Module 3 Week 8

1. Professor Sir Stephen Powis (National Medical Director, NHS England)
2. Amanda Pritchard (Chief Executive Officer of NHS England)
3. Sir Chris Wormald KCB (Permanent Secretary of the Department of Health and Social Care)
4. Dr Philip Kloer (Chief Executive Officer of Hywel Dda University Health Board, including Glangwili General Hospital)
5. Dr Andrew Goodall CBE (Director General of Health and Social Services and Chief Executive Officer, NHS Wales)
6. Judith Paget (Chief Executive Officer of NHS Wales)
7. Professor Colin McKay (Deputy Medical Director, NHS Greater Glasgow and Clyde)
8. Caroline Lamb (Chief Executive of NHS Scotland and Director General Health and Social Care)

Professor Sir Stephen Powis (National Medical Director, NHS England)

Data on 23 Jan 2021: The baseline beds are occupied 100% and 51.6% above base, 42.4% above beds within adult critical care. It means is that there were 51.6% above baseline.

We did collect healthcare worker deaths. NHS England recorded deaths of NHS staff from Covid-19 is 559 people.

Guidance

There was as much consultation as possible. Developing guidance quickly in an emerging pandemic where the need to get information out rapidly is paramount. But you can develop guidance too quickly. We did what we could but there is a trade-off between getting guidance out rapidly and doing the consultation you would want to do under normal circumstances. It's a set of lousy choices but you have to make that judgment.

Clinical Frailty Score

We were very clear that the Clinical frailty scale was not relevant to people with disability alone. NICE had issued some guidance earlier in the pandemic which included the Clinical Frailty Scale. They withdrew that and we wrote to inform people that it was not appropriate and should not be used. The NICE guidelines were amended on 25 March to make clear that the Clinical Frailty Scale should not be used in younger people and those with long-term disabilities, learning disability or autism. I suspect that had been a longer time to produce this guidance and more consultation and scrutiny, this would have been picked up.

The Decision Tool

I was personally terrified that the NHS was going to be overwhelmed, and doctors were going to be in a position where they would not be able to make the professional judgment about treatments and

escalation. In those circumstances we felt we should explore a decision tool. The decision tool was halted because we concluded that it should not be released. It was becoming increasingly clear that the tool would not be needed because we would not breach capacity. I also had a concern that there would be poor reaction from the public. It became clear that this was going to be controversial, and it hadn't been discussed with patient groups or with the public. The decision tool was never authorised, it was never officially released.

DNACPRS

There might have been inappropriate use of DNACPR. The 2019 learning disability mortality review found that in some of the DNACPR notices that they reviewed, learning disabilities had frequently been cited as a reason for a DNACPR notice. In 2019, in response to those findings, NHS England issued communications to make it clear that applying DNACPRs generally to patients with long-term conditions was entirely inappropriate.

We heard about blanket DNACPRs through a variety of sources at the end of March and early April and we took immediate action. We wrote on several occasions during the pandemic to state that the use of blanket DNACPRs is completely inappropriate.

3 April Letter: learning disability and Down's Syndrome should never be a reason for issuing a DNACPR order or be used to describe the cause of death. Learning disabilities are not fatal conditions.

We need to be aware that in times of emergency and stress, DNACPRs may be used in a way that wasn't anticipated.

Visiting

Visiting was one of the toughest areas of the pandemic and it was another area of difficult choices and the pain it gave to staff and public. I fully recognise that getting that balance right was really difficult. We wanted to be as flexible as we could and increasingly flexible as we learnt more, and we were able to put in more measures to protect staff, patients and visitors.

111

The training for the 111 service takes five weeks. In February 2020 we took the decision to stand up a standalone service to deal with people calling in with concerns about Coronavirus and that was the Covid-19 Response Service (CRS) to take the pressure off 111. It meant the people we recruited for CRS didn't require the length of training that they would need for the 111 service.

