a central part of the root branch cause analysis that you did, because you need to consider was this a one-off or is this indicative of wider practice, so isn't that a central question to ask?

A. So just reflecting on that question and I've had a little more time to think since your question. I was remembering back to the root cause analysis and the scenario at the time. My understanding at the time was that there was an issue of -- because other factors were found through that root cause analysis and there was an issue of communication between some of the more senior doctors at that time and I think it did lead to the junior doctor perhaps misinterpreting some of the guidance that -- some of the communication from some of the senior doctors.

So I think, actually, it wasn't quite as straightforward as them seeing somebody with learning disabilities in front of them and applying a DNACPR form. They were interpreting some discussion around intensive care and escalation.

MS MUNROE: Thank you very much, Professor. That's very helpful.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Munroe.

Ms Gowman.

I think you may have a better view of her than I do. That way.

MS GOWMAN: Thank you, my Lady.

Questions from MS GOWMAN

MS GOWMAN: Professor, I ask questions on behalf of Covid-19 Bereaved Families for Justice Cymru. At paragraph 123 of your statement on the issue of PPE, you explain that although there was considerable anxiety amongst staff supply was not an issue and there were no significant delays in procurement until summer 2020.

You repeat this at paragraph 140 and, indeed, you've repeated this in your evidence today.

Please can we bring up INQ000417548.

Now, you should have seen this document, Professor. It is a letter dated 6 April 2020 from the

then Chief Executive of Hywel Dda University Health Board, Steve Moore, in response to concerns raised by the Royal College of Nursing.

Page 1 of that letter acknowledges the "overwhelming sense of fear and anxiety amongst staff", the main concern highlighted being "the availability of appropriate PPE".

And if we turn over to page 2, Mr Moore acknowledges shortages of "some key items" in brackets, notably, "visors".

My question is this, Professor, did you know about the shortages within Hywel Dda University Health Board in April 2020?

A. Yes, well, we knew that some items were getting close to the level at which we would have concerns. So we generally try to keep, as I said earlier, a two-week supply. I think we managed to mitigate the visor issue, as you'll see, from exploring other procurement avenues. So my understanding was that we were never in a situation where we couldn't provide appropriate PPE for staff.

There were issues, as I said earlier, that were around -- that I was aware of, were around communication with staff on how to access it if they ran out on a ward and that we tried to address that as quickly as possible

with the local command centre and through our nursing workforce.

Q. Forgive me for delving into semantics. Your evidence was that there were no supply issues. That's a different question to whether PPE was available to those on the ground. Is it not right that a shortage of key items, most notably visors, would represent a supply issue?

A. I suppose -- well, it is a supply issue.

Q. One that the health board was having to explore alternative procurement options that deviated from its normal procurement processes; do you agree?

A. I do agree with that. But I think what we felt that with those alternative procurement options that -- were that we weren't giving people inadequate PPE at the time even with those alternative procurement options. But I don't want to -- I'm not seeking to downplay what was quite a close issue for us because two weeks' supply is not long and if we had an increasing surge we could have run out, so -- and staff were extremely extraordinarily anxious at the time so I'm not seeking to downplay it.

Q. And this was as early as April --

A. Yes.

Q. -- so quite significantly before summer 2020?

A. And there was significant uncertainty at that time for

staff as well, we understand that.

Q. And just moving on to how that impacted on Glangwili, we've heard in your evidence that staff at Glangwili felt unsafe in the workplace due to non-availability of PPE. Such was the level of concern that they resorted to buying their own PPE. But in terms of the lived experiences of the members of the group that I represent, they report seeing staff cared for -- staff caring for a loved one without appropriate PPE in April 2020.

So against the context of procurement issues on a health board level, against the context of genuine fear amongst staff resorting to buying their own PPE, and the lived experiences of the members of the group that I represent, do you maintain and can you be sure that staff at Glangwili hospital had adequate PPE in April 2020?

