

Tuesday, 12 November 2024

1
2 (10.00 am)
3 **LADY HALLETT:** Ms Carey.
4 **MS CAREY:** Good morning, my Lady, the first witness today is
5 Sir Christopher Wormald.
6 **LADY HALLETT:** Welcome back, Sir Chris.
7 **THE WITNESS:** Thank you.
8 **SIR CHRISTOPHER WORMALD (affirmed)**
9 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**
10 **MS CAREY:** Sir Christopher, good morning. I know it's not
11 your first time at Dorland House, I dare say it won't be
12 your last. You are the permanent secretary to the
13 Department of Health and Social Care and have been
14 since May 2016; is that correct?
15 **A.** That is correct. And if I could start, as I always do,
16 by putting on record the department's sorrow for
17 everyone who suffered during the Covid pandemic, and
18 particularly pertinent to this module, our ongoing
19 thanks to our amazing staff in the health and care
20 system who helped us all through.
21 **Q.** Thank you. Sir Christopher, you know I have a number of
22 questions to ask you spanning five statements that have
23 been prepared by the department. I think you are the
24 signatory to the first and the final statement, and then
25 a number of your colleagues have assisted with parts B,

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1 the Director General within the Cabinet Office before
2 that?
3 **A.** Yes.
4 **Q.** We will deal briefly, if I may, with the role of the
5 department, which is set out in your first statement
6 which I hope you've got in front of you.
7 I ought to say for the record there are five
8 statements, INQ000369658, INQ000389241, INQ000472172,
9 INQ000469724, and INQ000473872, all of which will be
10 published later today.
11 And I think you say this, that in broad terms it's
12 the department's role to support and advise the
13 government's health and social care ministers by shaping
14 policy, assisting in the setting of strategic direction,
15 and implementing agreed policy.
16 You support the Secretary of State, Mr Hancock and
17 Sir Sajid Javid, who were the relevant secretaries at
18 the time, and the department secures funds for the NHS,
19 and I think you're aware we heard from the CEO
20 Amanda Pritchard yesterday?
21 **A.** Yes.
22 **Q.** In relation to pandemics, it may be easiest if we could
23 have on screen INQ000369658 at page 39 and you've
24 helpfully provided there a document which I showed in
25 opening setting out in broad terms the structure and the

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1 C, and D.
2 Clearly you may not be able to speak to all of
3 them with direct knowledge, but can I ask that you do
4 your best to assist us with the questions I have for you
5 this morning?
6 **A.** Yes, of course, and I'll answer to the best of my
7 abilities. There may be occasions when I have to say
8 I'm sure the department knows and I'll go and check
9 because unlike my previous two appearances, I'm
10 answering on things I didn't directly witness so
11 I've been briefed on or read about, as opposed to, as
12 I say, previously when I normally had direct experience
13 but I will answer as fully as I can.
14 **Q.** Thank you. Fully and shortly, please, if I may make
15 that --
16 **A.** As shortly as I can.
17 **Q.** Thank you.
18 All right. As permanent secretary, as you set
19 out, you are responsible for ensuring ministers receive
20 advice on strategy and objectives for the health and
21 social care system. You are the department's CEO,
22 setting standards and managing risk and assurance and
23 you are the department's accounting officer as well and
24 I think before joining the department you were the
25 permanent secretary of the Department for Education and

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1 responsibilities in a pandemic. Clearly, at the time
2 preparations, were for a flu-like pandemic and at the
3 top there is the Department of Health. Under them the
4 Pandemic Influenza Preparedness Board, and sitting under
5 that PHE, NHS England and NHS Improvement, as it then
6 was, we're just calling it NHSE for now?
7 **A.** Yes, that's correct. So this is a, I thought a very
8 good document in fact produced by the National Audit
9 Office as part of one of their reports but we thought it
10 summarised the different roles, as you say, for a flu
11 pandemic exactly but actually it's true of -- well, it's
12 true of day-to-day business of the NHS.
13 The only thing I would add is some of these things
14 are administrative arrangements, some of them are
15 statutory.
16 **Q.** Right.
17 **A.** So the role of NHS England and clinical commissioning
18 groups and NHS providers, is all set out in the
19 governing legislation and the relationship between the
20 department and them is set by the legislation. Other
21 things are non-statutory and therefore are at the
22 discretion of the department as to how we set them up,
23 such as expert advisory committees and boards.
24 **Q.** I understand. I think, in fact, I wasn't going to go
25 through the statutory responsibilities, they're set out

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

4 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 an action plan.

2 **A.** Yes.

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

4 **A.** Yes.

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

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

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

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

14 **Q.** What's that?

15 **A.** So I would say a mixed picture.

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

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

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

7 **Q.** All right.

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

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

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

23 **Q.** Local resilience forms?

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

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

9 **Q.** Can I ask you about that, please.

10 **A.** I'll finish on your question.

11 **Q.** Please do.

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

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

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

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

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

7 **Q.** If I pause you there.

8 **A.** Yes.

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

10 **A.** Oh, sorry. I'm sorry.

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

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

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

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

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

12 Now, we ended up using I think somewhere around
13 15 billion items of PPE. I don't think anyone believes
14 you could reasonably stockpile that number of items, and
15 indeed the department worked out for that to be value
16 for money you'd have to have a pandemic about once every
17 ten years for it to do so.

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

22 Now, the PIPP stockpile that we had --

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

12

1 A. Yes.

2 Q. There are a number of different ways that PPE is
3 procured by the NHS so I just want to back up if I may.

4 A. Yes, let me explain. So --

5 Q. Can I just ask the question and then you can answer it.

6 A. Sorry, yes.

7 Q. Is this right, that there was a stockpile of PPE held
8 centrally known as the PIPP stockpile?

9 A. That's correct.

10 Q. Right. NHS trusts procured their own supplies as well,
11 one of those providers being the NHS Supply Chain?

12 A. Yes, so not as well. So the business as usual position
13 is that NHS trusts, and indeed care providers and
14 everyone, is responsible for buying their own PPE, just
15 as they're responsible for buying their own medicines,
16 procuring their own -- so in the normal course of events
17 this is not something that government is involved in.
18 And exactly as you say, SCCL is one supplier. The
19 majority supplier but one supplier.

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

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

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1 was required. And it was very, very hard. It was -- do
2 you want me to go on?

3 Q. Pausing there. I want to look at the stockpile and then
4 the other supplies that were required of PPE and do it
5 in that order.

6 In relation to the PIPP stockpile, is it correct
7 that in June of 2019 NERVTAG advised the department to
8 add gowns to the stockpile for use in aerosol-generating
9 procedures?

10 A. That is, indeed, correct and at the time of the pandemic
11 broke out we were in the very early stages of that
12 procurement, it having followed an entirely normal
13 procurement process in peace time.

14 Q. The reality is, though, as you set out in your
15 statement, as at 18 February -- can we have a look on
16 screen, please, at INQ000389241_0057.

17 Having been advised in June '19 to get gowns, as
18 at 18 February there was not a single surgical gown, was
19 there, in that stockpile?

20 A. No, absolutely. No, that's completely true. We were
21 seeking to buy somewhere around 20 million gowns for the
22 stockpile. As I say, it was following, and this was in
23 peace time an entirely normal government procurement
24 process which was ongoing at the time that the pandemic
25 started out. So given when the recommendation was made,

15

1 A. Yeah, it is --

2 Q. It's one and the same thing?

3 A. Yes, yeah, but -- it is a supplier into a market along
4 with other suppliers, but it does have the majority, so
5 it's a very significant thing.

6 Q. And is this the position, primary care at the start of
7 the pandemic were responsible for procuring their own
8 supplies of PPE from private suppliers?

9 A. Yes.

10 Q. And that changed during the pandemic?

11 A. So in the pandemic clearly, and this is set out in our
12 various statements, there was of course a world scramble
13 for PPE. Somewhere around 80% of all PPE on the planet
14 is made in China which was of course disrupted -- well,
15 it was (a) disrupted because that's where the pandemic
16 started, and (b) everyone was trying to buy from the
17 same place. We therefore took the decision that we
18 would have to do it nationally as various other
19 countries were doing, and I'm sure the Inquiry has seen
20 there are very similar stories from across the world
21 about difficulties in buying PPE and the expense of
22 doing so.

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

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1 it is entirely unsurprising that that number is at zero.

2 Q. Sir Christopher, does it take eight months for the
3 Department of Health to buy a sufficient supply, not
4 necessarily 20 million, not even 100,000 gowns, as at
5 the time we enter the pandemic?

6 A. Well, by normal government procurement, yes. So what
7 happens in that period, you get an initial view from
8 NERVTAG that we need gowns. You then have to specify
9 exactly what type of gown and where from and then you
10 have to run procurement processes which as you know are
11 in normal circumstances will take months and months
12 and months to do.

13 Q. All right.

14 A. So --

15 Q. Do you think it was too slow?

16 A. Well, the -- as I say -- well, there was nothing slow
17 about this procurement. Can you argue that government
18 procurement is very slow compared to other ways of doing
19 it, yes, you can and many people do. What I will say,
20 though, is there is a tradeoff here. So government
21 procurement has huge checks and balances in it to ensure
22 both value for money and fairness between suppliers.
23 Of course what we did in the pandemic was we massively
24 accelerated those things, raised our risk profile and
25 then, as I think we'll come on to in a different module,

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1 you face a whole series of different challenges about
 2 what is the quality of what you receive and et cetera.
 3 So the government does face this tradeoff.
 4 **Q.** And no one is suggesting that on 17 June when NERVTAG
 5 said, "Go and buy some gowns", they were going to be
 6 procured on the 18th, I follow that. But once it was
 7 obviously the pandemic was coming down the track
 8 from January 2020, why is it still as of 18 February
 9 there is not a single gown in the PIPP stockpile?
 10 **A.** Sorry, by the --
 11 **Q.** 18 February.
 12 **A.** By 18 February? Well, so what we did, so the
 13 procurement we were running for the 20 million was not
 14 going to deliver at that speed. We activated a whole
 15 series of what are known as sleeping contracts which was
 16 the other way which we procured -- planned to procure
 17 PPE in the pandemic and, again, as we have covered in
 18 a previous module, that is one of the bits of
 19 preparation that did not work, categorically did not
 20 work. And it's -- there was very little, I'm not quite
 21 sure what the right word is, nationalism that went on in
 22 the pandemic. We managed to procure large numbers of
 23 tests from abroad with one --
 24 **Q.** I'm not asking you about tests.
 25 **A.** No, sorry. The point I am making is PPE was about the

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1 have delivered gowns for that winter and it was not
 2 planned on that basis.
 3 I mean, as I said before, there are many critics
 4 of how government does procurement from many points of
 5 view including its timeliness so I can't disagree with
 6 your general point. What I'm saying is there was
 7 nothing particularly different about this procurement as
 8 opposed to what the government does normally.
 9 **Q.** Right. Can I look at the position outside of the PIPP
 10 stockpile for a moment because I think in January 2020
 11 NHS England requested a supply chain cell to be set up
 12 and is this right, that in February the department asked
 13 the supply chain cell to buy body bags, masks, FFP3
 14 masks and gowns?
 15 **A.** Well, the detail is set out in the department's
 16 statement so I think that is -- but as I say I'd refer
 17 to -- I think we set this out in some considerable
 18 detail in our statement so I'd refer you to that. But
 19 that's -- I think you're basically right.
 20 **Q.** Is this for supply of PPE outside of the PIPP stockpile?
 21 **A.** Yes. So as I say, the plan came in two parts. One,
 22 what you stockpile to get yourself through the initial
 23 period and then, two, speed buying because, as I say,
 24 no one can stockpile for everything you will need in
 25 an emergency, so this was the second part, as it were.

19

1 only area where a large number of national governments
 2 acted to prevent trade.
 3 **Q.** Okay.
 4 **A.** So we were not able to buy from the sources that we
 5 expected to buy because a whole series of countries had
 6 put restrictions on the export of PPE because of the
 7 world scare, so and I'll say I've been completely
 8 upfront about this, we -- our planning expected us to be
 9 able to buy at speed via the contracts we had signed and
 10 we were not able to do that.
 11 **Q.** The NERVTAG recommendation was for -- one for gowns for
 12 use in AGPs as this would bring the stockpile in line
 13 with standard infection control procedures for seasonal
 14 flu. And so putting the fact that no one knew back
 15 in June that the pandemic was coming down the track, by
 16 winter that year you still didn't have gowns for
 17 an ordinarily predicted flu outbreak?
 18 **A.** Yeah, well, I mean, so -- I mean, the government acts on
 19 the professional and clinical advice it receives.
 20 **Q.** Yes.
 21 **A.** So we had not received that advice from NERVTAG
 22 previously for reasons I completely understand and, as
 23 I say, it was following a completely normal government
 24 procurement process.
 25 So, no normal government procurement process would

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1 So you're using up the PIPP stockpile -- what's
 2 supposed to happen you're using up your stockpile as you
 3 put in place the long-term supply. Now, as I say, the
 4 PIPP stockpile played a huge part in keeping us going.
 5 The building up supply chains for the various reasons
 6 I've already explained was far harder than we
 7 anticipated and was a huge difficulty.
 8 Now, it was not the only difficulty, as we
 9 discussed before. There were two challenges for us in
 10 PPE: one, getting the stuff into the country nationally;
 11 and then two, and actually more difficult and more
 12 challenging and I know this caused huge worry and
 13 concern to many healthcare workers, the distribution of
 14 it within the country when we got it. And as I say,
 15 most of our biggest problems were on -- the first one
 16 was very, very challenging and we were some time, as
 17 you'll have seen in our evidence, very close to the
 18 wire. The second was very difficult indeed and caused
 19 huge concern, rightly, amongst our --
 20 **Q.** Pause there because I want to look at how close --
 21 **LADY HALLETT:** Sorry, just before you go to that.
 22 I am so sorry, I just wanted to go back. You said
 23 the sleeping contracts hadn't worked. Was that -- were
 24 they contracts where you hoped that British
 25 manufacturers would step in?

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

21

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

23

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

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

24

1 Q. A gown in 2019 I understand was 33p and between February
2 and July 2020 that rose to £4.50.

3 A. Yes.

4 Q. So that failure, whether it's systemic or naturally the
5 slowness of the government machine procurement process,
6 came at a significant financial cost, didn't it?

7 A. Well, so, I don't accept your word. I accept your
8 description of the situation. I don't accept the word
9 failure to --

10 Q. How would you describe it?

11 A. It was the playing out of normal government process.
12 I accept, of course, your general point that the more
13 things you have bought before the stockpile -- you have
14 in the stockpile the cheaper the thing. But government
15 faces a balancing act here and I'd refer you to the
16 evidence that George Osborne gave in Module 1 that there
17 is a choice between how much money you spend on
18 preparation, and there is a lot you can spend on
19 preparation, and having secure finances that allow you
20 to deal with whatever crisis it is when you deal -- and
21 that is a choice government faces.

22 Q. All right.

23 A. Now, the UK government chooses, and I think various
24 witnesses have said this already, to run its health
25 services with very little spare capacity. That is

25

1 department's inability to purchase those gowns is likely
2 to have contributed to the need for that acute shortages
3 IPC guidance?

4 A. Well, as I say --

5 Q. It's a "yes" or a "no", Sir Christopher.

6 A. I don't accept the word "inability", it was following
7 a normal process. The question, had we had gowns would
8 that have been better? The answer is clearly "yes".

9 Q. Had we had gowns, do you think we would have needed the
10 acute shortages guidance that came into being on
11 17 April?

12 A. I don't know, is the straight answer. As I say, it
13 would clearly have improved our position but would it
14 have solved the problem? Well, I say, there's no
15 counterfactual so I can't really tell you. But as
16 I say, the basis of your question is of course correct.
17 If we had had gowns in the stockpile that would have
18 been better.

19 Q. We know that England had to receive 25,000 gowns from
20 Northern Ireland the day after the acute shortages
21 guidance came out and the Chief Nursing Officer was
22 clear that that guidance caused real distress to the
23 nurses on the front line who were made to reuse or
24 sessionally use gowns.

25 A. Yes.

27

1 a choice. It saves money in peace time, it gives us
2 a huge challenge, but it does mean, as I say, as
3 George Osborne pointed out, that you have resilient
4 finances that allow you -- given you don't know what
5 crisis is coming -- so I agree with you to the extent
6 that that is a choice that governments make.

7 Q. All right. Now, put the economics to one side if you
8 may. But do you consider the department's inability to
9 purchase gowns for the PIPP stockpile is likely to have
10 contributed to the acute shortages IPC guidance that was
11 published on 17 April 2020?

12 A. As I say, had we -- it is self-evident that had we had
13 20 million gowns in the stockpile at that point, you
14 know, say, the pandemic had happened later, that would
15 have significantly improved our position. But as I say,
16 you cannot and I don't think anyone argues that you can
17 stockpile your way out of these challenges. It makes
18 the surge bit much easier. We would still have had to
19 buy 80% of the gowns that we needed on the markets at
20 the price that you say. So it would have eased the
21 position, quite clearly, couldn't argue with your
22 analysis at all on that. It would have eased the
23 position had we had gowns. Would it have "solved the
24 problem"? No, it would not.

25 Q. The question I asked you was, do you consider the

26

1 Q. Can I just ask you whether, on reflection, you think
2 that the purchasing of gowns is evidence that the DHSC
3 was well prepared for the disease outbreak?

4 A. No, I hope I've been quite blunt about what we think
5 went well and what didn't go well. We have certainly
6 reviewed how we do stockpiling since the pandemic, given
7 what we have learned. When I ask myself the question,
8 is there an individual who should, should rather than
9 could, done something different with the recommendation
10 we received from NERVTAG on that date, I couldn't say
11 that there is an instance where I say there is a person
12 or there is a decision that should have been done
13 differently. As I say, your general point of would it
14 have been better quite clearly stands.

15 **LADY HALLETT:** I think we've heard enough on procurement. I
16 have a module dedicated to it.

17 **MS CAREY:** No, my Lady, I was going to move on save for one
18 aspect, if I may.

19 Clearly you've acknowledged there was a supply
20 issue with gowns.

21 A. Yes.

22 Q. And on 10 April there was a PPE plan published by the
23 Department of Health.

24 A. Yes.

25 Q. And can we have up on screen, please, INQ000050008_14.

28

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

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

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

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

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

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

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

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

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

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

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

31

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

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

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

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

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

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

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

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

21 **Q.** We will.

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

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

32

1 A. Yes.

2 Q. -- healthcare, primary care, social care.

3 A. Yes.

4 Q. Understood. So they're not all hospitals ringing
5 saying: we need PPE --

6 A. No. And, of course, hospitals are big players, they
7 have their own supplies and they're big institute -- and
8 they're able to do the kind of compensatory measures
9 that we did. Obviously much more difficult if you're
10 an individual care home, much smaller scale, not used to
11 doing these things.

12 Q. Can you help, how many call handlers were there, do
13 you know, operating the NSDR?

14 A. I don't know. It may well be in our statements.
15 I don't have the number. I can find out the number.

16 Q. Thank you.

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

19 There are what are called the hotline Covid-19
20 disruption reports. This is the one from 26 March at
21 1 o'clock. You can see there a large number of detail
22 provided in the report, but it's the NSDR call data that
23 I'd like to ask you about, where we can see on this
24 date, at this time, what the position was for the
25 preceding few days. And calls arrived approaching 2,000

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

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

12 So would it be better if you never got the calls
13 abandoned in the first place? Yes, of course. But if
14 you were leading an organisation you would see that
15 as: management saw a problem and clearly had dealt with
16 it by the time of the next spike.

17 Q. Pause there. Two things. It's my own fault for asking
18 the question. I think I asked you how many advisers you
19 had logging the calls and it actually says at the bottom
20 of the page. As at 19 March there were 65. So that
21 gives us an indication of the numbers --

22 A. Yes.

23 Q. -- potentially involved.

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

35

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

3 Clearly there's approaching 500 calls abandoned on
4 or around 19 March. Was there any work done to
5 ascertain whether there was sufficient numbers of staff
6 manning the hotline to try to reduce the number of calls
7 that were abandoned?

8 A. The whole reason this data exists is because of the very
9 careful monitoring that was being done by the PPE cell.
10 This is exactly the kind of management data you would
11 want and expect to see at -- and particularly, as you
12 have done, to identify calls abandoned.

13 Now the interesting thing about this graph is --
14 so most calls abandoned, the people actually call back,
15 as it were.

16 Q. How do you know that?

17 A. Well, I mean, that is -- well, so that is a very fair
18 question. I don't know for a fact --

19 Q. No. One would assume they would call back, but --

20 A. Now, the interesting thing about this is -- so you get
21 a call spike, the first call spike, which leads to
22 a number of calls abandoned. There's then a second
23 spike, 23 March, where you will see the calls abandoned
24 remains absolutely flat.

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

34

1 demand on the disruption report hotline?

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

13 Not normally because it would then be for me to
14 deal but because I and ministers and indeed, in many
15 cases, the Prime Minister needed to know where there
16 were problems, partly for public explanation and also to
17 see if we could help, as it were.

18 Q. Right.

19 A. So I would expect, and I think you would find this from
20 any leader of any sort of organisation, that they
21 wouldn't be viewing this level of detail themselves --

22 Q. No, I wanted to get a sense of at what stage are you
23 brought in to sort out the problem.

24 A. Well, so, yes -- so brought in -- so -- and this is
25 particularly -- it's true of any organisation but it's

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

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

14 **Q.** Right.

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

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

20 **A.** Yeah, so it's --

21 **Q.** -- not in relation to this --

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

37

1 As set out in the table on our screen.
2 Halted for how long?

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

4 **Q.** Right.

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

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

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

25 **Q.** Than too little?

39

1 **Q.** All right.

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

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

11 **A.** Yes.

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

15 Could we have up on screen, please,
16 INQ000389241_74.

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

20 And in the statement you say:

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

38

1 **A.** -- than other questions.

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

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

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

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

18 **A.** Yes.

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

21 **A.** Yes.

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

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

40

1 the A&E --

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

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

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

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

25 **Q.** Yes.

41

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

8 On medical equipment, this is another area where
9 there were concerns pre-Covid which were massively
10 highlighted. So as a --

11 **Q.** I want to come on to pulse oximeters and other medical
12 equipment in a moment --

13 **A.** Well, I was going to make a more general point because
14 it does apply to PPE. Through the Whitehead report we
15 did find, which was -- had not put -- been put together
16 in the way -- and we think we are the first people in
17 the world, along with the Americans, to have done such
18 a study, we did find this bias in medical equipment
19 generally, including PPE, that had been there for quite
20 some time. And as I say, Covid shone a spotlight on it
21 but there quite clearly was a problem with how medical
22 equipment is designed, tested, researched and provided
23 that has biases in it.

24 **LADY HALLETT:** Sir Christopher, if I could ask you to slow
25 down or I'm going to have the stenographer going on

43

1 **A.** -- particularly, and the cell looked at this in
2 considerable detail, around the ethnicity questions. So
3 again, with hindsight, obviously the sooner we had done
4 that the better, but we did it in response to the
5 concerns that were raised with us. It would obviously
6 have been better had we done it quicker.

7 **Q.** And the current stockpile, does that have a sufficiently
8 diverse range of masks to cater for gender, ethnicity?
9 **A.** I think so. Again, I will check exactly how -- what --
10 because it's been constructed slightly differently --
11 yeah, I'm 99% certain yes, but I'll just check the last
12 per cent for you.

13 **Q.** One of the things you say in your statement is that the
14 department set up what are called engagement -- customer
15 engagement panels through staff groups with protected
16 characteristics, including those from different ethnic
17 backgrounds. And obviously in those forums PPE
18 provision was discussed.

19 **A.** Yeah.

20 **Q.** When were those engagement panels set up, do you know?
21 **A.** I can't remember when they were set up, but --
22 **Q.** Was it pre-pandemic or during the pandemic?
23 **A.** It was -- well, the -- I think the ones you're -- so we
24 do a lot of consultation anyway and we -- and then we
25 of course set up a whole load of things specifically for

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1 strike.

2 **A.** I'm terribly sorry.

3 **LADY HALLETT:** Also if you could wait for Ms Carey's
4 question, because otherwise what happens is if the two
5 of you are speaking at the same time it's a nightmare --

6 **A.** I'm sorry, I will slow down.

7 **LADY HALLETT:** Thank you.

8 **MS CAREY:** Let me try as well.

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

11 Can we have on screen, please, INQ000389241,
12 page 85. I just want to deal with the engagement
13 panels, because in March 2021 -- it will just be coming
14 up now. There you are, at paragraph 290:
15 "Further to the engagement panels,
16 in March 2021, the Department commissioned the CO
17 Covid-19 Taskforce Field Team to consult directly with
18 health and social care frontline workers ... [the]
19 engagement highlighted the following key themes:
20 "i. Some staff felt that they had been given
21 lower priority than others in PPE provision."
22 And it sets out some examples of that.
23 The other theme was:
24 "ii. A lack of confidence in some to raise
25 concerns or a feeling that they would not be listened

44

1 to."

2 And if we go over the page:

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

6 And then:

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

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

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

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

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

45

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

6 **Q.** Can you give some examples?

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

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

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

47

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

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

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

10 **A.** No, sorry, if --

11 **LADY HALLETT:** Wait, wait, wait. Please.

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

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

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

25 Now, clearly and, entirely understandably,

46

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

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

12 **A.** Yes.

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

17 **A.** Yeah.

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

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

48

1 Q. Right.

2 A. I wouldn't particularly have expected the department to,
3 you know, prior to the pandemic we were an organisation
4 of, I think, 1600 people. These are operational
5 questions and would be one of a number of operational
6 questions. But as I say, I'm not aware the department
7 was taking any action on that issue.

8 Q. Now, we are aware that NHS Race and Health Observatory
9 published, I think in March 2021, a Rapid Review about
10 pulse oximetry primarily and racial bias, and it made
11 a number of recommendations and then in November 2021
12 the department conducted its own independent review.
13 Can I just ask you, was the department's independent
14 review anything to do with the recommendations made by
15 the Race and Health Observatory?

16 A. As I remember it wasn't a direct recommendation, so this
17 was -- it was something that the then Secretary of State
18 Sajid Javid made a sort of personal mission. He was
19 very concerned about the situation. He, as I remember,
20 discussed it with his American counterpart and launched
21 the review as a result which, as I say, I think is the
22 first such review done anywhere and the findings
23 were -- well, you can read the review as well as me --
24 stark.

25 Q. I'm going to come on to the findings. The terms of

49

1 government published it in March 2024.

2 A. Yes. So the government took the decision, and this was
3 an explicit decision that it wished to publish the
4 report at the point it was ready to respond. So to set
5 out what the government would do as well as the problem
6 definition that -- the report, and that took till that
7 time. I should say although, as I say, the issues were
8 highlighted by the pandemic, I don't think there was
9 ever any suggestion that the review and its consequences
10 would have any effect upon the course of the pandemic
11 because timescales are much too long. So this was seen
12 as a long-term piece of work not as a -- it was caused
13 by the pandemic but it was not part of the response.

14 Q. It wasn't the solution to the problem that had been
15 identified. But do you think, Sir Christopher, that
16 a review being announced in November 2021 not in fact
17 being published until March 2024 is too long a time to
18 wait for such an important review?

19 A. Well, again, and I can't argue with you, all these
20 things it's better -- the quicker the better.
21 I completely understand the government's wish to be able
22 to say what it was doing about it and some of those
23 things are very complicated, regulatory changes are very
24 complicated, and obviously supply considerations and
25 market considerations are a very complicated thing to

51

1 reference for the review ask that consideration be given
2 as to how the UK should drive forward, their words not
3 mine, international standards on health equity in
4 medical devices. And so is there any work ongoing to
5 collaborate internationally to ensure that future
6 devices don't have an inbuilt ethnic bias?

7 A. Yes, and as I said, it started, as I remember with the
8 Secretary of State discussing it with his American
9 counterparts who, of course, drive a huge quantity of
10 the market. It does have to be -- this is a world
11 market, as I describe, so it has to be a world change,
12 but there are big things that the UK can do
13 unilaterally.

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

19 So we've made, and I say this is probably the
20 biggest thing, a specific regulatory change about those
21 devices that we regulate. But as you say, the world
22 market will have to change to actually solve the
23 problem.

24 Q. The review was announced in November 2021. I think it
25 was completed certainly in late 2023 and then the

50

1 do. You can take the view that you publish the review
2 as it is and the government responds some time later or
3 you can do it this way. The choice --

4 Q. Do you know why it wasn't done, that the review came out
5 when it was ready and the government quickly followed?

6 A. As I say, you'd have to ask the ministers in question
7 but I think they wished to be able to set out not just
8 the problem but what the government was actually going
9 to do about it and the action it was going --

10 Q. Can I ask you about one of the recommendations.
11 Could we have on screen, please, INQ000468614, and
12 perhaps when I have finished this, my Lady, it might be
13 a convenient moment for a break.

14 But recommendation 1 of the review was that:
15 "Regulators, developers, manufacturers and
16 healthcare professionals should take immediate
17 mitigation actions to ensure existing pulse oximeter
18 devices in the NHS can be used safely and equitably for
19 all patients groups across the range of skin tones."

20 And the government response is set out:
21 "The government is committed to ensuring that
22 pulse oximeters are safe and effective for all
23 patients. Work is already underway to mitigate any
24 inaccuracy in these devices fulfilling many of this
25 recommendation's sub-recommendations."

52

1 Can you help with, Sir Christopher, as to what
2 work is already underway to mitigate the inaccuracies?
3 **A.** Well, and this was done during the pandemic as well.
4 Well, the first thing to say this is a clinical device
5 so it's mainly a clinical matter for doctors and
6 I know -- so I am reporting what I have been told not my
7 professional expertise.

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

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

53

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

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

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

13 **A.** Yes.

14 **Q.** The department is not directly involved in commissioning
15 the services of 111 or their operation, but the Inquiry
16 has heard considerable amount of evidence about
17 111 calls going unanswered, indeed the Healthcare Safety
18 Investigation Branch found as such. Professor Snooks,
19 who we've heard from, told us, I think, at one stage
20 there was 1.1 million calls unanswered.

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

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

55

1 as they do with people with lighter skin.

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

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

4 **MS CAREY:** Thank you very much.

5 (11.13 am)

(A short break)

7 (11.29 am)

8 **LADY HALLETT:** Ms Carey.

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

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

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

54

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

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

8 **A.** Not that I recollect, no.

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

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

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

22 **Q.** No.

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

56

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

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

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

8 **A.** Yeah.

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

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

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

20 **A.** Yes.

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

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

57

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

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

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

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

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

59

1 **A.** Yes.

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

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

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

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

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

58

1 would say it is right yet.

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

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

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

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

20 **Q.** Is this an area that requires legislation?

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

60

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

6 **Q.** Right.

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

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

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

20 **A.** Yes.

21 **Q.** In your --

22 **A.** Sorry, DNRCPR --

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

25 **A.** Yes.

61

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

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

8 **A.** Yes.

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

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

20 But as I --

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

23 **A.** I don't --

24 **Q.** -- ever asked for evidence of it.

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

63

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

7 **A.** I think there was very --

8 **Q.** -- inappropriate use --

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

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

25 **Q.** Right.

62

1 **Q.** Yes. That was in October 2020.

2 **A.** Yes.

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

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

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

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

17 **A.** Yes.

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

20 **A.** And in line with the good practice.

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

25 **A.** Yeah.

64

1 Q. And can I ask, please, that is put on screen
 2 INQ000478907. Could we go to the final page, page 3 of
 3 that document, please.
 4 Because here we are now in September of 2020. And
 5 it's -- is the "MSC" the minister for social care?
 6 A. Yes.
 7 Q. "... MSC has ... requested that we have a method of
 8 assessing the scale of inappropriately applied DNACPRs.
 9 This is to include any data on the scale of the problem
 10 and what we are doing to monitor ... this ..."
 11 And the minister wanted a submission setting out
 12 what the position was.
 13 A. Yeah.
 14 Q. And if we go back then to page 2, I think in short there
 15 were questions being raised in Parliament about it.
 16 A. Yeah.
 17 Q. And there was an issue, in short, with not being able to
 18 quantify the extent of the problem.
 19 And could we go to page 1, please.
 20 "Thank you for this information. To further add
 21 to the commission to sub below - to provide different
 22 options for assessing the scale of ... DNACPRs ...
 23 please see the readout ... from the Quad Meeting ..."
 24 A. Yeah.
 25 Q. "[Secretary of State] ..."

65

1 you've now taken down the previous page -- was held
 2 because questions had been raised about whether it was
 3 happening. That was the point of the meeting at all.
 4 Q. Some might read this as you being more worried about
 5 being able to say it wasn't happening, irrespective of
 6 whether it was or it wasn't, that the optics were what
 7 you were worried about --
 8 A. No, no, not at all.
 9 Q. -- Sir Christopher, not the actual reality on the
 10 ground.
 11 A. No, not at all. We are required, ministers and we are
 12 required to tell the truth, and in particular tell the
 13 truth to Parliament. My point was that Parliament and
 14 the public would expect there to be a zero tolerance to
 15 this and that it shouldn't be happening and that we
 16 needed to get to the position where we could truthfully,
 17 in line with our requirements under the Ministerial Code
 18 and the Civil Service Code, truthfully say to Parliament
 19 that it wasn't happening.
 20 Simon Stevens then correctly sets out a slightly
 21 more caveated position, but I don't think -- well, you
 22 could ask him, but I don't think Simon would disagree
 23 with my position, which I think was a general position,
 24 that there ought to be complete zero tolerance of this
 25 and that the public and Parliament would expect the

67

1 Is that?
 2 "... raised the issue of blanket DNRs.
 3 Simon Stevens [the then COO NHS England] asked for
 4 details ... as this should not be happening."
 5 A. Yes.
 6 Q. "Chris Wormald noted that we need to be able to say
 7 publicly and in Parliament that this is not happening."
 8 A. Yeah.
 9 Q. Did you know whether it was happening?
 10 A. No, sorry, that was my whole point and the whole point
 11 of this conversation. So it's the NHS's job to deal
 12 with this issue, as the presence of Simon Stevens makes
 13 clear. My view here is not controversial and was widely
 14 held there ought to be a total zero tolerance and that
 15 that's what Parliament and the public would expect, that
 16 we had a complete zero tolerance of any blanket bans.
 17 And then Simon Stevens makes his slightly caveated
 18 point. But it was an issue for the NHS to take away and
 19 deal with and you would have -- expect Simon Stevens to
 20 do so. And as I say, the NHS, as I understand it, took
 21 a series of very important actions in this area.
 22 Q. If you didn't know whether it was or was not happening,
 23 can you account for why this note of the meeting doesn't
 24 say that in terms?
 25 A. Well, the whole point of the meeting, as I think your --

66

1 government to be able to say that.
 2 Q. So this was not a concern by you more of appearance
 3 than --
 4 A. No, we had huge concerns. I mean, so -- I mean, you'd
 5 have to ask clinicians, because obviously this is
 6 a clinical thing. My lay reading is that the guidance
 7 given is very clear indeed about what good practice and
 8 not good practice is. And just like every other area of
 9 clinical practice, you would expect clinicians to be
 10 following the guidance. And reports that they were not
 11 doing were taken incredibly seriously -- as I say, you
 12 have a Secretary of State meeting here with the
 13 Chief Executive of the NHS. That was its level of
 14 seriousness. Everyone was very, very concerned about
 15 the situation indeed.
 16 I mean, generally and personally -- I mean, anyone
 17 I think can probably put themselves in the shoes of
 18 someone who has a relative who has an inappropriate do
 19 not resuscitate order and how you would feel. And then
 20 of course, in terms of national policy, the position, as
 21 I say, was very, very clear and people should have been
 22 following it.
 23 Q. The interim report from the CQC identified that there
 24 was evidence of unacceptable and inappropriate DNACPRs
 25 being made at the start.

68

1 A. Yeah.

2 Q. And indeed concluded it was possible in some cases
3 DNACPR -- inappropriate DNACPRs remained in place. Once
4 the CQC had published their interim findings, can you
5 help with what action the department took to address the
6 concerns raised by the CQC?

7 A. Well, of course, the biggest action we took was to
8 commission the report in the first place, and it is in
9 the end a matter for the regulator, the CQC, to regulate
10 the system. That is their statutory responsibility.

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

17 As I say, I don't think there was anyone I am
18 aware of in the national system, be it CQC or
19 NHS England or anyone else, who didn't take this
20 issue incredibly seriously. So I don't -- my
21 recollection is it's not something the department had to
22 press people to action on. It was making sure that
23 action was effective and, as I say, that there was zero
24 tolerance of bad practice.

25 Q. In due course the CQC's final report was published in
69

1 statement from the department.

2 The scheme was announced I think on 27 April 2020.
3 It provided, in short, a £60,000 lump sum for the
4 families of those who had -- recovered by the scheme --
5 who had contracted Covid at work.

6 A. Yeah.

7 Q. And included in that I think were pharmacies, if the
8 pharmacist was based in a hospital or a GP setting. Do
9 you see it follow therefore that community pharmacists
10 were not initially included in the scheme?

11 A. So I'd like to say something general about these sorts
12 of schemes, if I may, before I start.

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

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

71

1 March 2021, and that resulted in a ministerial oversight
2 group being set up.

3 A. Yeah.

4 Q. And the terms of those we can read for ourselves but I'm
5 asked to ask you, did the department take any steps once
6 the CQC's final report had been published to ensure that
7 DNACPRs were being made on an individual basis?

8 A. Well, the actions are as set out in the CQC report,
9 importantly, as you say, with a ministerial oversight
10 group, the actions of which are set out in our
11 statements. I wouldn't repeat them. And that was the
12 action that fell to us.

13 As I said before, I detected absolutely no lack of
14 willpower on the basis of anyone working in the centre
15 to deal with this issue. I haven't met anyone, clinical
16 or otherwise, who doesn't have the same view that bad
17 practice in this area is unacceptable. And certainly,
18 as far as I could see, everyone was doing -- you know,
19 putting their shoulder to the wheel to deal with the
20 issue. Which isn't to say there aren't terrible cases
21 where it doesn't -- where it continues to happen, but
22 I don't think that is due to the lack of willpower from
23 any of the national bodies.

24 Q. Okay. New topic, please, the life assurance scheme that
25 was announced on 27 April. This is in your third
70

1 was actually originally the suggestion of the BMA. They
2 raised this issue with us.

3 Q. That community pharmacists should be included?

4 A. No, no, no, the original scheme.

5 Q. I see, thank you.

6 A. So if you are a returning worker, so you've retired,
7 you've taken your pension, you return to work in the
8 NHS, you're then not covered by the life insurance bit
9 of the pension scheme.

10 Q. Right.

11 A. The BMA raised this with us. As you know, we don't
12 agree with the BMA on everything but in this case they
13 made a hugely valid point. So we started with can we
14 replicate for returning workers.

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

18 You then have the question that you've raised
19 about where do you draw the line on people who are not
20 the employees of the NHS, and what ministers decided on
21 was that on top of, as it were, the people who qualified
22 automatically, there would be discretion --

23 Q. Right.

24 A. -- for other people and a number of pharmacists were
25 covered by a ministerial decision.

72

1 Q. Pausing there, Sir Christopher --
 2 A. So they're not in the main scheme but there was
 3 a discretionary scheme to allow people not just
 4 pharmacists to be included.
 5 Q. Right. Pausing there, please.
 6 Can we have a look at an email chain,
 7 INQ00050020_3.
 8 Bearing in mind the background you set out, there
 9 was then discretion to add groups in.
 10 A. Yes.
 11 Q. If one looks at the email at the top of the page which
 12 is 11 April 2020:
 13 "Apologies for the delay getting this back to you.
 14 "[Secretary of State] has considered and made the
 15 following decisions:
 16 "All pharmacy staff are to be included."
 17 A. Yes.
 18 Q. A very clear steer there from Mr Hancock as it would be
 19 at the time, that all pharmacy staff are to be included.
 20 And if we go to page 1 of the email, indeed
 21 I think the Minister for Social Care:
 22 "We have now had a discussion with minister" -- is
 23 that right, MS(C)?
 24 A. Yeah.
 25 Q. "... to go through the outstanding issues ...

73

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

75

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

74

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

76

1 month and then in April a significant drop to 7.4 and
2 7.7, with increasing rises -- well, sorry, decreases in
3 home visits and then increases in telephone
4 appointments.

5 **A.** Yes.

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

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

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

77

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

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

8 **A.** Yeah.

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

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

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

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

79

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

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

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

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

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

78

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

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

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

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

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

80

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

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

13 May I ask you this. Please don't take this
 14 rudely. We hear very big, broad themes but I want to
 15 know what actual work is being done to create a toolkit
 16 of capabilities by the Department of Health?

17 A. So it's completely central to what we do. As I said in
 18 Module 1, not only were we over-focused on an influenza
 19 plan, but we were over-focused on plans, period. It's
 20 incredibly difficult to plan for a crisis where you
 21 don't know what the disease is or how it will spread or
 22 any of those things, so the more you can have
 23 capabilities you can use for any crisis, the one you
 24 don't know about as opposed to specific, the better.

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

81

1 some very significant charities with endowments who
 2 invest in research. And then publicly there is the
 3 General Medical Council, part of UKRI, that invests in,
 4 as it were, pure research and then the department, and
 5 we're reasonably unique in government in doing this, we
 6 invest through NIHR in translational research.

7 Q. What does that mean?

8 A. So pure research is the discovery of things.
 9 Translational research is how you turn those
 10 discoverables into things that -- so we do the bit, the,
 11 sort of, in R&D the D end of: here we have a new thing,
 12 a vaccine or whatever, how do we get that used in
 13 hospitals and in health. We spend about 1 billion
 14 a year and, as I say, I think we're reasonably unique in
 15 government in providing this. And the great strength of
 16 our research base in this area is the diversity of the
 17 funding in different things from those four sources.

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

83

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

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

12 Again, of vital importance, continued investment
 13 in the science and research base --

14 Q. I want to come on to that because a number of witnesses
 15 have commended to her Ladyship the need for ongoing
 16 investment into research programmes and is --

17 A. Yes, that's -- (*inaudible words: multiple speakers*)

18 Q. -- it the department in part that funds the NIHR?

19 A. No, the NIHR is entirely funded by the department. So
 20 there are three types of -- we are blessed in the UK
 21 with one of the finest research capabilities in the
 22 world and we need to keep it. It is funded in three
 23 ways -- actually, four ways.

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

82

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

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

9 So that is what I mean by a capability.

10 So again, and many of my answers in this area will
 11 be the same, there is a lot of progress. Are we where
 12 we would want to be? No, it is a continuing thing. But
 13 as I say, the science base, absolutely key.

14 LADY HALLETT: Can I just ask a question. I appreciate I'm
 15 going to be having a Test and Trace module. So forgive
 16 me if this question comes out of the blue. At the very
 17 beginning of your evidence you said one of the strengths
 18 was testing.

19 A. At the research --

20 LADY HALLETT: Exactly. You meant producing the tests.

21 A. So very specifically --

22 LADY HALLETT: Just pause for the question.

23 A. Sorry.

24 LADY HALLETT: I do understand.

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

84

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

6 **A.** Yeah.

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

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

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

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

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

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

85

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

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

13 **A.** That's true.

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

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

20 **Q.** Quite.

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

87

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

5 **A.** Right, so immediately, UKHSA has reported to me that
6 they can do around 10,000 PCR tests a day as opposed to
7 1,000 that we could do pre the pandemic. That's
8 obviously a very big difference. I'll confirm the
9 numbers with -- as I say, my UKHSA colleagues are the
10 experts.

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

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

23 **LADY HALLETT:** Thank you.

24 Sorry to take you to a different module.

25 **MS CAREY:** Not at all.

86

1 I won't comment on.

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

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

88

1 Q. One of the matters you raise, obviously, clearly, is the
2 resilience of the workforce.
3 A. Yes.
4 Q. And acknowledging as we do that you don't employ the NHS
5 workforce, I would like to know nonetheless what
6 recommendations the department has got to try to help
7 the resilience of the workforce. Not NHSE's plan or the
8 various devolved nations' plans but the department
9 itself.
10 A. So I would refer you to the NHSE's workforce plan that
11 the department was very, very closely associated with,
12 and I think it was even co-branded, I'll check, but that
13 sets out for the first time a long-term projection not
14 just of the total workforce size but the individual
15 specialities and how we need to develop the workforce.
16 So that is the department's answer in that area.
17 And there's a general theme here that, as I say,
18 it goes with the what's the resilience of the system,
19 that you have to build this thinking into how we run the
20 health and care service day to day as opposed to
21 saying: we do that and then here's a separate pandemic
22 plan that we take off the shelf.
23 So if we deliver the workforce plan and have
24 a much more resilient workforce, that doesn't have the
25 kind of workforce gaps in it that we see at the moment,

89

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

91

1 we do that because that's how you get a great NHS, it
2 has the corollary that you are better prepared for
3 emergencies of all types, as opposed to the way of
4 thinking that goes "We need a separate emergency plan",
5 as opposed to saying what we need is, you know,
6 a properly staffed, properly skilled NHS workforce with
7 the right technology.
8 Q. Theme three, as identified, was the ability to scale up
9 staffing and equipment quickly as that is considered
10 essential. And we've heard from a number of witnesses
11 in the ways in which that was achieved, so I'm not going
12 to ask you about it, Sir Christopher.
13 But the theme four was an acknowledgement that
14 diagnostics and data are crucial in a pandemic response.
15 And we've touched on that in your evidence but can I ask
16 you this: is the Department of Health doing any work to
17 monitor the deaths of healthcare workers in the event of
18 a future pandemic?
19 A. Well, I mean, that's crucial the death of healthcare
20 workers for whatever reason is monitored.
21 We put this one in because -- I mean, you could
22 say it's a subset of some of the other ones but it was
23 so crucial -- the diagnostics question that I was
24 discussing with the chair was clearly very crucial and
25 when -- we discussed data earlier and the improvements

90

1 the question of Long Covid more generally which also
2 impacts on, so the research we do on Long Covid is just
3 as relevant to NHS staff as it is to anyone else.
4 Q. The fifth and final theme identified by the department
5 was that preparedness should be along the five routes of
6 disease transmission.
7 Clearly we've been concentrating on the
8 respiratory virus. Who does Department of Health say
9 should be responsible for preparing along the five
10 different routes?
11 A. Well, everybody. So UKHSA is absolutely key and they
12 are looking at all five routes. The NHS also needs to
13 think about these things. And not just for pandemics.
14 So there was a lot of publicity about Mpox, which
15 spreads in a very different way and requires very
16 different health response. We need, as they do, our NHS
17 colleagues to be thinking about all five routes. But
18 the actual -- the lead responsibility is with our
19 colleagues at UKHSA.
20 Q. If you could reflect on this finally, Sir Christopher.
21 Is there any one single recommendation that you would
22 urge upon her Ladyship which would improve the
23 healthcare system's response in the event of a future
24 pandemic?
25 A. It's incredibly difficult to pick one. I hope I've

92

1 highlighted --

2 **Q.** I know.

3 **A.** -- some of these. The science base and research I think

4 is absolutely vital. I think the capabilities over

5 plans, capabilities and resilience over plans is

6 absolutely vital. I've already talked about the vital

7 importance of surge. So I would particularly highlight

8 those ones, as I have in my evidence.

9 I can't remember if I said earlier, all this is

10 built on the technical report that Chris Whitty and

11 Patrick Vallance and others did, and I would say

12 commending that to future scientists and clinicians, we

13 will certainly be doing that, so that would be the other

14 thing on my list.

15 I don't think I can pick one. You know, getting

16 down from everything in the technical report to those

17 five, that was a considerable effort, so, beyond what

18 I've already said about the importance of things,

19 I don't think I can pick one, sorry.

20 **Q.** Don't worry, we have the technical report well in mind.

21 Sir Christopher, they are all the questions but

22 I know there are some questions, my Lady, from core

23 participants.

24 **LADY HALLETT:** There are, please.

25 Now, is it Ms Iengar today?

93

1 future research is very important, services are very

2 important, and public understanding I think is very

3 important.

4 **Q.** And the Inquiry has had sight of a recent joint letter.

5 I wouldn't take you to it but, my Lady, for reference,

6 it's INQ000498103. It's a letter from the Clinical Post

7 COVID Society and the British Society of Physical &

8 Rehabilitation Medicine, and they raise similar concern

9 that the ICBs were reallocating funding intended for

10 Long Covid to other services while there is

11 a significant unmet need for Long Covid patients. And

12 the letter continues to forewarn that depriving adults

13 of those services can lead to more serious chronic

14 health and, for children, deprivation of services

15 stunted biophysical development.

16 And my second and final question is this, simply,

17 do you agree with the experts and the clinicians in this

18 field that there is a need for ongoing and adequate

19 funding for Long Covid healthcare to ensure the

20 sustainable provision of Long Covid services?

21 **A.** In principle, yes. I can't comment on the letter

22 because I don't think I've seen it. And I don't know

23 whether ICBs are doing what you -- doing what you

24 describe. I mentioned the ten-year plan process for the

25 NHS, which I say is deliberately a very open process

95

Questions from MS IENGAR

1 **MS IENGAR:** My Lady.

2 Sir Christopher, I ask questions on behalf of the

3 Long Covid groups, and following on the theme of

4 recommendations, my two very brief questions look

5 forward to the future of Long Covid services.

6 The experts to the Inquiry, Professor Brightling

7 and Dr Evans, describe Long Covid services as the

8 foundation, the bedrock, as it were, to finding

9 solutions for people living with Long Covid. And they

10 raise concern that a number of the existing Long Covid

11 services were already under threat and noted that there

12 is likely to be shrinking of the clinical services next

13 year.

14 Sir, do you agree that Long Covid, both the

15 prevention of Long Covid and the provision of Long Covid

16 healthcare, are matters of ongoing public health

17 priority?

18 **A.** Yes, I do agree. Obviously -- and the service provision

19 questions are for my colleagues at NHS England. As you

20 will know, there are a lot of health priorities that

21 they have to maintain but I would agree with your

22 question, Long Covid is extremely important. Obviously

23 for the people who have -- sadly are afflicted by

24 Long Covid, including some NHS staff, and actually

94

1 where we are taking views from everybody about what the

2 priorities and the services of the NHS should be.

3 I know Long Covid will be a part of that and I hope that

4 your -- the groups you represent are full participants

5 in that, and I'm making the point -- and I -- not just

6 about how much money but what are the services that most

7 improve the lives of people with Long Covid.

8 And as I hinted at in my previous answer, the

9 research in this area is very, very important. This is

10 obviously a very new condition and we don't know enough

11 yet about how it is best managed and treated, so the

12 underlying research which allows us to make improvements

13 in both the services and further areas, those are very

14 important as well.

15 Final point, of course, ICS is -- the point of

16 them is to make difficult trade-off decisions based on

17 their own local populations about services. So, to the

18 extent that -- are they taking it in? Of course they

19 are. That is their job. I would hope that, as with

20 many other conditions, ICSs are well informed about

21 Long Covid needs as they take those very difficult

22 decisions locally about what services to provide and how

23 to provide them.

24 **MS IENGAR:** Thank you, Sir Christopher. Thank you, my Lady.

25 **LADY HALLETT:** Thank you very much.

96

1 Mr Burton.
 2 Mr Burton is in a similar position.
 3 **Questions from MR BURTON KC**
 4 **MR BURTON:** Thank you, my Lady.
 5 Good afternoon, Sir Christopher.
 6 **A.** Hello.
 7 **Q.** At paragraph 25 of your statement ending 3872 you
 8 mention the importance of having good data and that
 9 during the pandemic ONS data was used.
 10 **A.** Yeah.
 11 **Q.** Are you aware that the only way the ONS was able to
 12 compile any data on disability was by using the 2011
 13 census?
 14 **A.** I couldn't answer on exactly how the ONS compiles its
 15 data. I -- if you're telling me that's the case,
 16 I'll believe you.
 17 **Q.** Well, perhaps if I could ask you -- the follow-on
 18 question, really, was this then. I mean, do you believe
 19 during the pandemic the department had sufficient data
 20 available to it about the prevalence and relevance of
 21 disability?
 22 **A.** Probably not. And it was not alone in this area. We
 23 have some of the most fantastic data in the world on
 24 many, many issues of health. It's one of the advantages
 25 of a single payer system.

97

1 which very often is about place.
 2 So, going back to the discussion of ICSs I was
 3 having with your colleague, "Can an ICS plan services in
 4 an area that are better" is much more important than
 5 whether nationally we can observe something.
 6 **Q.** I understand that.
 7 I'm now very much focused, with two quick
 8 questions, on the future. Are any improvements being
 9 made or pursued by the department at the moment in terms
 10 of collation and deployment of disability-related data,
 11 as far as you're aware?
 12 **A.** So I refer you to my answer earlier about federated data
 13 platforms, which would also cover this area. So I'm not
 14 aware of a specific initiative but that general "can we
 15 have systems in the NHS that allow us to share data and
 16 draw conclusions better", you would hope. Well, the
 17 intention of it is that everyone benefits and that the
 18 people in most need of services benefit most. So that
 19 would cover ...
 20 **Q.** And my final question related to that, the department's
 21 own research demonstrates that there were very
 22 significant disparities in terms of mortality between
 23 disabled people and non-disabled people --
 24 **A.** Yes.
 25 **Q.** -- and I'm sure you're aware of that, but what I really

99

1 I won't repeat the challenges but very frequently
 2 the data exists but it's very difficult to share and
 3 sometimes for very good reasons. I mean, people care
 4 about their privacy as I described.
 5 What we found in the pandemic generally on data
 6 was very frequently the data was there, difficult to
 7 compile on a comparable basis for some of the reasons
 8 I've described, often with too great a lag. Not till
 9 2011, in terms of NHS data, but still it tells you what
 10 happened three months ago.
 11 And then the crucial bit, which your question
 12 points to, is there's quite a danger that you spend all
 13 your time observing data as opposed to taking decisions
 14 that help people. So that's the real challenge in this
 15 area: there is an awful lot of data, but how you get to
 16 "it is this data set that actually allows us" -- to your
 17 question -- "to plan services for people with
 18 disabilities better in a place."
 19 **Q.** Was your previous answer just now generic about data or
 20 specific about --
 21 **A.** Generic, but I would say it will apply to data of all
 22 types. So I'm sure in the NHS as a whole there will be
 23 enormous quantities of data about individuals with
 24 disabilities. It's the ability to bring that together
 25 and then take useful decisions about service planning,

98

1 want to ask you is this. By way of an example, the
 2 department's reports highlight that even where one
 3 controls for factors like age, et cetera, in relation to
 4 people with a learning disability they were at least two
 5 more times likely to die of Covid than people who were
 6 not disabled and this remains unexplained.
 7 **A.** Yes.
 8 **Q.** Do you feel that the department has done enough to
 9 understand why the disparities for disabled people in
 10 relation to mortality occurred?
 11 **A.** No, not yet, and we need more research. And this is not
 12 just true of the area you're describing, it's true of
 13 every area. Where something is unexplained we need our
 14 wonderful researchers that I described earlier, a number
 15 of them funded by the department, to move it into the
 16 category of explained and then to move it into the
 17 category of what are we going to do about it.
 18 **Q.** Well, exactly, Sir Christopher.
 19 **A.** So, no, and it's, I'll say not just about your area, and
 20 I don't know if you asked these questions of the Chief
 21 Medical Officer but he would be even stronger than I.
 22 The whole purpose of medical research is to move things
 23 from being unexplained to explained and then to: can we
 24 do something about it that makes people's lives better?
 25 **Q.** So insofar as it's not currently explained, you would be

100

1 anticipating that efforts will be made to explain it in
2 due course?
3 **A.** Exactly. And, as I say, both the government, the
4 department, the private sector and the voluntary sector
5 put huge resources into research, entirely rightly, for
6 exactly the kind of reason that you are describing.

7 **MR BURTON:** Thank you very much, Sir Christopher.
8 That's the end of my questions, my Lady.

9 **LADY HALLETT:** Thank you, Mr Burton, very grateful.
10 Mr Stanton.

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

13 **THE WITNESS:** Yes, I will turn back.