HSIB report found that the CRS Covid Response Service algorithm did not allow for assessment of callers' co-morbidities to establish whether a clinical assessment would be beneficial. There were many changes to the scripts and algorithms as the evidence emerged. It is an important principle to ensure that you are confident in that evidence before you introduce a change to the script.

Recommendations

Staff should have a set of general skills rather than solely being specialists. We are making progress with the colleges on ensuring that will happen.

Infrastructure, data collection, better IT systems that can talk to each other, that can automatically generate the data. That will give us much more insight into population health and into how we can run the health service more efficiently. Having said that, we would still need surge capacity in a pandemic.

Future hospitals should be predominantly single roomed. There are several reasons for that but one of those is around infection prevention and control. Ventilation is important and will reduce the risk of nosocomial infection.

Amanda Pritchard (Chief Executive Officer of NHS England)

NHS entered the pandemic with low bed numbers and high bed occupancy levels particularly when compared with other G7 and European countries. Coming into 2020 therefore, there was little flexibility in the existing capacity to respond to a rapid and significant surge in demand. The NHS was running at a very high level of occupancy so there were real pressures pre-pandemic and the challenge of not having that headroom meant that there were consequences to how we had to respond in a pandemic which did make it particularly challenging.

17th March 2020 – letter from Amanda Pritchard and Simon Stevens urging the recipients of the letter to free up the maximum possible inpatient and critical care capacity to prepare for the anticipated large numbers. The aim was to expand critical care capacity to the maximum and free up 30,000 or more of the NHS in England's 100,000 general acute beds. Cancelling elective operations was hoped to free up between 12 and 15,000 hospital beds. The urgent discharge of all hospital in-patients who were medically fit would potentially free up another 15,000 acute beds.

In July of 2020 NHS England sought 10,000 non-temporary beds to deal with recovery and the potential of future surges. The request for the funding for those beds was not approved by Her Majesty's Treasury. The Prime Minister's private office was involved in the decision to refuse saying they wanted more use to be made of Nightingales, more use of the independent sector, to go back to discharging patients if necessary and using flu vaccinations to deal with any flu upsurge. It was very disappointing I think we could be in a very different position now on elective recovery. If we had had that capacity, we could certainly have treated thousands more patients.

NHS England reduced other spending to make 4,000 extra permanent beds in the acute sector to increase capacity to deal with emergency care. Those additional beds have had a positive impact. Ambulance response times for Category 2 responses had reduced from 50 minutes to 36 minutes, so it made a big difference last year.

<u>Critical Care</u>

CRITCON 3: full stretch.

CRITCON 4: an emergency where resources are overwhelmed, there is a possibility of triage by resource or withdrawal of critical care due to resource limitation as being considered.

The peak of demand and the level of pressure in wave 2 was completely terrifying at times. We were very close at times to running out of beds. The fact there are so few declarations of CRITCON 4 illustrates that Trusts were often getting to the peak where they were right on the edge of their ability but were able to relieve the pressure in that locality such that we didn't reach widespread CRITCON 4 or the point of actively and systematically limiting care. I would not disagree with the suggestion that we were on the brink.

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

I think on reflection it is a clumsy statement. It was intended to make the point where we were reaching maximum capacity locally, there was an ability then to relieve local pressure either through patient transfer or moving equipment or staff, to support those places that were under maximum pressure. We never got to the point of the systematic limiting of access to treatment. That does not mean though, that it did not feel completely overwhelming to staff and it does not mean that the kind of care that was being provided was anything like normal.

Nightingales

London Nightingale

It was open for admissions from April to May 2020. During wave 1, 57 patients were admitted. It was then on standby. During wave 2 it was not used to admit Covid-19 patients, but 71 non-covid-19 patients were treated. From 11 January 2021 it was used as a mass Covid-19 vaccination centre until late June 2021.

Set up £77 million. £49 million to run. Just over £5 million to decommission. Total cost 132 million.

Harrogate Nightingale

It was opened on standby. No patients were admitted as the region managed within its existing capacity. It was able to be reactivated to admit patients within 7 days and it ended up being used because it had clinical imaging equipment, and it was able to provide CT scans. It was ready to be used in wave 2.

