Module 3 Week 10

Witnesses

1. Matt Hancock (Former Sec of State for Health and Social Care) continued
2. Sajid Javid (Former Sec of State for Health and Social Care)
3. Anna-Louise Marsh-Rees (Co-Leader, Covid-19 Bereaved Families for Justice Cymru)
4. Margaret Waterton (Member of Scottish Covid Bereaved)
5. Dr Saleyha Ahsan (Member and Health Care Worker Sub Group Leader at Covid-19 Bereaved Families for Justice UK)
6. Martina Ferguson (Group Lead for Northern Ireland Covid-19 Bereaved Families for Justice)

Closing Statements

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Matt Hancock – Day 2

Mr Wagner obo CVF

To argue that shielding didn't work because the people who were shielded needed hospital treatment, they were going to need hospital treatment anyway. You have to protect people who are clinically extremely vulnerable from community acquired infection and from hospital-acquired infection and to say that shielding is only a partial solution is reasonable. But to say that it is no solution because it can't be the whole solution, is false. I agree Shielding is only part of a picture which has to include protecting people in healthcare settings as well.

CVF has been advocating for a systemic review of all DNACPRs put in place in early 2020 and that the notes of all the formerly shielded people from 2020 be reviewed. I agree a review like that should be looked at. Because it's obvious that there were cases when DNR notices were wrongly applied

Ms Polaschek obo PBBO

There is a balance here between protecting people from infection and the very strong need for companionship in birth or bereavement. We went into this without a testing system, and so it simply wasn't an available choice. There was a clinical ordering of prioritisation for tests. My job was not to affect that clinical prioritisation. My job was to expand the number of tests available so we could get as far down that list as possible.

Mr Burton obo Disability Charities Consortium

My department did everything it could to reduce disproportionate impacts on disabled people ahead of the second wave. The challenge is the virus itself was more aggressive against people living with disabilities. And that is a sad fact. In the same way that it was more aggressive against people who were older. So, we took action to reduce the total number of people affected and the disparities. It is the clear evidence from the data that disabled people were clinically more likely to die from Covid-19 than non-disabled people.

Mr Pezzani obo MIND

This was a problem well before the pandemic. This is a clear and significant problem in the NHS. It remains so today irrespective of Covid. So, I would say that these services were not overwhelmed by Covid, they were already under very significant pressure before the pandemic. This was on his watch – what did he do about it?

Stephen Simblett obo CATA

The amount of PPE was effectively determined by the IPC process. Of course the availability of the higher end masks was extremely tight at the start of the pandemic and had we specified FFP3 masks right from the get-go, there would have been a risk that in extremely high-risk settings there would not have been

the availability of those masks had they been used across the board when the lower grade masks were available more widely. Those sorts of trade-offs do need to be considered.

My understanding is IPC guidance considered the real-world situation that we were in regarding supply. If there's only a certain number of FFP3 masks, then that guidance would consider the places where they were most in need and could save most lives. That was my understanding of it.

Ms Sen Gupta obo FMHWG

My attitude was not to try to prioritise one group or community over another, it was to try to support all those in those roles, no matter and irrespective of the colour of their skin or where they were born. BJC note - but this ignores the fact that treating all people/groups the same is not treating all people equally. Some people/groups will need something different to enable them to work safely.

Pete Weatherby KC obo CBFFJ UK

I agree the decision in policymaking on Asymptomatic Transmission should have proceeded on a precautionary basis. And should in future. Of course, it would have been far better if we'd had that presumption. I had a strong instinct that this was the problem. The problem is looking back, if I had simply said there was asymptomatic transmission, clinicians right up to the World Health Organisation would have said “you don't have the evidence for that."

I agree it is talking about an absence of evidence rather than evidence of absence. And generally, my approach was to take the reasonable worst-case scenario. And the reasonable worst-case scenario should have included the possibility of asymptomatic transmission.

<u>DNACPR</u>

I did know about concerns regarding inappropriate DNACPRs, and I acted on it at the time. On 12 February of 2020 we issued a response to a Report on it stating that it was "completely unacceptable." In April it came up again. As soon as I heard about this being a potential problem and these concerns being raised with me, I immediately acted because I feel so strongly about this, and I went public on it, including using the platform of the daily press conference to reiterate the total unacceptability of this, and I discussed it with the NHS leadership whose responsibility it was to stop it from happening. Looking back, I took the action that I ought to have taken.

