

Module 3 Week 5

Witnesses

1. Tamsin Mullen (13 Pregnancy, Baby and Parent Organisations – Impact evidence)
2. Jenny Ward (Chair of the Pregnancy and Baby Charities Network)
3. Gill Walton CBE (Chief Executive of the Royal College of Midwives)
4. Professor J S Bamrah CBE (Senior NHS consultant psychiatrist, Federation of Ethnic Minority Healthcare Organisations)
5. Dr Catherine Finnis (Volunteer Deputy Leader at Clinically Vulnerable Families)
6. Dr Daniele Bryden (Dean of the Faculty of Intensive Care Medicine, Royal College of Anaesthetists)
7. M3/W1 (Member of Frontline Migrant Health Workers Group – Impact evidence)
8. Professor Charlotte Summers and Dr Ganesh Suntharalingam OBE (Experts in Intensive Care)
9. Dr Stephen Mathieu (President, Intensive Care Society)
10. Professor Jonathan Wyllie (Former President of Resuscitation Council UK)
11. Alex Marshall (President of the Independent Workers' Union of Great Britain, Frontline Migrant Healthcare Workers Group)
12. Matt Stringer (Disabilities Charities Consortium, Chief Executive Officer of the Royal National Institute of Blind People)
13. Professor Habib Naqvi MBE (Chief Executive of the NHS Race and Health Observatory)
14. Johnathan Rees (Pharmacist, National Pharmacy Association – Impact evidence)

Tamsin Mullen (13 Pregnancy, Baby and Parent Organisations – Impact evidence)

Gave birth to twin boys on 13 April 2020. My husband was not allowed to accompany me to appointments. He felt excluded and like he didn't matter. He was however allowed to come in for the delivery and was able to stay with me for around an hour before being told to leave.

The twins were taken very quickly to the neonatal unit. After I was discharged, we would have to travel 1.5-hour trip each day to see them. Only one of us was allowed in at a time, even though there were two babies, even when they were in an isolation room with no other babies.

We were not kept informed. I only found out by reading their discharge notes that one of the boys had a chronic lung disease. That had never been brought to our attention. It didn't feel like we were being treated like parents, we were just visitors. No allowance was made for the fact that they were twins or that we had another child at home.

Jenny Ward (Chair of the Pregnancy and Baby Charities Network)

There are some conditions in pregnancy that can only be picked up by being seen face to face and having specific tests. Not being able to access that would potentially impact on their health. Women held back from going to hospital because of the “stay at home”.

Usually if a woman is worried about miscarriage, they could contact a health professional to get checked. If a miscarriage was confirmed, they would be given options on what to do. Early in the pandemic women were encouraged to take a “managed wait” which is to stay at home and let nature take its course. That had a huge impact. Miscarriage was downplayed, like it is something that just happens. Access to surgery following a miscarriage was problematic too. That was particularly distressing.

Choice of birth was decreased. The teams that would normally support families to have home birth were re-deployed elsewhere. Families who felt that going into a hospital was a risk so wanted to mitigate that risk by giving birth at home, were on their own.

Improvement in care may have made a difference for 7 in 10 women who died with Covid-19 whilst pregnant or in the immediate post-pregnancy period. There was an almost four-fold difference in maternity mortality rates amongst women from black ethnic background and two-fold differences from women from Asian background compared to white women. Women from the most deprived areas have higher mortality rates.

Some women felt obliged to undergo vaginal examinations to prove they were in active labour so that their partners could enter the room. If you were in labour you would be subject to vaginal examinations anyway to check how far along you were, but here the examination wasn't for a medical reason, it was purely so they could decide whether the partner was allowed in or not. Parents should not be considered visitors in the guidance.

28 March 2020, the NHS England guidance was that health visitors should be considered for redeployment to the frontline and that the health visiting should be stopped. Only a partial service would be offered including antenatal contact and new baby visits only, with face to face only if there was a compelling need and with PPE. The institute of health visiting described this as a profound mistake.

Gill Walton CBE (Chief Executive of the Royal College of Midwives)

The College does not produce educational standards and cannot hold its members to account. We recognised that guidance was needed but we could not make it mandatory.

We went into the pandemic with a shortage of midwives and maternity team of 1500 – 2000 which was already having an impact on the quality and safety of care. We were very concerned that maternity services weren't seen as an essential service. That had a major impact on the ability to deliver safe care. The focus was really on intensive care units, respiratory areas and emergency departments but maternity needs to be an essential service, you can't stop it so delivering that safe care is absolutely a priority for any NHS service.