Total cost £32 million.

Grand total of £358.5 million for all Nightingales. I do think this was a useful resource. This was a govt decision and we operationalised it. The fact we didn't need to open them at scale in the first wave was a huge relief.

London Nightingale was designed only to be used once every other bit of capacity had been exhausted. We were assuming everywhere would be working at a 1:6 ratio of ICU nurse to patient. London Nightingale opened before we got to that point because the clinicians thought it would be safer to open

it a bit earlier to have a couple weeks to test it out. We had also made plans to train airline staff who were at that time available and keen to help to be part of that volunteer workforce.

Thankfully nowhere was 1:6 for any extended period of time. Some places did hit those ratios for periods of time, and we certainly saw 1:4 in a number of places. But you would not have reached the point of opening a Nightingale unless everywhere had got to that extreme level. If everywhere was running at 1:6 that would have released staff to support the Nightingale BJC Note – that is assuming the full ICU work force was available and there were not high levels of staff sickness/self-isolation or unable to work in that capacity due to lack of fit tested PPE. It was clear that there were parts of the country that were under less pressure so we were looking at moving staff from other parts of the country who would be accommodated in hotels.

Ventilators

The story on ventilators is both a success story of rapid procurement and manufacture but also important caution about what lends itself to stockpiling and what doesn't. Because ventilators have parts that degrade, they need maintenance.

Lesson Learned

- effective ventilation and air quality is important in NHS buildings.
- additional guidance being published relating to ultraviolet lights and HEPA filters.
- maintenance backlog approaching 14 billion - competing demands on the capital budget.
- don't forget social care. We can only do what we can do in the NHS if we've got an equally strong social care.

Questions on behalf of CBFFJ UK

We didn't look at whether there were adverse outcomes from the discharge policy. We didn't do any work to look at whether people who were not medically fit for discharged were in fact discharged. That group that was discharged were medically fit for discharge, so our analysis was based on that initial categorisation being appropriate. BJC note – So, they assumed their initial decisions were correct but did not do any work to check. By not looking into whether there were any adverse outcomes they can assert that there were none.

Sir Chris Wormald KCB (Permanent Secretary of the Department of Health and Social Care)

Initially the Department for Health was the lead government department in responding to the pandemic. There is a point which is not set out formally but clearly happens when something is so big that it becomes a whole government response and therefore the responsibility of the Prime Minister and the entire government. We have put that time as 2nd March when the Prime Minister began to chair the COBR meetings and the first press conference. That is when the Prime Minister was clearly leading the response, and we moved from it being a health issue to it being a whole government issue. 2nd March is when the PM began to chair the COBR meetings.

The areas where we were weak prior to the pandemic, the pandemic magnified. It is not a secret that there were considerable challenges in the social care sector prior to the pandemic. There were aspects of the NHS that were very challenged, our colleagues in local government had faced some very, very difficult decisions around austerity which had left them not able to respond, there were issues with international supply chains and the underlying health of the nation. If I had to pick one thing that we need to do better, it would be the whole area of surge.

We had about 420 million items in the PPE stockpile which we believed at the time was sufficient not only for an influenza outbreak but a MERS style outbreak. The pandemic we got was very different and required us to put PPE into far more settings than we were anticipating. We end up using somewhere around 15 billion items of PPE. I don't think anyone believes you could reasonably stockpile that number of items.

In June 2019, NERVTAG advised the department to add gowns to the stockpile. When the pandemic broke out, we were in the very early stages of procuring the aprons. 8 months? In normal circumstances procurement processes do take months. There was nothing slow about this procurement. Checks and balances are to ensure both value for money and fairness between suppliers. In the pandemic we massively accelerated those things, raised our risk profile and then you face a whole series of different challenges about what is the quality of what you receive etc. The government does face this trade off. I do not accept this was a failure. It was the playing out of normal government process.