14 **Questions from MR STANTON**

15 **MR STANTON:** Good afternoon, Sir Christopher.
16 I ask questions on behalf of the British Medical
17 Association. I just have one question area to cover
18 with you which relates to an issue you were discussing
19 earlier with Ms Carey around the stop order on items of
20 PPE, specifically the stop order in relation to FFP3
21 masks which was put in place on 30 June 2020. You might
22 recall that particular section of your statement was
23 brought up on screen, I don't think there's any need to
24 go back to it unless you --

25 **A.** No, no.

101

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

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

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

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

25 **Q.** Yes.

103

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

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

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

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

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

102

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

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

6 **A.** Yes.

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

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

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

104

1 might give some insight into the basis of that guidance.
2 For example, some of the IPC cell members have
3 suggested that the guidance was based on sciences;
4 others have suggested it's based on supply.

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

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

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

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

25 In terms of the stop, that was based on -- well,
105

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

7 **MR STANTON:** Thank you, Sir Christopher.

8 Thank you, my Lady.

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

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

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

16 **A.** Oh hear. I walked into that.

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

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

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

24 **A.** Yes, yes.

25 **LADY HALLETT:** By clinicians, do you mean medically
107

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

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

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

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

25 So, I don't think there was a different
106

1 qualified doctors?

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

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

6 **A.** Not helping, to -- writing it.

7 **LADY HALLETT:** Writing it. Medically qualified doctors?

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

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

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

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

25 **MR STANTON:** No, my Lady, I'm happy to leave it there.
108

1 Thank you.

2 **LADY HALLETT:** Thank you.

3 Sir Chris, I appreciate you may wish to get away

4 but you were prepared to come back this afternoon.

5 There is still about half-an-hour's worth of questions,

6 so if you don't mind, the stenographer has had quite

7 a tough morning, we will break now --

8 **A.** No, I am at your disposal all day. I'm not going

9 anywhere until the questions have finished.

10 **LADY HALLETT:** Don't worry. You'll be gone by this

11 afternoon, mid-afternoon. 1.45, please.

12 **(12.45 pm)**

(The short adjournment)

14 **(1.45 pm)**

15 **LADY HALLETT:** Who was next? Is it Ms Sen Gupta? It is,

16 she is on her feet.

17 **MS SEN GUPTA:** It is, my Lady, thank you.

18 **Questions from MS SEN GUPTA KC**

19 **MS SEN GUPTA:** Good afternoon, Sir Christopher.

20 I represent the Frontline Migrant Health Workers Group.

21 Our client's members are outsourced non-clinical workers

22 largely from ethnic minority and migrant backgrounds and

23 clinical nursing and healthcare assistant staff, all of

24 whom are from a migrant background.

25 Ms Carey asked you about the life assurance

109

1 **Q.** And it was the third category, using your definition,
2 that I was asking you about. Is there anything else
3 you want to add in relation to that, rather than there's
4 a third category?

5 **A.** No, as I say, this scheme was very unusual. Well, (a)
6 in it was extended beyond NHS employees in the first
7 place. That was its first unusualness. And the second
8 was we had this discretionary element which -- well, I'm
9 sure you'll ask the ministers who did it when they are
10 here, but they were conscious that there were going to
11 be cases that were very deserving that didn't fit within
12 the scheme criteria, and therefore they wanted
13 discretion to be able to make payments to people who
14 they thought were deserving who were not in the defined
15 categories.

16 So -- and that -- as we know --

17 **Q.** I'll move on.

18 **A.** -- that's unusual for schemes of this type.

19 **Q.** Sir Christopher, I'll move on. I'm conscious of time.

20 Moving on to my next question. Did the scheme apply to
21 workers who worked at private hospitals caring for NHS
22 patients?

23 **A.** Not in the defined categories. Again, I think anyone
24 could be in the discretionary category. I'm not --
25 I don't know whether anyone was in that circumstance and

111

1 scheme. That scheme applied to what the DHSC described
2 as frontline workers. How did the department define
3 frontline?

4 **A.** Well, in exactly the way I described when I was
5 discussing this with lead counsel. So there were people
6 who were defined because they were employees of the NHS,
7 then there were people who were defined because they
8 were employees in social care, and then, as I said, we
9 had the additional discretionary scheme on top of that
10 for people who were frontline workers but weren't in
11 either of the previous two categories.

12 **Q.** And in your answer you've again that used that term
13 "frontline workers" and that's what I would like you to
14 define for me, please?

15 **A.** No, I said NHS employees. So there were people who were
16 working as employees of the NHS who would normally be in
17 the NHS pension scheme. As I say, then there were
18 social care workers, and then there was the
19 discretionary element for people who were not in those
20 two categories but were still deserving of a payout.
21 And this is all in the context of the -- I'm not quite
22 sure what the right word is -- dilemma -- problem with
23 government schemes of this type is you always draw
24 a line somewhere and there are always deserving cases on
25 the other side of that line.

110

1 tragically died, but if they had done I'm pretty sure
2 they would've been able to apply under the discretionary
3 element.

4 **Q.** Sir Christopher, in respect of migrant healthcare
5 workers, what efforts were made to ensure that their
6 overseas families were aware of the scheme and could
7 apply?

8 **A.** I'd have to go -- I know efforts were made to publicise
9 the scheme. On that specific point I'll need to go away
10 and check for you what was done.

11 **Q.** Thank you.

12 Moving on, then, to the risk reduction framework
13 referred to by Matthew Style in his statement. That's
14 inquiry reference INQ000472172, page 91, paragraph 322.

15 Mr Style refers to the framework having been sent
16 to NHS trusts, who have a duty of care towards their
17 directly employed NHS employees. To what extent was the
18 framework sent to subcontracted employees of hospital
19 workers to ensure that outsourced staff had the same
20 level of protection as their NHS staff colleagues?

21 **A.** Again, I am going to have to go and check for you. So
22 my knowledge is what is in the statement we have
23 submitted on this topic, so I'll go again -- at that
24 level of detail I'd need to go away and check for you,
25 which I will do.

112

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

5 A. Yes, that would be the same answer.

6 MS SEN GUPTA: Thank you.

7 My Lady, thank you.

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

9 Mr Thomas.

10 He's behind you.

11 Questions from PROFESSOR THOMAS KC

12 PROFESSOR THOMAS: Good afternoon, Sir Christopher.

13 A. Hello.

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

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

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

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

113

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

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

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

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

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

115

1 evidence --

2 LADY HALLETT: Could you make sure --

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

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

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

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

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

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

114

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

5 Q. But the UK can be a leader.

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

8 Q. Right.

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

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

16 A. Yes.

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

20 A. That's correct.

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

116

1 disproportionately redeployed into less safe or higher
2 risk roles?
3 **A.** Yes, so I think I covered most of my answers previously.
4 But to recap. So it shouldn't have happened. It was
5 against the guidance. Under operational pressures,
6 very, very difficult both for institutions and for
7 individual staff members and we appreciate the distress
8 that issue caused.
9 **Q.** Sir Christopher --
10 **A.** Then as I described in my previous answers, there was
11 first the review that the CMO ordered of how ethnic
12 minorities --
13 **Q.** Can I just jump in a second. You're right, you did
14 cover it earlier. So let me ask you a question that
15 follows on from that so you're not just repeating
16 yourself. And the question is this. Bearing in mind
17 the difficulties that you've just highlighted and you
18 highlighted earlier, question: what monitoring
19 mechanisms were in place to ensure that redeployment
20 decisions for minority ethnic staff were equitable in
21 line with the guidance?
22 **A.** Sorry, during the pandemic?
23 **Q.** Yes.
24 **A.** That's a matter for NHS England so it is -- it's
25 immediately a matter for the individual trust. They are

117

1 **Q.** Okay, well, if you're able to assist me on this
2 question. Can we expect any adjustments in the types of
3 PPE procured to reflect the fit challenges faced by
4 ethnic minority workers?
5 **A.** Yes, and as I described earlier, we have already done
6 that --
7 **Q.** Okay.
8 **A.** -- which is not to say that there is more --
9 **Q.** That can be done?
10 **A.** -- to do, yes.
11 **Q.** In paragraph 288 it's mentioned that customer engagement
12 panels were established to hear from staff groups with
13 protected characteristics including black, Asian, and
14 minority ethnic workers. Question: could you provide
15 more detail on the frequency and the scope of these
16 discussions and how much feedback from ethnic minority
17 workers was specifically incorporated into the PPE
18 provision decisions?
19 **A.** Again, I'll have to go away on the extra detail. I know
20 what is in the statements so I can come back on that.
21 I know that the whole issue was taken very, very
22 seriously indeed by the PPE cell and that they adjusted
23 their procurement as a result of not just the feedback
24 from the staff panels but a lot of other feedback.
25 I'll come back to you on the details --

119

1 the employer and they have the duties of care.
2 **Q.** You had no oversight?
3 **A.** And then we would expect NHS England in its oversight
4 capacity to be doing so. It's not something the
5 department would have done directly.
6 **Q.** Are you unaware of what those mechanisms were?
7 **A.** Well, the NHS -- NHSE has, and I'm sure Amanda Pritchard
8 described this yesterday, has a range of oversight
9 arrangements and responsibilities and it would have been
10 part of that. I can go away and ask for details from
11 NHSE of exactly what they did but it's not something the
12 department would have done.
13 **Q.** Let me move on. In paragraph 286 it states that fit
14 testing outcomes from NHS staff have been recorded
15 centrally since June 2022. Question: how has this data
16 been used to inform future procurement decisions
17 especially regarding the PPE needs of black, Asian, and
18 minority ethnic healthcare workers?
19 **A.** So that would be initially an issue for individual
20 trusts, because we are now in a business-as-usual
21 position where individual trusts procure PPE. I won't
22 repeat what I said about the central stockpile and how
23 we diversified that. And then, again, I'd have to check
24 with NHS England on exactly what they do with the data
25 you're describing.

118

1 **Q.** When you come back can you also come back on the next
2 question which is, and what specific changes, if any,
3 were implemented as a result of these discussions? Will
4 you do that for us, please?
5 **A.** Yes, and I've already quoted one around the fit masks
6 and I'll give you what else we have.
7 **Q.** Let me come to my final question. In Module 1 of this
8 Inquiry it was noted PPE that would fit minority ethnic
9 staff was purchased in smaller quantities. One
10 question, one word: why?
11 **A.** Well, I think as you say, we covered this in Module 1
12 and it's played out in the questions of this module.
13 And all the changes that we made on this area and the
14 reviews that we carried out were to deal with that
15 issue. Behind your question, would it have been much
16 better if those things had been done before --
17 **Q.** No, no, no, no, no.
18 **A.** Yes, it would.
19 **Q.** No, sorry, that wasn't my question. I'm going to repeat
20 it. It's a simple question. Why were they purchased in
21 smaller quantities for minority ethnic staff? Help us,
22 please.
23 **A.** What we appreciated during the pandemic as a result of
24 the feedback and what we've seen, brought to light these
25 challenges which we had underestimated previously. We

120

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

4 **Q.** Structural problems, would you agree?

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

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

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

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

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

22 **Q.** Well, words are important.

23 **A.** I quote the report we had done.

24 **Q.** Words are important, aren't they?

25 **A.** Yes, they are.

121

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

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

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

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

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

123

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

2 **LADY HALLETT:** Thank you.

3 Ms Munroe, who is just there.

4 **MS MUNROE:** Thank you, my Lady.

5 **Questions from MS MUNROE KC**

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

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

12 **LADY HALLETT:** Of course.

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

17 End of shielding. Now, the DHSC submission dated
 18 23 July 2021 regarding the end of the shielding
 19 programme stated as follows.

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

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

122

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

3 You never got to that position, did you?

4 **A.** Sorry?

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

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

15 Can we, and this is, I think, at the heart of
 16 Simon Stevens' comment after mine, can we guarantee that
 17 nowhere in a system covering 10% of the economy and
 18 1.2 million people is somebody not following the rules,
 19 is incredibly difficult to do but nevertheless our
 20 mindset ought to be not one case is acceptable.

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

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

124

1 on who is doing it because obviously they're not going
2 to admit it. That is one of the reasons why we asked
3 for the CQC study that has been referenced already, was
4 for the regulator on this subject to make an assessment
5 of how widespread it was and what we should do about it.

6 But as I say, when people are either deliberately or
7 accidentally breaking the rule that has been set, it's
8 incredibly difficult to have precise data on how many.

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

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

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

125

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

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

12 **A.** Yeah.

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

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

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

127

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

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

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

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

126

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

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

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

12 Firstly, quality assurance. Now, I accept,
13 of course, Sir Christopher, that while the DHSC
14 delegated responsibility for the commissioning of the
15 111 service to NHS England, do you accept that overall
16 responsibility in terms of the adequacy, and functioning
17 of the service lay with the department?

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

25 **Q.** So what's the department role?

128

1 **A.** The department -- well, again, it is set out in the
2 legislation.

3 **Q.** If you can just very briefly tell us. In relation to
4 NHS 111, then, what do you see as the department's role?

5 **A.** It is exactly the same as in relation to any other NHS
6 service and the department's role is as I described to
7 lead counsel.

8 **Q.** So do you not feel that you have -- the department has
9 any role in terms of oversight?

10 **A.** We hold -- as set out in legislation, we hold
11 NHS England to account for all the services that are
12 covered by the NHS, acute services, primary care
13 services, community services, 111. It is one of the
14 services that we hold the NHS to account for but it is
15 their duty to deliver the service.

16 **Q.** Perhaps you can assist me with this question then, still
17 on the issue of quality assurance. Did the department
18 or are you aware of whether or not there were any
19 quality assurance mechanisms in place or were the
20 department -- in any way did you satisfy yourselves as
21 to the quality and operational functioning of the
22 NHS 111 service?

23 **A.** We will have discussed the service with the NHS. We
24 will have assured ourselves, and I know they do this,
25 that they have quality assurance measures both for the
129

1 the context of all NHS services were under colossal
2 pressure. Hospitals were under colossal pressure, GPs,
3 community services. The pandemic put, as this Inquiry
4 well knows, pressure across all NHS services --

5 **Q.** I know that. Sir Christopher, the question is
6 specifically what steps -- not what discussions you
7 had -- what steps did the department take to ensure that
8 there would be capacity, bearing in mind what I've said,
9 it was inevitable that there would be --

10 **A.** I come back to the same answer. It is the NHS's
11 statutory responsibility to manage those things. The
12 department discusses those issues with the NHS but it is
13 their responsibility to manage capacity in all their
14 services, of which 111 is an example.

15 **Q.** My final question, again Ms Carey King's Counsel took
16 you to some figures about NHS 111, and I believe it's
17 right that in fact at the peak in the first wave, after
18 March 2020, half of all calls went unanswered. Firstly,
19 do you accept that level is completely unacceptable and
20 that, secondly, for many people, the service simply
21 failed them?

22 **A.** Sorry, I don't -- I don't not recognise but I'm not
23 aware of the number you've just quoted or where that was
24 in the evidence, so I can't really comment. I'll come
25 back to you on that question.

131

1 service and the quality of service.

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

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

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

15 Now, Sir Christopher, I'm going to suggest that
16 it's common sense and entirely predictable that in the
17 circumstances of an ensuing pandemic that we would see
18 the level in demand of the NHS 111 service saw. So my
19 question is this, that given the advice that the
20 department was handing out in March 2020, what steps did
21 the department take to ensure that there would be
22 capacity within NHS 111 to cope with the increased
23 demand?

24 **A.** We'd have discussed that with NHS England, who, as
25 I've said, are the statutorily responsible body. But in
130

1 **Q.** Do you accept that the service though was not -- it
2 failed many people because there were so many calls
3 unanswered?

4 **A.** I'm not going to accuse anyone in the NHS -- and the
5 NHS 111 is an NHS service just like all the others.
6 I think the staff of the NHS performed wonders during
7 the pandemic to help people, and I think that is true of
8 our doctors, our nurses, our support staff and our staff
9 who work on NHS 111. Now, of course there were
10 challenges in all those services and that's been widely
11 acknowledged and described to this Inquiry, but I'm
12 never going to say that the staff of the NHS -- well,
13 I'm not going to use the "failed" word in relation to
14 any NHS staff.

15 **Q.** It's not about the staff, it's about the system and the
16 services that are put in place. It's not about staff
17 and how wonderful they are and how hard people work. We
18 know that. We've heard that from them themselves. It's
19 about the systems that were put in place and whether
20 they were actually working.

21 **A.** Well, so, as I've said, and as this Inquiry has heard
22 from lots of witnesses, all aspects of the NHS were
23 under huge pressure and did the best they could in very,
24 very difficult circumstances. I wouldn't pick 111 out
25 as being different from the challenges that were across
132

132

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

3 **MS MUNROE:** Thank you very much.

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

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

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

8 **MS MUNROE:** Thank you.

9 Thank you, my Lady.

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

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

12 The HCIB report made findings that half of
13 111 calls went unanswered. That was in tab 10 at
14 INQ000320204 --

15 **A.** Sorry. Yes.

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

21 **A.** Yes, thank you very much.

22 **LADY HALLETT:** Thank you very much.

23 Thank you, Sir Christopher, that completes our
24 questions for you. I've said it before but I shall say
25 it again, I do understand the demands that this Inquiry
133

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

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

7 **Q.** Thank you.

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

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

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

21 Firstly, the lack of side rooms. There are only
22 20% side rooms available across our 388 beds. There's
23 very poor ventilation and air exchange. We don't have
24 air-conditioning or air filtration units across the
25 site.

135

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

4 **A.** Yes.

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

9 **A.** That's very generous of you.

10 **LADY HALLETT:** And that they will continue to give.

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

14 **LADY HALLETT:** Thank you.

15 (The witness withdrew)

16 **LADY HALLETT:** Ms Hand.

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

18 **DR PHILIP KLOER (affirmed)**

19 **Questions from COUNSEL TO THE INQUIRY**

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

21 **A.** No, thank you.

22 **MS HANDS:** Dr Kloer, good afternoon.

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

25 Dr Kloer, you are the formal medical director of
134

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

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

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

25 **Q.** Thank you, Doctor. I'm going to stop you there and
136

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

3 You've said that there were -- on the
4 1 March 2020, 348 of those beds were in fact occupied,
5 and all 11 of the level 3 funded ICU beds were also
6 occupied; is that right?

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

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

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

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

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

137

1 the pandemic; is that right?

2 **A.** That's correct.

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

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

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

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

139

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

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

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

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

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

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

138

1 We also, following the announcement of suspension
2 of non-essential elective surgery, we redeployed 600
3 staff in -- across the health board from those areas.

4 That was a challenge because many of our staff had
5 chosen to work in those areas and not to work on acute
6 wards so we had to have individual discussions with
7 staff. But it did mean, again, that we were able to
8 source additional staff for our acute wards and also for
9 some staff source staff for the command centre that we'd
10 set up.

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

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

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

140

1 **Q.** Can I just stop you there. How many patients would be
 2 on that ward?
 3 **A.** So there could be anything from around 20 to 24 people
 4 on the ward.
 5 **Q.** So it would be one nurse, to 20 to 24 patients?
 6 **A.** Registered nurse, my understanding is, but what I do
 7 understand, though, is that a lot of the tasks that
 8 those nurses would normally have been engaged with were
 9 then supported by other staff on that ward. So, for
 10 example, the family liaison officers were really
 11 important. They provided a bridge between the patients
 12 and their relatives. They -- also we had much more
 13 healthcare support workers, so a lot of the basic care
 14 was able to be provided by them. And we had more
 15 domestic staff to provide the enhanced cleaning because
 16 of our recruitment campaign.
 17 Also, we directed a lot of our therapists to the
 18 wards who were not undertaking outpatients so there was
 19 quite a big team around the patients and in some of the
 20 areas like ITU, A&E, and some of the respiratory wards
 21 we also had specialist psychological support embedded on
 22 the ward so the nurse wasn't sort of left on their own.
 23 **Q.** It's right, isn't it, that the hospital transferred 133
 24 non-Covid patients to the local field hospital during
 25 wave 2. Were those patients medically fit patients?
 141

1 working in a more green area than the hospital so,
 2 actually, we don't feel it impacted significantly.
 3 The worry was, though, that if we had had the wave
 4 that we were expecting in the numbers that we were
 5 expecting, our staffing would have been incredibly
 6 stretched if we'd had to staff all of the field hospital
 7 beds that we had provision for.
 8 **Q.** The hospital undertook a survey of staff in June 2021
 9 and I want to ask you about some of those responses
 10 received.
 11 If we can please have on screen INQ000466548,
 12 page 7. Thank you.
 13 This is at tab 2 of your bundle, should you wish
 14 to go to it.
 15 **A.** Thank you.
 16 **Q.** Some of the feedback reported that:
 17 "In terms of physical safety ... [it] was felt
 18 unanimously whether interviewing frontline workers,
 19 domestics or office bound work force. Feeling unsafe
 20 in the workplace is the single largest work based
 21 stressor whether someone feels physically threatened
 22 or psychologically threatened the equal result is work
 23 based stress and the resultant absenteeism or
 24 presentism in its lesser form. Much rebuilding needs
 25 to be considered to allow people to feel safe again in
 143

1 **A.** So the vast majority of them were -- so they were
 2 medically fit patients and the vast majority had not had
 3 Covid.
 4 **Q.** And did that hospital provide enough and the right kind
 5 of support around capacity for your hospital?
 6 **A.** So it was quite incredible how we transformed a leisure
 7 centre and a bowling alley into a clinical environment
 8 with the support of our local authorities. When
 9 I visited them they looked exact and felt exactly like
 10 a hospital. The patients -- what our experience was
 11 that patients, quite a number of patients were asking to
 12 be transferred to the field hospital because they wanted
 13 to be out of the main hospital. And we also noticed --
 14 the nursing staff noticed there that they tended to be
 15 more inclined to get up and mobilise than they were in
 16 the acute hospital. So from that perspective it was
 17 a success although, of course, the wave and the numbers
 18 of patients that we had envisaged at the start of the
 19 pandemic with the predictions that we had been given
 20 didn't actually materialise.
 21 **Q.** And did the -- the field hospital impact on staffing
 22 capacity at GGH at all?
 23 **A.** So relatively small numbers of staff who needed to staff
 24 the field hospital because it was small numbers, and
 25 they were staff members who generally needed to be
 142

1 the work space."
 2 What support did you put in place following that
 3 feedback?
 4 **A.** So, first of all, we knew this was an unprecedented
 5 time, obviously, and we really wanted to capture the
 6 learning from the experience of our staff which is why
 7 we commissioned this report in June 2021, and I think
 8 there was rich learning for us. There was some positive
 9 aspects of it but clearly that's one of the elements
 10 there where people just felt so worried that they, for
 11 example, they wouldn't have the right PPE, they were
 12 worried they might catch Covid but also that they may
 13 spread it to their families.
 14 From a physical perspective we really tried to
 15 make sure that we were risk assessing staff to make sure
 16 they were working in an area that was -- that fitted
 17 their risk assessment for Covid.
 18 We also -- we never ran out of PPE. We tried to
 19 provide people with adequate PPE and we believe we
 20 always had that in place. And if someone -- if, for
 21 example, when we had challenges with FFP3 masks we
 22 always increased the PPE so we provided people with
 23 powered hoods, if we didn't -- if they weren't able to
 24 fit test for an FFP3 mask. But one of the biggest
 25 challenges that our staff faced was around psychological
 144

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

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

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

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

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

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

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

145

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

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

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

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

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

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

147

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

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

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

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

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

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

146

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

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

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

148

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

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

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

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

149

1 procedures or outpatients.

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

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

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

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

151

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

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

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

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

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

150

1 whom did those guidelines apply?

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

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

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

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

25 If we could please have on screen INQ000466549,

152

1 page 1, tab 3.

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

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

11 And the answer was, essentially:

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

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

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

153

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

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

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

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

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

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

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

155

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

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

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

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

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

154

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

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

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

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

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

156

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

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

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

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

20 **Q.** Was there any additional guidance --

21 **A.** On top of that?

22 **Q.** Yes, during the pandemic specifically.

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

157

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

6 **A.** Yeah.

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

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

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

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

21 **LADY HALLETT:** Sorry to interrupt.

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

24 **LADY HALLETT:** Certainly.

25 **MS HANDS:** Thank you.

159

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

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

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

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

25 **LADY HALLETT:** And one theory, I can't remember if it was
158

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

3 **(3.00 pm)**

4 **(A short break)**

5 **(3.15 pm)**

6 **LADY HALLETT:** Ms Hands.

7 **MS HANDS:** My Lady.

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

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

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

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

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

160

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

10 We had to purposefully implement the guidance on
11 our site.

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

161

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

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

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

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

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

163

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

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

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

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

162

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

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

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

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

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

164

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

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

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

165

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

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

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

24 **Q.** Thank you.

25 Moving on to a different topic now. The Inquiry

167

1 or securing equipment, isn't it?

2 **A.** Correct.

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

7 **A.** Definitely.

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

13 **A.** Can I just mention with ventilators, if we had received
 14 192 ventilators we would have struggled to staff 192
 15 patients on ventilators. There's no doubt we were
 16 struggling to staff 16, as you've said earlier. So
 17 192 -- which is why that ethical guidance was -- we were
 18 trying to consider that almost impossible scenario which
 19 at the time we were worried might be real.

20 So on oxygen -- sorry to go back.

21 **Q.** Not at all.

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

166

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

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

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

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

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

25 So our understanding of visiting increased but the

168

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

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

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

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

25 **A.** Oh, okay.

169

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

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

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

24 **A.** Yes.

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

171

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

2 **MS HANDS:** It did.

3 **A.** Sorry.

4 **MS HANDS:** My mistake.

5 **A.** It's normally doctors who do that.

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

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

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

170

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

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

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

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

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

172

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

4 **MS HANDS:** Thank you.

5 Those are my questions, my Lady.

6 **LADY HALLETT:** Thank you.

7 Ms Iengar.

8 **Questions from MS IENGAR**

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

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

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

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

23 **Q.** Please do.

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

173

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

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

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

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

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

175

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

6 Our estimates were that we had about 10 people in
7 Glangwili, as you'll see from the statement, between
8 2020 and 2022, but I think -- you know, your point about
9 the data, we cannot completely rely on that data.

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

13 **A.** They are estimates.

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

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

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

174

1 service that you just mentioned?

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

7 **MS IENGAR:** Thank you, Doctor.

8 My Lady.

9 **LADY HALLETT:** Thank you very much.

10 Ms Munroe, who is just there.

11 **Questions from MS MUNROE KC**

12 **MS MUNROE:** Thank you.

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

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

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

176

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

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

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

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

17 **Q.** I see.

18 **A.** -- rather than the spotlight hospital.

19 **Q.** Thank you very much for clarifying that.

20 Then the short question is this. The email of
21 14 February 2021, from the learning and support
22 assistant, raised concerns that DNACPR notices were
23 being issued by HB staff for Covid patients with
24 learning disabilities without their consent.

25 Now, these are particularly vulnerable patients.

177

1 who are there to support the education of junior
2 doctors.

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

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

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

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

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

179

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

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

8 **Q.** A root and branch analysis?

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

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

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

178

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

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

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

180

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

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

8 Thank you, my Lady.

9 **LADY HALLETT:** Thank you, Ms Munroe.
10 Ms Gowman.

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

13 **MS GOWMAN:** Thank you, my Lady.

14 **Questions from MS GOWMAN**

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

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

23 Please can we bring up INQ000417548.

24 Now, you should have seen this document,
25 Professor. It is a letter dated 6 April 2020 from the
181

1 with the local command centre and through our nursing
2 workforce.

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

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

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

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

22 **Q.** And this was as early as April --

23 **A.** Yes.

24 **Q.** -- so quite significantly before summer 2020?

25 **A.** And there was significant uncertainty at that time for
183

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

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

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

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

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

22 There were issues, as I said earlier, that were
23 around -- that I was aware of, were around communication
24 with staff on how to access it if they ran out on a ward
25 and that we tried to address that as quickly as possible
182

1 staff as well, we understand that.

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

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

18 **A.** I can only present you, of course, with the evidence
19 that I have and of course it's evident that -- it will
20 be the evidence based on our colleagues who were
21 overseeing the PPE supply. So we had a PPE cell which
22 was overseeing all of this. Having said that, it's
23 difficult for me to know what the exact circumstances
24 were that you're describing there and there's no doubt
25 they sound concerning because, you know, we would have
184

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

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

14 **A.** It's difficult to know because, I mean, the evidence
 15 I have is that we hadn't run out of PPE.
 16 I suppose the communication issues that I was
 17 describing earlier are worrying, and so whether there
 18 were instances because of that that staff used the PPE
 19 that wasn't appropriate for that situation, that
 20 certainly wasn't our intention, and we -- you know, we
 21 felt we had enough PPEs and we were putting huge amounts
 22 of effort into trying to communicate that with staff.
 23 And we -- you know, we learnt -- we learnt in the
 24 first few months about how to effectively communicate
 25 with our staff, how to get supply lines to wards working

185

1 **LADY HALLETT:** Thank you, Ms Gowman, very grateful.
 2 I think that completes the questions for you,
 3 Doctor. You're a respiratory physician by training and
 4 experience.

5 **A.** Yes.

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

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

18 **LADY HALLETT:** I can imagine. Especially for a respiratory
 19 physician as a respiratory virus.
 20 Thank you very much for all that you did during
 21 the pandemic and of course for all the help that you
 22 have given to the Inquiry, I'm very grateful.

23 **A.** Thank you, my Lady.

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

187

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

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

7 **A.** Yes.

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

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

24 **MS GOWMAN:** Thank you, Professor.
 25 Thank you, my Lady.

186

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

4 **THE WITNESS:** Thank you.
 5 **(The witness withdrew)**

6 **LADY HALLETT:** Ms Nield.

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

9 **DR ANDREW GOODALL (sworn)**
 10 **Questions from COUNSEL TO THE INQUIRY**

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

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

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

17 **A.** My name is Andrew Goodall.

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

22 **A.** I do, yes.

23 **Q.** Thank you.
 24 Dr Goodall, you're currently the permanent
 25 secretary to the Welsh Government, in which role you

188

1 lead the Welsh Government Civil Service in delivering
2 the priorities of the First Minister and his ministerial
3 team; is that correct?
4 **A.** Yes, that's correct.
5 **Q.** And you've been in that role I think since November of
6 2021, prior to which you were the Director General of
7 the Health and Social Services Group of the
8 Welsh Government, a role which you held from June 2014;
9 is that right?
10 **A.** Yes, that's correct.
11 **Q.** And before that you were the Chief Executive Officer of
12 Aneurin Bevan University Health Board between 2009 and
13 2014; is that right?
14 **A.** Yes, that's right.
15 **Q.** Dr Goodall, my questions today are all focused upon the
16 work of the Welsh Government Health and Social Services
17 Group in relation to the response of the healthcare
18 system in Wales during the Covid-19 pandemic from
19 March 2020 to the end of June 2022. Is it correct that
20 the witness statement that you've provided to Module 3
21 of the Inquiry covers the entirety of that period,
22 notwithstanding that some of the information you provide
23 in that statement relates to the work of the Health and
24 Social Services Group after you had left the role of
25 Director General?

189

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

191

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

190

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

192

1 services.

2 **Q.** And we see also that there are three NHS trusts. That's
3 the "Welsh Ambulance Service Trust", "Public Health
4 Wales" and "Velindre Cancer University NHS Trust".
5 I think Velindre Trust provide a specialist cancer
6 hospital; is that right?

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

8 **Q.** And there are also special health authorities there. As
9 of 2020, the Health Education and Improvement Wales
10 health authority. I think during the pandemic they were
11 involved with the deployment of medical and nursing
12 students and the continuation of healthcare education
13 and training; is that correct?

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

15 **Q.** And I think now and later in fact, during the pandemic,
16 Digital Health and Care Wales was created as a special
17 health authority; is that right?

18 **A.** Yes, it was brought into a national single digital
19 organisation, yes.

20 **Q.** So would it be right to say that you were
21 chief executive in relation to all of those NHS bodies?

22 **A.** Yes, all the chief executives of all of those bodies
23 would have reported to me through accountable officer
24 arrangements, but, yes, they constituted NHS Wales,
25 which I oversaw.

193

1 within their budgets and their resources, so that would
2 come with a different responsibility.

3 **Q.** And to whom were you accountable as chief executive of
4 NHS Wales?

5 **A.** I was accountable to the health minister for -- in
6 my NHS Wales Chief Executive role.

7 **Q.** And could you describe, please, the role and
8 responsibilities of Chief Executive of NHS Wales, in
9 terms of the functions and responsibilities that came
10 with that role specifically in relation to the pandemic
11 response?

12 **A.** Yes, the role pre-pandemic is about the strategic
13 planning and leadership of the NHS in Wales across the
14 organisations and that needed to be translated into the
15 pandemic response as well.

16 So whilst of course respecting the operational
17 delivery that lay with the health boards, it meant there
18 was a higher degree of oversight and, at times, support
19 and guidance that was needed into the system. So there
20 would have been examples of needing to confirm that
21 funding was available, for example, or there would be
22 some examples in the pandemic where it was really
23 important to have consistency in some of the
24 expectations in delivery across Wales, whether that was
25 capacity assessments, for example.

195

1 **Q.** The Inquiry has also heard the seven NHS local health
2 boards and the three NHS trusts in Wales are designated
3 as Category 1 responders under the Civil Contingencies
4 Act, which means that each has their own EPRR framework;
5 is that right?

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

7 **Q.** And is it right that there's no single body with an EPRR
8 function which enables national command and control of
9 NHS Wales?

10 **A.** Yes, the legal responsibilities lie with the health
11 boards, because NHS Wales doesn't exist as
12 an organisation or an entity, that doesn't lie with the
13 NHS in Wales or with Welsh Government. So it's correct
14 that that responsibility lies with the individual health
15 boards.

16 **Q.** So in your role as Chief Executive of NHS Wales, did you
17 have the authority to direct those NHS bodies? Did you
18 have any statutory powers in relation to the NHS bodies?

19 **A.** The powers that I would discharge would reflect the
20 powers of Welsh ministers, so where Welsh ministers were
21 directing, I was able to delegate those responsibilities
22 down.

23 I did have a lever through the accountable officer
24 arrangements to the individual chief executives, and
25 that was a requirement for them to, for example, manage

194

1 **Q.** Can we look briefly, please, at the pandemic response
2 structure that was created within the Health and Social
3 Services Group.

4 Can we go, please, to page 76 of your witness
5 statement, organogram number 5.

6 You explain in your witness statement that the
7 planning and response group that we can see there in the
8 middle of this organogram had its first meeting on
9 20 February 2020. When did it first become apparent to
10 the Welsh Government that national co-ordination of the
11 healthcare system was going to be necessary and some
12 kind of structure would have to be created to facilitate
13 that?

14 **A.** It was clear to us in February 2020 as we were looking
15 at the tracking of the numbers, as we were looking at
16 the first steps that we had taken. We had started to
17 introduce some of the various steps, like the PPE
18 arrangements, because we knew we may need to access from
19 the supply. But it was during February, as we were
20 watching some of the both international and the UK
21 numbers start to change, that we felt the need to
22 introduce those more formal arrangements. And as you
23 said, they started on 20 February.

24 **Q.** So is it right then that in the existing pandemic
25 planning, this sort of structure hadn't been previously

196

1 designed or envisaged, there hadn't been any design of
 2 a Health and Social Services Group pandemic response
 3 structure until February 2020?
 4 **A.** There were mechanisms where we fed into Welsh
 5 Government's emergency preparedness arrangements more
 6 broadly and there was an establishment of a health
 7 intelligence cell, for example, that would feed into
 8 that, but it became clear that we were going to have to
 9 oversee the arrangements for the NHS in Wales in a very
 10 different way, and, while we made that early decision,
 11 building on some of that early pan-Wales response plan
 12 but actually making sure that it was going to be
 13 suitable for what we saw as emerging at that time.
 14 **Q.** Now, the Inquiry has already heard quite a lot of
 15 evidence about this structure from the Chief Medical
 16 Officer of Wales, so I'm not going to go through that
 17 structure in detail. I'd like to focus, if I may, on
 18 your role and that of the NHS organisations, in
 19 particular how the NHS bodies were represented within
 20 that structure. So we can see that on the right the
 21 NHS Wales medical directors and directors of nursing and
 22 midwifery report in -- is that the meaning of that arrow
 23 that points to the box with you heading it up?
 24 **A.** Yes.
 25 **Q.** So those are the medical directors of those ten NHS

197

1 and often it was about having the right individual for
 2 the representation. There was a formal link to the
 3 chief executives, of course, because they were
 4 responsible for their organisations.
 5 **Q.** Can I ask you this. In the event of a future pandemic
 6 or health emergency would you adopt this same structure
 7 within the Health and Social Services Group or would you
 8 do anything differently?
 9 **A.** We would look to generally adopt this. What the
 10 planning and response group gave us, and including
 11 through its subgroup arrangements, was a very early and
 12 important link out to the individual organisations
 13 across Wales to expertise and experience around the
 14 table. That meant that as we were considering guidance
 15 and advice out into the NHS it was being worked through
 16 together and I think that was a really powerful way in
 17 which we established right from the very start that that
 18 representation was very clear both from the planning and
 19 response group arrangements but, of course, fed through
 20 those individual areas, as well.
 21 So I do think this gave us something that was
 22 important in the pandemic response about that learning
 23 together, but it also meant that when we were
 24 implementing our national guidance there was some
 25 familiarity with it because of the way in which we had

199

1 bodies that we've seen identified previously.
 2 **A.** Yes --
 3 **Q.** And then --
 4 **A.** -- partly through the professional routes there, because
 5 medical directors would have reported to Frank, in the
 6 Chief Medical Officer role, to Jean, in the Chief
 7 Nursing Officer role, so it was an opportunity to draw
 8 in that through the professional route.
 9 **Q.** Thank you.
 10 Then if we can see, on the left, the NHS Wales
 11 health boards, trusts and Health Education and
 12 Improvement Wales, on the left-hand side appear to
 13 report in to the Health and Social Services Group
 14 Covid-19 planning and response cell, which in turn
 15 reports in to the planning and response group, which in
 16 turn reports up to you, the Chief Medical Officer and
 17 the Chief Nursing Officer.
 18 The NHS Wales health boards who are represented
 19 there, would that be through the chief executive
 20 officers of those boards?
 21 **A.** There would be delegation from those chief executives.
 22 They would certainly sit around the executive board
 23 table and participate in chief executive calls, but they
 24 were representatives of those individual health boards
 25 and trusts in the different response group arrangements

198

1 engaged with the organisations and that feedback I think
 2 genuinely helped us. So I'd really like to retain that
 3 into the future.
 4 **Q.** Were there any issues with a lack of clarity about roles
 5 or responsibilities within that organisational
 6 structure?
 7 **A.** I think the individual organisations were always clear
 8 about their own responsibilities. In answer to your
 9 question, I still feel there is something outstanding in
 10 the sense that because NHS Wales isn't established as
 11 an organisation, it is not enacting the Civil
 12 Contingencies Act, Category 1, Category 2 responder
 13 model, and I think there is a need for us to make sure
 14 that those things make sense into the future.
 15 But I didn't think that took away at all from
 16 local organisations understanding their Category 1
 17 responder responsibilities and the way in which they,
 18 for example, were involved in the strategic
 19 co-ordinating groups with other public partners.
 20 **Q.** Does it follow from that answer, Dr Goodall, that you
 21 think there would be a benefit in creating a mechanism
 22 or having some sort of body that is able to take
 23 national command and control of the NHS as part of
 24 an EPRR function?
 25 **A.** I think our structure in Wales is different but I do

200

1 agree that we need to settle how the planning response
 2 structure would work in our context in Wales and if that
 3 meant that we needed to change the arrangements to
 4 understand that but also just understand how it fits
 5 with the way we are currently set up.

6 **Q.** Do you think under the arrangements that were in
 7 existence during the Covid pandemic, with each of those
 8 10 NHS bodies having their own EPRR function and
 9 structure, that there was a risk of duplication of work,
 10 that the same thing was being done ten times over when
 11 it could have been done once for all of Wales?

12 **A.** There may well have been some risk on that but given
 13 that they would still have needed to discharge their
 14 operational and legal responsibilities. That's familiar
 15 in the way in which the NHS works anyway, day-to-day, so
 16 I almost feel that's part of our normal experience even
 17 though, of course, it would have been enhanced in a very
 18 exceptional period in a pandemic response.

19 **Q.** Thank you. Perhaps we can move on now and look at the
 20 steps that were taken by the Welsh Government to
 21 ascertain information about NHS capacity early in the
 22 pandemic and gathering data on the NHS system.

23 You've explained in your witness statement -- this
 24 is at your paragraph 425 -- that on 13 February 2020 the
 25 Chief Medical Officer of Wales wrote out to the local
 201

1 "An audit carried out by NHS Wales Shared Service
 2 Partnership -- the Specialist Estates Services in 2019
 3 ... reported that only 6 of the 22 isolation facilities
 4 in Wales were fully compliant with the guidance. For
 5 those of you who were non-compliant I ask that you
 6 report on any actions you have taken to date to achieve
 7 compliance."

8 Do you know whether any steps had been taken prior
 9 to the Chief Medical Officer writing that letter
 10 in February 2020 to respond to the findings of the audit
 11 in 2019 and ensure that local health boards in Wales
 12 achieve compliance with the isolation facility
 13 requirements?

14 **A.** I can't recall that and that's not represented in my
 15 statement so I can't answer that question directly.
 16 Obviously, Frank's very formal correspondence giving the
 17 emerging picture was to make sure that that was
 18 understood by health organisations and they very quickly
 19 needed to make sure that they were able to be prepared.

20 **Q.** It may be an obvious point but if on receipt of that
 21 audit in 2019 the local health boards had been asked or
 22 indeed required to comply with the Welsh Health
 23 Circular, the isolation facilities would have been place
 24 at the start of the pandemic, wouldn't they?

25 **A.** Yes, as I said, I would need to go to look at what
 203

1 health boards to ascertain their capacity to manage
 2 Covid-19 patients who require hospital admission. And
 3 perhaps we can look very briefly at that letter from the
 4 Chief Medical Officer. It's INQ000227377.

5 So this is:
 6 "Increasing capacity across the NHS estate for
 7 management of possible cases of COVID-19 who require
 8 hospital admission".

9 And then if we can look down the letter, in the
 10 third paragraph it says:
 11 "Delivering care to these individuals will
 12 require isolation facilities in line with the Welsh
 13 Health Circular ... [33 of 2018] -- Airborne Isolation
 14 Room Requirements (attached [to the letter]) and
 15 an appropriately trained workforce."

16 I think it's right at that stage Covid-19 was
 17 designated a high consequence infectious disease and so
 18 specific isolation facilities were required; is that
 19 correct?

20 **A.** That's correct and at that stage we hadn't had our first
 21 case in Wales either.

22 **Q.** Can we go to page 2, please, of that letter. And the
 23 Chief Medical Officer notes -- he sets out the
 24 requirements, briefly, for isolation facilities under
 25 that circular, and says that:
 202

1 precisely happened at that time but, yes that would be
 2 the case. I know Frank, in the responses that were
 3 received, did have that reassurance that by 5 March,
 4 that all organisations, with one exception, were able to
 5 comply with some of those immediate requirements, as
 6 well, so in very quick order I know health boards did
 7 respond but, yes, your point about understanding the
 8 audit actions is important.

9 **Q.** Perhaps we can move on a little then to 11 March of
 10 2020, and to try to ascertain the state of preparedness
 11 of the local health boards at this stage.

12 Can we go, please, to -- this is an email to the
 13 Minister for Health and Social Services, it's
 14 INQ000252505.

15 This is an email dated 11 March 2020 and you're
 16 copied into this, although it is sent to the private
 17 secretary to the minister.

18 This is:
 19 "... feedback and information from the Wales
 20 Critical Care and Trauma Network meeting [that was] held
 21 this morning ..."

22 It notes there at the first bullet point that:
 23 "Clinicians in each health board confirmed there
 24 were broad plans in place to double level 3 equivalent
 25 critical care beds ... [and] Cardiff have indicated they
 204

1 could go above double capacity depending on the
 2 availability of redeployed staff."
 3 And if we can move down the page, please. There
 4 in bold we can see the local health boards:
 5 "... are asking for elective surgery to be stopped
 6 immediately to start to address bed issues and also
 7 release staff for training and upskilling such as
 8 anaesthetists, theatre/recovery staff and to allow
 9 capacity to address the emergency surgery backlog ahead
 10 of the peak."
 11 And if we can look at the two bullet points below
 12 that, not all -- forgive me:
 13 "There was ... a strong clinical view, based on
 14 evidence from other countries, that non-invasive
 15 ventilation could have little benefit and potentially be
 16 harmful/spread the virus so we should not be planning on
 17 expanding this service."
 18 That's a snapshot of the early preparations on
 19 11 March.
 20 So local health boards, had they already been
 21 asked to try to increase their capacity in critical care
 22 at this point or was that coming from the health boards
 23 rather than from a request from the Welsh Government?
 24 **A.** No, they had -- Frank's request on capacity had been
 25 received by the health boards. We, at this point, were
 205

1 non-invasive ventilation being of little benefit?
 2 In fact, I think it's right that that view
 3 subsequently changed so that local health boards were
 4 providing most of the oxygen support for Covid patients
 5 by way of CPAP outside of intensive care units.
 6 Do you know when it was that the local health
 7 boards began to focus on CPAP capacity to support Covid
 8 patients or when that was brought to your attention that
 9 was the way those patients were going to be
 10 predominantly clinically managed?
 11 **A.** Certainly the discussions on CPAP machines being made
 12 available was happening through March, I would recall
 13 from around mid-March or so, not least because as we
 14 were trying to assess the numbers of ventilators that
 15 were available and which would be required, that they
 16 were part of the assessment of equipment that was done
 17 and the Critical Care Network was really useful as
 18 a national body to understand some of the requirements
 19 and expectations particularly from our clinicians. But
 20 we were also able to use some of the other planning and
 21 response mechanisms to oversee a proper assessment of
 22 the equipment was around, but I do agree with your point
 23 that the treatment that was available and the way in
 24 which patients could be supported was changing at that
 25 time, but CPAPs were definitely part of the assessment
 207

1 having chief executive calls which were picking up some
 2 of the expectations as well on the back of what was
 3 Frank's initial request.
 4 Also at this point some of the SAGE assessments
 5 and modelling were being made available, whether that
 6 was through Public Health Wales or through ourselves to
 7 share with executive directors across Wales, as well.
 8 And that was leading to some of these questions being
 9 asked about doubling of capacity and it starting to be
 10 socialised in this way. But at the time that this was
 11 happening there were already chief executive level
 12 meetings happening every couple of days, on occasion
 13 daily.
 14 And I think the reference in here about the asking
 15 for surgery to be stopped, rather than being from health
 16 boards directly at this stage, but this was actually
 17 from the Critical Care Network clinicians who were
 18 expressing that wider need to prepare so that was just
 19 giving a clinical voice to the scale of the preparations
 20 that we needed to make at that time which did line up
 21 with other colleagues, including medical directors and
 22 chief executives as well.
 23 **Q.** So it seems at that point the focus was on increasing
 24 capacity in terms of mechanical ventilation, invasive
 25 ventilation, is that right, given the view about
 206

1 during March.
 2 **Q.** Can we look, please, to see what capacity requirements
 3 were being communicated to the local health boards,
 4 what -- I appreciate this is a moving picture as to how
 5 much the -- or the extent to which the NHS in Wales is
 6 going to have to increase its capacity for critical care
 7 and acute beds.
 8 So can we look, please, at your paragraph 421 of
 9 your witness statement. This is on page 168. You say
 10 that technical advisory cell on 15 March 2020:
 11 "... indicated if all three social interventions
 12 (that's self-isolation, household quarantining,
 13 shielding vulnerable groups and over 70s) were in place
 14 in Wales early in the epidemic, there would be a peak
 15 need for 1,595 ICU units and 16,552 hospital beds. This
 16 meant if every single NHS Wales bed was available to
 17 Covid-19 patients there would be a deficit of 5,989 beds
 18 at peak and 1,447 [Intensive Care Unit] beds -- if all
 19 current NHS capacity was available. The advice was the
 20 deficit was likely to be higher."
 21 Were those projections of the hospital capacity
 22 that would be required for Covid-19 patients shared with
 23 the local health boards at that point?
 24 **A.** Yes, there were. As I said, particularly through those
 25 previous two weeks we had been meeting every couple
 208

1 of days or even daily talking through these areas.
 2 These were part of presentations that were given to
 3 individual groups across Wales, including medical
 4 directors but also chief executives. We were using the
 5 emerging information and model that had come out of SAGE
 6 and in a salutary way these predictions were showing us
 7 what the numbers would mean for Wales on the one hand
 8 looking into the future, and in pretty short order, but
 9 they were also tying very visibly with images we were
 10 starting to see, particularly from Italy and Spain, and
 11 I think those images were really showing us the reality
 12 of how this virus would spread very, very quickly and
 13 have an impact on capacity.

14 **Q.** So given that projected requirement for hospital beds,
 15 can we see, I think at that point, on 20 March you wrote
 16 to the local health boards requesting them to provide
 17 daily information on their hospital activity and their
 18 hospital capacity.

19 I think this is the letter that you wrote on
 20 20 March and we can see in bold that the requirement for
 21 this daily reporting has been changed to report a new
 22 imposition by 1 pm from Saturday, 21 March, so that's
 23 the following day, and this is an absolute deadline.
 24 Was this the first time that the Welsh Government had
 25 asked for this data from the local health boards?

209

1 care capacity. If we can see the fourth paragraph
 2 there:

3 [As read] "From early next week a new reporting
 4 system will be issued by ..."

5 Is this NHS Wales Informatics Service?

6 **A.** Yes, that's correct. They had a responsibility for the
 7 data, yes.

8 **Q.** [As read] "... that will capture a broader suite of
 9 data. This will include more detailed capacity and
 10 activity in the hospital outside of critical care."

11 And:

12 [As read] "The information will provide
 13 a hospital, health board and all-Wales view of Covid
 14 capacity activity and outcome."

15 Can we look, please, at the information or the
 16 nature of the information that was provided to the
 17 Welsh Government. You have provided at page 165 of your
 18 witness statement a table of the data from the sitreps
 19 on 30 March 2020. This shows, I think, the categories
 20 of information that was collected from the local health
 21 boards at that time. And so we can see that down the
 22 left-hand side they're broadly grouped together, with
 23 invasive ventilated beds. And we can see there are
 24 three kinds of invasive ventilated beds: in a critical
 25 care environment, in a hospital but outside of the

211

1 **A.** Yes, this was when the formal sitrep reporting was being
 2 introduced and despite health boards, of course, having
 3 their own access to information because they were
 4 responsible for their operational management, that we
 5 needed to be able to track that closer to realtime at
 6 a national level which, whilst it's unusual, was
 7 something that was really necessary for us to do at this
 8 time. And we weren't able to rely on some of the other
 9 sources of information that we would use, for example if
 10 we were responding to bed pressures during the
 11 winter months. It needed to have additional information
 12 available and this was really important to support our
 13 own decision-making and support but, of course, also to
 14 report up to ministers and beyond as well.

15 **Q.** So what you're asking there is you said the interim
 16 reporting arrangement has already been issued to you and
 17 focuses on the immediate priority to report critical
 18 care capacity and activity. So was this then asking
 19 them for more information?

20 **A.** Yes, it was.

21 **Q.** You've noted there --

22 **A.** So the ability to report other acute beds, for example,
 23 and, you know, that developed over time, which I'm sure
 24 we can touch on.

25 **Q.** So previously they had been asked to report critical

210

1 critical care environment, and temporary beds providing
 2 invasive ventilation out of a hospital building.

3 So was it the case that at that time there were
 4 patients who were sedated and receiving invasive
 5 ventilation but not in a critical care environment?

6 **A.** I may need to check on statements from Frank and other
 7 colleagues on the clinical side of things, but there
 8 were -- there were patients, as we were going through
 9 the first wave, who would have been outside of the
 10 traditional critical care units because, as they were
 11 expanding the potential to staff beds, there was
 12 a physical limit, so they would have gone into
 13 lower-level critical care areas, like high dependency
 14 for example, or they -- we were using theatres, for
 15 example, as expansion places. So, yes, patients were
 16 being cared for out of that environment.

17 **Q.** So we can see on here it says that there are 84 beds,
 18 invasive ventilated beds outside of the critical care
 19 environment. Six of those beds are shown as occupied.

20 So at this point on 30 March it seems that some
 21 patients are sedated, intubated, receiving mechanical
 22 ventilation, but outside of a critical care environment.

23 **A.** Yes, and that would have tended to have been
 24 geographical as well, in terms of those patients,
 25 because as we were going through the first wave the

212

1 capacity was being introduced as we really saw the virus
 2 move from the right-hand side, south east of Wales,
 3 across the M4 corridor, through South Wales. So that
 4 would show pressures in individual hospitals. And
 5 underneath this aggregate data we, of course, had the
 6 individual health board positions and we had the
 7 individual hospital positions as well.

8 **Q.** If we can look briefly then at the other categories of
 9 beds that are recorded here, there are then non-invasive
 10 ventilated beds: the designated Covid-19 hospital beds
 11 providing CPAP, designated Covid-19 hospital beds with
 12 non-invasive ventilation -- is that non-invasive
 13 ventilation other than CPAP? Because we've heard CPAP
 14 can be considered a form of non-invasive ventilation?

15 **A.** Yes, we categorised it, as I recall, at the time to make
 16 sure that we did have an understanding of those
 17 receiving the CPAP treatment.

18 **Q.** And then palliative beds and other beds, would those be
 19 general beds on a general medical ward?

20 **A.** They would typically be on a ward. And yes, you're
 21 quite right, typically they would probably be in
 22 a medical area.

23 **Q.** And we've got beds that are not designated as Covid-19
 24 hospital beds. That's presumably for patients who have
 25 come into hospital for another reason?

213

1 invasive ventilation capacity from around 150 to 304?

2 **A.** Yes, they doubled their available theoretical capacity.
 3 What they're not really reflecting here, which we
 4 introduced throughout the sitrep reporting, is the
 5 capacity that is available immediately with the
 6 confidence that that stat (*unclear*), that which would be
 7 available within 24 hours, within seven days, and then
 8 after seven days, I thought that gave us additional
 9 information.

10 Also, at this point, this is trying to give
 11 reassurance to our clinicians as well as to the public
 12 and to our ministers about the planning arrangements put
 13 in place but this is not clarifying the historical
 14 capacity that is available for critical care, for
 15 example, and certainly in our later reporting and in my
 16 own personal reporting, I have to say, we always wanted
 17 to be really clear about the level that we were used to
 18 in the normal NHS system so that we were clear where we
 19 started.

20 **Q.** So it doesn't show base line or the number of beds over
 21 the baseline, essentially?

22 **A.** And the baseline capacity at this point, just to put it
 23 into context, would have been 152 critical care beds.

24 **MS NIELD:** My Lady, I don't know if that's a suitable --

25 **LADY HALLETT:** Certainly. I'm sorry we're going to have to

215

1 **A.** Yes, it's the remainder of the capacity. We were trying
 2 to make sure that we, at least for our general beds,
 3 knew what were likely to be designated areas for
 4 patients with Covid working through, but, yes, there
 5 were other activities that were still going on,
 6 of course, within the NHS.

7 **Q.** And finally we've got "Temporary beds providing hospital
 8 care out of a hospital building". It says zero all
 9 along there. Was that to be completed once field
 10 hospitals had been stood up?

11 **A.** Yeah, this was just an early stage and we'd already,
 12 I think, at this stage, had the back beyond -- people
 13 working on field hospital plans that they were looking
 14 to any areas where they could expand physical capacity
 15 as well. So I think this was just introduced as a bit
 16 of a catchall at the time. But you're correct, we did
 17 introduce the field hospital reporting through the
 18 sitrep reporting later.

19 **Q.** Thank you.

20 Then, finally on this table, if we may, this is
 21 a snapshot as at 30 March 2020, and we can see that the
 22 total invasive ventilated beds that are available,
 23 whether occupied or not, is 304 at that point.

24 So is it correct to say that the Welsh hospitals
 25 have already by this point more or less doubled their

214

1 ask you to come back again tomorrow, Dr Goodall, but if
 2 you could be available for a 10 o'clock start,
 3 I suspect. They will want you a bit before just to set
 4 the technology up, but thank you very much for your help
 5 today and see you tomorrow.