Sajid Javid

NHS overwhelm would have been the NHS unable to cope with emergency cases, A&E effectively becoming closed because it was - had too many patients, ambulances not able to arrive and drop people off in any kind of reasonable time.

Even before the pandemic the NHS was massively stretched and that's important because the state of the NHS before the pandemic, especially around capacity and how much flexibility and capacity it has is hugely important in being able to deal with a pandemic. Prior to the pandemic the NHS has been run by successive

governments at almost full capacity in terms of beds - the measure is they try to run it at 95% of beds are taken. But if you broaden that out, if you look at the number of doctors, number of nurses, ventilators, IC units, whatever measure of the scale of the NHS it is per capita a lot less than comparable countries with universal healthcare systems.

And so I think the model is fundamentally flawed and one can measure that in terms of outcomes whether it's cancer outcomes, cardiovascular outcomes, diagnostics - whatever measure you take, the UK despite the hard workers in the NHS, the system is flawed and we are generally worse than every other country and that's a fundamental problem with the NHS. My Recommendation is we should have a royal commission to look at this and ensure we have an NHS that is fit for purpose. BJC Note - This will take years and kick the can down the road. What he really wants is to privatise the NHS. Everyone knows what it needs. There are thousands of staff vacancies. The way to fill them is to provide a salary that people are willing to work for and working conditions that are safe.

Unless the elephant in the room is addressed, everything else is slightly better than window-dressing because it won't deal with the fundamental issue, we will still have massive under capacity when we get to the next pandemic.

Anna-Louise Marsh-Rees (Co-Leader, Covid-19 Bereaved Families for Justice Cymru)

Part of the problem was there was only three symptoms that were attributed to Covid. If you had any of those other symptoms you were just told it's fine, just you know don't worry, when in fact they were clearly Covid symptoms. Many older people don't display those three cardinal symptoms. One of our members had had one of those experiences where they were calling the 111 service repeatedly and being told that their loved one was fine, there was no need to go to hospital it wasn't Covid and eventually I think that patient was admitted to hospital, did have Covid and sadly died from Covid.

No information was put out by hospitals about whether they had an outbreak of Covid at their hospital and to stay away. In fact, it was well hidden. It was proactively not broadcast. My father's GP and the out-of-hours doctors didn't seem to be aware that there'd been a cluster outbreak in my father's hospital, 21 patients, 13 staff, and yet the ward had been closed for 4 days after.

DNACPR: Most of us were not consulted. And most of us didn't find out there even was one placed until we got hold of hospital notes and that could be some months even years later.

IPC: cluster outbreak after cluster outbreak was happening in Wales and no one seemed to be saying "hang on a minute, are those IPC guidelines working because how is it still happening?" It's just a shame that there's been an investigation into nosocomial deaths by the Welsh Government but interestingly nothing on the cluster outbreaks, which is of course the whole point.

Margaret Waterton (Member of Scottish Covid Bereaved)

Any bereavement is devastating in its own right, but the complexities, the restrictions, the situation that we had to experience and endure and our loved ones had to experience and endure make that so much worse, and we all feel the trauma, we feel blame, we feel guilt that we could have done more to protect and shield and save their lives, and that we should have done more to do that. We are tortured by it every day. I'm haunted by it every day.

We have members who were told that they could be with their loved ones when they died, but if they did that, they wouldn't be able to attend the funeral. So that's no choice at all because those two things were vitally important to us. We haven't been able to put people to rest properly.

Yesterday I went to the national Covid Memorial Wall, and I found the hearts for both my mum and my husband. I put my hands on to those hearts and was weeping but two feet away from me were dozens of tourists. For the majority Covid is forgotten.

1 in 4 of our members lost loved ones to nosocomial infection so it's a significant area. Hamza Yousaf said that hospitals were safe and sterile environments. During the pandemic they were never safe. They were places of high risk because of the risk of hospital-acquired infection. Jeane Freeman said she understood the main cause of nosocomial infection was poor application of IPC practice. And I think that did a huge disservice to our healthcare workers who gave their all during the pandemic. Some gave their lives, and it completely ignored the other contributory factors such as bank and agency staff also moving from place to place, IPC guidance being changed frequently and the availability and the appropriateness of PPE.