The UK government chooses to run its health services with very little spare capacity. That is a choice that saves money in peace time and gives us a huge challenge, but it does mean you have the finances given you don't know what crisis is coming.

<u>PPE</u>

10 April a PPE plan was published by the Department of Health stating: *"The UK was well prepared with a national stockpile of PPE which had been reserved for our preparations for an outbreak of pandemic influenza and no deal Brexit."*

That statement is true but not sufficient. The words on the page are true because it relates to pandemic influenza and no deal Brexit. With hindsight we had not planned for an asymptomatic disease that required the level of PPE use that was made. On the date this was published we did not know the full significance of asymptomatic transmission. In retrospect I think this sentence while true, was too decisive. I think there ought to have been more doubt because we didn't know enough about the disease to know that our stockpile was going to be sufficient.

The PPE Stockpile had diversity in it but not enough. No one should be deployed to a high-risk area without that fit test having been completed and having a mask that suits them. If there wasn't a mask available that fitted your face type because of your gender or your ethnicity you shouldn't have been deployed to a high-risk area. The original stockpile had 4 different types of FFP3 mask, and we expanded that to about 20. We did that in response to the concerns that were raised with us. It would obviously have been better had we done it quicker. We did find this bias in medical equipment generally including

PPE. Quite clearly was a problem with how medical equipment is designed, tested, researched and provided that has biases in it.

DNACPR

During the early stages of the pandemic concerns were raised that there was blanket use or inappropriate use of DNACPRs. This was not a new issue; it was highlighted by the pandemic and made much bigger. BJC Note - If it is not a new issue why has it not been resolved? Why is it not being addressed at the teaching level? It was in March/April 2020 and a series of actions were taken to re-emphasise the existing position, that blanket DNACPRs are totally unacceptable. They have to be individual clinical choices. There is much more evidence of bad practice in consent than there are of actual blanket arrangements having been put in place.

In Sept 2020 there were increasing number of reports again of inappropriate or blanket use:

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

“SS [Simon Stevens] noted that it is appropriate to say that should not be happening.”

Q. Some might read this as you being more worried about being able to say it wasn't happening irrespective of whether it was or it wasn't. It was the optics is what you were worried about rather than the reality on the ground?

A. No, not at all. My view is there ought to be a total zero tolerance of any blanket bans. But it was an issue for the NHS to take away and deal with. It shouldn't be happening, and we needed to get to the position where we could truthfully say to Parliament that it wasn't happening. We commissioned the report from the CQC. They are the regulator.

Lessons Learned

The NHS was operating at high occupancy for general acute beds. High occupancy for critical care beds. The UK runs at very little spare capacity. It's a political choice with consequences for how much tax we pay and what we spend on other public services. We spend far more on health than any other public service.

Allison Munroe KC on behalf of CBFFJ UK

Blanket & Inappropriate DNACPR

When people are breaking rules, it is always a challenge to collect data on who is doing it because obviously they're not going to admit it. That is one of the reasons why we asked for the CQC study, to assess how widespread it was and what we should do about it. When people are either deliberately or accidentally breaking the rule, it's incredibly difficult to have precise data on how many. We accept the CQC report on this subject. There was definitely a problem.

111 Capacity

Half of all calls went unanswered. I am not aware of that so can't comment on that. I am not going to accuse anyone in the NHS of failing. BJC Note – but he has no problem of accusing doctors of breaking the rules of DNACPR. Is that not a failing?

Dr Philip Kloer (Chief Executive Officer of Hywel Dda University Health Board, including Glangwili General Hospital)

Hospital opened in 1959, so it wasn't designed with modern healthcare standards in mind. There are only 20% single rooms available across our 388 beds. There's very poor ventilation. The other limitations were bed spacing - we would lose around 113 of our 388 beds if we were to follow the exact environmental guidance.