6 10 o'clock on Wednesday, please.

7 (4.33 pm)

8 (The hearing adjourned until 10.00 am
 9 on Wednesday, 13 November 2024)

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 14
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 16
 17
 18
 19
 20
 21
 22
 23
 24
 25

216

	INDEX	
		PAGE
1		
2		
3	SIR CHRISTOPHER WORMALD	1
4	(affirmed)	
5	Questions from LEAD COUNSEL	1
6	TO THE INQUIRY for MODULE 3	
7	Questions from MS IENGAR	94
8	Questions from MR BURTON KC	97
9	Questions from MR STANTON	101
10	Questions from MS SEN GUPTA	109
11	KC	
12	Questions from	113
13	PROFESSOR THOMAS KC	
14	Questions from MS MUNROE KC	122
15	DR PHILIP KLOER	134
16	(affirmed)	
17	Questions from COUNSEL TO THE	134
18	INQUIRY	
19	Questions from MS IENGAR	173
20	Questions from MS MUNROE KC	176
21	Questions from MS GOWMAN	181
22	DR ANDREW GOODALL	188
23	(sworn)	
24	Questions from COUNSEL TO THE	188
25	INQUIRY	

LADY HALLETT: [67] 1/3 1/6 20/21 21/3 21/11 21/15 28/15 43/24 44/3 44/7 46/11 54/3 54/8 84/14 84/20 84/22 84/24 85/7 85/11 85/24 86/23 93/24 96/25 101/9 107/9 107/14 107/17 107/21 107/25 108/4 108/7 108/16 108/23 109/2 109/10 109/15 113/8 114/2 122/2 122/12 133/5 133/10 133/22 134/5 134/10 134/14 134/16 134/20 158/13 158/25 159/7 159/11 159/21 159/24 160/1 160/6 170/1 173/6 176/9 181/9 187/1 187/6 187/18 187/24 188/6 188/11 215/25	'long [1] 153/14 'long-term' [1] 153/14 'saving [2] 153/16 153/16 'short [1] 153/14 'short-term' [1] 153/14 [1] 23/6 0 0057 [1] 15/16 0063 [1] 21/19 01 [1] 33/18 1 1 billion [1] 83/13 1 March 2020 [1] 137/4 1 o'clock [1] 33/21 1 pm [1] 209/22 1,000 [1] 86/7 1,100 [1] 139/15 1,447 [1] 208/18 1,595 [1] 208/15 1.1 million [1] 55/20 1.2 million [1] 124/18 1.24 [1] 29/2 1.45 [1] 109/11 1.45 pm [1] 109/14 10 [8] 5/19 24/3 124/17 133/13 147/9 174/6 175/13 201/8 10 April [2] 28/22 29/1 10 February [1] 7/24 10 May 2024 [1] 188/19 10 o'clock [1] 216/6 10,000 [1] 86/6 10.00 [2] 1/2 216/8 100 million [1] 24/19 100,000 [1] 16/4 11 [2] 137/5 153/24 11 April 2020 [1] 73/12 11 March [2] 204/9 205/19 11 March 2020 [1] 204/15 11.13 [1] 54/5 11.29 [1] 54/7 11.30 [1] 54/3 111 [20] 55/12 55/15 55/22 56/7 79/11 128/11 128/15 129/4 129/13 129/22 130/9 130/11 130/18 130/22 131/14 131/16 132/5 132/9 132/24 133/4 111 calls [2] 55/17 133/13	113 [1] 136/16 12 November 2024 [1] 1/1 12.45 pm [1] 109/12 123 [1] 181/16 125 [1] 113/16 127 [1] 113/16 12th [1] 102/17 13 February 2020 [1] 201/24 13 November 2024 [1] 216/9 133 [1] 141/23 14 [1] 28/25 14 April 2022 [1] 177/2 14 February 2021 [2] 176/24 177/21 14,000 [1] 22/25 140 [1] 181/21 15 billion [1] 12/13 15 March 2020 [1] 208/10 15.9 [1] 76/25 150 [2] 130/14 215/1 152 [1] 215/23 153 [1] 130/14 16 [2] 138/1 166/16 16 March [1] 30/22 16,552 [1] 208/15 16-point [1] 165/5 1600 [1] 49/4 165 [1] 211/17 168 [1] 208/9 17 [1] 133/18 17 April [1] 27/11 17 April 2020 [1] 26/11 17 June [1] 17/4 18 [1] 17/8 18 February [4] 15/15 15/18 17/11 17/12 180 [1] 137/14 18th [1] 17/6 19 [18] 24/21 33/19 44/17 103/4 104/20 122/8 145/8 181/15 189/18 198/14 202/2 202/7 202/16 208/17 208/22 213/10 213/11 213/23 19 March [3] 34/1 34/4 35/20 19.2 million [1] 76/24 191 [1] 176/22 192 [6] 153/24 165/21 166/3 166/14 166/14 166/17 1949 [1] 135/11 1959 [1] 135/13 2 2 March 2020 [1]	6/17 2 metres [1] 136/21 2 million [1] 86/13 2,000 [1] 33/25 20 [5] 41/24 135/22 141/3 141/5 151/7 20 February [1] 196/23 20 February 2020 [1] 196/9 20 March [2] 209/15 209/20 20 million [5] 15/21 16/4 17/13 24/18 26/13 20-week [1] 168/24 2009 [1] 189/12 2011 [2] 97/12 98/9 2012 [1] 128/21 2014 [2] 189/8 189/13 2016 [1] 1/14 2018 [2] 23/3 202/13 2019 [7] 15/7 24/12 25/1 179/10 203/2 203/11 203/21 2020 [51] 6/17 17/8 19/10 25/2 26/11 31/4 31/5 38/12 40/4 40/13 57/7 62/19 64/1 65/4 71/2 73/12 101/21 102/11 123/19 130/10 130/20 131/18 137/4 137/9 146/18 152/9 153/4 157/25 162/15 164/21 167/13 174/8 181/20 181/25 182/13 183/24 184/10 184/17 189/19 192/18 193/9 196/9 196/14 197/3 201/24 203/10 204/10 204/15 208/10 211/19 214/21 2021 [29] 40/4 44/13 44/16 49/9 49/11 50/24 51/16 57/16 70/1 122/18 143/8 144/7 149/25 156/16 157/25 162/21 162/22 163/13 164/21 167/19 168/5 168/6 171/23 172/7 176/24 177/6 177/10 177/21 189/6 2022 [6] 118/15 157/25 174/8 177/2 179/10 189/19 2023 [1] 50/25 2024 [6] 1/1 51/1 51/17 114/14 188/19 216/9 205 [1] 175/15 21 March [2] 30/24 209/22 21st [1] 163/12	22 [1] 203/3 23 [1] 102/25 23 July 2021 [1] 122/18 23 March [1] 34/23 236 [1] 38/13 24 [2] 141/3 141/5 24 hours [2] 32/4 215/7 24/7 [1] 169/21 240 [1] 166/25 25 [2] 97/7 190/15 25,000 [1] 27/19 26 March [1] 33/20 27 [1] 57/22 27 April [2] 70/25 74/23 27 April 2020 [1] 71/2 280 [1] 116/17 286 [1] 118/13 288 [1] 119/11 290 [1] 44/14 3 3 March [2] 8/3 21/20 3.00 pm [1] 160/3 3.15 pm [1] 160/5 30 [1] 74/6 30 April [1] 74/23 30 April 2020 [1] 153/4 30 June 2020 [1] 101/21 30 March [1] 212/20 30 March 2020 [2] 211/19 214/21 304 [2] 214/23 215/1 322 [1] 112/14 33 [2] 192/15 202/13 33p [1] 25/1 348 [1] 137/4 36,277 [1] 31/6 3872 [1] 97/7 388 [2] 136/16 137/2 388 beds [1] 135/22 39 [1] 3/23 4 4.33 pm [1] 216/7 4.50 [1] 25/2 420 million [1] 12/1 421 [1] 208/8 422 [1] 127/19 425 [1] 201/24 47 [1] 173/15 5 5,989 [1] 208/17 50 [1] 148/24 500 [1] 34/3 58 [2] 102/18 102/25
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6	43/1 46/3 46/4 47/3 47/16 48/10 48/22 49/9 49/19 50/16 50/20 51/22 52/9 52/10 55/12 55/16	acceptable [4] 124/12 124/13 124/20 125/25	69/23 70/12 125/19 127/11 127/13 128/7 137/8 149/25 156/8 169/22	adjourned [1] 216/8 adjournment [2] 109/13 127/8 adjusted [1] 119/22 adjustments [1] 119/2
60,000 [1] 71/3 600 [2] 140/2 150/20 65 [2] 35/20 171/10	56/2 56/9 58/17 58/20 58/25 59/2 59/20 60/10 61/1 61/8 61/19 63/16 65/15 67/2 67/4 67/7 68/7 68/14 71/11 72/19 77/21 78/10 79/2 79/23 81/5 81/24 82/2 83/13 86/2 86/11 86/13 86/14 90/12 91/14 91/19 92/13 92/14 92/17 93/6 93/18 96/1 96/6 96/11 96/17 96/20 96/22 97/20 98/4 98/19 98/20 98/23 98/25 99/1 99/12 100/17 100/19 100/24 102/9 103/22 104/18 105/21 106/14 107/22 109/5 109/25 111/2 114/18 115/7 118/22 125/5 125/20 126/6 126/11 126/20 126/21 126/21 127/20 131/16 132/15 132/15 132/16 132/19 133/2 135/3 136/11 136/11 143/9 145/17 146/21 150/7 155/10 155/11 158/1 159/22 160/12 161/23 163/9 164/1 167/22 169/3 169/7 169/16 170/25 171/13 172/19 174/6 174/8 177/7 178/2 178/3 178/24 182/11 185/3 185/6 185/24 186/9 191/16 195/12 197/15 199/1 199/22 200/4 200/8 201/21 204/7 206/9 206/14 206/25 215/12 215/17	accepted [3] 10/11 107/15 155/25 access [12] 58/6 59/11 80/13 145/23 146/10 147/6 147/8 154/22 171/21 182/24 196/18 210/3 accessed [1] 154/24 accidentally [1] 125/7 accordance [1] 41/11 accordingly [1] 106/9 account [9] 54/16 54/23 66/23 69/15 123/12 127/10 129/11 129/14 160/23 accountable [4] 193/23 194/23 195/3 195/5 accounting [1] 2/23 accounts [2] 58/11 159/14 accuracy [1] 48/15 accurate [3] 29/9 58/10 113/19 accuse [1] 132/4 achieve [2] 203/6 203/12 achieved [1] 90/11 acknowledge [1] 173/17 acknowledged [4] 10/14 28/19 74/25 132/11 acknowledgement [2] 46/8 90/13 acknowledges [3] 76/9 182/4 182/9 acknowledging [1] 89/4 acronym [1] 170/1 across [27] 14/20 24/19 52/19 64/15 87/6 106/16 114/8 121/7 131/4 132/25 135/22 135/24 140/3 151/5 162/4 162/4 171/7 171/14 178/21 179/5 195/13 195/24 199/13 202/6 206/7 209/3 213/3 act [11] 25/15 128/21 135/11 137/19 137/20 139/22 140/16 158/4 178/16 194/4 200/12 acted [2] 18/2 180/8 action [20] 8/1 47/4 48/24 49/7 52/9 64/8 69/5 69/7 69/15 69/22	actions [9] 41/3 46/21 52/17 62/19 66/21 70/8 70/10 203/6 204/8 activated [1] 17/14 active [1] 79/19 activities [2] 80/12 214/5 activity [5] 56/3 209/17 210/18 211/10 211/14 acts [1] 18/18 actual [4] 63/3 67/9 81/15 92/18 actually [40] 4/11 5/21 20/11 31/15 34/14 35/9 35/19 37/17 39/20 40/12 46/23 50/22 52/8 60/21 72/1 82/23 85/16 91/5 94/25 98/16 107/12 124/22 132/20 138/3 138/20 142/20 143/2 156/1 158/5 166/24 167/6 167/15 170/20 170/22 174/16 179/16 181/1 186/14 197/12 206/16 actually know [1] 37/17 acute [13] 26/10 27/2 27/10 27/20 87/9 129/12 137/24 140/5 140/8 142/16 178/14 208/7 210/22 adapt [1] 160/25 adaptation [1] 161/19 adapted [3] 81/9 145/2 156/14 add [10] 4/13 15/8 46/5 65/20 73/9 83/19 103/20 103/22 111/3 115/5 addition [1] 148/2 additional [8] 110/9 140/8 157/15 157/20 158/5 162/17 210/11 215/8 address [11] 45/11 45/16 46/13 57/1 69/5 104/4 114/12 115/23 182/25 205/6 205/9 addressed [2] 123/21 176/20 adequacy [1] 128/16 adequate [8] 31/25 95/18 144/19 147/16 148/7 148/9 150/14 184/16	administrative [2] 4/14 150/3 admission [2] 202/2 202/8 admit [1] 125/2 adopt [2] 199/6 199/9 adopted [1] 152/14 adults [1] 95/12 advance [1] 29/25 advances [1] 60/13 advantages [1] 97/24 advice [18] 2/20 18/19 18/21 74/8 79/11 106/1 106/7 122/25 130/19 154/8 154/20 154/22 154/23 157/15 169/18 179/3 199/15 208/19 advise [1] 3/12 advised [3] 15/7 15/17 24/12 advisers [1] 35/18 advising [1] 192/5 advisory [3] 4/23 154/12 208/10 aerosol [4] 15/8 102/9 105/6 162/6 aerosol-generating [1] 15/8 affect [1] 157/2 affected [1] 91/12 affecting [1] 173/15 affirmed [4] 1/8 134/18 217/4 217/16 afflicted [1] 94/24 afraid [1] 121/18 after [11] 23/16 27/20 124/16 131/17 137/22 138/18 151/11 187/10 187/13 189/24 215/8 afternoon [11] 97/5 101/15 109/4 109/11 109/11 109/19 113/12 122/6 134/22 160/9 176/13 afterwards [1] 41/22 again [35] 10/1 17/17 41/16 42/3 42/9 51/19 60/23 62/16 64/24 76/21 79/18 82/12 83/19 83/22 84/10 91/11 104/23 110/12 111/23 112/21 112/23 115/16 118/23 119/19 127/7 129/1 131/15 133/25 140/7 143/25 151/16 161/3 175/8 180/3 216/1
7	56/2 56/9 58/17 58/20 58/25 59/2 59/20 60/10 61/1 61/8 61/19 63/16 65/15 67/2 67/4 67/7 68/7 68/14 71/11 72/19 77/21 78/10 79/2 79/23 81/5 81/24 82/2 83/13 86/2 86/11 86/13 86/14 90/12 91/14 91/19 92/13 92/14 92/17 93/6 93/18 96/1 96/6 96/11 96/17 96/20 96/22 97/20 98/4 98/19 98/20 98/23 98/25 99/1 99/12 100/17 100/19 100/24 102/9 103/22 104/18 105/21 106/14 107/22 109/5 109/25 111/2 114/18 115/7 118/22 125/5 125/20 126/6 126/11 126/20 126/21 126/21 127/20 131/16 132/15 132/15 132/16 132/19 133/2 135/3 136/11 136/11 143/9 145/17 146/21 150/7 155/10 155/11 158/1 159/22 160/12 161/23 163/9 164/1 167/22 169/3 169/7 169/16 170/25 171/13 172/19 174/6 174/8 177/7 178/2 178/3 178/24 182/11 185/3 185/6 185/24 186/9 191/16 195/12 197/15 199/1 199/22 200/4 200/8 201/21 204/7 206/9 206/14 206/25 215/12 215/17	accepted [3] 10/11 107/15 155/25 access [12] 58/6 59/11 80/13 145/23 146/10 147/6 147/8 154/22 171/21 182/24 196/18 210/3 accessed [1] 154/24 accidentally [1] 125/7 accordance [1] 41/11 accordingly [1] 106/9 account [9] 54/16 54/23 66/23 69/15 123/12 127/10 129/11 129/14 160/23 accountable [4] 193/23 194/23 195/3 195/5 accounting [1] 2/23 accounts [2] 58/11 159/14 accuracy [1] 48/15 accurate [3] 29/9 58/10 113/19 accuse [1] 132/4 achieve [2] 203/6 203/12 achieved [1] 90/11 acknowledge [1] 173/17 acknowledged [4] 10/14 28/19 74/25 132/11 acknowledgement [2] 46/8 90/13 acknowledges [3] 76/9 182/4 182/9 acknowledging [1] 89/4 acronym [1] 170/1 across [27] 14/20 24/19 52/19 64/15 87/6 106/16 114/8 121/7 131/4 132/25 135/22 135/24 140/3 151/5 162/4 162/4 171/7 171/14 178/21 179/5 195/13 195/24 199/13 202/6 206/7 209/3 213/3 act [11] 25/15 128/21 135/11 137/19 137/20 139/22 140/16 158/4 178/16 194/4 200/12 acted [2] 18/2 180/8 action [20] 8/1 47/4 48/24 49/7 52/9 64/8 69/5 69/7 69/15 69/22	actions [9] 41/3 46/21 52/17 62/19 66/21 70/8 70/10 203/6 204/8 activated [1] 17/14 active [1] 79/19 activities [2] 80/12 214/5 activity [5] 56/3 209/17 210/18 211/10 211/14 acts [1] 18/18 actual [4] 63/3 67/9 81/15 92/18 actually [40] 4/11 5/21 20/11 31/15 34/14 35/9 35/19 37/17 39/20 40/12 46/23 50/22 52/8 60/21 72/1 82/23 85/16 91/5 94/25 98/16 107/12 124/22 132/20 138/3 138/20 142/20 143/2 156/1 158/5 166/24 167/6 167/15 170/20 170/22 174/16 179/16 181/1 186/14 197/12 206/16 actually know [1] 37/17 acute [13] 26/10 27/2 27/10 27/20 87/9 129/12 137/24 140/5 140/8 142/16 178/14 208/7 210/22 adapt [1] 160/25 adaptation [1] 161/19 adapted [3] 81/9 145/2 156/14 add [10] 4/13 15/8 46/5 65/20 73/9 83/19 103/20 103/22 111/3 115/5 addition [1] 148/2 additional [8] 110/9 140/8 157/15 157/20 158/5 162/17 210/11 215/8 address [11] 45/11 45/16 46/13 57/1 69/5 104/4 114/12 115/23 182/25 205/6 205/9 addressed [2] 123/21 176/20 adequacy [1] 128/16 adequate [8] 31/25 95/18 144/19 147/16 148/7 148/9 150/14 184/16	advised [3] 15/7 15/17 24/12 advisers [1] 35/18 advising [1] 192/5 advisory [3] 4/23 154/12 208/10 aerosol [4] 15/8 102/9 105/6 162/6 aerosol-generating [1] 15/8 affect [1] 157/2 affected [1] 91/12 affecting [1] 173/15 affirmed [4] 1/8 134/18 217/4 217/16 afflicted [1] 94/24 afraid [1] 121/18 after [11] 23/16 27/20 124/16 131/17 137/22 138/18 151/11 187/10 187/13 189/24 215/8 afternoon [11] 97/5 101/15 109/4 109/11 109/11 109/19 113/12 122/6 134/22 160/9 176/13 afterwards [1] 41/22 again [35] 10/1 17/17 41/16 42/3 42/9 51/19 60/23 62/16 64/24 76/21 79/18 82/12 83/19 83/22 84/10 91/11 104/23 110/12 111/23 112/21 112/23 115/16 118/23 119/19 127/7 129/1 131/15 133/25 140/7 143/25 151/16 161/3 175/8 180/3 216/1
8	56/2 56/9 58/17 58/20 58/25 59/2 59/20 60/10 61/1 61/8 61/19 63/16 65/15 67/2 67/4 67/7 68/7 68/14 71/11 72/19 77/21 78/10 79/2 79/23 81/5 81/24 82/2 83/13 86/2 86/11 86/13 86/14 90/12 91/14 91/19 92/13 92/14 92/17 93/6 93/18 96/1 96/6 96/11 96/17 96/20 96/22 97/20 98/4 98/19 98/20 98/23 98/25 99/1 99/12 100/17 100/19 100/24 102/9 103/22 104/18 105/21 106/14 107/22 109/5 109/25 111/2 114/18 115/7 118/22 125/5 125/20 126/6 126/11 126/20 126/21 126/21 127/20 131/16 132/15 132/15 132/16 132/19 133/2 135/3 136/11 136/11 143/9 145/17 146/21 150/7 155/10 155/11 158/1 159/22 160/12 161/23 163/9 164/1 167/22 169/3 169/7 169/16 170/25 171/13 172/19 174/6 174/8 177/7 178/2 178/3 178/24 182/11 185/3 185/6 185/24 186/9 191/16 195/12 197/15 199/1 199/22 200/4 200/8 201/21 204/7 206/9 206/14 206/25 215/12 215/17	acceptable [4] 124/12 124/13 124/20 125/25 accepted [3] 10/11 107/15 155/25 access [12] 58/6 59/11 80/13 145/23 146/10 147/6 147/8 154/22 171/21 182/24 196/18 210/3 accessed [1] 154/24 accidentally [1] 125/7 accordance [1] 41/11 accordingly [1] 106/9 account [9] 54/16 54/23 66/23 69/15 123/12 127/10 129/11 129/14 160/23 accountable [4] 193/23 194/23 195/3 195/5 accounting [1] 2/23 accounts [2] 58/11 159/14 accuracy [1] 48/15 accurate [3] 29/9 58/10 113/19 accuse [1] 132/4 achieve [2] 203/6 203/12 achieved [1] 90/11 acknowledge [1] 173/17 acknowledged [4] 10/14 28/19 74/25 132/11 acknowledgement [2] 46/8 90/13 acknowledges [3] 76/9 182/4 182/9 acknowledging [1] 89/4 acronym [1] 170/1 across [27] 14/20 24/19 52/19 64/15 87/6 106/16 114/8 121/7 131/4 132/25 135/22 135/24 140/3 151/5 162/4 162/4 171/7 171/14 178/21 179/5 195/13 195/24 199/13 202/6 206/7 209/3 213/3 act [11] 25/15 128/21 135/11 137/19 137/20 139/22 140/16 158/4 178/16 194/4 200/12 acted [2] 18/2 180/8 action [20] 8/1 47/4 48/24 49/7 52/9 64/8 69/5 69/7 69/15 69/22	actions [9] 41/3 46/21 52/17 62/19 66/21 70/8 70/10 203/6 204/8 activated [1] 17/14 active [1] 79/19 activities [2] 80/12 214/5 activity [5] 56/3 209/17 210/18 211/10 211/14 acts [1] 18/18 actual [4] 63/3 67/9 81/15 92/18 actually [40] 4/11 5/21 20/11 31/15 34/14 35/9 35/19 37/17 39/20 40/12 46/23 50/22 52/8 60/21 72/1 82/23 85/16 91/5 94/25 98/16 107/12 124/22 132/20 138/3 138/20 142/20 143/2 156/1 158/5 166/24 167/6 167/15 170/20 170/22 174/16 179/16 181/1 186/14 197/12 206/16 actually know [1] 37/17 acute [13] 26/10 27/2 27/10 27/20 87/9 129/12 137/24 140/5 140/8 142/16 178/14 208/7 210/22 adapt [1] 160/25 adaptation [1] 161/19 adapted [3] 81/9 145/2 156/14 add [10] 4/13 15/8 46/5 65/20 73/9 83/19 103/20 103/22 111/3 115/5 addition [1] 148/2 additional [8] 110/9 140/8 157/15 157/20 158/5 162/17 210/11 215/8 address [11] 45/11 45/16 46/13 57/1 69/5 104/4 114/12 115/23 182/25 205/6 205/9 addressed [2] 123/21 176/20 adequacy [1] 128/16 adequate [8] 31/25 95/18 144/19 147/16 148/7 148/9 150/14 184/16	advised [3] 15/7 15/17 24/12 advisers [1] 35/18 advising [1] 192/5 advisory [3] 4/23 154/12 208/10 aerosol [4] 15/8 102/9 105/6 162/6 aerosol-generating [1] 15/8 affect [1] 157/2 affected [1] 91/12 affecting [1] 173/15 affirmed [4] 1/8 134/18 217/4 217/16 afflicted [1] 94/24 afraid [1] 121/18 after [11] 23/16 27/20 124/16 131/17 137/22 138/18 151/11 187/10 187/13 189/24 215/8 afternoon [11] 97/5 101/15 109/4 109/11 109/11 109/19 113/12 122/6 134/22 160/9 176/13 afterwards [1] 41/22 again [35] 10/1 17/17 41/16 42/3 42/9 51/19 60/23 62/16 64/24 76/21 79/18 82/12 83/19 83/22 84/10 91/11 104/23 110/12 111/23 112/21 112/23 115/16 118/23 119/19 127/7 129/1 131/15 133/25 140/7 143/25 151/16 161/3 175/8 180/3 216/1
9	56/2 56/9 58/17 58/20 58/25 59/2 59/20 60/10 61/1 61/8 61/19 63/16 65/15 67/2 67/4 67/7 68/7 68/14 71/11 72/19 77/21 78/10 79/2 79/23 81/5 81/24 82/2 83/13 86/2 86/11 86/13 86/14 90/12 91/14 91/19 92/13 92/14 92/17 93/6 93/18 96/1 96/6 96/11 96/17 96/20 96/22 97/20 98/4 98/19 98/20 98/23 98/25 99/1 99/12 100/17 100/19 100/24 102/9 103/22 104/18 105/21 106/14 107/22 109/5 109/25 111/2 114/18 115/7 118/22 125/5 125/20 126/6 126/11 126/20 126/21 126/21 127/20 131/16 132/15 132/15 132/16 132/19 133/2 135/3 136/11 136/11 143/9 145/17 146/21 150/7 155/10 155/11 158/1 159/22 160/12 161/23 163/9 164/1 167/22 169/3 169/7 169/16 170/25 171/13 172/19 174/6 174/8 177/7 178/2 178/3 178/24 182/11 185/3 185/6 185/24 186/9 191/16 195/12 197/15 199/1 199/22 200/4 200/8 201/21 204/7 206/9 206/14 206/25 215/12 215/17	acceptable [4] 12		

<p>A</p> <p>against [7] 23/22 117/5 155/14 158/13 159/4 184/11 184/12</p> <p>age [2] 100/3 135/9</p> <p>agency [3] 5/8 5/14 138/6</p> <p>aggregate [1] 213/5</p> <p>agility [1] 45/7</p> <p>ago [4] 64/13 80/3 98/10 104/17</p> <p>AGP [1] 106/19</p> <p>AGPs [3] 18/12 104/14 161/7</p> <p>agree [21] 8/9 26/5 72/12 80/2 94/15 94/19 94/22 95/17 102/4 113/22 113/25 121/4 126/13 175/22 176/2 176/6 183/12 183/13 185/10 201/1 207/22</p> <p>agreed [3] 3/15 74/15 121/16</p> <p>agreeing [1] 75/3</p> <p>ahead [3] 87/17 123/12 205/9</p> <p>aid [1] 47/20</p> <p>aiming [1] 124/14</p> <p>air [4] 135/23 135/24 135/24 136/20</p> <p>air-conditioning [1] 135/24</p> <p>airborne [3] 102/16 103/12 202/13</p> <p>alarms [2] 167/18 167/20</p> <p>albeit [2] 5/10 165/18</p> <p>all [111] 1/20 2/2 2/18 3/9 4/18 8/19 9/7 10/4 10/12 14/13 16/13 21/16 25/22 26/7 26/22 29/17 33/4 37/22 38/1 40/2 45/19 47/13 51/19 52/19 52/22 56/19 57/5 59/2 62/21 67/3 67/8 67/11 73/16 73/19 78/10 86/16 86/25 88/11 90/3 91/2 91/23 92/12 92/17 93/9 93/21 98/12 98/21 103/7 103/19 107/19 109/8 109/23 110/21 120/13 122/1 123/4 125/11 125/23 126/13 126/23 129/11 130/8 131/1 131/4 131/13 131/18 132/5 132/10 132/22 133/16 137/5 137/11 139/5 139/7 139/18 142/22 143/6 144/4 146/14 149/1 150/6</p>	<p>150/20 155/6 155/7 155/14 156/12 158/13 158/14 159/22 166/21 167/4 167/10 178/4 179/18 184/22 185/12 187/20 187/21 188/15 189/15 193/21 193/22 193/22 200/15 201/11 204/4 205/12 208/11 208/18 211/13 214/8</p> <p>all-Wales [1] 211/13</p> <p>alleviate [1] 30/20</p> <p>alley [1] 142/7</p> <p>Allison [2] 122/7 176/14</p> <p>Allison Munroe [1] 176/14</p> <p>allocation [1] 191/13</p> <p>allow [9] 25/19 26/4 58/6 59/10 73/3 85/25 99/15 143/25 205/8</p> <p>allowance [1] 175/19</p> <p>allowed [3] 75/10 123/5 172/18</p> <p>allows [4] 96/12 98/16 123/9 130/3</p> <p>almost [3] 21/1 166/18 201/16</p> <p>alone [1] 97/22</p> <p>along [7] 14/3 43/17 92/5 92/9 108/18 147/17 214/9</p> <p>already [25] 9/21 20/6 25/24 30/25 46/24 52/23 53/2 84/6 93/6 93/18 94/12 119/5 120/5 121/12 123/18 123/20 125/3 139/9 176/19 197/14 205/20 206/11 210/16 214/11 214/25</p> <p>also [75] 7/8 12/3 21/9 36/16 37/11 44/3 54/20 57/6 74/8 74/9 76/3 92/1 92/12 99/13 102/8 105/12 108/3 115/9 120/1 126/9 133/16 136/2 136/11 136/23 137/5 137/16 137/17 138/6 139/16 140/1 140/8 141/12 141/17 141/21 142/13 144/12 144/18 147/11 149/2 149/20 150/9 151/17 154/19 155/23 157/7 161/12 163/9 163/19 165/3 165/8 166/8 167/13 169/8 171/16 171/17 175/16 176/4 178/16 190/3 190/21 191/25 192/9 192/25 193/2 193/8 194/1 199/23 201/4 205/6 206/4 207/20</p>	<p>209/4 209/9 210/13 215/10</p> <p>alternative [5] 23/8 116/19 183/11 183/14 183/16</p> <p>alternatives [1] 23/10</p> <p>although [12] 12/24 51/7 58/8 142/17 153/13 153/22 154/15 154/24 172/5 179/7 181/18 204/16</p> <p>always [21] 1/15 58/22 62/15 71/13 71/15 71/17 71/22 105/11 110/23 110/24 124/14 124/24 124/25 126/20 138/11 144/20 144/22 146/22 185/2 200/7 215/16</p> <p>am [18] 1/2 12/23 17/25 20/22 53/6 54/5 54/7 55/24 69/17 80/11 85/24 105/15 106/10 109/8 112/21 121/19 159/22 216/8</p> <p>Amanda [4] 3/20 46/4 54/21 118/7</p> <p>Amanda Pritchard [4] 3/20 46/4 54/21 118/7</p> <p>amazing [1] 1/19</p> <p>amber [1] 22/11</p> <p>Ambulance [1] 193/3</p> <p>American [2] 49/20 50/8</p> <p>Americans [1] 43/17</p> <p>amongst [5] 20/19 91/21 181/18 182/5 184/13</p> <p>amount [5] 39/14 39/20 55/16 58/8 102/5</p> <p>amounts [2] 23/1 185/21</p> <p>anaesthetists [1] 205/8</p> <p>analysis [7] 26/22 157/5 178/8 178/9 180/11 180/17 180/20</p> <p>Andrew [4] 188/7 188/9 188/17 217/22</p> <p>Andrew Goodall [1] 188/17</p> <p>Aneurin [2] 171/5 189/12</p> <p>announced [8] 50/24 51/16 70/25 71/2 74/23 163/6 172/6 172/6</p> <p>announcement [2] 74/13 140/1</p> <p>announcements [1] 137/16</p>	<p>anomaly [2] 168/24 168/24</p> <p>another [13] 9/3 10/3 10/4 11/21 43/8 77/21 121/13 138/11 151/11 152/16 159/23 177/10 213/25</p> <p>answer [37] 2/6 2/13 13/5 24/25 27/8 27/12 31/8 56/4 64/13 80/3 88/21 89/16 91/15 96/8 97/14 98/19 99/12 103/15 104/1 110/12 113/5 113/24 114/4 126/25 131/10 133/7 153/6 153/11 154/14 175/8 179/12 179/22 179/23 180/8 200/8 200/20 203/15</p> <p>answered [1] 115/19</p> <p>answering [4] 2/10 39/23 114/4 123/22</p> <p>answers [6] 84/10 101/12 117/3 117/10 122/15 133/4</p> <p>anti [1] 47/20</p> <p>anticipated [2] 20/7 166/11</p> <p>anticipating [2] 12/8 101/1</p> <p>antivirals [1] 13/22</p> <p>anxiety [7] 32/10 32/15 145/16 147/13 161/24 181/18 182/5</p> <p>anxious [2] 149/23 183/21</p> <p>any [80] 23/2 23/21 31/6 34/4 36/20 36/20 36/25 41/7 49/7 50/4 51/9 51/10 52/23 55/21 56/13 64/9 65/9 66/16 70/5 70/23 74/11 79/14 80/4 80/22 81/9 81/22 81/23 83/25 87/24 90/16 91/5 92/21 97/12 99/8 101/23 103/20 103/21 104/24 106/2 106/3 108/19 108/21 115/19 119/2 120/2 122/21 124/6 125/12 129/5 129/9 129/18 129/20 132/14 137/8 156/1 157/15 157/20 158/5 158/19 162/23 162/24 164/23 168/9 169/11 169/18 170/10 171/25 172/7 173/2 175/1 186/5 187/13 187/25 191/6 194/18 197/1 200/4 203/6 203/8 214/14</p> <p>anyone [14] 12/13 26/16 59/24 68/16</p>	<p>69/17 69/19 70/14 70/15 92/3 111/23 111/25 125/25 132/4 133/18</p> <p>anything [7] 47/3 49/14 84/2 111/2 141/3 178/1 199/8</p> <p>anyway [2] 42/24 201/15</p> <p>anywhere [3] 11/4 49/22 109/9</p> <p>apart [1] 158/4</p> <p>apologies [2] 59/1 73/13</p> <p>app [1] 80/13</p> <p>appalled [1] 125/21</p> <p>apparent [1] 196/9</p> <p>appear [5] 84/4 173/9 173/14 188/8 198/12</p> <p>appearance [1] 68/2</p> <p>appearances [1] 2/9</p> <p>application [2] 114/18 157/1</p> <p>applied [2] 65/8 110/1</p> <p>apply [9] 43/14 98/21 111/20 112/2 112/7 140/21 152/1 154/15 156/18</p> <p>applying [2] 173/1 181/3</p> <p>appointed [2] 135/5 152/9</p> <p>appointment [3] 77/25 78/13 79/2</p> <p>appointments [10] 76/5 76/12 76/25 77/4 77/19 77/24 78/11 78/16 79/6 170/9</p> <p>appreciate [11] 84/14 104/7 104/23 108/16 109/3 117/7 125/23 134/12 159/4 188/13 208/4</p> <p>appreciated [1] 120/23</p> <p>approach [8] 82/8 82/9 125/19 162/20 164/9 165/13 174/23 185/2</p> <p>approaching [2] 33/25 34/3</p> <p>appropriate [11] 156/2 158/8 158/16 158/24 159/18 178/20 182/7 182/20 184/9 185/2 185/19</p> <p>appropriately [1] 202/15</p> <p>approval [1] 50/15</p> <p>approve [1] 50/18</p> <p>approved [2] 45/5 47/16</p> <p>approximately [1]</p>
---	--	--	---	--

<p>A</p> <p>approximately... [1] 165/22</p> <p>April [26] 26/11 27/11 28/22 29/1 62/19 64/3 70/25 71/2 73/12 74/23 74/23 77/1 137/9 153/4 155/24 157/25 157/25 167/13 168/18 170/20 177/2 181/25 182/13 183/22 184/10 184/17</p> <p>are [221]</p> <p>area [38] 10/3 10/4 10/25 18/1 37/4 38/7 41/8 41/15 43/8 45/23 60/20 66/21 68/8 70/17 83/16 84/10 89/16 96/9 97/22 98/15 99/4 99/13 100/12 100/13 100/19 101/17 104/23 108/3 108/10 120/13 121/13 126/1 138/17 138/18 138/22 143/1 144/16 213/22</p> <p>areas [30] 6/3 8/20 9/1 9/8 10/1 10/2 10/5 10/11 11/22 48/1 55/6 62/16 96/13 102/3 103/17 104/13 121/11 138/8 140/3 140/5 141/20 147/17 147/19 151/10 187/16 199/20 209/1 212/13 214/3 214/14</p> <p>aren't [2] 70/20 121/24</p> <p>argue [3] 16/17 26/21 51/19</p> <p>argues [1] 26/16</p> <p>argument [3] 61/12 79/2 80/4</p> <p>arisen [1] 115/25</p> <p>arising [1] 123/23</p> <p>armed [1] 9/4</p> <p>around [72] 9/20 12/12 14/13 15/21 34/4 35/11 37/23 38/3 40/4 42/2 46/21 55/8 59/14 59/23 84/8 86/6 101/19 106/11 120/5 136/16 136/17 137/1 137/14 137/16 139/9 139/20 139/22 141/3 141/19 142/5 144/25 145/16 145/18 146/1 147/23 149/9 149/22 150/18 151/3 151/3 151/22 152/7 152/11 152/23 155/18 156/6 157/9 157/16 158/4 160/12 161/4 161/5</p>	<p>161/6 162/5 164/15 167/17 168/1 169/9 171/10 172/16 174/20 176/23 178/15 179/18 181/4 182/23 182/23 198/22 199/13 207/13 207/22 215/1</p> <p>arrangement [1] 210/16</p> <p>arrangements [17] 4/14 22/22 63/3 118/9 191/12 193/24 194/24 196/18 196/22 197/5 197/9 198/25 199/11 199/19 201/3 201/6 215/12</p> <p>arrest [1] 156/24</p> <p>arrived [1] 33/25</p> <p>arriving [1] 178/23</p> <p>arrow [1] 197/22</p> <p>as [417]</p> <p>as April [1] 183/22</p> <p>as: [1] 35/15</p> <p>as: management [1] 35/15</p> <p>ascertain [4] 34/5 201/21 202/1 204/10</p> <p>Asian [4] 40/19 116/24 118/17 119/13</p> <p>ask [66] 1/22 2/3 5/20 7/1 7/23 11/9 13/5 28/1 28/7 32/23 33/17 33/23 34/2 35/24 38/9 38/17 43/24 45/15 47/16 48/10 49/13 50/1 52/6 52/10 53/22 55/12 56/6 56/9 56/12 61/19 63/11 63/21 65/1 67/22 68/5 70/5 77/17 81/5 81/13 84/14 90/12 90/15 91/4 94/3 97/17 100/1 101/16 106/14 107/17 111/9 117/14 118/10 122/1 122/7 123/21 126/3 135/2 143/9 145/24 176/14 180/1 180/14 181/15 199/5 203/5 216/1</p> <p>asked [23] 7/18 19/12 26/25 35/18 59/25 63/21 63/24 63/25 64/11 66/3 70/5 79/25 100/20 107/2 107/21 109/25 125/2 180/5 203/21 205/21 206/9 209/25 210/25</p> <p>asking [10] 17/24 35/17 63/22 111/2 142/11 159/7 205/5 206/14 210/15 210/18</p> <p>asks [2] 43/4 114/18</p> <p>aspect [1] 28/18</p>	<p>aspects [4] 9/16 79/12 132/22 144/9</p> <p>assertion [1] 186/10</p> <p>assess [4] 123/9 125/18 187/13 207/14</p> <p>assessing [3] 65/8 65/22 144/15</p> <p>assessment [10] 123/15 125/4 144/17 170/17 171/2 171/4 171/6 207/16 207/21 207/25</p> <p>assessments [7] 136/14 137/24 170/13 170/15 171/16 195/25 206/4</p> <p>asset [1] 83/22</p> <p>assimilate [1] 161/15</p> <p>assist [3] 2/4 119/1 129/16</p> <p>assistant [2] 109/23 177/22</p> <p>assistant's [1] 176/25</p> <p>assistants [1] 178/2</p> <p>assisted [4] 1/25 47/22 160/18 175/22</p> <p>assisting [1] 3/14</p> <p>associated [1] 89/11</p> <p>Association [3] 74/22 101/17 170/21</p> <p>assume [3] 34/19 85/19 86/4</p> <p>assuming [1] 85/16</p> <p>assurance [7] 2/22 70/24 109/25 128/12 129/17 129/19 129/25</p> <p>assured [1] 129/24</p> <p>asymptomatic [3] 30/5 30/8 164/4</p> <p>at [244]</p> <p>at all [12] 26/22 29/17 67/3 67/11 86/25 123/4 125/11 142/22 166/21 185/12 188/15 200/15</p> <p>Atherton [2] 177/4 177/13</p> <p>attach [1] 121/21</p> <p>attached [1] 202/14</p> <p>attempted [2] 156/18 156/25</p> <p>attempting [1] 180/7</p> <p>attend [1] 168/23</p> <p>attendance [1] 137/13</p> <p>attending [3] 79/7 130/11 137/12</p> <p>attention [6] 91/11 150/22 162/6 172/12 179/21 207/8</p> <p>attested [1] 133/17</p> <p>audit [9] 4/8 57/16 58/4 58/10 59/9 203/1</p>	<p>203/10 203/21 204/8</p> <p>audits [2] 179/7 179/10</p> <p>August [2] 164/7 168/22</p> <p>austerity [1] 9/20</p> <p>authorize [1] 58/17</p> <p>authorities [2] 142/8 193/8</p> <p>authority [3] 193/10 193/17 194/17</p> <p>automatically [1] 72/22</p> <p>autumn [2] 64/21 114/14</p> <p>autumn 2024 [1] 114/14</p> <p>availability [6] 182/6 184/4 185/8 186/9 186/10 205/2</p> <p>available [27] 22/4 22/4 41/12 48/2 82/3 97/20 105/13 135/22 146/23 165/25 169/21 183/5 188/21 195/21 206/5 207/12 207/15 207/23 208/16 208/19 210/12 214/22 215/2 215/5 215/7 215/14 216/2</p> <p>avenues [1] 182/18</p> <p>avoid [2] 77/19 122/21</p> <p>aware [34] 3/19 21/21 40/24 48/14 48/18 48/24 49/6 49/8 56/5 57/11 62/5 62/13 64/9 69/18 79/6 97/11 99/11 99/14 99/25 102/6 102/9 103/12 103/16 112/6 129/18 131/23 151/14 156/7 156/9 156/16 161/23 163/3 170/22 182/23</p> <p>awareness [1] 172/25</p> <p>away [8] 66/18 109/3 112/9 112/24 115/12 118/10 119/19 200/15</p> <p>awful [2] 71/18 98/15</p> <p>AZ [1] 84/3</p>	<p>180/17 186/13 188/14 206/2 214/12 216/1</p> <p>background [3] 73/8 109/24 170/25</p> <p>backgrounds [2] 42/17 109/22</p> <p>backlog [2] 151/14 205/9</p> <p>bad [5] 63/2 69/24 70/16 79/3 126/1</p> <p>bags [1] 19/13</p> <p>balance [6] 78/10 80/11 163/13 163/22 163/22 164/15</p> <p>balances [2] 16/21 80/19</p> <p>balancing [1] 25/15</p> <p>BAME [4] 170/24 171/4 171/12 171/13</p> <p>bans [1] 66/16</p> <p>BAPIO [1] 170/20</p> <p>barrier [1] 116/1</p> <p>barriers [3] 115/20 115/23 115/24</p> <p>base [11] 50/17 53/20 53/24 82/13 83/16 84/1 84/13 93/3 133/19 149/13 215/20</p> <p>based [24] 62/24 71/8 74/5 96/16 105/3 105/4 105/11 105/13 105/16 105/18 105/25 106/5 106/7 106/15 106/18 106/22 143/20 143/23 147/13 160/17 169/12 184/20 187/9 205/13</p> <p>baseline [2] 215/21 215/22</p> <p>basic [5] 141/13 149/15 157/3 157/19 158/6</p> <p>basically [3] 19/19 24/2 31/17</p> <p>basis [11] 19/2 24/23 27/16 64/19 70/7 70/14 98/7 102/1 105/1 123/16 186/18</p> <p>battle [3] 7/15 7/20 7/22</p> <p>be [243]</p> <p>bearing [5] 73/8 117/16 131/8 180/5 180/6</p> <p>became [7] 30/24 62/5 104/18 136/6 156/16 161/16 197/8</p> <p>because [110] 2/9 12/23 14/15 18/5 18/6 19/10 19/23 20/20 21/13 22/2 24/8 30/2 30/13 32/11 33/17 34/8 35/8 36/13 36/14 38/18 40/12 41/7</p>
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B	48/20 51/14 53/6 55/3 55/4 55/25 55/25 63/4 67/2 68/21 70/6 74/22 75/2 75/22 77/11 78/22 81/6 92/7 105/11 105/13 106/10 108/22 112/2 112/15 114/12 118/9 118/14 118/16 120/15 120/16 123/18 123/20 125/3 125/7 127/16 128/18 132/10 135/5 141/8 142/19 143/5 146/9 149/3 149/4 150/16 154/6 159/11 159/12 159/15 160/17 162/3 163/3 163/6 166/4 172/8 172/19 174/17 176/19 178/6 187/11 189/5 191/4 195/20 196/25 197/1 201/11 201/12 201/17 203/8 203/21 203/23 205/20 205/24 208/25 209/21 210/16 210/25 212/9 212/23 214/10 215/23	148/10 155/4 170/8 171/1 172/20 172/23 173/21 174/4 174/14 175/7 177/23 178/17 182/6 185/12 185/13 199/15 201/10 206/5 206/8 206/15 207/1 207/11 208/3 210/1 212/16 213/1 beings [1] 71/14 believe [5] 76/18 97/16 97/18 131/16 144/19 believed [1] 12/2 believes [3] 12/13 75/21 125/25 believing [1] 61/15 below [3] 65/21 147/4 205/11 benefit [5] 8/11 99/18 200/21 205/15 207/1 benefits [1] 99/17 bereaved [4] 122/8 127/19 176/15 181/16 bespoke [1] 175/19 best [14] 2/4 2/6 35/3 37/2 37/3 96/11 115/9 123/11 132/23 151/24 154/7 154/8 172/22 178/18 better [40] 8/12 10/18 11/16 11/20 27/8 27/18 28/14 35/12 37/7 37/16 42/4 42/6 45/4 47/22 51/20 51/20 58/14 59/14 59/15 59/24 61/4 61/18 75/22 80/20 81/24 90/2 98/18 99/4 99/16 100/24 104/1 106/12 106/21 120/16 125/14 126/22 126/22 127/1 153/8 181/11 between [20] 4/19 16/22 25/1 25/17 31/4 61/17 88/23 91/11 99/22 102/10 106/3 136/22 141/11 150/2 152/18 161/4 164/20 174/7 180/21 189/12 between February [1] 25/1 Bevan [2] 171/5 189/12 beyond [6] 37/25 72/16 93/17 111/6 210/14 214/12 bias [5] 43/18 49/10 50/6 114/8 153/13 biases [7] 43/23 44/9 48/9 121/9 121/14 121/17 121/20 big [13] 6/7 33/6 33/7 46/1 50/12 79/21	81/14 86/8 87/24 116/13 121/11 137/17 141/19 bigger [4] 22/24 23/13 23/17 62/17 biggest [10] 20/15 37/1 50/14 50/20 69/7 78/4 82/4 116/1 116/6 144/24 billion [2] 12/13 83/13 biophysical [1] 95/15 bit [11] 26/18 40/7 72/8 75/5 83/10 86/22 88/5 98/11 126/4 214/15 216/3 bits [2] 17/18 88/5 black [4] 40/19 116/24 118/17 119/13 blame [1] 126/21 blanket [13] 62/3 62/22 63/3 63/11 64/10 64/24 66/2 66/16 74/16 123/17 123/24 127/9 128/4 blessed [1] 82/20 blind [1] 186/9 blue [2] 84/4 84/16 blunt [3] 28/4 123/6 123/14 bluntly [5] 21/9 22/24 39/23 48/4 61/2 BMA [6] 72/1 72/11 72/12 102/4 105/20 105/23 board [28] 4/4 87/6 135/1 135/2 135/4 140/3 140/12 149/8 150/17 152/13 162/13 171/5 171/7 171/12 171/14 171/19 174/11 179/6 182/2 182/12 183/10 184/12 189/12 190/24 198/22 204/23 211/13 213/6 boards [32] 4/23 191/1 191/5 191/18 191/20 192/20 194/2 194/11 194/15 195/17 198/11 198/18 198/20 198/24 202/1 203/11 203/21 204/6 204/11 205/4 205/20 205/22 205/25 206/16 207/3 207/7 208/3 208/23 209/16 209/25 210/2 211/21 BOC [2] 167/12 167/19 bodies [16] 62/20 70/23 128/22 161/4 190/25 191/7 192/7 192/11 192/19 193/21 193/22 194/17 194/18	197/19 198/1 201/8 body [6] 5/15 19/13 130/25 194/7 200/22 207/18 bold [2] 205/4 209/20 both [23] 6/2 16/22 31/9 41/17 54/19 58/21 60/14 74/12 75/5 86/21 94/15 96/13 101/3 115/8 117/6 129/25 155/24 164/17 172/16 174/21 192/22 196/20 199/18 bottom [1] 35/19 bought [1] 25/13 bound [1] 143/19 bowling [1] 142/7 box [1] 197/23 brackets [1] 182/9 branch [4] 55/18 79/9 178/8 180/11 brand [1] 62/15 branded [1] 89/12 break [6] 52/13 54/6 109/7 159/23 160/2 160/4 breaking [5] 124/25 125/7 125/13 126/4 126/12 breaks [1] 147/14 Brexit [3] 29/6 30/3 31/1 bridge [1] 141/11 brief [3] 94/5 102/5 138/16 briefed [1] 2/11 briefly [10] 3/4 102/19 129/3 169/22 170/13 192/14 196/1 202/3 202/24 213/8 Brightling [1] 94/7 bring [5] 18/12 98/24 102/20 102/23 181/23 bringing [1] 61/13 British [6] 20/24 21/1 95/7 101/16 167/12 170/21 broad [6] 3/11 3/25 81/14 178/21 179/5 204/24 broaden [1] 79/5 broader [2] 176/3 211/8 broadly [2] 197/6 211/22 broke [1] 15/11 broken [1] 126/25 brought [9] 21/20 36/23 36/24 37/19 101/23 120/24 163/12 193/18 207/8 Bs [1] 105/12 budgets [1] 195/1 build [1] 89/19
----------	--	---	---	--

