Module 3 Week 9

1. Robin Swann – Former Minister for Health for NI
2. Jeane Freeman OBE (Former Cabinet Secretary for Health and Sport, Scotland)
3. Humza Yousaf MSP (Former Cabinet Secretary for Health and Social Care, Scotland)
4. Vaughan Gething MS attending remotely (Former Minister for Health and Social Services, Wales)
5. Baroness Eluned Morgan MS (First Minister of Wales; former Minister for Health and Social Services)
6. Matt Hancock (Former Secretary of State for Health and Social Care, UK)

Robin Swann – Former Minister for Health for NI

The HSC was not equipped to meet the needs of the NI population at the start of 2020. Northern Ireland was in a desperate situation regarding the length of waiting lists. The worst across the United Kingdom.

The critical care ICU capacity was 88 beds. The limiting factor to be able to supply ICU beds was the availability of trained staff to manage critical care beds. I don't think I asked specifically about how critical care was going to be scaled up. On reflection I should have asked that question. I was new to the role of health minister.

I had a conversation about ratios of nursing with the Chief Nursing Officer. It was something that distressed her greatly. It wasn't something that was taken lightly. It meant the ratio of critical care nurses wasn't to the desired level.

Access to PPE was a problem at the start. Our PPE supply mechanisms across health and social care were not as robust as it could have been. I did hear concerns from healthcare workers that they didn't feel safe with the PPE that they had been given.

<u>DNACPRs</u>

I made it clear that orders based on age or disability were discriminatory and unethical. Media reports that there was a blanket approach were ill founded. I was aware of the CQC report on DNACPRs. My understanding was that it did look at NI. I can't recall being aware of the report at the time. I am not sure if the Dept carried out an investigation into concerns about DNACPRs.

Waiting Lists is a challenge that has faced health and social care in Northern Ireland for quite some time. The reason they are so long is due to the flow of patients through our entire hospital system. It's not just moving patients from the emergency departments to available beds within wards, it's also the onward movement of people back into community settings.

Jeane Freeman OBE (Former Cabinet Secretary for Health and Sport, Scotland)

Although NERVTAG had decided that CPR would not be classified as an aerosol generating procedure, we said healthcare workers and ambulance staff conducting CPR who wished to wear them, could wear FFP3 masks. Where there was such a debate, the sensible approach was to go with the professional judgment of healthcare and clinical staff on the ground. Whilst the guidance might say one thing, if their professional judgment was that they should be wearing additional PPE, then we should provide that additional PPE.

Nosocomial

I was aware of the fact that nosocomial infection in Scotland was increasing prior to the pandemic. My understanding was that it was inconsistent application of basic infection prevention and control measures in a hospital setting. The awareness that nosocomial infection occurred informed an expectation on my part that we may well see it in the context of the Covid pandemic.

PPE

Email dated 24 March 2020 to my private office regarding the use of time expired PPE. Work had to be done to be assured of its efficacy before we could then issue it.

I know that the ambulance service had concerns about getting their hands on the PPE. My job was to try and resolve that issue. If we had that stock, we needed it to get to the frontline. I accept that at times healthcare workers in Scotland treating Covid patients did not have the ease of access to PPE that I would expect them to have, and those were the issues that I set out to resolve.

Overwhelm

I think overwhelmed means your capacity to respond to those cases that come to you as a result of the virus. The pausing of screening programmes is the most difficult decision I made. I would not agree pausing screening means the system was overwhelmed.

I was aware that the number of people who were in Hospital exceeded capacity on several occasions with hospitals having to adapt to effectively provide care. I would have a concern that it would have consequences for the quality of care. It's not simply about the number of beds you have, it's also about the staffing levels you have. One of the consequences of for example pausing elective work is that you free up staff.

I was aware of changes to staffing ratios by using one trained ICU nurse to supervise non-ICU trained nurses to maintain the ratios. I had no specific discussions about the rationing of healthcare. Where decisions are made in a hospital setting about the care that a patient should receive, those are clinical decisions.