The hospital had 348 beds and 11 level 3 funded ICU beds. We expanded ICU to 16 beds. In the second wave, for a short period we exceeded our capacity in ITU. We never reached a moment where we had to prioritise one patient over another, we were always able to provide ITU care for people if they needed it. We maintained one-to-one nursing care for level 3 patients throughout the pandemic. For those requires CPAP they all received one to two nursing, so we never had to comprise on our nursing ratios for those patients.

We never ran out of PPE. When we had challenges with FFP3 masks we always increased the PPE so we provided people with a powered hoods if they couldn't fit test for an FFP3 mask.

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

A. At the start of the pandemic there was huge anxiety around PPE and that was universal. We did have one moment where we had some challenges around visors but my understanding with as we never ran out of visors. When people were running out on a ward, they sometimes didn't know how to access the PPE that we had in the storage, they didn't know who to ask. It's regrettable that people were told off for using higher grade PPE. I can only imagine how stressed that staff member would have been with the worry of the not being able to access PPE and being told off, so I would very much regret that. My understanding is we didn't go below the 2 weeks supply, we got close to it.

We developed treatment guidelines not to ration care but as a pathway for best medical practice perceived at the time. We never had to consider one patient over another for our resources. Every single patient during the pandemic had an individualised decision.

<u>DNACPR</u>

It was a distressing issue that a junior doctor had attempted to apply a DNACPR form to somebody with learning disabilities. That was challenged by one of our nursing staff and it was immediately rescinded. We have shared it with our learning disability nurses who support the education and training of clinicians around these issues. Given the fact that we have new doctors and nurses coming every six months and sometimes more frequently, we know this is something that requires continuous training. It was clearly a learning experience for the junior doctor. I know it was discussed with them with their educational

supervisor and explained to them, but I don't know why they felt that why that was appropriate. That was never fed back to me.

That DNACPR notice that that junior doctor tried to issue was on the grounds of "poor quality of life".

My understanding is there was an issue of communication between some of the more senior doctors and I think it led to the junior doctor perhaps misinterpreting. So, I think it wasn't quite as straightforward as them seeing somebody with learning disabilities and applying a DNACPR form. They were interpreting some discussion around intensive care and escalation. BJC Note – what could they possibly have been told that would lead them to misinterpret someone with learning disabilities as having low quality of life sufficient to apply a DNACPR.

Dr Andrew Goodall CBE (Director General of Health and Social Services and Chief Executive Officer, NHS Wales)

My Director General role is an internal Welsh Government facing role, supporting and advising the Minister whilst my Chief Executive of NHS Wales role is an outward facing role facing the NHS bodies. I was accountable to the health minister for NHS Wales chief executive role.

Escalation of Care

23 March 2020 the Covid-19 Primary and Community Care Guideline: "Evidence shows that the following groups do not respond well to ICU escalation - Clinical Frailty Score of 5 or above."

Q: Was the purpose to minimise the number of Covid patients being admitted to hospital by GPs?

A. It was to try and support the overall preparation but also to try to push patients to the right level of service that needed to be available.

8 April 2020 it was updated to stated that the Clinical Frailty Scale should not be used in younger people, people with stable long-term disabilities such as cerebral palsy learning difficulties or autism. NICE guidelines made that amendment on 25 March so why did it take until the 8th of April for the Welsh Government to make similar amendments to this admission criteria?

A. I can't respond to why that delay would have been there. I would have thought that the planning and response group would have been looking at it again.

PPE

The supply set aside was inadequate for what we were seeing in respect of the Coronavirus experience. We were finding difficulties with the supply system being put in place at UK government level. NHS England was often buying up in bulk supply lines that meant that the NHS in Wales were sometimes not able to access its normal supply routes as well.

Testing

Q: Wales was behind England in relation to both the expansion of testing for asymptomatic healthcare workers and NHS patients. What was the reason for the delays in Wales in relation to those testing policies?

A: The testing policies that were set out were always set in context of the available testing capacity.