A. I can only present you, of course, with the evidence that I have and of course it's evident that -- it will be the evidence based on our colleagues who were overseeing the PPE supply. So we had a PPE cell which was overseeing all of this. Having said that, it's difficult for me to know what the exact circumstances were that you're describing there and there's no doubt they sound concerning because, you know, we would have

never expected our staff to be caring for people without appropriate PPE. And our approach was always, if we were worrying about PPE shortage or if there was difficulty with people using a particular piece of PPE, was to escalate the PPE that people were using. But I can't be sure about those specific circumstances.

Q. And one follow-up and hopefully final question. Whether there was a genuine lack of availability of PPE or a perception, rightly or wrongly, by staff working on the grounds that stocks were not there, do you agree that that was likely to have led to instances of PPE either not being used at all by staff or incorrect PPE being used?

A. It's difficult to know because, I mean, the evidence I have is that we hadn't run out of PPE.

I suppose the communication issues that I was describing earlier are worrying, and so whether there were instances because of that that staff used the PPE that wasn't appropriate for that situation, that certainly wasn't our intention, and we -- you know, we felt we had enough PPEs and we were putting huge amounts of effort into trying to communicate that with staff.

And we -- you know, we learnt -- we learnt in the first few months about how to effectively communicate with our staff, how to get supply lines to wards working

and -- so whilst the evidence I've had is that those were effective, generally, it's difficult for me to know in exactly every single circumstance because there were so many wards and so many situations.

Q. But on any view you had staff reporting in your survey that they felt unsafe --

A. Yes.

Q. -- staff reporting to the Royal College of Nursing their concerns about lack of availability of PPE. A blind assertion that there was PPE availability doesn't correlate with that feedback, does it?

A. No, and -- no. The staff -- in the end, the staff are feeding back their lived experience, so I'm not actually -- I'm not seeking to sort of dismiss those concerns or suggest that they were incorrectly representing their lived experience. Of course that was their lived experience and we took those experiences really seriously. I mean, the whole basis of our discovery report was so that we could -- so that staff could feed in those genuine concerns, and some of them quite difficult -- or very difficult to hear. So, you know, I wouldn't want to seek to diminish those concerns.

MS GOWMAN: Thank you, Professor.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Gowman, very grateful.

I think that completes the questions for you, Doctor. You're a respiratory physician by training and experience.

A. Yes.

LADY HALLETT: Did you work on the front line during the pandemic.

A. So I was still practising in the pandemic. I was -- by that time I was mostly outpatient based, but I -- so I was trying to work out how to look after patients virtually who I'd been used to seeing physically, which was extraordinarily -- it was new, it was different trying to look after -- assess people without any tests. So that was difficult. And I was in very close conversation with my colleagues on the front line visiting the areas and -- yeah, it was a really, really difficult time for everyone.

LADY HALLETT: I can imagine. Especially for a respiratory physician as a respiratory virus.

Thank you very much for all that you did during the pandemic and of course for all the help that you have given to the Inquiry, I'm very grateful.

A. Thank you, my Lady.

LADY HALLETT: And don't forget, even institutions that start with any Nissen huts can become like Heathrow,

because Heathrow started that way. My husband tells me Heathrow started as Nissen huts, so you never know. You may get your hospital into Terminal 5 state.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: Ms Nield.

MS NIELD: My Lady, the next witness is Dr Andrew Goodall who will appear by the remote link.

DR ANDREW GOODALL (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Dr Goodall, I'm so sorry to have kept you waiting for so long. I know you must have a very busy timetable. I appreciate you're going to have to come back tomorrow but I'm really grateful to you.

A. Not at all, Chair. Thank you very much.

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

A. My name is Andrew Goodall.

Q. And Dr Goodall, you provided a witness statement to this Inquiry dated 10 May 2024. That's INQ000485721. Can I just check that you have that witness statement available to you?