DNACPR

Concerns about DNACPRS came to me via media reports and questions from colleagues in Parliament. My understanding was that there was a perception that there was a blanket approach being adopted for particular groups of the population, to require a DNACPR to be imposed. That of course is utterly contrary to the principles and thinking behind those advanced care discussions. I knew that there was no blanket instruction emerging from Scottish Government and I wanted to ensure that we looked in detail at the

concerns. I approved a letter from the CMO Scotland to GPs and chief executives of NHS boards and that was issued on 10 April 2020, and that clarified that there was no specific requirement to have a DNACPR discussion as part of anticipatory care planning.

The letter didn't expressly say that there shouldn't be blanket use of DNACPRs. I think it said it in as much as it made crystal clear that DNACPR discussions are individualised to each patient. It is for the CMO to decide what balance he wants to strike between making it clear what those discussions are, and by implication it's not a blanket, or saying expressly it's not a blanket. I do think we covered it in media briefings. So, on the one hand it is for the CMO but on the other she approved the letter. She could have easily said she thought the letter needed to spell it out if that is really what they wanted clinicians to understand.

Humza Yousaf MSP (Former Cabinet Secretary for Health and Social Care, Scotland)

There's no doubt that there could have been greater level of data around staffing ratios but if we had required that, it could have also been quite intensive on individual staffing teams. It would be quite onerous at a time where we couldn't afford to place an additional burden on staff.

We were having significant capacity issues within our hospitals and therefore we were told with regularity that the staffing ratios were far more than they should be, there's not enough staff to patients as there should be.

I believe the measures we took in Scotland were effective in avoiding the NHS being Overwhelmed. I accept that somebody who had been waiting years for a hip replacement might well feel the NHS is being overwhelmed but I stand by that statement. At a time of extreme pressure, the NHS was able to focus and deliver an adequate level of emergency care. Now that doesn't mean that there wasn't an impact. There clearly was, particularly on elective care.

The concerns about DNACPRs are part of one of the reasons we set up a devolved inquiry and one of the terms of reference of that Scottish public inquiry is to look at the DNACPR and that's probably the right forum as opposed to the government doing a review of its own health boards.

Vaughan Gething MS attending remotely (Former Minister for Health and Social Services, Wales)

I was always concerned to make sure the NHS didn't get overwhelmed and that meant that we had to turn off parts of the NHS. None of that is comfortable or harm free but much greater harm would have been what we saw in northern Italy.

If the NHS had been overwhelmed, you would have seen large numbers of people not being able to get appropriate care including care that could save their lives. That was the nightmare scenario. It was not overwhelmed but that's only because we took extraordinary measures. If we try to run the system as normal, then it would have been overwhelmed. That's why we had to cut off parts of the service to allow the service to still function.

Pre-pandemic occupancy was regularly around 100% So it did leave us with greater vulnerability than if we were in a better position.

The statement that we didn't breach capacity is true, but it comes at a cost because we had to turn off other parts of the service. I can't honestly tell you whether patients were getting less than optimal care because I haven't looked at outcomes but there is a risk. That's why there are ratios in place, to make sure you can give assurance about the quality of care provided.

I did know that heartbreaking choices were being made because I knew that was inevitable and unavoidable but not specifically.

PPE

I understood FFP3 offered more protection than FRSM.

We had a pandemic reserve that was part of a UK arrangement, and we thought we had six months' supply, but we went through that a great deal faster than six months. By the end of March, early April we were burning through our stocks. At a national level we never ran out of PPE, but we had some very real challenges in distribution.

With testing and with PPE there were frankly an awful lot of shysters who were trying to make money out of inadequate equipment. The whole world wanted more, and some people saw that as an unscrupulous business opportunity, including inadequate equipment.

I'm afraid it's possible that at times in wave one, healthcare workers in Wales, treated Covid-19 patients with inadequate PPE at potential risk to their own health.

DNACPRs

I was aware of concerns. The older person's commissioner raised general concerns about DNACPRs. She didn't give me any specific examples, but we did have an instance where a practice had written to people suggesting DNACPRs and that just wasn't appropriate or in line with policy. It was never appropriate to have a blanket policy. So, we re-issued and reiterated that guidance on several occasions. Doesn't the fact that they had to do it more than once demonstrate that it was not adequate in meeting its aims?