Partners shouldn't be visitors; they are equal partners however we recognise the risk in having additional people there. The guidance caused a lot of stress and created friction between staff and the parents.

NHS England finally produced guidance on 8th September. If that guidance had come out even three or four weeks earlier, then the upset, the harm, the anxiety may have been reduced. The College did endorse that guidance but felt anxious about the local risk assessments because some services would be able to easily and safely accommodate women and their partner whereas others would really struggle to do that. We fed back those concerns, but midwifery leaders don't have a voice at the board.

Further guidance was issued in December, but the College did not endorse it. The gap between September and December was too long, infection rates were higher, there was a new variant etc. Instead, the College issued its own ten commonsense principles which were focused on localised decision-making and risk assessments.

The college made a plea at the end of March 2020 to ring fence maternity services by stopping the redeployment of maternity staff as it was having a serious impact on them being able to deliver safe maternity care. Nobody else can perform the role of the midwife – that is actually illegal. You can't take midwives out of maternity services to do other things because nobody else can replace them.

The guidance on PPE was not sufficient. Maternity services often get forgotten. It is not seen as an essential service and our members told us that access to PPE was really difficult and the guidance did not protect them. The response was about availability, and what was available had to be prioritised for people who were in high-risk areas and with known Covid patients. That was not acceptable to us, so we raised it. Midwives were working in a high-risk area and with patients with Covid.

In February 2021 the College signed a joint letter to Boris Johnson copied to Matt Hancock requesting a change in approach in the IPC guidance and advice on the use of PPE to reflect the airborne risks in health care settings. It went to Boris Johnson because we were frustrated with the lack of action and that attention on proper PPE guidance and access to the equipment.

Professor J S Bamrah CBE (Senior NHS consultant psychiatrist, Federation of Ethnic Minority Healthcare Organisations)

FEMHO is a consortium comprising of 55,000 members from over 40 organisations. The organisation was formed during the pandemic. Members are largely doctors, nurses, pharmacists but also people from admin background, managerial background and from social work background. It also includes cleaners, porters, catering and support staff.

All the statistics, including those from NHS England, have shown that unless employees of the NHS have senior managers who are black and brown the policies are not formed around them. They're not culturally sensitive. Communications have happened traditionally top-down rather than policies worked out with the communities. Members feel like they are here to provide a service but not to be part of the society.

It sent shock waves when the first ten doctors to die were all ethnic. It didn't seem as if our voice was being heard although many of us were trying to shout from rooftops to say there's something going on here that shouldn't be happening. So, the mistrust festered even more.

NHS is the largest employer of BAME staff, 26% of its employees are BAME. It's about 340,000 people. 119 NHS staff known to have died in the pandemic, 64% were from an ethnic minority background whereas only 20% of NHS staff are from an ethnic minority background. This disproportionate toll is shocking.

In April, the Chief Medical Officer commissioned Public Health England to conduct a review. It was published in June. People of Bangladeshi ethnicity had twice the risk of death when compared to people of white British ethnicity. People of Chinese, Indian, Pakistani, other Asian, Caribbean and other black ethnicity had between 10 and 50% higher risk of death when compared to white.

We are putting our own lives and our family's lives at risk with our work so while these statistics were there, we didn't feel that enough was being done to give us the tools by which we could look after patients safely.

We know of a lot of instances where medical directors would threaten the doctors and nurses saying if they saw them with a mask in the corridor or if they asked for a mask they would be disciplined. We also know that black and ethnic minority doctors and nurses are more likely to be disciplined, to be sacked or erased from the register. So that fear was there, and we have to keep quiet. We wrote to every Trust in late April and the DHSC saying we were concerned.

One of our members wrote to the Department of Health. Bearded Sikhs, Muslims and Jewish men did not pass the fit test for FFP3 masks so one of our members developed the Tata technique which he said passed the regulations. But he was categorically told by HSE that the requirement is to be clean shaven. If you understand the religion that was completely unacceptable. Some men did shave for the first time but there was no attempt to produce masks that fit bearded men.

There was a general feeling that bosses were not understanding that there are issues of culture, race and ethnicity that they need to be aware of. There have been multiple reports to say these are very important issues to your 1.3 million employees. There has been an abject failure to understand the sensitivities around that.