B	2/16 5/1 5/5 5/20 7/23 11/9 12/20 13/5 13/5 15/15 16/17 16/19 19/9 19/24 25/18 26/16 28/1 28/25 29/16 30/19 32/24 33/12 33/15 33/21 33/23 35/24 37/9 37/12 37/13 40/2 40/22 44/10 44/11 45/18 47/6 47/9 47/16 48/9 48/18 49/13 49/23 50/12 52/1 52/3 52/10 52/18 53/1 53/24 55/12 56/9 56/12 57/15 58/23 60/2 61/4 61/19 63/5 65/1 66/23 68/17 69/4 70/4 72/13 73/6 76/5 76/20 76/23 79/5 80/4 80/14 80/15 80/19 80/23 81/9 81/22 81/23 84/1 84/14 85/16 86/6 86/14 88/11 88/12 88/12 90/15 93/15 93/19 95/13 99/3 99/5 99/14 100/23 102/19 102/20 104/4 104/24 107/9 107/17 113/22 114/22 115/5 115/21 116/5 117/13 118/10 119/2 119/9 119/20 120/1 124/15 124/16 125/13 126/9 126/14 127/16 128/1 129/3 129/16 133/11 133/19 135/8 139/10 140/13 141/1 143/11 146/8 146/16 147/2 149/19 150/10 150/17 153/18 166/13 174/3 174/24 178/12 178/24 181/23 184/15 184/18 187/18 187/25 188/16 188/19 190/3 192/14 192/16 192/19 196/1 196/4 196/7 197/20 198/10 199/5 201/19 202/3 202/9 202/22 204/9 204/12 205/3 205/4 205/11 208/2 208/8 209/15 209/20 210/24 211/1 211/15 211/21 211/23 212/17 213/8 213/14 214/21	cannot [4] 21/7 26/16 105/8 174/9 capabilities [6] 81/9 81/16 81/23 82/21 93/4 93/5 capability [5] 81/12 82/3 84/9 85/2 85/8 capacity [51] 25/25 35/24 85/15 86/15 86/21 87/12 88/2 88/24 118/4 130/8 130/22 131/8 131/13 138/1 138/5 139/10 142/5 142/22 162/18 173/16 190/17 190/18 195/25 201/21 202/1 202/6 205/1 205/9 205/21 205/24 206/9 206/24 207/7 208/2 208/6 208/19 208/21 209/13 209/18 210/18 211/1 211/9 211/14 213/1 214/1 214/14 215/1 215/2 215/5 215/14 215/22 capture [2] 144/5 211/8 captures [1] 80/9 car [1] 147/14 cardiac [1] 156/24 Cardiff [1] 204/25 cardiology [1] 151/4 care [79] 1/13 1/19 2/21 3/13 6/25 9/13 13/13 14/6 14/25 31/24 32/20 33/2 33/2 33/10 37/1 44/18 47/19 59/18 59/20 60/11 65/5 72/17 73/21 74/13 87/10 89/20 98/3 104/19 110/8 110/18 112/16 118/1 129/12 137/17 138/12 138/13 138/14 138/25 139/5 141/13 149/21 149/22 151/22 151/24 152/11 153/9 153/20 154/10 155/11 155/19 155/23 157/2 159/19 168/15 181/5 192/22 193/16 202/11 204/20 204/25 205/21 206/17 207/5 207/17 208/6 208/18 210/18 211/1 211/10 211/25 212/1 212/5 212/10 212/13 212/18 212/22 214/8 215/14 215/23 cared [2] 184/8 212/16 careful [2] 34/9 140/17 carefully [3] 10/19 127/16 156/3	carers [1] 157/16 Carey [7] 1/3 21/15 54/8 101/19 109/25 123/22 131/15 Carey's [1] 44/3 caring [5] 111/21 113/4 163/25 184/9 185/1 carpark [1] 147/14 carried [3] 5/13 120/14 203/1 case [28] 22/9 23/23 23/25 24/1 24/4 39/6 39/6 39/7 39/9 39/11 39/17 53/18 59/4 71/23 72/12 74/4 85/21 97/15 106/23 108/12 114/7 122/23 124/9 124/20 128/20 202/21 204/2 212/3 cases [13] 24/4 36/15 39/3 39/18 69/2 70/20 75/8 110/24 111/11 124/9 124/13 179/8 202/7 catch [1] 144/12 catchall [1] 214/16 catching [1] 162/2 categorically [1] 17/19 categories [7] 38/24 110/11 110/20 111/15 111/23 211/19 213/8 categorised [1] 213/15 category [9] 100/16 100/17 111/1 111/4 111/24 194/3 200/12 200/12 200/16 Category 1 [2] 194/3 200/16 Category 2 [1] 200/12 cater [1] 42/8 caught [1] 145/9 cause [6] 32/10 157/4 178/9 180/11 180/17 180/20 caused [5] 20/12 20/18 27/22 51/12 117/8 causes [2] 41/17 88/10 caveated [2] 66/17 67/21 cell [14] 7/20 19/11 19/13 22/19 34/9 34/25 36/11 42/1 105/2 119/22 184/21 197/7 198/14 208/10 cells [1] 167/4 census [1] 97/13 cent [1] 42/12 central [7] 81/17 87/4	108/15 118/22 180/10 180/10 180/14 centralised [1] 125/9 centrally [3] 13/8 14/23 118/15 centre [9] 7/7 37/8 70/14 125/25 140/9 142/7 146/2 152/3 183/1 centres [4] 35/1 37/9 37/11 164/12 CEO [3] 2/21 3/19 177/5 certain [5] 29/17 42/11 76/22 107/1 107/6 certainly [19] 28/5 48/20 50/25 54/3 64/11 70/17 78/8 78/23 93/13 102/24 106/10 108/13 159/24 174/24 185/20 198/22 207/11 215/15 215/25 certainty [1] 102/15 cetera [5] 17/2 23/1 31/24 60/17 100/3 chain [8] 13/11 13/25 19/11 19/13 21/21 30/20 38/9 73/6 chains [3] 10/3 12/21 20/5 chair [6] 6/18 74/21 90/24 103/23 171/19 188/15 chaired [1] 171/19 chairing [1] 6/21 challenge [12] 26/2 37/25 45/20 60/6 60/12 98/14 124/24 124/25 140/4 158/7 158/9 158/11 challenged [3] 9/16 10/24 156/20 challenges [22] 9/13 11/5 17/1 20/9 26/17 32/22 60/15 61/16 98/1 116/25 119/3 120/25 132/10 132/25 137/18 144/21 144/25 145/18 150/18 150/19 165/4 179/9 challenging [4] 11/12 20/12 20/16 155/12 chance [1] 153/9 chances [1] 37/7 change [15] 46/23 47/7 47/12 50/11 50/14 50/20 50/22 53/17 60/13 114/16 115/10 121/1 161/23 196/21 201/3 changed [3] 14/10 207/3 209/21 changes [7] 51/23	
C	cabinet [3] 3/1 5/20 6/10 Cabinet Office [2] 3/1 5/20 calculation [2] 140/17 140/20 call [16] 33/12 33/22 34/14 34/19 34/21 34/21 35/1 37/8 37/9 37/11 46/8 61/23 63/17 134/17 148/8 154/25 called [6] 21/23 33/19 42/14 107/10 107/12 192/9 calling [3] 4/6 13/24 32/24 calls [22] 31/6 31/7 33/25 34/1 34/3 34/6 34/12 34/14 34/22 34/23 35/10 35/10 35/12 35/19 55/17 55/20 55/23 131/18 132/2 133/13 198/23 206/1 Cambridge [1] 83/21 came [13] 19/21 21/18 24/12 25/6 27/10 27/21 52/4 151/11 155/6 155/24 178/17 191/17 195/9 campaign [3] 139/15 141/16 164/11 can [178] 2/3 2/13	2/16 5/1 5/5 5/20 7/23 11/9 12/20 13/5 13/5 15/15 16/17 16/19 19/9 19/24 25/18 26/16 28/1 28/25 29/16 30/19 32/24 33/12 33/15 33/21 33/23 35/24 37/9 37/12 37/13 40/2 40/22 44/10 44/11 45/18 47/6 47/9 47/16 48/9 48/18 49/13 49/23 50/12 52/1 52/3 52/10 52/18 53/1 53/24 55/12 56/9 56/12 57/15 58/23 60/2 61/4 61/19 63/5 65/1 66/23 68/17 69/4 70/4 72/13 73/6 76/5 76/20 76/23 79/5 80/4 80/14 80/15 80/19 80/23 81/9 81/22 81/23 84/1 84/14 85/16 86/6 86/14 88/11 88/12 88/12 90/15 93/15 93/19 95/13 99/3 99/5 99/14 100/23 102/19 102/20 104/4 104/24 107/9 107/17 113/22 114/22 115/5 115/21 116/5 117/13 118/10 119/2 119/9 119/20 120/1 124/15 124/16 125/13 126/9 126/14 127/16 128/1 129/3 129/16 133/11 133/19 135/8 139/10 140/13 141/1 143/11 146/8 146/16 147/2 149/19 150/10 150/17 153/18 166/13 174/3 174/24 178/12 178/24 181/23 184/15 184/18 187/18 187/25 188/16 188/19 190/3 192/14 192/16 192/19 196/1 196/4 196/7 197/20 198/10 199/5 201/19 202/3 202/9 202/22 204/9 204/12 205/3 205/4 205/11 208/2 208/8 209/15 209/20 210/24 211/1 211/15 211/21 211/23 212/17 213/8 213/14 214/21 can't [16] 19/5 27/15 40/5 42/21 51/19 85/19 93/9 95/21 107/14 115/11 131/24 158/25 160/23 185/6 203/14 203/15 cancer [2] 193/4 193/5	cannot [4] 21/7 26/16 105/8 174/9 capabilities [6] 81/9 81/16 81/23 82/21 93/4 93/5 capability [5] 81/12 82/3 84/9 85/2 85/8 capacity [51] 25/25 35/24 85/15 86/15 86/21 87/12 88/2 88/24 118/4 130/8 130/22 131/8 131/13 138/1 138/5 139/10 142/5 142/22 162/18 173/16 190/17 190/18 195/25 201/21 202/1 202/6 205/1 205/9 205/21 205/24 206/9 206/24 207/7 208/2 208/6 208/19 208/21 209/13 209/18 210/18 211/1 211/9 211/14 213/1 214/1 214/14 215/1 215/2 215/5 215/14 215/22 capture [2] 144/5 211/8 captures [1] 80/9 car [1] 147/14 cardiac [1] 156/24 Cardiff [1] 204/25 cardiology [1] 151/4 care [79] 1/13 1/19 2/21 3/13 6/25 9/13 13/13 14/6 14/25 31/24 32/20 33/2 33/2 33/10 37/1 44/18 47/19 59/18 59/20 60/11 65/5 72/17 73/21 74/13 87/10 89/20 98/3 104/19 110/8 110/18 112/16 118/1 129/12 137/17 138/12 138/13 138/14 138/25 139/5 141/13 149/21 149/22 151/22 151/24 152/11 153/9 153/20 154/10 155/11 155/19 155/23 157/2 159/19 168/15 181/5 192/22 193/16 202/11 204/20 204/25 205/21 206/17 207/5 207/17 208/6 208/18 210/18 211/1 211/10 211/25 212/1 212/5 212/10 212/13 212/18 212/22 214/8 215/14 215/23 cared [2] 184/8 212/16 careful [2] 34/9 140/17 carefully [3] 10/19 127/16 156/3	carers [1] 157/16 Carey [7] 1/3 21/15 54/8 101/19 109/25 123/22 131/15 Carey's [1] 44/3 caring [5] 111/21 113/4 163/25 184/9 185/1 carpark [1] 147/14 carried [3] 5/13 120/14 203/1 case [28] 22/9 23/23 23/25 24/1 24/4 39/6 39/6 39/7 39/9 39/11 39/17 53/18 59/4 71/23 72/12 74/4 85/21 97/15 106/23 108/12 114/7 122/23 124/9 124/20 128/20 202/21 204/2 212/3 cases [13] 24/4 36/15 39/3 39/18 69/2 70/20 75/8 110/24 111/11 124/9 124/13 179/8 202/7 catch [1] 144/12 catchall [1] 214/16 catching [1] 162/2 categorically [1] 17/19 categories [7] 38/24 110/11 110/20 111/15 111/23 211/19 213/8 categorised [1] 213/15 category [9] 100/16 100/17 111/1 111/4 111/24 194/3 200/12 200/12 200/16 Category 1 [2] 194/3 200/16 Category 2 [1] 200/12 cater [1] 42/8 caught [1] 145/9 cause [6] 32/10 157/4 178/9 180/11 180/17 180/20 caused [5] 20/12 20/18 27/22 51/12 117/8 causes [2] 41/17 88/10 caveated [2] 66/17 67/21 cell [14] 7/20 19/11 19/13 22/19 34/9 34/25 36/11 42/1 105/2 119/22 184/21 197/7 198/14 208/10 cells [1] 167/4 census [1] 97/13 cent [1] 42/12 central [7] 81/17 87/4	108/15 118/22 180/10 180/10 180/14 centralised [1] 125/9 centrally [3] 13/8 14/23 118/15 centre [9] 7/7 37/8 70/14 125/25 140/9 142/7 146/2 152/3 183/1 centres [4] 35/1 37/9 37/11 164/12 CEO [3] 2/21 3/19 177/5 certain [5] 29/17 42/11 76/22 107/1 107/6 certainly [19] 28/5 48/20 50/25 54/3 64/11 70/17 78/8 78/23 93/13 102/24 106/10 108/13 159/24 174/24 185/20 198/22 207/11 215/15 215/25 certainty [1] 102/15 cetera [5] 17/2 23/1 31/24 60/17 100/3 chain [8] 13/11 13/25 19/11 19/13 21/21 30/20 38/9 73/6 chains [3] 10/3 12/21 20/5 chair [6] 6/18 74/21 90/24 103/23 171/19 188/15 chaired [1] 171/19 chairing [1] 6/21 challenge [12] 26/2 37/25 45/20 60/6 60/12 98/14 124/24 124/25 140/4 158/7 158/9 158/11 challenged [3] 9/16 10/24 156/20 challenges [22] 9/13 11/5 17/1 20/9 26/17 32/22 60/15 61/16 98/1 116/25 119/3 120/25 132/10 132/25 137/18 144/21 144/25 145/18 150/18 150/19 165/4 179/9 challenging [4] 11/12 20/12 20/16 155/12 chance [1] 153/9 chances [1] 37/7 change [15] 46/23 47/7 47/12 50/11 50/14 50/20 50/22 53/17 60/13 114/16 115/10 121/1 161/23 196/21 201/3 changed [3] 14/10 207/3 209/21 changes [7] 51/23

<p>C</p> <p>changes... [6] 53/21 76/10 81/4 120/2 120/13 164/24</p> <p>changing [3] 148/5 160/25 207/24</p> <p>Chappell [1] 113/18</p> <p>characterise [1] 192/3</p> <p>characteristics [4] 42/16 50/18 119/13 158/3</p> <p>charities [1] 83/1</p> <p>chart [1] 35/8</p> <p>charts [2] 36/4 36/7</p> <p>cheaper [1] 25/14</p> <p>check [20] 2/8 42/9 42/11 48/5 48/7 76/14 76/20 76/21 89/12 106/20 107/1 107/5 112/10 112/21 112/24 113/1 118/23 174/24 188/20 212/6</p> <p>checked [1] 57/2</p> <p>checking [1] 149/14</p> <p>checks [1] 16/21</p> <p>chief [42] 27/21 43/3 68/13 100/20 108/13 108/19 135/2 135/6 139/21 140/19 150/16 157/23 157/24 168/19 182/1 189/11 192/1 192/6 193/21 193/22 194/16 194/24 195/3 195/6 195/8 197/15 198/6 198/6 198/16 198/17 198/19 198/21 198/23 199/3 201/25 202/4 202/23 203/9 206/1 206/11 206/22 209/4</p> <p>chief exec [1] 150/16</p> <p>chief executive [15] 68/13 135/2 135/6 182/1 189/11 192/1 192/6 193/21 194/16 195/3 195/6 195/8 198/19 206/1 206/11</p> <p>chief executives [4] 194/24 198/21 199/3 206/22</p> <p>child [1] 168/16</p> <p>children [1] 95/14</p> <p>China [2] 14/14 21/2</p> <p>choice [8] 25/17 25/21 26/1 26/6 52/3 61/4 87/19 87/21</p> <p>choices [2] 62/24 87/25</p> <p>choose [1] 10/18</p> <p>chooses [1] 25/23</p> <p>chosen [1] 140/5</p> <p>Chris [6] 1/6 66/6</p>	<p>93/10 107/11 107/12 109/3</p> <p>Chris Whitty [1] 93/10</p> <p>Christopher [47] 1/5 1/8 1/10 1/21 8/9 10/9 16/2 21/17 24/11 27/5 34/2 43/24 51/15 53/1 54/9 59/12 62/5 67/9 73/1 76/9 80/24 90/12 92/20 93/21 94/3 96/24 97/5 100/18 101/7 101/15 103/10 107/7 107/10 109/19 111/19 112/4 113/12 117/9 122/6 122/13 123/21 128/13 130/15 131/5 133/5 133/23 217/3</p> <p>chronic [2] 95/13 174/22</p> <p>circular [3] 202/13 202/25 203/23</p> <p>circumstance [3] 31/12 111/25 186/3</p> <p>circumstances [9] 16/11 60/4 71/15 104/18 104/20 130/17 132/24 184/23 185/6</p> <p>cited [1] 147/12</p> <p>civil [7] 5/9 67/18 88/18 189/1 190/10 194/3 200/11</p> <p>clarification [1] 176/20</p> <p>clarify [2] 176/24 190/3</p> <p>clarifying [2] 177/19 215/13</p> <p>clarity [1] 200/4</p> <p>cleaning [2] 141/15 165/11</p> <p>clear [39] 6/22 12/24 27/22 32/24 38/18 45/5 47/3 47/9 47/17 47/18 48/4 54/12 55/5 58/13 62/9 66/13 68/7 68/21 73/18 74/11 74/14 75/2 88/9 88/13 105/5 105/12 121/17 121/20 127/4 127/5 158/1 165/19 168/11 196/14 197/8 199/18 200/7 215/17 215/18</p> <p>clearance [1] 22/5</p> <p>clearest [1] 47/7</p> <p>clearly [28] 2/2 4/1 6/7 6/8 6/13 14/11 22/3 24/16 24/25 26/21 27/8 27/13 28/14 28/19 34/3 35/15 43/21 46/25 78/23 88/2 88/19 89/1 90/24 92/7 114/7</p>	<p>115/24 144/9 158/18</p> <p>clergy [1] 154/5</p> <p>client's [1] 109/21</p> <p>clients [1] 115/14</p> <p>climate [1] 56/12</p> <p>clinical [33] 4/17 5/11 18/19 53/4 53/5 62/23 68/6 68/9 69/13 70/15 77/13 94/13 95/6 105/23 106/1 106/3 106/7 106/22 107/1 107/3 107/19 108/8 108/20 108/20 109/21 109/23 127/3 142/7 156/12 157/7 205/13 206/19 212/7</p> <p>clinically [5] 57/17 105/21 106/5 108/10 207/10</p> <p>clinician [1] 37/4</p> <p>clinicians [28] 68/5 68/9 93/12 95/17 105/9 105/10 105/17 106/13 107/18 107/20 107/23 107/25 108/22 123/9 126/6 126/7 126/14 127/4 152/4 154/20 154/24 155/20 155/25 157/9 204/23 206/17 207/19 215/11</p> <p>close [9] 20/17 20/20 21/17 22/21 74/8 147/5 182/14 183/18 187/14</p> <p>closely [2] 89/11 160/20</p> <p>closer [2] 152/5 210/5</p> <p>CMO [2] 117/11 177/4</p> <p>CMOs [1] 64/14</p> <p>CNO [1] 177/4</p> <p>co [4] 44/16 89/12 196/10 200/19</p> <p>co-branded [1] 89/12</p> <p>co-ordinating [1] 200/19</p> <p>co-ordination [1] 196/10</p> <p>COBR [2] 6/18 6/21</p> <p>Code [2] 67/17 67/18</p> <p>coded [1] 175/9</p> <p>coding [1] 175/24</p> <p>coffee [1] 147/15</p> <p>cold [1] 136/10</p> <p>collaborate [1] 50/5</p> <p>collate [1] 91/17</p> <p>collation [1] 99/10</p> <p>colleague [3] 80/1 99/3 103/18</p> <p>colleagues [19] 1/25 9/18 11/18 56/16 82/1 85/9 86/9 86/20 92/17 92/19 94/20 112/20</p>	<p>134/7 137/20 159/2 184/20 187/15 206/21 212/7</p> <p>collect [2] 124/25 176/4</p> <p>collected [4] 174/14 174/17 175/7 211/20</p> <p>collecting [2] 174/24 175/22</p> <p>collection [1] 163/18</p> <p>collective [1] 192/12</p> <p>College [2] 182/3 186/8</p> <p>colorectal [1] 151/4</p> <p>colossal [4] 58/15 84/7 131/1 131/2</p> <p>column [1] 22/7</p> <p>column D [1] 22/7</p> <p>combined [1] 171/4</p> <p>come [36] 16/25 21/7 22/10 32/19 38/12 40/12 43/11 44/9 48/6 48/8 48/9 49/25 63/5 63/15 64/21 79/15 79/16 82/14 109/4 119/20 119/25 120/1 120/1 120/7 131/10 131/24 133/6 149/19 150/14 166/3 188/13 191/23 195/2 209/5 213/25 216/1</p> <p>comes [3] 80/21 84/16 103/19</p> <p>coming [10] 17/7 18/15 22/7 26/5 31/5 44/13 58/2 64/3 157/12 205/22</p> <p>command [6] 140/9 146/2 154/9 183/1 194/8 200/23</p> <p>commend [2] 8/24 9/14</p> <p>commended [1] 82/15</p> <p>commending [1] 93/12</p> <p>comment [4] 88/1 95/21 124/16 131/24</p> <p>comments [1] 134/13</p> <p>commission [2] 65/21 69/8</p> <p>commissioned [4] 44/16 128/19 144/7 149/6</p> <p>commissioning [6] 4/17 55/14 64/22 77/14 128/14 128/23</p> <p>committed [2] 40/14 52/21</p> <p>Committee [1] 58/11</p> <p>committees [1] 4/23</p> <p>common [1] 130/16</p> <p>communicate [4]</p>	<p>76/4 150/11 185/22 185/24</p> <p>communicated [4] 75/22 149/1 178/6 208/3</p> <p>communicating [1] 56/14</p> <p>communication [14] 47/21 56/11 146/1 146/6 147/8 150/9 150/15 157/16 161/20 163/1 180/21 180/24 182/23 185/16</p> <p>communications [5] 78/8 78/25 79/19 191/6 191/17</p> <p>Communities [1] 56/17</p> <p>community [10] 71/9 72/3 74/14 74/17 74/20 74/24 129/13 131/3 164/25 165/2</p> <p>companies [1] 82/25</p> <p>company [3] 13/23 13/24 167/12</p> <p>comparable [1] 98/7</p> <p>compare [1] 87/11</p> <p>compared [4] 8/19 16/18 31/19 148/3</p> <p>Comparing [1] 153/8</p> <p>comparison [1] 153/19</p> <p>compassionate [1] 149/10</p> <p>compensatory [1] 33/8</p> <p>competence [1] 37/3</p> <p>compile [2] 97/12 98/7</p> <p>compiles [1] 97/14</p> <p>complacent [2] 178/24 179/20</p> <p>complaint [2] 177/1 177/12</p> <p>complaints [2] 156/6 156/9</p> <p>complete [5] 66/16 67/24 162/21 171/8 173/18</p> <p>completed [4] 41/9 50/25 164/5 214/9</p> <p>completely [9] 15/20 18/7 18/22 18/23 51/21 80/2 81/17 131/19 174/9</p> <p>completeness [1] 190/1</p> <p>completes [2] 133/23 187/2</p> <p>completion [1] 114/13</p> <p>compliance [3] 170/15 203/7 203/12</p> <p>compliant [2] 203/4</p>
---	---	---	---	---

C				
<p>compliant... [1] 203/5</p> <p>complicated [3] 51/23 51/24 51/25</p> <p>comply [4] 191/2 191/20 203/22 204/5</p> <p>components [1] 83/19</p> <p>comprise [2] 139/8 192/19</p> <p>compulsory [1] 170/11</p> <p>concentrate [1] 22/13</p> <p>concentrating [1] 92/7</p> <p>concern [20] 7/10 20/13 20/19 31/9 32/15 46/14 59/8 62/13 68/2 77/21 94/11 95/8 125/11 125/23 128/9 157/3 161/9 169/18 182/6 184/5</p> <p>concerned [11] 29/22 49/19 58/20 60/9 63/16 68/14 79/10 108/11 128/22 136/11 174/1</p> <p>concerning [3] 161/7 177/5 184/25</p> <p>concerns [26] 42/5 43/9 44/25 45/9 45/12 47/14 48/14 48/18 58/19 61/1 62/2 64/3 64/4 68/4 69/6 74/5 127/20 177/1 177/22 178/2 182/2 182/15 186/9 186/15 186/20 186/23</p> <p>concession [1] 46/8</p> <p>concise [1] 122/14</p> <p>concluded [1] 69/2</p> <p>conclusions [1] 99/16</p> <p>condition [4] 96/10 169/24 170/10 170/12</p> <p>conditioning [1] 135/24</p> <p>conditions [3] 96/20 160/18 174/21</p> <p>conduct [1] 64/23</p> <p>conducted [1] 49/12</p> <p>conference [1] 6/12</p> <p>conferences [2] 6/21 79/20</p> <p>confidence [3] 22/6 44/24 215/6</p> <p>confident [2] 38/21 59/12</p> <p>confirm [2] 86/8 195/20</p> <p>confirmed [2] 22/6</p>	<p>204/23</p> <p>confusing [1] 161/24</p> <p>confusion [1] 168/22</p> <p>connected [2] 160/21 162/4</p> <p>conscious [2] 111/10 111/19</p> <p>consent [4] 62/12 62/24 63/2 177/24</p> <p>consents [1] 128/4</p> <p>consequence [1] 202/17</p> <p>consequences [3] 51/9 87/21 104/15</p> <p>consider [14] 11/23 24/11 26/8 26/25 87/15 152/16 153/15 153/16 154/2 154/3 154/6 166/18 167/7 180/12</p> <p>considerable [11] 9/12 19/17 39/21 41/17 42/2 55/16 82/24 93/17 103/19 121/9 181/18</p> <p>consideration [2] 50/1 56/20</p> <p>considerations [2] 51/24 51/25</p> <p>considered [11] 73/14 87/3 90/9 143/25 153/18 154/19 155/13 156/3 167/2 167/5 213/14</p> <p>considering [7] 127/15 127/17 153/4 153/20 155/6 172/13 199/14</p> <p>considers [1] 103/1</p> <p>consistency [1] 195/23</p> <p>consistent [3] 126/10 126/11 169/12</p> <p>constant [4] 54/25 163/1 169/16 179/21</p> <p>constituted [2] 103/3 193/24</p> <p>constraints [1] 59/22</p> <p>constructed [1] 42/10</p> <p>consult [3] 44/17 55/1 155/2</p> <p>consultant [3] 152/19 152/19 156/3</p> <p>consultants [1] 156/24</p> <p>consultation [4] 42/24 45/22 74/9 76/6</p> <p>consulting [2] 45/24 55/1</p> <p>contact [2] 130/11 169/19</p> <p>contacted [1] 167/12</p> <p>contacting [1] 161/8</p>	<p>content [1] 108/24</p> <p>context [9] 102/5 110/21 131/1 152/2 153/22 184/11 184/12 201/2 215/23</p> <p>Contingencies [2] 194/3 200/12</p> <p>continually [2] 60/6 69/15</p> <p>continuation [1] 193/12</p> <p>continue [5] 56/24 56/25 60/14 134/10 175/20</p> <p>continued [1] 82/12</p> <p>continues [5] 70/21 95/12 125/9 128/5 149/10</p> <p>continuing [2] 84/12 149/24</p> <p>continuity [1] 21/25</p> <p>continuous [2] 60/19 157/14</p> <p>contract [1] 77/9</p> <p>contracted [1] 71/5</p> <p>contracting [1] 77/20</p> <p>contracts [5] 17/15 18/9 20/23 20/24 21/11</p> <p>contractual [1] 175/18</p> <p>contributed [2] 26/10 27/2</p> <p>contributing [2] 113/20 164/23</p> <p>contributor [1] 56/18</p> <p>control [7] 18/13 108/12 130/7 160/10 169/20 194/8 200/23</p> <p>controls [1] 100/3</p> <p>controversial [1] 66/13</p> <p>convenient [3] 52/13 54/2 159/23</p> <p>conversation [3] 66/11 169/16 187/15</p> <p>conversations [1] 150/12</p> <p>COO [1] 66/3</p> <p>cope [1] 130/22</p> <p>copied [1] 204/16</p> <p>core [4] 93/22 105/16 135/16 156/12</p> <p>corollary [1] 90/2</p> <p>Coronavirus [1] 84/6</p> <p>correct [40] 1/14 1/15 4/7 13/9 15/6 15/10 22/1 27/16 41/22 116/20 128/8 135/5 137/7 139/2 166/2 189/3 189/4 189/10 189/19 190/1 190/9 190/13 190/20 191/3 191/4 191/21</p>	<p>191/22 191/24 192/2 192/23 193/7 193/13 193/14 194/6 194/13 202/19 202/20 211/6 214/16 214/24</p> <p>correctly [2] 58/19 67/20</p> <p>correlate [1] 186/11</p> <p>correspondence [2] 122/21 203/16</p> <p>corridor [1] 213/3</p> <p>cost [3] 24/13 25/6 39/21</p> <p>could [70] 1/15 3/22 6/24 7/14 8/12 12/14 23/5 28/9 31/20 33/17 36/17 38/15 39/14 43/24 44/3 47/19 52/11 58/5 58/13 60/8 61/15 65/2 65/19 67/16 67/22 70/18 75/5 75/21 76/8 77/11 85/2 85/3 85/24 86/1 86/7 90/21 92/20 97/17 101/11 102/23 111/24 112/6 113/1 114/2 119/14 122/20 124/22 125/12 132/23 139/12 139/23 141/3 147/9 151/10 152/25 154/6 154/8 160/17 161/17 174/1 183/19 186/19 186/20 195/7 201/11 205/1 205/15 207/24 214/14 216/2</p> <p>couldn't [9] 26/21 28/10 47/2 78/24 79/11 97/14 133/7 150/25 182/20</p> <p>Council [2] 83/3 161/6</p> <p>counsel [12] 1/9 110/5 123/22 129/7 130/2 131/15 134/19 176/17 188/10 217/5 217/17 217/24</p> <p>counterfactual [1] 27/15</p> <p>counterpart [1] 49/20</p> <p>counterparts [1] 50/9</p> <p>countries [5] 8/19 14/19 14/23 18/5 205/14</p> <p>country [4] 20/10 20/14 21/12 115/1</p> <p>couple [5] 5/23 139/9 156/17 206/12 208/25</p> <p>course [63] 2/6 5/23 7/8 7/10 8/3 13/16 14/12 14/14 16/23 23/24 25/12 27/16 30/6 33/6 35/13 39/16</p>	<p>39/18 42/25 45/22 45/23 50/9 51/10 54/20 54/22 56/20 58/4 59/19 68/20 69/7 69/25 77/15 85/18 88/5 96/15 96/18 101/2 108/2 122/12 128/7 128/13 132/9 142/17 148/15 159/17 160/23 161/2 161/21 167/20 168/18 168/20 172/4 184/18 184/19 186/16 187/21 195/16 199/3 199/19 201/17 210/2 210/13 213/5 214/6</p> <p>cover [6] 54/10 99/13 99/19 101/17 117/14 160/8</p> <p>covered [8] 17/17 72/8 72/25 81/6 103/18 117/3 120/11 129/12</p> <p>covering [1] 124/17</p> <p>covers [2] 121/9 189/21</p> <p>Covid [98] 1/17 8/19 8/20 31/2 33/19 39/8 39/8 43/1 43/2 43/5 43/9 43/20 44/17 45/19 45/21 45/22 71/5 74/7 82/6 85/20 91/12 91/19 91/21 92/1 92/2 94/4 94/6 94/8 94/10 94/11 94/15 94/16 94/16 94/23 94/25 95/7 95/10 95/11 95/19 95/20 96/3 96/7 96/21 100/5 102/15 103/4 104/20 122/8 136/1 136/2 136/12 137/22 141/24 142/3 144/12 144/17 145/8 149/21 167/1 168/4 170/17 171/21 171/22 172/1 173/9 173/11 173/13 173/19 173/20 173/24 174/3 174/21 175/5 175/6 175/10 175/11 175/18 175/21 175/25 176/14 177/23 179/9 181/15 189/18 198/14 201/7 202/2 202/7 202/16 207/4 207/7 208/17 208/22 211/13 213/10 213/11 213/23 214/4</p> <p>Covid-19 [17] 33/19 44/17 103/4 104/20 122/8 145/8 181/15 189/18 198/14 202/2 202/7 202/16 208/17 208/22 213/10 213/11</p>

C	100/25 174/25 188/24 201/5 customer [2] 42/14 119/11 Cymru [1] 181/16	days' [2] 32/1 32/2 Dda [3] 135/1 182/1 182/12 deadline [1] 209/23 deal [17] 3/4 25/20 25/20 29/6 30/3 36/14 37/3 44/12 61/1 66/11 66/19 70/15 70/19 103/7 116/9 120/14 126/2 dealing [4] 48/24 71/14 104/19 169/22 deals [1] 179/24 dealt [5] 35/3 35/7 35/15 47/12 71/23 dear [1] 80/1 death [1] 90/19 deaths [4] 90/17 91/2 91/6 91/17 debate [3] 7/10 60/22 61/7 debated [1] 79/21 December [3] 149/7 162/15 165/14 decide [2] 6/24 63/18 decided [2] 72/15 72/20 decision [30] 14/17 28/12 51/2 51/3 55/5 55/7 55/8 57/4 72/25 77/13 79/24 87/14 103/11 103/21 103/23 104/3 106/4 123/16 134/5 151/22 152/18 154/21 162/25 163/13 163/22 164/15 169/12 190/22 197/10 210/13 decision-maker [1] 79/24 decision-making [4] 151/22 169/12 190/22 210/13 decisions [24] 6/22 6/23 9/19 73/15 96/16 96/22 98/13 98/25 106/9 117/20 118/16 119/18 134/2 152/7 153/20 153/21 155/11 156/1 157/19 158/7 159/3 168/9 169/21 178/19 decisive [2] 30/10 30/18 decreases [1] 77/2 dedicated [1] 28/16 deemed [1] 102/2 defend [1] 29/16 deficit [2] 208/17 208/20 define [2] 110/2 110/14 defined [4] 110/6 110/7 111/14 111/23 definitely [6] 59/24	128/2 146/5 148/19 166/7 207/25 definition [3] 51/6 107/4 111/1 degree [2] 22/6 195/18 delay [1] 73/13 delays [1] 181/20 delegate [1] 194/21 delegated [3] 128/14 128/18 128/18 delegation [1] 198/21 deliberately [2] 95/25 125/6 deliver [5] 17/14 32/18 89/23 129/15 162/24 delivered [2] 11/6 19/1 delivering [4] 7/17 32/7 189/1 202/11 delivery [6] 32/12 54/14 128/23 192/25 195/17 195/24 delving [1] 183/3 demand [7] 21/22 23/11 23/18 36/1 130/18 130/23 166/11 demand-manage [1] 23/11 demands [1] 133/25 dementia [1] 168/21 demonstrates [1] 99/21 demoralising [1] 75/1 demotivating [1] 75/1 department [121] 1/13 1/23 2/8 2/24 2/25 3/5 3/18 4/3 4/20 4/22 5/7 5/8 5/14 5/17 5/18 5/22 6/1 6/24 7/2 7/3 7/5 7/7 7/14 7/16 7/25 8/8 8/10 8/16 8/21 10/13 10/14 11/23 12/15 15/7 16/3 19/12 28/23 42/14 44/16 45/11 46/13 48/13 48/19 48/21 48/24 49/2 49/6 49/12 54/15 55/4 55/14 55/21 56/1 56/5 57/19 58/5 59/10 62/1 62/5 63/9 63/11 63/15 63/19 63/22 64/7 64/9 64/22 69/5 69/21 70/5 71/1 76/9 77/6 77/11 77/15 77/23 78/2 78/7 79/6 79/14 79/22 80/25 81/2 81/16 82/18 82/19 83/4 87/1 87/3 89/6 89/8 89/11 90/16 91/5 91/25 92/4	92/8 97/19 99/9 100/8 100/15 101/4 103/1 110/2 118/5 118/12 127/22 128/17 128/24 128/25 129/1 129/8 129/17 129/20 130/20 130/21 131/7 131/12 134/2 134/7 190/10 department's [15] 1/16 2/21 2/23 3/12 19/15 26/8 27/1 49/13 54/12 55/7 89/16 99/20 100/2 129/4 129/6 departmental [1] 91/20 departments [3] 87/12 130/11 151/4 dependency [1] 212/13 depending [2] 38/4 205/1 depends [1] 24/14 deployed [3] 41/8 41/14 163/6 deployment [5] 99/10 169/24 170/10 170/12 193/11 deprivation [1] 95/14 depriving [1] 95/12 describe [6] 25/10 41/4 50/11 94/8 95/24 195/7 described [30] 23/11 46/17 46/24 59/22 74/18 75/12 77/10 77/10 77/16 78/6 88/23 98/4 98/8 100/14 106/23 108/20 110/1 110/4 117/10 118/8 119/5 126/4 128/4 129/6 132/11 150/1 161/2 164/19 178/10 178/17 describing [7] 80/11 88/4 100/12 101/6 118/25 184/24 185/17 description [2] 25/8 88/9 deserving [5] 71/17 110/20 110/24 111/11 111/14 design [1] 197/1 designated [6] 194/2 202/17 213/10 213/11 213/23 214/3 designed [5] 32/18 43/22 116/3 135/14 197/1 despite [2] 156/22 210/2 detail [11] 19/15 19/18 33/21 36/21 42/2 103/19 112/24
----------	---	--	--	--

D	145/3 145/17 145/21 148/25 150/4 151/6 151/17 152/1 153/19 155/1 156/8 156/22 158/9 158/15 163/23 164/12 164/23 165/4 165/18 166/12 167/14 168/7 170/2 171/11 172/2 173/13 174/2 179/13 180/8 180/9 180/11 180/22 182/11 187/6 187/20 191/14 194/16 194/17 194/23 196/9 204/3 204/6 206/20 213/16 214/16	difficulties [5] 14/21 40/17 57/3 117/17 151/9 difficulty [5] 20/7 20/8 150/23 163/20 185/4 digital [3] 80/13 193/16 193/18 digitally [1] 80/13 dilemma [1] 110/22 diminish [2] 47/10 186/22 direct [5] 2/3 2/12 49/16 158/19 194/17 directed [1] 141/17 directing [1] 194/21 direction [3] 3/14 162/8 191/2 directions [3] 190/25 191/10 191/11 directly [9] 2/10 5/9 44/17 55/14 112/17 118/5 121/19 203/15 206/16 director [11] 3/1 134/25 160/20 165/8 169/15 189/6 189/25 190/8 191/24 191/25 192/4 Director General [7] 3/1 189/6 189/25 190/8 191/24 191/25 192/4 Directors [7] 197/21 197/21 197/25 198/5 206/7 206/21 209/4 disabilities [10] 98/18 98/24 156/19 157/8 158/2 168/21 177/24 178/25 180/4 181/3 disability [4] 97/12 97/21 99/10 100/4 disability-related [1] 99/10 disabled [4] 99/23 99/23 100/6 100/9 disadvantage [1] 114/10 disagree [3] 19/5 67/22 75/22 discharge [4] 137/8 137/9 194/19 201/13 discontinued [1] 179/8 discover [1] 158/15 discoverables [1] 83/10 discovered [1] 6/5 discovery [2] 83/8 186/19 discrete [2] 54/10 55/6 discretion [6] 4/22	72/22 73/9 111/13 169/1 169/13 discretionary [9] 73/3 74/18 75/9 110/9 110/19 111/8 111/24 112/2 168/9 discuss [1] 105/20 discussed [14] 20/9 42/18 49/20 55/25 56/1 64/4 77/11 85/10 90/25 106/12 129/23 130/24 153/3 158/21 discusses [1] 131/12 discussing [8] 50/8 55/3 90/24 101/18 105/14 110/5 114/6 115/7 discussion [6] 54/25 73/22 79/23 99/2 152/21 181/4 discussions [9] 64/8 105/24 119/16 120/3 131/6 140/6 157/17 170/22 207/11 disease [11] 8/6 28/3 30/5 30/13 60/8 81/10 81/21 92/6 103/7 103/16 202/17 diseases [1] 85/23 dismiss [1] 186/14 disparities [2] 99/22 100/9 disparity [1] 113/23 disposal [1] 109/8 disposing [1] 39/22 disproportionately [1] 117/1 disrupted [2] 14/14 14/15 disrupted -- well [1] 14/14 disruption [2] 33/20 36/1 distance [1] 148/11 distancing [1] 74/10 distress [4] 27/22 29/14 29/18 117/7 distressing [1] 156/17 distributing [1] 14/24 distribution [2] 20/13 30/22 diverse [2] 40/24 42/8 diversified [1] 118/23 diversifying [1] 40/10 diversity [2] 41/2 83/16 diverted [1] 163/17 DNACPR [20] 69/3 123/17 127/20 156/7 156/11 156/19 157/1 157/19 159/16 159/18	159/20 176/19 176/23 177/3 177/22 178/15 178/15 179/15 180/1 181/3 DNACPRs [13] 61/19 61/23 63/11 64/18 65/8 65/22 68/24 69/3 70/7 123/24 127/9 127/18 156/5 DNRCPR [1] 61/22 DNRs [3] 61/23 62/22 66/2 do [153] 1/15 2/3 7/14 8/16 10/18 11/11 11/23 12/17 12/19 14/18 15/1 15/4 16/12 16/15 16/19 18/10 23/7 23/8 23/13 23/14 23/15 23/20 24/10 26/8 26/25 27/9 28/6 29/8 31/17 33/8 33/12 34/16 36/9 37/5 37/13 38/7 38/12 42/20 42/24 45/11 47/2 49/14 50/12 51/5 51/15 52/1 52/3 52/4 52/9 53/25 54/1 56/20 56/24 58/17 60/21 61/23 62/10 62/21 63/16 66/20 68/18 71/8 72/16 72/19 77/23 78/14 78/18 80/5 80/14 81/17 82/10 83/10 83/12 84/24 85/3 85/4 86/6 86/7 87/15 89/4 89/21 90/1 91/9 91/14 91/15 92/2 92/16 94/15 94/19 95/17 97/18 100/8 100/17 100/24 103/24 107/22 107/25 112/25 114/22 115/8 115/9 115/9 115/19 118/24 119/10 120/4 123/1 123/16 124/10 124/19 125/5 125/15 125/23 125/23 128/9 128/15 129/4 129/8 129/24 131/19 132/1 133/25 140/16 141/6 148/2 154/7 158/7 158/11 158/16 159/5 161/21 170/5 173/23 174/17 176/2 176/6 178/22 178/25 179/7 181/12 183/12 183/13 184/15 185/10 188/22 199/8 199/21 200/25 201/6 203/8 207/6 207/22 210/7 doctor [22] 136/25 145/5 146/4 156/18 158/15 160/2 160/8 171/21 172/3 172/8
----------	--	---	---	---

D	108/23 109/6 109/10 111/25 127/23 131/22 131/22 135/23 140/15 143/2 147/1 158/8 158/22 158/23 159/19 171/10 171/10 178/24 183/17 187/24 215/24	drop [3] 77/1 79/7 137/13 droplet [2] 102/12 162/6 drops [1] 32/5 drugs [1] 22/25 dual [2] 191/25 192/3 due [11] 8/3 58/3 69/25 70/22 101/2 149/23 157/18 162/15 173/18 175/6 184/4 duplication [1] 201/9 during [40] 1/17 14/10 42/22 45/22 53/3 53/14 54/10 54/13 54/24 58/18 62/1 97/9 97/19 117/22 120/23 124/21 126/5 130/9 132/6 136/8 138/15 141/24 150/8 152/17 156/7 157/22 172/5 179/8 187/6 187/20 189/18 190/15 190/22 191/7 193/10 193/15 196/19 201/7 208/1 210/10 during February [1] 196/19 during March [1] 208/1 duties [1] 118/1 duty [6] 54/19 55/3 112/16 129/15 134/11 168/10 DWP [1] 37/12 dynamic [1] 31/22	169/6 eased [2] 26/20 26/22 easier [3] 26/18 59/3 153/15 easiest [1] 3/22 east [3] 152/14 155/22 213/2 easy [1] 58/6 eating [1] 147/14 economic [1] 24/13 economically [1] 83/24 economics [1] 26/7 economy [2] 88/4 124/17 ecosystem [2] 83/18 83/23 education [7] 2/25 156/12 157/9 179/1 193/9 193/12 198/11 educational [1] 158/21 effect [1] 51/10 effective [5] 52/22 69/23 127/13 165/18 186/2 effectively [3] 185/24 190/10 192/10 effectiveness [1] 176/5 effects [2] 43/5 91/13 effort [4] 45/23 93/17 149/5 185/22 efforts [4] 101/1 112/5 112/8 151/15 eight [1] 16/2 eight months [1] 16/2 either [13] 21/8 32/9 37/12 56/6 60/24 78/16 105/19 110/11 125/6 156/2 174/14 185/12 202/21 elderly [1] 56/23 elective [8] 137/17 137/21 140/2 149/22 150/18 151/10 151/12 205/5 element [3] 110/19 111/8 112/3 elements [1] 144/9 else [5] 37/6 69/19 92/3 111/2 120/6 elsewhere [1] 7/16 email [14] 56/13 56/20 56/21 57/1 73/6 73/11 73/20 123/18 123/20 123/23 176/24 177/20 204/12 204/15 embedded [1] 141/21 emergencies [5] 6/3 6/3 13/21 45/8 90/3	emergency [9] 13/20 19/25 84/1 90/4 103/2 190/15 197/5 199/6 205/9 emerging [3] 197/13 203/17 209/5 emphasise [1] 62/21 emphasised [1] 53/13 employ [1] 89/4 employed [1] 112/17 employees [9] 71/25 72/20 110/6 110/8 110/15 110/16 111/6 112/17 112/18 employer [1] 118/1 enable [2] 40/25 125/10 enables [1] 194/8 enacted [1] 171/7 enacting [1] 200/11 encourage [5] 148/25 158/7 171/8 171/15 171/16 encouraged [1] 170/6 end [21] 31/4 31/6 39/21 59/11 69/9 83/11 101/8 122/11 122/17 122/18 122/24 123/1 156/11 162/21 164/5 164/6 164/10 168/15 173/12 186/12 189/19 ended [5] 12/12 39/20 39/24 56/11 154/17 ending [1] 97/7 endowments [1] 83/1 engaged [3] 141/8 170/19 200/1 engagement [9] 42/14 42/15 42/20 44/12 44/15 44/19 45/10 88/17 119/11 England [38] 4/5 4/17 5/2 5/8 19/11 27/19 54/13 54/15 54/25 56/1 56/6 56/6 63/18 64/5 64/12 66/3 69/19 76/13 76/15 76/18 76/22 77/9 77/14 78/5 85/3 91/7 91/16 94/20 117/24 118/3 118/24 128/15 128/19 128/22 129/11 130/24 161/6 161/13 enhanced [5] 141/15 151/19 165/11 191/13 201/17 enormous [5] 11/7 22/25 45/24 98/23 151/15
	done [44] 8/12 8/22 11/17 28/9 28/12 29/16 34/4 34/9 34/12 39/5 42/3 42/6 43/17 45/16 45/19 49/22 52/4 53/3 60/25 74/3 81/15 86/20 88/7 88/18 91/25 91/25 100/8 106/21 112/1 112/10 115/22 116/7 118/5 118/12 119/5 119/9 120/16 121/23 127/5 139/11 178/1 201/10 201/11 207/16 donning [1] 147/17 door [1] 10/12 doors [1] 136/12 Dorland [1] 1/11 double [2] 204/24 205/1 doubled [2] 214/25 215/2 doubling [1] 206/9 doubt [5] 24/17 30/13 133/20 166/15 184/24 down [16] 17/7 18/15 43/25 44/6 67/1 76/25 93/16 145/7 145/12 147/10 149/20 150/14 194/22 202/9 205/3 211/21 downplay [2] 183/17 183/21 Dr [17] 94/8 134/17 134/18 134/22 134/25 177/4 177/13 188/7 188/9 188/11 188/18 188/24 189/15 200/20 216/1 217/15 217/22 Dr Andrew Goodall [3] 188/7 188/9 217/22 Dr Atherton [2] 177/4 177/13 Dr Evans [1] 94/8 Dr Goodall [6] 188/11 188/18 188/24 189/15 200/20 216/1 Dr Kloer [1] 134/25 Dr Philip Kloer [3] 134/17 134/18 217/15 drafting [1] 106/3 draw [10] 71/20 72/19 75/7 76/1 91/10 99/16 110/23 172/11 178/19 198/7 drive [2] 50/2 50/9	each [8] 38/25 45/11 58/24 81/5 165/7 194/4 201/7 204/23 earlier [36] 57/10 57/14 85/13 88/4 90/25 93/9 99/12 100/14 101/19 103/22 105/22 106/23 114/6 114/24 117/14 117/18 119/5 128/4 130/2 148/1 148/3 148/21 149/8 154/13 155/21 165/20 166/16 167/22 170/7 172/24 178/10 178/22 179/23 182/16 182/22 185/17 early [25] 8/22 15/11 43/3 47/1 62/2 62/4 62/18 64/3 76/23 139/23 145/25 167/5 167/6 169/5 169/6 173/1 183/22 197/10 197/11 199/11 201/21 205/18 208/14 211/3 214/11 early March [1]	E each [8] 38/25 45/11 58/24 81/5 165/7 194/4 201/7 204/23 earlier [36] 57/10 57/14 85/13 88/4 90/25 93/9 99/12 100/14 101/19 103/22 105/22 106/23 114/6 114/24 117/14 117/18 119/5 128/4 130/2 148/1 148/3 148/21 149/8 154/13 155/21 165/20 166/16 167/22 170/7 172/24 178/10 178/22 179/23 182/16 182/22 185/17 early [25] 8/22 15/11 43/3 47/1 62/2 62/4 62/18 64/3 76/23 139/23 145/25 167/5 167/6 169/5 169/6 173/1 183/22 197/10 197/11 199/11 201/21 205/18 208/14 211/3 214/11 early March [1]	

E	equitable [2] 115/20 117/20	199/5	210/9 210/22 212/14 212/15 215/15	187/4 199/13 201/16
enormously [1] 154/6	equitably [1] 52/18	events [1] 13/16	examples [8] 44/22 47/6 64/10 139/9 139/11 176/23 195/20 195/22	experienced [1] 150/8
enough [16] 12/19 28/15 30/13 41/3 59/15 60/3 60/25 96/10 100/8 102/14 106/19 142/4 147/16 158/20 171/2 185/21	equity [1] 50/3	eventually [1] 167/19	ever [7] 51/9 60/18 63/11 63/24 152/5 154/17 158/15	experiences [6] 40/16 146/14 148/12 184/7 184/14 186/17
ensuing [1] 130/17	equivalent [1] 204/24	every [14] 7/6 12/16 21/12 68/8 100/13 115/1 152/17 152/24 157/12 160/24 186/3 206/12 208/16 208/25	executed [1] 138/5	expert [5] 4/23 37/4 102/13 104/2 108/10
ensure [19] 16/21 22/22 50/5 52/17 59/10 70/6 77/23 87/2 95/19 112/5 112/19 115/15 116/23 117/19 130/4 130/21 131/7 169/11 203/11	escalate [3] 36/11 38/7 185/5	everybody [3] 92/11 96/1 145/17	excellent [4] 9/4 10/20 39/19 149/12	expertise [6] 37/8 41/5 53/7 53/16 54/20 199/13
ensured [1] 58/5	escalation [8] 37/6 138/2 151/22 152/7 152/11 153/20 155/18 181/5	everyone [15] 1/17 13/14 14/16 48/23 56/21 62/13 68/14 70/18 85/25 99/17 115/15 124/11 125/21 128/1 187/17	exception [1] 204/4	experts [5] 86/10 94/7 95/17 108/19 165/10
ensuring [3] 2/19 52/21 115/20	especially [2] 118/17 187/18	everything [4] 19/24 72/12 77/15 93/16	exceptional [1] 201/18	explain [8] 13/4 57/15 61/2 101/1 181/17 190/14 190/21 196/6
enter [1] 16/5	essence [1] 31/5	evidence [47] 9/10 20/17 25/16 28/2 29/11 36/3 54/11 55/16 63/2 63/10 63/12 63/24 64/11 68/24 75/16 81/7 84/17 90/15 93/8 102/14 102/22 103/12 113/18 113/22 114/1 114/16 116/21 127/8 127/15 127/17 131/24 133/19 137/1 147/24 151/3 160/11 165/20 168/1 181/22 183/3 184/3 184/18 184/20 185/14 186/1 197/15 205/14	exchange [1] 135/23	explained [11] 20/6 41/4 41/6 47/25 100/16 100/23 100/25 158/22 162/12 162/19 201/23
entered [1] 11/24	essential [3] 90/10 103/6 140/2	estate [9] 87/4 135/9 135/19 147/23 160/14 161/2 161/19 172/13 202/6	exec [1] 150/16	explaining [1] 23/6
entire [4] 6/10 6/10 64/15 121/2	essentially [3] 153/7 153/11 215/21	establish [1] 176/4	executive [22] 68/13 135/2 135/6 163/12 164/17 165/8 169/14 182/1 189/11 192/1 192/6 193/21 194/16 195/3 195/6 195/8 198/19 198/22 198/23 206/1 206/7 206/11	explicit [1] 51/3
entirely [14] 15/12 15/23 16/1 31/10 32/18 46/25 47/5 47/15 58/23 60/9 82/19 101/5 106/5 130/16	established [7] 39/5 113/23 119/12 135/11 156/10 199/17 200/10	establishment [1] 197/6	executives [6] 193/22 194/24 198/21 199/3 206/22 209/4	explore [2] 102/1 183/10
entirety [1] 189/21	Estates [1] 203/2	estimated [2] 175/13 175/24	exercises [1] 88/18	exploring [1] 182/18
entity [2] 192/9 194/12	estimate [4] 174/6 174/10 174/12 174/13	et [5] 17/2 23/1 31/24 60/17 100/3	exhibit [1] 165/12	export [1] 18/6
environment [11] 124/6 142/7 147/10 147/12 148/19 211/25 212/1 212/5 212/16 212/19 212/22	ethic [1] 120/21	et cetera [1] 60/17	exist [1] 194/11	expressing [1] 206/18
environmental [2] 136/15 136/17	ethical [7] 153/3 154/12 154/16 155/7 155/16 155/17 166/17	ethic [1] 120/21	existed [5] 30/25 45/14 62/10 84/5 121/12	extend [1] 72/15
environments [1] 74/7	ethicists [1] 154/4	ethical [7] 153/3 154/12 154/16 155/7 155/16 155/17 166/17	existence [1] 201/7	extended [3] 57/6 72/16 111/6
envisaged [2] 142/18 197/1	ethics [10] 153/2 153/25 154/4 154/19 154/19 155/2 155/5 155/10 155/13 155/15	evidence [3] 26/12 91/14 184/19	existing [5] 52/17 62/22 94/11 116/10 196/24	extension [1] 175/17
epidemic [1] 208/14	ethnic [18] 40/19 42/16 43/5 46/22 50/6 109/22 113/14 114/19 116/22 116/24 117/11 117/20 118/18 119/4 119/14 119/16 120/8 121/20	evolving [4] 60/6 103/1 103/14 103/16	expands [1] 214/14	extensive [1] 167/14
epidemiologists [1] 165/9	ethnicity [3] 41/14 42/2 42/8	exact [6] 48/6 63/13 136/17 136/17 142/9 184/23	expanded [4] 41/24 138/1 140/12 140/14	extent [9] 26/5 36/12 48/22 65/18 96/18 112/17 113/2 161/9 208/5
Epipens [2] 23/4 23/12	Europe [1] 162/4	exactly [25] 4/11 13/18 16/9 23/7 23/12 31/8 34/10 42/9 48/7 78/6 84/20 97/14 100/18 101/3 101/6 110/4 116/11 118/11 118/24 123/2 125/13 127/1 129/5 142/9 186/3	expanding [2] 205/17 212/11	extra [1] 119/19
EPRR [4] 194/4 194/7 200/24 201/8	Evans [1] 94/8	examination [1] 78/19	extraordinary [2] 183/20 187/12	extraordinary [2] 11/6 126/16
equal [1] 143/22	even [17] 16/4 24/18 32/6 59/7 89/12 100/2 100/21 124/9 153/17 154/3 154/13 155/25 163/20 183/16 187/24 201/16 209/1	example [28] 9/3 22/18 23/3 46/13 47/10 55/8 60/7 79/7 79/12 100/1 105/2 124/12 131/14 141/10 144/11 144/21 162/5 164/13 194/25 195/21 195/25 197/7 200/18	expansion [1] 212/15	extrapolated [2] 175/10 175/23
equalities [1] 154/5	event [6] 80/6 90/17 92/23 154/9 154/10		expect [15] 24/5 34/11 36/5 36/9 36/19 37/23 63/18 66/15 66/19 67/14 67/25 68/9 106/6 118/3 119/2	extreme [1] 29/18
Equality [2] 158/4 178/16			expectations [3] 195/24 206/2 207/19	extremely [4] 94/23 161/7 169/3 183/20
equipment [18] 23/1 43/8 43/12 43/18 43/22 44/9 48/10 81/11 87/5 90/9 102/7 114/8 121/7 136/23 166/1 166/6 207/16 207/22			expected [5] 18/5 18/8 24/21 49/2 185/1	extremis [1] 126/7
equipped [1] 103/7			expecting [2] 143/4 143/5	face [26] 17/1 17/3 41/13 47/18 76/6 76/6 76/25 76/25 77/19 77/19 77/24 77/24 77/25 77/25 78/13 78/13 78/20 78/20 79/3 79/3 79/16 80/15 80/15 80/16 80/16 146/18

F	February [29] 7/24 15/15 15/18 17/8 17/11 17/12 19/12 25/1 57/16 76/24 156/16 162/21 163/19 163/24 164/2 165/16 168/5 168/6 176/24 177/6 177/10 177/21 196/9 196/14 196/19 196/23 197/3 201/24 203/10	142/12 142/21 142/24 143/6 214/9 214/13 214/17 fifth [1] 92/4 figure [1] 175/12 figures [3] 131/16 171/10 171/11 filtration [1] 135/24 final [13] 1/24 65/2 69/25 70/6 80/23 92/4 95/16 96/15 99/20 120/7 128/11 131/15 185/7 finally [5] 92/20 130/8 175/15 214/7 214/20 finances [2] 25/19 26/4 financial [5] 8/25 25/6 88/11 191/12 191/14 find [5] 33/15 36/19 43/15 43/18 63/13 finding [1] 94/9 findings [6] 49/22 49/25 69/4 133/12 157/5 203/10 fine [1] 133/5 finest [2] 82/21 83/20 finish [2] 11/10 44/10 finished [2] 52/12 109/9 first [53] 1/4 1/11 1/24 3/5 6/12 11/2 11/3 11/13 20/15 31/5 34/21 35/13 43/16 45/13 49/22 53/4 58/9 63/16 69/8 75/6 81/8 82/3 85/19 89/13 103/10 111/6 111/7 115/25 117/11 130/9 131/17 135/10 137/11 144/4 148/17 150/6 150/19 163/25 164/1 170/8 170/14 175/4 178/4 185/24 189/2 196/8 196/9 196/16 202/20 204/22 209/24 212/9 212/25 first-up [2] 11/2 11/13 Firstly [4] 128/12 131/18 135/21 163/5 fit [13] 41/7 41/9 45/3 111/11 116/15 116/25 118/13 119/3 120/5 120/8 141/25 142/2 144/24 fits [1] 201/4 fitted [2] 41/13 144/16 five [13] 1/22 3/7 10/17 10/19 10/24 11/21 30/24 81/3 92/5	92/9 92/12 92/17 93/17 five days [1] 30/24 flagged [1] 178/21 flask [1] 147/15 flat [2] 34/24 35/10 flexible [2] 160/17 170/9 floated [1] 159/1 flow [8] 136/5 136/20 162/14 166/9 167/7 167/10 167/11 167/16 flows [1] 169/17 flu [5] 4/2 4/10 5/3 18/14 18/17 fluid [1] 151/13 focus [10] 7/16 23/5 40/22 80/15 86/1 162/9 165/11 197/17 206/23 207/7 focused [9] 7/7 7/13 7/21 11/5 32/3 81/18 81/19 99/7 189/15 focuses [1] 210/17 focusing [2] 24/7 62/11 fogging [1] 47/20 follow [12] 17/6 56/4 69/11 71/9 97/17 126/3 136/16 175/3 175/4 178/1 185/7 200/20 follow-on [1] 97/17 follow-up [1] 185/7 follow-ups [1] 69/11 followed [12] 15/12 52/5 62/15 116/22 125/18 126/24 127/6 155/18 165/4 165/5 168/7 174/19 following [19] 12/25 15/22 18/23 27/6 44/19 68/10 68/22 73/15 76/25 94/4 114/11 124/18 127/16 133/19 140/1 144/2 168/19 177/2 209/23 follows [4] 61/10 117/15 122/19 173/12 footnote [1] 76/19 force [2] 11/5 143/19 forces [1] 9/4 foresee [1] 115/19 forewarn [1] 95/12 forget [1] 187/24 forgive [3] 84/15 183/3 205/12 form [8] 56/10 143/24 156/19 157/1 161/19 181/4 191/9 213/14 formal [10] 54/17 134/25 168/3 177/1 177/12 191/11 196/22	199/2 203/16 210/1 formally [3] 6/6 54/23 155/2 forms [4] 9/23 102/8 159/16 159/20 forth [1] 169/17 fortunate [1] 159/8 fortunately [1] 23/24 forums [2] 9/24 42/17 forward [4] 50/2 59/20 94/6 150/17 found [9] 9/25 55/18 98/5 135/18 136/3 136/4 152/15 159/5 180/20 foundation [1] 94/9 four [11] 38/22 39/10 41/20 41/23 45/12 82/23 83/17 83/19 90/13 106/8 165/15 four months' [1] 106/8 four-month [1] 38/22 fourth [2] 76/7 211/1 framework [5] 112/12 112/15 112/18 113/3 194/4 Frank [3] 198/5 204/2 212/6 Frank's [3] 203/16 205/24 206/3 free [1] 14/24 freeing [1] 78/17 frequency [1] 119/15 frequently [6] 57/1 98/1 98/6 105/16 157/13 178/23 Friday [3] 30/23 161/16 161/21 front [10] 3/6 27/23 123/10 149/5 164/3 164/4 164/9 181/3 187/6 187/15 front-facing [3] 164/3 164/4 164/9 frontline [10] 29/14 29/19 44/18 109/20 110/2 110/3 110/10 110/13 143/18 150/2 fruition [1] 166/4 frustrated [1] 149/23 fulfil [1] 31/20 fulfilling [1] 52/24 full [5] 11/4 11/13 30/7 96/4 188/16 fully [8] 2/13 2/14 29/18 32/14 134/12 134/12 163/3 203/4 function [4] 154/20 194/8 200/24 201/8 functioning [2] 128/16 129/21 functions [2] 128/19
----------	--	--	--	--