We and our loved ones were denied the opportunity to be with them, to offer them comfort. We all had the right to be there. We all had that right and it had denied us because the guidance was not consistently applied. We've heard about moral injury to healthcare workers - we could have helped reduce, minimise, avoid that if we had been there with those we loved the most when they were dying.

Dr Saleyha Ahsan (Member and Health Care Worker Sub Group Leader at Covid-19 Bereaved Families for Justice UK)

Unfortunately, we've all been brought together by this unifying factor of having lost a loved one. We didn't know each other before, but we've suddenly become a member of this group that no one wanted to be part of.

When you have the knowledge of what's needed and you can't get that help through the door, it's really distressing. My heart really goes out to people who had loved ones in desperate need of someone with medical knowledge arriving to give help and they couldn't access that. The minutes would have dragged like hours and the hours would have dragged like days as they waited for someone to come and there was no one to come.

I didn't need a crystal ball to see how bad it was going to be, but I had made the decision around towards the end of November, December time to go home and impose a lockdown on my father even before national guidance because I could see the direction of travel. Unfortunately, I was a week too late, and he

caught Covid. This was during the partygate season. I think the messaging on shielding came too late for many, especially during the second wave and I think that's unforgivable.

When my father was in hospital, I had a frank discussion with the consultant and she said *"you know and I know that this isn't how it would normally be. I have got a 40-year-old male patients that I am trying to desperately find an ITU bed for across the region, that's what I'm dealing with."* And at that point I knew that this is it for my dad. He was not going to get that escalation of care.

I just remember feeling so completely helpless. The week before I was looking after other people's parents but now, I was really relying on others to look after mine. My dad would sometimes slide down the bed and Covid is so positional so the minute a patient moved, anything could just set them off and cause them to be fighting for breath. Seeing a grown man thrashing on the bed to breathe was really harrowing. If I hadn't been in the room, I don't know how the overworked nurses in that space would have been able to keep an eye on every single side room. I just kept thinking 'thank God I'm here, what about the others?' I hope that by being there, it took some of the pressure off the nurses for the other patients.

With DNACPR, and I really feel for the families, because the end of life happens once, it has to be done properly because the impact of when it's not done properly can last a lifetime for others. It's so important.

The Guidance on PPE changed. The guidance was if we come into contact with suspected Covid, and we were fit tested with the FFP3 we were to wear full PPE. During that same week, it was downgraded almost daily. By the end of the week, it was literally just a normal surgical mask and then an apron and gloves. You've got an informed scientifically minded workforce that are asking why? is there new evidence? Has something emerged and we would be pointed back to the guidelines. Colleagues were really alarmed. One person even posted on Facebook that we'll be in flip flops and speedos by the end of the week, that's how bad it was.

I spoke with a former advisor to Matt Hancock. She said that she was on the front line. Her frontline was just as hard and so it was very combative and defensive and that her experience was just as challenging and as hard as a frontline healthcare worker dealing with patients who couldn't breathe and were thrashing on the bed. And that gave me an insight into the absolute disconnect between the people that were making the decisions, were not connected with the people that were delivering the care. There was a massive gulf.

Martina Ferguson (Group Lead for Northern Ireland Covid-19 Bereaved Families for Justice)

We want a legislative Change. I was campaigning before my mummy died, after my mummy died for the care partner guidance. You will have heard during this Inquiry that that was ruled out in care homes in September 2020. It was extended in hospitals in February 2022. I want that on a legislative footing. We need to make sure that nobody dies alone ever again because it's so important that their family is with them because at the end of the day family is the most important people to those and they're dying hours and days.

Closing Statements

UKHSA

PHE recognise the possibility of asymptomatic transmission as early as 28 January 2020. However, at that time while the clinical evidence did not rule out the existence of asymptomatic transmission, expert opinion and scientific consensus concluded that it was less likely to be the major driver of transmission and there remained insufficient data to assess the scale of it until April 2020.

With PPE there is a need to balance benefits against harms. Using an FFP3 mask can make communication with patients more difficult. Prolonged use of such a mask can lead to pressure sores and the risk of infection. The second factor is that there may be a difference between a person's perception as to the effectiveness of a piece of equipment and the evidence of that effectiveness.