There was a complete inconsistency in guidance on PPE. That caused some senior managers to interpret the rules according to their whim. There was a tense palpable anxiety among BAME people that we are going to work to save our patients, but we don't know whether our employers have our own health and safety in their mind.

On 27 March a letter was sent to Mr Hancock from BAPIO (British Association of Physicians of Indian Origin) regarding distribution of PPE and a lack of testing for frontline staff. Similar letters were sent to Sir Simon Stevens, the Chief Medical Officer and Stephen Powis. They were not really listening, so we decided to take the Health Secretary to court for poor provision or no provision of PPE. Eventually they did, so the legal action served a purpose. It would not have happened had it not been for the court case.

Abolish the phrase “hard to reach.” The hardness is with us. It sends the wrong signal because it implies that the problem is with the “hard to reach’ and not with the people drafting the message.

It's not acceptable that in management only 15% are ethnic and in very senior management only 11% are ethnic. Nearly 50% of doctors are black and ethnic and over 20% of all NHS workers are black and ethnic. So that statistic is crying out for change. Get us into the room early. This us and them mentality is why things were so disjointed. It's about defining policies around people, not people around policies.

Use of Bank/Agency/Locum staff is growing number in NHS. These people do not have the kind of protection that people have in employment and that is a big worry. I feel that they are being disadvantaged and that is why they have ended up in jobs where they are on the front line and at risk, but they can't say no, because if they said no, they would not get another job somewhere else. They are really very vulnerable. Quite often they were left on their own wearing bin bags as aprons and flimsy masks. How many of these low paid workers did we expose to the virus unnecessarily? There has to be a system of support for them. We're losing them because they either just go off the NHS or they become ill and can't work.

Dr Catherine Finnis (Volunteer Deputy Leader at Clinically Vulnerable Families)

Trained as medical Doctor and practiced for 5 years when I had to leave face to face clinical work due to being severely immuno-suppressed.

CVF was formed in August 2020 at a time when shielding had been paused and children were required to be back in school in September 2020. For people who were living within clinical vulnerable families they were concerned about the risk of their children returning to school and contracting Covid. This is despite the assurances at the time that schools were safe and that children didn't transmit Covid.

The shielding list was publicly available and people who knew they should be on the list, but didn't have a shielding letter weren't able to work from home so their life was potentially at risk. Being put on the shielding list could take weeks.

Within our group we have a number of teachers, and it was really difficult for them. They were in school every day with lots of children. They knew they had one of these conditions on the list and they were not told to shield. They were not given any information what to do other than to wash their hands.

We received a number of text messages. There was one text that said you can open your window but do not go outside of your home. Another text told us to put a medical bag ready to be taken to hospital by the front door. These were very frightening messages to a group of people who hadn't really been given any information on how to reduce their risk, we were simply told to 'Stay at Home'. Many people didn't see themselves as vulnerable. A lot of us were disempowered hugely by being told to ask family, friends or neighbours to pick up our prescriptions from a pharmacy.

Not telling people the route of transmission, just telling people to 'Stay at Home', it made us a prisoner in our own home without any real understanding why we do not go outside our house. Any information

would have helped empower us to know what other things we could do to reduce our risk, things like ventilation, being outside etc.

At the peak of the first wave on 2 April 2020 the rate of deaths amongst this clinically vulnerable population was over 2.5 times that in the general population. By the end of August, the clinically extremely vulnerable population accounted for 19% of all deaths while only making up 4% of the total population.

When it comes to shielding, I think the whole household should have the protection to work from home or to get SSP as the pressure on those families during that time was immense.

Things were safer for clinically vulnerable in 2020 because everyone was wearing masks, there were more virtual appointments, and the hospitals were much quieter. Now it is impossible for us to access healthcare whilst following Government guidance for clinically vulnerable which includes not going to busy crowded areas, asking people around us to wear masks and to do tests and not to be around people with Covid-19. For us, almost all healthcare is high-risk. We have asked healthcare workers to wear masks, and they refuse. This happens on a daily basis. Many CVF members now feel they have no choice but to access healthcare through private hospitals because they consider the NHS unsafe due to the risk of hospital-acquired infection.

There is a deep concern amongst CVF regarding discriminatory and inappropriate use of DNACPR orders. CVF have experience of DNACPRs being over interpreted as a limit on treatment and are very concerned about that being left on their medical records.