F	genuine [3] 184/12 185/8 186/20	115/12 116/1 125/21 158/13	79/18 79/22 83/5 83/15 88/6 88/7 88/13 101/3 110/23 162/14 162/22 163/1 165/5 171/4 188/25 189/1 189/8 189/16 191/7 191/17 192/5 194/13 196/10 201/20 205/23 209/24 211/17	77/14 94/4 96/4 114/19 119/12 172/25 173/10 200/19 208/13 209/3
functions... [1] 195/9	genuinely [1] 200/2	going [58] 4/24 7/10 7/23 9/17 12/23 17/5 17/14 20/4 22/8 28/17 30/14 32/3 32/19 38/9 43/13 43/25 43/25 49/25 52/8 52/9 55/17 63/5 77/22 80/7 84/15 90/11 99/2 100/17 109/8 111/10 112/21 120/19 122/9 125/1 130/15 132/4 132/12 132/13 133/6 135/2 136/25 145/5 147/20 150/17 159/3 164/4 167/20 188/13 196/11 197/8 197/12 197/16 207/9 208/6 212/8 212/25 214/5 215/25	government's [8] 3/13 8/25 51/21 55/8 88/21 170/17 171/6 197/5	growing [1] 151/14
fundamentals [1] 128/8	geographical [1] 212/24	gone [2] 109/10 212/12	government-owned [1] 13/24	guarantee [1] 124/16
funded [7] 8/21 82/19 82/22 84/5 100/15 137/5 153/24	George [2] 25/16 26/3	good [33] 1/4 1/10 4/8 8/20 11/2 11/17 23/2 29/22 59/15 60/3 62/14 62/24 64/20 68/7 68/8 75/11 79/3 83/24 97/5 97/8 98/3 101/15 105/23 109/19 113/12 122/6 134/22 153/9 158/6 158/22 176/13 179/16 192/8	governments [2] 18/1 26/6	guess [1] 36/7
funding [8] 55/9 83/17 95/9 95/19 172/6 191/8 191/14 195/21	George Osborne [2] 25/16 26/3	gold [2] 154/9 169/6	Gowman [4] 181/10 181/14 187/1 217/21	guidance [96] 6/20 26/10 27/3 27/10 27/21 27/22 64/5 68/6 68/10 104/5 104/8 104/11 104/12 104/22 105/1 105/3 105/10 105/16 105/19 105/21 106/3 106/18 106/22 107/5 107/18 107/19 107/22 107/23 108/5 108/9 108/11 108/18 108/21 108/21 117/5 117/21 126/11 126/23 126/24 127/3 127/3 136/15 136/17 136/17 139/21 140/13 152/12 152/15 155/6 155/7 155/8 155/9 155/16 155/17 155/18 155/19 156/14 157/15 157/20 158/5 158/15 160/10 160/13 160/16 160/16 160/19 160/22 160/23 161/2 161/5 161/10 161/12 161/13 161/14 161/15 161/16 161/18 161/24 162/2 162/10 165/5 166/17 168/7 168/7 168/11 168/12 174/20 180/24 191/9 195/19 199/14 199/24 203/4
funds [3] 3/18 75/3 82/18	get [31] 12/20 12/20 15/17 16/7 19/22 22/8 34/20 36/22 37/18 41/21 60/19 67/16 79/11 80/19 82/10 83/12 90/1 98/15 109/3 115/9 122/20 123/25 124/11 126/17 137/24 142/15 150/25 151/15 166/24 185/25 188/3	good [33] 1/4 1/10 4/8 8/20 11/2 11/17 23/2 29/22 59/15 60/3 62/14 62/24 64/20 68/7 68/8 75/11 79/3 83/24 97/5 97/8 98/3 101/15 105/23 109/19 113/12 122/6 134/22 153/9 158/6 158/22 176/13 179/16 192/8	GP [6] 71/8 76/11 76/15 77/9 78/18 79/5	guidelines [5] 151/24 152/1 152/20 155/3 155/4
furniture [1] 136/24	getting [6] 11/12 20/10 73/13 93/15 152/24 182/14	Goodall [10] 188/7 188/9 188/11 188/17 188/18 188/24 189/15 200/20 216/1 217/22	GPs [7] 32/20 58/2 76/5 77/13 77/19 78/15 131/2	guilty [1] 145/10
further [8] 44/15 65/20 74/3 96/13 113/2 139/11 145/7 149/6	GGH [6] 142/22 156/9 174/11 174/15 175/17 175/22	goods [1] 61/17	graphs [1] 34/13	Gupta [4] 109/15 109/18 113/8 217/10
future [23] 10/18 11/16 11/20 45/7 50/5 80/6 81/10 86/18 90/18 91/8 92/23 93/12 94/6 95/1 99/8 103/9 118/16 162/11 172/13 199/5 200/3 200/14 209/8	gift [1] 170/11	got [27] 3/6 7/12 11/4 12/6 20/14 22/3 22/11 23/9 35/12 38/2 39/17 45/16 57/11 86/4 86/13 89/6 103/23 124/3 124/5 147/5 149/17 160/1 161/8 170/7 175/9 213/23 214/7	grateful [6] 101/9 122/15 176/17 187/1 187/22 188/14	had [187] 2/12 9/19 9/20 9/24 10/16 10/24 11/4 11/5 11/23 12/1 12/22 18/5 18/9 18/21 21/22 24/15 24/15 24/18 24/24 24/24 26/12 26/12 26/12 26/14 26/18 26/23 26/23 27/7 27/7 27/9 27/9 27/17 27/17 27/19 29/4 30/4 31/1 32/18 35/15 35/19 37/22 38/21 39/8 39/21 40/17 41/2 41/20 41/23 42/3 42/6 43/2 43/15 43/19
G	give [13] 47/6 56/20 61/3 61/4 74/8 104/25 105/1 120/6 134/10 154/9 179/19 188/16 215/10	governance [1] 179/19	greater [2] 45/7 102/7	H
gaps [1] 89/25	given [30] 15/25 24/21 26/4 28/6 29/7 30/11 44/20 46/14 47/7 50/1 56/13 59/9 68/7 74/4 74/11 122/24 130/19 134/8 142/19 149/20 157/11 158/13 160/24 172/14 179/3 187/22 201/12 206/25 209/2 209/14	governing [2] 4/19 128/20	green [3] 22/11 143/1 151/10	
gathering [1] 201/22	gives [4] 26/1 35/21 58/12 88/9	government [70] 5/17 5/21 6/1 6/8 6/10 6/15 6/23 7/3 7/6 9/19 13/17 13/23 13/24 15/23 16/6 16/17 16/20 17/3 18/18 18/23 18/25 19/4 19/8 25/5 25/11 25/14 25/21 25/23 37/11 51/1 51/2 51/5 52/2 52/5 52/8 52/20 52/21 56/17 60/24 61/10 68/1 71/15 71/18	ground [4] 67/10 162/3 162/8 183/6	
gave [5] 25/16 84/6 199/10 199/21 215/8	giving [4] 155/7 183/15 203/16 206/19	grounds [4] 180/3 180/4 180/6 185/10	group [27] 70/2 70/10 109/20 122/22 123/2 149/3 154/12 163/2 171/12 173/2 178/14 184/7 184/14 189/7 189/17 189/24 190/9 190/10 196/3 196/7 197/2 198/13 198/15 198/25 199/7 199/10 199/19	
gender [2] 41/13 42/8	Glangwili [9] 135/3 135/10 146/5 165/15 174/7 178/21 184/2 184/3 184/16	grouped [1] 211/22	groups [15] 4/18 42/15 43/1 52/19 73/9	
general [28] 3/1 19/6 25/12 28/13 43/13 64/10 67/23 71/11 77/21 83/3 85/22 87/9 88/19 89/17 99/14 104/10 105/9 135/3 155/5 189/6 189/25 190/8 191/24 191/25 192/4 213/19 213/19 214/2	go [38] 2/8 4/24 15/2 17/5 20/21 20/22 28/5 45/2 65/2 65/14 65/19 73/20 73/25 74/8 101/12 101/24 112/8 112/9 112/21 112/23 112/24 115/6 115/15 118/10 119/19 143/14 147/4 147/9 160/1 161/3 163/14 166/20 196/4 197/16 202/22 203/25 204/12 205/1	grouping [1] 192/10		
General Hospital [1] 135/3	goes [9] 12/9 12/18 88/15 89/18 90/4	groups [15] 4/18 42/15 43/1 52/19 73/9		
generalised [1] 123/14				
generally [17] 43/6 43/19 59/16 68/16 75/12 78/3 92/1 98/5 114/24 142/25 147/24 158/3 161/14 179/16 182/16 186/2 199/9				
generated [1] 130/3				
generating [1] 15/8				
generic [2] 98/19 98/21				
generous [2] 75/24 134/9				
genomic [2] 60/7 60/10				

H	happen [6] 20/2 24/3 35/8 70/21 123/3 126/9	HB CEO [1] 177/5	113/15 116/22 118/18	104/12 136/5 136/6
had... [134] 44/20 46/14 47/11 48/20 48/20 51/14 56/5 64/4 64/4 66/16 67/2 68/4 69/4 69/21 70/6 71/4 71/5 73/22 95/4 97/19 104/7 104/15 104/20 106/4 106/7 109/6 110/9 111/8 112/1 112/19 118/2 120/16 120/25 121/23 127/22 131/7 136/13 136/14 136/23 137/17 138/10 138/18 138/20 139/7 140/4 140/6 140/22 141/12 141/14 141/21 142/2 142/2 142/18 142/19 143/3 143/3 143/6 143/7 144/20 144/21 145/8 145/18 145/23 146/22 148/19 149/3 149/11 150/13 152/9 152/15 152/16 152/18 152/20 153/24 154/4 154/10 154/19 156/10 156/18 156/24 158/19 159/9 160/12 160/25 161/10 163/5 163/6 164/11 165/7 165/11 165/14 166/3 166/13 167/4 167/7 167/17 167/22 168/6 168/11 168/16 169/14 170/23 172/2 174/6 178/16 179/23 180/15 183/19 184/16 184/21 185/21 186/1 186/5 189/24 190/24 196/8 196/16 196/16 199/25 202/20 203/8 203/21 205/20 205/24 205/24 208/25 209/5 209/24 210/25 211/6 213/5 213/6 214/10 214/12	happened [13] 26/14 31/13 31/15 36/6 36/9 39/16 41/11 47/13 54/24 98/10 117/4 171/3 204/1	HB staff [1] 177/23	135/15 139/16 141/13 169/10 175/5 189/17 190/22 192/22 192/23 193/12 196/11	167/11 167/21 202/17 212/13
hadn't [6] 20/23 45/20 185/15 196/25 197/1 202/20	happening [14] 66/4 66/7 66/9 66/22 67/3 67/5 67/15 67/19 123/25 124/2 152/11 206/11 206/12 207/12	HCIB [1] 133/12	192/9 194/1 197/14 213/13	high-flow [1] 136/5
half [3] 109/5 131/18 133/12	happens [4] 6/7 16/7 44/4 121/7	he [10] 49/18 49/19 74/25 75/1 80/2 100/21 180/8 180/8 180/9 202/23	hearing [4] 29/25 58/11 106/24 216/8	higher [5] 74/6 88/16 117/1 195/18 208/20
halted [4] 38/19 38/24 38/25 39/2	happy [1] 108/25	He's [2] 101/11 113/10	heart [1] 124/15	highlight [2] 93/7 100/2
halting [1] 38/17	hard [2] 15/1 132/17	head [2] 40/6 84/7	Heathrow [3] 187/25 188/1 188/2	highlighted [9] 10/6 43/10 44/19 51/8 62/16 93/1 117/17 117/18 182/6
Hancock [5] 3/16 73/18 74/12 74/23 75/21	harder [1] 20/6	heading [1] 197/23	held [6] 13/7 59/18 66/14 67/1 189/8 204/20	him [2] 67/22 75/23
hand [6] 22/10 134/16 198/12 209/7 211/22 213/2	hardest [1] 126/2	health [134] 1/13 1/19 2/20 3/13 4/3 5/2 5/7 5/8 5/17 6/14 6/24 8/9 10/4 10/13 16/3 23/19 25/24 28/23 37/1 44/18 45/11 49/8 49/15 50/3 56/6 60/11 60/24 61/11 81/10 81/16 83/13 85/3 87/23 89/20 90/16 92/8 92/16 94/17 94/21 95/14 97/24 109/20 113/20 126/8 130/12 135/1 140/3 140/12 152/13 161/6 161/13 162/13 165/9 165/10 171/5 171/7 171/12 171/14 171/19 172/2 172/3 172/8 174/11 179/6 179/13 182/1 182/12 183/10 184/12 189/7 189/12 189/16 189/23 190/5 190/8 190/9 190/11 190/15 190/16 190/17 190/24 191/1 191/5 191/18 191/20 192/20 192/24 193/3 193/8 193/9 193/10 193/16 193/17 194/1 194/10 194/14 195/5 195/17 196/2 197/2 197/6 198/11 198/11 198/13 198/18 198/24 199/6 199/7 202/1 202/13 203/11 203/18 203/21 203/22 204/6 204/11 204/13 204/23 205/4 205/20 205/22 205/25 206/6 206/15 207/3 207/6 208/3 208/23 209/16 209/25 210/2 211/13 211/20 213/6	help [25] 5/5 21/8 21/20 22/16 31/13 33/12 36/17 37/12 37/19 40/2 47/22 48/18 53/1 60/2 62/4 69/5 89/6 98/14 102/20 120/21 132/7 134/7 139/19 187/21 216/4	historical [1] 215/13
handing [1] 130/20	hardwiring [1] 114/21	healthcare [44] 20/13 32/9 33/2 52/16 54/14 55/17 58/5 58/6 61/4 61/18 79/9 79/13 87/7 87/17 90/17 90/19 91/6 91/13 91/19 92/23 94/17 95/19 103/4 103/6 104/10 104/10 104/16 106/16 109/23 112/4	helped [7] 1/20 9/4 24/17 24/24 164/14 167/13 200/2	HIV [2] 85/17 91/12
handlers [1] 33/12	harm [1] 153/5		helpful [8] 7/6 147/3 153/13 160/15 162/10 171/3 175/2 181/7	HIV pandemic [1] 91/12
Hands [3] 160/6 176/18 179/24	harmful [1] 205/16		helpfully [4] 3/24 160/11 172/9 176/18	HIW [1] 179/13
	harmful/spread [1] 205/16		helping [2] 108/5 108/6	HMRC [1] 37/12
	harrowing [1] 159/14		helpline [2] 31/14 31/17	hold [9] 13/20 13/21 54/23 82/11 127/10 128/24 129/10 129/10 129/14
	has [64] 5/24 10/16 10/21 11/14 14/19 16/21 30/9 37/2 43/23 47/25 50/11 50/15 55/16 56/21 57/9 65/7 68/18 68/18 73/14 76/11 81/2 81/3 83/18 85/25 86/5 88/7 89/6 90/2 91/25 91/25 95/4 100/8 102/13 103/18 104/16 108/22 109/6 115/15 116/6 116/21 118/7 118/8 118/15 124/6 124/8 124/12 125/3 125/7 127/17 129/8 130/4 132/21 133/1 138/18 151/7 153/8 160/1 168/1 176/18 194/1 194/4 197/14 209/21 210/16		helps [1] 38/13	holding [1] 69/14
	have [345]		her [8] 82/15 92/22 109/16 133/17 145/8 172/12 180/5 181/11	holds [1] 54/15
	haven't [9] 39/3 46/7 70/15 75/23 107/2 125/24 134/20 158/19 159/5		her Ladyship [3] 82/15 92/22 180/5	home [5] 31/24 33/10 76/6 77/3 137/24
	having [33] 15/12 15/17 25/19 30/15 41/9 41/9 45/9 63/3 74/5 74/22 75/9 84/1 84/15 86/2 97/8 99/3 112/15 122/10 126/10 139/24 145/13 146/22 147/16 156/23 162/23 168/16 183/10 184/22 199/1 200/22 201/8 206/1 210/2		her Ladyship's [1] 172/12	homes [2] 14/25 32/20
	HB [3] 174/14 177/5 177/23		here [21] 16/20 23/8 23/21 24/6 25/15 31/22 57/3 60/19 61/2 65/4 66/13 68/12 75/3 83/11 89/17 111/10 123/4 206/14 212/17 213/9 215/3	honest [1] 7/4

H				
hospital... [8] 213/10 213/11 213/24 213/25 214/7 214/8 214/13 214/17	125/22 125/22 human [1] 71/14 Hunt [1] 126/20 husband [1] 188/1 huts [3] 135/12 187/25 188/2	I dare [1] 1/11 I describe [1] 50/11 I described [13] 59/22 75/12 77/10 98/4 100/14 106/23 110/4 117/10 119/5 128/4 129/6 178/10 178/17	I know [22] 1/10 10/21 20/12 41/16 46/4 48/1 53/6 79/20 93/2 93/22 96/3 105/8 112/8 119/19 119/21 129/24 131/5 158/20 161/8 169/14 188/12 204/2	48/19 49/6 49/21 50/19 51/7 52/6 53/15 53/22 59/21 68/11 68/21 69/13 69/17 69/23 75/7 75/23 78/1 84/13 86/9 86/14 88/11 89/17 91/2 95/25 101/3 106/12 107/1 110/17 121/8 121/16 125/6 125/20 127/2 130/5 133/4
hospitality [1] 139/18 hospitals [16] 14/24 32/17 33/4 33/6 58/2 83/13 111/21 113/3 131/2 165/2 165/7 167/2 172/21 213/4 214/10 214/24	Hywel [3] 135/1 182/1 182/12 Hywel Dda [1] 135/1	I detected [1] 70/13 I did [4] 29/21 37/9 38/6 194/23	I look [2] 19/9 30/19 I looked [2] 29/10 29/25	I see [2] 72/5 177/17 I set [1] 173/25 I shall [2] 54/3 133/24 I should [4] 51/7 58/9 125/20 179/13 I showed [1] 3/24 I simply [1] 53/16 I start [1] 71/12 I stated [1] 178/22 I still [1] 200/9 I suppose [7] 145/15 149/4 158/8 158/9 161/1 162/5 185/16 I suppose -- well [1] 183/9 I suspect [2] 7/18 216/3 I take [2] 7/23 91/15 I then [1] 104/4 I think [158] 1/23 2/24 3/11 3/19 5/18 8/3 11/2 12/12 16/25 19/10 19/16 19/17 19/19 22/19 22/25 24/19 25/23 28/15 29/10 29/25 30/9 30/16 30/17 30/20 30/23 35/18 37/10 37/11 40/5 40/6 40/7 41/20 41/22 41/24 42/23 43/1 45/19 47/17 48/5 48/6 49/4 49/9 49/21 50/24 52/7 53/13 60/22 61/7 61/8 62/18 62/18 65/14 66/25 67/23 68/17 71/2 71/7 73/21 74/23 75/5 75/6 75/6 75/11 75/14 76/14 79/6 83/14 86/12 88/16 89/12 93/3 93/4 95/2 103/18 104/1 105/20 106/21 108/11 108/13 111/23 114/15 114/24 115/25 117/3 120/11 124/15 132/6 132/7 135/14 137/11 137/13 139/11 140/11 144/7 145/21 145/25 146/5 148/3 149/10 150/6 150/8 150/11 150/12 150/18 154/15 155/1
hotline [5] 30/22 32/25 33/19 34/6 36/1 hour [2] 30/24 160/2 hour's [1] 109/5 hours [2] 32/4 215/7 House [1] 1/11 household [1] 208/12	I accept [3] 25/7 25/12 128/12 I actually [1] 107/12 I agree [2] 26/5 126/13 I also [1] 190/3 I always [1] 1/15 I am [12] 12/23 17/25 20/22 53/6 55/24 69/17 80/11 106/10 109/8 112/21 121/19 159/22 I and [1] 36/14 I appear [1] 173/9 I appreciate [6] 84/14 104/7 104/23 108/16 109/3 188/13 I ask [24] 2/3 5/20 11/9 28/7 33/17 35/24 47/16 52/10 55/12 56/9 56/12 61/19 65/1 81/13 90/15 91/4 94/3 101/16 122/1 122/7 123/21 176/14 199/5 203/5 I asked [3] 26/25 35/18 63/21 I believe [2] 76/18 131/16 I broaden [1] 79/5 I can [20] 2/13 2/16 29/16 33/15 37/13 45/18 47/9 57/15 88/12 93/15 93/19 102/20 115/5 118/10 119/20 146/8 147/2 174/24 184/18 187/18 I can't [12] 19/5 27/15 40/5 42/21 51/19 93/9 95/21 131/24 158/25 185/6 203/14 203/15 I cannot [1] 105/8 I certainly [1] 48/20 I come [2] 48/9 131/10 I completely [3] 18/22 51/21 80/2 I could [4] 1/15 43/24 70/18 97/17 I couldn't [4] 28/10 78/24 97/14 133/7 I covered [1] 117/3	I I didn't [4] 2/10 46/16 63/21 200/15 I do [16] 36/9 38/12 94/19 125/23 133/25 140/16 141/6 148/2 176/2 176/6 181/12 183/13 188/22 199/21 200/25 207/22 I don't [55] 12/13 25/7 25/8 26/16 27/6 27/12 30/15 32/19 33/14 33/15 34/18 37/15 47/10 51/8 57/15 59/24 59/25 60/18 60/21 60/23 61/7 67/21 67/22 69/17 69/20 70/22 75/14 75/15 76/20 78/8 82/1 85/10 93/15 93/19 95/22 95/22 100/20 101/23 102/22 103/21 106/2 106/25 107/3 111/25 131/22 140/15 147/1 158/22 158/23 159/19 171/10 171/10 178/24 183/17 215/24 I follow [1] 17/6 I fully [1] 134/12 I get [1] 41/21 I had [4] 10/24 37/22 167/22 169/14 I have [20] 1/21 2/4 2/7 11/22 24/21 52/12 53/6 60/22 76/8 85/12 93/8 103/21 106/10 135/5 145/20 160/8 173/10 184/19 185/15 215/16 I haven't [5] 70/15 75/23 107/2 125/24 158/19 I hinted [1] 96/8 I hope [6] 3/6 7/12 28/4 96/3 134/20 192/16 I just [19] 13/3 13/5 28/1 32/24 44/10 44/12 49/13 75/17 77/22 84/14 101/17 107/9 115/17 117/13 133/18 137/1 141/1 166/13 188/20	I made [1] 116/1 I may [10] 3/4 13/3 28/18 71/12 122/9 126/3 134/17 180/1 197/17 212/6 I mean [12] 19/3 37/13 45/18 68/4 68/16 68/16 80/9 80/17 84/9 90/19 125/20 137/11 I mentioned [5] 88/8 95/24 148/1 148/3 150/6 I might [1] 172/18 I move [2] 76/5 80/23 I mustn't [1] 85/25 I need [1] 173/22 I normally [1] 2/12 I ought [1] 3/7 I oversaw [1] 193/25 I pause [2] 10/7 63/5 I quote [2] 8/5 121/23 I quoted [1] 115/13 I really [1] 99/25 I recall [1] 213/15 I recollect [1] 56/8 I refer [1] 99/12 I referred [2] 114/15 155/21 I reiterate [1] 75/24 I remember [5] 49/16 49/19 50/7 170/24 170/25 I represent [3] 109/20 184/8 184/15 I ring [1] 37/9 I said [21] 19/3 22/20 24/23 31/8 32/13 50/7 70/13 81/17 93/9 103/22 105/21 110/8 110/15 114/24 118/22 125/24 170/7 182/16 182/22 203/25 208/24 I say [66] 2/12 5/13 6/19 18/23 19/16 19/21 19/23 20/3 20/14 21/2 21/12 24/14 26/12 26/15 27/12 27/14 27/16 28/11 28/13 29/12 29/16 29/24 30/12 32/8 35/9 39/12 41/5 43/20 46/1 46/6 47/10	I see [2] 72/5 177/17 I set [1] 173/25 I shall [2] 54/3 133/24 I should [4] 51/7 58/9 125/20 179/13 I showed [1] 3/24 I simply [1] 53/16 I start [1] 71/12 I stated [1] 178/22 I still [1] 200/9 I suppose [7] 145/15 149/4 158/8 158/9 161/1 162/5 185/16 I suppose -- well [1] 183/9 I suspect [2] 7/18 216/3 I take [2] 7/23 91/15 I then [1] 104/4 I think [158] 1/23 2/24 3/11 3/19 5/18 8/3 11/2 12/12 16/25 19/10 19/16 19/17 19/19 22/19 22/25 24/19 25/23 28/15 29/10 29/25 30/9 30/16 30/17 30/20 30/23 35/18 37/10 37/11 40/5 40/6 40/7 41/20 41/22 41/24 42/23 43/1 45/19 47/17 48/5 48/6 49/4 49/9 49/21 50/24 52/7 53/13 60/22 61/7 61/8 62/18 62/18 65/14 66/25 67/23 68/17 71/2 71/7 73/21 74/23 75/5 75/6 75/6 75/11 75/14 76/14 79/6 83/14 86/12 88/16 89/12 93/3 93/4 95/2 103/18 104/1 105/20 106/21 108/11 108/13 111/23 114/15 114/24 115/25 117/3 120/11 124/15 132/6 132/7 135/14 137/11 137/13 139/11 140/11 144/7 145/21 145/25 146/5 148/3 149/10 150/6 150/8 150/11 150/12 150/18 154/15 155/1
hospitals [16] 14/24 32/17 33/4 33/6 58/2 83/13 111/21 113/3 131/2 165/2 165/7 167/2 172/21 213/4 214/10 214/24	I accept [3] 25/7 25/12 128/12 I actually [1] 107/12 I agree [2] 26/5 126/13 I also [1] 190/3 I always [1] 1/15 I am [12] 12/23 17/25 20/22 53/6 55/24 69/17 80/11 106/10 109/8 112/21 121/19 159/22 I and [1] 36/14 I appear [1] 173/9 I appreciate [6] 84/14 104/7 104/23 108/16 109/3 188/13 I ask [24] 2/3 5/20 11/9 28/7 33/17 35/24 47/16 52/10 55/12 56/9 56/12 61/19 65/1 81/13 90/15 91/4 94/3 101/16 122/1 122/7 123/21 176/14 199/5 203/5 I asked [3] 26/25 35/18 63/21 I believe [2] 76/18 131/16 I broaden [1] 79/5 I can [20] 2/13 2/16 29/16 33/15 37/13 45/18 47/9 57/15 88/12 93/15 93/19 102/20 115/5 118/10 119/20 146/8 147/2 174/24 184/18 187/18 I can't [12] 19/5 27/15 40/5 42/21 51/19 93/9 95/21 131/24 158/25 185/6 203/14 203/15 I cannot [1] 105/8 I certainly [1] 48/20 I come [2] 48/9 131/10 I completely [3] 18/22 51/21 80/2 I could [4] 1/15 43/24 70/18 97/17 I couldn't [4] 28/10 78/24 97/14 133/7 I covered [1] 117/3	I I didn't [4] 2/10 46/16 63/21 200/15 I do [16] 36/9 38/12 94/19 125/23 133/25 140/16 141/6 148/2 176/2 176/6 181/12 183/13 188/22 199/21 200/25 207/22 I don't [55] 12/13 25/7 25/8 26/16 27/6 27/12 30/15 32/19 33/14 33/15 34/18 37/15 47/10 51/8 57/15 59/24 59/25 60/18 60/21 60/23 61/7 67/21 67/22 69/17 69/20 70/22 75/14 75/15 76/20 78/8 82/1 85/10 93/15 93/19 95/22 95/22 100/20 101/23 102/22 103/21 106/2 106/25 107/3 111/25 131/22 140/15 147/1 158/22 158/23 159/19 171/10 171/10 178/24 183/17 215/24 I follow [1] 17/6 I fully [1] 134/12 I get [1] 41/21 I had [4] 10/24 37/22 167/22 169/14 I have [20] 1/21 2/4 2/7 11/22 24/21 52/12 53/6 60/22 76/8 85/12 93/8 103/21 106/10 135/5 145/20 160/8 173/10 184/19 185/15 215/16 I haven't [5] 70/15 75/23 107/2 125/24 158/19 I hinted [1] 96/8 I hope [6] 3/6 7/12 28/4 96/3 134/20 192/16 I just [19] 13/3 13/5 28/1 32/24 44/10 44/12 49/13 75/17 77/22 84/14 101/17 107/9 115/17 117/13 133/18 137/1 141/1 166/13 188/20	I made [1] 116/1 I may [10] 3/4 13/3 28/18 71/12 122/9 126/3 134/17 180/1 197/17 212/6 I mean [12] 19/3 37/13 45/18 68/4 68/16 68/16 80/9 80/17 84/9 90/19 125/20 137/11 I mentioned [5] 88/8 95/24 148/1 148/3 150/6 I might [1] 172/18 I move [2] 76/5 80/23 I mustn't [1] 85/25 I need [1] 173/22 I normally [1] 2/12 I ought [1] 3/7 I oversaw [1] 193/25 I pause [2] 10/7 63/5 I quote [2] 8/5 121/23 I quoted [1] 115/13 I really [1] 99/25 I recall [1] 213/15 I recollect [1] 56/8 I refer [1] 99/12 I referred [2] 114/15 155/21 I reiterate [1] 75/24 I remember [5] 49/16 49/19 50/7 170/24 170/25 I represent [3] 109/20 184/8 184/15 I ring [1] 37/9 I said [21] 19/3 22/20 24/23 31/8 32/13 50/7 70/13 81/17 93/9 103/22 105/21 110/8 110/15 114/24 118/22 125/24 170/7 182/16 182/22 203/25 208/24 I say [66] 2/12 5/13 6/19 18/23 19/16 19/21 19/23 20/3 20/14 21/2 21/12 24/14 26/12 26/15 27/12 27/14 27/16 28/11 28/13 29/12 29/16 29/24 30/12 32/8 35/9 39/12 41/5 43/20 46/1 46/6 47/10	I see [2] 72/5 177/17 I set [1] 173/25 I shall [2] 54/3 133/24 I should [4] 51/7 58/9 125/20 179/13 I showed [1] 3/24 I simply [1] 53/16 I start [1] 71/12 I stated [1] 178/22 I still [1] 200/9 I suppose [7] 145/15 149/4 158/8 158/9 161/1 162/5 185/16 I suppose -- well [1] 183/9 I suspect [2] 7/18 216/3 I take [2] 7/23 91/15 I then [1] 104/4 I think [158] 1/23 2/24 3/11 3/19 5/18 8/3 11/2 12/12 16/25 19/10 19/16 19/17 19/19 22/19 22/25 24/19 25/23 28/15 29/10 29/25 30/9 30/16 30/17 30/20 30/23 35/18 37/10 37/11 40/5 40/6 40/7 41/20 41/22 41/24 42/23 43/1 45/19 47/17 48/5 48/6 49/4 49/9 49/21 50/24 52/7 53/13 60/22 61/7 61/8 62/18 62/18 65/14 66/25 67/23 68/17 71/2 71/7 73/21 74/23 75/5 75/6 75/6 75/11 75/14 76/14 79/6 83/14 86/12 88/16 89/12 93/3 93/4 95/2 103/18 104/1 105/20 106/21 108/11 108/13 111/23 114/15 114/24 115/25 117/3 120/11 124/15 132/6 132/7 135/14 137/11 137/13 139/11 140/11 144/7 145/21 145/25 146/5 148/3 149/10 150/6 150/8 150/11 150/12 150/18 154/15 155/1
hotline [5] 30/22 32/25 33/19 34/6 36/1 hour [2] 30/24 160/2 hour's [1] 109/5 hours [2] 32/4 215/7 House [1] 1/11 household [1] 208/12	I accept [3] 25/7 25/12 128/12 I actually [1] 107/12 I agree [2] 26/5 126/13 I also [1] 190/3 I always [1] 1/15 I am [12] 12/23 17/25 20/22 53/6 55/24 69/17 80/11 106/10 109/8 112/21 121/19 159/22 I and [1] 36/14 I appear [1] 173/9 I appreciate [6] 84/14 104/7 104/23 108/16 109/3 188/13 I ask [24] 2/3 5/20 11/9 28/7 33/17 35/24 47/16 52/10 55/12 56/9 56/12 61/19 65/1 81/13 90/15 91/4 94/3 101/16 122/1 122/7 123/21 176/14 199/5 203/5 I asked [3] 26/25 35/18 63/21 I believe [2] 76/18 131/16 I broaden [1] 79/5 I can [20] 2/13 2/16 29/16 33/15 37/13 45/18 47/9 57/15 88/12 93/15 93/19 102/20 115/5 118/10 119/20 146/8 147/2 174/24 184/18 187/18 I can't [12] 19/5 27/15 40/5 42/21 51/19 93/9 95/21 131/24 158/25 185/6 203/14 203/15 I cannot [1] 105/8 I certainly [1] 48/20 I come [2] 48/9 131/10 I completely [3] 18/22 51/21 80/2 I could [4] 1/15 43/24 70/18 97/17 I couldn't [4] 28/10 78/24 97/14 133/7 I covered [1] 117/3	I I didn't [4] 2/10 46/16 63/21 200/15 I do [16] 36/9 38/12 94/19 125/23 133/25 140/16 141/6 148/2 176/2 176/6 181/12 183/13 188/22 199/21 200/25 207/22 I don't [55] 12/13 25/7 25/8 26/16 27/6 27/12 30/15 32/19 33/14 33/15 34/18 37/15 47/10 51/8 57/15 59/24 59/25 60/18 60/21 60/23 61/7 67/21 67/22 69/17 69/20 70/22 75/14 75/15 76/20 78/8 82/1 85/10 93/15 93/19 95/22 95/22 100/20 101/23 102/22 103/21 106/2 106/25 107/3 111/25 131/22 140/15 147/1 158/22 158/23 159/19 171/10 171/10 178/24 183/17 215/24 I follow [1] 17/6 I fully [1] 134/12 I get [1] 41/21 I had [4] 10/24 37/22 167/22 169/14 I have [20] 1/21 2/4 2/7 11/22 24/21 52/12 53/6 60/22 76/8 85/12 93/8 103/21 106/10 135/5 145/20 160/8 173/10 184/19 185/15 215/16 I haven't [5] 70/15 75/23 107/2 125/24 158/19 I hinted [1] 96/8 I hope [6] 3/6 7/12 28/4 96/3 134/20 192/16 I just [19] 13/3 13/5 28/1 32/24 44/10 44/12 49/13 75/17 77/22 84/14 101/17 107/9 115/17 117/13 133/18 137/1 141/1 166/13 188/20	I made [1] 116/1 I may [10] 3/4 13/3 28/18 71/12 122/9 126/3 134/17 180/1 197/17 212/6 I mean [12] 19/3 37/13 45/18 68/4 68/16 68/16 80/9 80/17 84/9 90/19 125/20 137/11 I mentioned [5] 88/8 95/24 148/1 148/3 150/6 I might [1] 172/18 I move [2] 76/5 80/23 I mustn't [1] 85/25 I need [1] 173/22 I normally [1] 2/12 I ought [1] 3/7 I oversaw [1] 193/25 I pause [2] 10/7 63/5 I quote [2] 8/5 121/23 I quoted [1] 115/13 I really [1] 99/25 I recall [1] 213/15 I recollect [1] 56/8 I refer [1] 99/12 I referred [2] 114/15 155/21 I reiterate [1] 75/24 I remember [5] 49/16 49/19 50/7 170/24 170/25 I represent [3] 109/20 184/8 184/15 I ring [1] 37/9 I said [21] 19/3 22/20 24/23 31/8 32/13 50/7 70/13 81/17	

I	194/19 203/25 207/12	75/14 76/21 76/21	174/11	immediately [6] 86/5
I think... [52] 157/24	I wouldn't [9] 24/22	84/14 90/11 96/5	ie [1] 80/9	117/25 156/21 156/21
160/19 160/21 162/1	36/2 49/2 70/11 75/22	98/22 99/7 99/13	lengar [6] 93/25 94/1	205/6 215/5
162/10 162/10 163/7	95/5 132/24 179/19	99/25 102/3 105/14	173/7 173/8 217/7	impact [11] 79/25
163/13 164/13 165/1	186/22	108/25 109/8 110/21	217/19	88/24 88/24 122/24
165/17 168/22 169/2	I'd [20] 19/16 19/18	111/8 111/19 111/24	if [158] 1/15 2/14 3/4	137/17 142/21 148/19
171/3 172/6 172/13	25/15 33/23 57/21	112/1 113/14 118/7	3/22 7/18 8/8 8/18	172/25 173/11 175/21
172/15 172/17 172/21	71/11 81/5 85/13	120/19 122/9 123/6	10/7 10/9 10/13 10/24	209/13
173/3 174/8 174/17	102/1 102/19 112/8	127/2 127/15 130/15	11/19 13/3 23/5 24/15	impacted [2] 143/2
176/2 176/4 177/16	112/24 114/4 114/5	131/22 132/4 132/11	24/18 24/24 26/7	184/2
179/5 179/18 179/20	118/23 121/8 158/10	132/13 134/3 134/5	27/17 28/18 31/22	impacts [1] 92/2
179/22 180/22 181/1	187/11 197/17 200/2	135/2 136/25 145/5	32/4 32/6 32/8 32/15	Imperial [1] 83/21
182/17 183/13 187/2	I'd been [1] 187/11	158/9 159/7 174/16	32/19 33/9 35/1 35/5	implement [4]
189/5 191/24 192/20	I'd have [2] 112/8	174/18 176/17 177/15	35/6 35/12 35/13	161/10 161/17 162/13
193/5 193/10 193/15	118/23	183/17 183/21 186/13	36/17 37/13 38/13	163/24
200/1 200/7 200/13	I'd like [7] 33/23	186/14 187/22 188/11	41/12 41/21 43/24	implemented [3]
200/25 202/16 206/14	57/21 71/11 81/5	188/14 197/16 210/23	44/3 44/4 45/2 45/15	120/3 163/21 163/23
207/2 209/15 209/19	102/1 102/19 197/17	215/25	46/10 53/9 57/13 58/7	implementing [5]
211/19 214/12 214/15	I'd need [1] 112/24	I'm sorry [1] 10/10	59/11 59/25 60/6 61/3	3/15 134/2 134/5
I thought [2] 85/13	I'd pursue [1] 85/13	I've [30] 2/11 11/3	63/15 64/3 65/14	160/13 199/24
215/8	I'd really [1] 200/2	11/17 18/7 20/6 28/4	66/22 71/7 71/12 72/6	importance [7] 82/12
I transposed [1] 8/8	I'd refer [6] 19/16	29/15 46/24 47/7	73/11 73/20 75/21	93/7 93/18 97/8
I understand [16]	19/18 25/15 114/4	74/18 75/14 78/6	76/23 77/12 77/24	149/14 158/2 168/20
4/24 24/10 25/1 46/8	114/5 121/8	92/25 93/6 93/18	78/14 78/21 79/11	important [47] 46/18
47/24 50/15 57/3	I'd want [1] 158/10	95/22 98/8 116/6	79/14 79/15 80/19	51/18 53/12 54/18
66/20 74/15 91/4 99/6	I'll [29] 2/6 2/8 5/23	120/5 121/5 130/25	82/1 83/18 84/16	59/22 60/7 61/9 66/21
106/5 106/20 106/21	11/10 18/7 22/1 41/22	131/8 132/21 133/24	85/10 85/24 86/1	69/11 84/2 88/3 94/23
114/17 165/15	42/11 48/5 48/7 76/14	150/13 150/14 161/2	87/14 89/23 92/20	95/1 95/2 95/3 96/9
I very [1] 106/14	76/21 86/8 89/12	178/4 180/15 186/1	93/9 97/15 97/17	96/14 99/4 102/6
I visited [1] 142/9	91/10 97/16 100/19	I've already [5] 20/6	100/20 101/11 102/20	103/3 108/3 114/22
I walked [1] 107/16	103/15 111/17 111/19	46/24 93/6 93/18	102/23 107/15 108/20	114/23 115/4 115/6
I want [11] 12/23	112/9 112/23 113/24	120/5	108/23 109/6 112/1	121/22 121/24 128/6
15/3 22/13 38/17	119/19 119/25 120/6	I've been [3] 2/11	115/5 116/17 119/1	139/19 141/11 152/7
38/18 43/11 81/14	122/14 131/24 162/1	18/7 28/4	120/2 120/16 122/9	153/15 160/19 161/5
82/14 143/9 151/21	I'll answer [3] 2/6	I've described [3]	122/15 124/9 125/12	161/22 162/11 164/18
152/23	103/15 113/24	78/6 98/8 161/2	125/13 126/3 129/3	171/14 171/19 172/14
I wanted [7] 29/12	I'll believe [1] 97/16	I've given [1] 47/7	134/17 136/16 136/22	172/17 173/3 195/23
34/1 36/22 37/18	I'll check [4] 48/5	I've had [3] 150/13	138/12 139/3 143/3	199/12 199/22 204/8
40/12 46/12 77/17	48/7 76/14 76/21	180/15 186/1	143/6 143/11 144/20	210/12
I was [18] 35/1 43/13	I'll come [2] 119/25	I've just [1] 74/18	144/20 144/23 144/23	importantly [1] 70/9
88/4 90/23 99/2 110/4	131/24	I've read [2] 75/14	145/13 147/2 147/3	imposed [1] 64/18
111/2 174/1 180/16	I'll confirm [1] 86/8	150/14	147/9 151/11 152/25	imposition [1]
182/23 185/16 187/8	I'll correct [1] 41/22	I've said [7] 11/17	154/17 154/20 158/25	209/22
187/8 187/9 187/10	I'll draw [1] 91/10	29/15 121/5 130/25	161/18 163/17 163/20	impossible [2] 103/8
187/14 194/21 195/5	I'll finish [1] 11/10	131/8 132/21 133/24	166/3 166/13 169/17	166/18
I wasn't [1] 4/24	I'll give [1] 120/6	I've seen [1] 95/22	172/18 175/2 178/1	improve [2] 92/22
I will [11] 2/13 16/19	I'll go [2] 2/8 112/23	I've set [1] 116/6	178/19 179/5 180/1	96/7
42/9 44/6 60/23	I'll have [1] 119/19	ICBs [2] 95/9 95/23	182/8 182/24 183/19	improved [4] 26/15
103/20 106/20 107/1	I'll just [1] 42/11	ICS [2] 96/15 99/3	185/2 185/3 191/23	27/13 47/4 146/5
107/5 112/25 133/6	I'll move [2] 111/17	ICSS [2] 96/20 99/2	192/16 197/17 198/10	improvement [4] 4/5
I wish [1] 145/6	111/19	ICU [8] 104/13	201/2 202/9 203/20	60/19 193/9 198/12
I won't [6] 46/5 88/1	I'll need [1] 112/9	106/19 137/5 138/1	205/3 205/11 208/11	improvements [3]
98/1 118/21 128/1	I'll say [5] 5/23 18/7	139/3 152/4 155/20	208/16 208/18 210/9	90/25 96/12 99/8
161/3	22/1 100/19 162/1	208/15	211/1 213/8 214/20	improving [1] 40/15
I wondered [1] 105/5	I'll try [1] 122/14	idea [2] 47/19 75/11	215/24 216/1	inability [3] 26/8 27/1
I would [28] 4/13	I'm [83] 2/8 2/9 7/23	ideally [2] 80/7 80/10	ii [1] 44/24	27/6
8/15 9/14 35/2 36/5	10/10 11/18 14/19	identified [13] 35/2	iii [1] 45/3	inaccuracies [1] 53/2
36/6 36/9 36/19 37/23	17/20 17/24 19/6 23/3	35/4 35/6 43/3 43/6	illness [1] 178/14	inaccuracy [1] 52/24
39/23 54/10 76/14	23/6 29/21 32/23	51/15 55/25 68/23	images [2] 209/9	inadequate [1]
86/22 89/5 89/10 93/7	34/25 38/9 38/13	81/3 87/1 90/8 92/4	209/11	183/15
93/11 94/22 96/19	42/11 43/25 44/2 44/6	198/1	imagine [4] 76/14	inappropriate [15]
98/21 105/24 110/13	46/18 47/3 48/23 49/6	identify [3] 34/12	146/8 150/17 187/18	62/3 62/8 63/10 63/10
146/10 159/8 172/24	49/25 58/24 60/13	59/5 179/11	immediate [4] 52/16	64/24 68/18 68/24
	63/5 63/22 64/9 70/4	identifying [1]	114/11 204/5 210/17	69/3 123/17 123/24

<p>I</p> <p>inappropriate... [5] 127/9 127/20 128/3 159/3 159/20</p> <p>inappropriately [3] 64/11 65/8 159/16</p> <p>inaudible [2] 79/16 82/17</p> <p>inbuilt [2] 50/6 121/14</p> <p>incidence [1] 41/15</p> <p>incidences [2] 177/8 178/15</p> <p>incident [3] 177/5 179/4 179/25</p> <p>incidents [1] 178/3</p> <p>inclined [1] 142/15</p> <p>include [2] 65/9 211/9</p> <p>included [13] 71/7 71/10 72/3 73/4 73/16 73/19 74/14 74/20 74/25 75/19 108/13 147/11 168/13</p> <p>includes [1] 81/11</p> <p>including [17] 11/2 11/6 14/25 19/5 42/16 43/19 48/3 74/4 88/15 88/22 94/25 105/22 119/13 150/1 199/10 206/21 209/3</p> <p>inclusion [1] 74/17</p> <p>inclusiveness [1] 50/17</p> <p>inconsistency [1] 161/4</p> <p>incorporated [1] 119/17</p> <p>incorporates [1] 174/21</p> <p>incorrect [1] 185/12</p> <p>incorrectly [1] 186/15</p> <p>increase [4] 74/6 190/18 205/21 208/6</p> <p>increased [4] 130/22 139/10 144/22 168/25</p> <p>increases [1] 77/3</p> <p>increasing [5] 64/23 77/2 183/19 202/6 206/23</p> <p>incredible [3] 126/15 142/6 148/13</p> <p>incredibly [12] 11/18 46/18 68/11 69/20 71/13 71/22 81/20 92/25 124/19 125/8 136/19 143/5</p> <p>indeed [22] 11/7 12/15 13/13 15/10 20/18 36/6 36/14 40/22 47/19 55/17 62/18 64/15 68/7</p>	<p>68/15 69/2 73/20 74/12 83/25 119/22 181/21 191/18 203/22</p> <p>independent [4] 5/10 49/12 49/13 165/25</p> <p>INDEX [1] 216/10</p> <p>Indian [1] 170/21</p> <p>indicated [2] 204/25 208/11</p> <p>indication [1] 35/21</p> <p>indicative [1] 180/13</p> <p>indicator [1] 153/12</p> <p>individual [32] 28/8 33/10 36/8 59/6 62/23 64/18 70/7 77/13 89/14 116/17 117/7 117/25 118/19 118/21 123/9 123/10 123/11 123/13 128/3 140/6 152/24 194/14 194/24 198/24 199/1 199/12 199/20 200/7 209/3 213/4 213/6 213/7</p> <p>individualised [2] 152/18 152/21</p> <p>individuals [8] 31/10 40/15 41/18 62/12 98/23 125/22 130/10 202/11</p> <p>industries [1] 60/25</p> <p>industry [3] 86/11 86/15 139/18</p> <p>inequalities [1] 113/21</p> <p>inevitability [1] 7/9</p> <p>inevitable [1] 131/9</p> <p>inevitably [1] 160/24</p> <p>infected [1] 104/18</p> <p>infection [5] 18/13 108/12 108/15 160/9 169/19</p> <p>infectious [1] 202/17</p> <p>influenza [5] 4/4 12/3 29/5 30/2 81/18</p> <p>inform [1] 118/16</p> <p>Informatics [1] 211/5</p> <p>information [24] 45/18 65/20 134/11 145/20 150/13 169/14 169/17 171/11 171/18 175/1 189/22 201/21 204/19 209/5 209/17 210/3 210/9 210/11 210/19 211/12 211/15 211/16 211/20 215/9</p> <p>informed [3] 62/11 96/20 106/11</p> <p>infrastructure [3] 81/12 86/2 135/9</p> <p>initial [8] 12/20 16/7 19/22 85/15 86/21 136/14 190/17 206/3</p> <p>initially [4] 5/16 30/23 71/10 118/19</p>	<p>initiative [1] 99/14</p> <p>injury [1] 175/19</p> <p>inpatient [2] 137/2 168/4</p> <p>input [1] 39/13</p> <p>INQ00050008 [1] 28/25</p> <p>INQ00050020 [1] 73/7</p> <p>INQ00059879 [1] 57/22</p> <p>INQ000227377 [1] 202/4</p> <p>INQ000252505 [1] 204/14</p> <p>INQ000320204 [1] 133/14</p> <p>INQ000339335 [1] 33/18</p> <p>INQ000369658 [2] 3/8 3/23</p> <p>INQ000389241 [5] 3/8 15/16 21/19 38/16 44/11</p> <p>INQ000398241 [1] 130/14</p> <p>INQ000417548 [1] 181/23</p> <p>INQ000466548 [1] 143/11</p> <p>INQ000466549 [1] 152/25</p> <p>INQ000468614 [1] 52/11</p> <p>INQ000469724 [2] 3/9 76/8</p> <p>INQ000472172 [2] 3/8 112/14</p> <p>INQ000473872 [2] 3/9 102/24</p> <p>INQ000475209 [1] 134/24</p> <p>INQ000478907 [1] 65/2</p> <p>INQ000485721 [1] 188/19</p> <p>INQ000486014 [1] 192/15</p> <p>INQ000498103 [1] 95/6</p> <p>inquiries [1] 134/1</p> <p>inquiry [41] 1/9 5/24 9/15 10/16 10/21 12/5 14/19 29/10 30/8 55/15 57/9 83/25 94/7 95/4 104/16 104/17 112/14 116/21 120/8 127/16 127/17 131/3 132/11 132/21 133/1 133/25 134/12 134/19 147/2 167/25 175/2 176/18 187/22 188/10 188/19 189/21 194/1 197/14 217/6 217/18</p>	<p>217/25</p> <p>Inquiry's [2] 54/22 102/13</p> <p>insight [1] 105/1</p> <p>insights [2] 102/18 104/24</p> <p>insofar [1] 100/25</p> <p>inspection [1] 179/14</p> <p>Inspectorate [1] 179/13</p> <p>instance [2] 28/11 29/19</p> <p>instances [4] 176/23 177/9 185/11 185/18</p> <p>instilling [1] 149/15</p> <p>institute [1] 33/7</p> <p>instituted [2] 170/10 170/17</p> <p>institution [2] 31/23 32/10</p> <p>institutions [4] 31/10 41/18 117/6 187/24</p> <p>insufficient [1] 166/10</p> <p>insurance [1] 72/8</p> <p>integrated [1] 115/21</p> <p>intelligence [1] 197/7</p> <p>intended [1] 95/9</p> <p>intense [1] 126/17</p> <p>intensive [3] 181/5 207/5 208/18</p> <p>intention [2] 99/17 185/20</p> <p>interest [1] 178/18</p> <p>interesting [2] 34/13 34/20</p> <p>interim [5] 68/23 69/4 135/1 168/6 210/15</p> <p>internal [1] 192/4</p> <p>international [5] 10/2 21/11 21/12 50/3 196/20</p> <p>internationally [1] 50/5</p> <p>interpreting [2] 139/22 181/4</p> <p>interrelated [1] 58/16</p> <p>interrupt [2] 85/24 159/21</p> <p>interruption [1] 160/1</p> <p>intervention [1] 82/4</p> <p>interventions [1] 208/11</p> <p>interviewing [1] 143/18</p> <p>into [50] 5/24 9/17 12/7 14/3 20/10 27/10 40/4 57/24 82/16 83/10 86/3 89/19 100/15 100/16 101/5 101/12 102/18 105/1 105/14 107/4 107/16</p>	<p>114/21 115/22 117/1 119/17 121/10 121/14 142/7 149/16 171/5 175/25 178/17 178/19 178/20 183/3 185/22 188/3 193/18 195/14 195/19 197/4 197/7 199/15 200/3 200/14 204/16 209/8 212/12 213/25 215/23</p> <p>introduce [3] 196/17 196/22 214/17</p> <p>introduced [9] 21/22 136/21 170/14 170/16 171/22 210/2 213/1 214/15 215/4</p> <p>introduction [1] 169/23</p> <p>intubated [1] 212/21</p> <p>invasive [14] 205/14 206/24 207/1 211/23 211/24 212/2 212/4 212/18 213/9 213/12 213/12 213/14 214/22 215/1</p> <p>invest [2] 83/2 83/6</p> <p>investigation [5] 55/18 79/9 157/4 178/5 178/10</p> <p>investigations [1] 137/23</p> <p>investment [3] 82/12 82/16 82/24</p> <p>invests [1] 83/3</p> <p>involve [1] 103/9</p> <p>involved [12] 13/17 35/23 53/23 55/14 77/7 77/8 77/15 160/20 178/6 178/13 193/11 200/18</p> <p>involvement [1] 104/7</p> <p>IPC [16] 26/10 27/3 103/5 104/5 104/8 104/11 105/2 105/10 106/18 107/5 107/22 107/22 108/19 160/16 161/4 162/7</p> <p>Ireland [1] 27/20</p> <p>irrespective [1] 67/5</p> <p>is [539]</p> <p>is chairing [1] 6/21</p> <p>is: [1] 154/14</p> <p>is: no [1] 154/14</p> <p>isn't [11] 23/23 70/20 124/21 126/5 141/23 158/20 166/1 168/3 171/22 180/13 200/10</p> <p>isolation [9] 147/18 202/12 202/13 202/18 202/24 203/3 203/12 203/23 208/12</p> <p>issue [71] 6/15 6/15 7/7 7/9 21/7 28/20</p>
---	--	--	--	---