Dept of Health NI

It should be clear that in Northern Ireland blanket decisions or policies based solely on age, disability, or a clinician's view of quality of life did not occur.

Since 2015 the department has been planning the introduction of an electronic record system, that digitises health and social care records at present it is in place in 3 out of 5 of the health trusts, the two remaining trusts are scheduled to implement encompass in 2025.

The department would like to refute any perception that planning for a Nightingale hospital in Northern Ireland was too slow. The department rejects the suggestion that the Belfast city hospital was the incorrect location.

Welsh Govt

The Inquiry will make such recommendations as are considered necessary to cure any significant deficiency, this may be a situation where the Inquiry is better assisted by an approach of less is more.

Scottish Govt

Across Scotland, in hospital settings alone 9,573 people, workers included lost their Lives. Certainly, at times the system was severely tested and stretched but, as Ms Freeman said, it was not overwhelmed, though others may define that term differently.

A number of key decisions were taken that increased capacity allowed staff to be redeployed and prevented the NHS from being overwhelmed. Elective and non-urgent healthcare was cancelled. Cancer screening programmes were paused.

The CMO was unaware of any resource-based escalation of care decisions being taken. Miss Freeman said there were no decisions at all about the rationing of healthcare. She was concerned that an increase in capacity would have consequences for the quality of care, yet as she said everyone worked to make it as good as it can be.

NHS England

The NHS's overriding goal throughout was always to treat as many patients as possible with the resources that were available. That inevitably led to over stretching those resources, including our staff causing exhaustion and trauma. Sacrifice was an inevitable consequence and sadly suffering was an unavoidable reality. That applies to staff and to patients. Patients who experienced the postponement of care or diluted care or curbs on visits. But all of these were fundamentally necessary steps.

You've heard about whether decision-makers applied a precautionary principle, but also that the balance of risk is a more helpful framework. Chris Whitty said the precautionary principle is only a useful principle where there are no downsides, otherwise you are talking about balance of risk and balance of risk is a different concept. We specifically urge the Inquiry to adopt the latter framework, when considering lessons learnt.

Should the principle of individual clinical decision-making remain paramount in a pandemic? We've heard discussion of decision-making tools to guide triage decisions. To avoid this, NHS England worked tirelessly to ensure that there was no need to apply systematic rationing guidance.

Group of Welsh Health Bodies

All modern hospitals should be designed with pandemics or serious infection outbreaks in mind with existing buildings being upgraded.

The development of reusable PPE would, he thought, change the landscape.

British Medical Association

Almost five years on from the start of the pandemic, the UK's health systems are in an even worse position to cope with day-to-day care let alone an emergency. Waiting lists across the UK are around 9.4 million. There are severe staff shortages, bed numbers remain far too low. The UK's maintenance backlog sits at 17.3 billion, staff mental health and morale is in crisis and population health and inequalities have worsened.

When the pandemic began, the UK had a shortfall of around 40,000 doctors per capita compared to OECD averages. There were nearly 40,000 nursing vacancies in England alone, a shortage of around 2,000 midwives and obstetricians, 50% too few anaesthetists, a 10% critical care vacancy rate and too few GPs to meet patient demand.

Professor Sir Chris Whitty said that healthcare workers were at higher risk of infection from Covid-19. An ONS data suggests that this increased risk was six times that of the general population. Despite that increased risk, the Health and Safety Executive abrogated its responsibility to protect staff by failing to challenge the adequacy of the IPC guidance, to act on concerns raised by organisations such as the BMA, and to ensure that employers complied with their health and safety responsibilities.

In relation to PPE, some witnesses have stated that the UK never ran out of PPE and that the problems were with distribution. However, if a healthcare worker who needs PPE does not have it readily available and is thereby exposed to risk of serious injury, then this is a PPE shortage, regardless of whether the problem relates to distribution or stock quantity.

A precautionary approach should have been taken and the use of FFP3 masks recommended for all staff caring for patients with or suspected to have Covid-19. Instead, FFP3 was restricted to just intensive care, and to aerosol-generating procedures through a combination of concerns that intensive care might run out of FFP3, fears that staff might refuse to work if the recommended PPE was not available and an over reliance on droplet transmission. Worse, once the evidence in support of aerosol transmission became clear, the IPC cell stubbornly refused to change its approach, seemingly more worried about not wanting to look like they'd got it wrong and advancing before this Inquiry a series of after the event justifications such as comfort and the need for further studies. If the efficacy of FFP3 is seriously in doubt, why are they recommended for intensive care and aerosol-generating procedures?