A. I do, yes.

Q. Thank you.

Dr Goodall, you're currently the permanent secretary to the Welsh Government, in which role you

lead the Welsh Government Civil Service in delivering the priorities of the First Minister and his ministerial team; is that correct?
A. Yes, that's correct.
Q. And you've been in that role I think since November of 2021, prior to which you were the Director General of the Health and Social Services Group of the Welsh Government, a role which you held from June 2014; is that right?
A. Yes, that's correct.
Q. And before that you were the Chief Executive Officer of Aneurin Bevan University Health Board between 2009 and 2014; is that right?
A. Yes, that's right.
Q. Dr Goodall, my questions today are all focused upon the work of the Welsh Government Health and Social Services Group in relation to the response of the healthcare system in Wales during the Covid-19 pandemic from March 2020 to the end of June 2022. Is it correct that the witness statement that you've provided to Module 3 of the Inquiry covers the entirety of that period, notwithstanding that some of the information you provide in that statement relates to the work of the Health and Social Services Group after you had left the role of Director General?

A. Yes, that's correct. And for completeness, we wanted to set it out in that way.
Q. Thank you. Can I also clarify, your title is doctor. You're not a medical doctor; is that right?
A. No, it's a PhD in health service management.
Q. Thank you.
Turning then, please, to your previous role as the Director General of the Health and Social Services Group. Is it correct the Health and Social Services Group is the Civil Service department, effectively, which provides support for the minister of health and social services?
A. Yes, that's correct.
Q. And you explain in your witness statement at paragraph 25 that during a health emergency the minister of health and social services is responsible for the preparedness of the health sector, NHS initial capacity and ability to increase capacity and resilience; is that right?
A. Yes, that's correct.
Q. You also explain that, in terms of operational decision-making in the healthcare system during the pandemic, that was principally the responsibility of the local health board but the Welsh ministers had the power to issue directions to the NHS bodies such as the local

health boards, and those were mandatory, it was mandatory to comply with those direction; is that correct?
A. Yes, that's correct they would have been operational matters for the health boards.
Q. Is it right that in relation to any communications from the Welsh Government to the NHS bodies during the pandemic other than funding matters, in fact took the form of guidance and requests rather than mandatory and ministerial directions?
A. Yes, the directions tended to have to relate to formal financial arrangements, whether it was suspension of enhanced services or it was simply the allocation of funding to the NHS for a financial year. So they did tend to be issued in that respect, yes.
Q. So we'll be talking about a number of those communications that came from the Welsh government to the local health boards, or indeed ministerial statements, but it's right that none of those were in fact mandatory for the local health boards to comply with; is that correct?
A. That's correct.
Q. So if we may come on, please, to your role specifically as Director General, I think it's correct that that's a dual role, so the Director General is also the

chief executive of NHS Wales?
A. Yes, that's correct.
Q. And would it be right to characterise the dual role in this way: the Director General role is an internal Welsh Government-facing role, supporting and advising the minister, whilst the chief executive of NHS Wales is an outward-facing role, facing the NHS bodies?
A. Yes, that would be a good way of summarising it.
Q. We've also heard that there is no single entity called NHS Wales. It's effectively a grouping of the NHS bodies in Wales; is that right?
A. Yes, it represents the collective organisations in Wales.
Q. Can we have a look, please, briefly, at an organogram.
This is on INQ000486014 at page 33.
And I hope we'll see an -- if we can see the topmost of those two organograms, please. This is the stretch of the organisation of Wales as of 2020, just so that we can see what those bodies comprise of.
There are seven local health boards. I think they're responsible for the planning and provision of healthcare services both at secondary care and healthcare; is that correct?
A. Yes, they have population health responsibilities but they are also responsible for the delivery of the local

services.
Q. And we see also that there are three NHS trusts. That's the "Welsh Ambulance Service Trust", "Public Health Wales" and "Velindre Cancer University NHS Trust". I think Velindre Trust provide a specialist cancer hospital; is that right?
A. That's correct, yes.
Q. And there are also special health authorities there. As of 2020, the Health Education and Improvement Wales health authority. I think during the pandemic they were involved with the deployment of medical and nursing students and the continuation of healthcare education and training; is that correct?
A. Yes, that's correct.
Q. And I think now and later in fact, during the pandemic, Digital Health and Care Wales was created as a special health authority; is that right?
A. Yes, it was brought into a national single digital organisation, yes.
Q. So would it be right to say that you were chief executive in relation to all of those NHS bodies?
A. Yes, all the chief executives of all of those bodies would have reported to me through accountable officer arrangements, but, yes, they constituted NHS Wales, which I oversaw.