I	161/12 162/23 163/4 169/22 172/17 176/23 178/16 182/22 183/4 184/11 185/16 200/4 205/6 issuing [1] 156/6 it [533] it's [145] 1/10 3/11 4/11 4/11 6/21 9/14 9/18 10/18 10/22 10/23 11/21 14/2 14/5 17/20 21/8 21/9 21/22 22/13 23/19 24/2 25/4 27/5 29/10 29/19 29/25 30/16 32/14 33/22 34/1 35/17 36/25 36/25 37/20 40/5 41/4 41/6 42/10 44/5 45/15 45/25 51/20 53/5 54/15 57/2 58/8 60/4 61/4 61/12 63/14 65/5 66/11 69/21 71/21 77/8 77/12 78/4 79/5 79/18 80/8 81/17 81/19 86/20 87/19 87/21 90/22 92/25 95/6 95/6 97/24 98/2 98/24 100/12 100/19 100/25 105/4 106/21 106/22 113/18 114/3 115/6 116/17 117/24 118/4 118/11 119/11 120/12 120/20 121/17 124/24 125/7 125/12 125/16 125/22 125/25 126/4 126/9 126/11 126/20 126/21 127/3 128/18 130/5 130/16 131/16 132/15 132/15 132/16 132/18 134/12 135/14 141/23 146/7 146/21 149/4 151/7 158/6 158/11 158/22 165/24 168/2 169/10 170/5 171/22 174/16 175/8 175/10 175/13 176/2 176/6 179/12 184/19 184/22 185/14 186/2 190/5 191/19 191/24 192/10 194/13 202/4 202/16 204/13 207/2 210/6 214/1 Italy [3] 137/18 137/20 209/10 item [4] 23/20 31/16 82/9 82/9 item by [1] 82/9 item of [1] 82/9 items [9] 5/6 12/1 12/13 12/14 24/7 101/19 182/9 182/14 183/7 its [16] 19/5 25/24	49/12 51/9 64/23 68/13 88/14 91/13 97/14 111/7 118/3 143/24 183/11 196/8 199/11 208/6 itself [5] 69/12 84/2 89/9 123/1 157/2 ITU [11] 138/5 138/12 138/15 141/20 152/3 152/19 153/25 156/2 156/3 159/9 178/19 iv [1] 45/7	J January [7] 17/8 19/10 31/4 163/12 163/19 164/21 165/15 January 2020 [1] 31/4 January 2021 [1] 164/21 jargon [1] 59/1 Javid [2] 3/17 49/18 Jean [1] 198/6 Jeremy [1] 126/20 job [7] 7/19 7/21 54/23 66/11 69/13 96/19 127/10 joining [1] 2/24 joint [4] 5/13 95/4 149/2 177/3 Jonathan [1] 113/17 Jonathan Marron [1] 113/17 judged [1] 23/22 July [5] 25/2 31/5 122/18 162/22 164/6 July 2020 [1] 31/5 July 2021 [1] 162/22 jump [1] 117/13 June [23] 15/7 15/17 17/4 18/15 24/12 24/21 38/12 38/23 57/7 57/13 101/21 103/11 118/15 143/8 144/7 149/6 149/25 171/9 171/12 172/7 172/7 189/8 189/19 June 2020 [1] 38/12 June 2021 [1] 172/7 junior [10] 146/4 156/18 161/7 177/6 178/23 179/1 179/25 180/2 180/6 180/23 just [107] 4/6 7/8 10/1 13/3 13/5 13/14 14/24 20/21 20/22 21/19 23/6 23/17 28/1 32/24 37/18 40/22 42/11 43/5 44/10 44/12 44/13 46/22 47/11 49/13 52/7 57/21 68/8 71/18 71/20 73/3 74/18	75/11 75/17 77/22 79/5 82/6 84/14 84/22 85/19 86/1 88/22 89/14 91/9 92/2 92/13 96/5 98/19 100/12 100/19 101/17 102/5 103/17 104/4 104/17 107/9 108/8 108/9 115/1 115/17 117/13 117/15 117/17 119/23 122/3 125/12 126/3 129/3 130/5 131/23 132/5 133/18 135/5 137/1 138/20 139/4 141/1 144/10 146/13 147/7 149/12 149/13 149/14 151/8 152/2 155/5 158/6 163/6 166/13 174/2 175/16 176/1 176/10 176/15 176/20 176/23 179/22 180/1 180/15 184/2 188/20 192/18 201/4 206/18 214/11 214/15 215/22 216/3 Justice [3] 122/8 176/15 181/16	knighthood [1] 107/15 know [125] 1/10 1/21 9/21 10/21 16/10 20/12 22/8 26/4 26/14 27/12 27/19 29/22 30/7 30/11 30/13 30/14 32/7 32/11 32/19 33/13 33/14 34/16 34/18 36/3 36/3 36/15 37/17 38/2 39/13 41/16 42/20 43/4 46/4 46/12 47/2 48/1 49/3 52/4 53/6 56/15 57/1 59/21 59/25 61/3 61/11 64/6 66/9 66/22 70/18 71/16 72/11 76/2 77/17 78/18 79/20 81/15 81/21 81/24 82/1 85/10 88/23 89/5 90/5 91/24 93/2 93/15 93/22 94/21 95/22 96/3 96/10 100/20 105/8 107/21 108/14 108/23 111/16 111/25 112/8 119/19 119/21 126/6 126/14 129/24 131/5 132/18 140/16 145/23 145/24 148/13 150/7 150/16 154/16 157/11 157/13 158/20 158/22 158/23 161/8 168/11 169/14 170/19 171/10 172/5 174/8 176/2 179/12 179/20 180/8 182/11 184/23 184/25 185/14 185/20 185/23 186/2 186/22 188/2 188/12 203/8 204/2 204/6 207/6 210/23 215/24 knowing [5] 37/7 38/5 53/8 53/9 53/11 knowledge [11] 2/3 37/3 102/9 103/2 103/16 103/19 103/22 112/22 153/19 154/23 162/3 known [6] 13/8 17/15 30/5 48/22 56/2 113/24 knows [3] 2/8 12/5 131/4
				L lack [9] 44/24 70/13 70/22 135/21 147/18 162/15 185/8 186/9 200/4 Lady [30] 1/4 28/17 52/12 54/2 93/22 94/2 95/5 96/24 97/4 101/8 107/8 108/25 109/17	

L	learned [5] 28/7 80/17 80/25 81/3 121/13	170/14 174/15 182/15 184/5 184/12 204/24 206/11 210/6 212/13 215/17	listened [1] 44/25 lists [2] 151/18 151/20	long-standing [3] 46/6 46/19 47/11
Lady... [17] 113/7 122/1 122/4 122/9 133/9 133/11 134/17 159/22 160/7 173/5 176/8 181/8 181/13 186/25 187/23 188/7 215/24	learning [24] 100/4 103/3 144/6 144/8 156/19 157/7 158/2 158/18 158/19 168/18 168/21 172/19 172/22 173/1 176/5 176/25 177/21 177/24 178/2 178/11 178/25 180/3 181/2 199/22	levels [9] 31/9 32/14 125/23 136/3 136/4 136/6 146/18 146/24 167/21	little [12] 7/4 10/9 17/20 25/25 39/25 59/19 87/12 126/4 180/16 204/9 205/15 207/1	long-term [2] 20/3 153/9
Ladyship [3] 82/15 92/22 180/5	learnings [2] 145/25 149/11	lever [1] 194/23	lived [5] 184/6 184/14 186/13 186/16 186/17	longer [2] 7/2 35/9
Ladyship's [1] 172/12	learnt [4] 146/14 152/12 185/23 185/23	LFD [2] 86/15 86/19	lives [3] 84/8 96/7 100/24	look [37] 8/18 15/3 15/15 19/9 20/20 21/6 21/17 23/8 23/9 23/10 24/15 30/19 38/6 53/21 57/21 63/6 73/6 76/23 94/5 106/8 114/3 128/5 137/21 187/10 187/13 192/14 196/1 199/9 201/19 202/3 202/9 203/25 205/11 208/2 208/8 211/15 213/8
lag [1] 98/8	least [6] 48/16 100/4 154/25 168/17 207/13 214/2	liaison [2] 139/17 141/10	living [1] 94/10	looked [8] 5/24 7/22 29/7 29/10 29/25 42/1 63/1 142/9
laid [2] 10/12 175/16	leave [1] 108/25	licensed [1] 114/20	load [1] 42/25	looking [13] 11/20 12/19 22/19 30/17 32/1 32/11 35/1 92/12 137/18 196/14 196/15 209/8 214/13
large [9] 17/22 18/1 31/7 33/21 39/20 58/19 162/6 164/25 165/2	led [6] 7/11 64/8 76/10 106/5 146/3 185/11	lie [2] 194/10 194/12	local [36] 9/18 9/23 9/24 56/17 96/17 141/24 142/8 146/2 149/1 151/6 160/17 160/24 170/15 178/1 183/1 190/24 190/25 191/18 191/20 192/20 192/25 194/1 200/16 201/25 203/11 203/21 204/11 205/4 205/20 207/3 207/6 208/3 208/23 209/16 209/25 211/20	looks [1] 73/11
largely [1] 109/22	left [6] 9/20 141/22 189/24 198/10 198/12 211/22	lies [1] 194/14	locally [3] 96/22 160/25 163/4	Lord [2] 9/15 88/12
largest [1] 143/20	left-hand [2] 198/12 211/22	life [9] 46/1 70/24 72/8 104/15 109/25 153/17 156/11 168/15 180/4	lockdown [1] 122/25	Lord Darzi [1] 88/12
last [6] 1/12 42/11 56/4 85/17 127/7 162/1	legal [6] 54/17 54/19 58/16 154/5 194/10 201/14	life-years' [1] 153/17	logging [1] 35/19	Lord Darzi's [1] 9/15
lastly [3] 172/24 179/12 179/12	legals [1] 55/10	light [2] 10/6 120/24	long [56] 20/3 39/2 46/6 46/19 47/11 51/11 51/12 51/17 82/9 89/13 91/19 91/21 92/1 92/2 94/4 94/6 94/8 94/10 94/11 94/15 94/16 94/16 94/23 94/25 95/10 95/11 95/19 95/20 96/3 96/7 96/21 134/20 151/20 153/9 171/21 171/22 172/1 173/9 173/11 173/13 173/19 173/20 173/24 174/3 174/4 174/21 175/5 175/6 175/10 175/11 175/18 175/21 175/25 179/12 183/19 188/12	lose [1] 136/16
late [2] 50/25 57/7	legislation [10] 4/19 4/20 60/20 61/9 61/10 61/11 61/13 128/21 129/2 129/10	lighter [1] 54/1	long Covid [35] 91/19 91/21 92/1 92/2 94/6 94/8 94/10 94/11 94/15 94/16 94/16 94/23 94/25 95/10 95/11 95/19 95/20 96/3 96/7 96/21 171/21 171/22 172/1 173/13 173/19 173/20 174/3 174/4 174/21 175/5 175/6 175/10 175/11 175/18 175/21 175/25 179/12 183/19 188/12	lot [35] 8/21 8/24 9/4 11/17 25/18 38/6 39/13 42/24 45/22 46/3 47/4 60/16 80/7 80/18 82/2 83/22 84/11 92/14 94/21 98/15 105/22 115/3 119/24 121/10 121/13 128/7 141/7 141/13 141/17 150/12 150/13 163/7 168/1 170/18 197/14
late June 2020 [1] 57/7	lesser [1] 143/24	like [42] 4/2 5/11 10/1 14/23 22/5 22/25 33/23 35/5 36/4 44/10 54/10 57/21 58/3 60/7 62/16 63/7 64/14 68/8 71/11 78/14 81/5 89/5 100/3 102/1 102/19 106/8 110/13 121/10 125/12 132/5 141/20 142/9 149/13 158/17 162/2 174/21 178/3 187/25 196/17 197/17 200/2 212/13	lots [6] 41/16 48/3 86/17 121/6 124/7 132/22	Lord Darzi's [1] 9/15
later [13] 3/10 5/18 26/14 30/24 47/12 52/2 147/3 168/22 171/11 173/16 193/15 214/18 215/15	lessons [3] 80/24 81/4 150/4	likelihood [1] 74/6	loved [2] 62/12 184/9	lose [1] 136/16
lateral [1] 162/14	let [11] 7/1 13/4 22/2 44/8 45/15 115/17 116/15 117/14 118/13 120/7 145/12	likely [10] 24/3 26/9 27/1 94/13 100/5 166/23 166/23 185/11 208/20 214/3	low [1] 62/13	lot [35] 8/21 8/24 9/4 11/17 25/18 38/6 39/13 42/24 45/22 46/3 47/4 60/16 80/7 80/18 82/2 83/22 84/11 92/14 94/21 98/15 105/22 115/3 119/24 121/10 121/13 128/7 141/7 141/13 141/17 150/12 150/13 163/7 168/1 170/18 197/14
latest [1] 174/16	letter [18] 95/4 95/6 95/12 95/21 140/19 168/19 170/20 170/23 177/3 177/12 181/25 182/4 202/3 202/9 202/14 202/22 203/9 209/19	likewise [1] 122/16	lower [3] 44/21 46/14 212/13	lower-level [1] 212/13
launched [3] 49/20 174/17 174/19	letters [4] 56/10 56/25 64/14 157/23	limit [1] 212/12	lowering [1] 127/8	lump [2] 71/3 74/2
law [2] 61/15 130/5	level [30] 30/6 31/18 36/21 53/17 53/20 62/13 68/13 88/16 106/1 112/20 112/24 124/14 128/9 130/18 131/19 137/5 138/1 138/25 139/5 156/23	limitations [2] 136/13 173/17	lying [1] 75/3	lucky [2] 83/19 148/17
lay [7] 68/6 103/20 127/2 128/17 154/5 175/15 195/17		limited [3] 85/25 104/11 122/13		Lucy [1] 113/18
lead [18] 1/9 5/17 5/21 6/1 6/16 7/3 7/16 56/15 64/22 92/18 95/13 110/5 129/7 130/2 163/2 180/22 189/1 217/5		limiting [2] 106/17 135/19		Lucy Chappell [1] 113/18
lead-up [1] 64/22		limits [1] 126/9		luncheon [1] 127/8
leader [3] 36/20 116/5 149/15		line [20] 12/21 18/12 27/23 35/10 64/20 67/17 71/20 72/19 75/7 75/9 76/1 76/2 110/24 110/25 117/21 187/6 187/15 202/12 206/20 215/20		machine [1] 25/5
leaders [5] 37/23 38/7 148/24 149/1 149/12		lines [1] 185/25		
leadership [9] 36/8 37/2 149/3 149/9 149/10 149/16 150/7 150/15 195/13		lip [1] 47/21		
leading [7] 6/13 6/21 8/23 35/5 35/14 36/10 206/8		lip-reading [1] 47/21		
leads [1] 34/21		list [5] 10/16 56/12 57/25 93/14 151/17		
leakages [1] 167/15		listed [1] 126/23		
learn [1] 146/16				

M	21/22 23/18 34/10 35/5 35/15 150/3 190/5 202/7 210/4 manager [1] 34/25 managing [3] 2/22 5/2 34/25 mandatory [4] 191/1 191/2 191/9 191/20 manning [1] 34/6 manual [2] 162/16 163/18 manufacture [1] 21/8 manufactured [1] 116/4 manufacturers [3] 20/25 21/1 52/15 many [47] 10/22 16/19 19/3 19/4 20/13 29/18 30/9 33/12 35/18 36/14 45/14 52/24 54/22 55/1 56/23 78/10 78/11 78/12 78/12 78/13 84/7 84/7 84/10 85/3 85/23 91/9 96/20 97/24 97/24 108/18 116/22 125/8 131/20 132/2 132/2 133/1 140/4 140/18 141/1 150/1 151/5 167/2 167/3 171/8 172/21 186/4 186/4 March [46] 6/17 8/3 21/20 30/22 30/24 33/20 34/1 34/4 34/23 35/20 44/13 44/16 49/9 51/1 51/17 57/10 62/19 64/3 70/1 102/11 130/10 130/20 131/18 137/4 152/9 155/20 164/2 164/5 164/10 165/16 169/6 189/19 204/3 204/9 204/15 205/19 207/12 207/13 208/1 208/10 209/15 209/20 209/22 211/19 212/20 214/21 March 2020 [4] 102/11 130/10 131/18 189/19 March 2021 [1] 70/1 March/April 2020 [1] 62/19 marked [1] 24/8 market [6] 14/3 50/10 50/11 50/22 51/25 116/3 markets [4] 26/19 114/9 114/25 115/10 Marron [1] 113/17 mask [6] 41/9 41/12 41/23 104/21 104/25 144/24 masking [1] 102/8	masks [21] 19/13 19/14 40/2 40/9 40/25 40/25 41/6 42/8 45/5 47/8 47/17 47/18 48/4 101/21 102/6 103/12 106/16 116/25 120/5 144/21 146/18 mass [2] 164/11 164/12 massively [2] 16/23 43/9 materialise [1] 142/20 materials [2] 21/7 21/14 maternity [1] 58/3 matter [13] 29/20 31/23 53/5 59/8 69/9 69/13 76/16 91/20 91/20 91/22 117/24 117/25 126/10 matters [5] 5/11 89/1 94/17 191/5 191/8 Matthew [2] 112/13 113/17 Matthew Style [2] 112/13 113/17 may [52] 1/14 2/2 2/7 2/14 3/4 3/22 12/25 13/3 21/17 26/8 28/18 33/14 61/9 71/12 76/19 77/18 81/6 81/13 86/17 86/18 86/19 103/9 106/14 109/3 115/18 116/24 122/9 126/3 126/19 126/22 127/1 134/17 137/14 144/12 153/13 153/15 159/3 159/23 164/5 171/3 175/3 180/1 181/11 188/3 188/19 191/23 196/18 197/17 201/12 203/20 212/6 214/20 maybe [1] 106/20 MDT [1] 174/22 me [41] 7/1 13/4 15/2 32/23 36/12 36/13 37/7 37/24 40/2 41/4 41/6 44/8 45/15 46/2 46/17 47/25 49/23 84/16 86/5 97/15 105/8 105/9 110/14 115/17 116/15 117/14 118/13 119/1 120/7 127/4 129/16 158/24 161/8 170/25 174/22 183/3 184/23 186/2 188/1 193/23 205/12 mean [36] 5/21 18/18 18/18 19/3 22/17 26/2 34/17 36/2 37/13 45/18 46/16 62/21 68/4 68/4 68/16 68/16	75/21 76/15 80/9 80/17 83/7 84/9 84/25 90/19 90/21 97/18 98/3 107/25 125/20 125/20 137/11 137/13 140/7 185/14 186/18 209/7 meaning [1] 197/22 means [6] 6/1 37/16 76/1 165/25 166/5 194/4 meant [10] 84/20 136/20 136/23 139/23 152/4 195/17 199/14 199/23 201/3 208/16 measure [1] 162/9 measures [7] 21/22 33/8 103/5 129/25 162/7 165/17 175/17 mechanical [2] 206/24 212/21 mechanism [2] 38/5 200/21 mechanisms [5] 117/19 118/6 129/19 197/4 207/21 media [2] 78/9 78/23 medical [49] 23/15 43/3 43/8 43/11 43/18 43/21 48/9 50/4 50/16 53/9 53/23 60/14 69/12 79/11 83/3 87/5 100/21 100/22 101/16 114/8 115/20 121/7 125/17 126/8 134/25 135/17 139/24 140/16 140/18 151/25 157/24 158/6 158/13 190/4 193/11 197/15 197/21 197/25 198/5 198/6 198/16 201/25 202/4 202/23 203/9 206/21 209/3 213/19 213/22 medically [6] 107/25 108/7 108/8 108/17 141/25 142/2 Medicine [1] 95/8 medicines [2] 13/15 58/2 meet [1] 166/10 meeting [15] 37/22 37/24 38/4 65/23 66/23 66/25 67/3 68/12 123/19 153/3 157/6 169/6 196/8 204/20 208/25 meetings [4] 6/18 165/6 165/7 206/12 member [4] 7/18 145/8 145/10 146/9 members [8] 105/2 109/21 117/7 142/25 154/4 157/16 184/7 184/14	memory [2] 41/21 108/11 mental [1] 126/8 mention [2] 97/8 166/13 mentioned [9] 88/8 95/24 116/17 119/11 148/1 148/3 150/6 165/20 176/1 MERS [1] 12/4 MERS/SARS-style [1] 12/4 message [2] 78/6 78/7 messages [3] 57/6 57/9 79/23 messaging [4] 79/15 122/20 126/11 130/10 met [3] 24/20 70/15 125/25 method [1] 65/7 meticulous [1] 165/13 metres [1] 136/21 MHRA [2] 50/15 114/17 microbiologists [1] 165/10 microphone [3] 101/12 105/15 173/22 mid [3] 38/23 109/11 207/13 mid-afternoon [1] 109/11 mid-June [1] 38/23 mid-March [1] 207/13 middle [3] 136/20 163/11 196/8 midwifery [1] 197/22 might [16] 21/3 52/12 60/21 67/4 80/5 85/14 101/21 105/1 144/12 153/12 158/16 166/19 166/25 167/1 172/18 175/2 migrant [4] 109/20 109/22 109/24 112/4 miles [1] 123/12 military [1] 9/3 million [11] 12/1 15/21 16/4 17/13 24/18 24/19 26/13 55/20 76/24 86/13 124/18 mind [10] 61/17 73/8 93/20 109/6 117/16 131/8 135/15 152/20 180/5 180/6 mindful [1] 58/22 mindset [2] 124/11 124/20 mine [2] 50/3 124/16 minimising [1] 153/5
----------	---	--	--	---

M	12/5	168/16	Ms Nield [1] 188/6	147/3 147/6 154/23
minister [18] 6/9	moment [15] 19/10	move [19] 28/17 76/5	Ms Sen Gupta [4]	159/22 160/1 160/7
6/12 6/17 6/20 36/15	40/23 43/12 52/13	80/23 100/15 100/16	109/15 109/18 113/8	160/15 168/2 170/4
65/5 65/11 73/21	54/2 64/13 80/3 89/25	100/22 111/17 111/19	217/10	171/2 171/9 173/5
73/22 74/1 74/12	99/9 138/10 145/18	115/17 116/2 116/15	Ms Tranka [1] 177/13	173/5 173/25 175/4
189/2 190/11 190/15	163/6 163/10 164/16	118/13 149/19 151/21	MSC [2] 65/5 65/7	175/20 176/8 176/13
192/6 195/5 204/13	175/7	159/22 201/19 204/9	much [60] 7/13 7/23	176/19 177/15 178/5
204/17	Monday [1] 30/23	205/3 213/2	21/10 22/24 23/12	178/22 179/24 180/18
ministerial [7] 67/17	money [6] 12/16	moved [3] 6/14 38/3	23/13 23/13 23/17	181/8 181/13 182/11
70/1 70/9 72/25 189/2	16/22 25/17 26/1	152/2	25/17 26/18 33/9	182/19 186/25 187/15
191/10 191/18	75/10 96/6	moves [1] 60/5	33/10 39/7 39/23	187/23 188/1 188/7
ministerially [1] 7/11	monitor [4] 65/10	moving [7] 111/20	39/24 45/25 51/11	188/17 189/15 195/6
ministers [13] 2/19	90/17 91/5 91/16	112/12 123/14 156/5	54/4 57/10 57/13	203/14 215/15 215/24
3/13 36/14 52/6 67/11	monitored [1] 90/20	167/25 184/2 208/4	59/13 62/17 63/2	my Lady [18] 1/4
72/15 72/20 111/9	monitoring [7] 22/19	Mpox [1] 92/14	75/24 82/10 86/1 87/6	28/17 52/12 54/2
190/24 194/20 194/20	34/9 36/4 55/21 56/2	Mr [18] 3/16 73/18	87/22 88/2 88/16	93/22 95/5 96/24
210/14 215/12	117/18 125/10	74/12 74/23 75/21	89/24 96/6 96/25 99/4	113/7 122/1 122/9
Ministry [1] 56/16	month [3] 38/22	97/1 97/2 97/3 101/9	99/7 101/7 113/8	134/17 160/7 173/5
minorities [2] 43/5	39/10 77/1	101/10 101/14 107/22	119/16 120/15 125/13	176/8 181/8 186/25
117/12	months [8] 16/2	108/24 112/15 113/9	133/3 133/21 133/22	188/7 215/24
minority [13] 40/19	16/11 16/11 16/12	182/8 217/8 217/9	141/12 143/24 146/10	my NHS [1] 195/6
46/22 109/22 113/15	98/10 157/13 185/24	Mr Burton [1] 97/1	150/11 167/3 167/3	myself [5] 28/7 36/7
116/22 116/24 117/20	210/11	MR BURTON KC [2]	169/1 169/10 172/24	48/1 75/23 86/1
118/18 119/4 119/14	months' [1] 106/8	97/3 217/8	176/9 177/19 179/24	
119/16 120/8 120/21	Moore [2] 182/2	Mr Hancock [5] 3/16	181/6 187/20 188/15	N
miscommunication	182/8	73/18 74/12 74/23	208/5 216/4	name [4] 122/6
[1] 75/4	moral [2] 154/12	75/21	multiple [3] 79/17	176/13 188/16 188/17
misinterpreting [1]	169/7	Mr Moore [1] 182/8	82/17 178/3	nation [1] 10/4
180/23	morally [1] 75/8	Mr Stanton [5]	multiplied [1] 39/9	national [36] 4/8 18/1
missing [1] 31/16	morbidity [1] 157/6	101/10 101/14 107/22	multiplier [1] 39/7	29/3 30/21 37/5 57/16
mission [1] 49/18	more [58] 7/1 12/7	108/24 217/9	mum [1] 145/9	58/4 58/10 59/9 68/20
mistake [1] 170/4	20/11 20/11 21/10	Mr Style [1] 112/15	Munroe [10] 122/3	69/18 70/23 74/21
mistakes [2] 126/9	24/5 25/12 30/12 33/9	Mr Thomas [1] 113/9	122/5 122/7 133/10	78/9 78/23 79/18
126/17	35/9 36/8 43/6 43/13	Ms [38] 1/3 21/15	176/10 176/11 176/14	79/21 83/22 137/9
mitigate [6] 52/23	45/4 45/18 60/8 61/9	44/3 54/8 73/23 93/25	181/9 217/14 217/20	140/13 154/11 155/14
53/2 53/24 115/8	63/2 67/4 67/21 68/2	94/1 101/19 109/15	Munroe's [1] 133/20	160/16 160/19 160/23
164/24 182/17	75/24 79/2 81/22 82/2	109/18 109/25 113/8	must [1] 188/12	162/10 163/2 168/7
mitigation [1] 52/17	87/23 89/24 92/1	122/3 122/5 123/22	mustn't [1] 85/25	174/20 193/18 194/8
mixed [1] 8/15	95/13 99/4 100/5	131/15 133/10 133/20	my [125] 1/4 2/6 2/9	196/10 199/24 200/23
mobilise [1] 142/15	100/11 104/2 115/20	134/16 160/6 173/7	7/19 9/10 10/16 11/18	207/18 210/6
model [3] 139/20	119/8 119/15 126/5	173/8 176/10 176/11	12/18 28/17 31/8	nationalism [1] 17/21
200/13 209/5	127/22 128/3 136/21	176/18 177/13 179/24	35/17 37/22 38/5 40/6	nationally [7] 14/18
modelled [1] 106/7	141/12 141/14 142/15	181/9 181/10 181/14	41/5 52/12 53/6 53/16	20/10 22/23 32/1 99/5
modelling [7] 106/1	143/1 147/24 153/15	187/1 188/6 217/7	54/2 56/16 66/10	160/21 168/11
106/15 106/15 106/18	157/13 160/17 162/9	217/10 217/14 217/19	66/13 67/13 67/23	nations' [1] 89/8
107/5 172/16 206/5	163/20 166/5 180/16	217/20 217/21	68/6 69/20 75/15 79/1	natural [1] 31/22
moderate [1] 102/14	180/21 196/22 197/5	Ms Carey [6] 1/3	80/1 80/17 82/1 84/10	naturally [1] 25/4
modern [2] 135/15	210/19 211/9 214/25	54/8 101/19 109/25	85/9 86/9 86/20 93/8	nature [1] 211/16
148/4	morning [6] 1/4 1/10	123/22 131/15	93/14 93/22 94/2 94/5	near [2] 39/17 152/3
Moderna [1] 82/6	2/5 81/7 109/7 204/21	Ms Carey's [1] 44/3	94/20 95/5 95/16 96/8	nearly [2] 164/12
module [19] 1/9 1/18	mortality [3] 99/22	Ms Gowman [4]	96/24 97/4 99/12	170/7
12/25 16/25 17/18	100/10 157/6	181/10 181/14 187/1	99/20 101/8 101/8	necessarily [2] 10/12
25/16 28/16 81/18	most [26] 11/12	217/21	102/22 103/10 103/18	16/4
84/15 85/12 86/24	20/15 32/4 32/5 32/7	Ms Hand [1] 134/16	103/19 107/6 107/8	necessary [4] 86/2
103/24 106/21 120/7	34/14 38/23 53/14	Ms Hands [3] 160/6	108/16 108/17 108/25	151/8 196/11 210/7
120/11 120/12 134/24	69/11 96/6 97/23	176/18 179/24	109/17 111/20 112/22	need [54] 16/8 19/24
189/20 217/6	99/18 99/18 114/22	Ms Iengar [4] 93/25	113/7 115/18 117/3	27/2 33/5 37/5 61/9
Module 1 [4] 25/16	117/3 122/22 123/2	173/7 173/8 217/19	117/10 120/7 120/19	66/6 78/13 78/17
81/18 120/7 120/11	124/9 139/13 161/22	Ms Munroe [4] 122/3	122/1 122/4 122/6	78/18 79/1 79/15 80/4
Module 3 [2] 12/25	163/25 164/1 165/1	133/10 176/11 217/20	122/9 122/14 123/20	80/16 82/10 82/15
189/20	171/20 183/7 207/4	MS MUNROE KC [2]	127/7 128/11 130/18	82/22 85/4 89/15 90/4
Module 5 [1] 106/21	mostly [3] 139/16	122/5 217/14	131/15 133/4 133/9	90/5 91/1 91/13 92/16
modules [2] 5/25	139/17 187/9	Ms Munroe's [1]	133/11 134/17 140/22	95/11 95/18 99/18
	mother [2] 135/13	133/20	141/6 145/18 146/21	100/11 100/13 101/23

N	13/13 13/24 19/11 21/21 22/24 46/4 47/18 49/8 52/18 53/13 54/13 54/14 54/15 54/19 54/25 55/6 55/12 55/22 56/1 56/3 56/6 56/7 56/19 58/15 58/21 59/21 59/25 63/18 64/5 64/12 66/3 66/18 66/20 68/13 69/12 69/19 71/24 71/25 72/8 72/20 77/9 77/14 77/20 78/1 78/4 78/5 78/25 80/12 80/19 87/9 88/10 88/15 88/19 89/4 90/1 90/6 91/7 91/16 91/20 91/21 91/25 92/3 92/12 92/16 94/20 94/25 95/25 96/2 98/9 98/22 99/15 110/6 110/15 110/16 110/17 111/6 111/21 112/16 112/17 112/20 113/4 115/22 116/11 116/14 117/24 118/3 118/7 118/14 118/24 128/11 128/15 128/19 128/22 128/22 129/4 129/5 129/11 129/12 129/14 129/22 129/23 130/4 130/9 130/18 130/22 130/24 131/1 131/4 131/12 131/16 132/4 132/5 132/5 132/6 132/9 132/12 132/14 132/22 133/1 135/11 165/23 190/17 190/25 191/7 191/14 192/1 192/6 192/7 192/10 192/10 193/2 193/4 193/21 193/24 194/1 194/2 194/9 194/11 194/13 194/16 194/17 194/18 195/4 195/6 195/8 195/13 197/9 197/18 197/19 197/21 197/25 198/10 198/18 199/15 200/10 200/23 201/8 201/15 201/21 201/22 202/6 203/1 208/5 208/16 208/19 211/5 214/6 215/18 NHS 111 [12] 55/12 55/22 56/7 128/11 129/4 129/22 130/9 130/18 130/22 131/16 132/5 132/9 NHS England [26] 4/5 4/17 19/11 54/13 54/15 54/25 56/1 56/6 63/18 64/5 64/12 69/19 77/9 77/14 78/5	91/7 91/16 94/20 117/24 118/3 118/24 128/15 128/19 128/22 129/11 130/24 NHS Improvement [1] 4/5 NHS Wales [4] 194/9 195/4 197/21 203/1 NHS's [4] 58/25 66/11 78/6 131/10 NHSE [4] 4/6 91/22 118/7 118/11 NHSE's [2] 89/7 89/10 nicely [1] 173/12 Nield [1] 188/6 nightmare [1] 44/5 NIHR [6] 82/18 82/19 83/6 84/5 114/13 115/3 Nissen [3] 135/12 187/25 188/2 no [95] 7/2 15/20 15/20 17/4 17/25 18/14 18/25 19/24 21/1 21/1 21/1 21/5 21/16 23/6 23/16 24/17 24/22 26/24 27/5 27/14 28/4 28/17 29/6 30/3 32/8 33/6 34/19 36/22 37/18 41/7 46/10 55/24 56/8 56/22 57/15 59/25 60/4 66/10 67/8 67/8 67/11 68/4 70/13 72/4 72/4 72/4 74/15 75/17 82/19 84/12 86/14 91/4 100/11 100/19 101/25 101/25 102/22 104/7 107/12 108/16 108/25 109/8 110/15 111/5 118/2 120/17 120/17 120/17 120/17 120/17 120/19 123/4 124/13 124/22 125/9 128/18 133/20 134/21 153/22 154/14 158/18 159/12 165/25 166/15 167/9 168/3 181/19 183/4 184/24 186/12 186/12 190/5 192/9 194/7 205/24 no one [1] 19/24 no-deal [2] 29/6 30/3 No. [1] 5/19 No. 10 [1] 5/19 non [16] 4/21 88/17 99/23 109/21 140/2 141/24 149/21 172/17 184/4 203/5 205/14 207/1 213/9 213/12 213/12 213/14 non-availability [1] 184/4	non-clinical [1] 109/21 non-compliant [1] 203/5 non-Covid [2] 141/24 149/21 non-disabled [1] 99/23 non-essential [1] 140/2 non-invasive [6] 205/14 207/1 213/9 213/12 213/12 213/14 non-pandemic [1] 172/17 non-public [1] 88/17 non-statutory [1] 4/21 none [5] 45/13 48/4 165/16 178/20 191/19 nonetheless [1] 89/5 nor [1] 47/11 normal [13] 13/16 15/12 15/23 16/6 16/11 18/23 18/25 25/11 27/7 37/25 183/12 201/16 215/18 normally [15] 2/12 19/8 23/1 36/13 45/25 56/25 75/25 108/2 110/16 138/18 138/19 140/17 141/8 159/4 170/5 Northern [1] 27/20 Northern Ireland [1] 27/20 nosocomial [1] 164/20 not [249] notably [2] 182/10 183/7 note [1] 66/23 noted [6] 66/6 94/12 103/23 113/18 120/8 210/21 notes [2] 202/23 204/22 nothing [6] 16/16 19/7 22/23 29/15 46/9 46/17 notice [2] 180/2 180/7 noticed [4] 7/19 142/13 142/14 145/25 notices [3] 61/24 156/7 177/22 notwithstanding [1] 189/22 novel [2] 81/10 140/20 November [6] 1/1 49/11 50/24 51/16 189/5 216/9 now [69] 4/6 6/5 6/11	11/1 12/9 12/12 12/19 12/22 20/3 20/8 22/22 24/1 25/23 26/7 30/6 31/22 32/17 34/13 34/20 35/8 39/16 39/23 41/20 44/14 45/20 46/20 46/25 48/6 48/18 49/8 54/17 58/15 59/4 63/1 64/13 65/4 67/1 73/22 79/18 80/17 82/3 86/17 93/25 98/19 99/7 105/20 108/11 109/7 113/23 114/5 118/20 122/17 122/24 125/15 127/15 127/24 128/12 130/15 132/9 149/20 167/25 174/14 175/16 177/25 179/22 181/24 193/15 197/14 201/19 nowhere [2] 39/17 124/17 NSDR [2] 33/13 33/22 nuanced [1] 126/5 number [55] 1/21 1/25 10/11 12/14 13/2 13/21 16/1 18/1 22/21 31/7 31/11 33/15 33/15 33/21 34/6 34/22 36/9 39/11 40/10 47/1 47/8 49/5 49/11 54/9 54/12 58/20 64/23 72/24 74/19 76/5 77/18 79/12 82/14 90/10 91/24 94/11 100/14 121/5 131/23 135/19 137/10 140/24 142/11 152/10 156/6 156/23 163/4 172/9 173/20 174/11 175/25 177/7 191/16 196/5 215/20 numbers [16] 17/22 22/19 24/6 34/5 35/21 41/21 76/12 86/9 142/17 142/23 142/24 143/4 196/15 196/21 207/14 209/7 nurse [9] 140/11 140/23 140/25 141/5 141/6 141/22 146/3 158/9 169/20 nurses [11] 27/23 108/2 108/16 132/8 139/20 140/18 141/8 156/13 157/8 157/12 169/16 nursing [30] 27/21 108/14 108/14 109/23 126/7 138/25 139/6 139/7 139/8 139/21 139/22 139/24 140/16 140/19 142/14 156/20
----------	---	---	---	--

N	27/21 43/3 100/21 108/14 139/22 157/24 157/24 168/19 189/11 193/23 194/23 197/16 198/6 198/7 198/16 198/17 201/25 202/4 202/23 203/9 Officer's [1] 140/19 officers [3] 139/17 141/10 198/20 often [4] 35/25 98/8 99/1 199/1 Oh [7] 10/10 31/8 58/8 91/7 107/16 114/3 169/25 okay [7] 18/3 45/15 70/24 119/1 119/7 126/24 169/25 on [404] on January 21st [1] 163/12 on that [1] 148/20 on-shore [1] 82/7 on-shoring [1] 82/5 once [10] 6/20 11/4 12/16 17/6 38/21 69/3 70/5 156/9 201/11 214/9 oncology [1] 164/1 one [127] 4/9 7/24 10/13 10/23 10/24 11/15 11/21 13/11 13/18 13/19 14/2 17/4 17/18 17/23 18/11 18/14 19/21 19/24 20/10 20/15 22/17 26/7 28/17 32/8 33/20 34/19 37/10 40/9 41/8 42/13 47/7 48/1 49/5 50/16 52/10 53/8 53/12 53/14 55/19 56/19 58/16 58/19 59/4 59/25 60/4 61/17 61/18 71/22 73/11 77/20 78/4 79/22 80/5 81/23 82/21 84/17 84/25 86/14 88/8 89/1 90/21 92/21 92/25 93/15 93/19 97/24 100/2 101/17 102/3 102/22 103/17 104/21 114/15 120/5 120/9 120/10 121/6 124/9 124/12 124/13 124/20 125/2 125/15 125/16 129/13 130/2 138/11 138/25 138/25 139/6 139/6 139/7 140/22 141/5 144/9 144/24 145/6 145/8 145/17 145/21 145/25 149/10 151/9 151/11 152/16 152/23 156/20 158/25 161/5 161/12 162/5	164/16 165/22 168/17 172/11 176/20 177/9 177/10 177/16 179/14 179/15 180/12 183/10 184/9 185/7 204/4 209/7 one-third [1] 165/22 onerous [1] 7/2 ones [7] 42/23 45/21 62/12 90/22 93/8 161/5 172/18 ongoing [8] 1/18 15/24 50/4 58/7 82/15 94/17 95/18 149/5 online [3] 78/11 78/16 79/3 only [33] 4/13 12/2 18/1 20/8 57/12 64/18 76/13 76/15 76/22 81/18 85/3 97/11 106/17 106/18 114/7 124/9 135/21 136/1 138/1 138/3 138/9 138/23 146/8 149/2 149/18 151/7 153/24 155/17 159/8 165/21 169/14 184/18 203/3 ONS [3] 97/9 97/11 97/14 open [4] 95/25 136/9 146/15 172/19 opened [1] 135/13 opening [4] 3/25 7/22 136/11 136/11 operating [2] 33/13 87/9 operation [1] 55/15 operational [11] 49/4 49/5 54/14 116/13 117/5 129/21 190/21 191/4 195/16 201/14 210/4 operationally [1] 161/17 operations [1] 115/22 opinion [2] 11/1 61/14 opportunity [1] 198/7 opposed [13] 2/11 6/23 19/8 61/14 64/10 79/3 81/24 86/6 89/20 90/3 90/5 98/13 108/21 optics [1] 67/6 options [4] 65/22 183/11 183/14 183/16 or [140] 2/11 5/6 7/1 7/16 7/20 8/9 21/14 22/8 22/20 23/16 25/4 27/5 27/23 28/12 31/15 31/24 31/24 32/9 34/4 37/4 40/19 40/24 41/13 42/22	43/25 44/25 45/10 46/8 47/21 48/1 48/24 52/2 55/8 55/15 56/6 60/24 60/24 61/24 62/3 63/10 64/3 64/24 66/22 67/6 69/18 69/19 70/16 71/8 74/24 75/4 76/12 78/17 78/19 79/3 80/13 80/22 81/10 81/21 81/21 83/12 83/25 86/19 89/7 91/20 98/19 99/9 102/20 104/19 104/24 105/19 106/18 108/24 115/24 116/18 117/1 125/6 127/9 129/18 129/18 129/19 130/12 131/23 135/24 136/5 143/19 143/22 143/23 147/17 151/1 153/20 156/2 157/15 157/16 159/9 160/16 161/18 161/19 161/19 161/20 163/25 164/15 166/1 167/19 168/16 168/21 168/21 170/12 172/11 174/15 175/24 178/20 180/12 185/3 185/8 185/9 185/12 186/15 186/21 191/13 191/18 194/12 194/13 195/21 197/1 199/6 199/7 200/5 200/22 203/21 205/22 206/6 207/8 207/13 208/5 209/1 211/15 212/14 214/23 214/25 215/20 orally [1] 175/16 order [13] 15/5 22/5 22/7 38/22 68/19 101/19 101/20 122/10 122/21 145/13 175/20 204/6 209/8 ordered [1] 117/11 ordering [3] 21/23 103/11 145/11 orders [4] 61/23 62/10 63/16 104/25 ordinarily [1] 18/17 ordinating [1] 200/19 ordination [1] 196/10 organisation [14] 35/6 35/14 36/20 36/25 37/10 37/23 49/3 146/15 158/11 171/20 192/18 193/19 194/12 200/11 organisational [1] 200/5 organisations [11] 113/15 192/12 195/14 197/18 199/4 199/12 200/1 200/7 200/16	203/18 204/4 organogram [3] 192/14 196/5 196/8 organograms [1] 192/17 origin [2] 40/20 170/21 original [2] 41/22 72/4 originally [1] 72/1 origins [1] 121/20 Osborne [2] 25/16 26/3 other [85] 4/20 5/25 8/19 11/15 13/22 13/22 14/4 14/18 14/23 14/25 15/4 16/18 17/16 31/19 32/20 40/1 41/7 43/11 44/23 46/5 53/8 55/1 58/24 59/2 62/16 68/8 71/20 72/24 74/7 75/8 76/2 76/18 80/13 80/22 82/6 83/25 87/11 87/22 87/24 88/24 90/22 93/13 95/10 96/20 102/8 105/17 108/21 110/25 115/3 119/24 121/10 125/12 126/8 128/22 129/5 130/12 134/1 136/13 136/21 140/24 141/9 145/6 155/18 161/19 168/21 172/18 177/16 178/15 179/3 179/7 179/15 180/19 182/18 191/8 200/19 205/14 206/21 207/20 210/8 210/22 212/6 213/8 213/13 213/18 214/5 others [15] 10/22 40/22 44/21 46/15 47/9 54/22 58/21 83/22 84/5 93/11 105/4 108/2 115/14 116/11 132/5 otherwise [4] 21/3 40/24 44/4 70/16 ought [8] 3/7 30/12 66/14 67/24 78/10 78/17 105/20 124/20 our [162] 1/18 1/19 7/12 7/15 9/2 9/18 14/11 16/24 18/8 19/18 20/15 20/17 20/19 26/15 27/13 29/4 30/14 31/1 33/14 36/3 39/1 40/5 46/20 54/23 55/4 57/4 60/12 67/17 69/13 70/10 83/16 91/24 92/16 92/18 100/13 106/8 107/19 109/21 124/19
----------	---	---	---	---

<p>O</p> <p>our... [123] 125/14 127/10 127/19 130/3 132/8 132/8 132/8 132/8 133/23 134/11 135/22 136/5 136/7 136/16 136/18 137/21 138/5 138/6 139/8 139/14 139/16 139/17 139/20 139/24 140/4 140/8 141/16 141/17 142/8 142/10 143/5 144/6 144/25 145/2 146/14 148/15 149/1 149/9 149/11 149/16 151/3 151/5 152/2 152/4 152/13 152/14 152/17 154/8 154/9 155/25 156/14 156/20 157/5 157/6 157/7 158/7 160/20 161/11 163/2 163/4 163/7 163/12 163/20 163/24 164/1 164/3 164/3 164/6 164/11 164/11 164/13 164/14 164/17 165/6 165/7 165/13 166/24 167/2 167/13 167/14 167/16 167/18 167/18 167/19 167/20 167/21 168/25 169/6 169/16 170/8 170/11 171/7 171/9 171/14 172/2 172/8 172/14 172/19 172/19 174/6 178/12 178/14 179/5 179/14 179/15 183/1 184/20 185/1 185/2 185/20 185/25 186/18 199/24 200/25 201/2 201/16 202/20 207/19 210/12 214/2 215/11 215/12 215/15</p> <p>ourselves [4] 70/4 87/11 129/24 206/6</p> <p>out [102] 2/19 3/5 3/25 4/18 4/25 5/13 6/6 6/19 7/14 11/7 11/21 12/15 14/11 15/11 15/14 15/25 19/15 19/17 21/18 22/23 23/10 25/11 26/3 26/17 27/21 31/9 31/15 31/18 32/4 32/8 33/15 36/23 39/1 39/10 39/15 40/5 40/13 44/22 46/20 48/13 51/5 52/4 52/7 52/20 55/6 56/10 57/23 62/1 62/20 63/13 64/5 64/14 65/11 67/20 70/8 70/10 73/8 74/1 76/7</p> <p>76/11 78/9 84/4 84/16 89/13 116/6 120/12 120/14 123/10 128/20 129/1 129/10 130/20 132/24 140/19 142/13 144/18 145/19 145/22 155/7 155/24 159/5 167/9 172/9 173/25 174/4 175/15 175/16 176/22 182/24 183/20 185/15 187/10 190/2 199/12 199/15 201/25 202/23 203/1 209/5 212/2 212/16 214/8</p> <p>outbreak [8] 12/3 12/4 18/17 28/3 29/5 165/6 165/7 165/14</p> <p>outbreaks [6] 8/7 164/20 164/23 165/13 165/19 172/16</p> <p>outcome [2] 153/9 211/14</p> <p>outcomes [1] 118/14</p> <p>outlined [1] 29/8</p> <p>outlining [1] 163/13</p> <p>outpatient [1] 187/9</p> <p>outpatients [2] 141/18 151/1</p> <p>outreach [3] 152/9 152/10 178/16</p> <p>outside [11] 19/9 19/20 71/17 138/15 139/3 207/5 211/10 211/25 212/9 212/18 212/22</p> <p>outsourced [2] 109/21 112/19</p> <p>outstanding [2] 73/25 200/9</p> <p>outward [1] 192/7</p> <p>over [19] 5/19 7/12 21/23 45/2 53/21 81/18 81/19 93/4 93/5 138/11 152/16 157/3 161/3 161/18 182/8 201/10 208/13 210/23 215/20</p> <p>over-focused [2] 81/18 81/19</p> <p>over-ordering [1] 21/23</p> <p>overall [7] 5/18 6/2 8/24 79/1 128/15 153/5 162/9</p> <p>overloading [1] 77/20</p> <p>overriding [1] 7/9</p> <p>oversaw [1] 193/25</p> <p>overseas [2] 82/10 112/6</p> <p>oversee [2] 197/9 207/21</p> <p>overseeing [3] 178/18 184/21 184/22</p>	<p>oversees [1] 178/14</p> <p>oversight [10] 70/1 70/9 118/2 118/3 118/8 129/9 130/3 165/8 169/11 195/18</p> <p>overwhelming [1] 182/5</p> <p>own [22] 13/10 13/14 13/15 13/16 14/7 33/7 35/17 49/12 96/17 99/21 126/7 126/8 141/22 145/13 184/6 184/13 194/4 200/8 201/8 210/3 210/13 215/16</p> <p>owned [1] 13/24</p> <p>Oxford [2] 83/21 84/3</p> <p>oximeter [4] 52/17 53/10 53/15 53/18</p> <p>oximeters [7] 43/11 48/11 48/15 52/22 113/16 113/19 115/21</p> <p>oximetry [1] 49/10</p> <p>oxygen [18] 48/15 136/3 136/4 136/5 136/6 166/9 166/20 166/22 167/3 167/5 167/11 167/12 167/16 167/17 167/18 167/20 167/21 207/4</p>	<p>P</p> <p>pace [1] 60/5</p> <p>pack [2] 75/16 102/22</p> <p>page [29] 3/23 30/1 35/20 44/12 45/2 65/2 65/2 65/14 65/19 67/1 73/11 73/20 102/25 112/14 133/16 133/18 143/12 145/7 147/9 153/1 182/4 182/8 192/15 196/4 202/22 205/3 208/9 211/17 217/2</p> <p>page 1 [4] 65/19 73/20 153/1 182/4</p> <p>page 10 [1] 147/9</p> <p>page 165 [1] 211/17</p> <p>page 168 [1] 208/9</p> <p>page 17 [1] 133/18</p> <p>page 2 [3] 65/14 182/8 202/22</p> <p>page 23 [1] 102/25</p> <p>page 3 [1] 65/2</p> <p>page 33 [1] 192/15</p> <p>page 39 [1] 3/23</p> <p>page 7 [2] 133/16 143/12</p> <p>page 76 [1] 196/4</p> <p>page 85 [1] 44/12</p> <p>page 91 [1] 112/14</p> <p>painting [1] 135/8</p> <p>palliative [2] 159/18</p>	<p>213/18</p> <p>pan [1] 197/11</p> <p>pan-Wales [1] 197/11</p> <p>pandemic [156] 1/17 4/1 4/2 4/4 4/11 5/2 5/22 6/6 9/1 9/2 9/6 9/9 9/10 9/14 9/17 9/25 10/5 10/6 11/24 12/6 12/16 14/7 14/10 14/11 14/15 15/10 15/24 16/5 16/23 17/7 17/17 17/22 18/15 21/6 23/16 23/17 24/20 26/14 28/6 29/5 30/2 42/22 42/22 47/2 48/2 48/19 48/25 49/3 51/8 51/10 51/13 53/3 53/14 54/24 55/11 58/18 59/8 59/11 59/17 62/2 62/11 62/14 62/17 76/10 76/23 80/6 80/10 80/18 80/22 81/4 82/4 83/25 85/1 85/4 85/17 85/21 86/7 86/18 87/4 87/18 88/7 89/21 90/14 90/18 91/8 91/10 91/12 92/24 97/9 97/19 98/5 103/9 113/25 115/12 117/22 120/23 121/6 124/21 126/6 126/15 130/17 131/3 132/7 135/18 139/1 139/23 142/19 145/3 145/15 146/1 149/24 150/8 152/8 152/17 153/6 153/23 154/1 154/13 155/20 156/8 156/14 157/22 163/11 166/22 167/5 168/12 168/14 169/3 169/6 170/18 172/14 172/16 172/17 173/2 178/18 187/7 187/8 187/21 189/18 190/23 191/8 193/10 193/15 195/10 195/12 195/15 195/22 196/1 196/24 197/2 199/5 199/22 201/7 201/18 201/22 203/24</p> <p>pandemics [3] 3/22 92/13 162/11</p> <p>panel [11] 153/2 153/3 154/1 154/4 154/19 154/19 155/2 155/5 155/10 155/14 155/15</p> <p>panels [7] 42/15 42/20 44/13 44/15 45/10 119/12 119/24</p> <p>paper [1] 163/11</p> <p>paragraph [21] 29/2</p>	<p>38/13 44/14 97/7 102/18 102/25 112/14 113/16 116/17 118/13 119/11 173/15 175/15 176/22 181/16 181/21 190/15 201/24 202/10 208/8 211/1</p> <p>paragraph 1.24 [1] 29/2</p> <p>paragraph 123 [1] 181/16</p> <p>paragraph 125 [1] 113/16</p> <p>paragraph 140 [1] 181/21</p> <p>paragraph 189-191 [1] 176/22</p> <p>paragraph 205 [1] 175/15</p> <p>paragraph 236 [1] 38/13</p> <p>paragraph 25 [2] 97/7 190/15</p> <p>paragraph 280 [1] 116/17</p> <p>paragraph 286 [1] 118/13</p> <p>paragraph 288 [1] 119/11</p> <p>paragraph 290 [1] 44/14</p> <p>paragraph 322 [1] 112/14</p> <p>paragraph 421 [1] 208/8</p> <p>paragraph 425 [1] 201/24</p> <p>paragraph 47 [1] 173/15</p> <p>paragraph 58 [2] 102/18 102/25</p> <p>paragraphs [1] 130/14</p> <p>paragraphs 148-150 [1] 130/14</p> <p>parallel [1] 38/9</p> <p>parameters [1] 154/17</p> <p>Parliament [8] 65/15 66/7 66/15 67/13 67/13 67/18 67/25 124/1</p> <p>part [28] 4/9 19/25 20/4 23/19 31/1 51/13 64/7 74/17 77/6 79/23 82/18 83/3 96/3 104/3 118/10 124/21 130/13 146/12 157/19 163/2 169/10 178/7 180/11 200/23 201/16 207/16 207/25 209/2</p> <p>part B [1] 130/13</p> <p>partially [2] 8/11 8/11</p> <p>participants [2]</p>
--	---	--	--	--