Capacity is now worse not better than five years ago, which is a damning indictment. The resourcing and configuration of the NHS is a choice, and one that can be made differently.

National Pharmacy Association

There was huge and increased demand for their services as other parts of the NHS were required to limit availability.

Community pharmacies and their teams were not treated equally with other frontline healthcare workers and they did not receive the support that they needed. The most significant and demoralising example of this different treatment by government was the initial exclusion of pharmacy workers from the life assurance scheme for frontline workers in England. Pharmacists were unable to access the NHS PPE portal to order PPE until August 2020, some months into the pandemic.

At the start of the pandemic, people who worked in community pharmacy were not recognised as key workers, which would allow their children to attend school while they worked, notwithstanding that they were working in a frontline healthcare environment. Nor was Covid-19 testing initially available for community pharmacy staff. Community pharmacy was initially categorised as a retail setting as opposed to a healthcare establishment.

Since the start of the pandemic approximately 1,000 pharmacies have closed in England.

Royal Pharmaceutical Society

Relegation of a central element of primary care to an afterthought, and a lower priority than other parts of the healthcare system is a very significant concern that explains much of the unfair treatment of community pharmacy throughout the pandemic.

Pharmacy teams within hospitals were often responsible for oxygen supplies and the real concerns about oxygen shortages to support ventilators. The pharmacy team was on call-out of hours to move and handle oxygen cylinders which was physically demanding and risky work for which no risk assessment was ever undertaken.

Despite being an essential part of primary care, community pharmacy teams were only able to access the government's PPE portal from 3 August 2020, after the first wave of the pandemic. It is the RPS's position that frontline staff should have the same support across the whole of primary care.

Northern Ireland Covid-19 Bereaved Families for Justice

John Sullivan: His devotion to his daughter on vivid display throughout his evidence. He told us about Susan who needed him and his wife as her voice throughout her life and never more so than when she was taken into hospital during the pandemic. But the doors were closed on them. His efforts to be recognised on Susan's behalf as her advocate, her care partner went unmet including and up to that decision not to admit Susan to critical care because it seems, of her disability.

Julia Jones of John's Campaign gave powerful evidence of the legacy of grief, guilt, anger, and mistrust that is left behind when people are left to die alone because guidance was allowed to trump the most basic human right to dignity and to the comfort of a loved one in death.

How could anyone listen to the evidence of Professor Fong and continue to maintain that the NHS was not overwhelmed during the pandemic ... and yet that was the position of Matt Hancock and other health ministers from across the UK.

It seems that it's the position of the Department of Health that the chief executive of the PHA, who has been in post for almost four years, since the middle of the pandemic, doesn't yet understand what data was available to his agency and from where it came. Its beggars' belief.

Trades Union Congress

Professor Whitty suggested that the pandemic was a wakeup call to the problems in inequalities that exist within the health service. But has it been a wakeup call? The answer we say is unfortunately, no. It is striking that two consecutive health secretaries, Mr Hancock, and Sir Javid have both in their evidence espoused a policy of colour blindness, the idea as long as everyone is treated the same, the disproportionate impacts of an action, policy or system do not matter. Public authorities are under a duty to take steps to advance equality of opportunity which may include removing or reducing the disadvantage faced by persons with protected characteristics or taking steps to meet the specific needs of people with those characteristics. It appears that at a ministerial level there was a fundamental misunderstanding of this duty owed to black, Asian and minority ethnic workers in healthcare and what practically is required to limit systemic barriers.

There is a need for recommendations which fundamentally prompt a shift from a practice of recording systemic racism to actually removing it. A need to remedy the problem of NHS England abrogating too much responsibility to the trusts as the employers.

Academy of Medical Royal Colleges

Where there is genuine difference of clinical opinion, and that may well be the case, that this is evidence-based and clearly set out and explained.

Frontline Migrant Health Workers Group

The persistent and recurring theme in the accounts of outsourced and migrant workers is that they had no voice throughout the pandemic. They could not speak out for fear of the consequences for their employment, and their immigration status. Even when they did speak, no one listened.