Q. The Inquiry has also heard the seven NHS local health boards and the three NHS trusts in Wales are designated as Category 1 responders under the Civil Contingencies Act, which means that each has their own EPRR framework; is that right?
A. Yes, that's correct.
Q. And is it right that there's no single body with an EPRR function which enables national command and control of NHS Wales?
A. Yes, the legal responsibilities lie with the health boards, because NHS Wales doesn't exist as an organisation or an entity, that doesn't lie with the NHS in Wales or with Welsh Government. So it's correct that that responsibility lies with the individual health boards.
Q. So in your role as Chief Executive of NHS Wales, did you have the authority to direct those NHS bodies? Did you have any statutory powers in relation to the NHS bodies?
A. The powers that I would discharge would reflect the powers of Welsh ministers, so where Welsh ministers were directing, I was able to delegate those responsibilities down.

I did have a lever through the accountable officer arrangements to the individual chief executives, and that was a requirement for them to, for example, manage

within their budgets and their resources, so that would come with a different responsibility.
Q. And to whom were you accountable as chief executive of NHS Wales?
A. I was accountable to the health minister for -- in my NHS Wales Chief Executive role.
Q. And could you describe, please, the role and responsibilities of Chief Executive of NHS Wales, in terms of the functions and responsibilities that came with that role specifically in relation to the pandemic response?
A. Yes, the role pre-pandemic is about the strategic planning and leadership of the NHS in Wales across the organisations and that needed to be translated into the pandemic response as well.

So whilst of course respecting the operational delivery that lay with the health boards, it meant there was a higher degree of oversight and, at times, support and guidance that was needed into the system. So there would have been examples of needing to confirm that funding was available, for example, or there would be some examples in the pandemic where it was really important to have consistency in some of the expectations in delivery across Wales, whether that was capacity assessments, for example.

Q. Can we look briefly, please, at the pandemic response structure that was created within the Health and Social Services Group.

Can we go, please, to page 76 of your witness statement, organogram number 5.

You explain in your witness statement that the planning and response group that we can see there in the middle of this organogram had its first meeting on 20 February 2020. When did it first become apparent to the Welsh Government that national co-ordination of the healthcare system was going to be necessary and some kind of structure would have to be created to facilitate that?
A. It was clear to us in February 2020 as we were looking at the tracking of the numbers, as we were looking at the first steps that we had taken. We had started to introduce some of the various steps, like the PPE arrangements, because we knew we may need to access from the supply. But it was during February, as we were watching some of the both international and the UK numbers start to change, that we felt the need to introduce those more formal arrangements. And as you said, they started on 20 February.
Q. So is it right then that in the existing pandemic planning, this sort of structure hadn't been previously

designed or envisaged, there hadn't been any design of a Health and Social Services Group pandemic response structure until February 2020?

A. There were mechanisms where we fed into Welsh Government's emergency preparedness arrangements more broadly and there was an establishment of a health intelligence cell, for example, that would feed into that, but it became clear that we were going to have to oversee the arrangements for the NHS in Wales in a very different way, and, while we made that early decision, building on some of that early pan-Wales response plan but actually making sure that it was going to be suitable for what we saw as emerging at that time.

Q. Now, the Inquiry has already heard quite a lot of evidence about this structure from the Chief Medical Officer of Wales, so I'm not going to go through that structure in detail. I'd like to focus, if I may, on your role and that of the NHS organisations, in particular how the NHS bodies were represented within that structure. So we can see that on the right the NHS Wales medical directors and directors of nursing and midwifery report in -- is that the meaning of that arrow that points to the box with you heading it up?

A. Yes.

Q. So those are the medical directors of those ten NHS

bodies that we've seen identified previously.

A. Yes --

Q. And then --

A. -- partly through the professional routes there, because medical directors would have reported to Frank, in the Chief Medical Officer role, to Jean, in the Chief Nursing Officer role, so it was an opportunity to draw in that through the professional route.