<p>P</p> <p>participants... [2] 93/23 96/4</p> <p>participate [1] 198/23</p> <p>particular [15] 29/24 38/2 48/10 55/22 56/23 59/4 62/11 67/12 77/6 82/11 101/22 140/20 156/15 185/4 197/19</p> <p>particularly [24] 1/18 19/7 34/11 36/25 37/1 42/1 45/21 46/21 47/1 49/2 59/18 82/25 93/7 103/5 122/23 148/16 156/13 158/2 167/7 172/11 177/25 207/19 208/24 209/10</p> <p>partly [3] 36/16 84/5 198/4</p> <p>partner [1] 168/23</p> <p>partners [1] 200/19</p> <p>Partnership [1] 203/2</p> <p>parts [3] 1/25 19/21 103/15</p> <p>pass [1] 61/15</p> <p>passage [2] 102/19 102/21</p> <p>pathogen [1] 103/9</p> <p>pathway [1] 151/24</p> <p>patient [10] 57/25 138/11 140/11 152/16 152/17 152/21 152/24 156/22 162/15 180/3</p> <p>patient's [1] 157/2</p> <p>patient-facing [1] 162/15</p> <p>patients [60] 52/19 52/23 74/7 74/9 95/11 111/22 113/4 113/20 136/5 136/10 136/23 137/8 137/22 137/24 138/7 138/22 138/25 139/5 139/8 141/1 141/5 141/11 141/19 141/24 141/25 141/25 142/2 142/10 142/11 142/11 142/18 150/21 151/5 151/18 153/8 164/14 166/15 166/23 166/24 166/25 167/16 169/4 169/8 177/23 177/25 187/10 202/2 207/4 207/8 207/9 207/24 208/17 208/22 212/4 212/8 212/15 212/21 212/24 213/24 214/4</p> <p>Patrick [1] 93/11</p> <p>Patrick Vallance [1] 93/11</p>	<p>pause [7] 10/7 12/23 20/20 22/2 35/17 63/5 84/22</p> <p>Pausing [3] 15/3 73/1 73/5</p> <p>pay [4] 75/8 75/10 87/22 175/18</p> <p>payer [1] 97/25</p> <p>payments [1] 111/13</p> <p>payout [1] 110/20</p> <p>PCR [3] 82/2 85/22 86/6</p> <p>peace [8] 15/13 15/23 21/10 23/2 26/1 72/16 80/9 80/20</p> <p>peak [5] 35/9 131/17 205/10 208/14 208/18</p> <p>peers [1] 103/20</p> <p>pension [4] 71/24 72/7 72/9 110/17</p> <p>people [140] 16/19 21/3 21/13 22/2 29/22 31/19 32/3 32/5 32/24 34/14 36/10 37/8 37/17 40/19 41/16 43/16 46/23 48/3 48/15 48/21 49/4 53/19 53/25 54/1 54/19 54/20 55/2 56/24 57/13 60/9 61/8 63/1 63/18 68/21 69/14 69/22 71/17 71/20 71/21 72/19 72/21 72/24 73/3 75/10 76/1 77/18 77/23 78/10 78/11 78/12 78/12 78/14 78/18 79/3 79/7 79/10 79/22 80/12 80/16 81/11 94/10 94/24 96/7 98/3 98/14 98/17 99/18 99/23 99/23 100/4 100/5 100/9 108/9 110/5 110/7 110/10 110/15 110/19 111/13 114/10 115/3 115/6 121/21 123/7 123/15 124/18 124/24 125/6 126/10 127/10 131/20 132/2 132/7 132/17 136/2 137/24 138/12 138/19 139/15 141/3 143/25 144/10 144/19 144/22 145/22 146/7 148/18 151/20 153/24 154/5 158/3 159/3 159/12 159/14 159/16 159/17 159/18 161/20 167/3 167/11 168/14 168/15 168/20 171/8 171/13 171/15 171/16 171/20 174/3 174/3 174/6 175/11 175/12 178/19 183/15</p>	<p>185/1 185/4 185/5 187/13 214/12</p> <p>people's [6] 32/16 47/12 47/14 60/25 100/24 126/7</p> <p>per [2] 42/12 148/5</p> <p>per cent [1] 42/12</p> <p>perceived [1] 151/25</p> <p>percentage [1] 24/3</p> <p>perception [3] 78/22 78/24 185/9</p> <p>perceptions [1] 47/13</p> <p>perfect [1] 60/18</p> <p>perfectly [1] 78/21</p> <p>performance [3] 55/22 56/7 88/23</p> <p>performed [1] 132/6</p> <p>perhaps [18] 40/3 52/12 59/13 97/17 113/1 127/23 129/16 139/12 157/17 158/19 160/17 162/8 172/10 175/24 180/23 201/19 202/3 204/9</p> <p>period [16] 12/20 16/7 19/23 54/13 81/19 138/4 138/9 138/15 138/16 138/23 146/19 168/8 174/4 179/9 189/21 201/18</p> <p>permanent [8] 1/12 2/18 2/25 35/24 36/5 37/16 87/16 188/24</p> <p>permeates [1] 79/12</p> <p>person [4] 28/11 53/12 104/20 157/18</p> <p>personal [7] 11/1 49/18 58/21 59/7 59/16 60/8 215/16</p> <p>personally [3] 68/16 105/8 114/22</p> <p>perspective [2] 142/16 144/14</p> <p>perspex [1] 136/20</p> <p>pertinent [2] 1/18 59/5</p> <p>pharmaceutical [1] 82/25</p> <p>pharmacies [4] 71/7 74/5 74/17 74/24</p> <p>pharmacist [1] 71/8</p> <p>pharmacists [9] 71/9 72/3 72/24 73/4 74/14 74/19 74/20 74/24 75/20</p> <p>pharmacy [5] 73/16 73/19 74/4 74/8 74/21</p> <p>phase [1] 163/15</p> <p>phased [3] 162/20 164/8 175/19</p> <p>phasing [1] 164/8</p> <p>PhD [1] 190/5</p> <p>PHE [4] 4/5 5/13 8/22</p>	<p>11/19</p> <p>phenomenally [1] 31/7</p> <p>Philip [3] 134/17 134/18 217/15</p> <p>phrase [1] 80/8</p> <p>physical [8] 78/19 95/7 143/17 144/14 169/8 172/13 212/12 214/14</p> <p>physically [2] 143/21 187/11</p> <p>physician [4] 146/3 156/4 187/3 187/19</p> <p>physicians [2] 152/4 170/21</p> <p>physiotherapist [1] 104/19</p> <p>pick [8] 10/23 10/24 92/25 93/15 93/19 132/24 137/1 152/23</p> <p>picking [1] 206/1</p> <p>picture [4] 8/15 135/8 203/17 208/4</p> <p>piece [6] 10/23 29/11 51/12 91/7 102/6 185/4</p> <p>pieces [1] 53/15</p> <p>pilot [1] 47/23</p> <p>piloting [2] 47/18 48/5</p> <p>pipes [1] 167/14</p> <p>PIPP [10] 12/22 13/8 15/6 17/9 19/9 19/20 20/1 20/4 21/24 26/9</p> <p>place [36] 14/17 20/3 35/13 63/4 69/3 69/8 86/3 98/18 99/1 101/21 111/7 115/25 117/19 129/19 132/16 132/19 137/10 144/2 144/20 146/2 148/22 151/17 152/12 153/19 156/10 159/16 162/17 165/17 172/1 172/2 175/17 178/17 203/23 204/24 208/13 215/13</p> <p>placed [1] 37/2</p> <p>places [1] 212/15</p> <p>plan [27] 7/15 7/20 7/22 8/1 8/5 19/21 24/1 24/5 28/22 29/1 81/19 81/20 88/14 88/20 89/7 89/10 89/22 89/23 90/4 95/24 98/17 99/3 105/12 149/25 152/24 165/6 197/11</p> <p>plan Bs [1] 105/12</p> <p>planet [1] 14/13</p> <p>planned [3] 17/16 19/2 30/4</p> <p>planning [17] 18/8 21/24 98/25 156/11</p>	<p>172/14 192/21 195/13 196/7 196/25 198/14 198/15 199/10 199/18 201/1 205/16 207/20 215/12</p> <p>plans [8] 81/19 89/8 93/5 93/5 138/2 145/2 204/24 214/13</p> <p>platform [3] 59/1 82/5 84/4</p> <p>platforms [1] 99/13</p> <p>play [1] 55/21</p> <p>playbook [1] 23/19</p> <p>played [3] 20/4 78/9 120/12</p> <p>players [1] 33/6</p> <p>playing [1] 25/11</p> <p>please [56] 2/14 10/9 11/9 11/11 15/16 22/16 23/5 28/25 30/19 33/18 38/15 44/11 46/11 47/16 52/11 56/9 57/21 61/19 65/1 65/3 65/19 65/23 70/24 73/5 76/8 80/23 81/13 93/24 109/11 110/14 113/2 120/4 120/22 134/6 143/11 147/10 152/25 160/9 173/23 176/16 181/23 188/16 190/7 191/23 192/14 192/17 195/7 196/1 196/4 202/22 204/12 205/3 208/2 208/8 211/15 216/6</p> <p>pleased [1] 158/9</p> <p>plural [1] 177/1</p> <p>pm [6] 109/12 109/14 160/3 160/5 209/22 216/7</p> <p>point [67] 6/6 6/11 6/11 6/13 9/17 12/18 17/25 19/6 23/2 25/12 26/13 28/13 29/21 35/5 43/13 51/4 55/5 64/13 66/10 66/10 66/18 66/25 67/3 67/13 71/24 72/13 75/24 86/22 87/8 96/5 96/15 96/15 102/14 105/5 105/10 108/16 108/17 112/9 115/5 124/11 150/7 152/23 153/6 158/23 163/18 164/21 165/5 168/8 170/19 174/8 176/20 179/7 203/20 204/7 204/22 205/22 205/25 206/4 206/23 207/22 208/23 209/15 212/20 214/23 214/25 215/10 215/22</p> <p>pointed [3] 26/3</p>
--	--	---	---	---

P	14/13 14/13 14/21 14/25 15/4 17/17 17/25 18/6 19/20 20/10 21/2 21/5 21/14 22/3 23/5 23/13 28/22 29/4 29/22 30/6 31/15 31/15 31/25 32/11 33/5 34/9 36/10 38/18 38/21 38/24 38/25 39/20 39/24 40/13 40/15 40/17 40/24 41/7 42/17 43/6 43/14 43/19 44/10 44/21 45/3 46/15 46/22 82/8 101/20 116/15 118/17 118/21 119/3 119/17 119/22 120/8 144/11 144/18 144/19 144/22 145/13 145/14 145/16 145/23 146/10 147/6 165/11 167/4 181/17 182/7 182/20 183/5 183/15 184/5 184/6 184/9 184/13 184/16 184/21 184/21 185/2 185/3 185/4 185/5 185/8 185/11 185/12 185/15 185/18 186/9 186/10 196/17 PPEs [1] 185/21 practical [4] 58/23 80/5 125/15 145/4 practicalities [1] 59/3 practically [1] 31/13 practice [19] 5/21 6/5 6/20 39/16 54/24 62/14 62/24 63/2 64/20 68/7 68/8 68/9 69/24 70/17 126/1 151/25 158/6 179/17 180/13 practices [2] 53/23 76/11 practising [1] 187/8 pre [8] 6/20 9/1 42/22 43/9 45/14 45/19 86/7 195/12 pre-Covid [2] 43/9 45/19 pre-pandemic [3] 9/1 42/22 195/12 preceding [1] 33/25 precise [1] 125/8 precisely [1] 204/1 predict [1] 103/8 predictable [1] 130/16 predicted [5] 18/17 153/23 165/21 166/3 166/23 predictions [2] 142/19 209/6 predominantly [1]	207/10 prefer [3] 78/11 78/17 107/12 preference [1] 107/15 preferred [1] 107/10 preferring [1] 74/2 preparation [4] 17/19 25/18 25/19 84/1 preparations [5] 4/2 29/5 31/1 205/18 206/19 prepare [3] 6/2 169/23 206/18 prepared [11] 1/23 8/6 8/10 8/17 28/3 29/3 61/3 87/17 90/2 109/4 203/19 preparedness [7] 4/4 81/5 87/4 92/5 190/17 197/5 204/10 preparing [1] 92/9 presence [1] 66/12 present [1] 184/18 presentations [1] 209/2 presentism [1] 143/24 press [6] 6/12 6/21 69/15 69/22 79/19 127/10 pressure [9] 80/14 80/21 126/17 131/2 131/2 131/4 132/23 148/14 148/18 pressures [3] 117/5 210/10 213/4 presumably [2] 22/6 213/24 pretty [6] 23/12 74/11 76/21 87/6 112/1 209/8 prevalence [1] 97/20 prevent [2] 18/2 21/23 prevention [4] 94/16 108/12 160/10 169/19 previous [18] 2/9 12/5 17/18 29/13 31/8 67/1 88/15 96/8 98/19 110/11 114/15 114/16 116/2 117/10 126/19 149/4 190/7 208/25 previously [11] 2/12 18/22 77/10 77/10 113/25 117/3 120/25 121/3 196/25 198/1 210/25 price [1] 26/20 primarily [1] 49/10 primary [3] 14/6 33/2 129/12 prime [6] 6/9 6/12 6/17 6/20 7/11 36/15	Prime Minister [5] 6/9 6/12 6/17 6/20 36/15 principally [1] 190/23 principle [1] 95/21 principles [4] 153/5 154/11 155/14 157/3 prior [11] 8/20 9/9 9/13 10/5 48/18 48/25 49/3 62/10 62/14 189/6 203/8 priorities [3] 94/21 96/2 189/2 prioritise [3] 23/9 137/23 138/10 prioritised [1] 122/10 priority [4] 44/21 46/15 94/18 210/17 Pritchard [4] 3/20 46/4 54/21 118/7 privacy [6] 58/19 59/4 61/1 61/3 61/17 98/4 private [8] 14/8 59/19 82/24 101/4 111/21 113/3 151/6 204/16 probably [9] 50/19 68/17 82/4 85/11 97/22 104/1 147/7 161/22 213/21 problem [28] 21/9 24/18 26/24 27/14 35/2 35/15 36/23 37/3 38/2 43/21 46/1 50/23 51/5 51/14 52/8 53/24 61/15 65/9 65/18 71/18 75/3 110/22 124/21 124/23 125/15 127/21 128/2 128/10 problems [11] 20/15 30/20 32/19 35/7 36/11 36/16 38/8 59/13 85/1 121/4 121/11 procedures [6] 15/9 18/13 104/13 106/19 151/1 151/11 process [11] 15/13 15/24 18/24 18/25 25/5 25/11 27/7 29/17 88/13 95/24 95/25 processes [3] 16/10 179/16 183/12 procure [3] 17/16 17/22 118/21 procured [5] 13/3 13/10 17/6 17/16 119/3 procurement [25] 15/12 15/13 15/23 16/6 16/10 16/17 16/18 16/21 17/13 18/24 18/25 19/4 19/7 24/14 25/5 28/15	118/16 119/23 181/20 182/18 183/11 183/12 183/14 183/16 184/11 procuring [3] 13/16 14/7 166/5 produce [2] 161/14 161/15 produced [8] 4/8 22/17 134/23 155/9 155/15 155/16 155/20 175/13 producing [1] 84/20 product [2] 23/15 114/19 productive [1] 105/24 products [3] 116/10 116/10 116/12 professional [7] 18/19 39/13 41/5 53/7 53/16 198/4 198/8 professionals [2] 52/16 156/13 professions [1] 69/12 Professor [17] 10/21 10/22 11/14 55/18 80/1 94/7 102/13 103/18 113/11 133/17 176/13 181/6 181/15 181/25 182/11 186/24 217/13 Professor Beggs [1] 102/13 Professor Brightling [1] 94/7 Professor Snooks [2] 55/18 133/17 PROFESSOR THOMAS [2] 113/11 217/13 Professor Vallance [1] 10/22 Professor Whitty [4] 10/21 11/14 80/1 103/18 profile [2] 16/24 41/15 profile -- a high-incidence [1] 41/15 profound [1] 104/15 profoundly [1] 29/15 programme [9] 56/15 57/11 122/19 123/1 149/18 163/5 163/7 163/17 170/6 programmes [5] 59/2 59/23 82/16 149/3 149/17 progress [2] 48/7 84/11 projected [1] 209/14 projection [1] 89/13
----------	---	---	---	---

P	215/11	98/23 120/9 120/21	172/18 204/6	140/13
projections [1]	Public Health Wales [2] 165/9 206/6	quantity [1] 50/9	quicker [2] 42/6	ration [3] 151/24
208/21	publicise [1] 112/8	quarantining [1]	51/20	154/10 159/9
proper [4] 10/22	publicity [1] 92/14	208/12	quickly [13] 29/13	rational [4] 74/1
10/23 116/13 207/21	publicly [3] 48/22	Quarter [1] 160/2	31/16 32/4 52/5 85/3	74/5 104/24 104/25
properly [6] 53/25	66/7 83/2	Queen [1] 135/13	85/20 90/9 106/14	ratios [3] 139/8
78/15 90/6 90/6 103/6	publish [2] 51/3 52/1	question [87] 11/10	137/25 167/12 182/25	139/24 140/14
116/9	published [14] 3/10	11/12 11/25 12/9 13/5	203/18 209/12	raw [2] 21/7 21/14
proportion [1] 24/20	8/3 26/11 28/22 29/1	24/15 24/24 26/25	quite [36] 6/22 11/6	re [1] 62/21
protect [1] 164/14	30/7 49/9 51/1 51/17	27/7 27/16 28/7 29/13	17/20 24/16 24/25	re-emphasise [1]
protected [4] 42/15	57/16 69/4 69/25 70/6	34/18 35/18 37/2 44/4	26/21 28/4 28/14	62/21
119/13 145/12 158/3	107/5	46/12 52/6 72/18	43/19 43/21 55/10	reached [4] 23/25
protecting [2] 57/17	pulse [10] 43/11	75/15 80/1 80/3 84/14	64/21 85/20 87/20	138/10 146/18 146/24
136/2	48/10 48/15 49/10	84/16 84/22 85/9	98/12 102/10 109/6	read [14] 2/11 39/19
protection [4] 102/8	52/17 52/22 53/10	90/23 91/4 92/1 94/23	110/21 141/19 142/6	49/23 67/4 70/4 75/14
112/20 116/19 165/10	113/16 113/19 115/21	95/16 97/18 98/11	142/11 145/24 147/13	88/12 102/20 128/1
protective [1] 102/6	purchase [3] 26/9	98/17 99/20 101/17	150/23 151/13 161/24	148/12 150/14 211/3
protocol [1] 116/21	27/1 38/23	103/10 104/2 107/2	170/18 174/4 177/11	211/8 211/12
proud [1] 11/18	purchased [2] 120/9	107/9 107/17 111/20	178/23 181/1 183/18	reader [1] 127/3
provide [22] 65/21	120/20	113/2 113/24 115/2	183/24 186/21 197/14	reading [5] 47/21
96/22 96/23 102/7	purchasing [2] 28/2	115/6 115/18 116/2	213/21	53/10 53/11 53/17
119/14 134/11 138/12	165/25	116/23 117/14 117/16	quotation [1] 145/6	68/6
138/13 139/10 139/12	pure [2] 83/4 83/8	117/18 118/15 119/2	quote [2] 8/5 121/23	readout [1] 65/23
141/15 142/4 144/19	purpose [2] 91/2	119/14 120/2 120/7	quoted [3] 115/13	ready [2] 51/4 52/5
147/2 167/10 169/8	100/22	120/10 120/15 120/19	120/5 131/23	real [6] 27/22 98/14
175/1 182/20 189/22	purposefully [1]	120/20 122/11 127/7	quoting [1] 121/19	104/15 148/15 148/18
193/5 209/16 211/12	161/10	128/8 129/16 130/8		166/19
provided [18] 3/24	purposes [1] 24/6	130/19 131/5 131/15	R	real-life [1] 104/15
33/22 43/22 71/3	pursue [2] 85/13	131/25 153/7 155/10	Race [2] 49/8 49/15	realisation [1] 166/9
104/21 116/18 135/19	108/23	160/15 175/3 175/20	racial [1] 49/10	realised [1] 166/12
138/14 139/9 141/11	pursued [1] 99/9	177/20 179/25 180/5	racism [2] 121/14	reality [3] 15/14 67/9
141/14 144/22 154/13	pushed [1] 126/9	180/10 180/14 180/15	121/18	209/11
162/24 188/18 189/20	put [40] 6/11 12/7	180/16 182/11 183/5	raise [8] 44/24 56/18	reallocating [1] 95/9
211/16 211/17	18/6 20/3 22/22 23/18	185/7 200/9 203/15	63/19 89/1 94/11 95/8	really [46] 22/8 27/15
providers [3] 4/18	26/7 43/15 43/15	questionable [1]	114/23 125/24	60/4 77/17 97/18
13/11 13/13	45/23 63/4 64/5 65/1	48/16	raised [20] 16/24	99/25 131/24 136/7
provides [1] 190/11	68/17 80/20 86/3	questioned [1] 82/2	42/5 45/9 48/14 48/21	139/19 140/17 141/10
providing [8] 46/24	90/21 101/5 101/21	questioning [1]	62/3 63/22 65/15 66/2	144/5 144/14 145/3
83/15 104/19 136/4	121/1 131/3 132/16	173/12	67/2 69/6 72/2 72/11	148/4 148/7 149/12
207/4 212/1 213/11	132/19 136/19 137/10	questions [72] 1/9	72/18 77/12 85/13	150/6 150/9 150/20
214/7	138/19 144/2 145/3	1/22 2/4 39/24 40/1	105/9 127/20 177/22	152/6 154/2 159/14
provision [12] 42/18	146/2 148/22 151/17	42/2 49/5 49/6 50/16	182/2	161/20 162/25 164/16
44/21 46/15 46/22	152/12 159/1 159/19	65/15 67/2 88/16	raising [3] 115/7	164/17 170/6 170/9
94/16 94/19 95/20	162/8 162/17 165/17	88/21 93/21 93/22	115/15 176/25	171/3 171/14 172/24
104/9 119/18 143/7	175/17 215/12 215/22	94/1 94/3 94/5 94/20	ran [5] 32/8 74/3	186/18 187/16 187/16
168/23 192/21	putting [6] 1/16	97/3 99/8 100/20	144/18 145/19 182/24	188/14 195/22 199/16
psychological [4]	18/14 70/19 116/7	101/8 101/14 101/16	rang [1] 31/14	200/2 207/17 209/11
141/21 144/25 145/2	126/21 185/21	106/12 109/5 109/9	range [10] 42/8 45/4	210/7 210/12 213/1
148/21	Q	109/18 113/11 120/12	52/19 103/17 105/22	215/3 215/17
psychologically [1]	QCovid [2] 123/5	121/5 122/5 122/7	106/16 114/8 118/8	realtime [1] 210/5
143/22	123/9	122/9 122/14 123/20	149/17 154/18	reason [11] 24/1 34/8
public [37] 5/1 5/8	Quad [2] 65/23	123/22 133/6 133/20	ranging [1] 178/21	39/11 77/21 90/20
7/10 36/16 56/6 58/11	123/19	133/24 134/19 153/3	rapid [3] 49/9 160/25	101/6 104/11 146/12
58/20 60/22 60/23	qualified [4] 72/21	154/18 168/2 173/5	178/14	159/19 174/18 213/25
61/7 61/14 61/16	108/1 108/7 108/17	173/8 173/10 176/11	rapidly [2] 115/21	reasonable [11] 22/9
61/17 66/15 67/14	176/14 176/16 176/19	176/21 179/23 181/14	164/2	23/22 23/24 24/1 24/4
67/25 79/15 79/19	176/21 179/23 181/14	181/15 187/2 188/10	rate [4] 137/12	39/5 39/6 39/11 39/17
81/10 85/3 87/22	181/15 187/2 188/10	189/15 206/8 217/5	166/10 167/8 167/10	47/15 106/23
87/24 88/17 88/17	217/7 217/8 217/9	217/7 217/8 217/9	rates [1] 122/23	reasonably [4] 12/14
88/19 88/24 94/17	217/10 217/12 217/14	217/10 217/12 217/14	rather [10] 28/8	39/14 83/5 83/14
95/2 134/1 137/11	217/17 217/19 217/20	217/17 217/19 217/20	39/23 53/17 111/3	reasons [14] 18/22
161/6 161/13 165/9	217/21 217/24	217/21 217/24	130/11 175/23 177/18	20/5 24/23 29/8 29/23
193/3 200/19 206/6	quantify [1] 65/18	quick [4] 74/25 99/7	191/9 205/23 206/15	55/11 58/16 75/12
	quantities [4] 11/8		ratio [3] 139/3 140/11	77/18 98/3 98/7 125/2

R	138/17 138/22 150/1 205/8	114/21 116/7	report [53] 10/20 33/22 36/1 43/4 43/14 51/4 51/6 57/17 57/18 57/23 58/10 58/12 64/23 68/23 69/8 69/25 70/6 70/8 79/10 88/12 93/10 93/16 93/20 114/6 115/13 121/8 121/16 121/19 121/23 127/25 133/12 133/17 144/7 146/12 149/5 149/7 149/7 149/11 149/19 150/10 150/14 172/19 172/20 184/8 186/19 197/22 198/13 203/6 209/21 210/14 210/17 210/22 210/25	67/12 107/4 167/10 167/16 202/18 203/22 207/15 208/22
reasons... [2] 125/17 168/21	recruit [1] 139/15	Rehabilitation [1] 95/8	requirement [5] 31/20 31/21 194/25 209/14 209/20	
reassurance [3] 179/19 204/3 215/11	recruitment [3] 139/14 141/16 164/11	reinstated [1] 40/3	requirements [7] 67/17 202/14 202/24 203/13 204/5 207/18 208/2	
reassure [1] 46/23	red [3] 22/11 22/13 24/8	reiterate [1] 75/24	requires [4] 41/7 60/20 92/15 157/14	
reassured [1] 154/25	redeployed [5] 116/18 117/1 140/2 150/20 205/2	reiterating [1] 64/15	requiring [3] 139/5 139/6 167/11	
reassuring [1] 61/8	redeployment [1] 117/19	relate [3] 45/21 177/13 191/11	rescinded [1] 156/21	
rebalance [2] 79/1 80/4	reduce [2] 34/6 167/15	related [3] 99/10 99/20 177/16	research [24] 8/21 50/17 81/12 82/13 82/16 82/21 83/2 83/4 83/6 83/8 83/9 83/16 83/23 84/19 92/2 93/3 95/1 96/9 96/12 99/21 100/11 100/22 101/5 115/3	
rebuilding [1] 143/24	reduced [1] 179/8	relates [3] 30/2 101/18 189/23	researched [1] 43/22	
rebuying [1] 39/3	reduces [1] 80/14	relation [24] 3/22 15/6 24/10 37/21 40/2 100/3 100/10 101/20 103/5 111/3 116/2 123/20 127/9 129/3 129/5 132/13 175/5 175/6 179/25 189/17 191/6 193/21 194/18 195/10	researchers [1] 100/14	
recall [6] 101/22 105/8 140/14 203/14 207/12 213/15	reducing [2] 78/15 140/13	relationships [1] 105/23	researching [1] 84/6	
recap [1] 117/4	reduction [3] 112/12 113/3 137/14	relationship [3] 4/19 106/2 152/7	reserved [1] 29/4	
receipt [1] 203/20	refer [9] 19/16 19/18 25/15 89/10 99/12 114/4 114/5 121/8 174/10	relative [1] 68/18	reserves [1] 166/10	
receive [6] 2/19 17/2 27/19 31/16 63/10 166/25	reference [10] 21/18 40/16 50/1 57/12 95/5 102/24 112/14 130/13 134/6 206/14	relatively [1] 142/23	resilience [8] 9/23 9/24 87/2 89/2 89/7 89/18 93/5 190/18	
received [21] 18/21 28/10 31/4 64/9 106/7 139/6 139/7 139/21 143/10 149/7 150/5 150/10 157/23 165/22 165/23 166/13 166/23 170/20 170/23 204/3 205/25	referenced [1] 125/3	relatives [1] 141/12	resilient [3] 26/3 88/4 89/24	
receives [1] 18/19	referrals [1] 175/25	release [2] 21/24 205/7	resolved [1] 161/9	
receiving [6] 35/25 57/13 139/4 212/4 212/21 213/17	referred [7] 112/13 114/15 139/4 148/21 148/23 155/4 155/21	relentlessly [1] 7/17	resorted [1] 184/5	
recent [1] 95/4	referring [2] 40/7 146/20	relevance [1] 97/20	resorting [1] 184/13	
recognise [7] 60/25 127/23 127/23 131/22 145/21 148/2 174/2	refers [2] 112/15 123/19	relevant [4] 3/17 54/13 92/3 102/21	resource [2] 155/11 159/10	
recognised [3] 127/22 128/7 145/1	reflect [3] 92/20 119/3 194/19	rely [2] 174/9 210/8	resources [4] 38/3 101/5 152/17 195/1	
recollect [1] 56/8	reflecting [2] 180/15 215/3	remain [2] 55/2 124/8	respect [3] 81/4 112/4 191/15	
recollection [1] 69/21	reflection [1] 28/1	remainder [2] 54/11 214/1	respecting [1] 195/16	
recommendation [8] 15/25 18/11 24/21 28/9 49/16 52/14 92/21 163/14	regard [2] 58/7 162/14	remained [1] 69/3	respirators [3] 103/14 104/9 104/12	
recommendation's [1] 52/25	regarding [2] 118/17 122/18	remains [2] 34/24 100/6	respiratory [14] 92/8 136/3 136/6 141/20 146/3 152/2 152/4 152/19 156/4 167/21 178/20 187/3 187/18 187/19	
recommendations [9] 49/11 49/14 52/10 52/25 57/18 89/6 94/5 105/17 172/10	regardless [2] 7/15 71/19	remember [11] 23/3 40/5 42/21 49/16 49/19 50/7 93/9 158/25 170/24 170/25 177/15	request [5] 45/4 47/16 205/23 205/24 206/3	
recommended [2] 58/4 59/9	regime [2] 61/13 62/10	remembering [1] 180/17	request on [1] 205/24	
recommends [1] 162/14	region [1] 127/19	remit [1] 125/16	requested [4] 7/25 19/11 65/7 165/22	
record [4] 1/16 3/7 124/22 133/11	registered [2] 140/23 141/6	remote [2] 76/6 188/8	requesting [1] 209/16	
recorded [4] 118/14 173/21 174/12 213/9	regret [2] 29/20 146/11	remove [1] 136/24	requests [2] 45/7 191/9	
recording [1] 173/24	regrettable [1] 146/7	repair [1] 167/14	require [4] 47/21 202/2 202/7 202/12	
recovered [1] 71/4	regulate [2] 50/21 69/9	repeat [6] 53/16 70/11 98/1 118/22 120/19 181/21	required [13] 12/6 15/1 15/4 30/5 67/11	
recovery [5] 138/8	regulator [6] 63/17 69/9 125/4 125/16 125/17 128/5	repeated [1] 181/22		
	Regulators [1] 52/15	repeating [1] 117/15		
	regulatory [6] 50/20 51/23 61/13 114/16	replace [1] 167/13		
		replaced [2] 167/19 167/19		
		replacing [2] 123/4 123/8		
		replicate [2] 71/24 72/14		

R	reverse [1] 122/10	190/7 191/23 191/25	110/8 110/15 114/24	78/24 81/2 81/10
response... [33] 11/2	review [20] 9/15 36/7	192/3 192/4 192/5	118/22 121/5 123/23	83/14 84/13 86/9
11/13 30/22 42/4	49/9 49/12 49/14	192/7 194/16 195/6	125/24 127/1 127/8	86/14 87/19 88/11
51/13 52/20 79/13	49/21 49/22 49/23	195/7 195/10 195/12	130/25 131/8 132/21	88/16 89/17 90/22
87/7 90/14 92/16	50/1 50/24 51/9 51/16	197/18 198/6 198/7	133/24 137/3 138/24	91/2 91/15 92/8 93/11
92/23 103/4 153/2	51/18 52/1 52/4 52/14	roles [3] 4/10 117/2	140/12 145/8 146/17	95/25 98/21 100/19
155/10 175/3 178/14	56/7 63/25 88/8	200/4	148/24 151/23 152/23	101/3 102/25 106/12
182/2 189/17 195/11	117/11	roll [1] 11/7	155/1 166/8 166/16	107/1 107/2 107/17
195/15 196/1 196/7	reviewed [1] 28/6	roll-out [1] 11/7	170/7 179/23 182/16	110/17 111/5 116/11
197/2 197/11 198/14	reviews [2] 63/13	Room [1] 202/14	182/22 184/22 196/23	119/8 120/11 121/8
198/15 198/25 199/10	120/14	rooms [7] 135/21	203/25 208/24 210/15	121/14 121/14 121/16
199/19 199/22 201/1	rich [1] 144/8	135/22 147/18 147/18	Sajid [2] 3/17 49/18	124/1 124/7 124/10
201/18 207/21	right [95] 2/18 4/16	148/6 148/6 148/7	Sajid Javid [2] 3/17	125/6 125/20 125/20
responses [2] 143/9	9/7 13/7 13/10 16/13	root [6] 157/4 178/8	49/18	127/2 130/5 132/12
204/2	17/21 19/9 19/12	178/9 180/11 180/17	salutary [1] 209/6	133/4 133/6 133/11
responsibilities [12]	19/19 25/22 26/7 32/7	180/20	same [24] 14/2 14/17	133/18 133/24 135/14
4/1 4/25 118/9 192/24	32/13 32/24 36/18	rose [1] 25/2	44/5 53/11 70/16	159/8 162/1 172/24
194/10 194/21 195/8	37/14 38/1 39/4 40/2	rough [1] 24/2	84/11 112/19 113/1	173/13 173/18 175/24
195/9 200/5 200/8	49/1 57/5 60/1 61/6	route [3] 102/11	113/5 115/2 115/16	179/14 193/20 208/9
200/17 201/14	62/25 72/10 72/23	102/16 198/8	126/18 129/5 131/10	214/24 215/16
responsibility [21]	73/5 73/23 80/19	routes [8] 92/5 92/10	137/12 139/3 145/10	saying [5] 19/6 46/18
5/5 5/13 5/19 6/2 6/9	85/14 86/5 90/7 91/19	92/12 92/17 103/2	146/21 152/8 163/5	90/5 126/18 149/13
56/16 69/10 77/8	91/23 105/19 105/21	103/7 156/17 198/4	173/16 177/11 199/6	saying: [2] 33/5
91/16 92/18 104/24	110/22 116/8 117/13	Royal [2] 182/3 186/8	201/10	89/21
128/14 128/16 130/4	121/1 122/21 126/21	rudely [1] 81/14	sandwiches [1]	saying: we [2] 33/5
130/6 131/11 131/13	126/25 130/8 131/17	rule [6] 125/7 125/13	147/15	89/21
190/23 194/14 195/2	135/4 137/6 138/2	126/4 126/12 126/25	SARS [1] 12/4	says [9] 29/2 35/19
211/6	138/13 139/1 141/23	127/5	satisfy [1] 129/20	39/10 40/8 57/5
responsible [17]	142/4 144/11 145/1	rule-breaking [1]	Saturday [1] 209/22	202/10 202/25 212/17
2/19 5/2 5/9 13/14	145/2 154/1 155/3	125/13	save [1] 28/17	214/8
13/15 14/7 54/14 92/9	163/10 165/24 166/4	rules [6] 41/12 71/16	saved [1] 84/7	scale [11] 22/24
104/8 128/23 130/25	166/22 168/2 168/9	122/25 124/18 124/25	saves [1] 26/1	23/13 23/17 33/10
157/8 190/16 192/21	168/12 168/13 169/2	125/18	saw [5] 35/15 130/18	65/8 65/9 65/22 86/12
192/25 199/4 210/4	170/18 171/22 177/8	run [18] 6/3 16/10	137/14 197/13 213/1	90/8 124/22 206/19
rest [5] 5/6 106/11	178/17 183/6 189/9	22/23 23/10 25/24	say [163] 1/11 2/7	scaled [3] 85/2 85/8
148/6 148/7 164/6	189/13 189/14 190/4	32/3 37/7 37/8 39/15	2/12 3/7 3/11 4/10	86/3
restart [1] 150/18	190/19 191/6 191/19	54/19 55/6 78/5 87/15	5/13 5/23 6/16 6/19	scan [2] 168/24
restrictions [3] 18/6	192/3 192/11 193/6	89/19 130/6 149/18	7/19 8/15 8/16 10/6	168/24
157/18 168/2	193/17 193/20 194/5	183/20 185/15	13/18 15/22 16/16	scare [1] 18/7
result [7] 38/3 47/23	194/7 196/24 197/20	running [10] 17/13	16/19 18/7 18/23	SCCL [2] 13/18 13/23
49/21 119/23 120/3	199/1 199/17 202/16	31/14 31/23 32/9	19/16 19/21 19/23	scenario [8] 22/9
120/23 143/22	206/25 207/2 213/2	57/11 88/14 135/12	20/3 20/14 21/2 21/12	23/23 23/25 24/5 39/6
resultant [1] 143/23	213/21	145/22 151/16 167/4	22/1 24/14 26/2 26/12	39/7 166/18 180/18
resulted [3] 70/1	right-hand [1] 213/2	runs [2] 37/11 87/12	26/14 26/15 26/20	scenarios [6] 24/2
177/3 177/12	rightly [4] 20/19		27/4 27/12 27/14	24/4 39/9 39/12 39/17
resuscitate [3] 61/23	87/25 101/5 185/9	S	27/16 28/10 28/11	106/23
62/10 68/19	ring [2] 37/9 37/10	sadly [2] 74/19 94/24	28/13 29/12 29/12	scheme [25] 70/24
resuscitation [3]	ringing [1] 33/4	safe [5] 24/2 39/14	29/16 29/24 30/12	71/2 71/4 71/10 71/25
63/16 156/25 161/6	rises [1] 77/2	52/22 117/1 143/25	30/16 30/21 32/8 35/2	72/4 72/9 72/16 73/2
retail [2] 74/7 139/18	rising [1] 122/23	safely [2] 52/18	35/9 37/12 38/20	73/3 74/18 74/20
retain [1] 200/2	risk [23] 2/22 16/24	151/10	39/12 39/14 41/5	74/22 75/9 75/12
retained [1] 173/19	41/8 81/10 102/9	safety [4] 24/6 55/17	42/13 43/20 45/13	75/25 110/1 110/1
retired [1] 72/6	104/13 105/6 112/12	79/9 143/17	46/1 46/6 46/6 47/10	110/9 110/17 111/5
retrain [1] 137/21	113/2 117/2 123/13	SAGE [2] 206/4	47/17 48/16 48/19	111/12 111/20 112/6
retrospect [1] 30/9	144/15 144/17 170/13	209/5	49/6 49/21 50/19	112/9
retrospectively [1]	170/15 170/17 171/2	said [63] 11/3 11/17	50/21 51/7 51/7 51/22	schemes [5] 71/12
47/3	171/4 171/6 171/15	17/5 19/3 20/22 22/20	52/6 53/4 53/15 53/22	71/15 71/19 110/23
return [2] 54/3 72/7	172/15 201/9 201/12	24/23 25/24 29/15	58/9 59/21 60/1 60/23	111/18
returning [3] 71/25	risks [1] 164/24	31/8 31/14 32/13	62/4 66/6 66/20 66/24	science [9] 8/21
72/6 72/14	role [30] 3/4 3/12	40/14 46/5 50/7 60/22	67/5 67/18 68/1 68/11	82/13 83/23 84/1
returns [1] 175/19	4/17 6/16 55/21 79/14	63/9 69/14 70/13 75/1	68/21 69/13 69/17	84/13 93/3 105/11
reuse [1] 27/23	128/25 129/4 129/6	79/15 80/2 80/3 81/17	69/23 70/9 70/20	105/18 106/6
revealed [1] 116/21	129/9 155/5 188/25	84/17 93/9 93/18	71/11 74/24 75/6 75/7	science-base [1]
	189/5 189/8 189/24	103/22 105/21 107/9	75/23 76/19 78/1 78/7	84/1

S	79/10 183/17 183/21 186/14	211/5	157/5 157/7 158/1 178/10 178/11 203/1 208/22	shown [1] 212/19	
sciences [1] 105/3	seems [3] 127/4 206/23 212/20	services [64] 23/20 25/25 55/15 76/15 77/9 78/5 80/14 80/15 80/16 87/23 88/24 94/6 94/8 94/12 94/13 95/1 95/10 95/13 95/14 95/20 96/2 96/6 96/13 96/17 96/22 98/17 99/3 99/18 128/19 128/24 129/11 129/12 129/13 129/13 129/14 131/1 131/3 131/4 131/14 132/10 132/16 133/1 137/21 139/16 150/1 150/3 150/19 151/16 189/7 189/16 189/24 190/8 190/9 190/12 190/16 191/13 192/22 193/1 196/3 197/2 198/13 199/7 203/2 204/13	sharing [6] 58/15 59/3 59/6 59/23 60/10 91/1	shows [4] 22/3 114/7 128/10 211/19	shrinking [1] 94/13
scientists [1] 93/12	seen [10] 14/19 20/17 51/11 54/21 58/25 95/22 120/24 179/6 181/24 198/1	session [1] 155/15	she [6] 104/18 104/20 109/16 145/9 145/10 145/12	sickness [1] 175/18	
scope [1] 119/15	self [3] 26/12 91/14 208/12	sessionally [1] 27/24	she's [1] 46/5	side [13] 26/7 71/20 75/9 76/2 110/25 128/3 135/21 135/22 147/18 198/12 211/22 212/7 213/2	
scramble [1] 14/12	self-evident [2] 26/12 91/14	sessions [1] 149/3	sheer [1] 55/22	side rooms [1] 135/22	
screen [16] 3/23 15/16 21/20 28/25 33/17 38/15 39/1 44/11 52/11 65/1 76/8 101/23 102/20 102/23 143/11 152/25	self-isolation [1] 208/12	set [63] 2/18 3/5 4/18 4/20 4/22 4/25 6/6 6/19 7/14 14/11 15/14 19/11 19/15 19/17 21/18 30/22 32/18 38/10 39/1 40/5 40/13 42/14 42/20 42/21 42/25 43/7 46/20 48/13 51/4 52/7 52/20 55/6 62/19 63/13 70/2 70/8 70/10 73/8 74/1 76/7 76/11 98/16 116/6 125/7 128/20 129/1 129/10 130/5 134/5 140/10 140/19 153/25 155/8 155/9 171/12 171/13 172/9 173/25 176/3 176/22 190/2 201/5 216/3	shelf [1] 89/22	signed [2] 18/9 58/9	
seasonal [1] 18/13	semantics [1] 183/3	sets [7] 44/22 56/10 57/23 62/1 67/20 89/13 202/23	shielded [2] 57/24 123/8	signatory [1] 1/24	
second [19] 19/25 20/18 30/21 34/22 36/7 38/13 40/10 95/16 111/7 117/13 136/8 138/3 138/4 138/5 148/16 148/17 163/11 165/1 170/8	Sen [4] 109/15 109/18 113/8 217/10	setting [6] 2/22 3/14 3/25 65/11 71/8 104/8	shielding [15] 56/9 56/11 56/14 57/6 57/10 59/6 122/11 122/17 122/18 122/25 123/1 123/5 123/6 123/12 208/13	signed [2] 18/9 58/9	
secondary [1] 192/22	send [1] 45/18	settles [1] 201/1	shoes [1] 68/17	significance [2] 30/8 103/13	
secondly [1] 131/20	senior [8] 146/3 146/3 152/19 156/23 171/20 178/13 180/22 180/25	seven [4] 192/20 194/1 215/7 215/8	shone [4] 9/10 10/6 43/20 121/11	significant [17] 14/5 23/21 24/13 25/6 56/18 77/1 83/1 95/11 99/22 105/6 140/24 150/23 165/4 173/14 174/3 181/19 183/25	
secret [3] 9/12 9/14 9/18	sense [6] 36/22 37/18 130/16 182/5 200/10 200/14	seven days [2] 215/7 215/8	shore [1] 82/7	significantly [6] 26/15 102/7 102/10 143/2 166/5 183/24	
secretaries [1] 3/17	sent [9] 29/11 57/6 57/10 57/12 64/14 112/15 112/18 113/3 204/16	several [1] 10/17	shoring [1] 82/5	similar [6] 14/20 95/8 97/2 172/22 175/8 177/11	
secretary [19] 1/12 2/18 2/25 3/16 5/10 7/25 21/21 35/25 36/6 37/16 49/17 50/8 65/25 68/12 73/14 87/16 126/19 188/25 204/17	sentence [3] 29/24 30/10 173/17	shall [2] 54/3 133/24	short [24] 23/7 23/20 29/7 54/6 65/14 65/17 71/3 75/19 87/14 109/13 114/13 115/8 138/4 138/9 138/23 146/19 154/14 160/4 166/5 168/2 173/10 176/21 177/20 209/8	Simon [7] 66/3 66/12 66/17 66/19 67/20 67/22 124/16	
section [2] 101/22 153/4	separate [6] 85/12 89/21 90/4 154/20 167/23 177/7	share [3] 98/2 99/15 206/7	short-term [2] 114/13 115/8	Simon Stevens [5] 66/3 66/12 66/17 66/19 67/20	
sector [5] 9/13 88/17 101/4 101/4 190/17	September [4] 40/13 65/4 102/12 123/19	shared [8] 60/16	shortage [4] 23/4 23/15 183/6 185/3	Simon Stevens' [1] 124/16	
secure [3] 25/19 58/6 138/6	September 2020 [1] 123/19		shortages [6] 26/10 27/2 27/10 27/20 182/9 182/12	simple [1] 120/20	
secured [1] 167/15	series [11] 8/25 9/5 9/8 17/1 17/15 18/5 32/22 46/21 62/19 66/21 164/19		shortly [2] 2/14 2/16	simply [9] 48/2 53/8 53/16 95/16 115/19 126/11 131/20 175/23 191/13	
secures [1] 3/18	serious [2] 95/13 158/12		should [41] 5/12 22/10 28/8 28/8 28/12 29/17 41/8 41/11 45/3 50/2 51/7 52/16 53/22 58/9 59/10 64/18 66/4 68/21 72/3 75/8 75/21 78/21 78/22 79/24 92/5 92/9 96/2 108/9 116/18 124/14 125/5 125/20 127/4 130/11 143/13 159/5 173/1 179/13 180/10 181/24 205/16	since [7] 1/14 28/6 118/15 149/18 151/19 180/16 189/5	
securing [1] 166/1	seriously [5] 68/11 69/20 91/3 119/22 186/18		shouldn't [7] 41/14 67/15 107/14 117/4 123/25 159/11 159/15	since June 2022 [1] 118/15	
security [1] 87/5	seriousness [1] 68/14		show [3] 102/18 213/4 215/20	since May 2016 [1] 1/14	
sedated [2] 212/4 212/21	servants [1] 5/9		showed [4] 3/24 9/2 9/6 130/2	since November [1] 189/5	
see [46] 5/1 33/21 33/23 34/11 34/23 35/6 35/14 36/17 37/13 47/19 65/23 70/18 71/9 72/5 74/9 76/24 89/25 102/25 129/4 130/17 137/12 151/2 154/11 165/12 174/7 177/17 178/12 182/18 192/16 192/16 192/19 193/2 196/7 197/20 198/10 205/4 208/2 209/10 209/15 209/20 211/1 211/21 211/23 212/17 214/21 216/5	service [41] 30/24 67/18 87/24 89/20 91/3 94/19 98/25 128/15 128/17 129/6 129/15 129/22 129/23 130/1 130/1 130/6 130/9 130/18 131/20 132/1 132/5 151/18 171/23 172/1 172/5 174/18 174/19 174/25 174/25 176/1 176/3 176/3 176/5 176/6 189/1 190/5 190/10 193/3 203/1 205/17		showing [2] 209/6 209/11	single [13] 15/18 17/9 50/14 82/4 92/21 97/25 143/20 152/17 186/3 192/9 193/18 194/7 208/16	
seeing [4] 74/7 181/2 184/8 187/11				Sir [53] 1/5 1/6 1/8 1/10 1/21 3/17 8/9 10/9 16/2 21/17 24/11 27/5 34/2 43/24 51/15 53/1 54/9 59/12 62/5 67/9 73/1 76/9 80/24 90/12 92/20 93/21 94/3 94/15 96/24 97/5	
seek [1] 186/22					
seeking [5] 15/21					

S	slowness [1] 25/5	180/24 181/4 182/9	source [4] 58/2 140/8	205/16 209/12
Sir... [23] 100/18	small [5] 142/23	182/14 186/20 189/22	140/9 147/13	spreads [1] 92/15
101/7 101/15 103/10	142/24 149/13 149/15	195/22 195/23 196/11	sources [3] 18/4	spring [2] 157/24
107/7 107/10 107/11	151/7	196/17 196/20 197/11	83/17 210/9	157/25
107/13 109/3 109/19	smaller [3] 33/10	199/24 200/22 201/12	sourcing [1] 11/7	staff [152] 1/19 7/18
111/19 112/4 113/12	120/9 120/21	204/5 206/1 206/4	south [2] 213/2 213/3	34/5 42/15 44/20
117/9 122/6 122/13	snapshot [2] 205/18	206/8 207/18 207/20	space [5] 136/22	45/21 46/14 46/22
123/21 128/13 130/15	214/21	210/8 212/20	137/21 144/1 148/8	47/1 53/9 71/25 73/16
131/5 133/5 133/23	Snooks [2] 55/18	somebody [7] 32/9	148/10	73/19 74/4 74/8 88/19
217/3	133/17	37/6 53/9 104/2	spaces [1] 74/9	91/21 92/3 94/25
Sir Chris [1] 1/6	so [492]	124/18 156/19 181/2	spacing [1] 136/13	109/23 112/19 112/20
Sir Christopher [41]	social [29] 1/13 2/21	someone [6] 68/18	Spain [3] 137/19	116/24 117/7 117/20
1/5 1/8 1/10 1/21 8/9	3/13 6/25 9/13 33/2	114/3 138/18 143/21	137/20 209/10	118/14 119/12 119/24
10/9 16/2 24/11 34/2	44/18 47/19 59/18	144/20 156/1	spanning [1] 1/22	120/9 120/21 126/8
43/24 51/15 53/1 54/9	59/20 65/5 73/21	something [33] 6/7	spare [4] 25/25 87/12	132/6 132/8 132/8
59/12 62/5 67/9 73/1	74/10 74/13 110/8	6/23 11/15 11/20	88/2 88/23	132/12 132/14 132/15
76/9 80/24 90/12	110/18 189/7 189/16	13/17 22/25 28/9	speak [2] 2/2 24/6	132/16 136/7 136/10
92/20 93/21 94/3	189/24 190/8 190/9	29/12 30/25 45/16	speakers [2] 79/17	136/18 137/21 138/6
96/24 97/5 100/18	190/12 190/16 196/2	47/24 49/17 69/21	82/17	138/7 138/21 140/3
101/7 101/15 103/10	197/2 198/13 199/7	71/11 99/5 100/13	speaking [3] 44/5	140/4 140/7 140/8
107/10 111/19 112/4	204/13 208/11	100/24 105/20 108/20	148/14 154/24	140/9 140/9 140/24
113/12 117/9 122/13	Social Care [1] 6/25	118/4 118/11 124/8	special [2] 193/8	141/9 141/15 142/14
123/21 128/13 130/15	socialised [1] 206/10	127/18 150/15 156/11	193/16	142/23 142/23 142/25
131/5 133/23 217/3	socially [1] 148/10	157/11 157/14 158/16	specialist [3] 141/21	143/6 143/8 144/6
sister [2] 168/10	society [3] 88/18	167/6 175/4 199/21	193/5 203/2	144/15 144/25 145/4
169/1	95/7 95/7	200/9 210/7	specialities [2] 89/15	145/8 145/10 145/11
sister's [1] 169/13	solution [2] 51/14	sometimes [7] 32/2	151/6	145/13 146/1 146/6
sisters [1] 169/18	123/11	98/3 145/23 151/12	specialty [1] 156/24	146/8 146/14 147/5
sit [1] 198/22	solutions [2] 37/17	157/13 162/2 162/4	specific [22] 43/1	147/9 147/11 147/13
site [2] 135/25	94/10	somewhere [5] 8/23	43/2 50/20 64/9 81/24	147/16 147/20 148/6
161/11	solve [3] 21/9 50/22	12/12 14/13 15/21	81/25 85/22 98/20	148/7 148/9 148/13
sites [2] 179/14	61/15	110/24	99/14 104/3 104/13	148/22 149/11 149/22
179/15	solved [3] 24/18	sooner [2] 42/3	112/9 120/2 122/14	150/2 150/7 150/13
sitrep [3] 210/1	26/23 27/14	162/24	123/15 140/15 147/1	150/20 150/24 152/13
214/18 215/4	some [117] 4/13 4/14	sorrow [2] 1/16	155/8 155/9 175/9	152/14 154/15 156/20
sitreps [1] 211/18	5/24 9/19 11/3 11/6	29/20	185/6 202/18	158/7 161/21 161/22
sitting [1] 4/4	13/22 17/5 19/17	sorry [38] 9/21 10/10	specifically [14]	161/25 162/15 163/7
situation [19] 7/8	20/16 23/2 30/19	10/10 13/6 17/10	42/25 48/21 55/24	163/17 163/25 163/25
25/8 32/16 47/4 49/19	37/15 39/3 40/22	17/25 20/21 20/22	61/12 84/21 101/20	164/3 164/4 164/6
68/15 114/5 115/24	43/20 44/20 44/22	21/15 23/6 29/11 36/2	114/18 119/17 131/6	164/9 164/13 166/14
126/18 140/20 151/13	44/24 46/14 47/6 47/7	44/2 44/6 46/10 58/9	146/4 155/13 157/22	166/16 170/8 170/13
154/7 154/18 158/12	51/22 52/2 55/6 57/17	61/22 62/19 66/10	191/23 195/10	170/19 171/25 172/4
160/24 160/25 173/2	58/16 59/13 61/2 61/3	77/2 84/23 85/24	specified [1] 104/12	172/20 172/23 173/18
182/20 185/19	61/11 67/4 69/2 81/6	86/24 91/7 93/19	specify [2] 16/8	173/20 174/12 175/6
situations [4] 154/2	81/25 83/1 83/20	105/14 114/3 117/22	104/22	175/25 177/23 178/23
155/12 172/23 186/4	87/24 88/15 90/22	120/19 121/19 124/4	speculate [1] 159/7	178/23 179/3 181/18
six [3] 157/13 165/14	93/3 93/22 94/25	131/22 133/15 159/21	speed [5] 17/14 18/9	182/5 182/21 182/24
212/19	97/23 98/7 102/18	166/20 170/3 188/11	19/23 45/24 126/17	183/20 184/1 184/3
six months [1]	105/1 105/2 115/12	215/25	spend [6] 25/17	184/8 184/8 184/13
157/13	123/7 123/19 131/16	sort [22] 12/3 22/20	25/18 83/13 87/22	184/16 185/1 185/9
size [1] 89/14	133/4 138/6 139/11	36/20 36/23 37/25	87/23 98/12	185/12 185/18 185/22
skilled [2] 81/11 90/6	139/12 140/9 141/19	49/18 79/2 80/8 80/22	spike [5] 34/21 34/21	185/25 186/5 186/8
skin [8] 48/16 52/19	141/20 143/9 143/16	83/11 108/21 115/13	34/23 35/3 35/16	186/12 186/12 186/19
53/11 53/19 53/25	144/8 145/3 145/18	141/22 154/17 162/3	spoke [3] 46/4	205/2 205/7 205/8
54/1 113/20 114/10	147/20 147/22 148/1	167/22 169/7 171/11	104/17 160/12	212/11
sleeping [3] 17/15	148/12 148/21 149/11	172/15 186/14 196/25	spoken [1] 11/14	staffed [1] 90/6
20/23 21/11	149/22 150/24 150/25	200/22	spotlight [8] 9/10	staffing [8] 90/9
slightly [3] 42/10	151/3 152/13 159/14	sorts [5] 71/11 71/19	38/4 43/20 121/11	142/21 143/5 148/15
66/17 67/20	160/12 161/1 161/9	76/2 80/19 127/2	156/15 177/9 177/18	148/16 163/20 169/22
slogans [1] 79/20	161/17 161/19 165/4	sought [2] 77/23	179/14	173/15
slow [5] 16/15 16/16	165/18 169/22 171/1	121/1	spotlighted [1] 62/16	stage [10] 7/24 36/22
16/18 43/24 44/6	172/15 173/10 175/16	sound [2] 46/16	spread [9] 81/21	45/17 55/19 202/16
slower [1] 10/9	176/19 179/8 179/19	184/25	136/12 144/13 151/5	202/20 204/11 206/16
	180/21 180/23 180/24	sounds [1] 178/3	162/6 162/6 169/4	214/11 214/12