Dr Daniele Bryden (Dean of the Faculty of Intensive Care Medicine, Royal College of Anaesthetists)

Early in the pandemic we had concerns about the timeliness of advice on PPE, the consistency of that advice and the availability of appropriate PPE.

There was an understanding from the get-go that intensive care units were areas that had aerosol generating procedures and people needed full levels of PPE. But there was less clear understanding about other areas of the hospital and what PPE was required. A study from early in the pandemic demonstrated that 119 healthcare workers died but there were no intensivist and anaesthetist deaths. The reasons may include higher performing PPE and the stage at which patients in intensive care are treated in terms of the development of the virus.

In early 2020 some clinicians were concerned that services would be overwhelmed and that there was a desire for additional triage guidance. The Faculty of Intensive Care Medicine was involved in drafting a guideline which they co-authored with NICE. The aim was to have a document that would support clinicians in making usual clinical decisions in extraordinary circumstances. This guidance was not ethical or legal guidance on how to triage patients in the event of saturation of critical care capacity. It was to help ward staff to help patients with deciding whether they would want to go to critical care if they deteriorated. It was to give patients an understanding of what was involved and an ability to express their views whilst they were still able to do so.

NICE Guidelines state: *“On admission to hospital assess all adults for frailty, irrespective of age and Covid-19 status. Consider comorbidities and underlying health conditions. Use the Clinical Frailty Score for frailty assessment”*

The clinical frailty scale is not appropriate to use on people who have long-term stable disabilities or are under 65. I agree the guideline did not make that clear. I don't know why that omission was allowed into the published version. We provided advice to NICE in the drafting of it, but the final decision was theirs. The guidance was amended but I agree those caveats should have been present in the first version.

When we have less resources available our ability to take patients who need monitoring is impacted but it does not impact on the decision about whether an individual should come to intensive care. We made that very clear to our members throughout.

We did not endorse any prioritisation tool. We were clear to our members that we wanted them to continue using their normal decision-making processes. Individual hospital developing their own critical care prioritisation tool probably happened because there was an absence of nationally agreed guidance so people with the best intentions were trying to develop a tool in case it was needed.

We made it very clear, right from the beginning that capacity was not just about physical space, a bed and a piece of equipment, it was around the human resource and the ability to care for and treat an individual. We had identified the fact that we didn't have sufficient critical care staff who had been adequately trained at start of the pandemic. There may be a physical bed space but if there's not the staff to look after the bed then it's not an operational bed, it doesn't exist in terms of a bed that you can safely admit a patient in to.

We did not advise that the Nightingales hospital project was unviable. We said we could not staff the Nightingale hospitals and continue to run existing critical care units because the staff were needed at the existing critical care units. The only way that we could consider it would be moving staff to the nightingale hospitals wholesale.

M3/W1 (Member of Frontline Migrant Health Workers Group – Impact evidence)

I worked as a cleaner in a private hospital. Before the pandemic I worked 3 hours per day. Once the pandemic hit, I was working 10-12 hours. That was usually 5 days per week but sometimes at the weekend as well. I didn't want to work additional hours but felt pressured by the circumstances and I feared losing my job if I said no.

I was not given any information on IPC. I didn't complain because I couldn't be without a job. We only had the blue facemasks; they wouldn't give us any PPE. I did not feel safe, but I had to go ahead.

Professor Charlotte Summers and Dr Ganesh Suntharalingam OBE (Experts in Intensive Care)

Advance care planning it is a way of ensuring the patient's informed wishes are taken into account when making what are inevitably time critical decisions by the nature of these conditions, they can happen quickly, sometimes unexpectedly.

DNACPR

Where a clinician says we shouldn't do CPR because it won't work, the patient or their loved one does not have to consent to that decision. They should be aware of it and be able to question it, but they don't need to consent to it. It is about what treatment may be clinically appropriate. The law requires that a patient or their loved one is consulted but they cannot demand CPR if it would be clinically inappropriate.

We were asked to draw up a clinical prioritisation tool for if critical care was saturated. The lead on this was Prof Whitty. This was where no bed was available after mutual aid and decompression had already happened and we were at CRITCON 4. CRITCON 4 is a national situation not just in that hospital. We have talked about scenarios where CRITCON might be triggered as an alerting tool but where CRITCON 4 is agreed by those in authority to be a national state.

It is not about ruling people in or out of ICU, it is saying for the next available bed, who should take precedence over anybody else on the grounds of who is most likely to survive.