Q. Thank you.

Then if we can see, on the left, the NHS Wales health boards, trusts and Health Education and Improvement Wales, on the left-hand side appear to report in to the Health and Social Services Group Covid-19 planning and response cell, which in turn reports in to the planning and response group, which in turn reports up to you, the Chief Medical Officer and the Chief Nursing Officer.

The NHS Wales health boards who are represented there, would that be through the chief executive officers of those boards?

A. There would be delegation from those chief executives. They would certainly sit around the executive board table and participate in chief executive calls, but they were representatives of those individual health boards and trusts in the different response group arrangements

and often it was about having the right individual for the representation. There was a formal link to the chief executives, of course, because they were responsible for their organisations.

Q. Can I ask you this. In the event of a future pandemic or health emergency would you adopt this same structure within the Health and Social Services Group or would you do anything differently?

A. We would look to generally adopt this. What the planning and response group gave us, and including through its subgroup arrangements, was a very early and important link out to the individual organisations across Wales to expertise and experience around the table. That meant that as we were considering guidance and advice out into the NHS it was being worked through together and I think that was a really powerful way in which we established right from the very start that that representation was very clear both from the planning and response group arrangements but, of course, fed through those individual areas, as well.

So I do think this gave us something that was important in the pandemic response about that learning together, but it also meant that when we were implementing our national guidance there was some familiarity with it because of the way in which we had

engaged with the organisations and that feedback I think genuinely helped us. So I'd really like to retain that into the future.

Q. Were there any issues with a lack of clarity about roles or responsibilities within that organisational structure?

A. I think the individual organisations were always clear about their own responsibilities. In answer to your question, I still feel there is something outstanding in the sense that because NHS Wales isn't established as an organisation, it is not enacting the Civil Contingencies Act, Category 1, Category 2 responder model, and I think there is a need for us to make sure that those things make sense into the future.

But I didn't think that took away at all from local organisations understanding their Category 1 responder responsibilities and the way in which they, for example, were involved in the strategic co-ordinating groups with other public partners.

Q. Does it follow from that answer, Dr Goodall, that you think there would be a benefit in creating a mechanism or having some sort of body that is able to take national command and control of the NHS as part of an EPRR function?

A. I think our structure in Wales is different but I do

agree that we need to settle how the planning response structure would work in our context in Wales and if that meant that we needed to change the arrangements to understand that but also just understand how it fits with the way we are currently set up.

Q. Do you think under the arrangements that were in existence during the Covid pandemic, with each of those 10 NHS bodies having their own EPRR function and structure, that there was a risk of duplication of work, that the same thing was being done ten times over when it could have been done once for all of Wales?

A. There may well have been some risk on that but given that they would still have needed to discharge their operational and legal responsibilities. That's familiar in the way in which the NHS works anyway, day-to-day, so I almost fee that's part of our normal experience even though, of course, it would have been enhanced in a very exceptional period in a pandemic response.

Q. Thank you. Perhaps we can move on now and look at the steps that were taken by the Welsh Government to ascertain information about NHS capacity early in the pandemic and gathering data on the NHS system.

You've explained in your witness statement -- this is at your paragraph 425 -- that on 13 February 2020 the Chief Medical Officer of Wales wrote out to the local

health boards to ascertain their capacity to manage Covid-19 patients who require hospital admission. And perhaps we can look very briefly at that letter from the Chief Medical Officer. It's INQ000227377.

So this is:

"Increasing capacity across the NHS estate for management of possible cases of COVID-19 who require hospital admission".

And then if we can look down the letter, in the third paragraph it says:

"Delivering care to these individuals will require isolation facilities in line with the Welsh Health Circular ... [33 of 2018] -- Airborne Isolation Room Requirements (attached [to the letter]) and an appropriately trained workforce."

I think it's right at that stage Covid-19 was designated a high consequence infectious disease and so specific isolation facilities were required; is that correct?