Baroness Eluned Morgan MS (First Minister of Wales; former Minister for Health and Social Services)

There are different ways of describing what being overwhelmed means. Did we have enough beds? We never ran out of beds but were the people working in the NHS overwhelmed?

Nosocomial Infections

Every single individual case was investigated. 18,630-odd so every I think ours was probably more detailed in terms of why things were happening and trying to make sure that we learnt the lessons. It's really difficult to get to what exactly is the cause because there are potentially lots of causes. It would be difficult to say a precise cause. So, what was the point of the individual investigations?

We had a follow-up report to find out why they hadn't implemented the recommendation of the first wave. That is something that probably needs to be explained by the health boards. But it was her role to hold them accountable?

DNACPR

We had a very clear policy on this, so if that was happening, they were not following the guidance. We had had a report by Health Inspectorate Wales who had done a sample review, and they didn't raise any issues. I would have to check if that review took place during the pandemic.

Ambulance Service

There were persistent issues with excessive ambulance response times throughout 2021 and 2022 and those problems were exacerbated by staff shortages due to high absence rates and lengthy handover delays at hospital. The national target for immediately life-threatening red calls had not been achieved since July of 2020. Unfortunately, ambulance performance continued to decline into October of 2021

Matt Hancock (Former Secretary of State for Health and Social Care, UK)

It was obviously extremely difficult to keep healthcare workers as safe as possible because effectively the wards of the NHS became the frontline in this deadly battle. I, and the team did everything we could but of course every decision was not perfect. Of course it wasn't.

Visiting Restrictions

We were balancing incredibly difficult considerations on both sides. I think on balance we got those broadly right across the pandemic, but I entirely understand the very strong arguments on both sides. On the one hand protecting lives and on the other hand the deep emotional considerations that were important. Where I think we got it wrong for instance was the way the funeral guidance was applied on the ground.

ICU

NHS Overwhelm would mean that people wouldn't be able to get any treatment at all in hospitals. That there would be the inability to give the basic level of care that people needed. Of course, every part of the NHS was under pressure, and some individual parts found that pressure overwhelming, but the system as a hold withstood the pressures, thanks to enormous efforts from literally millions of people. Budget constraints were rarely the problem, it was resource constraints more broadly.

Asymptomatic Transmission

The advice was that it could not be considered a material factor. That only changed in April 2020. My failure was my inability to override that consensus but that was a global clinical consensus. Whilst the formal advice was that asymptomatic transmission wasn't the most likely and therefore shouldn't be

considered as the basis for policy decisions, we effectively overrode that and put in place PPE requirements that took into account the possibility of asymptomatic transmissions.

WHO were saying there'd been no documented asymptomatic transmission but by its nature it's very hard to document because it's asymptomatic. But that wasn't evidence that there was no asymptomatic transmission. It was deeply frustrating. They were trying to prove a negative, saying because there's no documented evidence - they can't say that it's happening.

The advice was don't assume asymptomatic transmission until we know it's happening. I agree we should assume it is happening until we know that it's not happening. The precautionary principle should be adopted which we did on things like the guidelines around use of PPE within Hospitals. That would be the safer assumption in future.

Overwhelm

There's no formal definition of overwhelm, but the best approximation you could have and what I held in my mind was what happened in Lombardi in Feb 2020. What it does not mean is that the availability of things was not stretched, and in some cases deeply stretched. The system as a whole though withstood the challenges.

Ratios

It was me who suggested to Sir Simon Stevens the then chief executive of NHS England that ratios be stretched. I think the ratio of 1:6 was an NHS decision. appreciate in the context of intensive care stretching to ratios of 1:6 would mean providing a very different level of care to patients. I had to rely on my clinical advisers and the NHS England advice.

The stretching of ratios does not establish Overwhelm because people could get treatment. The treatment was not as good as normal in the same way that the waiting times for a knee operation was not as good as pre-pandemic. But that is not the measure. I'm not saying that the NHS was perfect in the pandemic. And I'm not saying that it wasn't pressured in many areas and that that pressure had consequences. The point of saying that it wasn't overwhelmed is that the system as a whole withstood the pressure. It was also important to say during the pandemic because we had to reassure people that the NHS remained there for them.