The standout feature of the evidence is that even when they were making the ultimate sacrifice, outsourced and migrant workers were routinely overlooked. Up until 22 April 2020, 63% of the healthcare worker deaths were ethnic minority workers and of that 63%, at least 83% were migrants.

Federation of Ethnic Minority Healthcare Organisations

Of all the forms of injustice, injustice in health is the most shocking and the most inhuman because it often results in physical death.

The pandemic laid bare the pervasive inequalities in our healthcare system, inequalities that left ethnic minority healthcare workers on the front line, ill-equipped, unsupported, and ultimately betrayed by the institutions that they served and that were there to protect them.

a flawed system that tolerated inequity in its operation. The failure to address these shortcomings sooner demonstrates the systemic disregard for the unique needs of minority populations, a disregard that should never have been acceptable.

John's Campaign, Care Rights UK, and Patients Association

DNACPR notices should never be imposed without individualised assessments or the participation of patients' families.

The NHS is for all, no group is unworthy of treatment because for example of their age, disability, care needs or place of residence, all lives are of equal value and health policies and practices must reflect that.

Even in a pandemic, quality matters. We've heard too many accounts of quality standards, human rights and ethical principles being abandoned or least worse decisions being made. We challenge the wisdom of that approach and of course our healthcare system should serve people not institutions the patient's rights must be at the heart of how the system operates not peripheral to it.

We ask you to recommend a new legislative right to a care supporter such as a relative or friend, for all patients who would like this across all healthcare settings.

Clinically Vulnerable Families

The vast majority of people who died in the pandemic were vulnerable including many healthcare workers and people who caught Covid-19 in hospitals which was supposed to be places of safety. We need to make healthcare safe for vulnerable people. It bears repeating we need to make healthcare save for clinically vulnerable and by making it safe for them by improving ventilation and putting in place other protective measures we make it safe for others too.

“You are more likely to catch Covid in hospital than in almost any other setting" they were the words of the former health secretary Matt Hancock to this Inquiry. What an admission and what a dire reflection on our healthcare system. If you cannot keep clinically vulnerable people safe in healthcare settings then it rendered policies like shielding almost ineffective. Because those people are kept out of the frying pan of community transmission, but then thrown into the fire of healthcare settings where Covid is rife.

The important question is whether nosocomial hospital-acquired infection is inevitable, as Mr Hancock seemed to suggest, or something that can be reduced. We say the answer is the latter. Matt Hancock's assessment that there is a cultural problem within the NHS that it simply does not do enough to tackle nosocomial infection is a serious admission.

CVF are calling for the Inquiry to recommend a full review of all DNACPRs put in place from the start of the pandemic to date.

Covid-19 Airborne Transmission Alliance

The decision not to pursue the precautionary principle was corrupted by pragmatic concerns. Those failings are compounded by the denial of the obvious of those in leadership positions in healthcare both during the pandemic and in your inquiry and are serious public health failings.

The failure to pursue the precautionary approach was not a scientific failure but a political one. There were concerns about the availability of FFP3 masks, and the signal that that would send to the public about an airborne pandemic that we weren't prepared for. Those considerations predominated over technical scientific advice in the development of IPC guidance. Mr Hancock was very clear that he thought the development of IPC guidance was and should have been influenced by these considerations.

Problems were compounded by there being insufficient safeguards in relation to what was produced by the UK IPC Cell. Public health bodies did not review the guidance before publishing it. The witness from Public Health Wales and Public Health Agency in Northern Ireland said this in their oral evidence, the CNOs and CMOs did not review the Guidance despite having oversight responsibility.

Trust in IPC measures has been catastrophically lost during the pandemic and it requires serious action to win it back now. We say that healthcare workers can no longer have confidence in the current IPC leadership.

13 Pregnancy, Baby and Parent Organisations

The healthcare response to Covid-19 failed to properly value the care of women, pregnant people, and newborn babies.

The correct balance was not struck between necessary, proportionate restrictions and the need to ensure the continuity of pregnancy related care. Across the UK it was acknowledged too late that partners and supporting for a birthing woman and at all stages of the pregnancy journey are not visitors but partners

in care. There was belated recognition of maternity care being essential. This should have been locked in from the start.