A. That's correct and at that stage we hadn't had our first case in Wales either.

Q. Can we go to page 2, please, of that letter. And the Chief Medical Officer notes -- he sets out the requirements, briefly, for isolation facilities under that circular, and says that:

"An audit carried out by NHS Wales Shared Service Partnership -- the Specialist Estates Services in 2019 ... reported that only 6 of the 22 isolation facilities in Wales were fully compliant with the guidance. For those of you who were non-compliant I ask that you report on any actions you have taken to date to achieve compliance."

Do you know whether any steps had been taken prior to the Chief Medical Officer writing that letter in February 2020 to respond to the findings of the audit in 2019 and ensure that local health boards in Wales achieve compliance with the isolation facility requirements?

A. I can't recall that and that's not represented in my statement so I can't answer that question directly. Obviously, Frank's very formal correspondence giving the emerging picture was to make sure that that was understood by health organisations and they very quickly needed to make sure that they were able to be prepared.

Q. It may be an obvious point but if on receipt of that audit in 2019 the local health boards had been asked or indeed required to comply with the Welsh Health Circular, the isolation facilities would have been place at the start of the pandemic, wouldn't they?

A. Yes, as I said, I would need to go to look at what

precisely happened at that time but, yes that would be the case. I know Frank, in the responses that were received, did have that reassurance that by 5 March, that all organisations, with one exception, were able to comply with some of those immediate requirements, as well, so in very quick order I know health boards did respond but, yes, your point about understanding the audit actions is important.

Q. Perhaps we can move on a little then to 11 March of 2020, and to try to ascertain the state of preparedness of the local health boards at this stage.

Can we go, please, to -- this is an email to the Minister for Health and Social Services, it's INQ000252505.

This is an email dated 11 March 2020 and you're copied into this, although it is sent to the private secretary to the minister.

This is:

"... feedback and information from the Wales Critical Care and Trauma Network meeting [that was] held this morning ..."

It notes there at the first bullet point that:

"Clinicians in each health board confirmed there were broad plans in place to double level 3 equivalent critical care beds ... [and] Cardiff have indicated they

could go above double capacity depending on the availability of redeployed staff."

And if we can move down the page, please. There in bold we can see the local health boards:

"... are asking for elective surgery to be stopped immediately to start to address bed issues and also release staff for training and upskilling such as anaesthetists, theatre/recovery staff and to allow capacity to address the emergency surgery backlog ahead of the peak."

And if we can look at the two bullet points below that, not all -- forgive me:

"There was ... a strong clinical view, based on evidence from other countries, that non-invasive ventilation could have little benefit and potentially be harmful/spread the virus so we should not be planning on expanding this service."

That's a snapshot of the early preparations on 11 March.

So local health boards, had they already been asked to try to increase their capacity in critical care at this point or was that coming from the health boards rather than from a request from the Welsh Government?

A. No, they had -- Frank's request on capacity had been received by the health boards. We, at this point, were

having chief executive calls which were picking up some of the expectations as well on the back of what was Frank's initial request.

Also at this point some of the SAGE assessments and modelling were being made available, whether that was through Public Health Wales or through ourselves to share with executive directors across Wales, as well. And that was leading to some of these questions being asked about doubling of capacity and it starting to be socialised in this way. But at the time that this was happening there were already chief executive level meetings happening every couple of days, on occasion daily.

And I think the reference in here about the asking for surgery to be stopped, rather than being from health boards directly at this stage, but this was actually from the Critical Care Network clinicians who were expressing that wider need to prepare so that was just giving a clinical voice to the scale of the preparations that we needed to make at that time which did line up with other colleagues, including medical directors and chief executives as well.

Q. So it seems at that point the focus was on increasing capacity in terms of mechanical ventilation, invasive ventilation, is that right, given the view about

non-invasive ventilation being of little benefit?

In fact, I think it's right that that view subsequently changed so that local health boards were providing most of the oxygen support for Covid patients by way of CPAP outside of intensive care units.

Do you know when it was that the local health boards began to focus on CPAP capacity to support Covid patients or when that was brought to your attention that was the way those patients were going to be predominantly clinically managed?