S	151/23 155/1 156/8 162/12 162/19 164/19 166/8 172/10 173/13 173/15 173/16 173/25 174/7 181/17 188/18 188/20 189/20 189/23 190/14 196/5 196/6 201/23 203/15 208/9 211/18	stockpiling [1] 28/6 stocks [2] 38/18 185/10 stood [1] 214/10 stop [9] 101/19 101/20 103/11 105/25 106/4 136/25 141/1 145/5 151/13 stopped [2] 205/5 206/15 stopping [1] 104/25 storage [1] 145/24 store [1] 39/21 stores [1] 147/8 stories [3] 14/20 76/3 146/13 straight [1] 27/12 straightforward [1] 181/2 strategic [4] 3/14 153/2 195/12 200/18 strategy [2] 2/20 40/13 strength [1] 83/15 strengths [1] 84/17 stress [5] 41/17 143/23 159/2 159/15 162/17 stressed [2] 146/8 159/13 stressful [1] 146/8 stressor [1] 143/21 stretch [2] 139/23 192/18 stretched [2] 143/6 148/16 strict [1] 55/10 strides [1] 59/17 strike [1] 44/1 striking [1] 80/10 strong [9] 8/20 9/1 9/2 9/5 10/1 58/12 150/9 158/20 205/13 stronger [1] 100/21 strongly [1] 102/15 struck [1] 85/1 structural [2] 121/4 121/14 structure [13] 3/25 196/2 196/12 196/25 197/3 197/15 197/17 197/20 199/6 200/6 200/25 201/2 201/9 struggled [1] 166/14 struggling [1] 166/16 studded [1] 136/19 students [1] 193/12 study [3] 43/18 114/13 125/3 stuff [3] 20/10 47/14 82/10 stunted [1] 95/15 style [4] 12/4 112/13 112/15 113/17	sub [2] 52/25 65/21 sub-recommendatio ns [1] 52/25 subcontracted [1] 112/18 subgroup [1] 199/11 subject [5] 22/4 80/8 80/18 125/4 127/25 subjects [1] 88/20 submission [2] 65/11 122/17 submitted [1] 112/23 subsequently [1] 207/3 subset [1] 90/22 success [1] 142/17 successful [2] 139/13 139/14 such [15] 4/23 32/14 43/17 49/22 51/18 55/18 60/5 63/12 104/13 104/13 115/21 153/19 184/5 190/25 205/7 Sue [1] 177/4 suffered [1] 1/17 sufficient [11] 11/23 12/2 16/3 30/1 30/14 34/5 38/21 97/19 102/2 145/14 151/8 sufficiently [1] 42/7 suggest [4] 37/15 102/15 130/15 186/15 suggested [3] 105/3 105/4 179/16 suggesting [3] 17/4 22/10 113/18 suggestion [3] 51/9 72/1 163/14 suggests [1] 35/8 suitable [3] 165/24 197/13 215/24 suite [1] 211/8 suits [2] 41/10 79/2 sum [2] 71/3 74/2 summarise [1] 128/1 summarised [3] 4/10 75/17 156/5 summarising [1] 192/8 summer [4] 136/15 146/18 181/20 183/24 supervisor [1] 158/21 supplier [4] 13/18 13/19 13/19 14/3 suppliers [4] 14/4 14/8 16/22 21/5 supplies [11] 11/24 11/25 13/10 14/8 15/4 23/8 23/9 31/25 33/7 38/22 87/6 supply [44] 10/3 12/21 13/11 13/25	16/3 19/11 19/13 19/20 20/3 20/5 21/6 21/21 21/25 23/2 28/19 29/7 30/20 30/22 32/2 38/9 38/22 47/9 48/2 51/24 103/14 105/4 106/2 106/8 106/16 106/19 145/14 146/22 147/5 162/16 166/9 181/19 182/17 183/4 183/7 183/9 183/18 184/21 185/25 196/19 supply days' [1] 32/2 support [42] 3/12 3/16 132/8 138/7 139/16 139/19 139/25 140/24 141/13 141/21 142/5 142/8 144/2 145/4 148/22 148/24 148/25 151/17 153/10 154/23 156/23 157/8 162/23 168/14 168/15 169/7 169/8 169/20 171/21 171/25 172/7 173/1 176/25 177/21 178/2 179/1 190/11 195/18 207/4 207/7 210/12 210/13 supported [9] 78/7 78/25 141/9 164/11 165/6 165/9 168/23 172/3 207/24 supporting [2] 168/20 192/5 supportive [1] 175/16 supports [1] 172/22 suppose [8] 145/15 149/4 158/8 158/9 161/1 162/5 183/9 185/16 supposed [1] 20/2 sure [37] 2/8 14/19 17/21 23/3 31/25 32/23 55/24 58/24 60/13 69/22 85/7 98/22 99/25 101/11 110/22 111/9 112/1 114/2 116/12 118/7 123/6 127/13 127/15 139/14 144/15 144/15 146/13 174/16 184/15 185/6 197/12 200/13 203/17 203/19 210/23 213/16 214/2 surge [8] 10/25 11/21 12/18 26/18 82/8 86/22 93/7 183/19 surgery [7] 138/18 138/20 140/2 151/12 205/5 205/9 206/15 surgical [2] 15/18 135/17
----------	---	--	--	--

S	145/6 150/4 153/19 156/8 160/23 165/18 200/22 take months [1] 16/11 taken [28] 5/19 29/17 30/19 39/12 39/13 57/23 62/20 63/6 64/8 67/1 68/11 72/7 87/14 103/11 114/12 116/23 119/21 123/18 125/19 128/7 137/8 148/25 169/23 176/18 196/16 201/20 203/6 203/8 taking [8] 48/24 49/7 82/8 96/1 96/18 98/13 150/16 174/3 talk [2] 58/24 78/20 talked [3] 11/22 93/6 167/22 talking [11] 43/1 105/14 115/7 126/6 126/20 161/20 170/25 171/1 177/7 191/16 209/1 task [1] 45/10 Taskforce [1] 44/17 tasks [1] 141/7 tat [1] 147/14 tax [1] 87/22 taxpayer [1] 88/25 teach [1] 170/1 team [15] 44/17 45/10 85/11 141/19 152/9 152/10 154/5 154/5 157/7 163/12 164/17 172/2 178/16 178/25 189/3 teams [3] 149/16 164/1 169/15 tech [1] 60/15 technical [5] 10/20 93/10 93/16 93/20 208/10 technically [1] 123/11 techniques [1] 23/14 technological [1] 60/13 technology [4] 60/5 60/24 90/7 216/4 telephone [1] 77/3 tell [5] 27/15 37/24 67/12 67/12 129/3 telling [2] 36/12 97/15 tells [2] 98/9 188/1 temporary [2] 212/1 214/7 ten [6] 12/17 88/14 88/20 95/24 197/25 201/10 ten years [1] 12/17 ten-year [3] 88/14	88/20 95/24 tend [1] 191/15 tended [3] 142/14 191/11 212/23 term [7] 20/3 51/12 89/13 110/12 114/13 115/8 153/9 term' [2] 153/14 153/14 termed [1] 80/24 Terminal [1] 188/3 Terminal 5 [1] 188/3 terms [39] 3/11 3/25 7/5 29/17 49/25 56/2 66/24 68/20 70/4 79/25 87/4 87/6 91/12 98/9 99/9 99/22 103/15 103/21 105/25 107/2 114/5 115/8 121/7 128/3 128/16 129/9 134/6 140/11 143/17 153/16 155/8 167/7 170/13 171/21 184/6 190/21 195/9 206/24 212/24 terrible [3] 70/20 71/14 75/7 terribly [1] 44/2 test [16] 41/7 41/9 84/15 84/25 85/2 85/8 85/16 85/18 85/20 85/22 86/4 86/4 86/19 86/19 116/18 144/24 tested [4] 43/22 114/9 116/4 178/12 testing [16] 8/22 22/5 82/2 84/18 85/15 86/21 116/15 118/14 162/14 162/20 163/2 163/15 163/18 163/21 164/4 164/15 tests [11] 11/3 17/23 17/24 84/20 85/4 85/22 86/6 86/13 86/15 163/10 187/13 text [2] 57/5 57/9 texts [1] 57/12 than [47] 12/7 20/6 23/16 24/5 28/8 36/8 37/8 37/17 39/25 40/1 44/21 46/5 46/15 53/17 61/9 63/3 68/3 74/7 75/25 82/3 87/23 88/17 99/4 100/5 100/21 102/8 104/3 107/5 111/3 113/19 126/5 127/22 128/4 130/11 136/21 142/15 143/1 148/24 152/5 175/23 177/18 181/11 191/8 191/9 205/23 206/15 213/13 thank [84] 1/7 1/21 2/14 2/17 33/16 44/7	48/9 54/4 65/20 72/5 86/23 96/24 96/24 96/25 97/4 101/7 101/9 107/7 107/8 109/1 109/2 109/17 112/11 113/6 113/7 113/8 115/17 116/15 122/2 122/4 122/16 128/11 133/3 133/5 133/8 133/9 133/10 133/21 133/22 133/23 134/7 134/14 134/21 135/7 136/25 143/12 143/15 145/5 147/10 149/13 149/20 151/21 153/6 159/25 162/12 167/24 172/9 173/4 173/6 173/22 174/10 176/7 176/9 176/12 177/19 179/22 181/6 181/8 181/9 181/13 186/24 186/25 187/1 187/20 187/23 188/4 188/15 188/23 190/3 190/6 198/9 201/19 214/19 216/4 thanks [1] 1/19 that [1261] that's [83] 4/7 13/9 14/15 15/20 19/19 21/19 22/6 24/3 24/7 40/12 43/7 47/4 47/9 61/9 63/21 66/15 80/22 82/17 86/7 87/13 90/1 90/19 91/16 97/15 98/14 101/8 104/23 107/6 107/15 110/13 111/18 112/13 113/14 114/22 115/5 116/20 117/24 122/1 126/17 130/13 132/10 133/5 134/3 134/9 134/13 135/5 137/7 139/2 144/9 145/19 158/10 163/22 173/14 176/25 177/1 177/6 181/6 183/4 188/19 189/4 189/10 189/14 190/1 190/13 190/20 191/4 191/22 191/24 192/2 193/2 193/7 193/14 194/6 201/14 201/16 202/20 203/14 205/18 208/12 209/22 211/6 213/24 215/24 that's February 2021 [1] 177/6 theatre [5] 138/7 138/17 138/21 138/22 205/8 theatre/recovery [1] 205/8 theatres [2] 138/8	212/14 their [73] 4/9 5/5 13/10 13/14 13/15 13/16 14/7 33/7 40/15 50/2 55/2 55/5 55/15 58/20 60/10 62/12 69/4 69/10 70/19 74/9 79/10 86/21 96/17 96/19 98/4 112/5 112/16 112/20 119/23 126/2 126/8 129/15 130/6 131/13 131/13 138/19 138/20 141/12 141/22 144/13 144/17 145/13 147/14 147/14 150/22 152/22 155/21 158/21 169/21 177/24 178/2 184/6 184/13 186/8 186/13 186/16 186/17 194/4 195/1 195/1 199/4 200/8 200/16 201/8 201/13 202/1 205/21 209/17 209/17 210/3 210/4 214/25 215/2 them [62] 2/3 4/3 4/14 4/20 4/22 9/20 22/18 24/9 36/11 36/12 37/24 41/9 41/10 41/22 46/4 54/23 56/2 57/13 61/1 61/23 64/4 70/11 75/17 81/6 81/6 96/16 96/23 100/15 121/12 122/10 123/10 127/19 128/24 131/21 132/18 141/14 142/1 142/9 148/9 148/14 149/14 150/2 150/21 150/24 150/24 154/25 158/18 158/21 158/22 164/2 164/5 169/20 170/16 171/1 171/1 177/4 181/2 181/3 186/20 194/25 209/16 210/19 theme [10] 9/9 44/23 53/8 81/8 87/1 89/17 90/8 90/13 92/4 94/4 themes [3] 44/19 81/3 81/14 themselves [5] 24/7 36/21 68/17 128/2 132/18 then [108] 1/24 4/5 6/3 6/22 9/8 13/5 13/20 14/24 15/3 16/8 16/9 16/25 19/23 20/11 22/7 22/10 31/19 31/20 34/22 36/13 37/5 39/8 40/16 42/24 45/6 45/15 49/11 49/17 50/25 58/3 61/12 65/14 66/3 66/17 67/20 68/19
T	tab [3] 133/13 143/13 153/1 tab 10 [1] 133/13 tab 2 [1] 143/13 tab 3 [1] 153/1 table [7] 21/18 22/16 39/1 198/23 199/14 211/18 214/20 table on [1] 39/1 tables [1] 22/17 tail [1] 173/12 take [32] 7/23 16/2 16/11 22/2 52/1 52/16 53/24 60/7 66/18 69/19 70/5 81/13 82/9 86/24 89/22 91/2 91/15 95/5 96/21 98/25 102/19 122/9 125/18 130/21 131/7			
			(89) surging - then	

T	52/7 53/10 54/1 54/18 54/25 55/1 55/2 55/3 56/24 60/12 62/21 62/23 63/21 68/10 72/1 72/12 72/15 75/15 76/17 77/24 77/24 78/20 79/11 82/1 82/3 86/6 86/11 91/14 92/11 92/16 93/21 94/10 94/22 95/8 96/18 96/18 96/21 100/4 102/7 110/6 110/7 111/9 111/10 111/12 111/14 112/1 112/2 116/18 117/25 118/1 118/11 118/24 119/22 120/20 121/2 121/24 121/25 123/16 126/15 129/24 129/25 132/17 132/20 132/23 134/6 134/10 138/12 138/14 138/18 138/19 139/3 139/7 141/11 141/12 142/1 142/9 142/12 142/14 142/15 142/25 144/10 144/11 144/11 144/12 144/12 144/16 144/23 145/22 145/24 147/6 148/7 148/9 149/23 150/21 152/5 152/20 154/16 154/21 154/24 155/15 156/25 157/17 158/8 158/23 159/4 159/13 161/23 168/11 168/16 168/17 169/3 169/19 169/21 170/14 171/13 171/18 174/13 178/5 179/10 181/4 182/24 184/5 184/8 184/25 186/6 186/15 191/4 191/14 192/24 192/25 193/10 193/24 196/23 198/22 198/23 199/3 200/17 201/13 203/18 203/19 203/24 204/25 205/20 205/24 207/15 209/9 210/3 210/25 211/6 212/10 212/12 212/14 213/20 213/21 214/13 214/14 215/2 216/3 they'd [4] 7/19 152/20 159/4 163/3 they're [16] 4/25 10/20 13/15 23/20 33/4 33/7 33/8 59/19 73/2 75/17 125/1 125/19 158/8 192/21 211/22 215/3 they've [2] 105/11 134/8 thing [34] 4/13 6/19 14/2 14/5 24/3 25/14	32/7 32/13 34/13 34/20 36/5 38/7 43/7 45/13 50/14 50/20 51/25 53/4 58/9 63/14 68/6 75/6 75/25 83/11 84/12 85/19 93/14 114/22 115/14 116/6 159/8 161/22 162/1 201/10 things [68] 2/10 4/13 4/21 5/11 5/23 7/14 7/17 8/12 9/5 10/16 10/17 11/6 11/17 13/22 13/22 16/24 22/21 23/7 23/10 25/13 33/11 35/17 37/5 40/9 42/13 42/25 45/19 45/24 47/24 50/12 51/20 51/23 53/13 55/2 58/17 63/14 63/19 81/22 81/25 82/11 83/8 83/10 83/17 91/25 92/13 93/18 100/22 105/22 105/23 115/12 116/3 120/16 124/7 126/14 126/16 126/16 126/23 127/2 128/10 131/11 137/10 145/21 149/13 149/15 152/10 179/18 200/14 212/7 think [216] 1/23 2/24 3/11 3/19 4/24 5/18 8/3 8/11 10/17 11/2 11/14 12/12 12/13 13/23 16/15 16/25 19/10 19/16 19/17 19/19 22/19 22/25 24/19 25/23 26/16 27/9 28/1 28/4 28/15 29/8 29/10 29/25 30/9 30/16 30/17 30/20 30/23 35/18 36/19 37/10 37/11 40/5 40/6 40/7 41/20 41/22 41/24 42/9 42/23 43/1 43/16 45/19 47/17 48/5 48/6 49/4 49/9 49/21 50/24 51/8 51/15 52/7 53/13 54/11 55/19 57/15 59/24 60/2 60/18 60/21 60/22 60/24 61/7 61/7 61/8 62/7 62/18 62/18 65/14 66/25 67/21 67/22 67/23 68/17 69/17 70/22 71/2 71/7 73/21 74/23 75/5 75/6 75/6 75/8 75/11 75/14 75/14 75/15 76/14 76/14 76/20 78/8 79/6 80/4 83/14 83/18 86/12 88/16 89/12	92/13 93/3 93/4 93/15 93/19 95/2 95/22 101/23 102/22 103/18 103/21 104/1 105/20 106/2 106/21 106/25 107/3 108/11 108/13 111/23 114/15 114/24 115/25 117/3 120/11 124/15 132/6 132/7 135/14 137/11 137/13 139/11 140/11 144/7 145/21 145/25 146/5 148/3 149/10 150/6 150/8 150/11 150/12 150/18 154/15 155/1 157/24 160/19 160/21 162/1 162/10 162/10 163/7 163/13 164/13 165/1 165/17 168/22 169/2 171/3 172/6 172/13 172/15 172/17 172/21 173/3 174/8 174/17 176/2 176/4 177/16 178/24 179/5 179/18 179/20 179/22 180/16 180/22 181/1 181/11 182/17 183/13 187/2 189/5 191/24 192/20 193/5 193/10 193/15 199/16 199/21 200/1 200/7 200/13 200/15 200/21 200/25 201/6 202/16 206/14 207/2 209/11 209/15 209/19 211/19 214/12 214/15 thinking [3] 89/19 90/4 92/17 third [6] 58/23 70/25 111/1 111/4 165/22 202/10 thirdly [1] 177/5 this [353] Thomas [3] 113/9 113/11 217/13 those [140] 6/3 7/17 10/2 10/4 10/11 10/19 12/24 13/11 16/24 24/7 27/1 32/15 39/11 42/16 42/17 42/20 43/6 45/9 45/12 45/20 47/3 47/13 47/21 50/20 51/22 55/24 56/11 56/14 59/21 60/4 60/15 70/4 71/4 71/18 71/21 78/16 79/23 80/12 80/15 80/19 81/8 81/22 83/9 83/17 83/19 93/8 93/16 95/13 96/13 96/21 104/12 105/24 106/11 110/19 115/9 116/12 118/6 120/16 122/25 124/13 126/13	127/2 127/18 128/9 131/11 131/12 132/10 137/4 139/6 139/8 139/12 139/18 140/3 140/5 141/8 141/25 143/9 147/22 148/1 149/15 150/20 150/23 150/25 151/15 152/1 152/20 153/17 155/3 155/14 155/24 156/9 157/17 162/23 164/24 165/18 165/23 167/4 173/5 174/10 174/12 178/21 179/18 183/6 183/14 183/16 185/6 186/1 186/14 186/17 186/20 186/22 191/1 191/2 191/16 191/19 192/17 192/19 193/21 193/22 194/17 194/21 196/22 197/25 197/25 198/20 198/21 198/24 199/20 200/14 201/7 203/5 204/5 207/9 208/21 208/24 209/11 212/19 212/24 213/16 213/18 though [11] 15/14 16/20 57/3 78/2 108/2 132/1 141/7 143/3 147/4 165/9 201/17 thought [14] 4/7 4/9 10/19 56/13 58/12 85/12 85/13 102/11 107/10 111/14 156/2 158/16 164/22 215/8 thousands [3] 22/18 36/3 85/4 third [1] 94/12 threatened [2] 143/21 143/22 three [12] 22/20 58/16 76/18 82/20 82/22 90/8 98/10 177/7 193/2 194/2 208/11 211/24 three months [1] 98/10 through [38] 1/20 4/25 12/20 19/22 42/15 43/14 47/20 61/18 73/25 74/3 79/11 81/7 83/6 156/14 156/14 156/16 172/8 180/20 183/1 193/23 194/23 197/16 198/4 198/8 198/19 199/11 199/15 199/19 206/6 206/6 207/12 208/24 209/1 212/8 212/25 213/3 214/4 214/17 through March [1] 207/12
----------	---	--	---	---

T	216/1 216/5	transferred [2] 141/23 142/12	Tweets [2] 75/15 75/23	132/23 135/11 147/20 148/13 159/2 194/3 201/6 202/24
throughout [3] 138/25 168/8 215/4	tones [2] 52/19 53/19	transformed [1] 142/6	two [36] 2/9 19/21 19/23 20/9 20/11 19/23 20/9 20/11	underestimated [2] 120/25 121/2
throwing [1] 60/15	too [15] 11/15 16/15 30/10 30/17 39/24 39/25 51/11 51/17 85/25 98/8 115/4 134/20 145/9 148/23 150/11	translated [1] 195/14	22/20 35/17 39/9 40/9 44/4 47/24 61/17 88/5 94/5 99/7 100/4 103/15 104/17 110/11 110/20 123/17 139/7 146/22 147/5 153/8 165/16 171/17 172/11 172/18 176/20 177/9 182/16 183/18 192/17 205/11 208/25	undergo [1] 159/17
Thursday [2] 161/14 161/23	took [17] 14/17 41/3 46/20 47/4 51/2 51/6 66/20 69/5 69/7 85/18 86/16 123/12 131/15 147/14 186/17 191/8 200/15	translational [2] 83/6 83/9	two weeks [2] 104/17 208/25	underlying [3] 10/3 87/2 96/12
till [2] 51/6 98/8	took years [1] 85/18	transmission [10] 30/8 92/6 102/10 103/2 103/8 103/13 105/7 164/25 165/3 165/3	two weeks' [1] 147/5	undermines [1] 87/16
time [92] 1/11 3/18 4/1 5/11 12/2 15/10 15/13 15/23 15/24 16/5 20/16 21/10 22/4 23/2 26/1 30/11 33/24 35/16 38/12 43/20 44/5 51/7 51/17 52/2 53/21 56/19 59/14 72/16 73/19 78/18 80/9 80/20 85/25 86/1 89/13 98/13 102/2 111/19 113/1 122/13 122/23 127/23 138/4 138/9 138/17 138/23 144/5 146/19 146/21 146/25 148/14 148/14 149/25 151/25 152/8 153/24 155/6 159/23 162/17 163/5 163/21 163/23 164/10 164/21 164/25 165/18 166/19 172/5 172/7 174/5 178/12 180/16 180/18 180/18 180/22 183/15 183/21 183/25 187/9 187/17 197/13 204/1 206/10 206/20 207/25 209/24 210/8 210/23 211/21 212/3 213/15 214/16	tool [3] 123/5 123/9 153/12	transposed [1] 8/8	two-week [1] 146/22	underneath [1] 213/5
timeliness [1] 19/5	toolkit [2] 81/9 81/15	trauma [2] 155/23 204/20	tying [1] 209/9	underpinned [1] 133/20
times [7] 10/17 22/20 100/5 140/22 161/1 195/18 201/10	top [6] 4/3 40/6 72/21 73/11 110/9 157/21	transmitted [1] 102/15	type [7] 16/9 38/25 41/13 86/15 103/8 110/23 111/18	underreporting [1] 174/2
timescale [1] 60/2	topic [11] 70/24 112/23 123/17 127/7 128/11 149/21 151/21 156/5 159/23 167/25 173/10	Treasury [2] 74/16 75/3	types [11] 22/3 36/4 36/4 40/11 41/23 47/8 82/20 90/3 91/10 98/22 119/2	understand [34] 4/24 18/22 24/10 25/1 46/8 47/24 50/15 51/21 53/20 55/11 57/3 66/20 74/15 77/22 84/24 91/4 99/6 100/9 106/5 106/14 106/20 106/21 107/22 108/17 114/17 133/19 133/25 141/7 150/25 165/15 184/1 201/4 201/4 207/18
timescales [1] 51/11	topics [2] 54/10 160/8	Treasury's [1] 74/4	typically [2] 213/20 213/21	understandable [3] 31/11 32/14 47/15
timetable [1] 188/13	topmost [1] 192/17	treated [1] 96/11	U	understandably [7] 22/13 41/18 46/25 60/9 159/13 163/8 169/2
timing [1] 161/13	total [3] 66/14 89/14 214/22	treatment [9] 60/8 139/4 149/21 151/23 152/24 153/21 166/11 207/23 213/17	UCL [1] 83/21	understanding [19] 40/14 95/2 107/6 140/22 141/6 145/19 146/21 147/4 147/7 168/25 171/9 172/4 177/15 178/5 180/18 182/19 200/16 204/7 213/16
title [1] 190/3	touch [4] 115/18 151/5 151/19 210/24	triage [1] 31/18	UK [19] 8/6 8/8 8/18 21/8 25/23 29/3 50/2 50/12 64/16 76/12 82/20 87/12 114/22 116/5 116/6 122/8 162/4 176/15 196/20	understood [7] 29/18 33/4 55/12 57/5 107/18 108/4 203/18
today [8] 1/4 3/10 93/25 135/16 147/25 181/22 189/15 216/5	touched [1] 90/15	tried [7] 144/14 144/18 151/2 154/7 171/8 180/2 182/25	UK-wide [1] 76/12	undersupply [1] 23/22
together [8] 39/9 43/15 98/24 152/5 152/6 199/16 199/23 211/22	touching [1] 149/13	truth [14] 4/11 4/12 15/20 30/1 30/2 30/10 30/12 30/16 36/25 37/1 87/13 100/12 100/12 132/7	UKHSA [7] 82/1 85/10 86/5 86/9 86/21 92/11 92/19	undertake [3] 151/10 170/11 171/15
toilet [2] 147/16 148/4	tough [1] 109/7	trust [5] 31/14 117/25 193/3 193/4 193/5	UKRI [1] 83/3	undertaken [1] 172/22
told [7] 41/16 53/6 55/19 74/22 145/11 146/7 146/10	toward [1] 153/13	trusts [9] 13/10 13/13 112/16 118/20 118/21 193/2 194/2 198/11 198/25	ultimate [1] 6/22	undertaking [3] 141/18 164/10 179/10
tolerance [10] 66/14 66/16 67/14 67/24 69/24 124/6 124/8 124/10 125/21 127/14	towards [4] 29/13 104/4 112/16 173/22	truth [2] 67/12 67/13	ultimately [1] 55/5	undertook [3] 143/8 157/4 178/4
tomorrow [3] 188/14	Trace [4] 84/15 85/2 85/8 86/4	truthfully [2] 67/16 67/18	unable [1] 162/13	underway [2] 52/23 53/2
	track [3] 17/7 18/15 210/5	try [16] 30/19 34/6 44/8 45/16 46/13 77/23 89/6 104/4 122/14 137/23 146/15 151/15 164/24 182/16 204/10 205/21	unacceptable [4] 62/23 68/24 70/17 131/19	unexplained [3] 100/6 100/13 100/23
	tracking [1] 196/15	trying [15] 7/16 14/16 29/21 60/19 126/1 159/15 166/18 171/15 177/15 185/22 187/10 187/13 207/14 214/1 215/10	unanswered [6] 55/17 55/20 55/23 131/18 132/3 133/13	unfortunately [2] 156/22 156/25
	trade [3] 18/2 88/22 96/16	Tuesday [1] 1/1	unaware [1] 118/6	unilaterally [1] 50/13
	trade-off [2] 88/22 96/16	turn [7] 83/9 84/2 101/13 173/22 182/8 198/14 198/16	unbelievably [1] 115/6	unique [2] 83/5 83/14
	tradeoff [2] 16/20 17/3	turnaround [2] 75/1 75/19	unclear [2] 36/8 215/6	Unit [1] 208/18
	tradeoffs [2] 61/2 61/16	Turning [1] 190/7	under [19] 4/3 4/4 67/17 80/21 94/12 112/2 117/5 122/13 126/16 131/1 131/2	units [4] 135/24
	traditional [2] 21/5 212/10	tweeted [1] 74/24		
	tragically [1] 112/1			
	trained [1] 202/15			
	training [11] 126/10 126/22 127/1 156/12 157/9 157/14 157/19 158/14 187/3 193/13 205/7			
	Tranka [2] 177/4 177/13			
	transfer [1] 58/18			

<p>U</p> <p>units... [3] 207/5 208/15 212/10</p> <p>universal [1] 145/16</p> <p>universities [1] 83/20</p> <p>University [5] 135/1 182/1 182/12 189/12 193/4</p> <p>unless [1] 101/24</p> <p>unlike [1] 2/9</p> <p>unlikely [1] 39/15</p> <p>unmet [1] 95/11</p> <p>unprecedented [2] 76/10 144/4</p> <p>unsafe [3] 143/19 184/4 186/6</p> <p>unsurprising [2] 16/1 31/12</p> <p>until [9] 5/18 6/17 51/17 109/9 168/4 168/8 181/20 197/3 216/8</p> <p>until February 2020 [1] 197/3</p> <p>until March 2024 [1] 51/17</p> <p>unusual [3] 111/5 111/18 210/6</p> <p>unusualness [1] 111/7</p> <p>unventilated [1] 147/18</p> <p>up [81] 4/22 9/6 11/2 11/12 11/13 12/12 13/3 19/11 20/1 20/2 20/5 21/20 28/25 30/22 31/14 33/17 37/9 37/10 38/10 38/15 39/20 39/24 42/14 42/20 42/21 42/25 43/7 44/14 56/11 57/11 60/15 61/3 61/13 63/13 64/22 70/2 76/8 78/18 85/3 85/8 85/14 86/3 86/12 86/13 90/8 101/23 102/20 102/23 121/21 121/21 126/3 137/1 138/1 140/10 142/15 148/25 151/12 151/15 151/16 152/23 153/25 154/17 162/2 166/25 168/8 170/7 171/12 171/13 175/4 176/3 178/1 181/23 185/7 197/23 198/16 201/5 206/1 206/20 210/14 214/10 216/4</p> <p>updates [2] 69/15 127/11</p> <p>upfront [1] 18/8</p> <p>upon [8] 38/4 51/10 88/25 92/22 115/18</p>	<p>134/1 180/6 189/15</p> <p>ups [1] 69/11</p> <p>upskilling [1] 205/7</p> <p>uptake [2] 148/25 164/13</p> <p>urge [1] 92/22</p> <p>urged [1] 137/19</p> <p>urgency [1] 31/19</p> <p>urgent [2] 32/7 154/21</p> <p>us [64] 1/20 2/4 5/5 9/4 12/6 12/20 18/8 20/4 20/9 22/16 26/1 29/20 35/21 37/12 41/16 42/5 45/14 48/3 55/1 55/19 57/21 59/15 70/12 72/2 72/11 74/22 79/15 79/15 80/20 82/9 84/6 96/12 98/16 99/15 115/1 115/14 120/4 120/21 129/3 135/8 135/19 136/7 136/9 137/17 144/8 149/4 150/2 151/9 162/25 167/13 167/15 167/20 171/18 179/19 183/18 196/14 199/10 199/21 200/2 200/13 209/6 209/11 210/7 215/8</p> <p>usage [1] 39/8</p> <p>use [32] 9/2 15/8 18/12 27/24 30/6 56/13 56/25 61/8 62/3 62/3 62/8 63/11 64/10 64/24 81/23 104/12 115/9 121/18 123/17 123/24 127/9 127/20 132/13 136/22 138/6 145/11 148/6 151/6 155/11 170/1 207/20 210/9</p> <p>used [21] 23/14 24/19 33/10 52/18 58/21 64/11 83/12 85/23 97/9 110/12 118/16 134/2 138/17 138/21 138/21 154/11 185/12 185/13 185/18 187/11 215/17</p> <p>useful [4] 31/3 53/18 98/25 207/17</p> <p>user [1] 40/15</p> <p>uses [2] 22/24 116/12</p> <p>using [13] 12/12 20/1 20/2 40/15 97/12 111/1 153/12 165/12 175/23 185/4 185/5 209/4 212/14</p> <p>usual [3] 13/12 80/11 118/20</p> <p>UV [1] 165/12</p>	<p>V</p> <p>vaccinated [1] 170/8</p> <p>vaccination [9] 163/5 163/7 163/17 164/12 164/16 169/24 170/6 170/12 171/17</p> <p>vaccine [6] 11/7 82/5 83/12 84/3 170/10 170/12</p> <p>vaccines [3] 82/6 82/7 84/6</p> <p>valid [1] 72/13</p> <p>validated [1] 153/12</p> <p>Vallance [2] 10/22 93/11</p> <p>value [2] 12/15 16/22</p> <p>vaporiser [1] 167/13</p> <p>variably [1] 150/8</p> <p>varied [1] 45/4</p> <p>variety [2] 32/25 50/17</p> <p>various [14] 7/12 14/12 14/18 20/5 25/23 57/24 58/2 62/20 63/1 76/12 79/20 89/8 128/22 196/17</p> <p>vast [2] 142/1 142/2</p> <p>VCOD [1] 169/23</p> <p>Velindre [2] 193/4 193/5</p> <p>ventilate [1] 153/24</p> <p>ventilated [6] 139/5 211/23 211/24 212/18 213/10 214/22</p> <p>ventilating [1] 138/22</p> <p>ventilation [13] 135/23 138/7 205/15 206/24 206/25 207/1 212/2 212/5 212/22 213/12 213/13 213/14 215/1</p> <p>ventilators [9] 165/21 165/23 166/3 166/11 166/13 166/14 166/15 167/2 207/14</p> <p>versa [1] 79/4</p> <p>versus [1] 162/6</p> <p>very [200] 4/7 7/4 7/6 7/13 8/20 9/2 9/16 9/19 9/19 10/19 11/2 12/6 12/24 14/5 14/20 15/1 15/1 15/11 16/18 17/20 20/16 20/16 20/17 20/18 21/13 22/21 24/8 25/25 29/22 29/22 31/25 34/8 34/17 39/15 41/6 41/6 43/3 46/19 46/19 47/9 49/19 51/23 51/23 51/25 53/12 54/4 54/17 58/8 58/12 58/12 59/5 59/7 59/18</p>	<p>59/22 60/7 60/7 60/9 62/7 62/9 62/18 66/21 68/7 68/14 68/14 68/21 68/21 71/17 73/18 75/11 76/3 76/3 79/19 81/14 81/25 83/1 83/24 84/16 84/21 86/8 87/12 88/9 88/13 88/22 89/11 89/11 90/24 91/8 91/8 92/15 92/15 94/5 95/1 95/1 95/2 95/25 96/9 96/9 96/10 96/13 96/21 96/25 98/1 98/2 98/3 98/6 99/1 99/7 99/21 101/7 101/9 105/12 105/16 106/14 108/3 108/14 111/5 111/11 113/8 114/3 114/23 114/23 115/4 117/6 117/6 119/21 119/21 121/17 121/19 123/6 127/4 127/5 128/6 129/3 132/23 132/24 133/3 133/21 133/22 134/9 134/13 135/23 136/6 138/9 138/16 138/23 139/14 145/4 145/25 146/10 149/15 151/14 151/14 151/20 152/21 156/23 158/1 158/12 160/11 160/20 167/4 167/4 167/5 167/11 169/1 169/5 169/10 172/9 172/18 172/19 173/1 173/10 176/9 176/17 177/19 178/4 178/9 179/22 179/24 181/6 181/6 186/21 187/1 187/14 187/20 187/22 188/12 188/15 197/9 199/11 199/17 199/18 201/17 202/3 203/16 203/18 204/6 209/9 209/12 209/12 216/4</p> <p>via [4] 18/9 76/6 80/13 80/13</p> <p>vice [1] 79/4</p> <p>videos [1] 161/19</p> <p>VIE [1] 167/19</p> <p>view [19] 16/7 19/5 23/21 31/6 52/1 55/5 66/13 70/16 74/11 79/1 80/17 155/7 171/2 181/11 186/5 205/13 206/25 207/2 211/13</p> <p>viewed [1] 75/23</p> <p>viewing [1] 36/21</p> <p>views [2] 96/1 103/20</p> <p>viral [1] 174/20</p> <p>virtually [1] 187/11</p> <p>virus [6] 77/20 92/8</p>	<p>187/19 205/16 209/12 213/1</p> <p>visible [1] 150/15</p> <p>visibly [1] 209/9</p> <p>visited [1] 142/9</p> <p>visiting [6] 157/18 168/1 168/4 168/25 169/16 187/16</p> <p>visitor [1] 168/17</p> <p>visitors [1] 169/8</p> <p>visits [2] 76/6 77/3</p> <p>visor [1] 182/17</p> <p>visors [6] 145/11 145/18 145/19 146/19 182/10 183/7</p> <p>vital [6] 60/10 82/12 83/22 93/4 93/6 93/6</p> <p>vitality [1] 84/2</p> <p>voice [2] 5/10 206/19</p> <p>volume [1] 55/23</p> <p>voluntary [1] 101/4</p> <p>vulnerability [1] 78/20</p> <p>vulnerable [12] 56/23 57/17 122/22 123/2 123/15 163/25 164/1 169/4 172/25 173/2 177/25 208/13</p> <hr/> <p>W</p> <p>wait [5] 44/3 46/11 46/11 46/11 51/18</p> <p>waiting [8] 32/12 134/20 147/19 150/22 151/17 151/18 151/20 188/12</p> <p>Wales [60] 135/11 139/22 140/16 152/14 155/22 161/14 165/9 165/23 174/19 179/13 189/18 192/1 192/6 192/10 192/11 192/13 192/18 193/4 193/9 193/16 193/24 194/2 194/9 194/11 194/13 194/16 195/4 195/6 195/8 195/13 195/24 197/9 197/11 197/16 197/21 198/10 198/12 198/18 199/13 200/10 200/25 201/2 201/11 201/25 202/21 203/1 203/4 203/11 204/19 206/6 206/7 208/5 208/14 208/16 209/3 209/7 211/5 211/13 213/2 213/3</p> <p>walked [1] 107/16</p> <p>walls [1] 136/19</p> <p>want [40] 10/17 11/16 12/23 13/3 15/2 15/3 20/20 22/2 22/13 29/21 31/24 32/1 34/11 37/15 38/12</p>
---	--	--	--	---

W	192/4 192/8 197/10 199/16 199/25 200/17 201/5 201/15 206/10 207/5 207/9 207/23 209/6 ways [8] 8/16 13/2 16/18 80/5 82/23 82/23 90/11 123/7 we [733] we'd [15] 24/18 77/12 130/24 140/9 143/6 151/12 162/3 163/16 163/19 164/5 164/11 167/2 167/6 179/6 214/11 we'll [3] 16/25 191/16 192/16 we're [10] 4/6 7/15 12/19 31/14 39/15 83/5 83/14 115/15 177/6 215/25 we've [39] 6/11 7/12 13/24 22/3 28/15 29/7 29/15 38/2 46/20 50/19 55/19 77/9 81/6 82/5 86/4 88/22 90/10 90/15 92/7 103/23 120/24 132/18 149/17 149/18 151/19 157/5 172/19 174/17 174/19 174/19 175/9 178/12 179/3 184/3 192/9 198/1 213/13 213/23 214/7 weak [2] 9/8 10/5 weaker [1] 10/2 weakness [1] 10/14 weaknesses [1] 10/12 weapon [2] 123/6 123/14 Wearable [1] 60/15 wearing [1] 40/17 Wednesday [2] 216/6 216/9 week [5] 85/4 146/22 168/24 182/16 211/3 weekend [1] 161/18 weeks [2] 104/17 208/25 weeks' [2] 147/5 183/18 weight [1] 11/13 Welcome [1] 1/6 well [139] 2/23 4/11 7/1 8/6 8/10 8/16 8/18 8/18 10/16 11/25 13/10 13/12 14/14 16/6 16/16 16/16 17/12 18/18 19/15 23/6 24/14 25/7 27/4 27/14 28/3 28/5 28/5 29/3 30/5 33/14 34/17 34/17 36/24 38/10	42/23 43/13 44/8 45/13 45/15 46/16 49/23 49/23 51/5 51/19 53/3 53/3 53/4 58/13 60/21 62/9 63/13 63/25 64/4 64/6 66/25 67/21 69/7 70/8 77/2 77/8 77/13 78/1 78/4 78/9 79/25 80/7 85/14 88/12 90/19 91/14 91/21 92/11 93/20 96/14 96/20 97/17 99/16 100/18 105/25 107/14 108/8 108/8 110/4 111/5 111/8 113/23 113/24 118/7 119/1 120/11 121/16 121/22 124/24 125/12 126/19 127/25 129/1 131/4 132/12 132/21 134/3 134/11 137/17 138/3 145/1 145/2 145/12 146/15 147/9 148/8 148/10 150/19 152/6 157/19 157/23 158/1 158/18 165/6 171/13 172/20 172/23 174/21 177/9 178/4 182/14 183/9 184/1 195/15 199/20 201/12 204/6 206/2 206/7 206/22 210/14 212/24 213/7 214/15 215/11 well-being [4] 145/1 145/2 172/20 172/23 well-known [1] 30/5 Welsh [27] 155/23 162/13 162/22 163/1 165/5 171/6 188/25 189/1 189/8 189/16 190/24 191/7 191/17 192/5 193/3 194/13 194/20 194/20 196/10 197/4 201/20 202/12 203/22 205/23 209/24 211/17 214/24 Welsh Government [14] 162/22 163/1 165/5 188/25 189/1 189/8 189/16 191/7 194/13 196/10 201/20 205/23 209/24 211/17 Welsh Government's [1] 171/6 Welsh Government-facing [1] 192/5 went [12] 14/23 17/21 28/5 37/25 57/24 58/13 76/24 107/4 131/18 133/13 151/15 167/18 were [429]	were -- well [1] 49/23 weren't [9] 45/24 79/10 110/10 144/23 147/6 148/9 157/17 183/15 210/8 what [226] what's [6] 8/14 20/1 22/5 85/15 89/18 128/25 whatever [7] 7/20 25/20 37/5 83/12 85/17 86/20 90/20 wheel [1] 70/19 when [81] 2/7 2/12 6/3 6/4 6/7 6/11 6/12 6/13 6/17 7/2 7/9 15/25 17/4 20/14 23/7 23/15 23/20 25/20 28/7 29/10 31/13 36/11 37/18 38/19 42/20 42/21 52/5 52/12 57/6 57/10 60/2 62/4 62/5 63/1 74/13 80/20 85/1 87/11 88/3 88/17 90/25 102/11 102/12 103/11 110/4 111/9 114/4 120/1 124/24 125/6 125/19 126/14 126/16 127/5 127/16 136/4 136/8 136/14 139/21 140/14 142/8 144/21 145/22 149/12 151/25 157/17 158/8 163/23 165/2 166/12 168/15 169/12 170/13 170/15 174/10 196/9 199/23 201/10 207/6 207/8 210/1 where [72] 8/18 8/20 8/24 9/1 9/8 10/1 10/11 10/24 11/13 12/9 14/15 14/25 16/9 18/1 20/24 22/11 28/11 31/20 31/22 32/22 33/23 34/23 36/15 37/24 38/4 39/14 40/8 43/8 55/7 60/5 61/14 67/16 70/21 70/21 71/19 72/19 74/9 74/19 75/8 78/20 81/20 84/11 96/1 100/2 100/13 102/3 104/20 118/21 121/13 124/7 124/10 124/13 125/21 131/23 133/19 138/10 138/18 144/10 145/18 151/10 156/1 159/9 161/4 163/10 170/20 176/22 182/20 194/20 195/22 197/4 214/14 215/18 whereas [1] 153/14 wherever [1] 75/7 whether [34] 7/15	8/10 22/8 25/4 28/1 31/23 34/5 57/2 63/21 63/22 66/9 66/22 67/2 67/6 80/21 95/23 99/5 111/25 129/18 132/19 143/18 143/21 160/15 160/16 178/13 178/15 183/5 185/7 185/17 191/12 195/24 203/8 206/5 214/23 which [136] 3/5 3/6 3/9 3/24 6/6 8/3 8/21 9/5 9/9 9/10 9/20 10/5 12/2 14/14 15/24 16/10 17/15 17/16 21/7 22/24 24/15 29/4 29/16 29/24 32/23 34/21 35/9 43/9 43/15 47/9 48/5 49/21 55/6 56/24 57/23 58/18 58/23 59/2 59/17 59/18 62/13 62/21 67/23 70/10 70/20 73/11 79/2 80/5 80/15 81/3 83/18 83/22 86/13 86/17 87/25 88/8 88/11 90/11 92/1 92/14 92/22 95/25 96/12 98/11 99/1 99/13 101/18 101/21 102/1 104/18 111/8 112/25 114/7 114/10 114/16 114/25 116/13 119/8 120/2 120/25 121/6 121/8 123/5 123/9 125/9 131/14 135/3 144/6 146/2 146/19 151/18 154/20 155/20 155/21 158/1 158/14 162/17 162/20 166/17 166/18 167/22 167/22 170/22 171/14 173/11 175/12 177/11 177/15 178/9 178/14 180/6 182/15 184/21 187/11 188/25 189/6 189/8 190/11 193/25 194/4 194/8 198/14 198/15 199/17 199/25 200/17 201/15 206/1 206/20 207/15 207/24 208/5 210/6 210/23 215/3 215/6 while [8] 30/10 30/12 45/22 95/10 105/12 126/13 128/13 197/10 whilst [13] 21/19 74/25 136/9 139/24 148/8 159/12 161/17 164/8 179/7 186/1 192/6 195/16 210/6 white [1] 53/12 Whitehead [4] 43/14 114/6 121/8 121/16
----------	--	--	---	--

W	180/8 180/10	188/5 188/7 188/18	78/14 78/21 86/11	wrongly [1] 185/9
Whitty [5] 10/21	wide [2] 76/12 134/6	188/20 189/20 190/14	110/16 126/7 126/14	wrote [3] 201/25
11/14 80/1 93/10	widely [4] 66/13	196/4 196/6 201/23	132/20 143/1 144/16	209/15 209/19
103/18	132/10 178/11 178/11	208/9 211/18	147/10 147/12 152/6	Y
who [102] 1/17 1/20	wider [3] 55/8 180/13	witnessed [1] 48/1	155/22 185/9 185/25	yeah [29] 14/1 14/3
3/17 9/4 21/3 27/23	206/18	witnesses [6] 25/24	214/4 214/13	18/18 23/24 29/10
28/8 32/3 36/10 37/2	widespread [2] 125/5	30/9 59/25 82/14	workload [1] 74/6	37/20 41/2 42/11
37/17 40/19 41/18	127/22	90/10 132/22	workplace [2] 143/20	42/19 48/17 57/8
50/9 55/19 56/11	will [68] 2/13 3/4 3/9	women [1] 40/17	184/4	64/25 65/13 65/16
56/14 59/6 68/18	9/9 16/11 16/19 19/24	won't [7] 1/11 46/5	works [1] 201/15	65/24 66/8 69/1 70/3
68/18 69/19 70/16	24/5 32/21 34/23	88/1 98/1 118/21	world [23] 8/23 11/4	71/6 73/24 79/8 85/6
71/4 71/5 71/17 71/17	39/19 42/9 44/6 44/13	128/1 161/3	14/12 14/20 18/7 21/2	97/10 127/12 148/9
72/19 72/21 74/19	46/9 50/22 53/11	wondered [1] 105/5	21/13 23/4 43/17	148/18 159/6 187/16
74/22 75/10 78/11	53/20 54/21 55/3	wonderful [2] 100/14	50/10 50/11 50/21	214/11
78/12 78/14 78/16	55/24 58/24 60/2	132/17	60/5 60/14 82/22	year [10] 18/16 59/12
78/18 79/22 80/12	60/12 60/13 60/14	wonders [1] 132/6	83/21 84/8 97/23	83/14 88/14 88/20
80/16 83/1 91/12 92/8	60/18 60/23 61/11	word [8] 17/21 25/7	114/9 114/25 115/1	94/14 95/24 149/8
94/24 100/5 105/16	77/11 80/20 81/21	25/8 27/6 110/22	115/10 116/3	177/2 191/14
108/4 108/9 109/15	82/9 84/10 93/13	120/10 121/18 132/13	Wormald [4] 1/5 1/8	years [4] 12/17 85/18
110/6 110/7 110/10	94/21 96/3 98/21	words [7] 30/1 50/2	66/6 217/3	85/18 149/4
110/15 110/16 110/19	98/22 101/1 101/13	79/16 82/17 121/20	worried [13] 24/9	years' [2] 153/17
111/9 111/13 111/14	103/20 106/20 107/1	121/22 121/24	67/4 67/7 144/10	153/17
111/21 112/16 113/3	107/5 109/7 112/25	work [53] 7/4 7/19	144/12 145/17 163/9	yes [157] 2/6 3/3 3/21
116/24 122/3 123/8	115/22 120/3 123/7	10/23 17/19 17/20	163/16 163/19 166/19	4/7 5/4 8/2 8/4 8/11
125/1 125/25 130/24	125/14 129/23 129/24	31/18 34/4 45/10 50/4	169/3 169/7 171/1	9/24 10/8 13/1 13/4
132/9 133/18 138/20	133/6 134/10 151/2	51/12 52/23 53/2	worry [10] 20/12	13/6 13/12 14/3 14/9
138/21 139/17 141/18	162/11 164/13 170/1	53/25 54/22 58/7 58/8	41/19 93/20 109/10	16/6 16/19 18/20
142/23 142/25 145/24	172/21 184/19 188/8	59/2 71/5 71/16 72/7	143/3 146/9 148/15	19/21 22/1 22/12
147/5 149/3 150/20	202/11 211/4 211/8	74/3 76/10 80/7 81/15	161/8 170/23 170/25	22/15 24/25 25/3 27/5
150/22 152/13 153/8	211/9 211/12 216/3	86/20 88/5 88/6 90/16	worrying [4] 136/7	27/8 27/25 28/21
157/8 167/12 169/20	willpower [2] 70/14	91/5 123/10 132/9	136/10 185/3 185/17	28/24 30/25 31/17
170/5 172/3 175/11	70/22	132/17 139/15 140/5	worst [11] 22/9 23/23	33/1 33/3 35/13 35/22
176/10 178/13 178/17	windows [2] 136/9	140/5 143/19 143/20	23/25 24/1 24/4 39/6	36/24 37/22 38/11
179/1 184/20 187/11	136/11	143/22 144/1 147/13	39/7 39/9 39/11 39/17	40/18 40/21 41/25
188/8 198/18 202/2	winning [3] 60/22	149/9 160/21 171/5	106/23	42/11 48/12 50/7 51/2
202/7 203/5 206/17	61/7 61/12	172/22 174/4 175/12	worst-case [11] 22/9	54/3 54/17 55/13
212/4 212/9 213/24	winter [5] 18/16 19/1	175/19 187/6 187/10	23/23 23/25 24/1 24/4	57/20 58/1 58/8 61/20
whole [31] 6/8 6/15	40/4 136/8 210/11	189/16 189/23 201/2	39/6 39/7 39/9 39/11	61/25 63/8 64/1 64/2
6/23 7/6 8/25 9/5	winter months [1]	201/9	39/17 106/23	64/17 65/6 66/5 73/10
10/25 17/1 17/14 18/5	210/11	worked [14] 12/15	worth [3] 32/1 32/3	73/17 75/18 75/21
24/18 32/22 34/8 35/4	wire [3] 20/18 21/18	20/23 39/10 45/20	109/5	77/5 81/1 82/17 85/9
42/25 46/21 66/10	22/21	55/10 78/9 78/25	would [226]	85/14 89/3 91/18
66/10 66/25 79/19	wish [6] 51/21 78/20	111/21 148/9 152/5	would've [2] 38/5	94/19 95/21 99/24
98/22 100/22 103/17	109/3 143/13 145/6	152/13 164/2 167/9	112/2	100/7 101/13 103/17
103/23 105/22 106/16	172/11	199/15	wouldn't [16] 7/19	103/25 104/6 107/24
116/3 119/21 140/23	wished [5] 48/3 48/3	worker [2] 32/9 72/6	24/22 36/2 36/21 49/2	107/24 108/2 108/8
157/6 186/18	51/3 52/7 72/15	workers [31] 20/13	63/14 63/18 70/11	108/20 113/5 113/25
whole-government	withdrew [2] 134/15	29/14 29/19 44/18	75/22 95/5 115/25	114/15 115/24 116/6
[1] 6/23	188/5	72/14 72/17 90/17	132/24 144/11 179/19	116/16 117/3 117/23
whom [3] 109/24	within [25] 3/1 6/24	90/20 91/6 91/13	186/22 203/24	119/5 119/10 120/5
152/1 195/3	20/14 32/4 40/25 46/3	91/19 104/10 104/16	wraparound [2]	120/18 121/25 133/15
whose [1] 37/8	59/21 81/3 111/11	109/20 109/21 110/2	139/20 139/25	133/21 134/4 134/11
why [37] 17/8 23/18	130/22 135/4 138/2	110/10 110/13 110/18	wrapped [1] 139/20	135/10 138/3 138/16
24/7 24/8 32/14 38/19	147/8 150/13 153/20	111/21 112/5 112/19	write [2] 105/12	139/5 148/1 155/9
39/19 39/24 41/3 43/7	170/11 182/12 195/1	116/23 118/18 119/4	108/5	157/22 168/6 168/11
45/15 46/9 48/5 52/4	196/2 197/19 199/7	119/14 119/17 139/17	writing [4] 108/6	171/24 175/13 178/9
56/24 57/11 66/23	200/5 214/6 215/7	141/13 143/18 175/5	108/7 108/18 203/9	182/14 183/23 186/7
77/18 78/2 100/9	215/7	workforce [17] 87/5	30/15 30/17 105/10	187/5 188/22 189/4
120/10 120/20 121/7	without [7] 41/8	89/2 89/5 89/7 89/10	105/17 107/18 107/19	189/10 189/14 190/1
121/18 125/2 125/10	107/12 166/5 177/24	89/14 89/15 89/23	107/23 108/9 108/22	190/13 190/20 191/4
125/16 144/6 145/13	184/9 185/1 187/13	89/24 89/25 90/6	168/3	191/11 191/15 192/2
150/25 158/23 158/23	witness [19] 1/4 2/10	139/10 162/18 173/11	wrong [2] 41/21	192/8 192/12 192/24
166/17 175/12 175/12	76/7 104/17 104/17	175/21 183/2 202/15	125/22	193/7 193/14 193/18
	134/15 134/23 159/1	working [18] 70/14		

<p>Y</p> <p>yes... [23] 193/19 193/22 193/24 194/6 194/10 195/12 197/24 198/2 203/25 204/1 204/7 208/24 210/1 210/20 211/6 211/7 212/15 212/23 213/15 213/20 214/1 214/4 215/2</p> <p>yesterday [3] 3/20 46/5 118/8</p> <p>yet [6] 39/3 46/7 59/15 60/1 96/11 100/11</p> <p>you [704]</p> <p>you know [23] 1/21 16/10 33/13 36/3 43/4 56/15 59/21 71/16 72/11 76/2 78/18 91/24 108/14 126/6 148/13 150/7 170/19 172/5 174/8 176/2 179/20 185/23 186/22</p> <p>you want [2] 31/24 111/3</p> <p>you'd [3] 12/16 52/6 68/4</p> <p>you'll [12] 20/17 32/23 55/11 102/3 102/8 102/25 109/10 111/9 154/11 165/12 174/7 182/18</p> <p>you're [42] 3/19 12/24 19/19 20/1 20/2 22/8 32/11 32/12 32/19 33/9 35/5 37/19 40/7 42/23 43/1 56/5 71/14 72/8 97/15 99/11 99/25 100/12 102/5 104/8 114/4 117/13 117/15 118/25 119/1 126/16 134/2 146/20 175/4 184/24 187/3 188/13 188/24 190/4 204/15 210/15 213/20 214/16</p> <p>you've [33] 3/6 3/23 23/9 23/11 28/19 29/8 67/1 72/6 72/7 72/18 77/16 79/20 110/12 117/17 123/18 126/3 127/15 131/23 134/13 134/23 137/3 139/9 140/11 148/22 155/1 162/19 164/19 166/16 181/22 189/5 189/20 201/23 210/21</p> <p>your [134] 1/11 1/12 1/25 2/4 3/5 6/2 6/16 11/10 12/9 12/21 15/14 19/6 20/2 21/18 24/15 24/23 25/7 25/7</p>	<p>25/12 26/17 26/21 27/16 28/13 29/12 30/21 31/25 32/11 35/24 41/13 41/13 41/13 42/13 54/11 54/11 59/25 61/4 61/21 63/9 63/16 66/25 70/25 72/7 76/7 80/23 81/7 84/17 85/15 88/2 88/15 90/15 91/10 94/22 96/4 97/7 98/11 98/13 98/16 98/19 99/3 100/19 101/11 101/22 102/17 104/23 105/9 106/12 107/15 109/8 110/12 111/1 115/2 115/5 115/14 116/2 120/15 122/15 127/7 127/22 128/8 134/1 134/7 137/1 138/24 139/10 139/11 140/12 142/5 143/13 146/17 147/24 148/23 151/23 153/19 155/1 156/8 158/13 159/2 160/11 162/12 162/19 164/19 165/20 166/8 172/10 173/13 173/15 174/8 176/22 180/16 181/17 181/22 183/3 184/3 186/5 188/3 188/16 190/3 190/7 190/14 191/23 194/16 196/4 196/6 197/18 200/8 201/23 201/24 204/7 207/8 207/22 208/8 208/9 211/17 216/4</p> <p>yourself [4] 19/22 102/17 117/16 158/14</p> <p>yourselves [1] 129/20</p> <hr/> <p>Z</p> <p>zero [16] 16/1 35/11 37/9 66/14 66/16 67/14 67/24 69/23 124/6 124/8 124/10 124/11 124/14 125/21 127/13 214/8</p>			
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