Shielding

There were some problems with 13,000 of the initial 91,000 shielding letters being sent out to a previous address. That was addressed very immediately, and they were sent out within a few days. The shielding patient list was updated to include adults with Down's syndrome. That decision was made by the four nations Chief Medical Officers on 30 September 2020. However, the easy read version for people with DS was not drafted until November 2020. I don't recall why there was a delay. It should have been issued when the CMO made the changes.

Lessons Learned

There is a need for us to improve the critical care capacity that is available. We had started that before the pandemic but the levels across the UK need to be raised if they are to be able to respond to a future pandemic.

I am concerned about the impact of underlying health conditions and characteristics of our population. There needs to be a recovery plan for health otherwise we won't be ready for the next pandemic as well.

In hindsight, I do accept that clinically vulnerable patients would have need additional assurance about measures that were put in place in healthcare settings. The health boards were operationally responsible for any measures put in place, but I do accept if we had made that clearer at national level then that would have helped with the confidence of people coming into our hospitals for care.

Wherever a critical care bed was asked for when it was beyond the capacity of the critical care department itself, the advice I received was we were always able to accommodate those patients. But clinicians can make individual decisions based on the pressures that a hospital site is under, and we were under very significant pressures.

Judith Paget (Chief Executive Officer of NHS Wales)

The Welsh Government does not hold or publish official or verified data on the number of NHS staff who died from Covid-19. At local health board level, they would know whether they had lost members of staff. Welsh Government relied on the ONS data for that.

DNACPR

A review was undertaken by Healthcare Inspectorate Wales into DNACPR decisions. We requested that Health Inspectorate Wales undertake the review. The review considered DNACPR forms submitted by the health boards. 280 forms were reviewed plus 66 clinical records. The Review concluded "We are

therefore not assured, based on the records we reviewed, that the DNACPR decision-making process is always completed in line with the all-Wales policy, for patients who were deemed to lack capacity"

In the last four weeks I brought the chief executives of NHS Wales together to review the Module 1 report. BJC note - 4 weeks ago? The report came out in July. Why has it taken 3 months?

A national bereavement pathway has been developed by NHS Wales. It is a consistent policy that all organisations are required to implement. Every organisation now has bereavement services in place and the executive teams of those organisations are charged with ensuring that they monitor, evaluate and get feedback on the effectiveness of those services.

Wales managed to ensure a good supply through procurement arrangements put in place by NHS Wales shared services. I don't recall any difficulty around the availability of PPE during the pandemic.

Questions on behalf of CBFJ Cymru

Q: Photographs were taken in hospitals within Aneurin Bevan University Health Board. Some of those photographs included photographs of patients being treated and body bags. Were those photographs taken with patient consent or the consent of their family members?

A: There was an absolute requirement of consent.

The Chair refused permission to ask follow-up questions on the process of how consent was obtained.

Q: what steps have you taken to satisfy yourself that all nosocomial deaths in Wales have in fact been recorded as patient safety incidents?

A. I have to rely that the system has done what it's been asked to do. I understand over 18,000 cases have been reviewed as part of this process which is a substantial number. I have to rely that the process has captured all cases.

Professor Colin McKay (Deputy Medical Director, NHS Greater Glasgow and Clyde)

The model in the first wave was for one ICU nurse to supervise up to 4 non-ICU nurses who had been redeployed. There were times when the intensive-care-trained nurses felt that they were unable to deliver the quality of care and supervision that they would normally expect to provide to patients under their care. And feeling responsible for the actions of staff who were less well skilled posed an additional stress on them as that time.

<u>IPC guidance</u>

It was clear on the ground that some of the advice about infection control was incorrect and unhelpful. We were advised about droplet spread when airborne spread seemed increasingly possible. This was first flagged to us by our infection control team who were seeing strange patterns of spread, which were indicative of airborne spread. That did not lead to us treating C19 as being airborne spread. We were very careful to comply as far as was possible with the guidance. We sought to influence guidance where

we possibly could but at no time did we feel that we were in a position to deviate significantly from the national guidance that we were given.