ICU Capacity

At no stage was I advised that intensive care capacity was exceeded. I understand there may have been some individual hospitals where intensive care capacity was exceeded, and patients needed to be transported elsewhere but there was capacity in the system as a whole.

What we successfully avoided, was an overall ration to say people according to these characteristics aren't going to be cared for. That's what would have happened if we had let the virus get more out of control. And we managed to avoid that both in the first and the second phase. Did people get as good care as they would have done in normal times? Of course not. There was a pandemic.

PPE

I have said that there was no national shortage of PPE. That is true. It is verified by all the paperwork. But that doesn't mean that there weren't shortages in individual places where the logistics couldn't get it to people. My responsibility was for the system as a whole and then to try to relieve the individual pressures as much as possible.

Clinical Prioritisation Tool / Escalation Tool

My view was that these decisions must not be taken by ministers. They are best taken as close to the patient as possible with as much information about that individual patient and that doctors make these sorts of decisions all the time.

I immediately went to see Chris Whitty who I knew was sceptical of such a tool, so I was surprised to see that it had been commissioned by the CMOs. He agreed with me that it wasn't necessary. I felt strongly that if we tried to write a national tool, its local interpretation might end up being too legalistic or box ticking.

I think it would have been a mistake to bring this in and I think in a future pandemic it would be important not to constrain decision-makers in this way. We train doctors to an incredibly high standard, including to be able to make decisions like this.

Ambulances

You can't see the hospital in isolation. It's one system from the call handling, whether it's 999, 111 through to A&E, through to the admitted element part of the hospital, through to discharge and social care, it's one system. And if you've got a blockage in one part of the system it bungs up every other part of the system so you can't look at this in isolation from the challenges of discharge into social care, which is why we had discharge from hospital into social care. When the ambulances turned up at A&E, we had to make sure that people could get off the ambulance into A&E and the only way to make enough space there was to make sure people get from the A&E department into the hospital properly.

DNACPR

Any DNR notice without appropriate consent is wrong and potentially illegal. I heard these concerns directly from families, and I heard them through a number of different routes. It's appalling and totally unacceptable. The steps I took was to make clear publicly as soon as I heard about it that this was completely unacceptable. And we reiterated and made clearer as far as I can remember the guidance around it.

PPE

I do accept that at times healthcare workers treated Covid-19 patients with inadequate PPE, thereby putting themselves at potential risk. It is obvious that FFP3 masks were more protective than FRSM blue masks.

You have to consider the reasonable worst-case scenario and act on that basis where you can. The central balancing that had to be done with respect to PPE was supply, set against precautionary healthcare considerations. That's what those drawing up the IPC recommendations had to balance what was

realistically available to buy, with what was needed to save the most lives. I left that balance to them to make. I regarded it as a clinical decision taking into account available stock. That isn't something I would have interfered with.

In a pandemic availability of stock has to be taken into account. On the IPC guidance itself, of course you have to consider what is feasible, because this isn't some academic exercise, it's about saving lives. I accepted the guidance as a piece of clinical guidance with which I wouldn't quibble.

My point about supply is you have to live in the real world once you're fighting a pandemic. Of course, people who were drafting the guidance would have been aware of it. The balance here is the practical reality is that there is only a certain amount of PPE, and you have to use it as effectively as you can.

The failure to recommend masks to the general public until later was a consequence of asymptomatic transmission being ruled out in the official advice. But it was adopted within our hospitals demonstrating that there was an element of precautionary principle there.

On the whole we did not run out of PPE but at individual locations we did. We came extremely close. We came when you know small numbers of items on a regular basis during April and May 2020. In some places they did run out and that was awful. And my job was to ensure that that happened as little as possible and nationally we never ran out of it.

We faced cultural problems tackling nosocomial infection in the NHS. Somebody might say, we're not going to test because what's that going to do to our shift patterns if people have to go home is an example of in my view a cultural problem with the NHS that it simply does not do enough to tackle nosocomial infection. And I'd been worried about that from before the pandemic and that is something that I raised from January 2020 onwards but again the responsibility for dealing with that lies with the NHS.

Shielding

I don't think that hospital-acquired infections undermined shielding at all.

I don't recall being involved in any discussions about the specific measures that might address the heightened risk that clinically vulnerable people faced when going to healthcare appointments.