The UK picture was that 141 extra intensive care units were required in January 2021 above the capacity that was available in January 2020. We did not create that physical capacity of 141 extra ICUs with any more staff. We did it with exactly the same number of staff as we had in January 2020. We stretched what we had to make that extra capacity.

There were fewer older people being admitted to ICU during the pandemic. As a result of changes in behaviour and in people's trying to do the best that they could, people were probably dying at home rather than being admitted to hospital. I'm aware of absolutely no circumstances in which a policy was issued about age as a cut-off in the UK.

The catastrophic failure of the healthcare system would not be a switch that was just thrown in an instant where we went from everything being okay to everything not being okay the next second. It is in the dilution of a million and one tiny little things. When we stretch those things, we are unable to pay attention to the details in the way we would want to. We are failing our patients.

In general, there were adequate numerical quantities of PPE in ICUs as these were often prioritised over other parts of the health and social care system. I use the word numerical because there were factors that were the opposite of reassuring such as different models of PPE arriving that hadn't been fit tested. So, it felt under pressure. It felt dangerous. It felt like shortages.

AGPs: The focus on procedures, rather than risk, is a problem. It means that when there is no procedure being carried out, the risk is diminished in the guidance, but you are in front of an infected patient, so the risk is still there.

Whilst there was no policy that decision making on ICU admission should change, I cannot say that didn't happen informally at a local level with alterations in decision-making by individual clinicians.

At times of strain people who were thought to be less likely to survive, so people who were older and had a greater burden of healthcare, co-morbidity, were less likely to be admitted into an intensive care unit and that their mortality was thereby increased.

I cannot say either way whether the informal "rationing of care", due to a lack of ICU capacity likely caused or contributed to deaths during this period.

Dr Stephen Mathieu (President, Intensive Care Society)

3rd January 2021 The Society issued a document advising all hospitals to use the baseline data of ICU beds as a reporting figure. There was a variation in the way that data was being recorded and that was leading to confusion. At the start of the pandemic everyone was asked to see where there were opportunities to expand their intensive care bed spaces. We did that but they were not staffed Intensive care beds with access to the same level of equipment, so it looked like there was more available ICU bed capacity than there was.

I can understand the rationale for looking into Nightingale Hospitals, but the reality is that intensive care is reliant on a multi-professional team that needs to be in the same place. With the best intentions the Nightingale Hospitals were not going to be able to do that reliably for intensive care. We can't just generate Intensive care staff. They take years and years of training, and those staff were not available. Stretching the staffing models is reliant on the existing staff working harder, working more shifts. So, moving to a Nightingale Hospital not only meant it was the same staff doing that work, but also made you less resilient within your own organisations.

On 22 June 2021 the Society issued a statement re Pulse oximeters and race as the readings on darker skin were not reliable. The issue has been known about for 30 odd years, but it was important to spread awareness because of our reliance on Pulse Oximetry and to put some pressure on industry to make equipment that is calibrated for all our populations. This is a really important, basic level piece of equipment that we use all the time and therefore it is essential that it can be used for all the patients that we look after.

Professor Jonathan Wyllie (Resuscitation Council UK)

Members are experts in resuscitation. PHE did not conclude CPR was an AGP (Aerosol Generating Procedure) and therefore full PPE was not required. RCUK took a different view. We looked at the same evidence as PHE, but I think that the Public Health England regarded a lack of evidence as effectively showing that there was no potential aerosol production. We took a lack of evidence as being not enough evidence. Also, from a practical point of view all of us have done CPR so we know what happens. We couldn't prove it because we hadn't published studies, but we know that that happens.

From studies around the world into deaths in healthcare workers, it showed that those working in the highest risk environment, intensive care, seemed to be under-represented which definitely suggests that

PPE was protective. We felt we had to take a precautionary approach because we had to balance the benefit to the patient with the risk to the health of healthcare workers.

RCUK did receive reports of blanket DNRs. One of our members informed us their Trust had implemented a blanket DNACPR on age disability and condition. We put out a very clear statement that blanket DNACPRs were not appropriate and should not be implemented. There was no engagement with that particular Trust or NHS Authorities about that particular issue. If I'm brutally honest I would say that our bandwidth was probably taken up by trying to sort out the issue with guidelines and get on the same page with Public Health England.