Long Covid

There are around 2 million adults and children who continue now to suffer the harm of Long Covid. More than once, witnesses to the Inquiry have suggested that the pandemic is historic. This is both incorrect and dangerous. Current unmitigated spread of Covid-19 is causing ongoing harm to our public health.

The delay in formally recognising Long Covid has meant that there is still disbelief of Long Covid in the medical profession. The Inquiry has heard distressing evidence from multiple sources of patients and parents have fight to be believed. Seriously unwell patients were forced to fight for recognition of their symptoms and access to the necessary healthcare.

Mr Hancock gave evidence that levels of stock of PPE dictated the level of protection the IPC guidance recommended. Decision-makers should have taken a precautionary approach, informed healthcare workers of the very real risk they faced and provided suitable PPE. Protection should only ever be dictated by level of risk, not levels of supply.

MIND

The pandemic undoubtedly had a mental health impact stemming from the psychological effect of the pandemic and from systemic reactions to it. It is not simply that presentations and contacts with services increased but rather the nature and severity of mental illness among those presenting had worsened markedly.

Disability Charities Consortium

There was a persistent problem with inaccessible communications from lockdown announcements all the way through to shielding letters e.g. shielding letters not sent in an accessible format such as braille for the blind or easy reading for those with learning disabilities.

The risks inherent in not consulting with disabled people, the failure to make modest practical steps to consult disabled people led to DHSC and NHS output being revised only after the event, often with serious adverse consequences for disabled people. GPs had sent letters to care setting implying that people with learning disabilities would not be treated if they went to hospital and advanced decisions including using DNACPR orders should be made.

Consultation – Nothing for us without us.

It is clear that there was misuse of DNACPR that affected disabled people adversely. This was not surprising. We know it happened before the pandemic. We also know that disablism conscious or otherwise remains a real phenomenon in society.

Royal College of Nursing

There should be input from non-IPC specialists, when producing future IPC guidance, including health and safety experts, aerosol scientists, occupational health, and wider professional stakeholders such as paramedics. This avoids group think, ensures that IPC guidance is workable, and provides an opportunity for specialisms to raise concerns at an early stage before guidance is finalised and published. Had it been in place during the pandemic, concerns over the applicability of such guidance could have been addressed prior to publication.

There should be funding for the development of reusable respiratory PPE.

Royal College of Anaesthetists, The Faculty of Intensive Care Medicine, and The Association of Anaesthetists

We wish to reinforce how precarious capacity in intensive care was prior to the pandemic. As early as 2018 the bed fill rate in ICUs had almost reached recommended safe limits in Scotland and was already surpassing it in England, Wales, and Northern Ireland. Efforts included shutting down other hospital services, converting non-ICU spaces into ICUs, and sourcing or repurposing essential equipment like ventilators to fill these spaces. This had significant consequences for waiting lists which continue to impact on patients to this day.

Expanding capacity also required cancellation of leave, reduced staff to patient ratios, the curtailment of normal educational opportunities, and re-deploying staff, often to act outside of their normal skill set.

While ICU capacity was increased with staffed beds rising from around 4,100 to over 6,000 in England, this came at considerable cost.

In early 2020 the short fall of anaesthetists across the UK had reached 1400. Surgical waiting lists significantly increased when anaesthetists were redeployed to bolster ICU capacity during the pandemic. This impacted other services that rely on anaesthetists, particularly maternity services where there is a constant need for their expertise. The shortfall of anaesthetists now stands at 1900. This limits the rate at which the NHS can perform operations and risks a repeat of untenable waiting list increases, were another crisis to occur.

Independent Ambulance Association

We need a national NHS protocol for engaging independent sector ambulance services.

Key worker status must be granted on the basis of an individual's role, not the name of their employer.

During the pandemic there was a chronic national shortage of portable oxygen cylinders in particular. Independent ambulance providers had to desperately scrape around to find their own sources.

The inability to source oxygen and cylinders in particular had an immediate and devastating impact, as it meant ambulances were often taken out of operation all together. At one stage 20 new and otherwise fully operational ambulances sat idle for several weeks awaiting portable oxygen cylinders.

Covid-19 Bereaved Families for Justice Cymru

The Cymru group considers the inadequacy of the Welsh Government's approach to lessons learned is compounded by its continued failure to open itself up to detailed scrutiny by the Inquiry. The Cymru Group has long highlighted concerns that the Welsh Government cherry-picked the disclosure it sends to the Inquiry.