That did create tension within the hospital at time because we're introducing uncertainty to the staff and perhaps making them feel less safe in the workplace, when we were not in possession of strong evidence on which to overrule what we were being given as the national guidance.

AGPs (Aerosol Generating Procedures)

The medical teams on the ground who had obviously a lot of experience of managing CPR, were concerned that the guidance underestimated the risk of chest compressions to staff. That was reinforced by guidance issued by Royal Colleges and others. That led to us adapting guidance to allow chest compressions to be considered as an AGP.

PPE

By the second week of March 2020 the hospital had used the bulk of its FFP3 masks to fit test staff. We were assured there was a national stockpile of FFP3 masks which would be delivered but when that supply arrived it turned out to be a different mask. So, we started to fit test staff again. There were reports of failure rates of up to 75% with one of the masks. This meant that we stopped using those and looked for other supplies. There was never a scenario where we actually ran out of PPE, but there were certainly weeks where we were looking at having no more than one- or two-days' supply, which created a great deal of anxiety.

In the future we should adopt the precautionary principle from the outset and then de-escalate PPE as it becomes apparent that it's not required when we know more about the illness itself. There is nothing more alarming for staff than escalating up.

March 2020 – Covid Escalation Plan

"Due to the sheer numbers expected, the aim is to establish which patients are for further escalation or not, at an early stage of their admission, ideally on admission."

The treatment escalation plan was already in place. Because patients often deteriorated quickly, having the treatment escalation plan in place from the outset was helpful for managing decisions. Intensive care referral is for patients for whom it could be anticipated they could survive prolonged ventilation and be able to resume a high quality of life or an acceptable quality of life following recovery.

I'm not aware of any concerns regarding inappropriate DNACPR decisions. We sometimes received complaints about failures in communication or sometimes in failures of documentation, but these are complaints that arise from time to time under normal circumstances.

Caroline Lamb (Chief Executive of NHS Scotland and Director General Health and Social Care)

As Director General I am responsible for 11 health and social care directorates. I am the accountable officer, meaning I am answerable to Parliament for the expenditure of those directorates. I line manage the health and social care directors and senior clinical advisers including the CMO, the CNO and the national clinical director. I report to the permanent secretary in Scotland and I'm also responsible to the Cabinet Secretary for Health and Social Care and to the Ministers in the health portfolio.

IPC Guidance

At the start of the pandemic SG aligned with the rest of the UK in relation to IPC measures to reduce Covid-19 transmission. This ensured a consistent approach until further scientific evidence was available.

In October 2020 there was change in the IPC guidance produced by ARHAI. The change was to recognise that whilst the guidance was that in the low-risk pathways, where patients had not tested positive for Covid, there was no need to use FFP3s when performing aerosol-generating procedures, we recognised that staff may be anxious about that and therefore they could choose to wear an FFP3 respiratory.

In March 2022 WHO issued an update to recommend use of FFP3 masks by healthcare workers in view of the increased transmissibility of the Omicron variant. The UK infection prevention and control structures decided that that didn't merit a change in the guidance. Our ministers asked for evidence and took a view that we should offer that enhanced level of protection to staff who expressed a preference for that. This was not a change in the IPC guidance, it was a policy decision taken by the Scottish Government. Ministers were concerned to ensure that staff felt protected.

I cannot recall any circumstances when supply constraints were part of the conversation about PPE. There was insufficient supply of PPE for some of our social care organisations. Prior to the pandemic we had focused on the requirements in healthcare settings. We must take much more cognisance of the PPE that's required across all our health and social care settings.

We expanded the range of masks available and have set up a manufacturing base that would pay close attention to the Scottish demographics.

Treatment escalation Plan

Having these arrangements in place are pretty much what our clinicians do every day because being mechanically ventilated is not the best option for all people and the earlier you can have those conversations the better.

Lessons Learned

- Take advice from the royal colleges and other clinical experts on to how to prioritise tests and treatment.
- shared aid across NHS health boards to maximise available capacity and to minimise backlog.
- protected sites so keeping effectively green sites for cancer treatment.