A. Certainly the discussions on CPAP machines being made available was happening through March, I would recall from around mid-March or so, not least because as we were trying to assess the numbers of ventilators that were available and which would be required, that they were part of the assessment of equipment that was done and the Critical Care Network was really useful as a national body to understand some of the requirements and expectations particularly from our clinicians. But we were also able to use some of the other planning and response mechanisms to oversee a proper assessment of the equipment was around, but I do agree with your point that the treatment that was available and the way in which patients could be supported was changing at that time, but CPAPs were definitely part of the assessment

during March.

Q. Can we look, please, to see what capacity requirements were being communicated to the local health boards, what -- I appreciate this is a moving picture as to how much the -- or the extent to which the NHS in Wales is going to have to increase its capacity for critical care and acute beds.

So can we look, please, at your paragraph 421 of your witness statement. This is on page 168. You say that technical advisory cell on 15 March 2020:

"... indicated if all three social interventions (that's self-isolation, household quarantining, shielding vulnerable groups and over 70s) were in place in Wales early in the epidemic, there would be a peak need for 1,595 ICU units and 16,552 hospital beds. This meant if every single NHS Wales bed was available to Covid-19 patients there would be a deficit of 5,989 beds at peak and 1,447 [Intensive Care Unit] beds -- if all current NHS capacity was available. The advice was the deficit was likely to be higher."

Were those projections of the hospital capacity that would be required for Covid-19 patients shared with the local health boards at that point?

A. Yes, there were. As I said, particularly through those previous two weeks we had been meeting every couple

of days or even daily talking through these areas. These were part of presentations that were given to individual groups across Wales, including medical directors but also chief executives. We were using the emerging information and model that had come out of SAGE and in a salutary way these predictions were showing us what the numbers would mean for Wales on the one hand looking into the future, and in pretty short order, but they were also tying very visibly with images we were starting to see, particularly from Italy and Spain, and I think those images were really showing us the reality of how this virus would spread very, very quickly and have an impact on capacity.

Q. So given that projected requirement for hospital beds, can we see, I think at that point, on 20 March you wrote to the local health boards requesting them to provide daily information on their hospital activity and their hospital capacity.

I think this is the letter that you wrote on 20 March and we can see in bold that the requirement for this daily reporting has been changed to report a new imposition by 1 pm from Saturday, 21 March, so that's the following day, and this is an absolute deadline. Was this the first time that the Welsh Government had asked for this data from the local health boards?

A. Yes, this was when the formal sitrep reporting was being introduced and despite health boards, of course, having their own access to information because they were responsible for their operational management, that we needed to be able to track that closer to realtime at a national level which, whilst it's unusual, was something that was really necessary for us to do at this time. And we weren't able to rely on some of the other sources of information that we would use, for example if we were responding to bed pressures during the winter months. It needed to have additional information available and this was really important to support our own decision-making and support but, of course, also to report up to ministers and beyond as well.

Q. So what you're asking there is you said the interim reporting arrangement has already been issued to you and focuses on the immediate priority to report critical care capacity and activity. So was this then asking them for more information?

A. Yes, it was.

Q. You've noted there --

A. So the ability to report other acute beds, for example, and, you know, that developed over time, which I'm sure we can touch on.

Q. So previously they had been asked to report critical

care capacity. If we can see the fourth paragraph there:

[As read] "From early next week a new reporting system will be issued by ..."

Is this NHS Wales Informatics Service?

A. Yes, that's correct. They had a responsibility for the data, yes.

Q. [As read] "... that will capture a broader suite of data. This will include more detailed capacity and activity in the hospital outside of critical care."

And:

[As read] "The information will provide a hospital, health board and all-Wales view of Covid capacity activity and outcome."

Can we look, please, at the information or the nature of the information that was provided to the Welsh Government. You have provided at page 165 of your witness statement a table of the data from the sitreps on 30 March 2020. This shows, I think, the categories of information that was collected from the local health boards at that time. And so we can see that down the left-hand side they're broadly grouped together, with invasive ventilated beds. And we can see there are three kinds of invasive ventilated beds: in a critical care environment, in a hospital but outside of the

critical care environment, and temporary beds providing invasive ventilation out of a hospital building.