In terms of recommendations the Welsh Government suggests that less is more. With respect given its poor track record for reflection and learning lessons to date, the Cymru group considers that for the Welsh Government less would in fact just mean less and there is clearly a need for a suite of substantive recommendations which go beyond the Welsh Government's current proposals if there to be meaningful change in Wales.

The IPC cell, though not a decision-making body became a de facto decision-making body because their recommendations were not challenged. As a consequence, the fundamentally flawed IPC guidance was simply adopted by all, including decision-makers in Wales without question. The Cymru group finds this particularly concerning given Sir Frank Atherton and the Welsh nosocomial transmission group took a completely different view on the science regarding transmission.

There is evidence that healthcare workers didn't accept the guidance intellectually because it was intellectually dishonest as to how decisions had been arrived at.

Vaughan Gething accepted in his evidence, that the Welsh Government's assurances regarding not reaching critical care capacity did not necessarily mean that all patients in Wales were escalated at the right time and received the treatment they needed. Rather than congratulate themselves for never breaching the care capacity they should consider what hospitals looked like for those patients who desperately needed care. The data does not tell the whole story, it does not show the conscious and subconscious decisions made by doctors. The diluted nursing ratios whether there was sufficient compass fit ventilators, medication, equipment, and consumables in the hospital where it was needed at the time it was needed.

Scottish Covid Bereaved

Mr Hancock suggested it was important that real world solutions be found and as such, the availability of stock was of course a factor to be taken into consideration. The charade of suggesting that the NHS as a whole, never ran out of appropriate PPE, must be measured by the circularity that the advice being tendered on what was appropriate was being influenced by the stock held.

DNACPR - Nothing heard in evidence has explained why those issues arose or comforted them that DNACPR orders were being properly considered and applied.

Despite what politicians said, the NHS was overwhelmed. The counting of beds is not a useful metric. The fact is that the most important resource, those who work for the NHS, were overwhelmed and those that remained are still suffering the psychological consequences. Beds are useless if you don't have staff to care for the people in them.

Covid-19 Bereaved Families for Justice UK

A false narrative was cynically developed by decision-makers because there were clearly periods within the NHS was overwhelmed. The NHS lacked the capacity to expand and withstand a surge in demand. The UK's overall response to Covid-19 is a story of failure. The UK, one of the wealthiest countries in the world, said to be having a world leading health system also ranks in the top 20 of countries in the world in terms of death from Covid-19 per 100,000 people.

The evidence in this module has established that many parts of the healthcare system were overwhelmed at multiple points, yet there is still the false narrative perpetuated from the very top of the government down through decision-makers and we urge the Inquiry to call this out. The so-called success that Mr Hancock and Mr Johnson talk of is disingenuous and an insult to the staff and patients.

Mr Hancock described his visit to the hospital as him doing "a night shift". With the greatest respect, he did not. Our families say putting himself in the same sentence as a healthcare workers in ICU was breathtakingly arrogant. Mr Hancock and the ICU staff he encountered were not on the same page, not in the same chapter, not in the same book. Those healthcare workers were experiencing the horrors Professor Fong so vividly described. That Mr Hancock would centre himself doing a night shift when in fact he was cosplaying, perhaps for PR purposes, was unedifying.

Mr Hancock brazenly maintained that the NHS coped.

Our families have very strong views about Mr Hancock and his evidence. They are angry, they are frustrated, they are astounded, they are tired. Tired of ministers and decision-makers who will not take responsibility. Tired of the false narrative. Tired of the disingenuous portrayal of how we as a country and specifically the NHS fared during the Covid-19 pandemic. They ask simply how could you Mr Hancock come to this Inquiry and still pedal that false narrative? How could you and your government allow healthcare workers and patients to be in those awful conditions as a direct result of the abject failure to properly and adequately plan and prepare? How could you allow so many people to endure those conditions in hospital and have no dignity, even in Death?

There was a rise in DNACPRs during the pandemic, and inappropriate use, particularly for groups such as the elderly, learning and physically disabled. The experiences of DNACPRs during the pandemic have had a lasting impact upon the trust between clinicians, patients, and their loved ones.