Alex Marshall (President of the Independent Workers' Union of Great Britain, Frontline Migrant Healthcare Workers Group)

During the pandemic I worked as a medical courier. We represent a huge part of healthcare workers, a lot of whom are deemed as less important than the doctors and nurses. A lot of these workers were making basic demands. These were frontline workers who knew they were going to be particularly vulnerable, and they were asking for things to be implemented that would protect them and their families and to ensure they were not spreading the virus to the vulnerable people they came into contact with on hospital wards and in care homes.

Many of our members are individually raising this with management but were being told 'no' time and time and time again. Government messaging was designed to protect those people who were staying at home, there was nothing for those who had to head to work and be around the exact thing everyone was being told to stay home and away from. There was no time where we felt people were listening to us to ensure that the people heading into these incredibly dangerous situations were being looked after.

I didn't feel like I had a choice due to not having the money, not having enough sick pay, not enough security in place. Many of our members were having to go into work and risk their lives or 'Stay at Home' and potentially face destitution. That is not a choice that any individual should be making. That is a choice that should have been taken care of by the employers and the government who had the resources to make that decision for them.

As a medical courier we were seeing Covid swabs from January. I was working as a private medical firm. This is a place that makes huge amounts of profits from being experts in medical diagnostics. This is a place that you would think would have not only the PPE that's used for the lab staff but would understand the situation and be ahead of the game. However, due to the fact that we were outsourced workers, no thought seemed to be given to how to keep us safe. If we complained we were made to feel like we were being annoying, like we were asking for too much and they just wanted to silence us. There are power dynamics at play whether you're on an unstable visa or you're an outsourced worker.

Risk assessments were largely insufficient. People were reporting workplaces to the HSE and very often they weren't responded to. When risk assessments did take place, they were done quite late. They should

have been done in those months leading up to the first lockdown not during the pandemic when people were getting infected and dying.

Outsourcing within the health sector should be ended. Inequalities contribute to health crisis rather than helping with efficiencies or savings. We need an end to outsourcing and for everyone to have the same rights. The Hostile Environment policies feeds into people who have their work tied to their visa. If they to push back, they can find themselves fired and they have only two months to find different work. This meant people worked in situations that were not safe.

Matt Stringer (Disabilities Charities Consortium, Chief Executive Officer of the Royal National Institute of Blind People)

Between January 2020 and November 2020, 30,000 of the 50,000 people who died were disabled people. That is 60% of the total when disabled people represent 20% of the UK population. So, there was a very disproportionate impact on disabled people.

DNACPR guidance was issued by NICE on 20th March. We felt that guidance encouraged or opened the door to that slightly more blanket approach. The guidance was rescinded on 3rd April, but we felt that the guidance had permeating into the health service in those 2 weeks and the horse had already bolted.

Many disabled people were not identified as CEV which left them open to harm. A clinical lens was applied to this consideration rather than a more rounded view of individuals to work out whether or not they should be thought of as clinically vulnerable or clinically extremely vulnerable.

Having public health information in an accessible format is something we have been campaigning for since 2016. We have been campaigning for it recently because it's still not in place now.

Professor Habib Naqvi MBE (Chief Executive of the NHS Race and Health Observatory)

Its purpose is to identify and tackle racial inequalities in health by focussing on some of the deep-seated issues within the healthcare system but also within the determinants of health as well.

There were concerns within the observatory about pulse oximeters and that they could put people at risk. The colour of your skin should not determine your chances of survival. Where there were doubts around a medical device, we thought it was absolutely critical that we highlight those, particularly during a pandemic that was affecting the level of oxygen in people's bodies.

Mortality rates highlight the causes of the inequalities but not the causes of the causes of the inequalities. What I mean by that is we were informed that ethnic minority people were more likely to work on the frontline including within the NHS. But what we weren't informed of was why that's the case, why is it that ethnic minority staff or more likely to find themselves on the frontline and less likely to find and themselves in managerial positions or being able to progress within their field to that level? So, we must focus on the causes of the causes if we are to have permanent solutions for these challenges.

The NHS wasn't built to reflect inequality it was built to remedy inequality and that should be our aim and focus as we move forward.

Johnathan Rees (Pharmacist, National Pharmacy Association – Impact evidence)

We had more patients coming to us because they couldn't get access to GPs. We quite literally became the front door of the NHS. We were triaging patients we would not normally see in a pharmacy, and we had no control over whether they came to us with Covid.

There was one month where we had to source our own PPE as there was no access to the national supply. We did not have access to the life assurance scheme which was introduced for frontline staff. there was relief when we were incorporated. Likewise, we were not granted access to the key worker status.