So was it the case that at that time there were patients who were sedated and receiving invasive ventilation but not in a critical care environment?

A. I may need to check on statements from Frank and other colleagues on the clinical side of things, but there were -- there were patients, as we were going through the first wave, who would have been outside of the traditional critical care units because, as they were expanding the potential to staff beds, there was a physical limit, so they would have gone into lower-level critical care areas, like high dependency for example, or they -- we were using theatres, for example, as expansion places. So, yes, patients were being cared for out of that environment.

Q. So we can see on here it says that there are 84 beds, invasive ventilated beds outside of the critical care environment. Six of those beds are shown as occupied.

So at this point on 30 March it seems that some patients are sedated, intubated, receiving mechanical ventilation, but outside of a critical care environment.

A. Yes, and that would have tended to have been geographical as well, in terms of those patients, because as we were going through the first wave the

capacity was being introduced as we really saw the virus move from the right-hand side, south east of Wales, across the M4 corridor, through South Wales. So that would show pressures in individual hospitals. And underneath this aggregate data we, of course, had the individual health board positions and we had the individual hospital positions as well.

Q. If we can look briefly then at the other categories of beds that are recorded here, there are then non-invasive ventilated beds: the designated Covid-19 hospital beds providing CPAP, designated Covid-19 hospital beds with non-invasive ventilation -- is that non-invasive ventilation other than CPAP? Because we've heard CPAP can be considered a form of non-invasive ventilation?

A. Yes, we categorised it, as I recall, at the time to make sure that we did have an understanding of those receiving the CPAP treatment.

Q. And then palliative beds and other beds, would those be general beds on a general medical ward?

A. They would typically be on a ward. And yes, you're quite right, typically they would probably be in a medical area.

Q. And we've got beds that are not designated as Covid-19 hospital beds. That's presumably for patients who have come into hospital for another reason?

A. Yes, it's the remainder of the capacity. We were trying to make sure that we, at least for our general beds, knew what were likely to be designated areas for patients with Covid working through, but, yes, there were other activities that were still going on, of course, within the NHS.

Q. And finally we've got "Temporary beds providing hospital care out of a hospital building". It says zero all along there. Was that to be completed once field hospitals had been stood up?

A. Yeah, this was just an early stage and we'd already, I think, at this stage, had the back beyond -- people working on field hospital plans that they were looking to any areas where they could expand physical capacity as well. So I think this was just introduced as a bit of a catchall at the time. But you're correct, we did introduce the field hospital reporting through the sitrep reporting later.

Q. Thank you.

Then, finally on this table, if we may, this is a snapshot as at 30 March 2020, and we can see that the total invasive ventilated beds that are available, whether occupied or not, is 304 at that point.

So is it correct to say that the Welsh hospitals have already by this point more or less doubled their

invasive ventilation capacity from around 150 to 304?

A. Yes, they doubled their available theoretical capacity. What they're not really reflecting here, which we introduced throughout the sitrep reporting, is the capacity that is available immediately with the confidence that that stat (*unclear*), that which would be available within 24 hours, within seven days, and then after seven days, I thought that gave us additional information.

Also, at this point, this is trying to give reassurance to our clinicians as well as to the public and to our ministers about the planning arrangements put in place but this is not clarifying the historical capacity that is available for critical care, for example, and certainly in our later reporting and in my own personal reporting, I have to say, we always wanted to be really clear about the level that we were used to in the normal NHS system so that we were clear where we started.

Q. So it doesn't show base line or the number of beds over the baseline, essentially?

A. And the baseline capacity at this point, just to put it into context, would have been 152 critical care beds.

MS NIELD: My Lady, I don't know if that's a suitable --

LADY HALLETT: Certainly. I'm sorry we're going to have to

ask you to come back again tomorrow, Dr Goodall, but if you could be available for a 10 o'clock start, I suspect. They will want you a bit before just to set the technology up, but thank you very much for your help today and see you tomorrow.

10 o'clock on Wednesday, please.

(4.33 pm)

(The hearing adjourned until 10.00 am on Wednesday, 13 November 2024)

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